NHS
North West Anglia
NHS Foundation Trust

FRAILTY SAME DAY EMERGENCY CARE

Transforming urgent care for older pepole

We redesigned the frailty front door by introducing a Frailty SDEC model that provides rapid, multidisciplinary assessment and same-day decision-making, reducing delays, avoidable admissions and supporting older people to remain at home.

THE 4S MODEL

Scope: Identifying the project area, setting aims, and understanding the problem.
Shape: Designing the change, mapping processes, and planning the intervention.
Shift: Implementing the change through small-scale tests, often using PDSA cycles.
Sustain: Monitoring, auditing, and embedding the improvement into daily work.

WHAT DID WE DO?

We redesigned the front door for frailty. In response to rising demand, long waits and avoidable admissions, we created a Frailty Same Day Emergency Care (SDEC) model that delivers rapid assessment, stabilisation and same-day decision-making for older people with frailty. Built through strong clinical leadership and deep partnership working, the model brings together geriatricians, ACPs, nurses, therapists, pharmacy, social care, Virtual Ward and community IV teams to provide integrated, multidisciplinary care from the moment a frail patient arrives.

Using structured quality improvement methodology — daily huddles, PDSA cycles, real-time data dashboards and process mapping — we redesigned pathways to reduce delays, prevent social admissions and keep people where they want to be: at home. The model embeds a shared Comprehensive Geriatric Assessment (CGA), therapy-led decision-making and early senior clinical input, ensuring safe, timely and person-centred care.

This work has also begun to build the evidence base for a left shift of frailty care into the community, demonstrating that early assessment and stabilisation can safely happen outside the acute hospital and aligning directly with the ambitions of the NHS 10 Year Plan.

WHAT WAS THE IMPACT? THE IMPACT WAS IMMEDIATE, MEASURABLE AND TRANSFORMATIVE.

58 BEDS RELEASED ANNUALLY THROUGH BETTER UTILISATION

READMISSIONS REDUCED FROM 22% TO 10%, DEMONSTRATING SAFER, MORE EFFECTIVE CARE

50%

LENGTH OF STAY HALVED
(12.6 HOURS VS 28.2 HOURS)

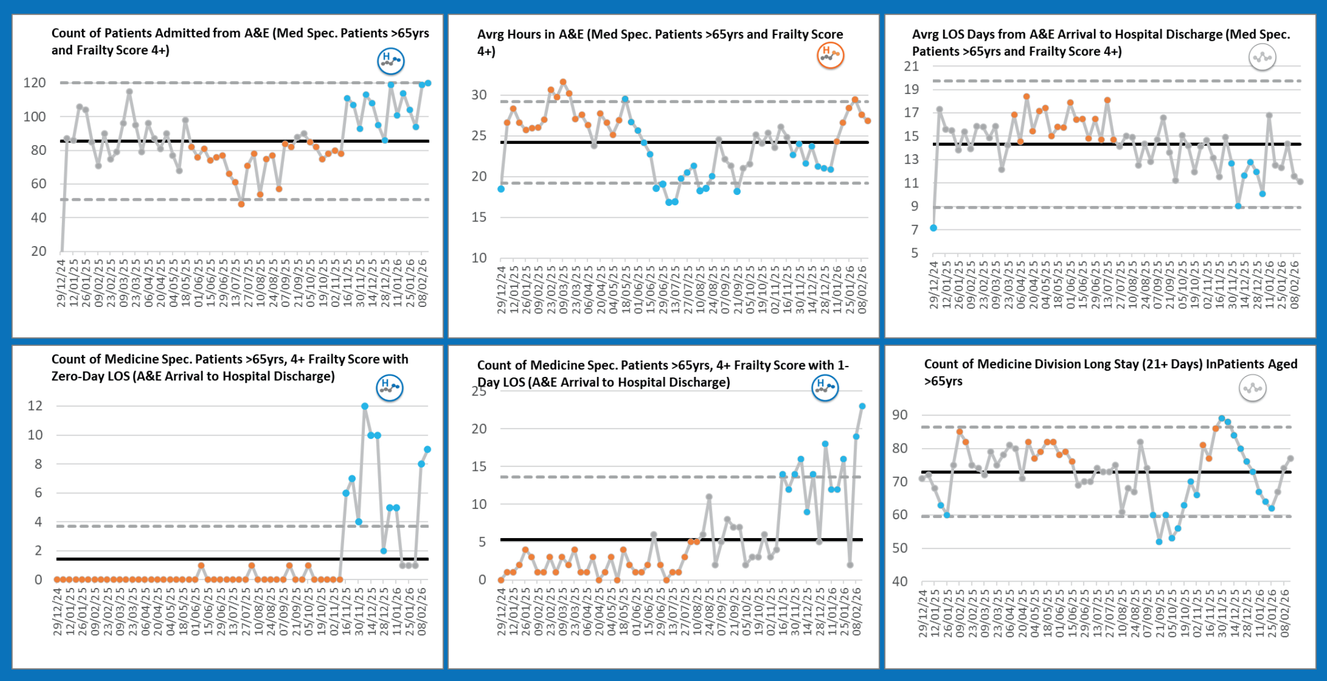
ED TIME REDUCED BY 5–10 HOURS FOR FRAIL PATIENTS STREAMED TO SDEC

SOCIAL ADMISSIONS AVOIDED THROUGH EMBEDDED THERAPY AND SOCIAL CARE

STRONGER **COMMUNITY INTEGRATION**, ENABLING SAME-DAY IVS, VIRTUAL WARD MONITORING AND RAPID FOLLOW-UP

94% **POSITIVE PATIENT EXPERIENCE**, WITH FAMILIES PRAISING SPEED, KINDNESS AND DIGNITY

The model didn't just improve metrics — it changed culture. Staff confidence grew, MDT working strengthened and the system saw what is possible when frailty care is redesigned around the needs of older people. The evaluation demonstrated that frailty admissions are often driven by system design rather than clinical need, and that early MDT intervention can safely prevent escalation.



Top: Counts of A&E Admissions and their Journey time in A&E and in Hospital for Frail Patients aged >65yrs.
Bottom: Counts of patients turned over in 1-Day and 2-Days (from A&E arrival to Hospital Discharge) and the Count of Long Stay patients aged >65yrs across all Medicine Base wards.

WHAT WERE THE OUTCOMES?

- Safer, faster, more dignified care for older people
- Fewer avoidable admissions and reduced deconditioning
- Improved flow and winter resilience
- Better continuity through integrated community follow-up
- A consistent, high-quality frailty pathway
- A strong foundation for shifting activity into the community

Patients experienced quicker decisions, earlier therapy input and smoother transitions home. Staff reported improved morale, clearer pathways and stronger relationships across acute and community teams. The model demonstrated that when the right MDT is available at the right time, many frailty admissions can be safely avoided.

WHAT HAPPENS NEXT?

Our future vision includes:

- Relocating Frailty SDEC into a community hub, closer to where people live
- Shifting activity and workforce upstream, enabling earlier assessment and stabilisation
- Strengthening seven-day therapy, social care and senior decision-making
- Building a single integrated frailty operating model across acute, community and primary care
- Digitising the CGA and improving shared records

We are now ready for the next phase: **moving frailty care into a community setting.**

- Expanding Virtual Ward and community IV capacity
- Aligning commissioning to outcomes, supporting the left shift

This is the next evolution of the model: a proactive, preventative, community-based frailty service that keeps people independent, reduces hospital demand and delivers the ambitions of the NHS Long Term Plan.

Working together to provide **outstanding care** for our local communities

CARE PEOPLE SUSTAINABLE