TRANSFORMING URGENT AND EMERGENCY FRAILTY CARE: THE ONE BROMLEY HOSPITAL AT HOME MODEL

Authors Dr Sovrila Soobroyen I Fiona Hodson I Dr Joy Ross I Dr Lynette Linkson

Affiliations Bromley GP Alliance I St Christophers Hospice I Bromley Healthcare

INTRODUCTION

Frailty in older adults increases risk of hospital admission, prolonged stay, and poorer outcomes. The NHS Long-Term Plan emphasises early identification, admission avoidance, and shifting care into the community to reduce system pressures and improve patient outcomes. Bromley has one of the largest and fastest-growing older populations in South East London. The One Bromley Hospital at Home (H@H) service is a multidisciplinary, person-centred service, integrating step-up and step-down pathways. Dedicated frailty and palliative care arms ensure high-risk patients receive coordinated, specialist-led care, embedding multidisciplinary meetings with geriatricians and palliative care teams.

Figure 1: . Framework for achieving person centred care

OBJECTIVE

Evaluate the One Bromley Hospital at Home (H@H) service in delivering multidisciplinary, person-centred care for frail and palliative patients. The study examines its role in early frailty identification, hospital admission avoidance, and enhanced community care.

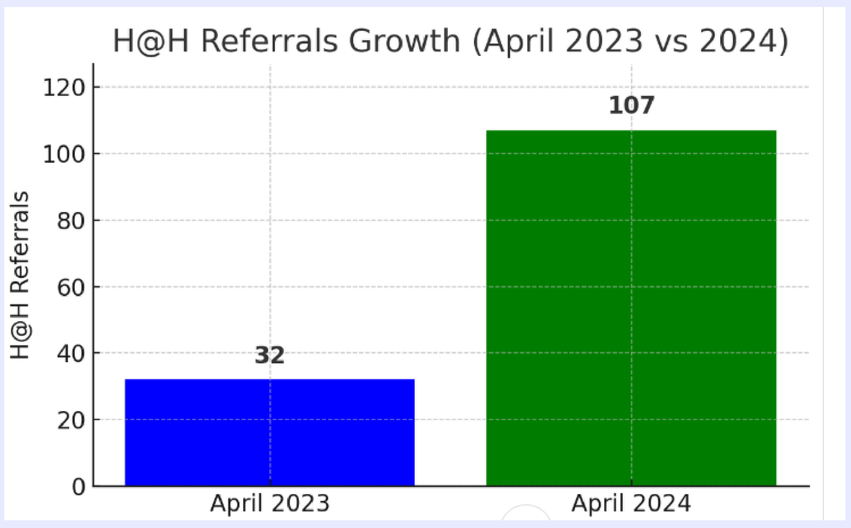
METHODOLOGY

A one-year retrospective evaluation (April 2023–2024) assessed service utilisation, clinical outcomes, technology integration and patient satisfaction for frailty/palliative arms of this service.

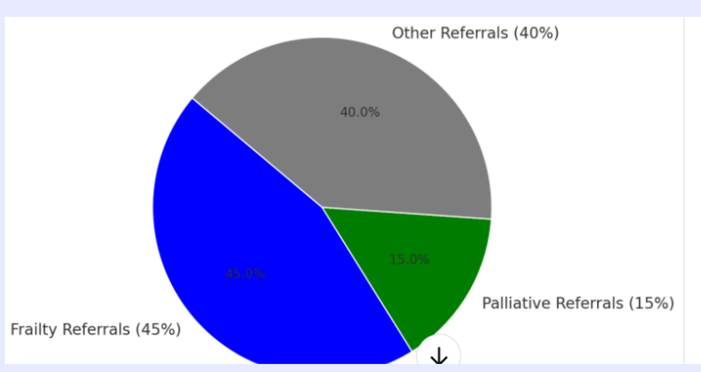
RESULTS

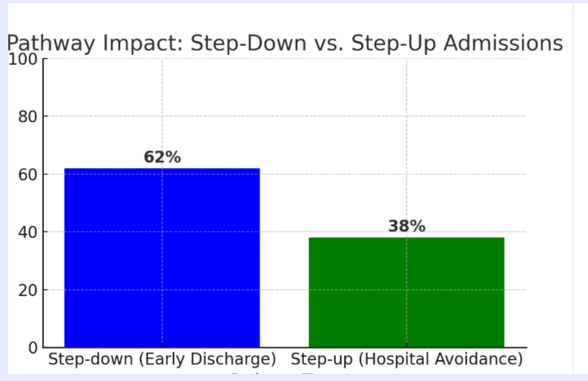
Service Growth: H@H referrals tripled (32→107, Apr 2023–24); 800 patients received care with 17,400 contacts (53% face-to-face).
Frailty & Palliative Expansion: Frailty referrals rose 200% (45% of H@H); palliative care (15%) supported complex end-of-life needs.
Patient Profile: Avg. age 84.1 years; 55.1% male.
Pathway Impact: Step-down (62%) enabled early discharge; step-up (38%) prevented hospitalisation. LoS: Frailty 8 days, Palliative 4.5 days.
Digital Integration: 25-30% used remote monitoring
Readmission Rate: 12.5%, reflecting case complexity.
Patient Satisfaction: >90%, supporting home-based frailty care.

Graph 1. Service Growth



Graph 3 (L) : Frailty & Palliative care expansion
Graph 4 (R): Pathway Impact





CONCLUSION

This H@H model aligns with national UEC transformation priorities by: reducing hospital dependency through proactive frailty management, integrating frailty/palliative pathways within the virtual ward, enhancing health equity and access to out-of-hospital care. Future research to evaluate long-term sustainability and cost-effectiveness is key before wider adoption across Integrated Care Systems.