In My Place: Combined Hospital Avoidance and Future Care Planning Service

Comisiwn Bevan Commission

Rainbow Foundation

Susan Ikin, Caroline Tudor-James, The Rainbow Foundation

Opportunity to Alleviate System Pressure and Improve Quality of Care and Experience for Older People Living and Dying in Wrexham

1. CONTEXT

System Pressure on Acute Services

Nationally, falls in people over 65 account for over 4 million bed days and more than 220,000 emergency admissions per year, with two-thirds being over 80 years old. In Wrexham alone, 8,053 emergency department attendances per year are people over 65 (2024 data), occupying 8,456 bed days.

End-of-Life Care Gaps

The current flow of patients in their last year of life through A&E and hospital wards restricts bed capacity. Over-medicalisation of care at the end of life, highlighted by NICE guidelines, often stems from late identification of the dying phase, poor communication, and limited future care planning—leading to avoidable interventions, prolonged hospital stays, and failure to honour patient preferences, especially for those with dementia. While 50–70% of this cohort prefer to die at home, 52% of deaths occur in hospital and only 22% at home.

Impact of Falls and Long Lie

Many frail older people who fall endure a long, distressing wait for an ambulance. Remaining on the floor for more than an hour ("long lie") increases the risk of dehydration, hypothermia, pressure ulcers, and pneumonia. Approximately half of those who experience a long lie die within six months of hospital admission, with mortality risk doubling for every additional hour on the floor.

Population Trends and Future Demand

Wrexham's over-85 population is expected to double by 2030 (from 3,000 to 6,000), with an estimated 42% increase in palliative care demand by 2040.

Whilst 1,942 of residents have dementia (Community Insight Profile estimate) of these, 1,212 are predicted to have severe dementia, expected to be in the last 6 months of life (Social Care Wales 2021) a figure projected to rise significantly by 2040.

Maureen was 91 years old, living with moderate dementia and frailty. When Maureen had a fall at home she was taken to A&E by an ambulance, then admitted to hospital. Maureen remained in hospital for four months whilst her needs were reassessed, despite being medically fit to leave. Maureen was finally discharged in a wheelchair and entered a residential home where she developed a Urinary Tract Infection (UTI). In hospital again, her UTI was treated but she remained in hospital for another 6 months whilst her daughter fought for her to return home. Maureen did return home briefly but was later treated for pain caused by gallstones, as she was too frail for them to be removed. She eventually died in hospital despite having expressed a preference to die at home.

John was 80 years old, living with moderate dementia and mild frailty, which resulted in him walking with a stick. He lived with his wife Carol, who was his principal carer. When John had a fall at home, Carol called 999, after a long lie John was taken to hospital and became a non-elective admission. In hospital, John's care was over-medicalised - despite being fully continent, he was fitted with catheter. The family was told this was routine to prevent falls. John's frailty increased and he remained in hospital for eight weeks despite being medically fit to leave. At point of discharge, medical staff decided the catheter should stay in place, and John, now in a wheelchair due to deconditioning, was discharged to a residential care home. Carol wanted John to return home but the catheter care scared her. He died a few months later after battling recurrent UTI's. Carol believes John was taken from her too soon as a result of overmedicalisation and his preferences being ignored. Carol says she will always live with the guilt that she was unable to honour his end-of-life wishes.

2. AIMS

- Decrease non-elected admissions to hospital
- Decrease number of bed days in hospital and over-medicalisation during end stages of life
- Promote a move from resistance to acceptance and dignity at end of life
- Increase the number of people who die well in a place of their choice
- Increase patients and carers understanding of end-of-life stages and choices at end-of-life
- Reduce repeat hospital readmissions in the last 2 years of life.

3. INTEGRATED MODEL OF CARE

'In My Place' addresses the lack of Future Care Planning (FCP) across Wrexham, as well as the need for behaviour change among stakeholder groups to consider the project's sentiment. Making FCP as usual as birth planning, our work will reduce the stigma of FCP, allow professionals across all sectors to honour end-of-life wishes, and build on best practice around end-of-life support.

In My Place Model: Tailoring healthcare to individual patient needs, preferences, and values. Noting FCP is essential to prevent repeated, unnecessary transfers to A&E during the last years of life

Rainbow Response Team + Future Care Planning Service

Rainbow Response (Hospital Avoidance) **Service**

Provides proactive community-based response to prevent unnecessary hospital admissions

- Nurse prescriber -led team (4 Nurses, 5 HCAs), available 7 days/week, 7 am to 10 pm, with a 2-hour rapid response time.
- Supports 2,347 call-outs/year.
- Integrated with the Wrexham-wide hospital. avoidance scheme and the Palliative Care Team
- Responds to uninjured falls, deterioration in health, UTIs, chest infections, and end-of-life support.
- For people over 65, living with frailty and/or dementia, at home or in residential care.

Future Care Planning (FCP) Service

Engages patients and communities in advance care discussions to align treatment to long term goals.

- Direct referrals from Rainbow Response Team and within the Community
- Accessible 5 days/week,9 am to 5 pm
- Led by enhanced social prescribers linked to all GP practices
- Supports individuals to make informed decisions about their end-of-life wishes.
- Provides training for carers (1-2-1 and group support) building a greater understanding of and confidence around the natural stages of dying, enabling people to die well at the end of life.

4. INNOVATIVE FUNDING MODEL

In My Place attracted full investment funding through a Social Impact Bond, offering a pioneering **Invest-to-Save** model for end-of-life care in Wrexham. This approach enables risk-free testing of the service with repayment for service costs only required if ALL outcomes are achieved (e.g. full reduction in unplanned hospital bed days).

Transformation funding from Social Finance included data analytics, operational expertise, and dashboard development. This innovative funding structure aligns system incentives and ensures that investment is only repaid when measurable improvements in patient care and system efficiency are fully delivered, presenting a risk-free opportunity for service transformation.

The initial investment offer from Social Finance in 2022 was not progressed within the original timeframe, and in 2025 the funding was redirected to another Welsh Health Board to support innovation. While governance processes took longer than anticipated, strong clinical leadership and identified repayment mechanisms remain in place. All partners are now revisiting this opportunity to ensure Wrexham benefits from this proven model of care.

5. IMPACT ASSUMPTIONS & BENEFIT ANALYSIS

The target population is 1,261 End-of Life patients per year. The service is expected to support 50% annually, which would be approximately 631 patients per year. The median number of admissions in the last year of life is 2.3 non-elective admissions with an average length of stay of 16.7 days. The service aims to reduce these admissions by 435 non-elective patients per year

For patients like Maureen and John, In My Place would have avoided admissions, prolonged hospital stays, whilst supporting them to maintain independence for longer, and receive care aligned with their preferences.

System Value over 3 years
= £6.54m (System Savings to the NHS)

with £4.49M retained by the Health Board

6. KEY INSIGHTS & LEARNING

Billy's Story...a small step in the right direction

When Billy had a fall he experienced a long lie of 20 hours, before being admitted to hospital, the Red Bag (& Future Care Plan) ensured that Billy's medical information and care preferences were immediately available. Billy experienced a smooth transition to his chosen place of care where his dying wishes were treated with dignity and respect.

Future Care Planning alone has shown:

- Improved Patient Agency
- Reduced Hospitalisation
- Better Carer Confidence & System Coordination

Next Steps

- Turn insight into action.
- Mobilise the In My Place model to transform end-of-life care in Wrexham

Wider System Change:

Unfortunately, the experiences of Maureen, John and Billy remains common for many frail elderly people who are admitted to hospital in Wrexham. Older people continue to experience the long lie, followed by prolonged hospital stays, unnecessary medical interventions and loss of independence.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

www.rainbowfndn.org.uk
01948 830730 info@rainbowfndn.org.uk
registered charity number: 1199932