Wirral University Teaching Hospital NHS
NHS Foundation Trust

Wirral's Acute Frailty and Cross Boundary Care

Frailty and Urgent Care Meeting

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15th February 2019

#PROUD

Wirral

Courtesy of Google Map

- Population of 322,800 (2017) – ONS
- Wirral Clinical Commissioning Group
- Wirral University Teaching Hospital NHS Foundation Trust
- Wirral Community NHS Foundation Trust

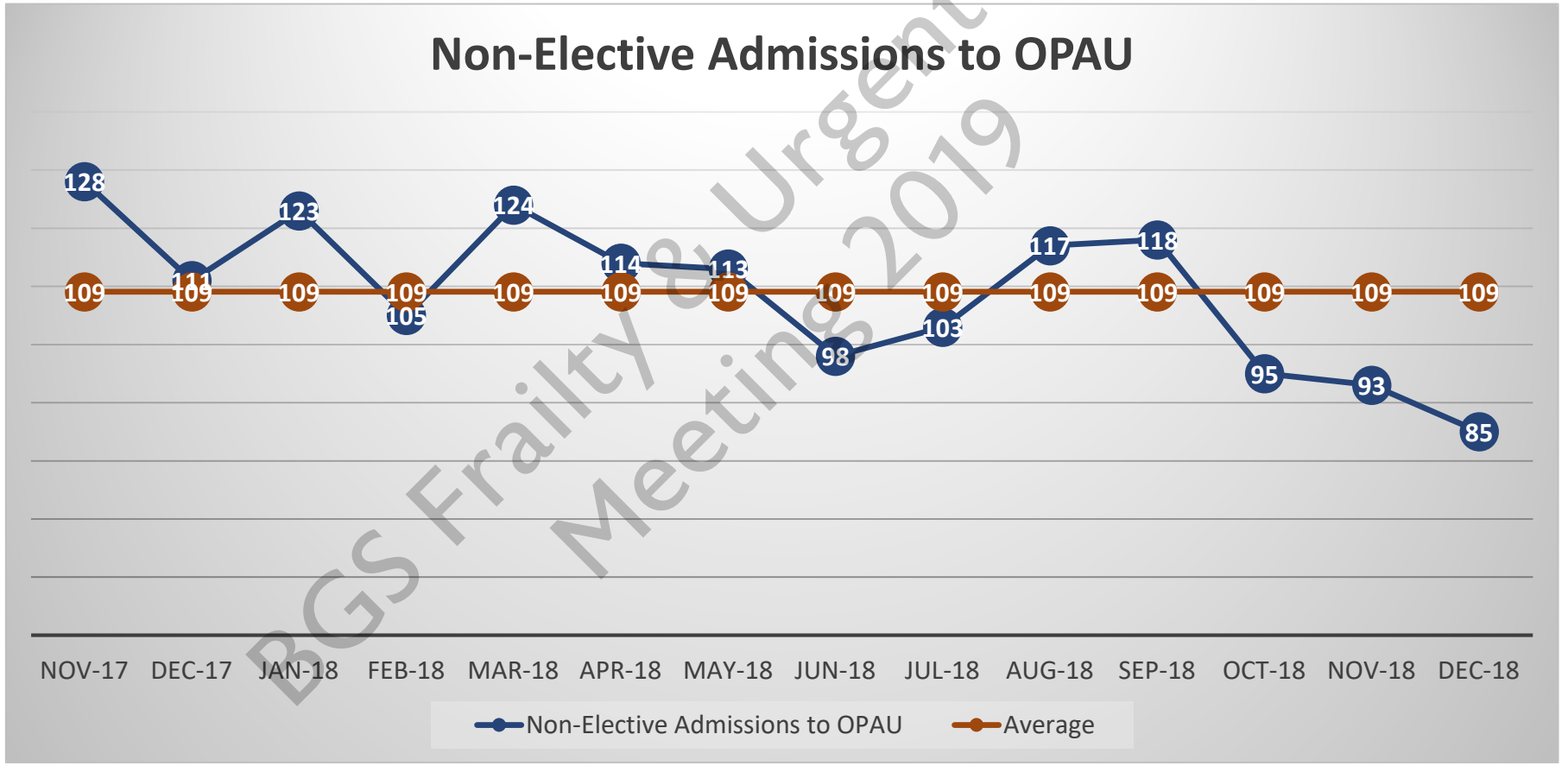
#PROUD

Older Persons Assessment Unit (OPAU)

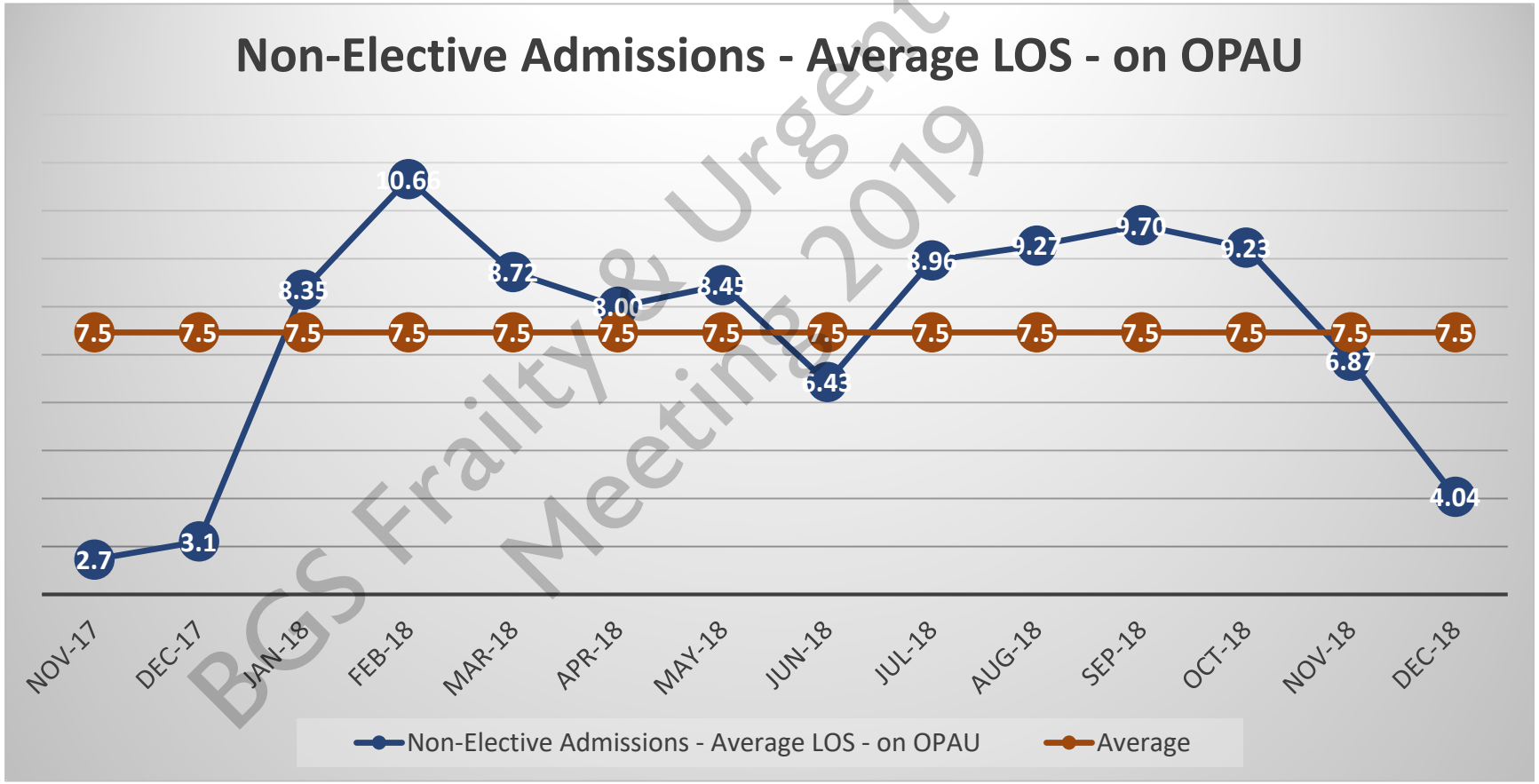
- 24 bedded unit
- Team
  - 5 consultants providing 13 sessions in the mornings
    - Aiming for 2 consultant ward rounds each morning
  - On call consultant reviews admissions in the afternoon
  - 4 Specialist Nurses for Older People (SNOPs)
    - 8am - 8pm
    - Identifying frail patients in the A&E, ACU, start CGA
    - OPAU's Frailty Criteria
  - MDT approach – physiotherapist, occupational therapist, nurses (1:6), lead nurse
  - Social Worker
  - Dementia Liaison Nurse, AGE UK representative
  - 2 pharmacists on ward rounds, 2 registrars, 1 SHO, 2F1s, a ANPs
- Board rounds – 8.30am and 1.30pm

OPAU Team

OPAU



OPAU



OPAU / OPRA Challenges

- Significant challenges over past 12 months
- Estates – move of ward from 18 to 24 bedded unit in June 2018
- Staffing
- Recognition as an assessment unit, not a DME ward
  - Executive champion
- Flow – consistent SW, POC, STAR, Rehab / T2A beds

- Infection control
- 1 Band 3 CSW and 1 nurse needed on OPRA area
  - CSW trained to perform venipuncture, IV access, observations, ECG, bladder scan

Older Persons Assessment / Ambulatory Clinic (OPRA)

- Patients at the brink of admission, usually with complex problems
  - Falls, memory concerns, not managing, deteriorating mobility
- Consultant led Comprehensive Geriatric Assessment (CGA) 1-2 patients
- Investigations – xrays, CT staging / CT head, USS abdo / renal tract
- Hydration pre-CT for patients with CKD
- Interventions
  - Blood transfusions –
    - G&S done in community at least day before and blood ready for patient on arrival
  - Iron infusions
- Liaising with Integrated Care Coordination Hubs / Rapid Response
  - Supporting patient at home – package of care, equipment, voluntary services

Role of a Community Geriatrician

- 4 Community Geriatricians
  - 1.4 whole time equivalent
- Interface between secondary care and the community
- Care Home support
  - 2800 care home residents
- Anticipatory clinical plans
  - Emergency Health Care Plans
- Supporting various community teams
  - Nurse Practitioners for Older People, Community Matrons, Teletriage Service, EOL facilitators
- Review of housebound patients, particularly those who are in severely frail category
  - Difficult to get to clinics and likely to need to embark on EOL discussions

Community Geriatrician Phone Line

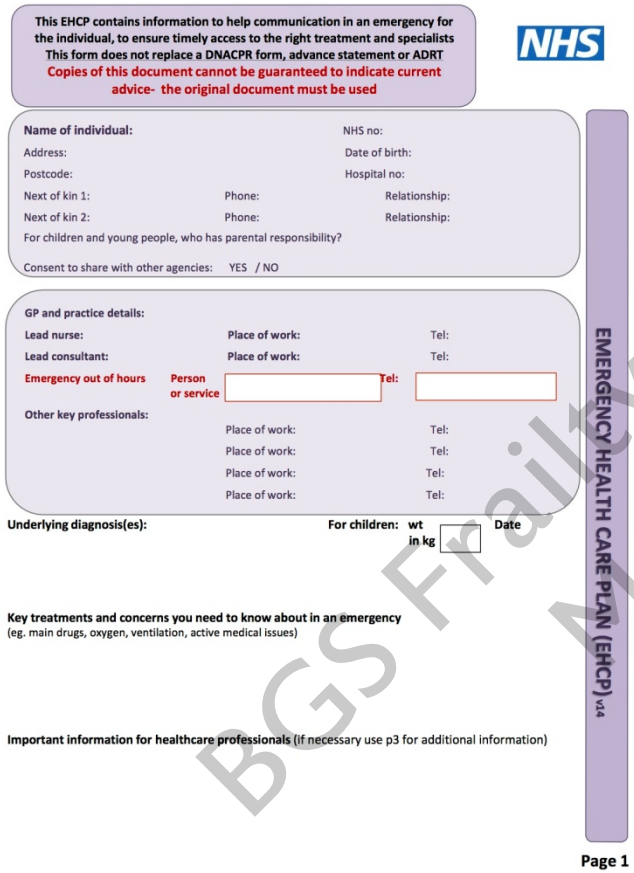
- 9am – 5pm Mondays - Fridays
- Advice line of health care professionals
  - GPs, community teams, care homes
- Discussion of patients at brink of admission
  - ?Suitable for OPRA assessment
- Signposting to services
- Making sense of a recent discharge and next steps

- Our **Silver Phone** as recommended by AFN

Emergency Health Care Plans (EHCPs)

- Anticipatory clinical plans
  - Documentation of agreed management plan with family in the event of deterioration
  - Capacity assessment, best interest decision
- Recognition of EOL status amongst care home residents
  - GSF Prognostic Indicator Guidance
- Pragmatic management in care home
- Avoiding burdensome interventions including conveyance to hospital
- Compliments Six Steps EOL Programme
- Well recognized in care homes, GPs, community teams
- Increased awareness amongst paramedics and GPOOH
- GP Enhanced Care Home Scheme - increased use of EHCPs

Emergency Health Care Plans



This EHCP contains information to help communication in an emergency for the individual, to ensure timely access to the right treatment and specialists
This form does not replace a DNACPR form, advance statement or ADRT
Copies of this document cannot be guaranteed to indicate current advice- the original document must be used

NHS

Name of individual: NHS no:
Address: Date of birth:
Postcode: Hospital no:
Next of kin 1: Phone: Relationship:
Next of kin 2: Phone: Relationship:
For children and young people, who has parental responsibility?
Consent to share with other agencies: YES / NO

GP and practice details:
Lead nurse: Place of work: Tel:
Lead consultant: Place of work: Tel:
Emergency out of hours Person or service Tel:
Other key professionals:
Place of work: Tel:
Place of work: Tel:
Place of work: Tel:
Place of work: Tel:

Underlying diagnosis(es): For children: wt in kg Date

Key treatments and concerns you need to know about in an emergency
(eg. main drugs, oxygen, ventilation, active medical issues)

Important information for healthcare professionals (if necessary use p3 for additional information)

EMERGENCY HEALTH CARE PLAN (EHCP) v2.4

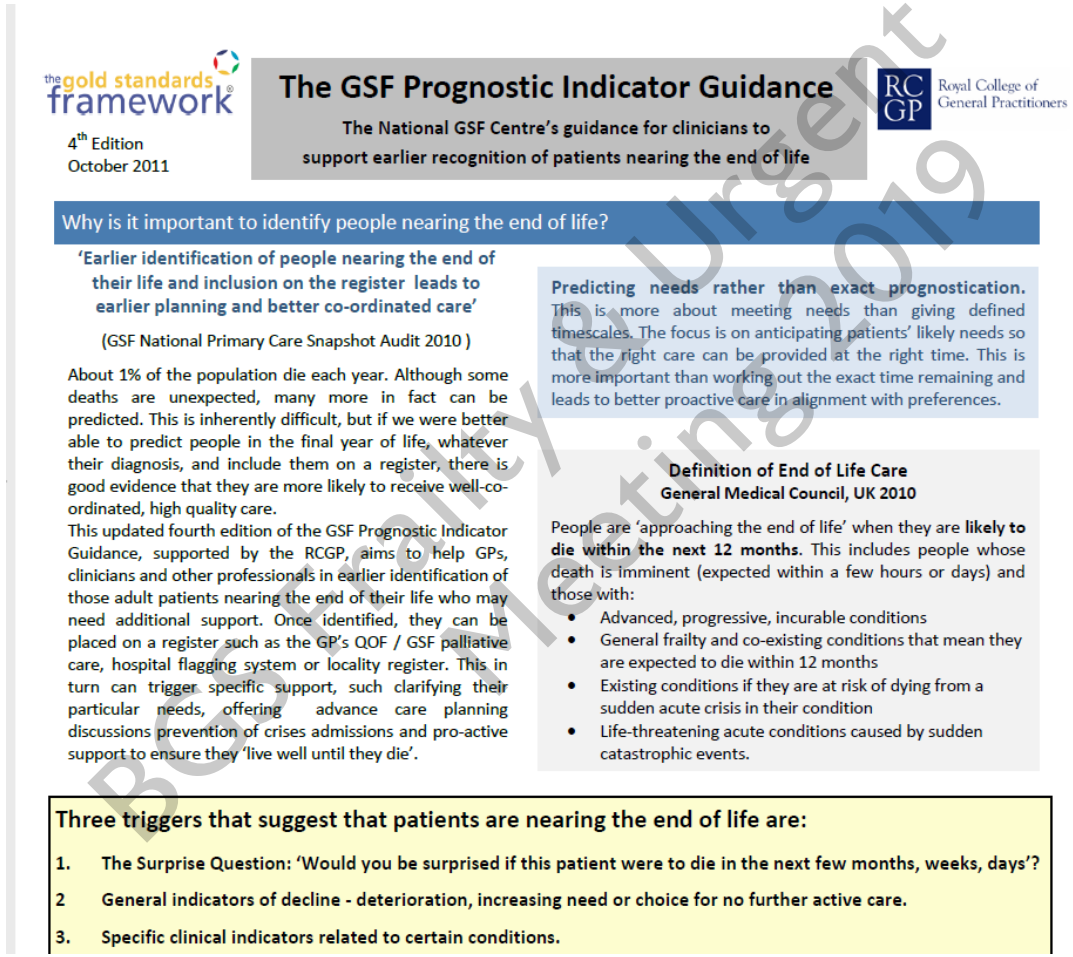
Page 1

Information Shared on various systems :

- **Systm1** for Community Trust
- **ADASTRA**
- **Cerner** for WUTH
  - EHCP flag on Cerner
  - Letter on Cerner
- **ERISS** for NWAS

- GP :
  - Copy of EHCP and letter
  - Flag on their system

GSF Prognostic Indicator Guidance



the gold standards framework

4th Edition
October 2011

The GSF Prognostic Indicator Guidance

The National GSF Centre's guidance for clinicians to support earlier recognition of patients nearing the end of life

RCGP Royal College of General Practitioners

Why is it important to identify people nearing the end of life?

'Earlier identification of people nearing the end of their life and inclusion on the register leads to earlier planning and better co-ordinated care'

(GSF National Primary Care Snapshot Audit 2010)

About 1% of the population die each year. Although some deaths are unexpected, many more in fact can be predicted. This is inherently difficult, but if we were better able to predict people in the final year of life, whatever their diagnosis, and include them on a register, there is good evidence that they are more likely to receive well-co-ordinated, high quality care.

This updated fourth edition of the GSF Prognostic Indicator Guidance, supported by the RCGP, aims to help GPs, clinicians and other professionals in earlier identification of those adult patients nearing the end of their life who may need additional support. Once identified, they can be placed on a register such as the GP's QOF / GSF palliative care, hospital flagging system or locality register. This in turn can trigger specific support, such clarifying their particular needs, offering advance care planning discussions prevention of crises admissions and pro-active support to ensure they 'live well until they die'.

Predicting needs rather than exact prognostication. This is more about meeting needs than giving defined timescales. The focus is on anticipating patients' likely needs so that the right care can be provided at the right time. This is more important than working out the exact time remaining and leads to better proactive care in alignment with preferences.

Definition of End of Life Care
General Medical Council, UK 2010

People are 'approaching the end of life' when they are **likely to die within the next 12 months**. This includes people whose death is imminent (expected within a few hours or days) and those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

Three triggers that suggest that patients are nearing the end of life are:

1. **The Surprise Question: 'Would you be surprised if this patient were to die in the next few months, weeks, days'?**
2. **General indicators of decline - deterioration, increasing need or choice for no further active care.**
3. **Specific clinical indicators related to certain conditions.**

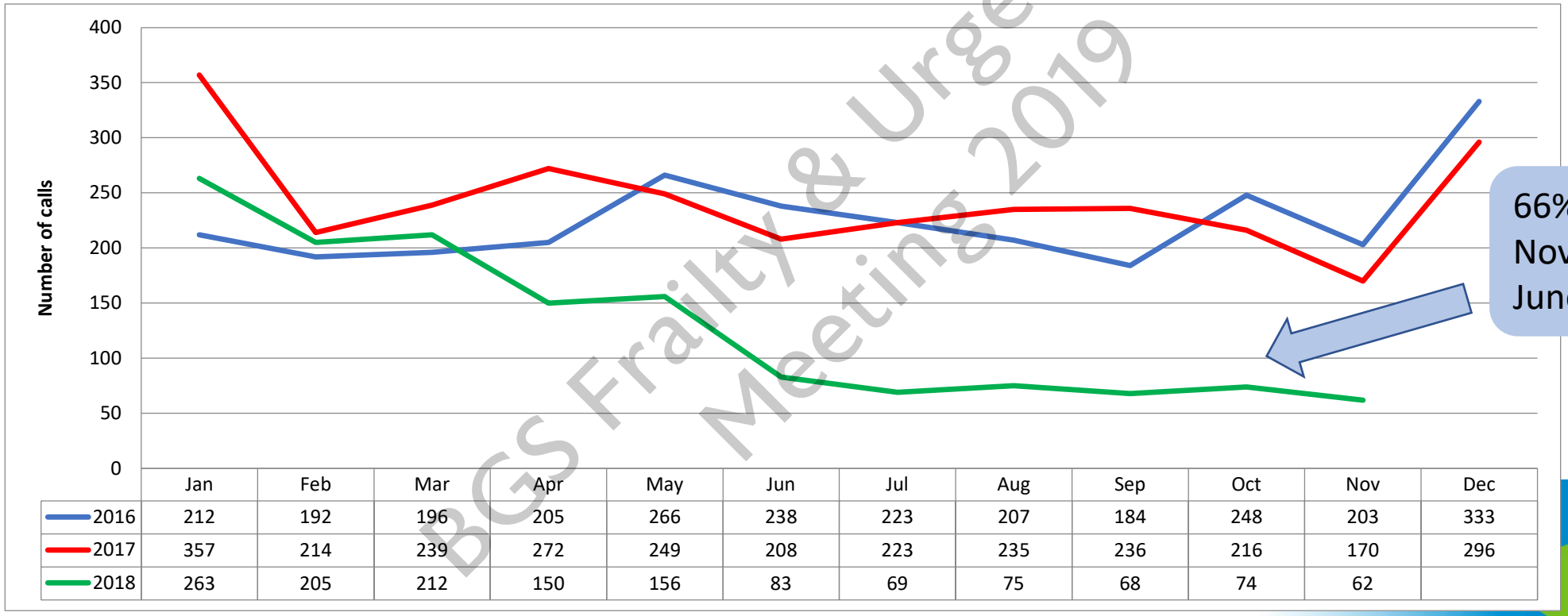
Wirral's Teletriage Service

- Started in July 2017, commissioned to Wirral Community NHS Trust
- 4G Broadband, Ipads
- Assessment via Skype
- 10 care homes initially ; rolled out to 76 care homes by June 2018
- Care home staff taught to perform basic observations
- 24 hour service
  - 3 Band 7 nurses (8am – 8pm)
  - After 8pm, by GPOOH
- Recognition of EOL status, respects EHCP / PPC – takes pragmatic approach
- Importance of engagement of care homes and gaining trust
- Works closely with GPs, Community Geriatricians and other community teams to support the resident in their PPC

Wirral Health & Care Commissioning

NHS 111 use by Care Homes

CALL 111 when it's less urgent than 999

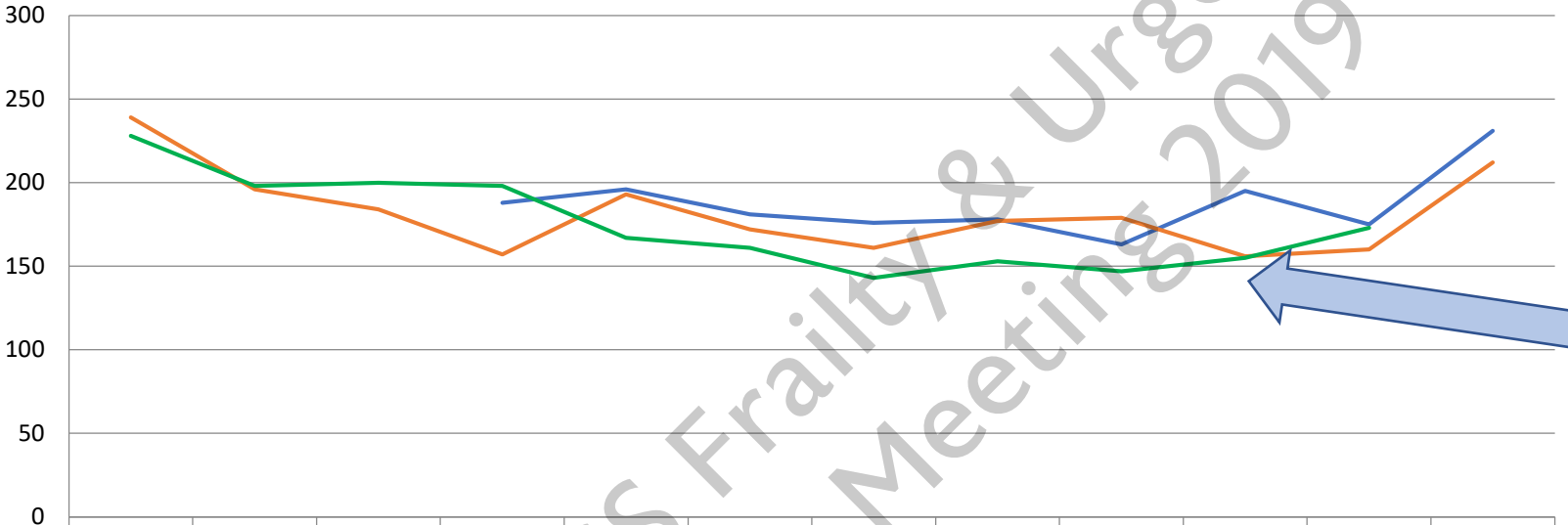


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016	212	192	196	205	266	238	223	207	184	248	203	333
2017	357	214	239	272	249	208	223	235	236	216	170	296
2018	263	205	212	150	156	83	69	75	68	74	62	

66% reduction June – Nov 2018 compared to June-Nov 2017

Wirral Health & Care Commissioning

Ambulance Conveyances to A&E from Care Homes



	January	February	March	April	May	June	July	August	September	October	November	December
2016				188	196	181	176	178	163	195	175	231
2017	239	196	184	157	193	172	161	177	179	156	160	212
2018	228	198	200	198	167	161	143	153	147	155	173	

7% reduction in June - Nov 2018 compared to June - Nov 2017

Wirral Health & Care Commissioning

NHS Wirral Community NHS Foundation Trust

Data July to December 2018

Outcome	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total	Percentage
Patient Advised to contact own GP/ GP to follow up	109	117	143	156	142	207	874	51%
Home Management/ Advice from Teletriage/No follow up	61	41	45	71	73	95	386	22%
Emergency Ambulance	26	26	23	31	39	35	180	10%
Referred to District Nurse	12	21	19	14	17	17	100	6%
Patient Deceased (expected)	6	4	6	9	19	15	59	3%
Referred to A&E	11	8	9	10	7	11	56	3%
Referred to ACU/SAU/Other Assessment Area	11	6	6	7	3	13	46	3%
Other	4	6	3	2	5	7	27	2%
Total Referrals	**240**	**229**	**254**	**300**	**305**	**400**	**1728**	

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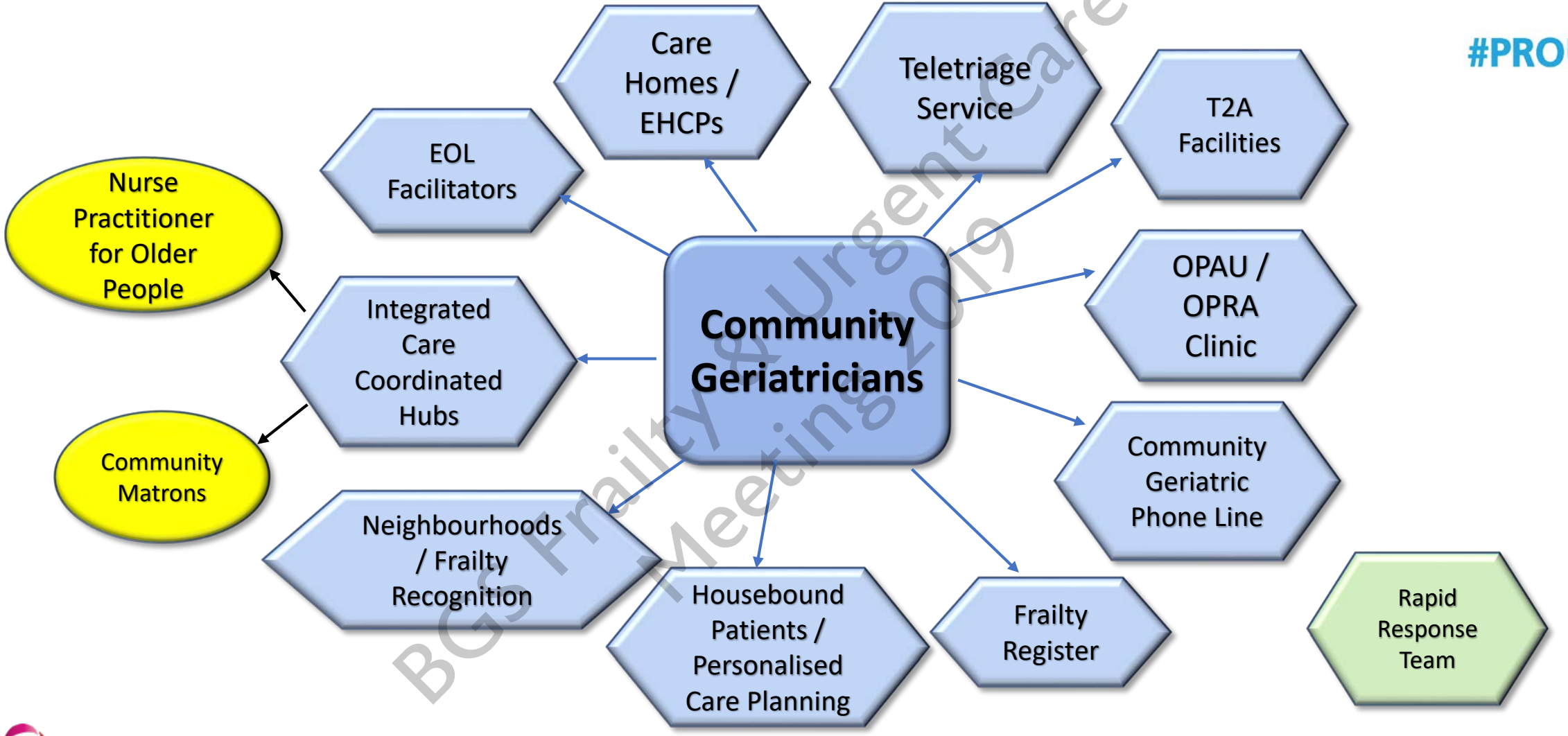
- 88 M
- Parkinson's Disease, Dementia, MDS, T2DM, Chol, Severely frail
- Lives with wife and son, Hoist transfer, Doubly incont
- 7 admissions between April – Aug 2017
- Ref by GP end of August 2017 ?ACP
- OPRA clinic 7/9/17– elective transfusions, DNACPR, PPC at home
- 2 weekly transfusions thereafter – G&S in community
- No further admissions
- Died in December 2017 – aspiration pneumonia, IV antibiotics at home, SC fluids, then palliated at home
- Family felt it had given 3 months which was good quality to him



Focus of admission prevention