

Collaborative Project with Acute Frailty,
WMAS and Community ACP/CPs
Over 80's

Avoiding conveyance
&
Virtual wards

Why Frailty?

Impact on Elective and Emergency Flow

Age group	Proportion of beds occupied in SWFT	Proportion not meeting CtR within the age group
<18	1%	0%
18-74	42%	21%
>75	57%	34%

Getting frailty right – best patient experience AND will release inpatient capacity

Why Ambulance Service?

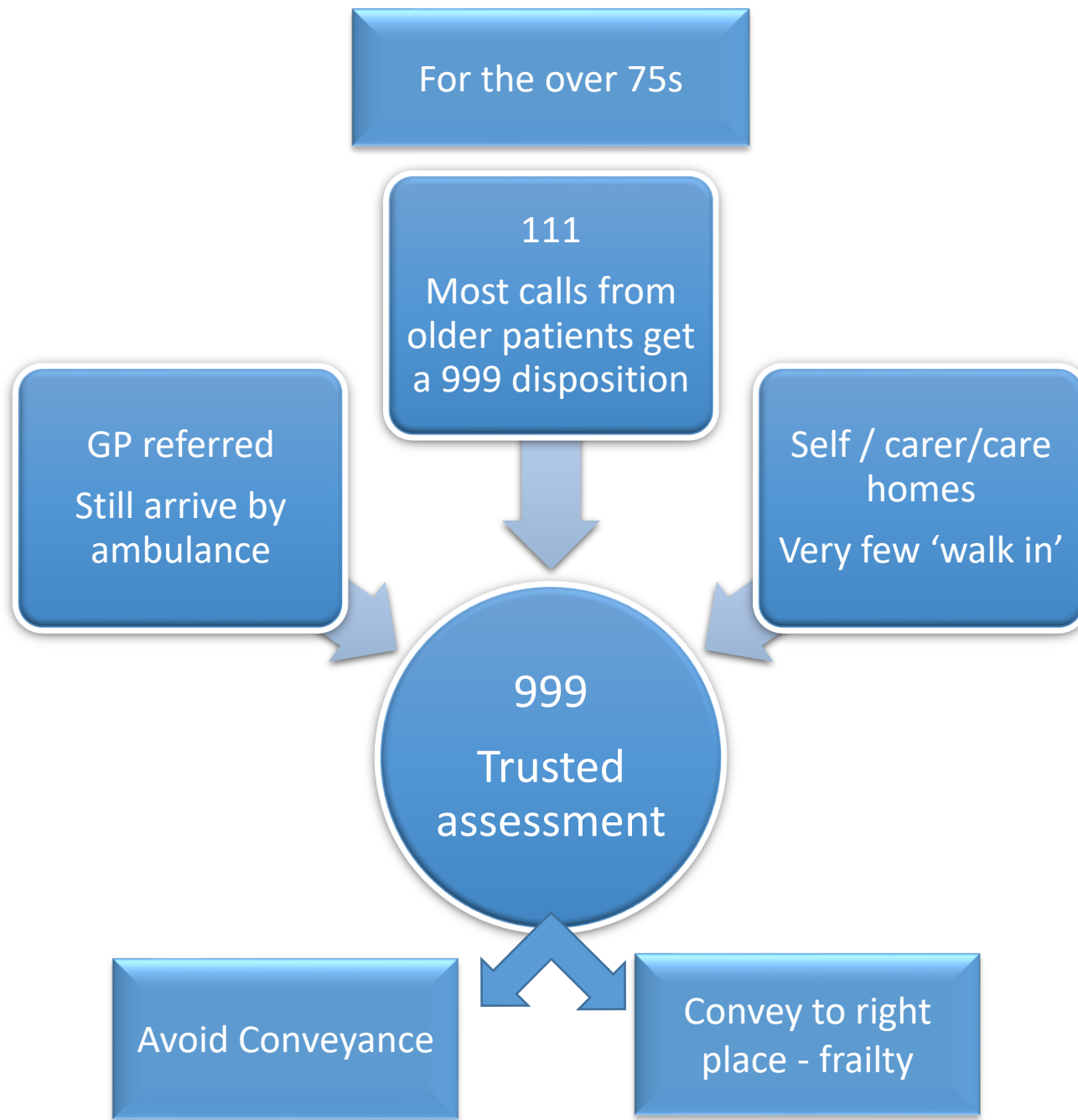
Most older patients come to the hospital via ambulance however they are referred

Frailty is a significant part of WMAS workload

Over 70s's make up 50% of all calls in WMAS

Average 59 minutes spent per frail older patients

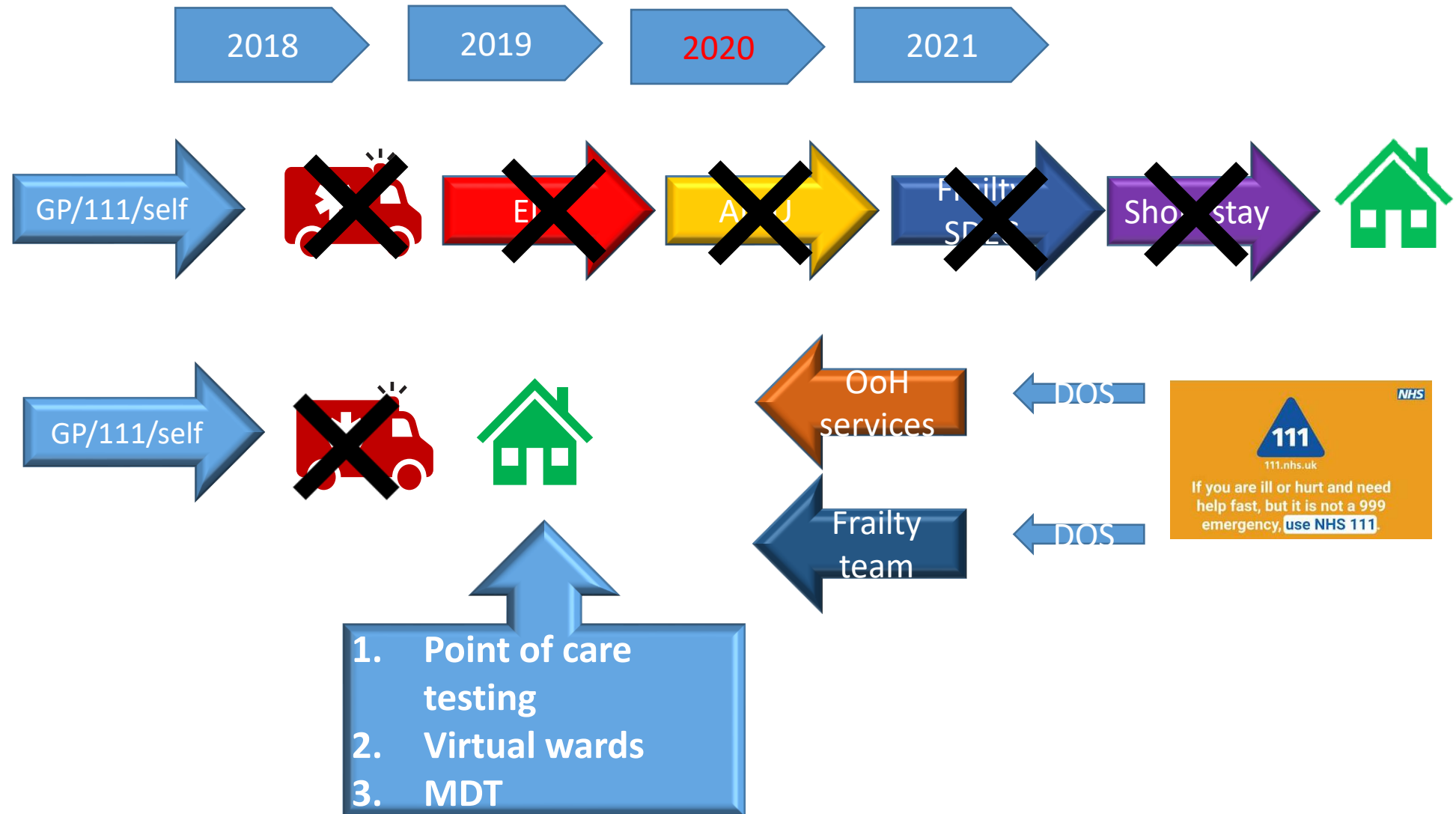
60% see and convey and 40% see and treat



Advantages of paramedic assessments

- Trained to identify very sick
- Comprehensive assessments
- EPR accessible to all
- Can be confident patient is stable therefore alternative places for conveyances

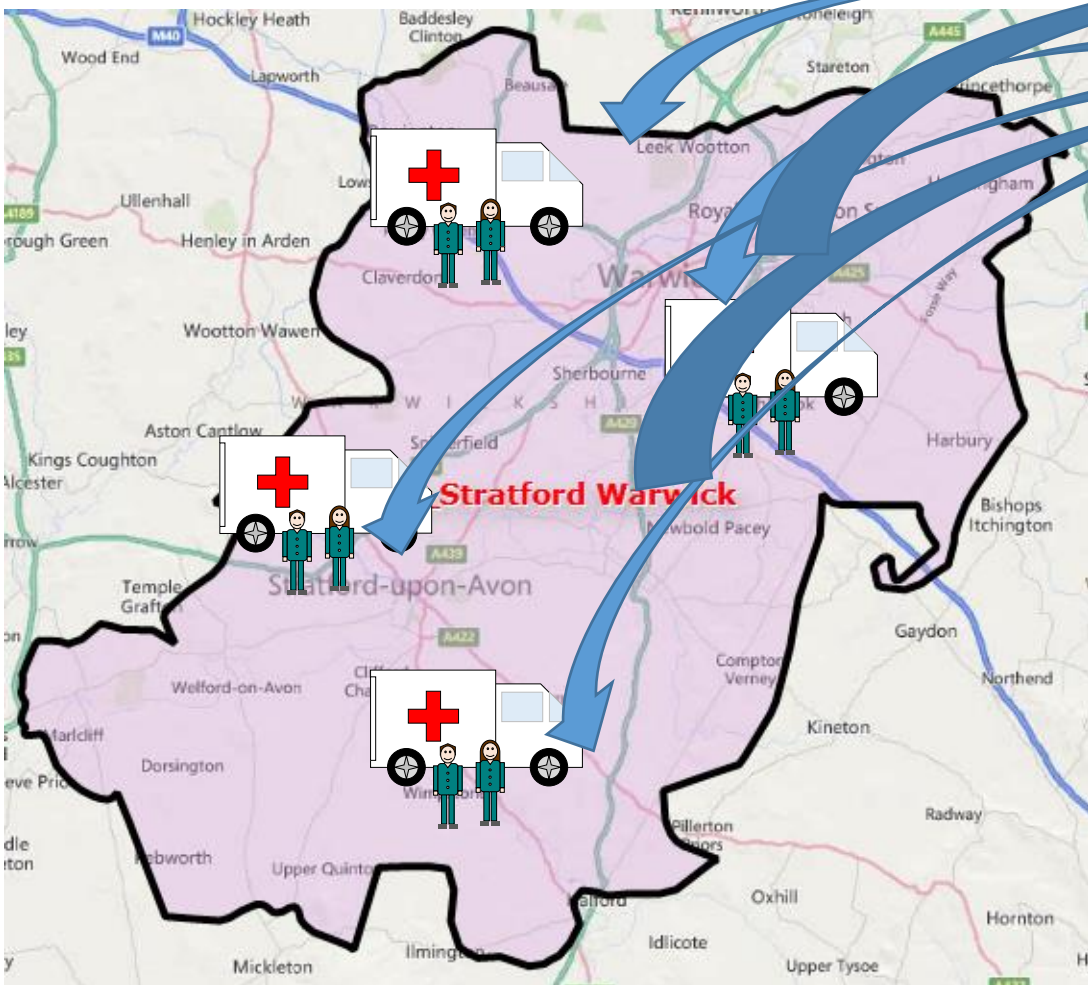
SWFT – Frailty Journey



Key interventions

- Over 80's with a South Warwickshire postcode
- Once the crew assessed the patient on site, and excluded patients who needed blue lighting, we requested the strategic cell /crew to contact us **BEFORE** patient is put in the ambulance
- Invested in a dedicated SENIOR clinician to take the calls – This ensured that decision making was of high quality and the response was timely.
- The clinical discussion determined whether they could be left at home with enhanced care or conveyed and if conveyed, to the right place first time i.e. frailty unit bypassing ED and Acute Medicine.
- We also tried to get to the job BEFORE the crew and successfully stand down some call outs
- Enhanced care at home was provided by the acute and community ACP/CP resource and patients managed on virtual ward

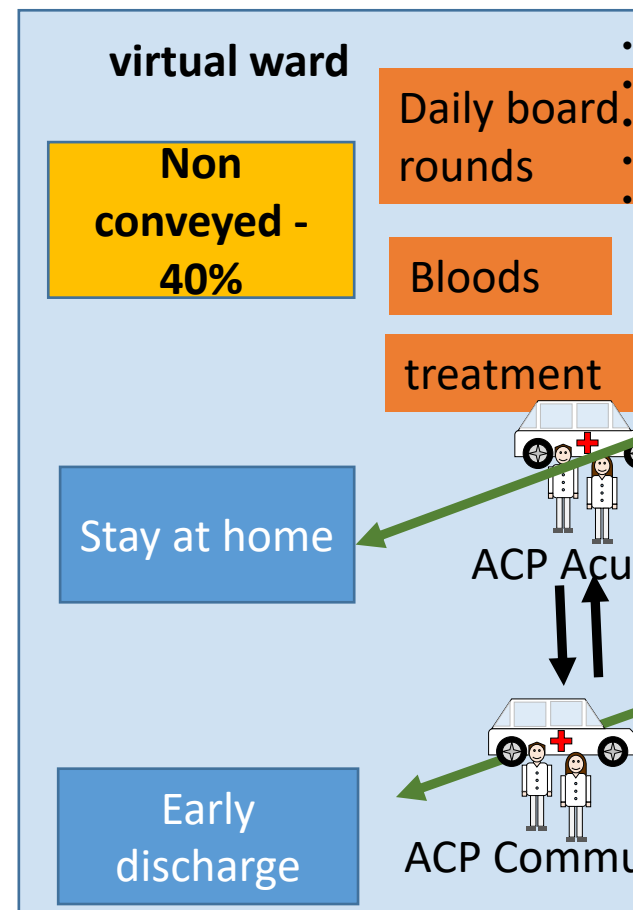




100% conveyed – 60%

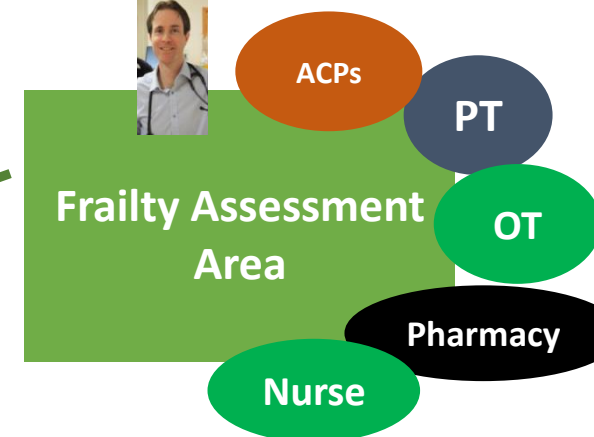
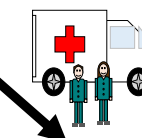


List of non conveyed



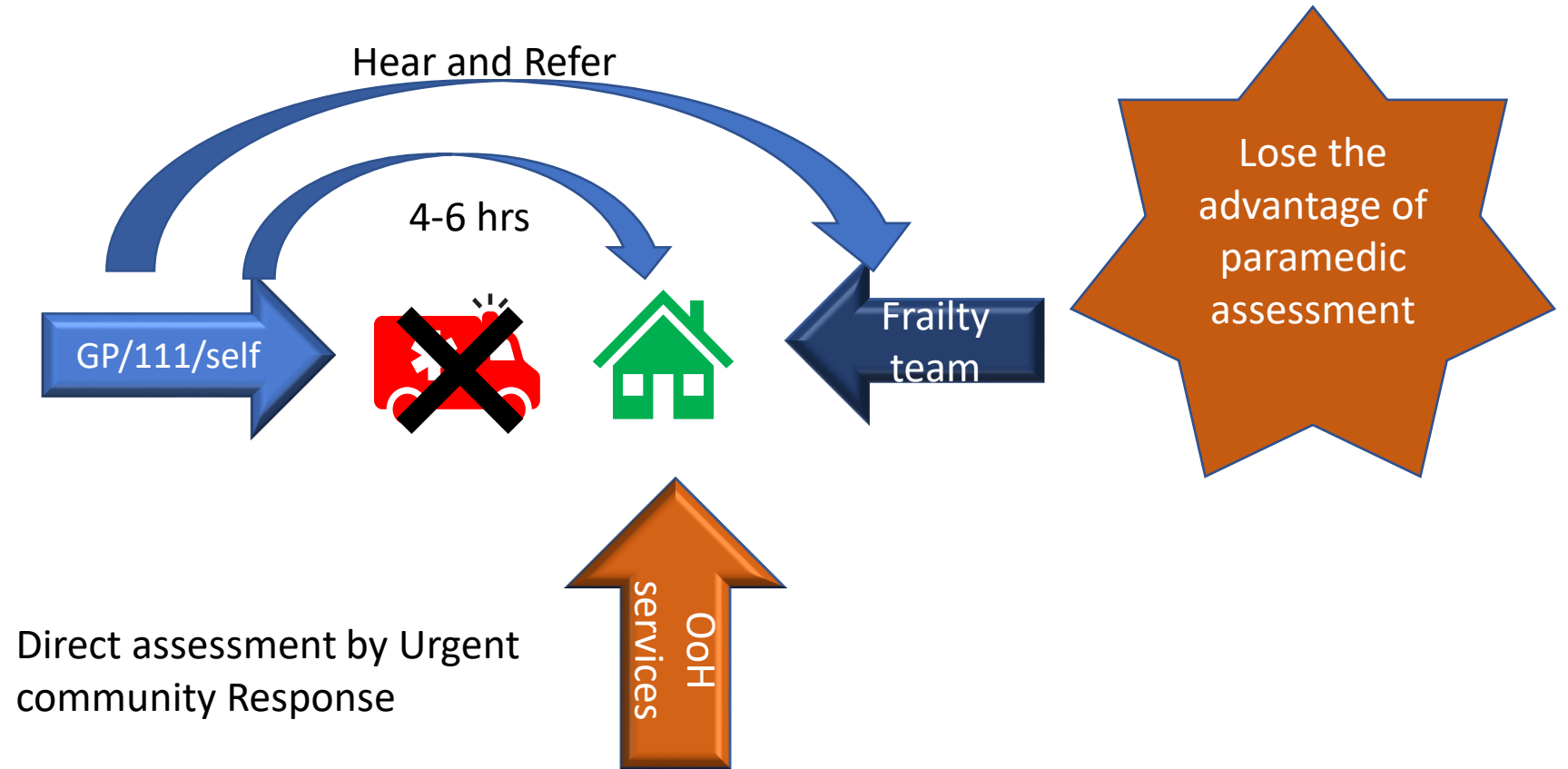
- Frailty
- Community heart failure
- Resp – COPD
- Diabetes
- Palliative care

Clinical discussion



PDSA 8

PDSA 8b
Community
ACP access
BEFORE
ambulance
crew



What did we achieve?

- WMAS calls increased by nearly 500%
- In the over 80's where a clinical discussion took place, 48% of the conveyances were avoided
- A step change drop in the proportion of conveyances of over 80s
- Only 25% of over 80's conveyed directly to ED (impact on ambulance handovers and queueing in ED)
- A reduction in LoS of over 80s
- Virtual ward set up and running (Multidisciplinary and Multispecialty)
- Demonstrated it is safe to manage patients at home
- Proved the concept that we can get to the job BEFORE the ambulance crew and stand down the crew releasing WMAS capacity to other higher priority calls



safe, effective, compassionate, trusted

Some Thoughts...

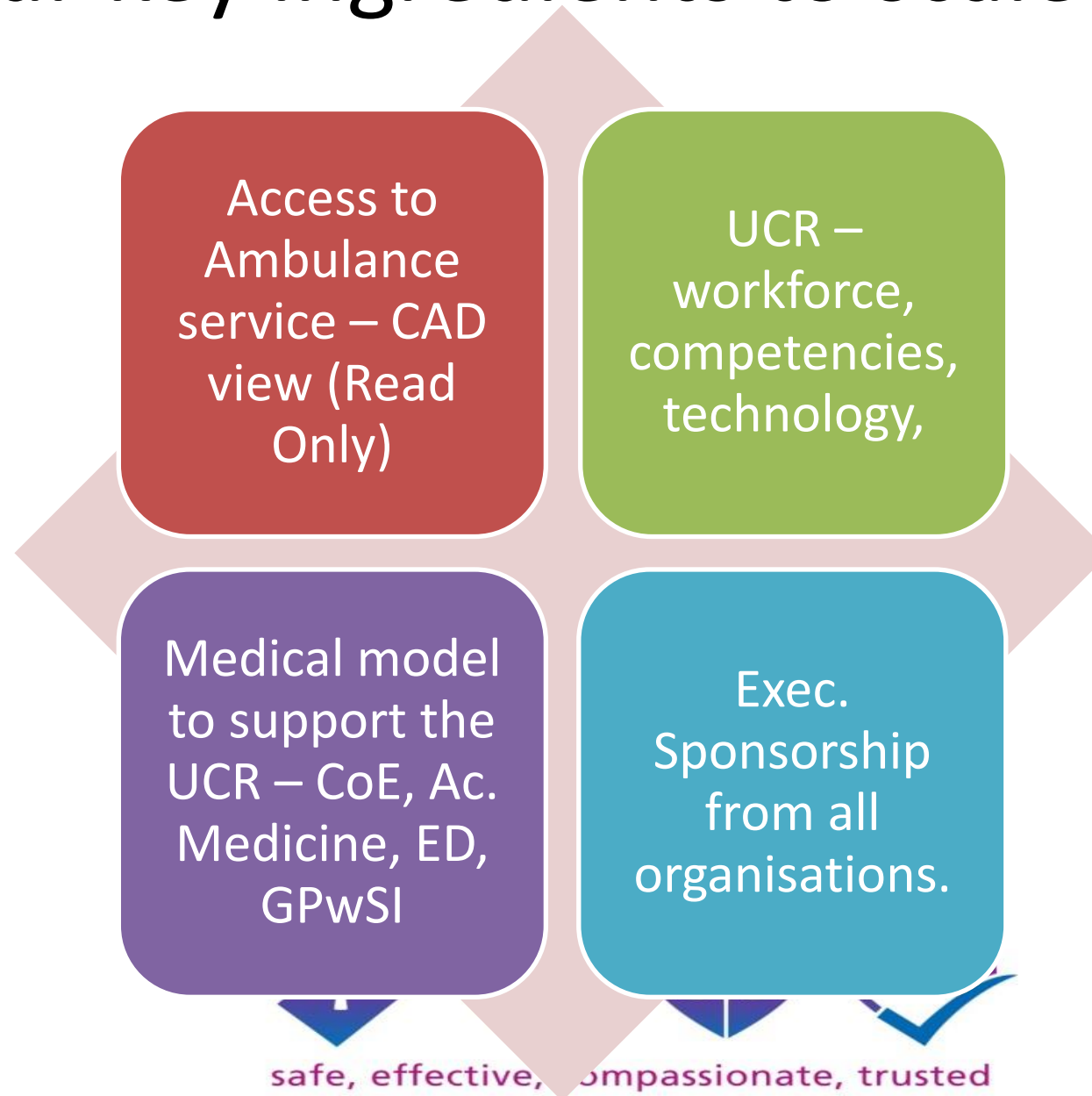
These calls should have come directly to UCR/Frailty/Primary care

Profile of patients managed at home similar to profile of patients managed in hospital

What forces an admission is lack of some one at home in between care packages – same for earlier discharges

Role of Primary Care

The four key ingredients to scale up



Why Scale up...

All systems have to implement Urgent Community Response by 31st March 2022

Right time to **Right Size** the community services and adequately resource them with

- Work force with competencies
- Technology for communication and monitoring patients at home
- Accessibility and responsiveness near 24/7 and 7/7
- Right medical model to support virtual wards.

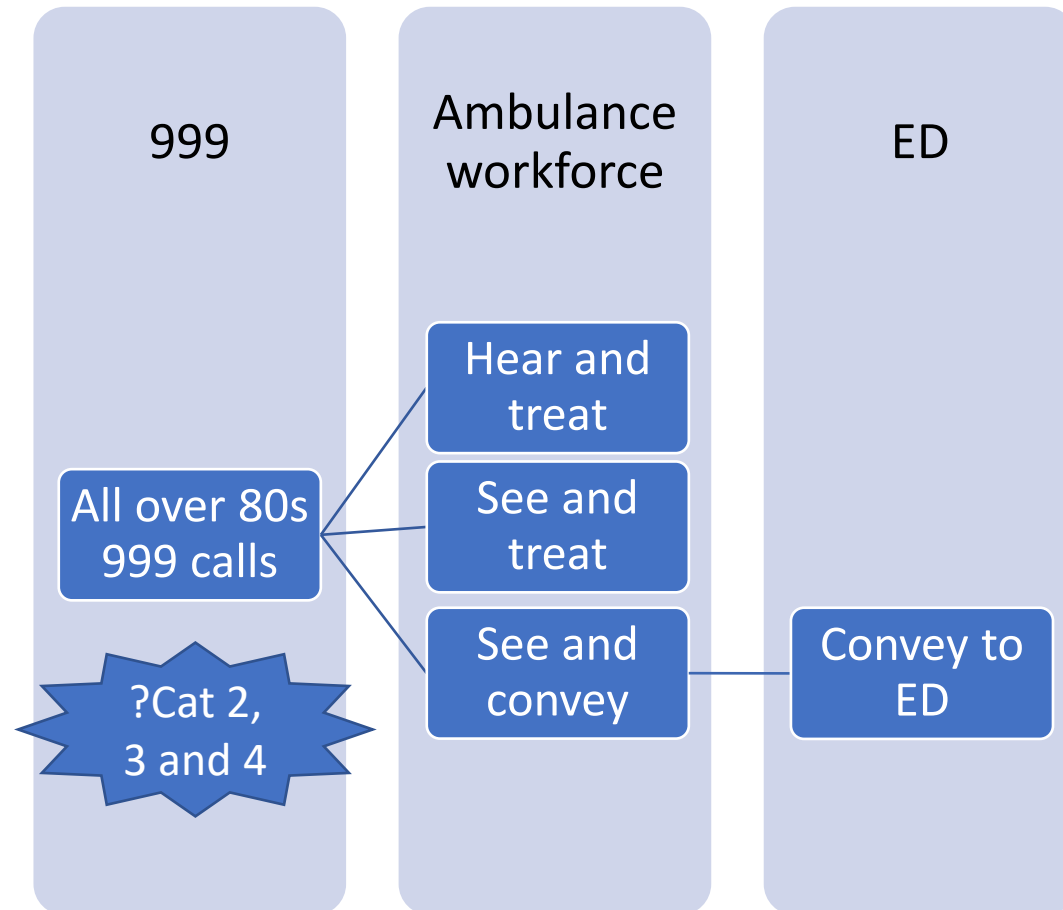
Scaling up...

WMAS, EMAS/Acute frailty Collaborative – West Midlands – Regional UEC programme

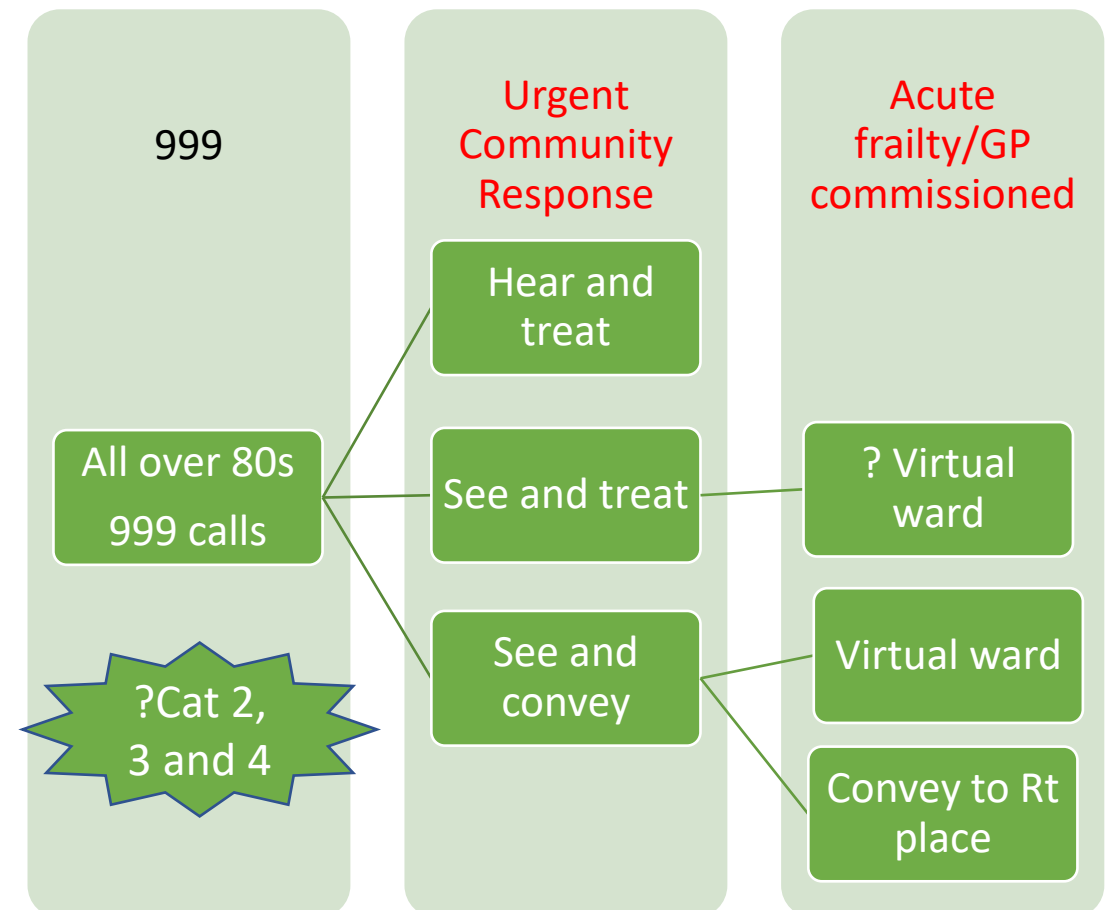
- 8 systems – 4 from EMAS and 4 from WMAS
- Starting Mid October for 6 months
- Run by NHS Elect – supported by ECIST
- Systems can choose the model – Start at any point and build up over a period of time

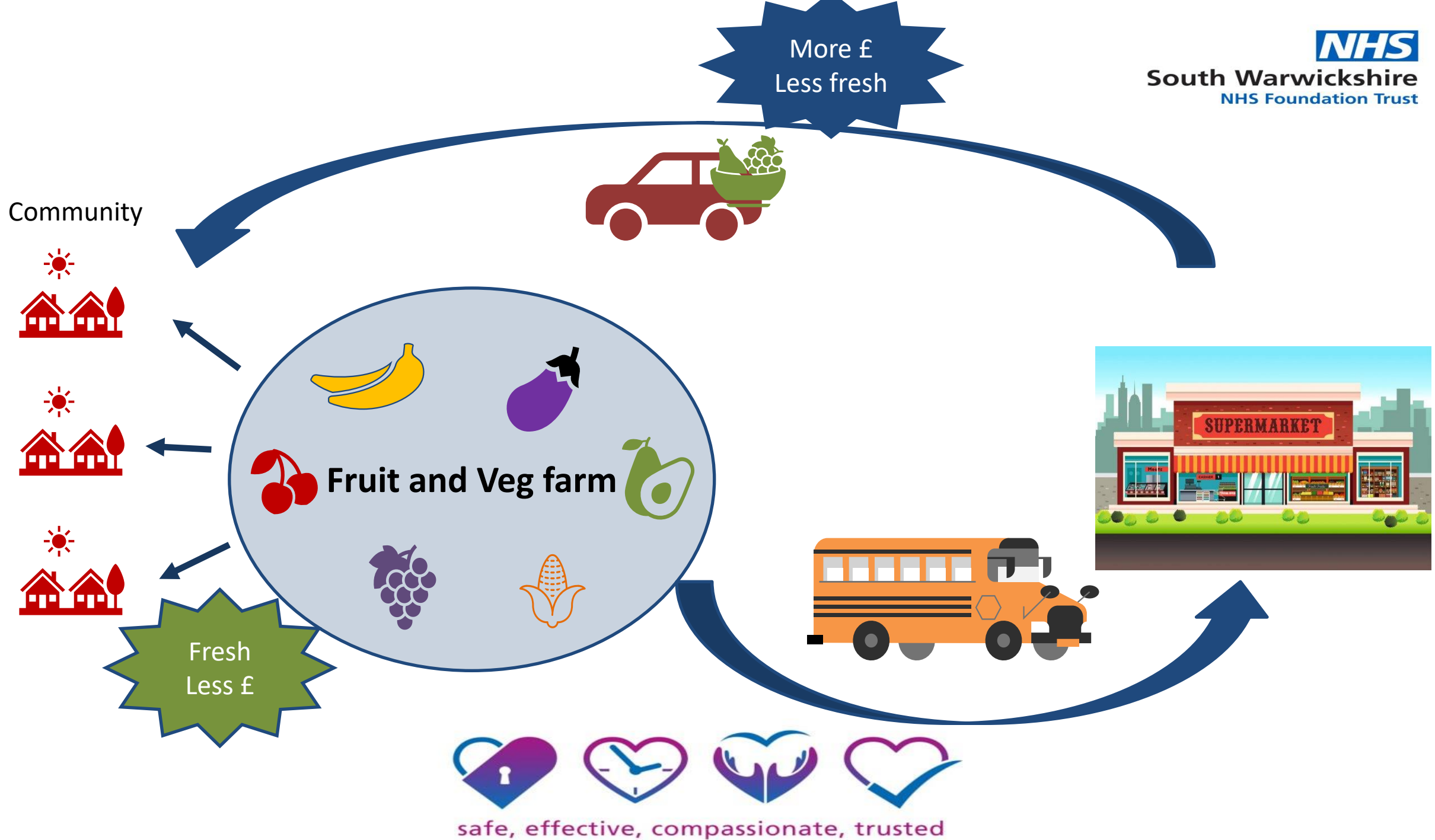


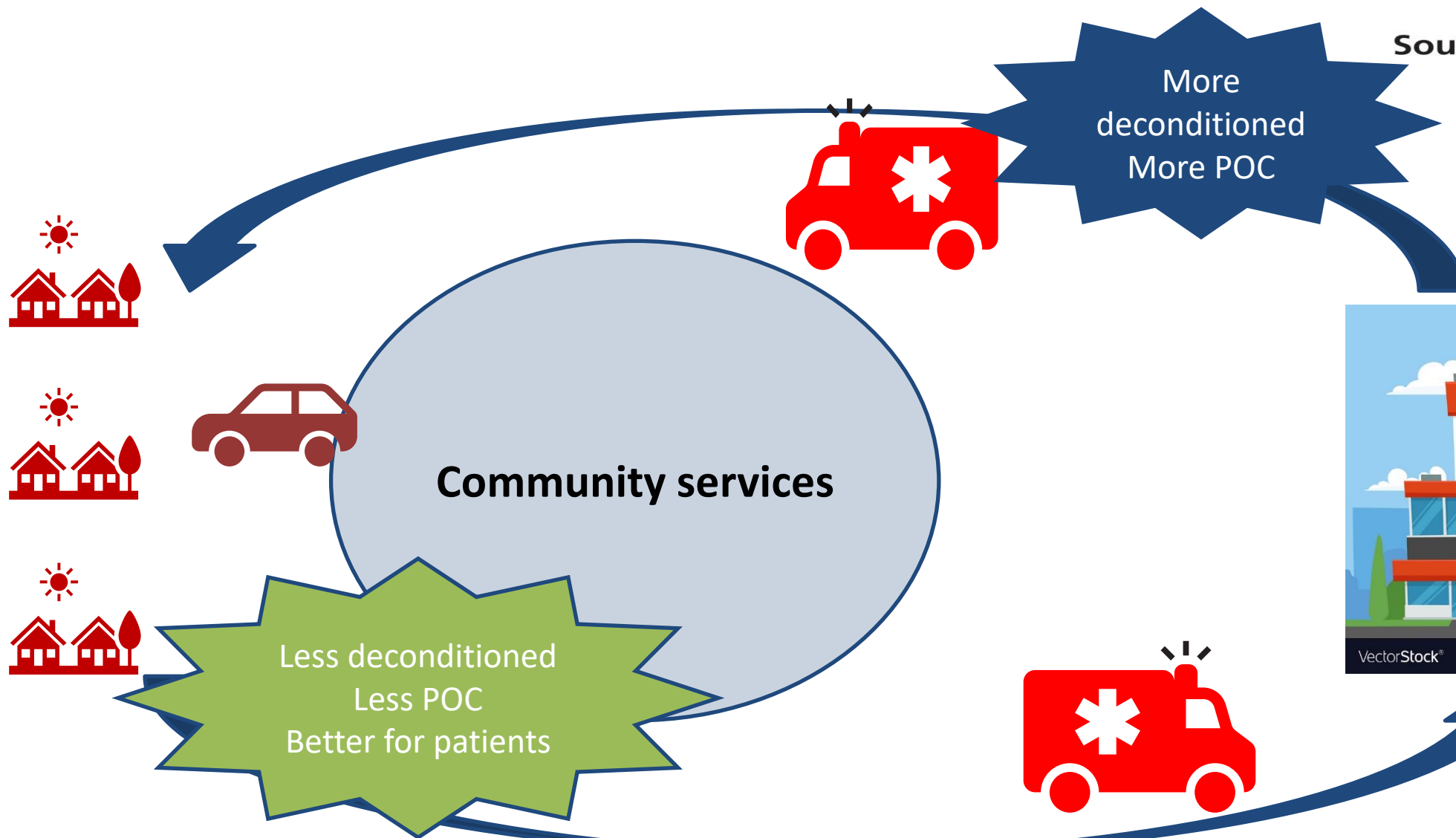
Current process



Intended process





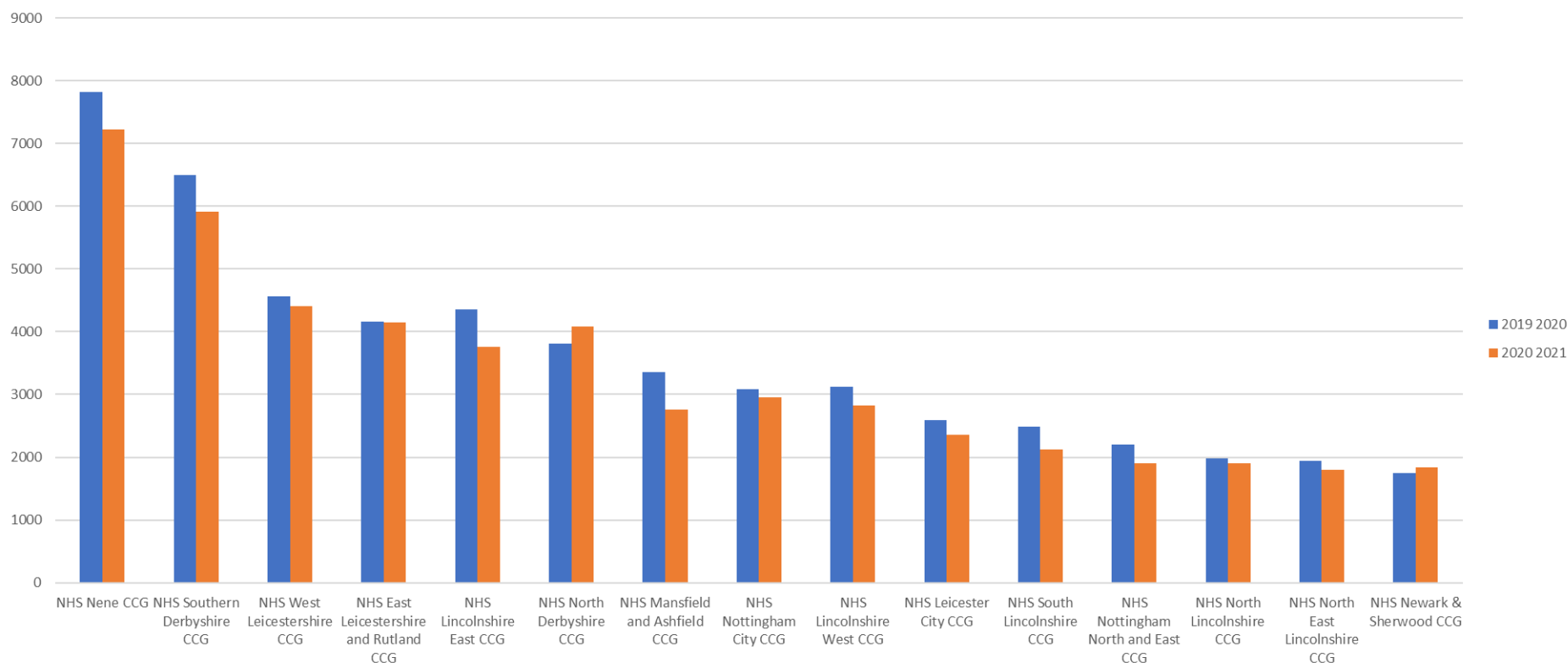


safe, effective, compassionate, trusted

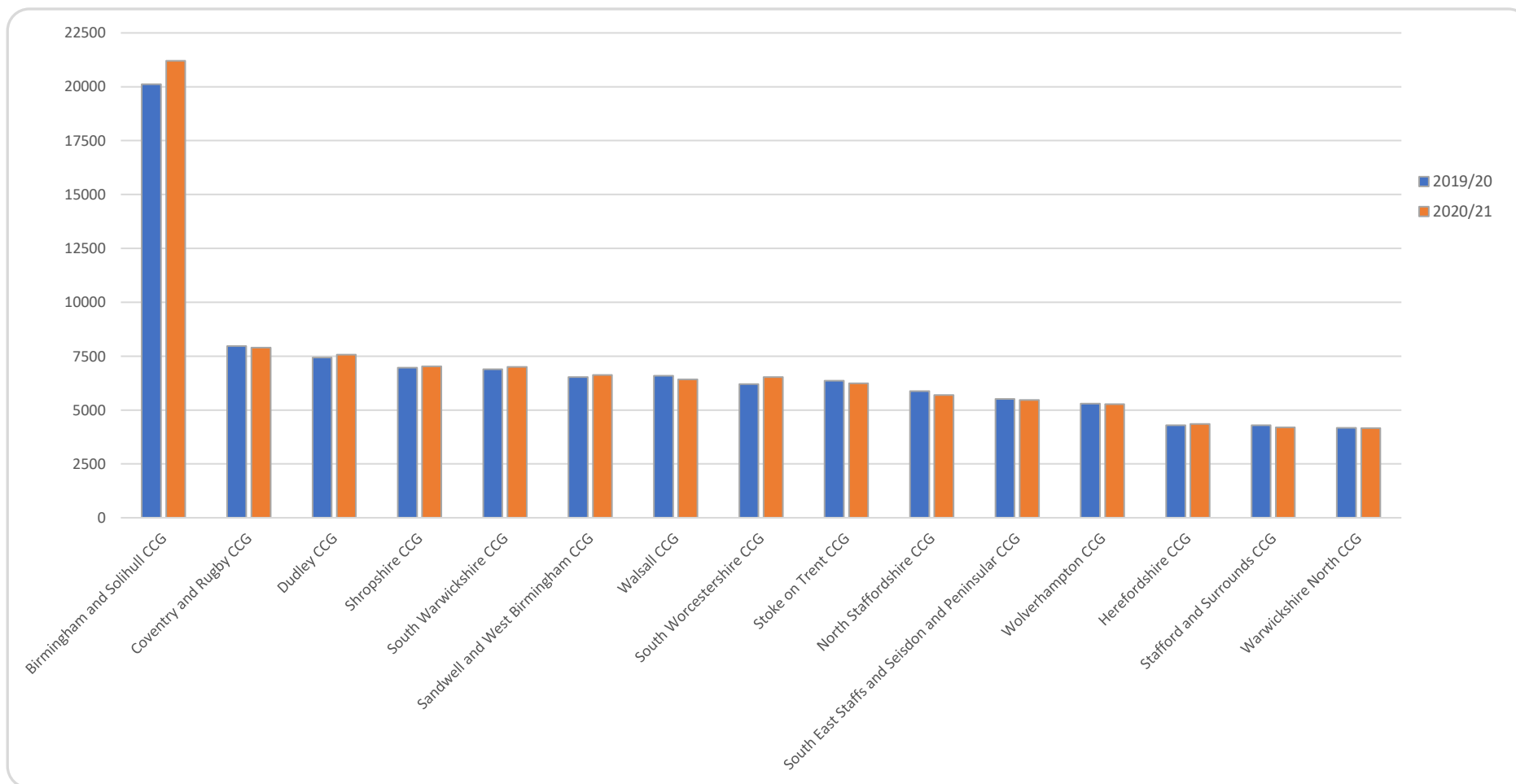
What is the size of the workload transferred to UCR? (EMAS data)

Over 80s C3/C4	160210	9%
Over 70s C3/C4	243567	13%
All calls over 80s	510373	28%
All calls over 70s	821279	45%
EMAS TOTAL Incidents:	1839983	100%

EAST MIDLANDS Top 15 CCG locations by call volume C3 and C4 call categories (all origins, all outcomes) Ages 80 and over – full year data 19/20 and 20/21

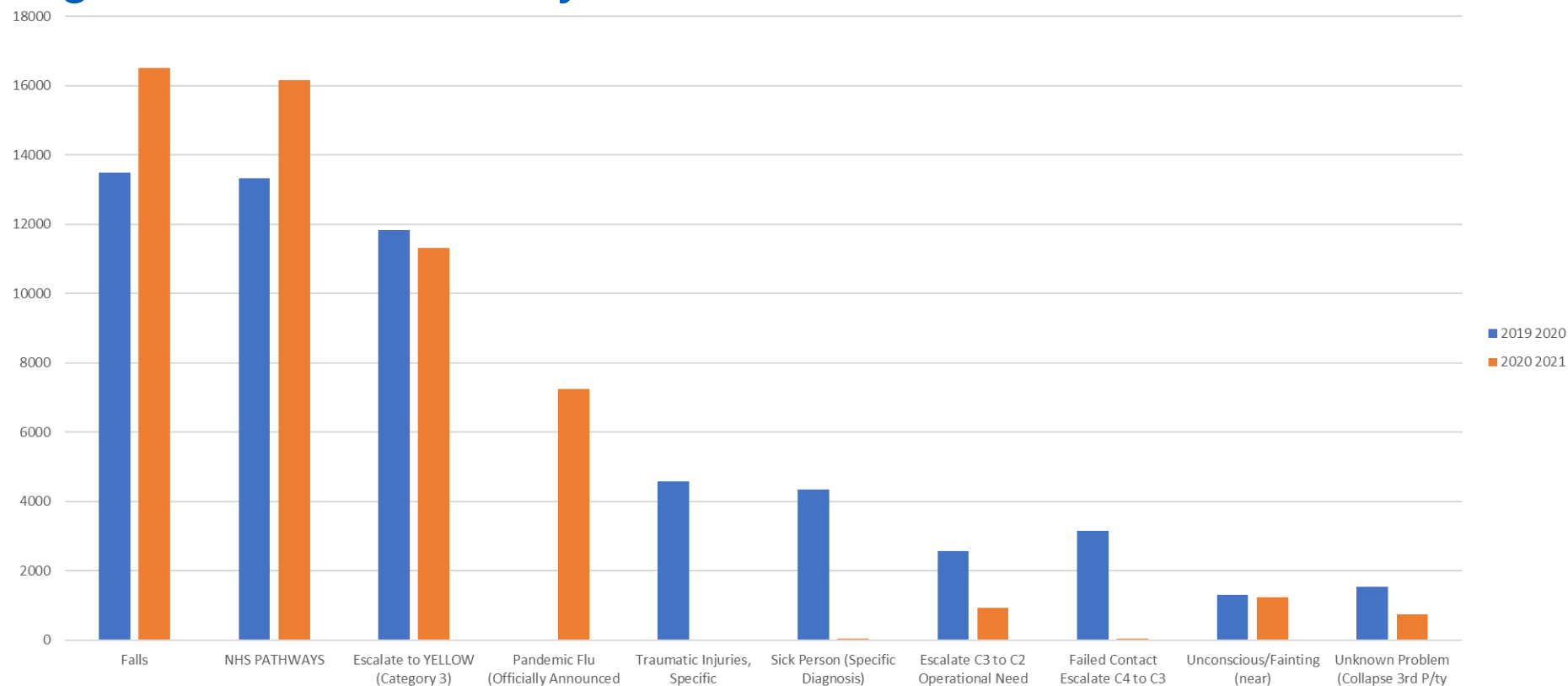


WEST MIDLANDS Top 15 CCG locations by **call volume** **C3 and C4** call categories (all origins, all outcomes) Ages 80 and over – full year data 19/20 and 20/21



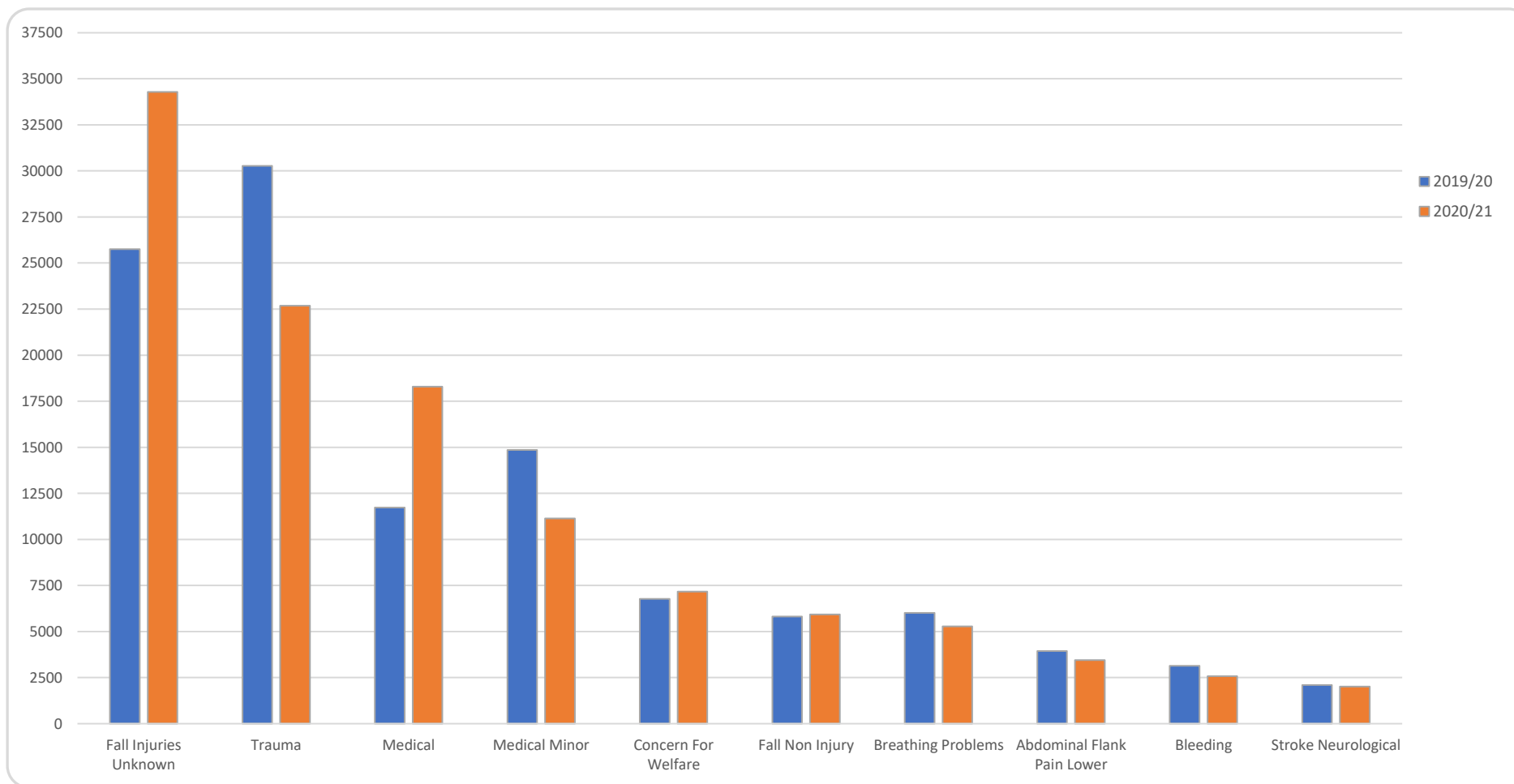
EAST MIDLANDS Top 10 Chief Complaints

C3 and C4 calls, all call origins, all outcomes
Ages 80 and over, full year data 19/20 and 20/21



WEST MIDLANDS Top 10 Chief Complaints

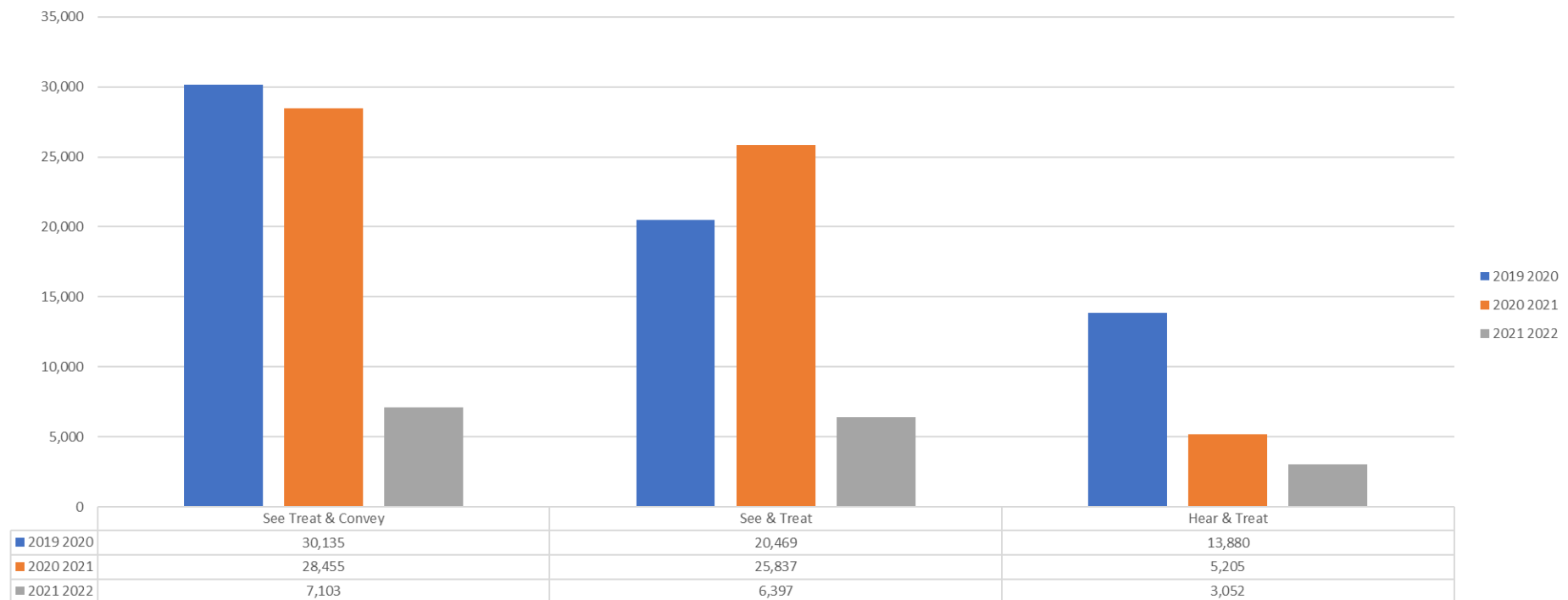
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EAST MIDLANDS Call Outcomes

C3 and C4 calls, all call origins

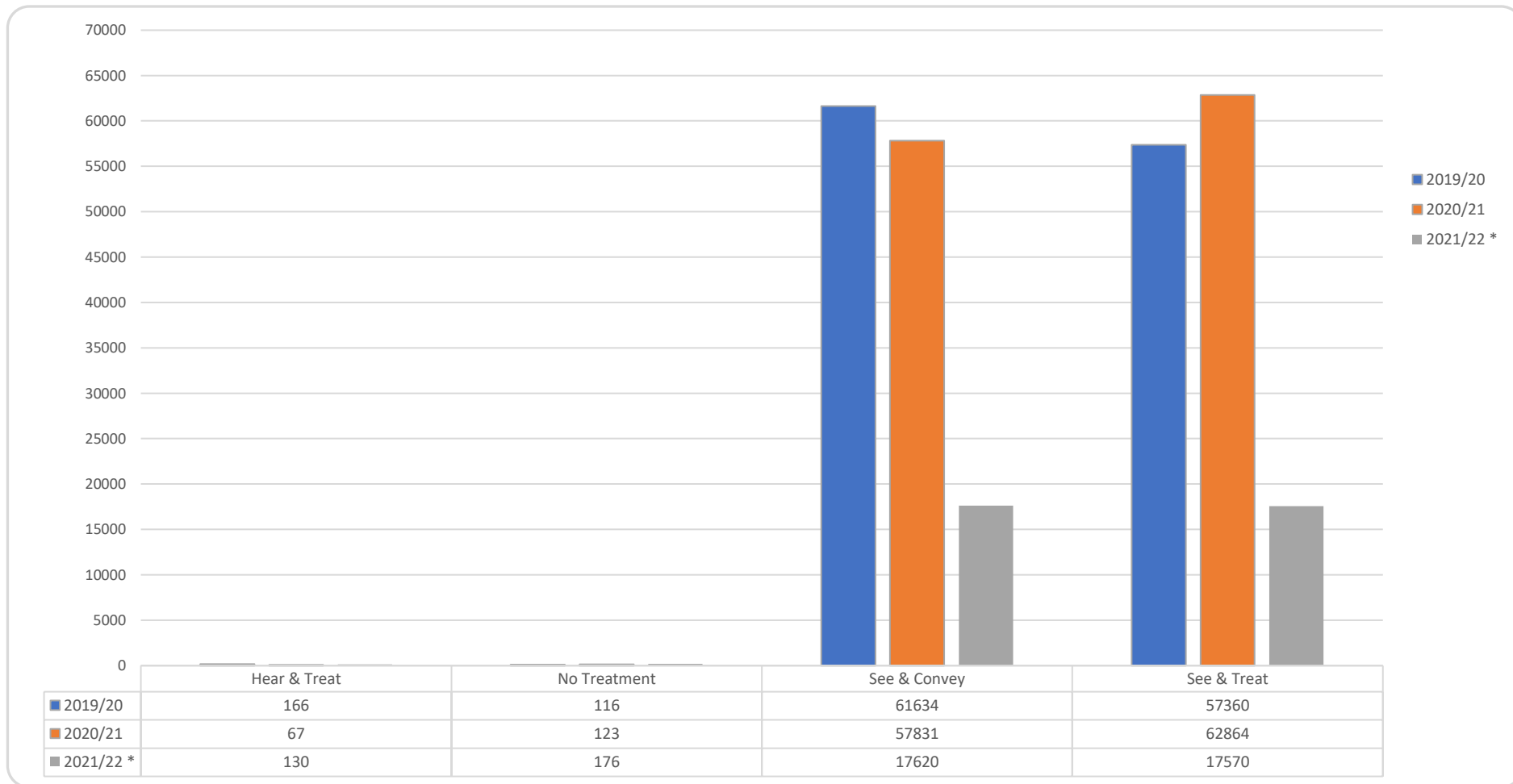
Ages 80 and over, including 2021 year so far



WEST MIDLANDS Call Outcomes

C3 and C4 calls, all call origins

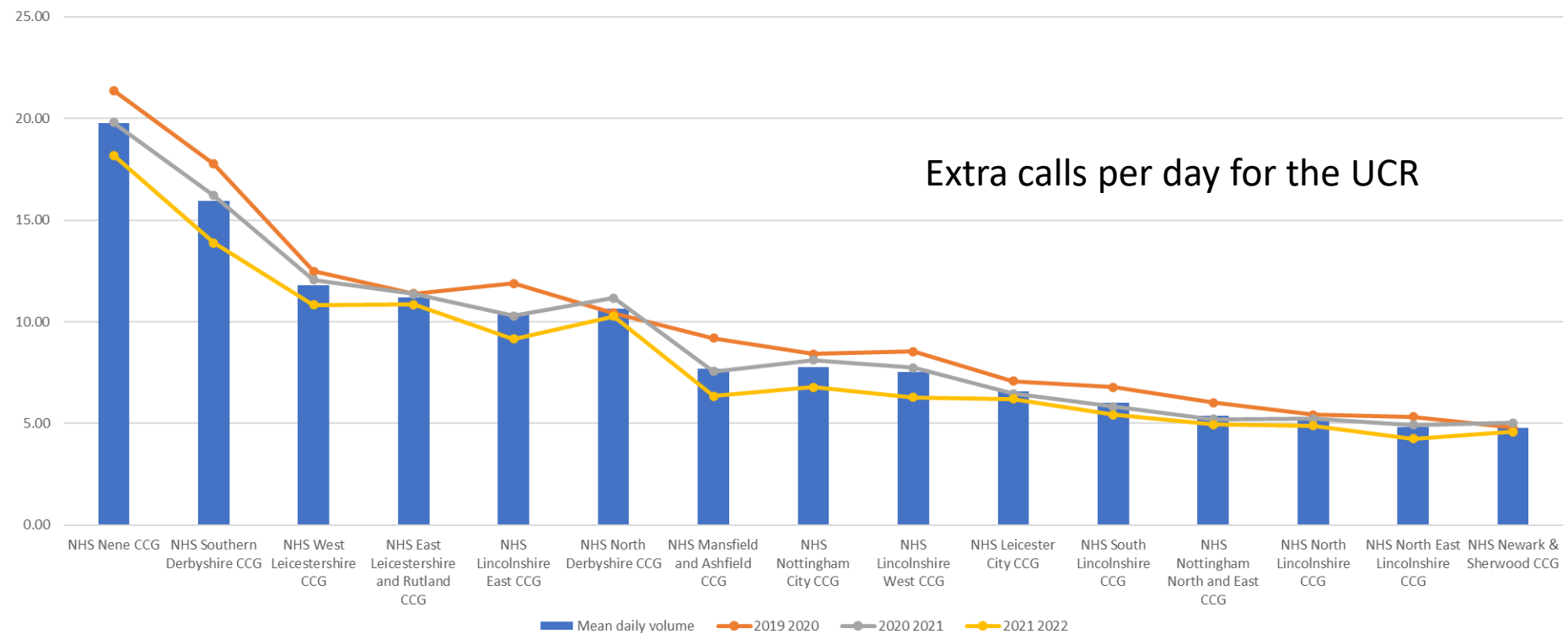
Ages 80 and over, including 2021



EAST MIDLANDS Top 15 CCG locations by incident volume



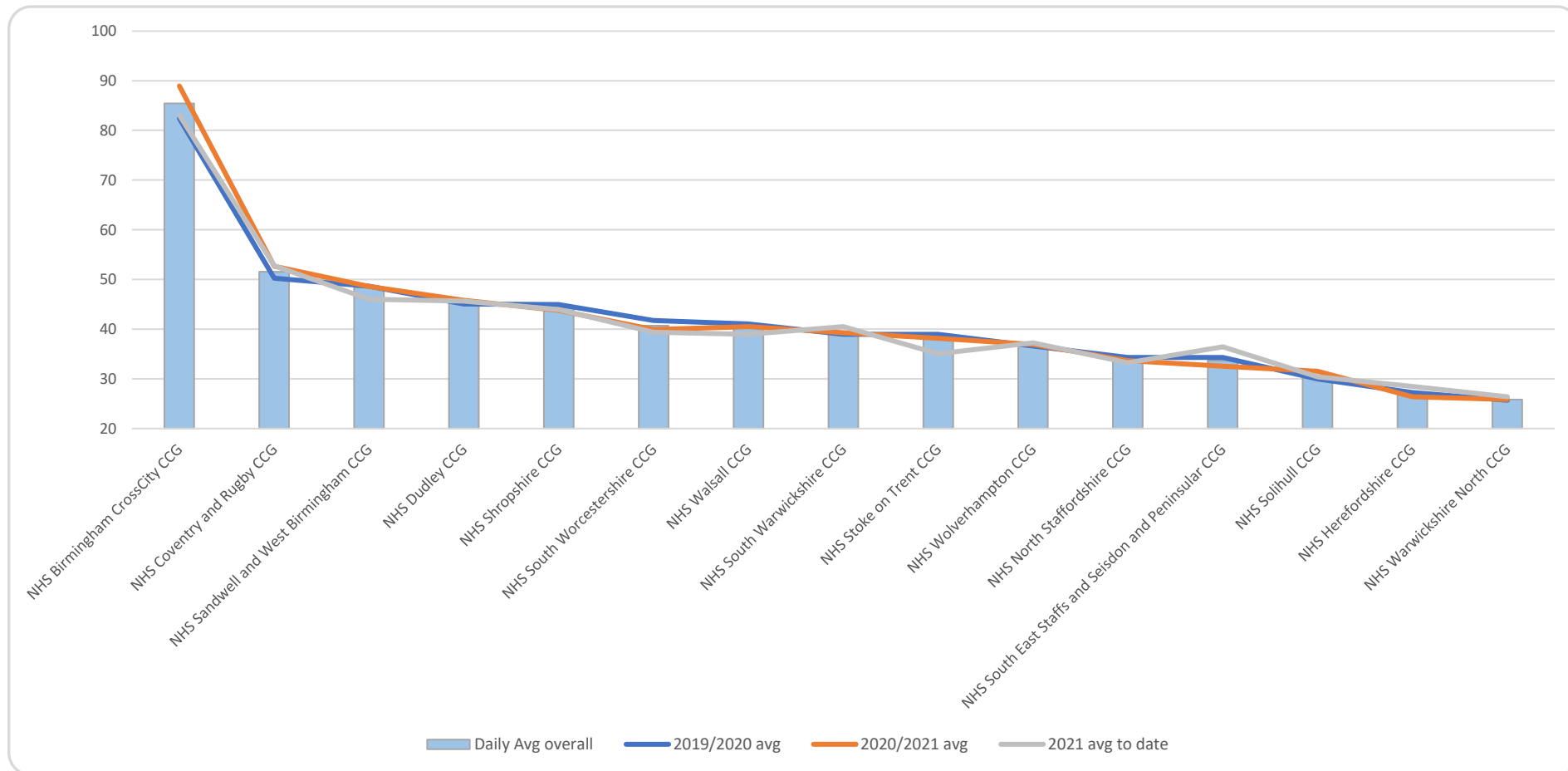
C3 and C4 calls – average daily volumes
Including Hear and Treat
Ages 80 and over – all data



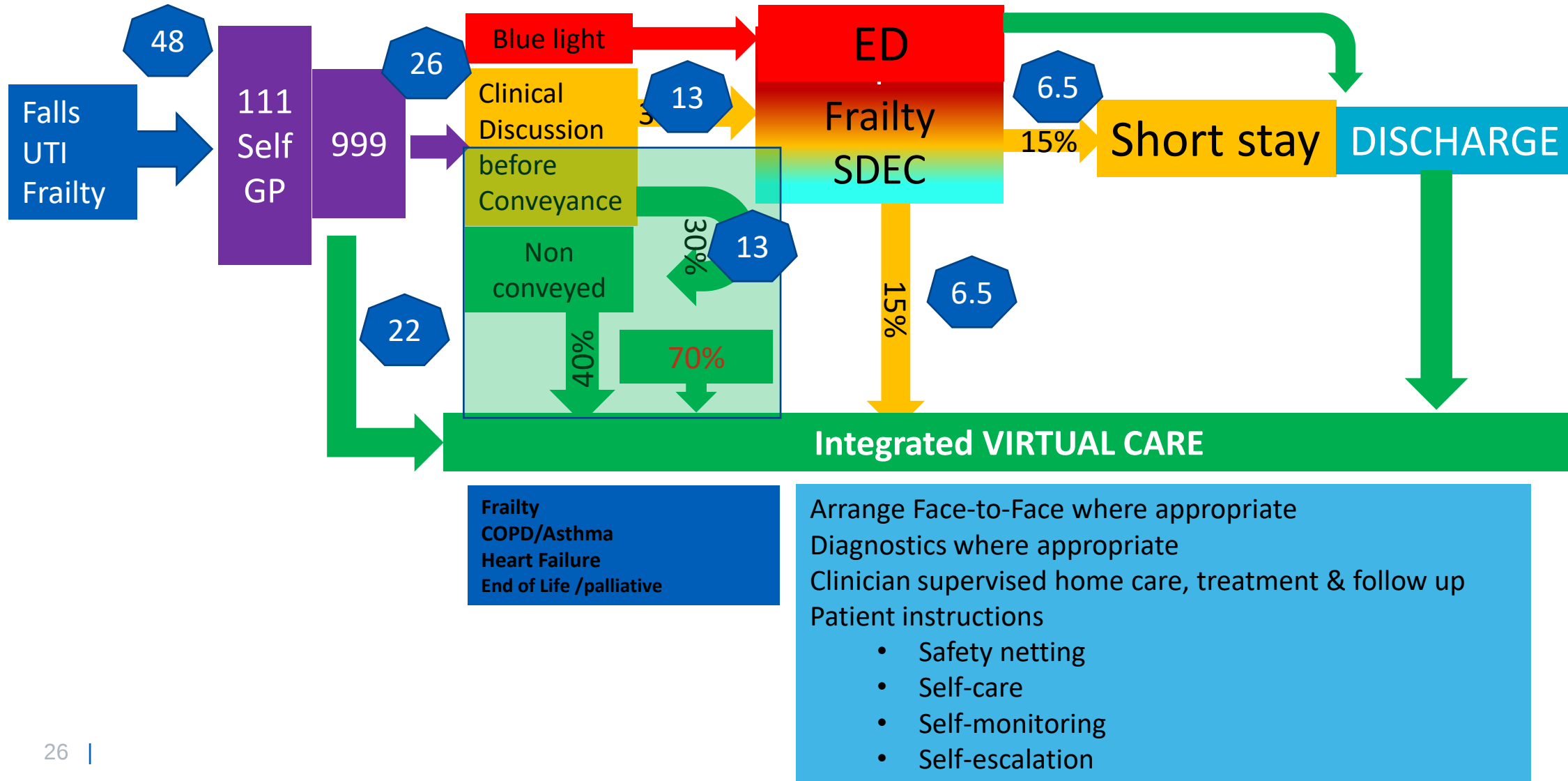
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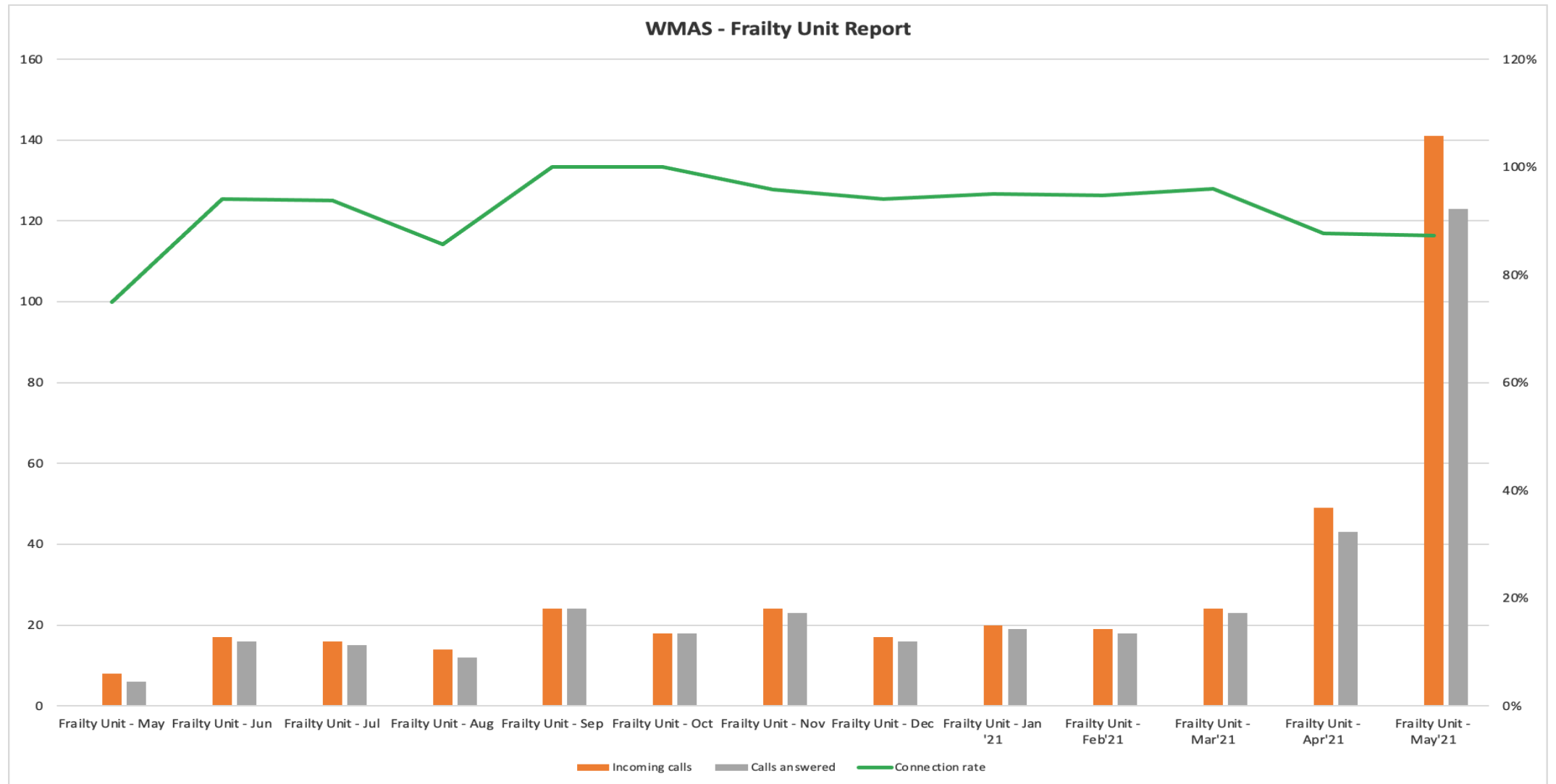
Frailty pathway with virtual care



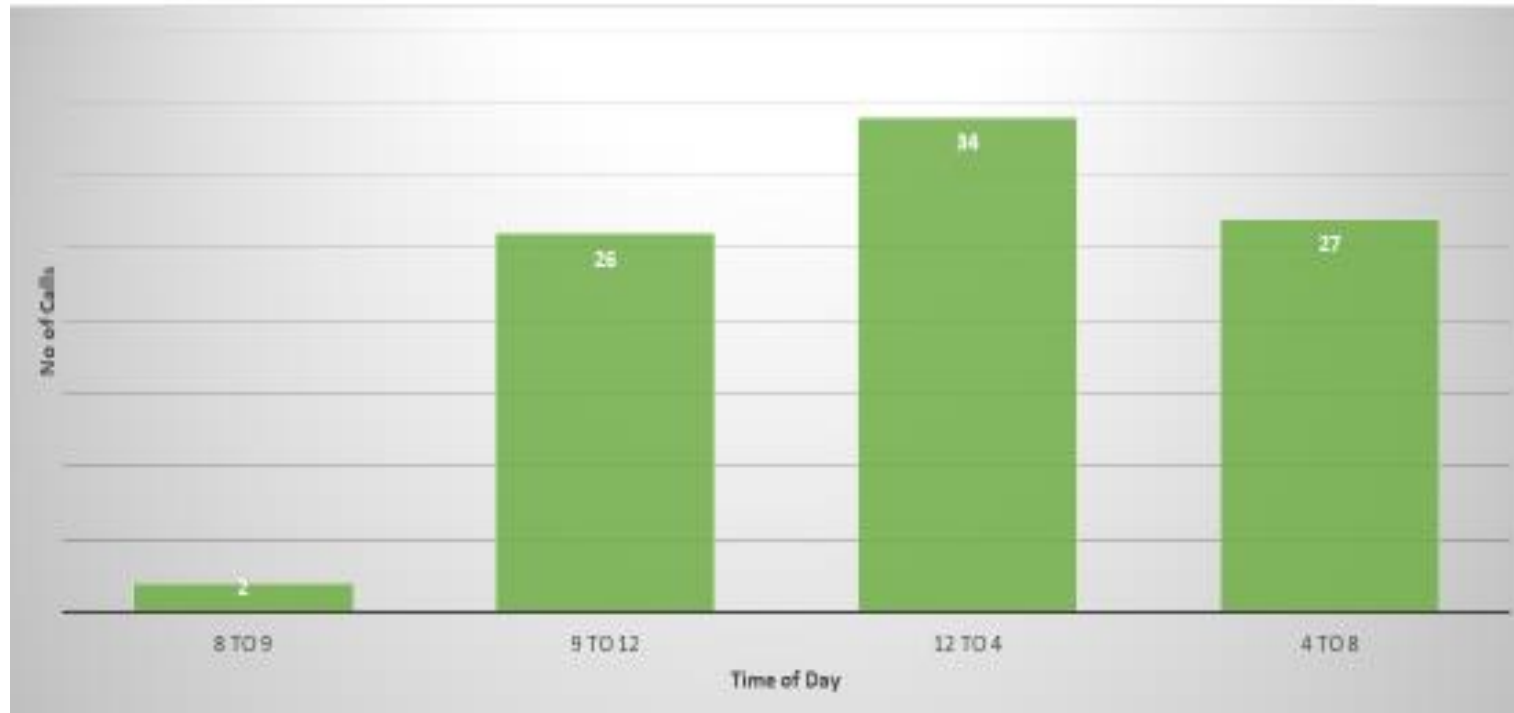


Questions?

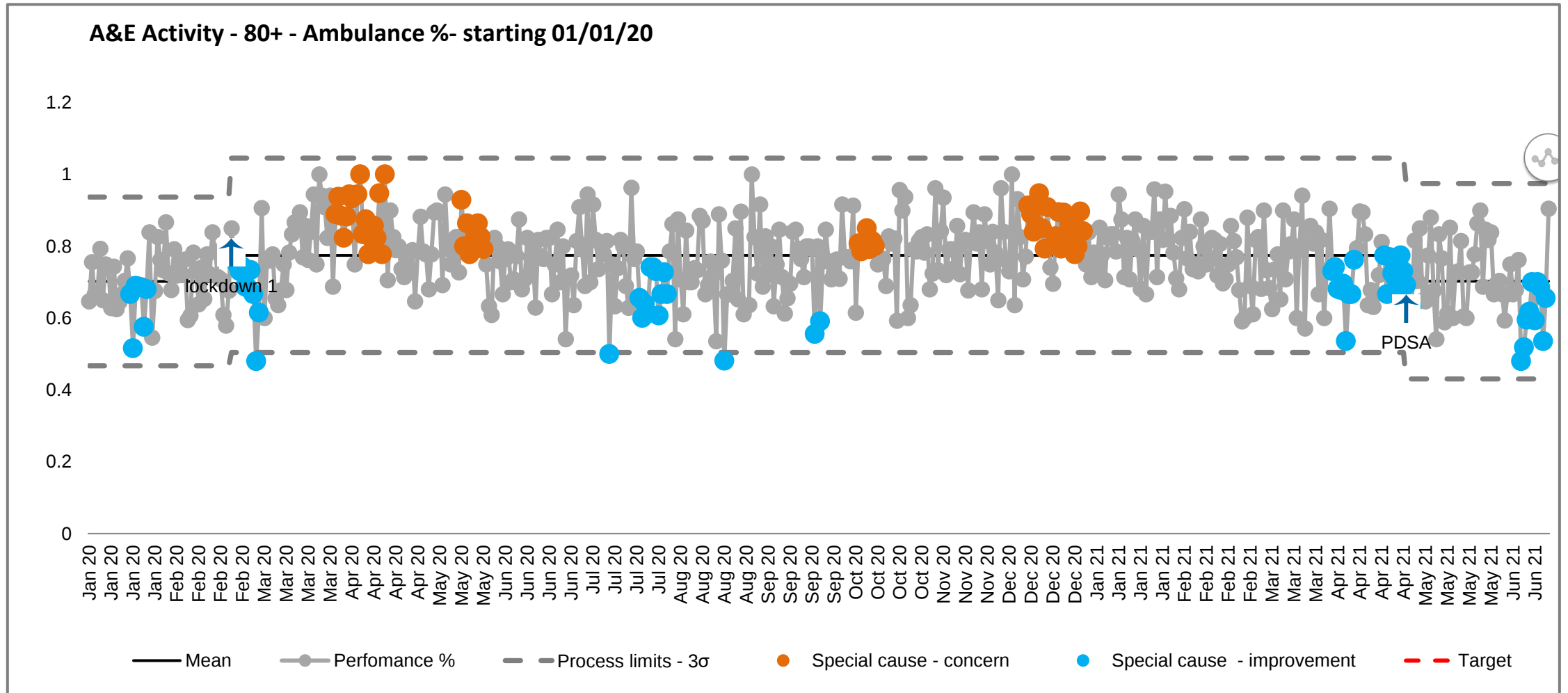
Consultant connect – WMAS calls /responses



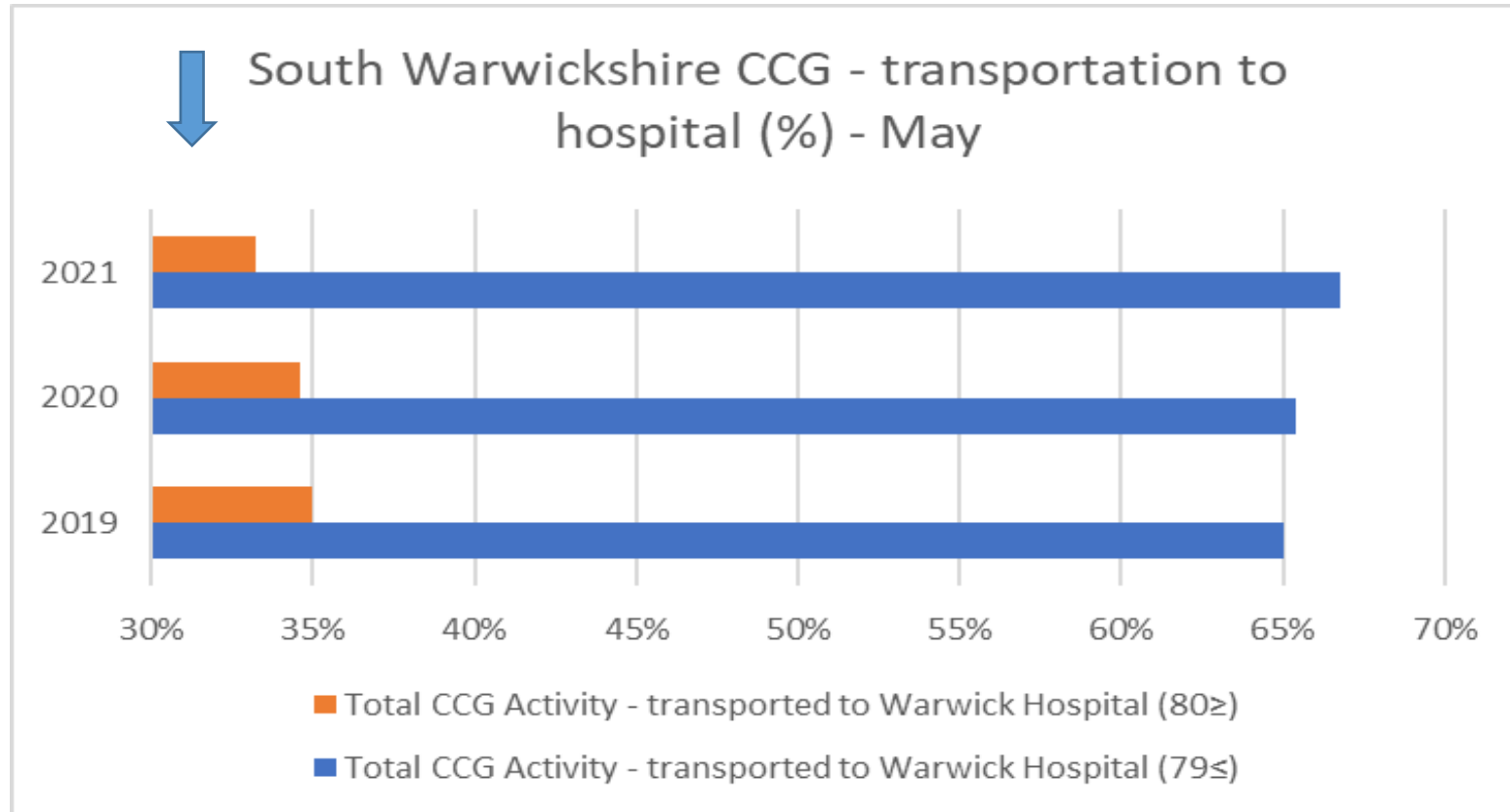
Call Volumes and Times



Drop in proportion of ambulance conveyances in over 80s



Triangulation with WMAS data



Drop in over 80's conveyed

Significant increase in the use of non-Emergency Department assessment areas - 80≥

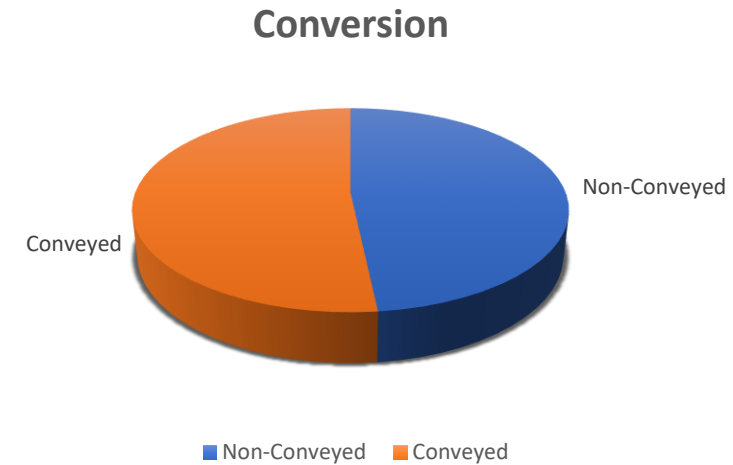
Increase transportations from out of area into Warwick Hospital

PDSA Data:

89 Calls with clear documentation recorded

43 were converted to CP visit/ non WMAS (48%)

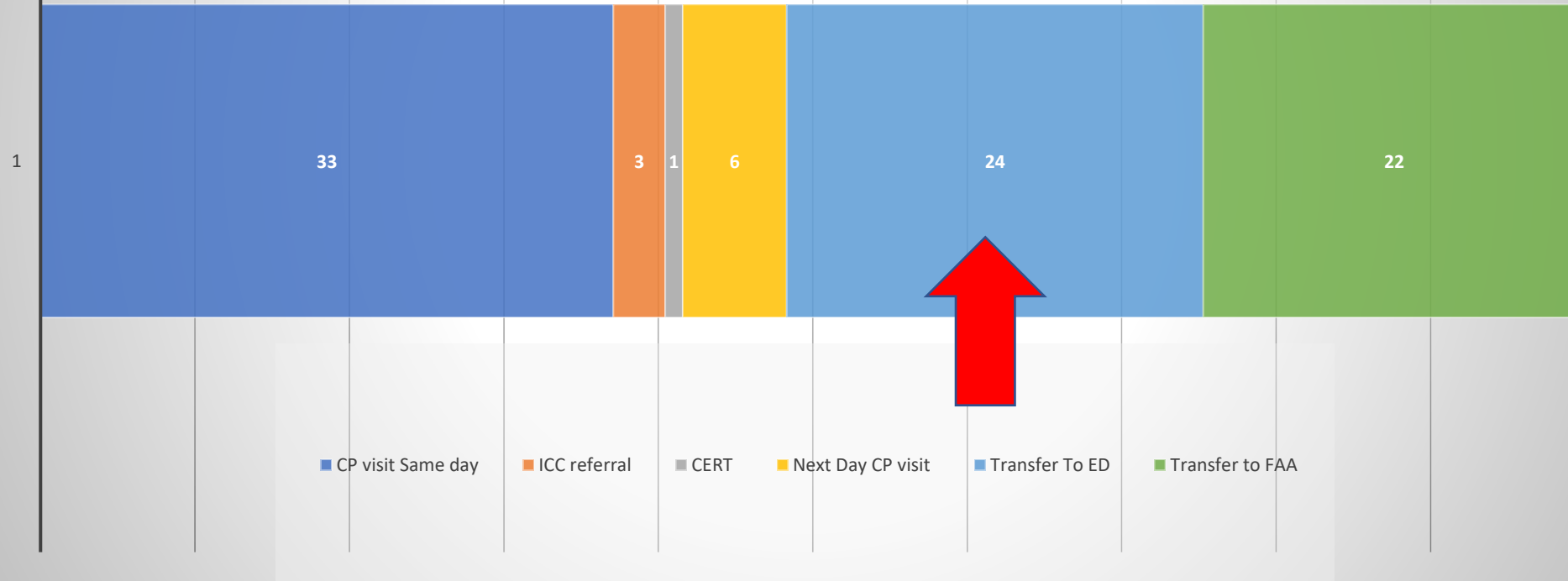
46 were conveyed (52%)



Outcomes From All Calls

Only 25% of over 80s needed to be conveyed to ED
Even less if ? Fractures come straight to frailty too.

Would that impact on the ambulance handover times and Queues?



Outcomes From CP Visits

29 CP visits, patients discharged no subsequent admissions

8 patients admitted, many too unwell to manage at home – with average LOS on COE wards of 2.85 days.

1 patient was admitted to non-COE ward and had LOS of 42 days.

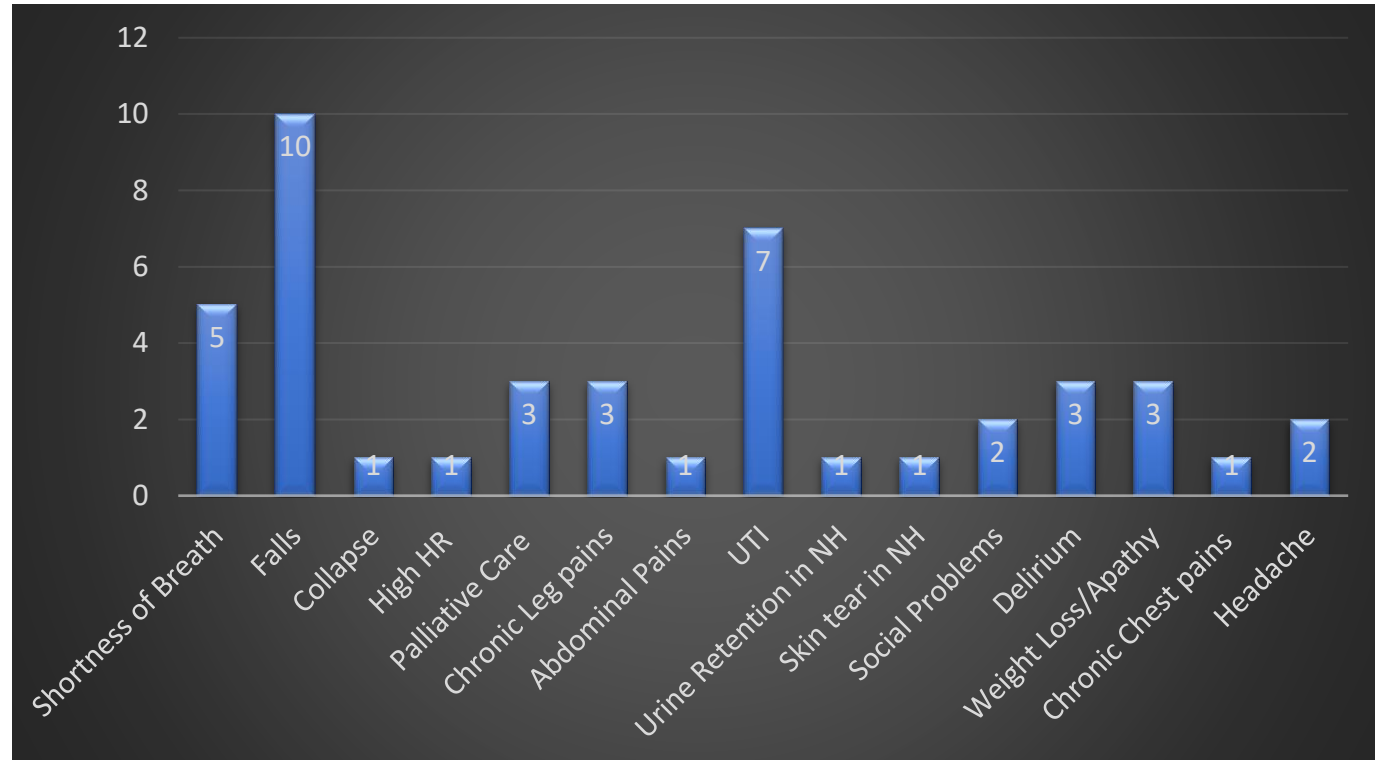
1 died of heart disease unrelated to visit.

1 patient died 2 weeks after the visit, unrelated.

Rest no outcome data to date.

Non conveyed: Case Profiles

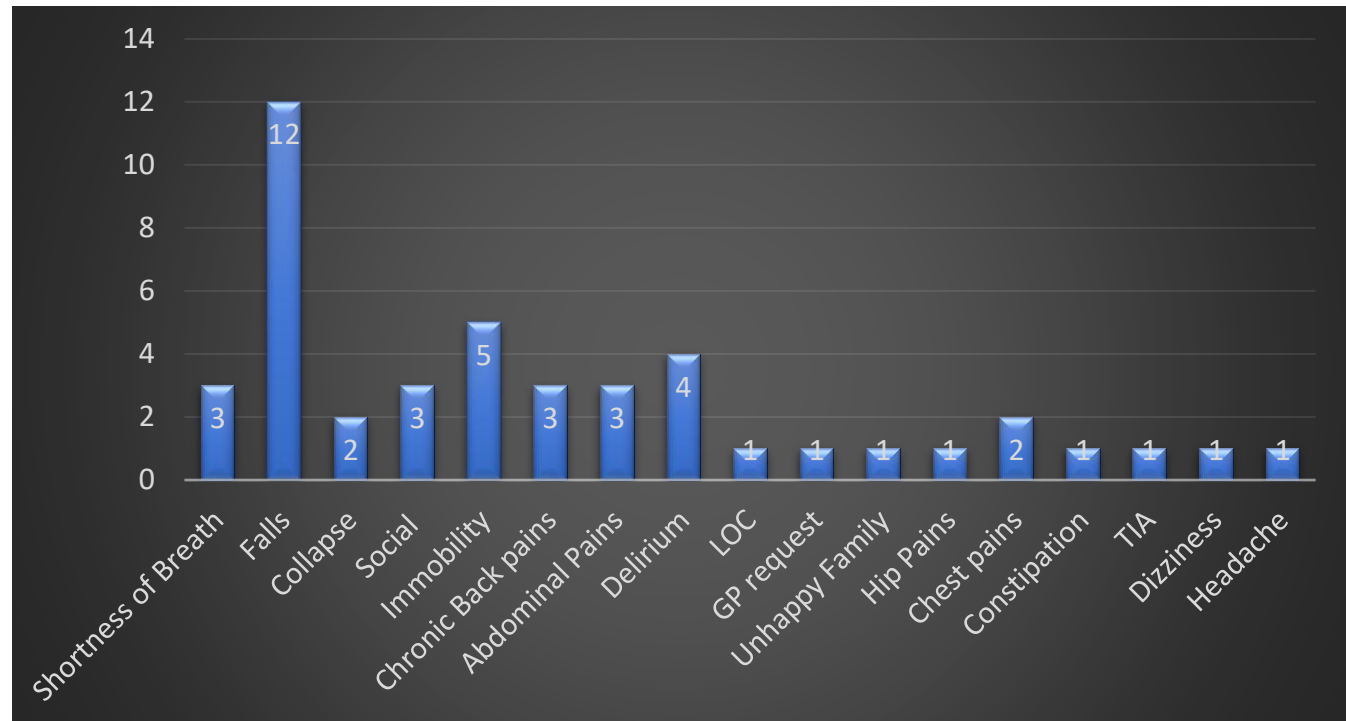
Shortness of Breath	5
Falls	10
Collapse	1
High HR	1
Palliative Care	3
Chronic Leg pains	3
Abdominal Pains	1
UTI	7
Urine Retention in NH	1
Skin tear in NH	1
Social Problems	2
Delirium	3
Weight Loss/Apathy	3
Chronic Chest pains	1
Headache	2



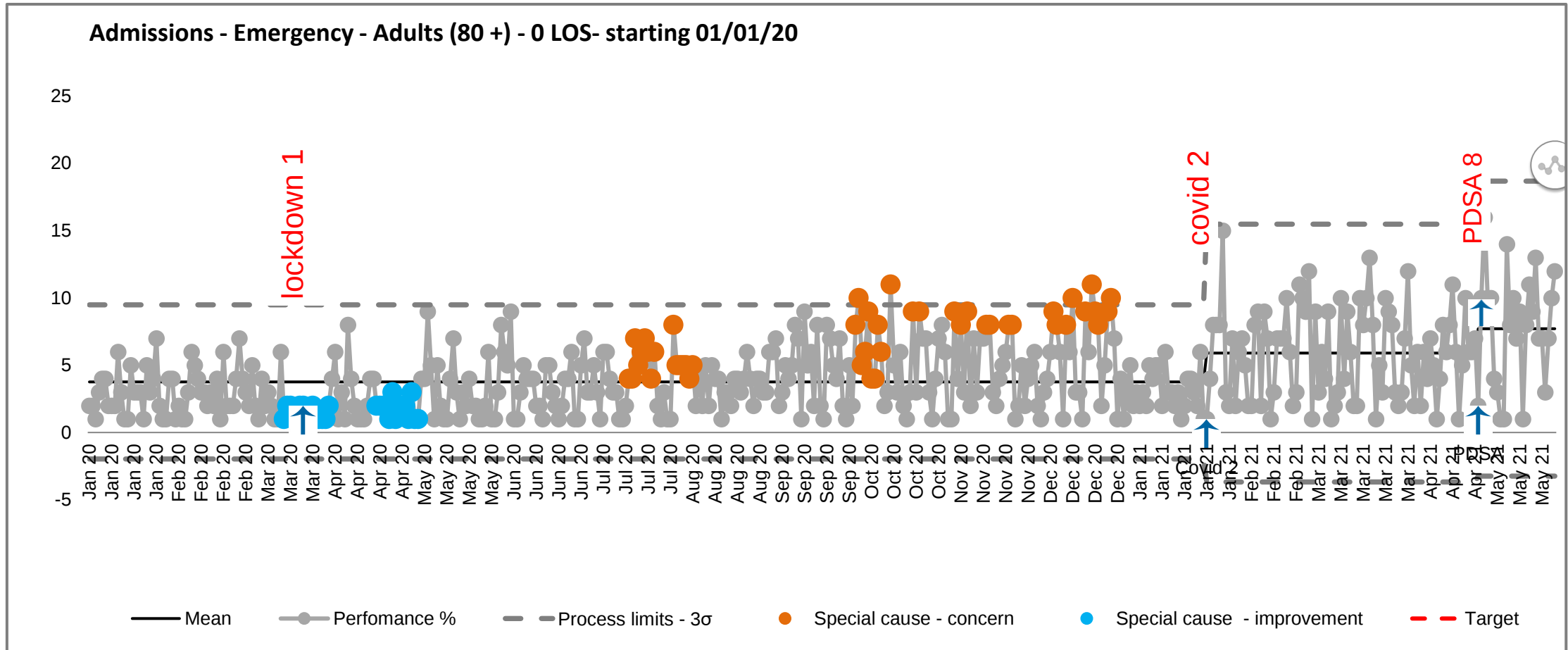
Case Profiles of Conveyed Patients

The case profiles of the patients managed at home seem to be similar to the ones conveyed.

Shortness of Breath	3
Falls	12
Collapse	2
Social	3
Immobility	5
Chronic Back pains	3
Abdominal Pains	3
Delirium	4
LOC	1
GP request	1
Unhappy Family	1
Hip Pains	1
Chest pains	2
Constipation	1
TIA	1
Dizziness	1
Headache	1



80+ - Increased SDEC activity



80+ - Average LoS

