Healthy Wirral

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Wirral's Acute Frailty and Cross Boundary Care

BGS Autumn Meeting

Dr Cindy Chu
Consultant Community Geriatrician
Wirral University Teaching Hospital NHS Foundation Trust

6th November 2019

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Wirral

Courtesy of Google Map

- Population of 322,800 (2017) – ONS
- Wide variation in socio-economic demographics (West Wirral vs Rockferry)
- Wirral Clinical Commissioning Group
- Wirral University Teaching Hospital NHS Foundation Trust
- Wirral Community NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust

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Older Persons Assessment Unit (OPAU)

- 24 bedded unit
- Acute Frailty Network Involvement in 2016
- 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, D2A representative
  - Dementia Liaison Nurse, Close links with AGE UK
  - 2 pharmacists on ward rounds, 2 middle grades,2 ANPs, 1 SHO, 2F1s
- Board rounds – 8.30am and 1.30pm

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OPAU Team

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OPAU NEL LOS

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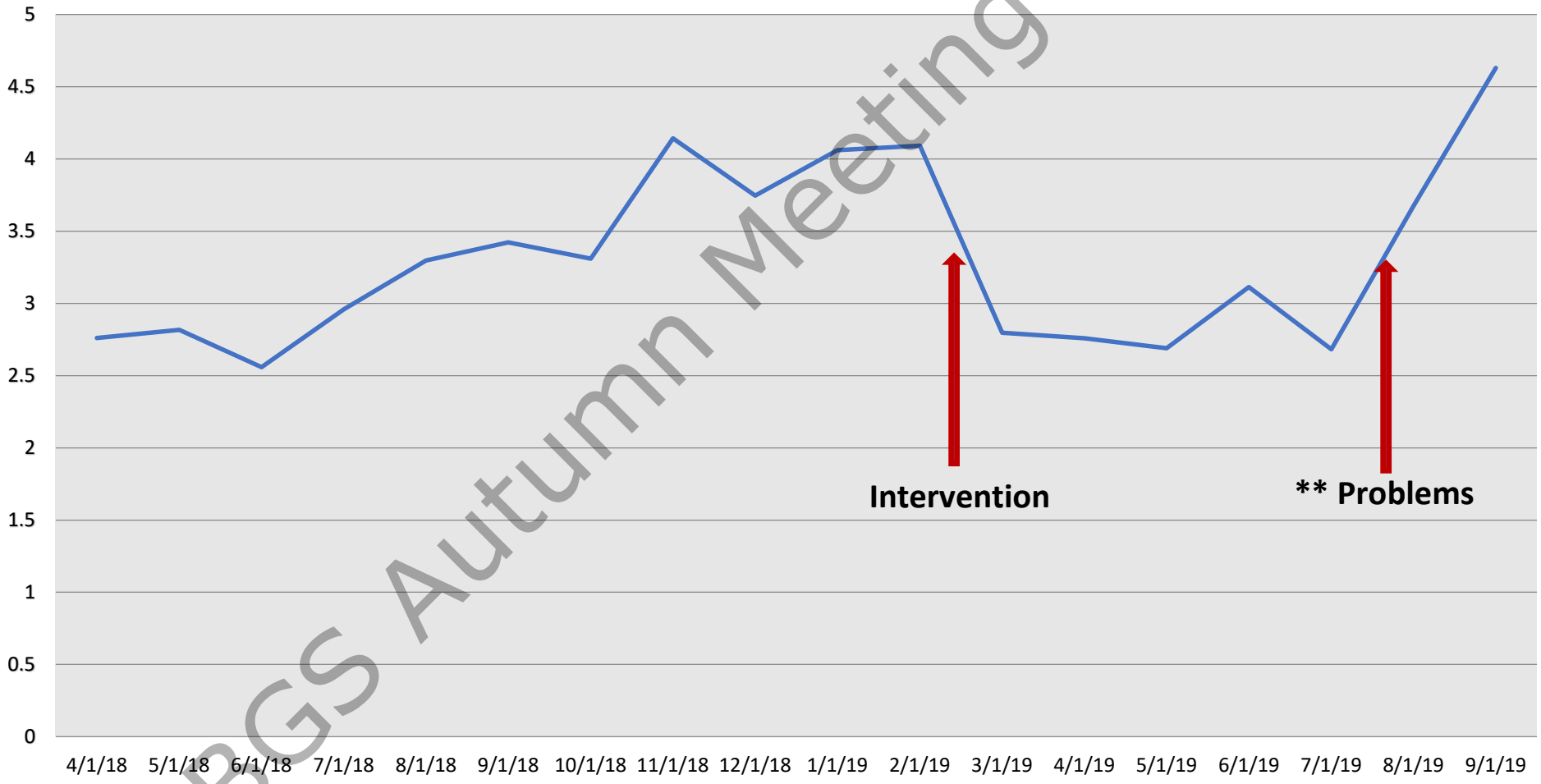
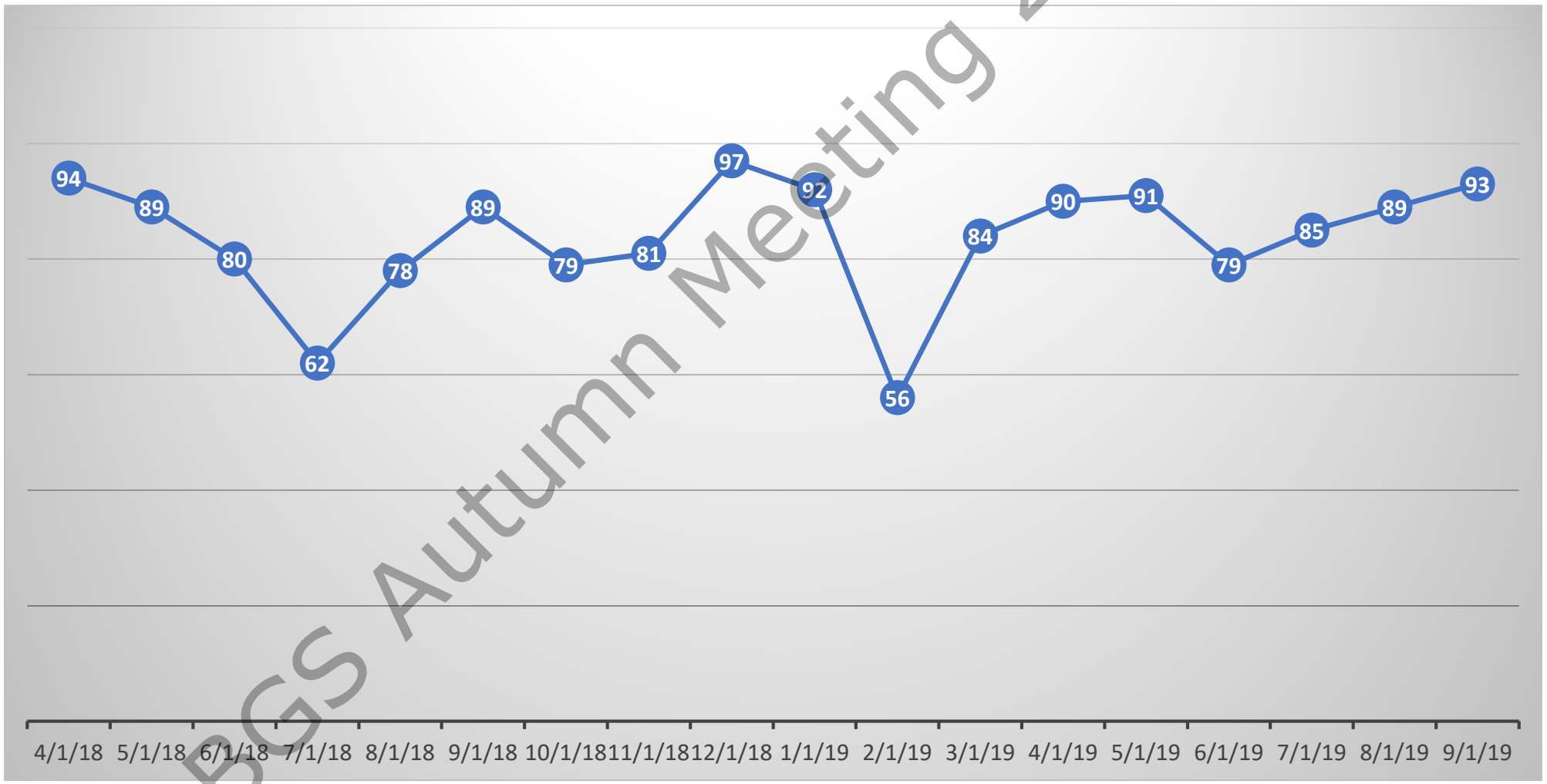


** Annual leave – Cons, SW ; Norovirus outbreak

OPAU Throughput



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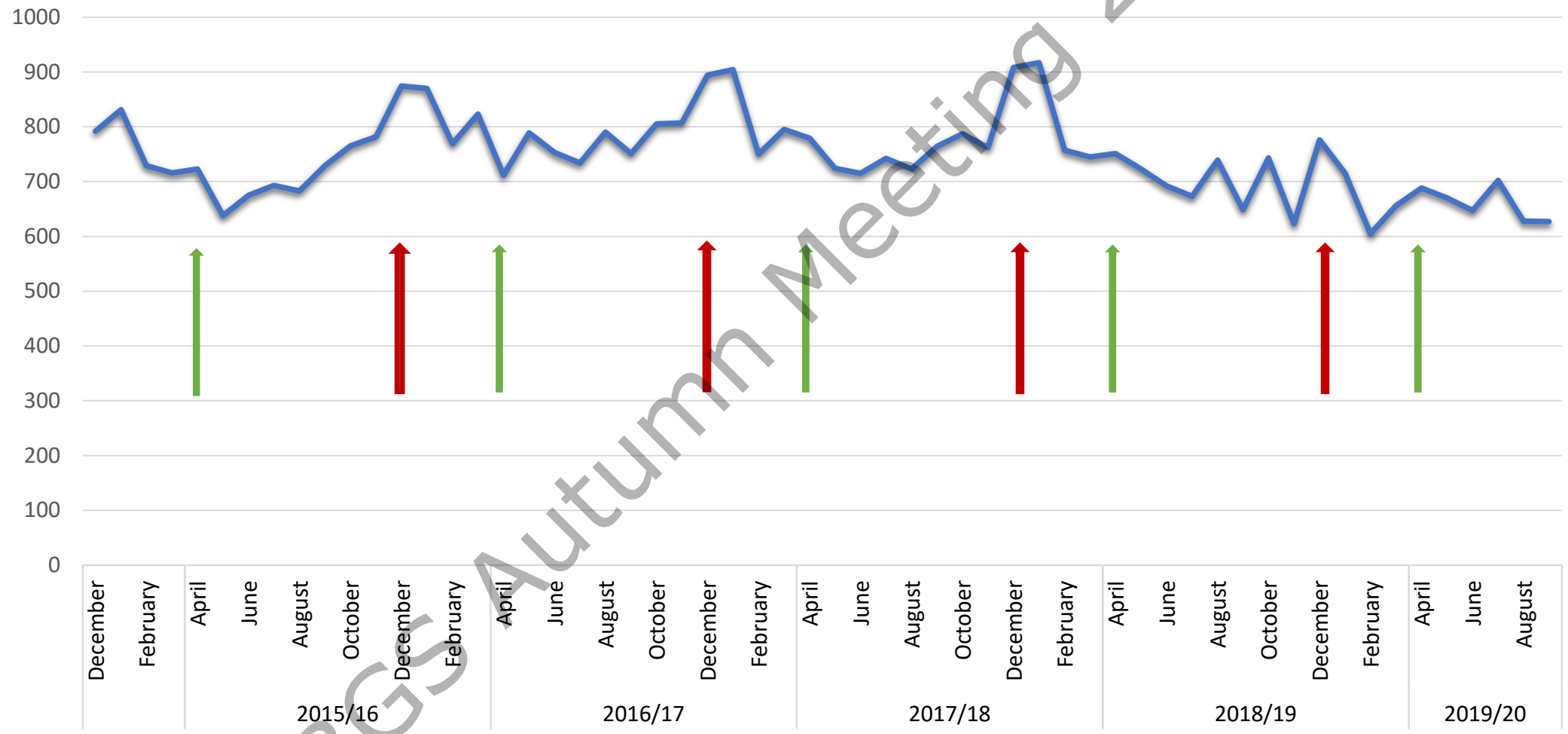
Medical Admission (From A&E)



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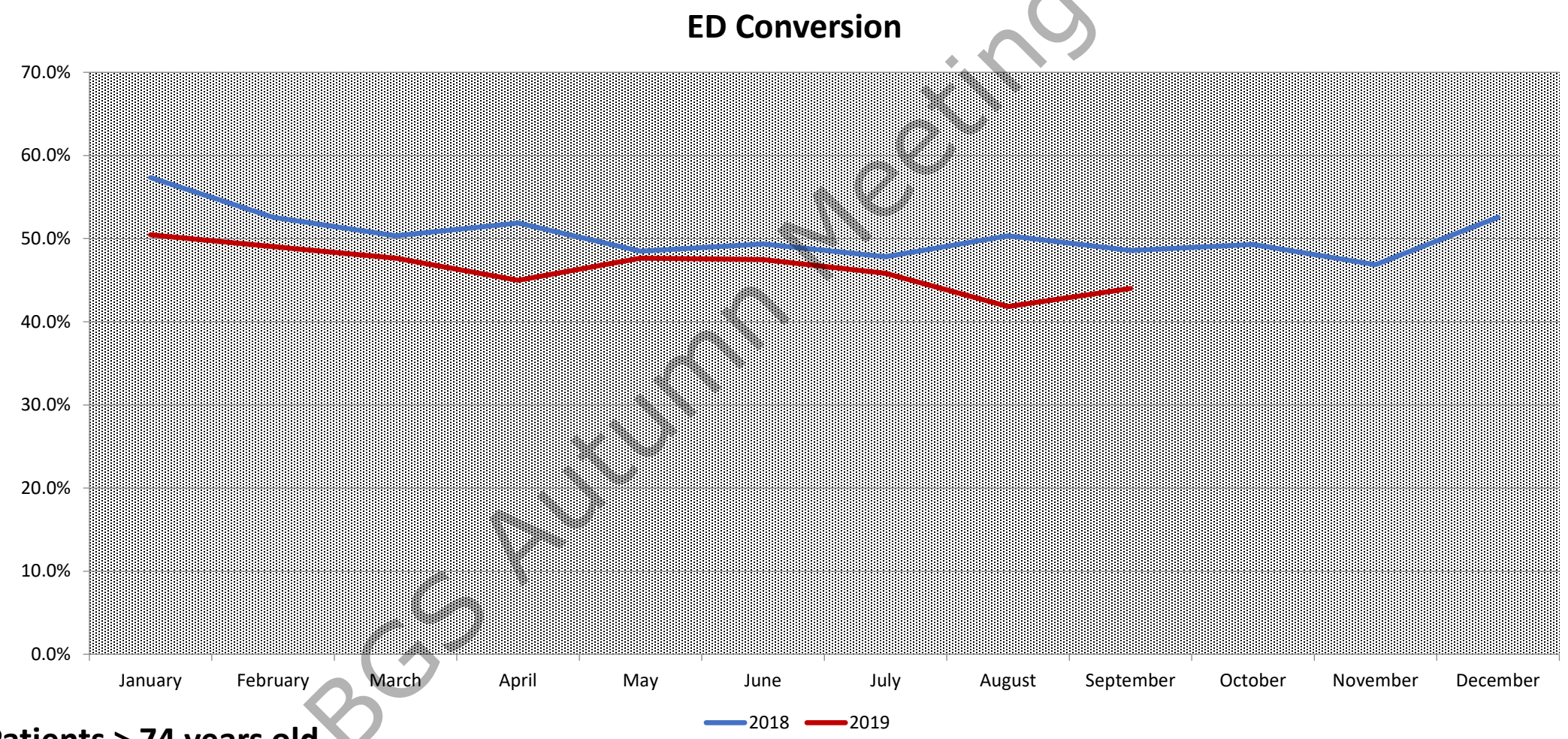
Patients > 74 years old

December

April

ED Presentation : Med Admission Conversion



Patients > 74 years old

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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, D2A

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

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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) 3-5 patients
- Investigations – Xrays, CT staging / CT head, USS abdo / renal tract Same Day
- 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

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Integrated Care Coordination Hubs

- 4 Hubs
  - Wallasey
  - West Wirral
  - South Wirral
  - Birkenhead
- Weekly MDT meetings
- Community Matrons, Nurse Practitioner for Older People, Social Services, MHLT, DN, Hub coordinator. Also liaison with voluntary sectors
- Complex patients are brought to monthly meetings with Community Geriatrician

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Role of a Community Geriatrician

- 4 Community Geriatricians
  - 1.3 whole time equivalent
- Interface between secondary care and the community
- Care Home support
  - 3000 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 severely frail
  - Difficult to get to clinics and likely to need to embark on EOL discussions

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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

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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
  - Personalised and exceptional conditions
- 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

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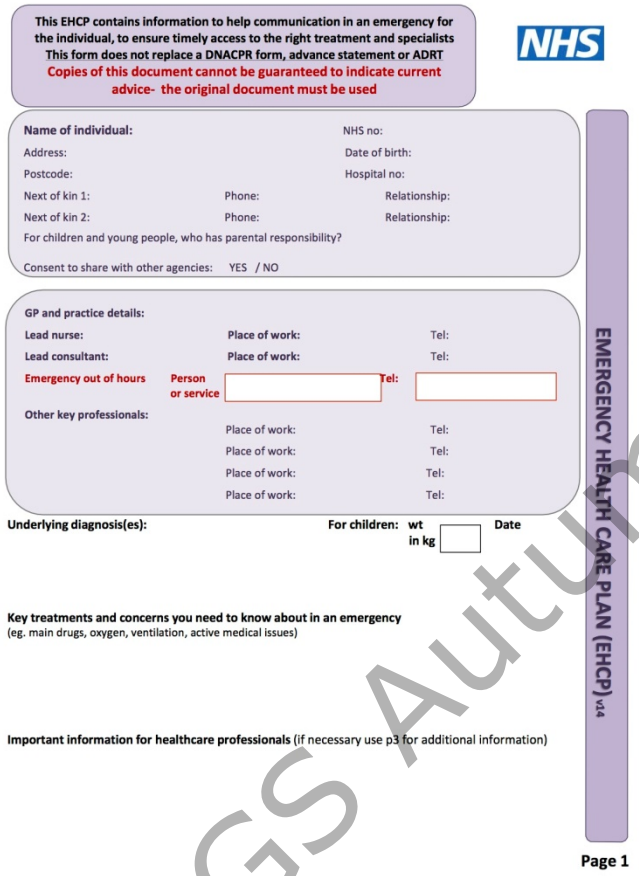
Emergency Health Care Plans



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) v1.4

Page 1

From Deciding Right

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

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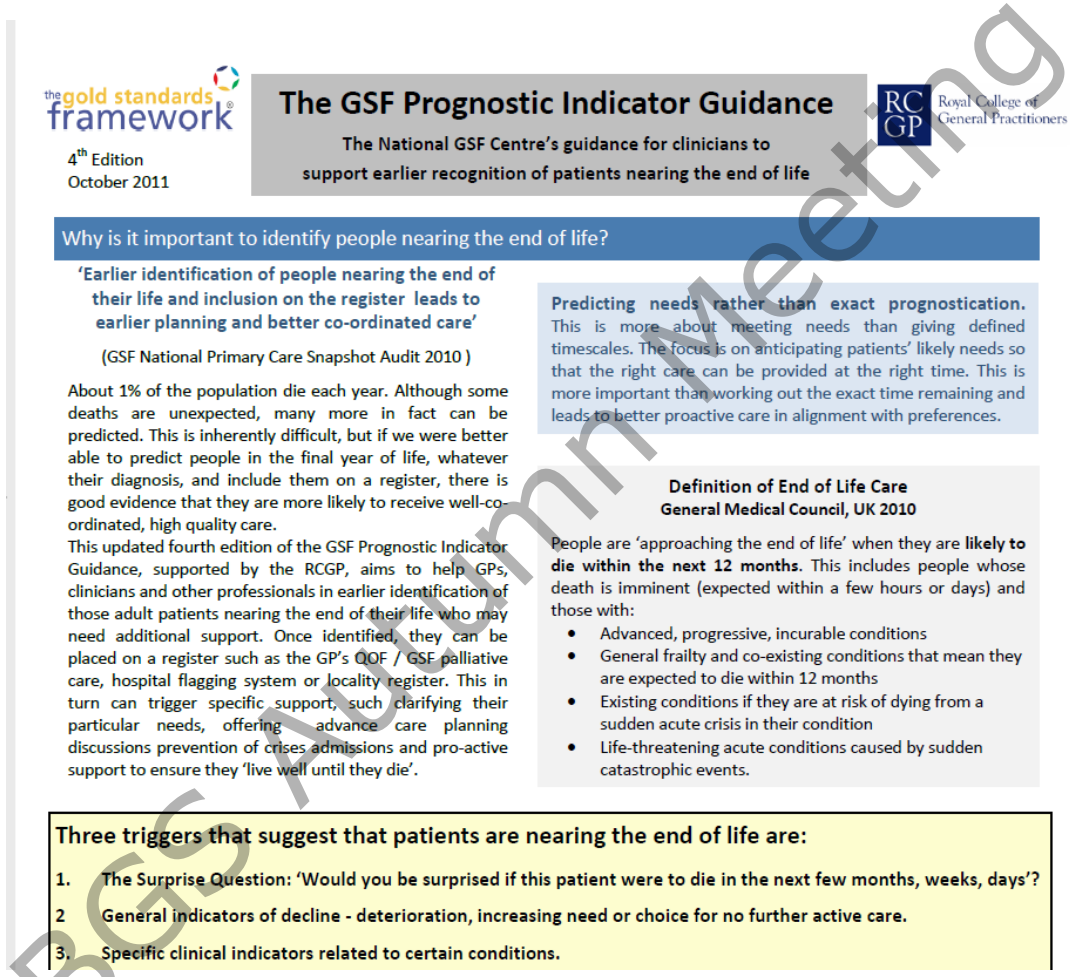
GSF Prognostic Indicator Guidance



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.**

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Housebound Patients

- For those who may be severely frail or other life limiting illnesses
  - Who wishes for pragmatic management at home
  - Comfort as priority of care
- Emergency Health Care Plans, DNACPR
- Yellow district nurse folder
- Lion's bottle – kept in the fridge (Paramedics will look for it)
  - Message in a bottle – contact details of NOK, where relevant paperwork are kept
- Contact numbers for local GPOOH
- DN are aware of wishes and shared on EOL register

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Wirral's Teletriage Service

Wirral Health & Care Commissioning

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- 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 where appropriate

Wirral care home Teletriage

Wirral University Teaching Hospital NHS
NHS Foundation Trust

Wirral Health & Care Commissioning

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Alison Smith
Teletriage Nurse Clinician

Emma James
Teletriage Nurse Clinician

Michelle Highton
Teletriage Nurse Clinician

Jeff Harris
System Support Analyst

Sara Shaikh
Commissioning Manager,
Wirral Health and Care Commissioning

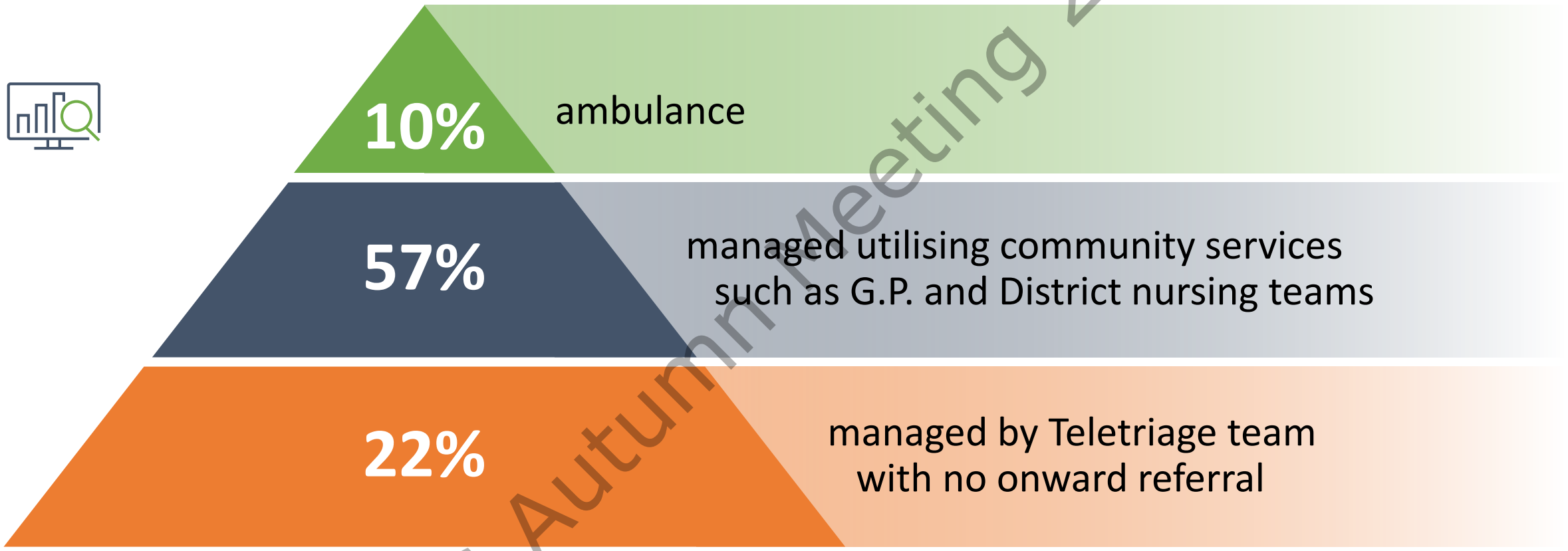
NHS Wirral Clinical Commissioning Group

WIRRAL

Wirral Health and Care Commissioning is a strategic partnership between NHS Wirral Clinical Commissioning Group and Wirral Council

NHS Wirral Community NHS Foundation Trust

Teletriage outcomes



- **Receive 300-400 calls a month (busier at weekends)**

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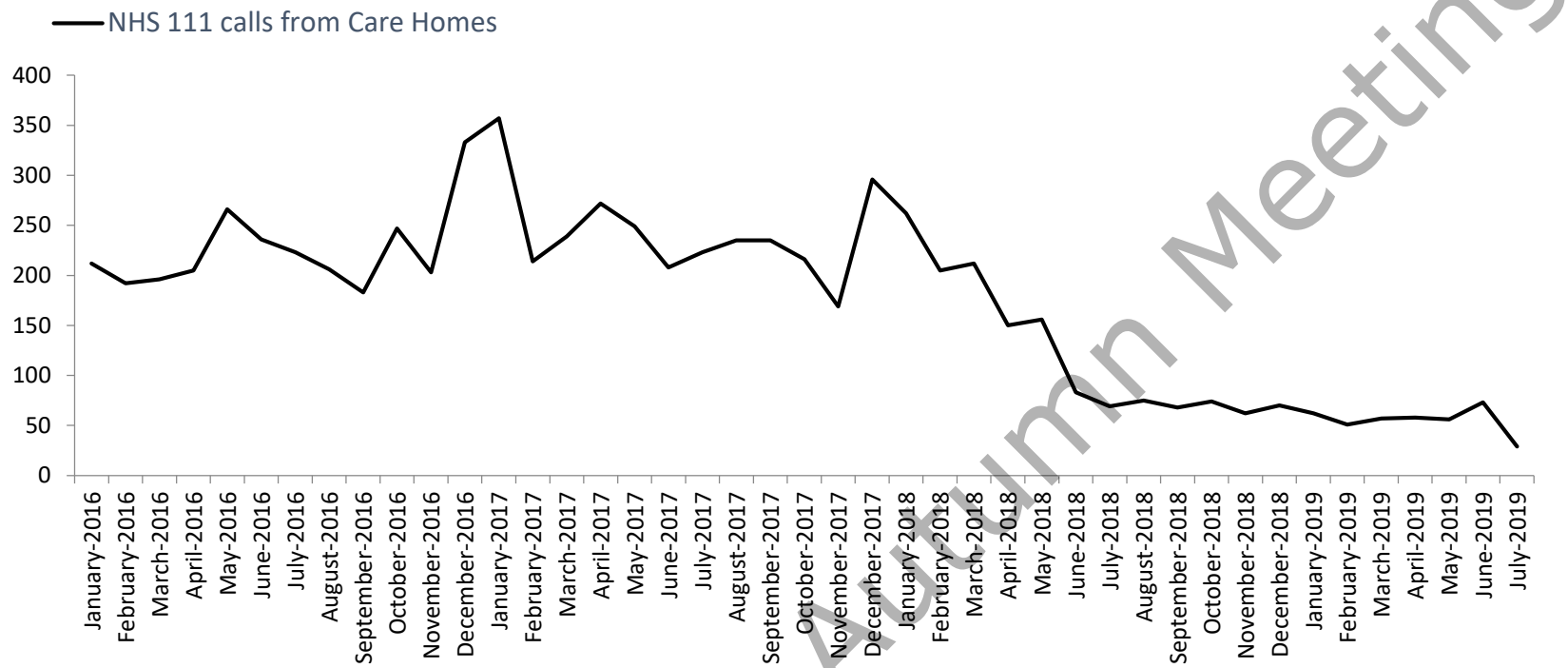
Reduction in NHS 111 calls from care homes

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Health & Care Commissioning



78% reduction

in 2019* compared to 2017 (*January – July)

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NHS Wirral Clinical Commissioning Group

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Reduction in Ambulance conveyances to A&E from care homes

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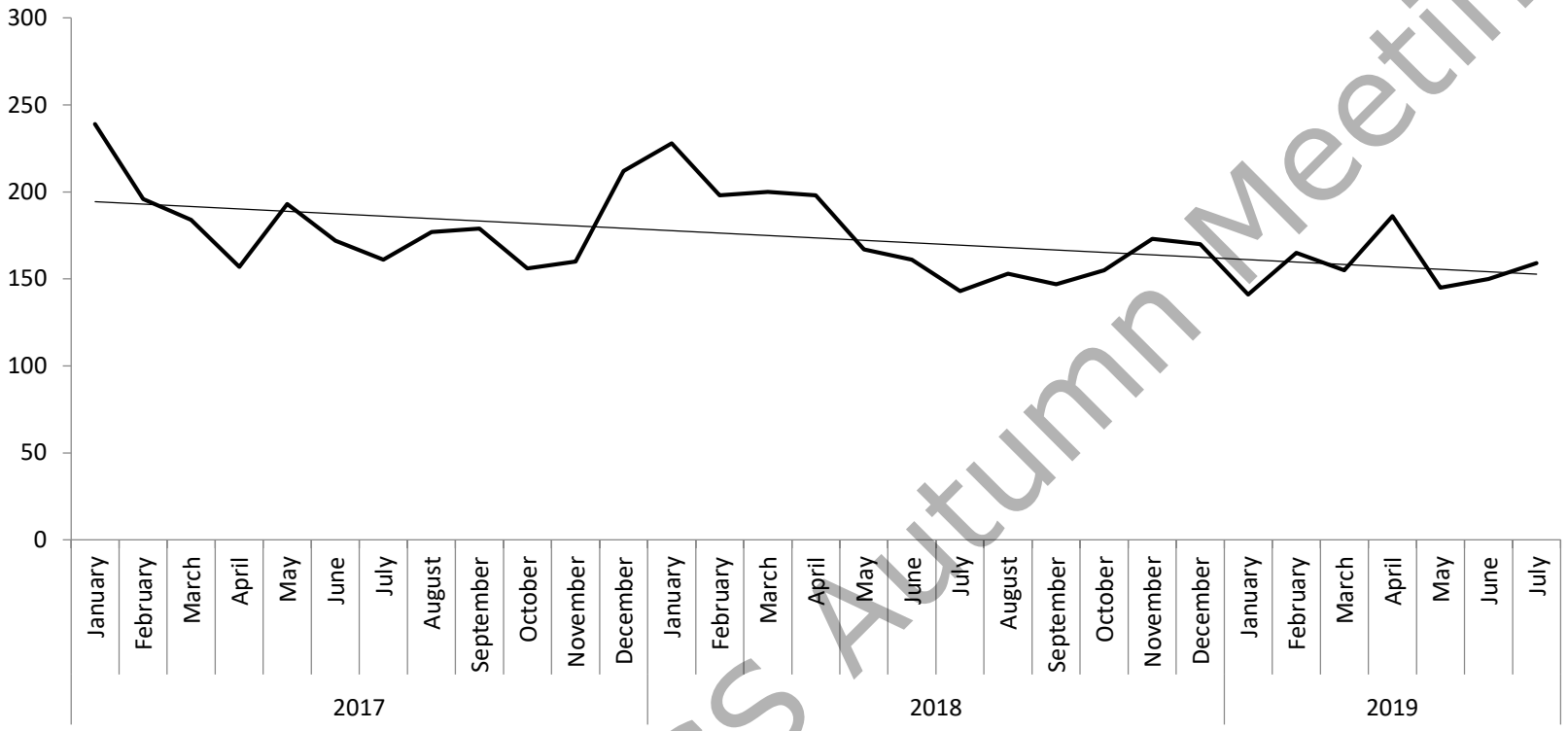
Ambulance Conveyances from teletriage care homes to Arrowe Park Hospital



15% reduction

in 2019* compared to 2017 (*January – July)

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Primary Care Networks

- 5 Networks (2 of which have 2 further 2 delivery units)
    - Wellbeing Wallsey (2 Delivery Units)
        - North Coast Alliance
        - Central Wallasey
    - Moreton & Meols
    - Birkenhead (2 Delivery Units)
        - Arno Primary Care Alliance
        - Brighter Birkenhead
    - Healthier South Wirral
    - Healthier West Wirral

- Population Health Management (covering 30 – 50,000 people)
- Opportunity to reduce variation, improve awareness of local services and influence local development of services

- For Geriatricians - Excellent Opportunity to raise awareness about frailty and to influence changes which would promote proactive management

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Central Wallasey PCN Meeting

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Digital Integration

- Wirral is deemed to be one of the Global Digital Exemplar (GDE) sites
  - Working with Cerner
- Health Information Exchange
- Wirral Care Record
  - Health Registries
  - Health Analytics

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Healthy Wirral

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NHS Foundation Trust

Information available

Acute (WUTH)

51 GP Practices

Available now

NHS Wirral Community Health and Care NHS Foundation Trust

Community (WCHCT)

Wirral Hospice St John's

Coming Soon

Health Information Exchange

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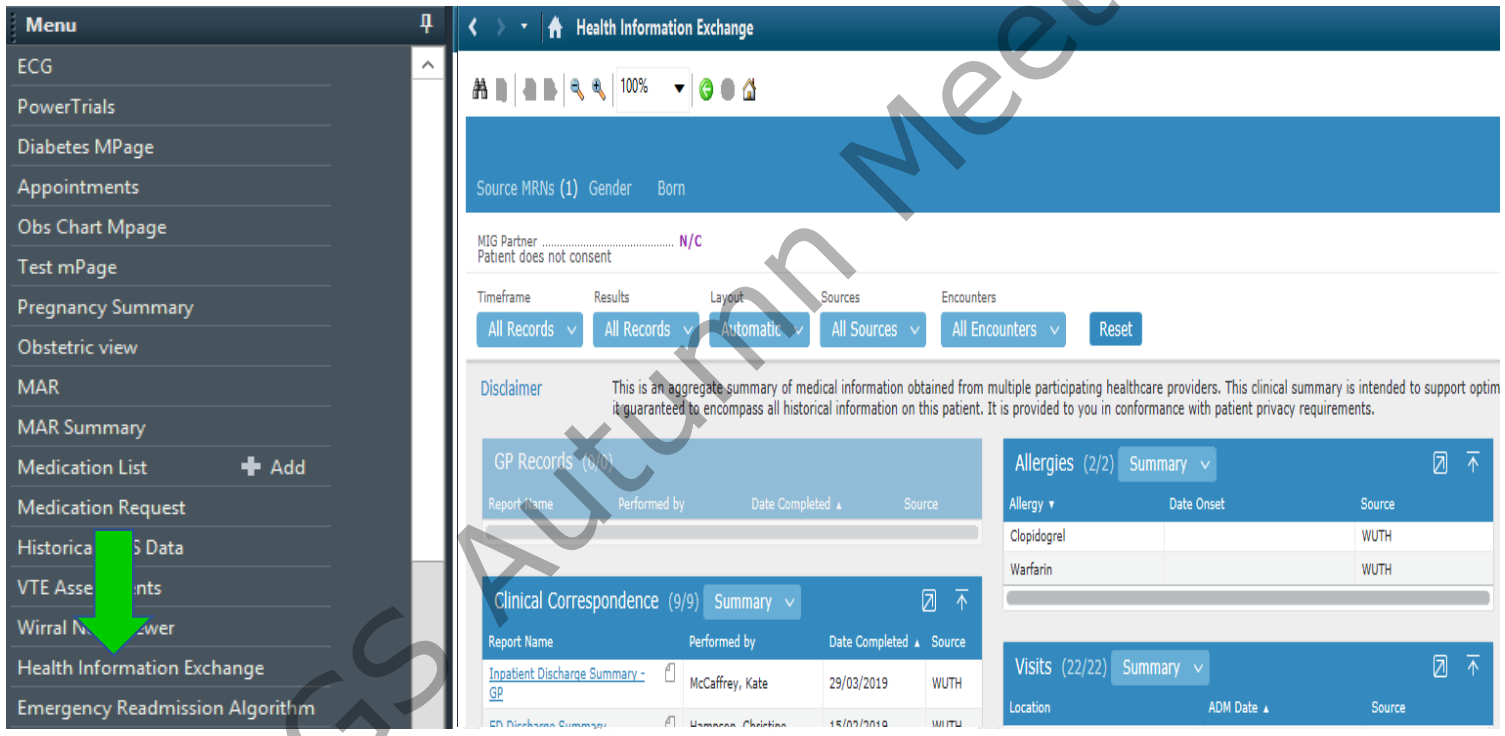
Health Information Exchange (HIE)

Accessing Cerner Portal within Millennium



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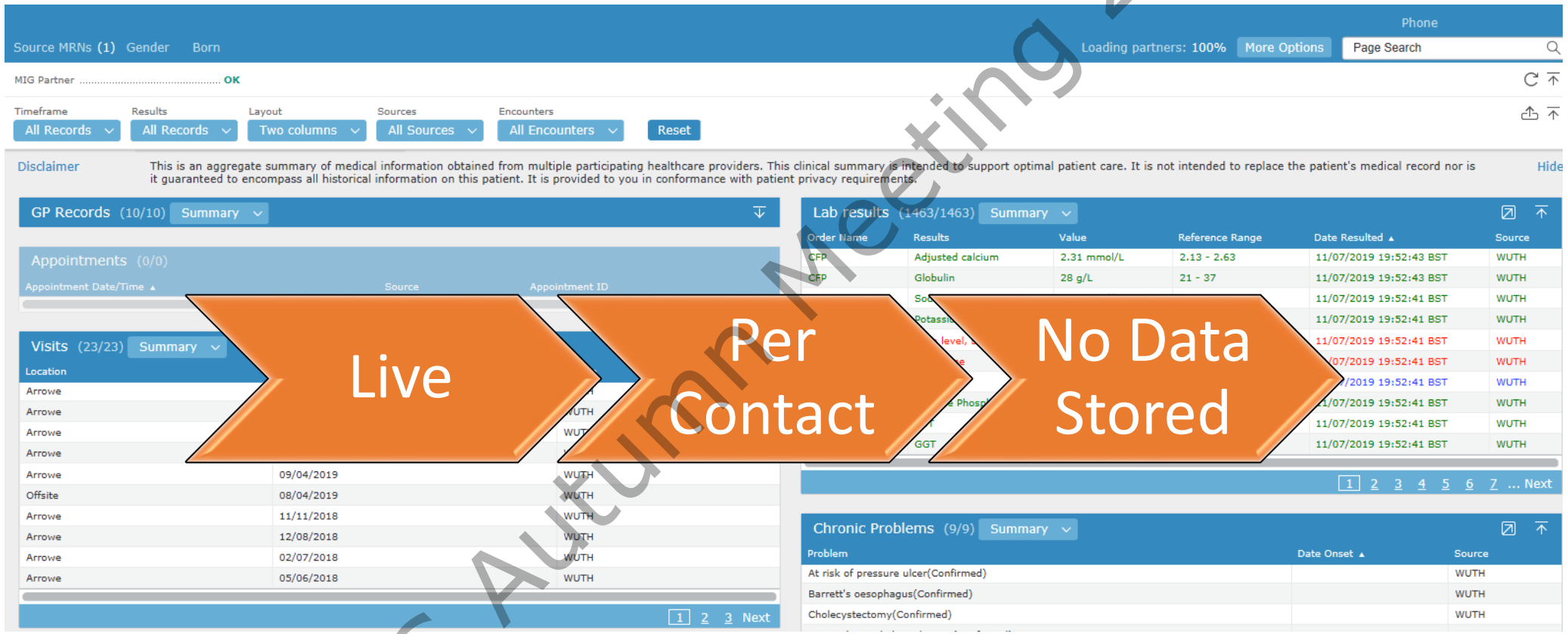
Health Information Exchange (HIE)



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Healthy Wirral

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How it works

Separate Patient Records → One Patient Record → Complete View → Improved Care

NHS Cheshire and Wirral Partnership NHS Foundation Trust

NHS Wirral Community Health and Care NHS Foundation Trust

NHS Wirral University Teaching Hospital NHS Foundation Trust

NHS Wirral Clinical Commissioning Group

WIRRAL

Wirral Hospice St John's

NHS The Clatterbridge Cancer Centre NHS Foundation Trust

The Wirral Care Record

HealtheRegistries

HealtheAnalytics

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Healthy Wirral

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Health Registries

- T2 Diabetes Mellitus, COPD, Asthma, Supportive Care Registry (EOL), Frailty
- Designed to support targeted intervention and prevention based on a set of wellness and condition registries
- Give means of monitoring patient cohorts and identifying gaps in their care when certain measures are not met

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Frailty Registry

- Medication review
- CGA
- Cognitive assessment
- Falls assessment
- Advanced care planning
- Carer assessment
- Mobility and Activities of Daily Living
- Nutrition
- Personalised Comprehensive Clinical Care Plan
- Weight and BMI
- Personalised Social Care Plan
- DNACPR

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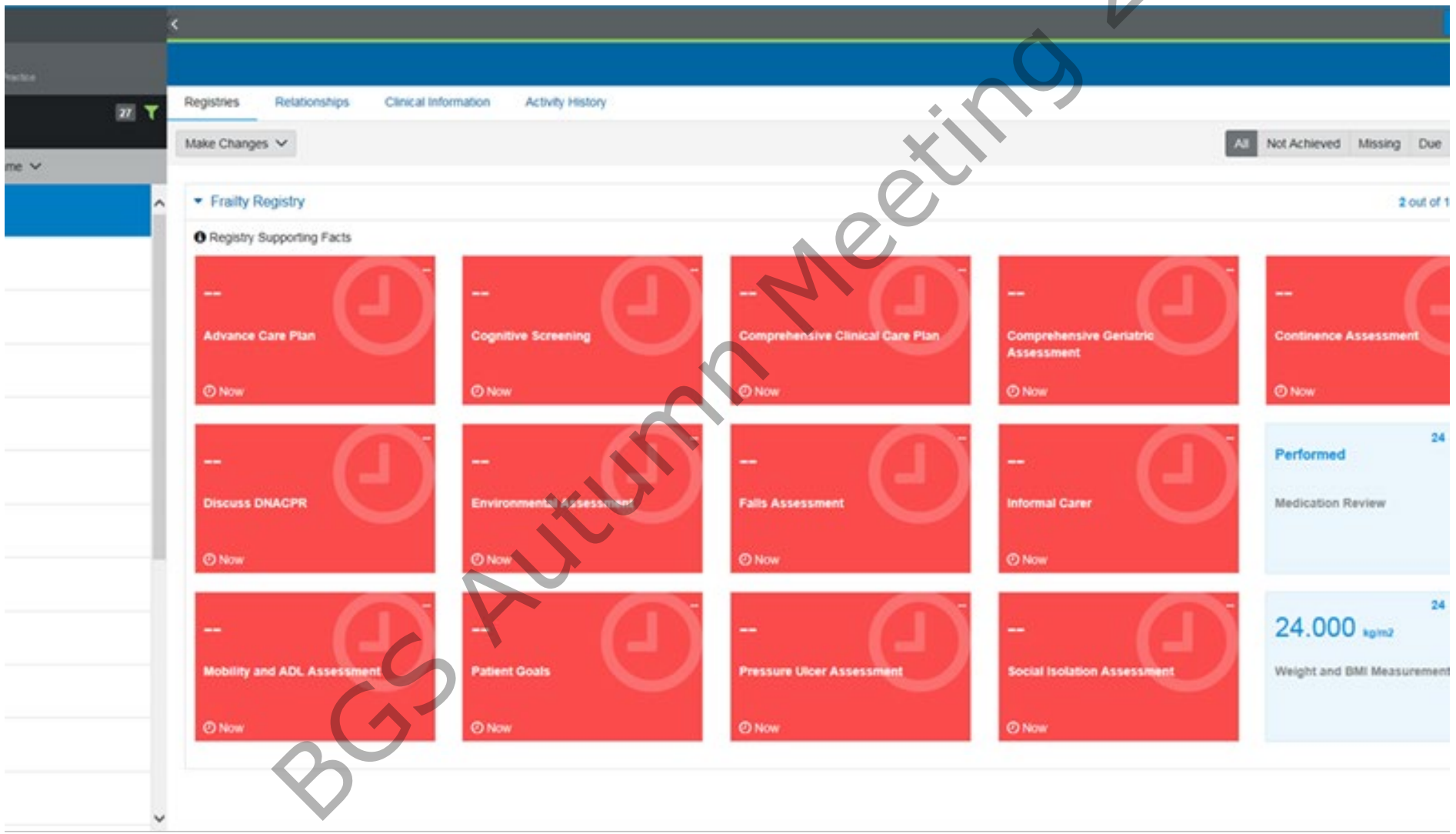
Frailty Registry



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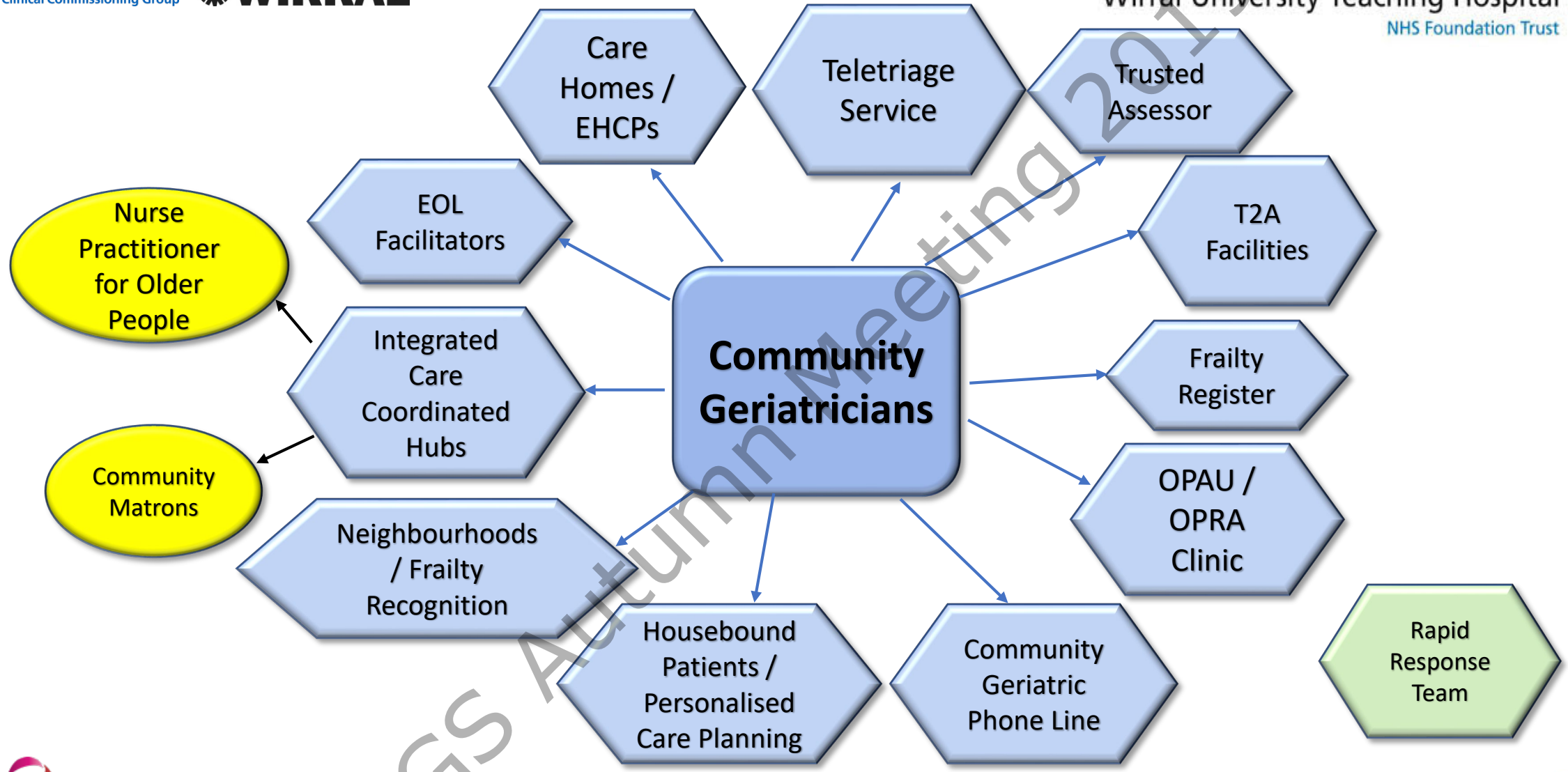

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Focus of admission prevention

JH

- 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
- Ref by GP end of August ?ACP
- OPRA clinic September – 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

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Thank You

Questions?

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