

The Ipswich Hospital NHS Trust

Frailty Assessment Base

FFT & Patient Insight for Improvement

FAB

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@Ipswichhosp



Respect

Kindness

Listen and
involve

Professional

Efficient

Improving
together

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Scene setting

- Ipswich Hospital catchment approx. 330,500
- In comparison to England average:
 - Older population
 - Longer life expectancy
 - 13.6% increase in over 60 year olds by 2021
 - Higher rate of disease prevalence
- Recent change in community health provider
- Winter pressure initiatives an opportunity for change



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FAB – The Service

Comprehensive Geriatric Assessment with a focus on acute issues.

- Multidisciplinary rapid assessment
- Assessment within 48 hours
- 8am – 6pm Monday to Friday
- Referrals from GP, Community teams, ED. Phone direct to consultant or email.
- All patients leave with a shared care plan



FAB - The Team

Our aim is to promote patient independence so they can live well in the community either in their own home or in the appropriate care setting.

- Consultant Geriatrician
- Integration Lead Nurse
- 3 Senior Nurses
- 2 Physiotherapists
- 2 Occupational Therapists
- 1 Therapy Assistant Practitioner
- 1 Healthcare Assistant
- Suffolk Family Carers
- 1 Administrator
- 1 Pharmacist



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Positive Stakeholder Feedback

I didn't think you would add anything to what I already knew, but you did and have really helped manage my patient (GP)



Thank you and the team for the fantastic level of support you provided. This maintained her independence and reduced risk of muscle bulk loss hospitalisation is at risk of causing (GP)



This service has been invaluable to EAU (Consultant)



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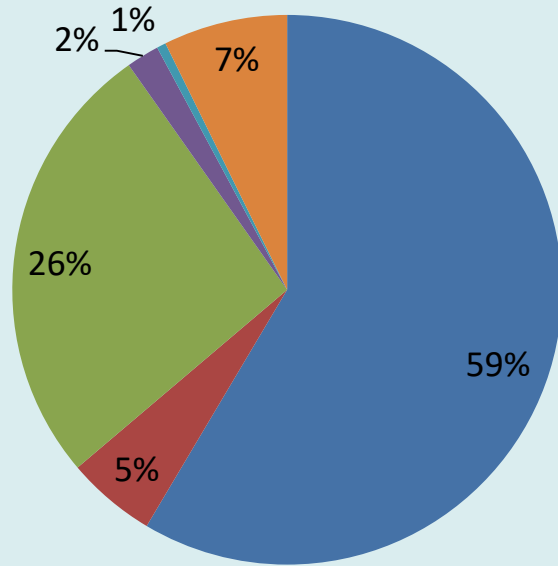
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Discharge Destination from FAB



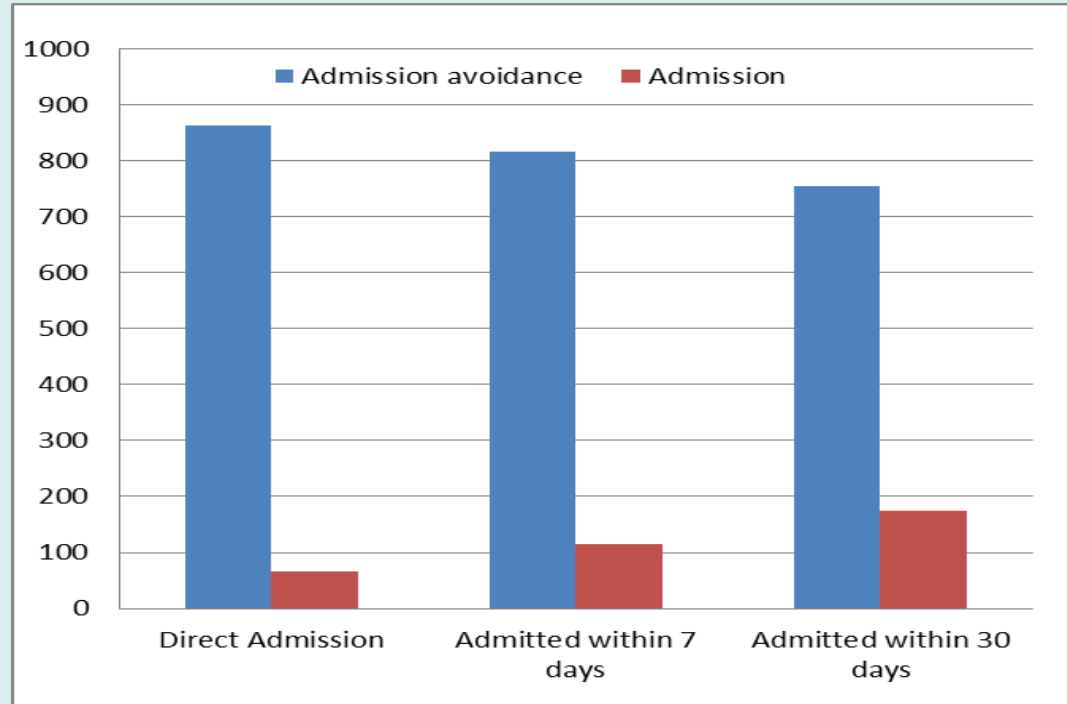
- Home
- Home with Crisis Action Team
- Home with Local Healthcare Team / Equipment
- Intermediate Care Bed
- Respite bed

Admission Avoidance

- A total of 931 patients were seen in our first year
- 90% returned home 31% with additional support or review
- 3% were stepped up into intermediate care beds
- 7% were admitted to hospital

All had CGA

81% admission prevention at 30 days



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Case study 1

- 92 year old male
- History of Parkinson's disease, prostate cancer, ischaemic heart disease and has a long term catheter
- He lives alone in sheltered accommodation and has carers 3 times a day

- He attended ED 5 times in last 7 months, 2 of which resulted in admissions
- Presented to ED following a fall, and transferred directly to FAB

- Clinically stable
- Diagnosed and treated on FAB
- SB therapy team. Footwear advice given and LHCT referral made to assess home circumstances
- Shared care plan
- No further ED attendances since this attendance

Case study 2

- 90 year old female
- Frailty score 4
- Complex medical problems
- Experienced a loss in confidence and abdominal symptoms
- GP was asked to arrange admission by family



- Referred to FAB
- Seen within 48 hours
- Admission avoided
- Patient reassured and provided with advice on self management
- Onward referral and sharing of care plan with LHCT



- Patient greatly reassured
- went home and has been managing well.
- GP felt this to be a very successful outcome

What's Next for FAB?

What's new?

- Dementia Friendly 6 bedded assessment area opened in December
- Proactive ED case finding implemented

What's coming up?

- FAB to move to 7 day working
- To implement telephone patient follow-up
- Further staff training required

What are the challenges?

- Match capacity with volatile demand
- IT interface





Questions



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