Case study 1 - 78 year old gentleman with dementia, heart failure and diabetes

Sandwell and West Birmingham NHS Trust

Current experience / actual events

14/9/21	15/9/21	16/9/21	21/9/21	1/10/21	2/10/21	2/10/21	25/10/21	4/11/21	1/12/21
Tom's wife contacted his GP concerned that he was breathless and confused. No GP appointments for several days.	Tom's wife called 999 and Tom attended Sandwell ED. 9 hour total LOS in ED.	Tom was admitted to AMU & then a medical ward, treated with IV furosemide for worsening heart failure. Frailty score was high & he was confused.	Tom was discharged home. He was more confused and frail, required help with washing and dressing.	Tom's wife was finding it difficult to care for Tom & was anxious about his breathing. She contacted the GP.	Tom's GP carried out a telephone assessment & arranged blood tests. The results indicated poor renal function. Tom's GP contacted SPA who arranged for Tom to attend AMU.	Tom was seen in AMU & admitted. He was treated with IV fluids for dehydration and later furosemide for pulmonary oedema. His acute hospital stay was 23 days.	Tom was transferred to Rowley hospital to await a package of care.	Tom was transferred to a care home.	Care home called 999 as Tom was very breathless and in pain. Tom was transferred to Sandwell ED where he sadly died 3 hours later.

Opportunities for intervention

Earlier appointment with GP	Provision of support via community UCR2 and admission avoidance with direct pathways from ED overseen by CNC	Provision of frailty virtual ward with remote monitoring Community teams are now administering IV furosemide in the community	Increased capacity in community services such as OBI. The integrated discharge hub are now providing seamless multi-agency support	Town teams would register Tom as a high risk citizen and provide proactive care to prevent / respond to events. Carer support through 3rd sector partners and dementia navigators would be available to support Tom's wife	The CNC would have access directly to a range of alternative options such as virtual wards, Community admission avoidance	Town teams will in reach into hospitals to operate a 'pull' model to expedite discharge	The integrated Discharge hub will support pre-emption of need to support discharge and avoid the use of the medically Fit For Discharge model and use of RRH beds	Support for care homes regarding advance care planning and provision of urgent community response to support care homes and avoid use of 999 and ED	Oversight and support from the town teams and in particular specialist palliative care to support advance care planning and anticipatory prescribing

Measurable outcome

✔ Reduction in ED attendances	✔ Reduced ED LOS ✔ Reduction in associated harm risk	✔ Reduce total bed days ✔ Reduction in over 65s bed days ✔ Support MMUH delivery	✔ Improved patient and carer experience	✔ Improved patient and carer experience ✔ Reduction in GP demand	✔ Reduced emergency admissions	✔ Reduce total bed days ✔ Reduction in over 65s bed days ✔ Support MMUH delivery	✔ Improved patient experience ✔ Less Infection control risk associated with multiple transfers	✔ Improved patient experience	✔ Reduced ED attendances ✔ Achievement of preferred place of death ✔ Improved patient and carer experience

- Primary Care
- Intermediate Care
- CNC
- Town teams
- Healthier Communities