

**Royal College of General Practitioners and Warwick Medical School**  
**Annual Education, Research and Innovation Symposium 18<sup>th</sup> May 2017**  
**Abstract Submission Form**

<b>PRESENTER'S DETAILS</b>	
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<b>Department or organisation</b> Coventry and Rugby GP Alliance	
<b>Category</b> Innovation	
<b>PRESENTATION DETAILS</b>	
<b>Authors</b> Dr Cat Roberts Dr Ben Atkins Dr Juan Corkill	<b>Title of Study</b> "Transition of care" for frail older adults – Bridging the gap
<b>What's the problem you are tackling?</b> Frail older patients are vulnerable, complex and prone to dependency. Recurrent and prolonged hospital stays are detrimental to patient wellbeing and costly to the NHS economy. Over 50% of readmissions were occurring within the first seven days of discharge. These factors drive demand for fully integrated MDT working to facilitate a "transition of care" between primary and secondary care, ensuring appropriate care is delivered in the appropriate place. Through working collaboratively with various healthcare professionals and providers, social care and voluntary sector we are able to identify patients' needs in a holistic manner and this collaboration is augmented through inter-professional learning.	
<b>How did/will you do it?</b> Demonstrate the importance of facilitating a "transition of care" for frail patients through use of a central multi-disciplinary hub. Experiences of an innovative GP-led multi-disciplinary team (MDT) based in secondary care; Highlighting the importance of supporting a "transition of care" to prevent admissions via GP Liaison Nurse and reduce readmissions via MDT and community follow-up.	
<b>What did you find?</b> Patients whose transition of care was facilitated through the MDT process had an average length of stay of 5.1 days and a readmission rate of 17.6%. This reduction in length of stay and readmissions, compared to an age and presentation matched cohort, represents a potential reduction of over 4000 bed nights in the past 3 months.	
<b>Why does this matter?</b> Outcomes suggest patient and cost benefits as a result of collaborative working. Positive early signs and support from the Trust and wider health community have secured funding for ongoing development.	