Locality Geriatrics

Dundee and Angus Services

NHS Tayside

James Shaw Consultant Angus

Shazia Din GP Co-Lead DECS-A/SpDr Dundee

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- The journey to full locality geriatrics in Dundee and Angus
- My job as a rural locality geriatrician
- The Dundee Enhanced Community Support Acute (DECSA) service

MFE Dundee/ Angus service 2008

1. Community 	MFE clinic/ day hospital	
	Odd home visit	
2. Ninewells Acute Hosp	MFE liaison to Acute Wards	
		
3. Step Down	Palliative care Rehabilitation MFE assessment	
	Step down Ninewells	

The Vision

- Geriatricians working in Primary Care MDT teams in/ around general practices
- Secondary Care fully comprehensive service from front door to discharge

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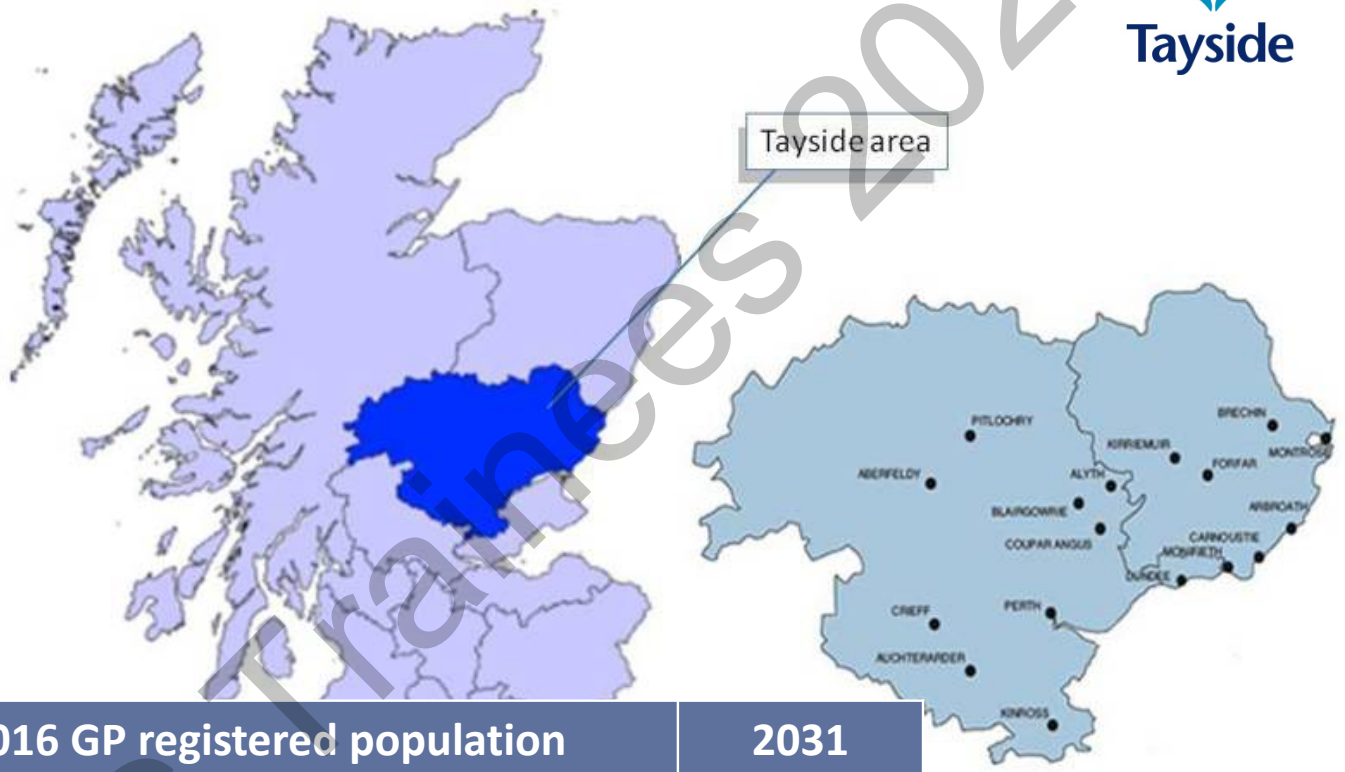

	Oct 2016 GP registered population			2031
	Total	**Over 65**	**Over 65 (%)***	**Over 65**
Angus	110,424	24,436	22.13% (17.9-27.42)	34,995
Dundee	167,958	29,076	17.31% (11.37-29)	32,287
P&K	146,308	32,633	22.53% (16.5-36)	44,355
Tayside	424,690	86,145	20.28%	111,367

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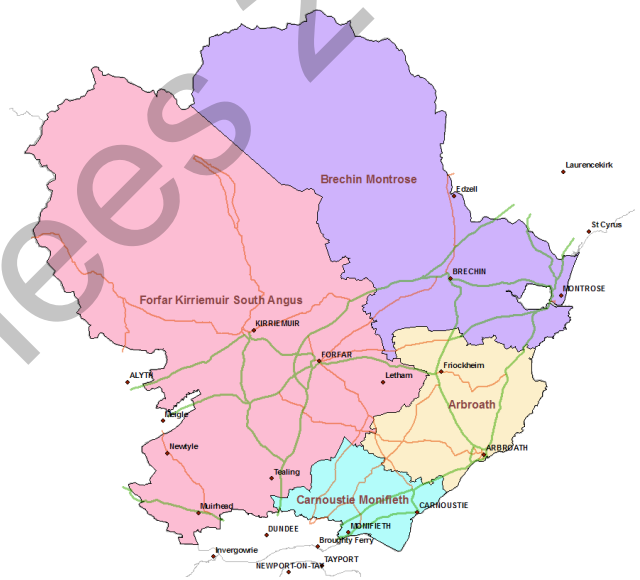

DUNDEE & ANGUS

4 Dundee Clusters with the Dundee locality

Practices are near to each other but patients an be all over the city

4 Angus Localities

Practices near to each other and patients within the locality

Services available to older people...

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Nine Principles of Enhanced Community Support:

1. General practitioners and community nurses will use clinical judgment to identify frail community-dwelling older people requiring comprehensive community-based MDT/ multi-agency assessment (**Enhanced Community Support**) and specialist support.
2. General practitioners have additional capacity to deliver "Specialist Generalist" role to undertake comprehensive medical review.
3. Occupational therapists, pharmacy, pharmacy technicians, physiotherapists, and community nurses are also provided additional capacity to support ECS.
4. The overall care of these patients is co-ordinated by a single named primary care clinician, usually district nurse.
5. These patients should have timely access (within 24 hours) to the full multidisciplinary team in the community, including physiotherapy, occupational therapy and pharmacy.
6. These teams are aligned to respective GP Practices. Many of the team are based in the Practice building.
7. Level III medication review and assessment of medication compliance should be undertaken, if appropriate.
8. Weekly multidisciplinary meetings attended by the locality MFE team and the practice based multidisciplinary team.
9. All these patients should be considered for an anticipatory care plan, including a CPR decision.

ECS Phase I
Winter project 2013-2014

What did we do ?

-Frail patients identified by community staff, OOH, community alarm, paramedics, and are reviewed by GP to ensure medical plan.

-Care co-ordinated same day by senior community nurse and comprehensive assessment delivered.

-MDT General Practice based support available:

Pharmacist, physiotherapist, occupational therapist, pharmacy technician, Locality MFE Consultant/ ANP, Old age psychiatry/ community mental health team, social work Home Care Assessor, Carers agencies, voluntary agency …

-Patients discussed real-time via various communications forms including email, face to face and also weekly MDT meeting in GP Practice..

-MDT anticipatory care plan created and documented, if appropriate

ECS Phase I

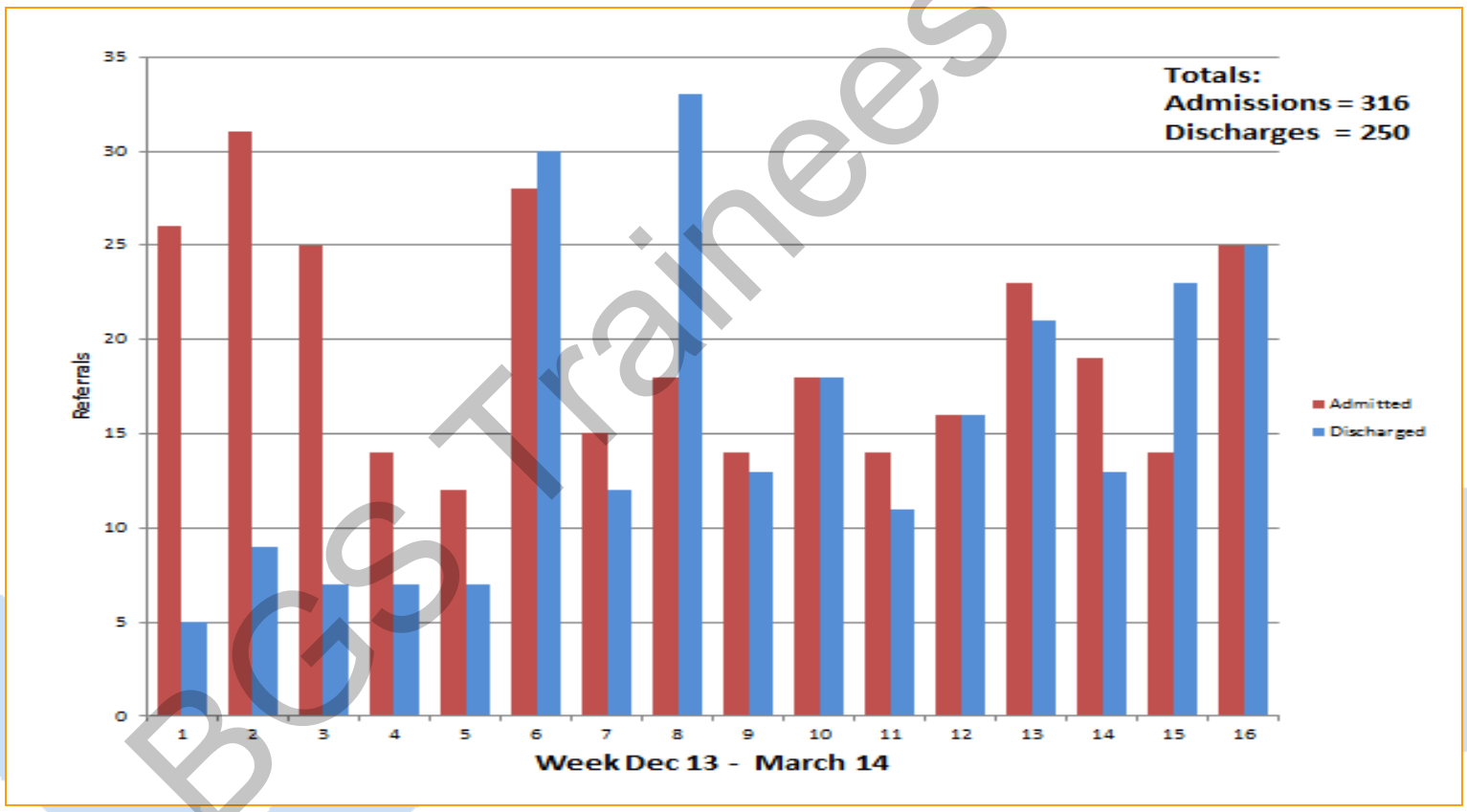
- Pilot with “winter moneys” in Dec 2013 to March 2014 to test model to increase MDT and GP capacity.

- 4 Practices: 2 in East Dundee and the two in South West Angus.

- Evaluation in June 2015:

Ninewells and Angus hospital bed day data Dec 13-March 14 for the piloted population	
Emergency admissions	**Reduction of 8%**
Length of stay	**Reduction of 1.5 days**
Hospital bed days used	**Reduction 23%**

ECS Activity numbers – population coverage 40,000

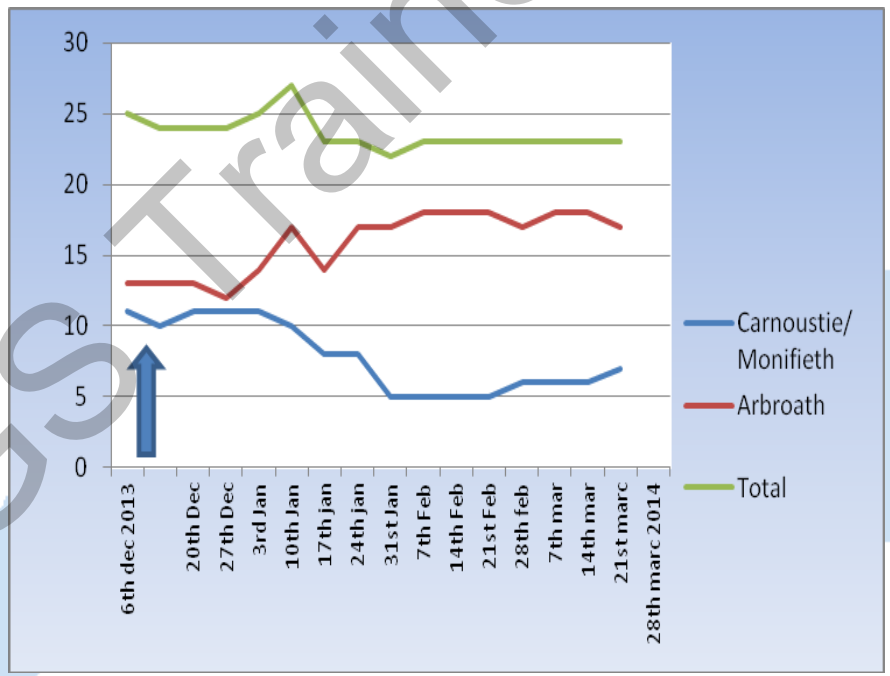


Dr Ellie Hothersall, Consultant in Public Health Medicine, NHS Tayside
Public Health evaluation June 2014

ECS Phase I

Hospital beds occupied per night South Angus

Dec 2013 to March 2014



ECS Phase II Angus

- Following the success of ECS phase I.

- Rolled out to all GP Practices in both localities of South Angus on 1st Feb 2015.

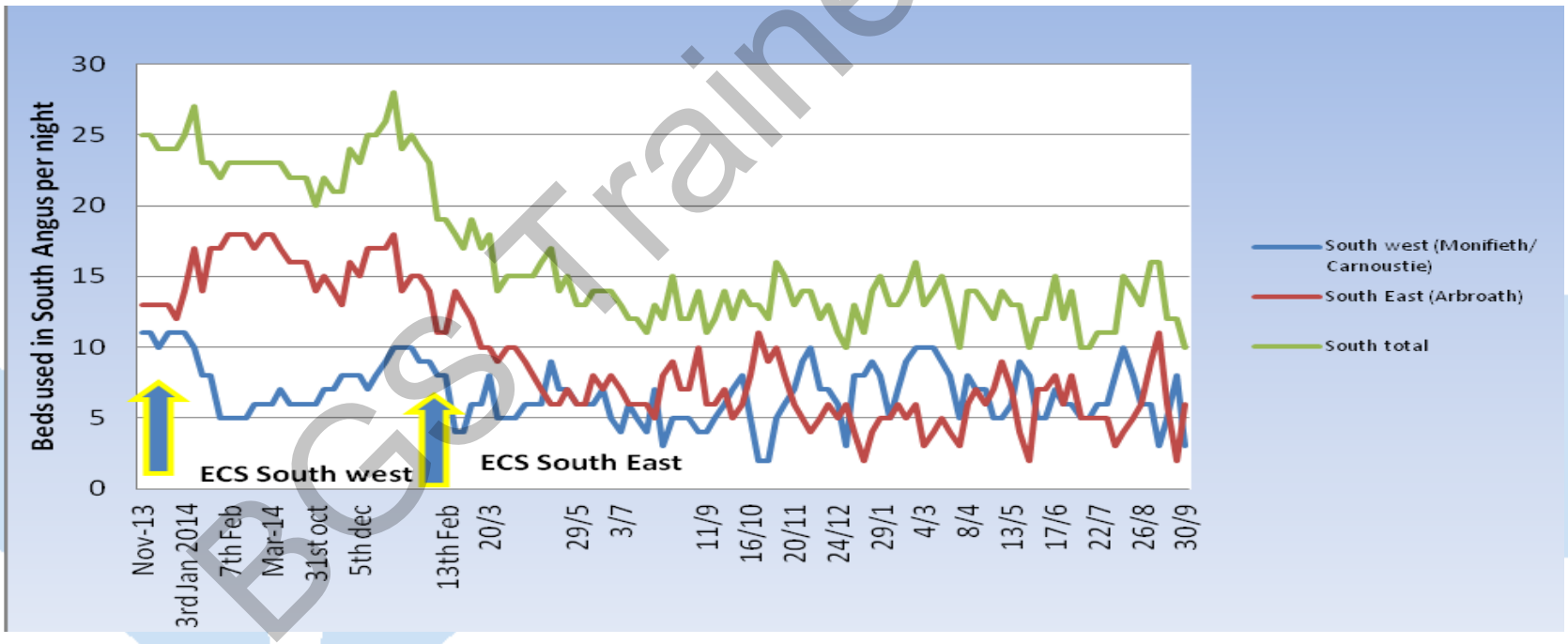
- Integrated Care Fund made available to employ nursing, pharmacy technician and AHPs . Service Level Agreement used to increase GP capacity.

- Decreased in local hospital beds made possible a transition of care from local hospital to the community by Little Cairnie Hospital becoming non-operational. This allowed the funding of ECS in the South Locality of Angus.

ECS Phase II Angus Outcomes

Reduction in hospital bed days used

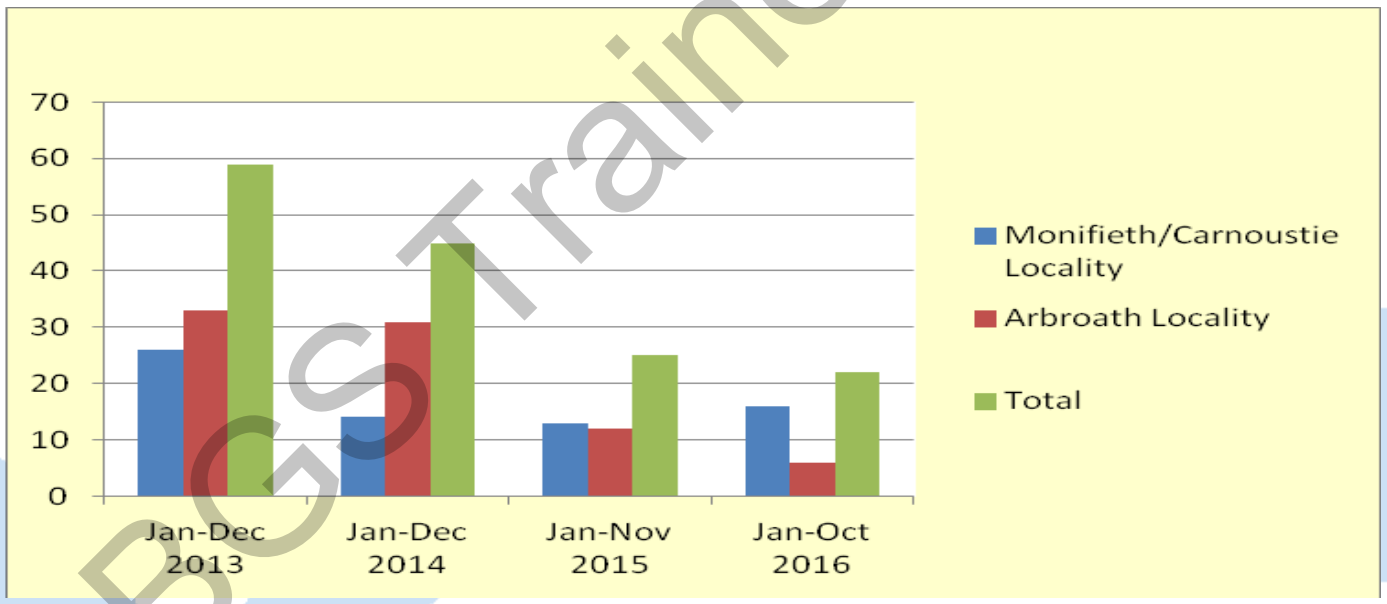
Nov 2013 to September 2016



ECS Phase II Angus Outcomes

Reduction in transfer to institutional care

Number of patients going from a South Angus bed to a care home



Enhanced Community Support Phase III

North East Angus – November 2016

- Role out to North East Angus Locality
- Integrated change Fund resource from South Locality to “pump prime” ECS in North East Locality
- ECS model with coverage of 12 General Practices and population 84,000

North West Angus – February 2018

- Whole Angus coverage.

Financial impact of ECS in Angus

ECS Phase I:

Between Jan 14 and Nov 16 there have been approximately 1,700 potential bed days saved, which at a unit cost of £230 per day, adds up to around £400,000.

ECS Phase II:

Between Feb 15 and Nov 16 there have been approximately 3,000 potential bed days saved, which at a unit cost of £230 per day, adds up to around £700,000.

Reduction in bed days resulted in 3 community hospitals being able to be closed

ECS Dundee

Phase II: Dundee city August 2014 - 2015

- Light coverage all 24 practise with ECS nurse managing caseload of frail people, supported by 2-6 weekly MDT meetings
- Integrated change Fund resource
- ECS model with coverage of 24 General Practices and population 170,000

Phase III: February 2018

- Dundee Enhanced Community Support rapid Assessment (DECSA)

MFE Dundee/ Angus service 2020

1. Community	MFE clinic
	Polypharmacy clinics (level 3)
	Care home support
	Day assess/ treatment
	Enhanced Community Support
	Telephone/ email advice
	Intermediate care
2. Ninewells Acute Hosp	Acute Frailty Team/ on-call Acute Geriatric Unit
	Orthogeriatrcis
	Surgery liaison
3. Step Down	Palliative care Rehabilitation MFE assessment
	Step down Ninewells
	Community step -up

Other aspects of Locality Geriatrics in Angus

- Acute Care Work for our Locality
  - Patients within Medicine (Acute MFE Units)
  - Review of patients in other specialities
  - Liaison with orthogeriatrics team
  - Liaison with new acute surgical team

  Working closely with Angus Discharge Team in Ninewells

- Polypharmacy work
  - Mini-CGA as well inc. ACPs, etc
  - GP, MFE, Pharmacist +/- DN
  - Care Homes Reviews
    - Care home manager
  - Hospital
    - Started in Hospital
  - Community
    - Select high risk populations

    eg DN caseload

Other aspects of Locality Geriatrics in Angus

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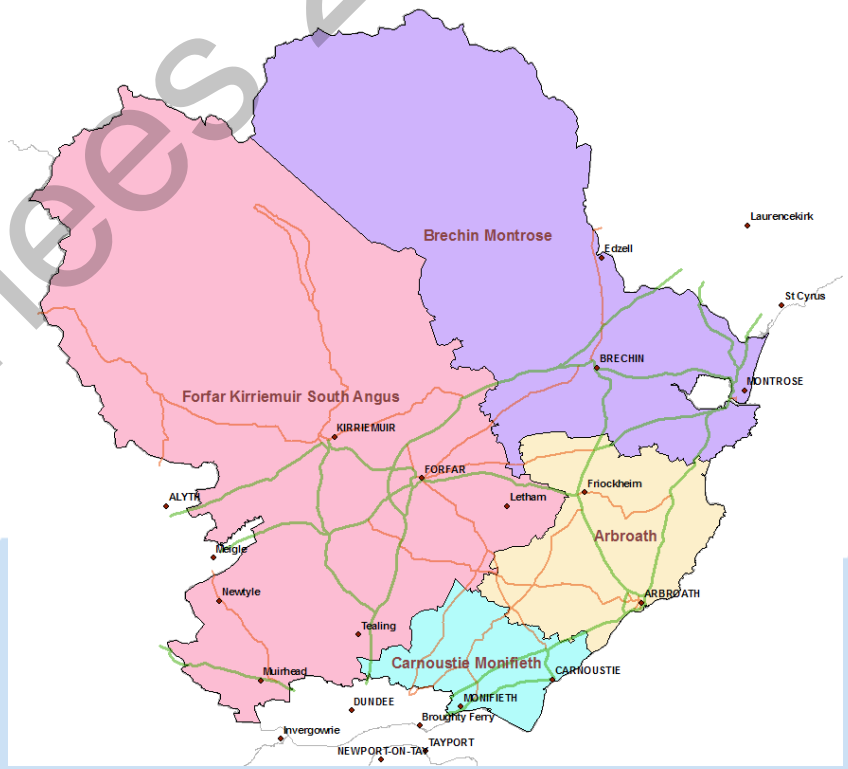
- Virtual contact
  - Locality Consultant
  - Advice for GPs, pharmacists
  - Arrange admission (acute or community hospital), MFE ANP visit
- Intermediate Care beds
  - Supported by MFE
- Care Home visits
  - Individual basis by Dr/ANP
- Clinics
  - Locality based Parkinsons Service - 1 PDNS for Angus
  - Centrally coordinated falls service ->locality teams
- Day Treatments
  - 2nd line OP treatments >75
  - IV iron infusions

- Involved with service design and management with Angus HSCP

My Life as a Locality Geriatrician in ANgus

- Split time between Ninewells and locality
- Community Hospital MFE Led
  - Whitehills Hospital
  - 21 beds
- Community
  - Clinic / day treatments
  - ECS meetings
  - Community Visits
  - Care home/ polypharmacy clinics



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Typical Day Tuesday

9am - Start in Ninewells seeing Acute patients (post take/ Day 2+ after AFT have seen)

11 am - Ninewells Angus MDT

1pm Forfar ECS MDTs

3pm Whitehills check

Typical Thursday

9am - Kirriemuir ECS MDT

10am – Clinic

11.15 – Whitehills Board Rounds

2pm Review clinic or / community clinic/ visits/ Back to Ninewells

Community Geriatrics in Dundee

Dr Shazia Din

GP Co-Lead DECS-A/Sp Dr MFE

Royal Victoria Hospital Dundee

Services to support Older people at Home in Tayside

- Community Rehab team
- Community Mental Health team
- **Enhanced Community Support**
- District Nursing Teams
- **Dundee Enhanced Community Support Acute (DECSA)**
- First Contact team
- Community Alarm
- Community Physio / OT
- Enablement team
- Care Home Team
- Dundee Carers Centre
- Dundee Voluntary Action
- Royal Volunteer Service
- Food train
- Community cars
- Day care
- HOPE project
- Dementia Cafes
- Befriending services
- Fire service

…. Any many more

Dundee Enhanced Community Support- Acute

- Model aligned to Hospital at Home service
- Patients acutely unwell needing co-ordinated medical care, access to further investigations, need urgent social care (Red Cross)
- GPs would have otherwise admitted patient to hospital
- MFE consultant led, daily ward round

REFERRALS FOR OVER 65 YEARS AND REGISTERED WITH A DUNDEE GP

Dundee Enhanced Community Support – Acute (DECS-A)

Does your patient meet the following criteria?

Over 65 and Acute Medical need with ONE of the following:

- Confusion (dementia/delirium)
- Care Home resident
- A fall with low trauma fracture not requiring surgery
- Deterioration in Parkinson's Disease
- Increased frequency of falls (more than 3 falls in 3 months)
- Acute exacerbation of an existing Long Term Condition
- Acute Infection

OR

- Patients greater than 85 with an illness that is NOT better served by a single organ specialism
- Unexplained sudden functional decline

ALL PATIENTS REFERRED REQUIRE TO HAVE BEEN SEEN BY A GP WITHIN 24HRS OF REFERRAL

EXCLUSIONS

TIA OR CVA – FOLLOW STROKE PATHWAY

APPROACHING END OF LIFE CARE

HEAD INJURY WITH LOSS OF CONSCIOUSNESS OR OTHER SUSPECTED NEUROLOGICAL ISSUES

LOSS OF CONSCIOUSNESS

ACUTE ABDO PAIN

GI BLEED

ACUTE COLLAPSE GCS LESS THAN 9

RESUSCITATION IN PROGRESS

CARDIAC RELATED CHEST PAIN

TRACHEOSTOMY OR NIV USER

NEWS GREATER THAN 7

SEPTIC PATIENT

USE THE AFT BLEEP NUMBER TO DISCUSS REFERRALS TO DECS-A TEAM: 4385

Mon- Fri 09.00-18.00

Except PH/Weekends

REFERRALS taken before 3pm will be seen on the same day if there is capacity, otherwise will be seen the following day.

CARE Home patients: refer to Care Home Team 423186

ECS: If patient fits criteria for current ECS Red, but is not acute- contact ECS team or rapid response mobile 07776 465 742

MFE Cluster Consultants can also be contacted to discuss patients & referred to DECS-A

Version 2 March 2018

Essential criteria for DECSA

- Dundee city only service
- Patient and family need to be on board
- Must be seen by GP within last 24hr prior to referral
- NEWS score <7 (HR, SP02, BP, RR, Temp)
- Referral made via – Acute Frailty bleep or via MFE Cluster Consultant
- Step up only service from Primary care

Essential Information

- Service operates Monday – Friday (9am-5pm)
- **All New referrals to be made before 3pm to allow for same day assessment**
- Aim to see patients within 2hrs of referral

What's different about DECSA?

- MFE Consultant led service – Daily input (face-to face or virtually)
- To provide a CGA approach to managing patients within own home
- Access and interpretation of diagnostic tests
- Access to carers – Red cross (overnight sitter service!)

DECSA team – at present

- MFE Consultant/GP Co-Lead Service
- Nurse Consultant for Older People
- 1 GP - specialist interest in MFE
- 1 Clinical Fellow MFE
- 1 ANP and 2 Trainee ANPs
- Part time admin support

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DECSA enables vulnerable frail older people to be safely assessed and managed at home rather than be admitted to hospital which is often not clinically required but was previously the only option for many. This avoids the risks associated with hospitals such as falls, delirium and further loss of function.

Hospital at home service to enable frail older people to stay at home and receive multidisciplinary assessment and care in a more homely environment reducing risk from hospital admission for vulnerable people.

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Frail person referred by GP with acute deterioration in function

Comprehensive assessment by doctor or advanced nurse practitioner in person's home within 24 hours

- Ongoing review and management of patient medical needs by DECSA
- Referral to other allied health professionals as required
- Emergency social care provided by Red Cross if required and ongoing assessment of need for social care

Results

DECSA results

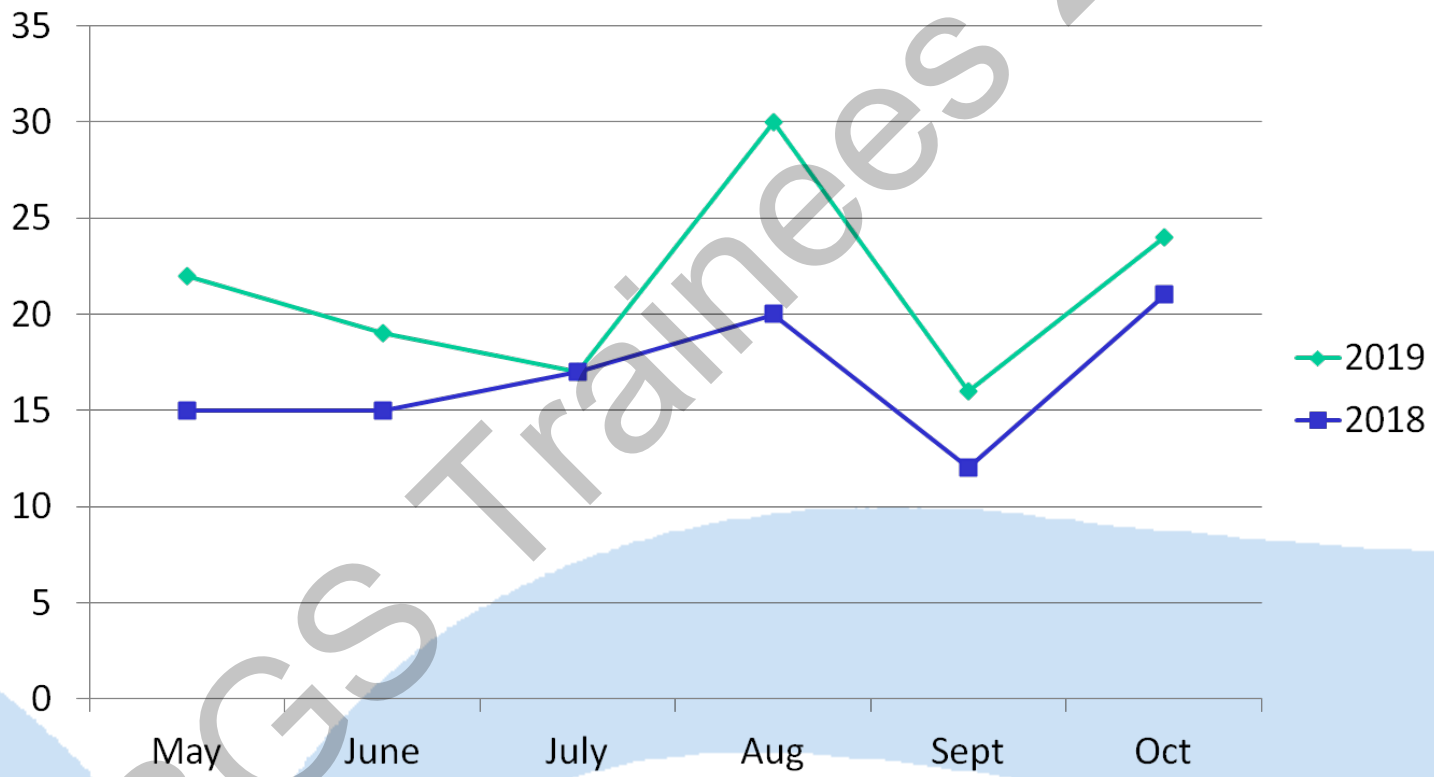
Referrals over 10 months

- 270 patients referred since Jan'18
  - Mean no. of referrals per month = 18
  - Mean length of stay in DECSA = 7 days

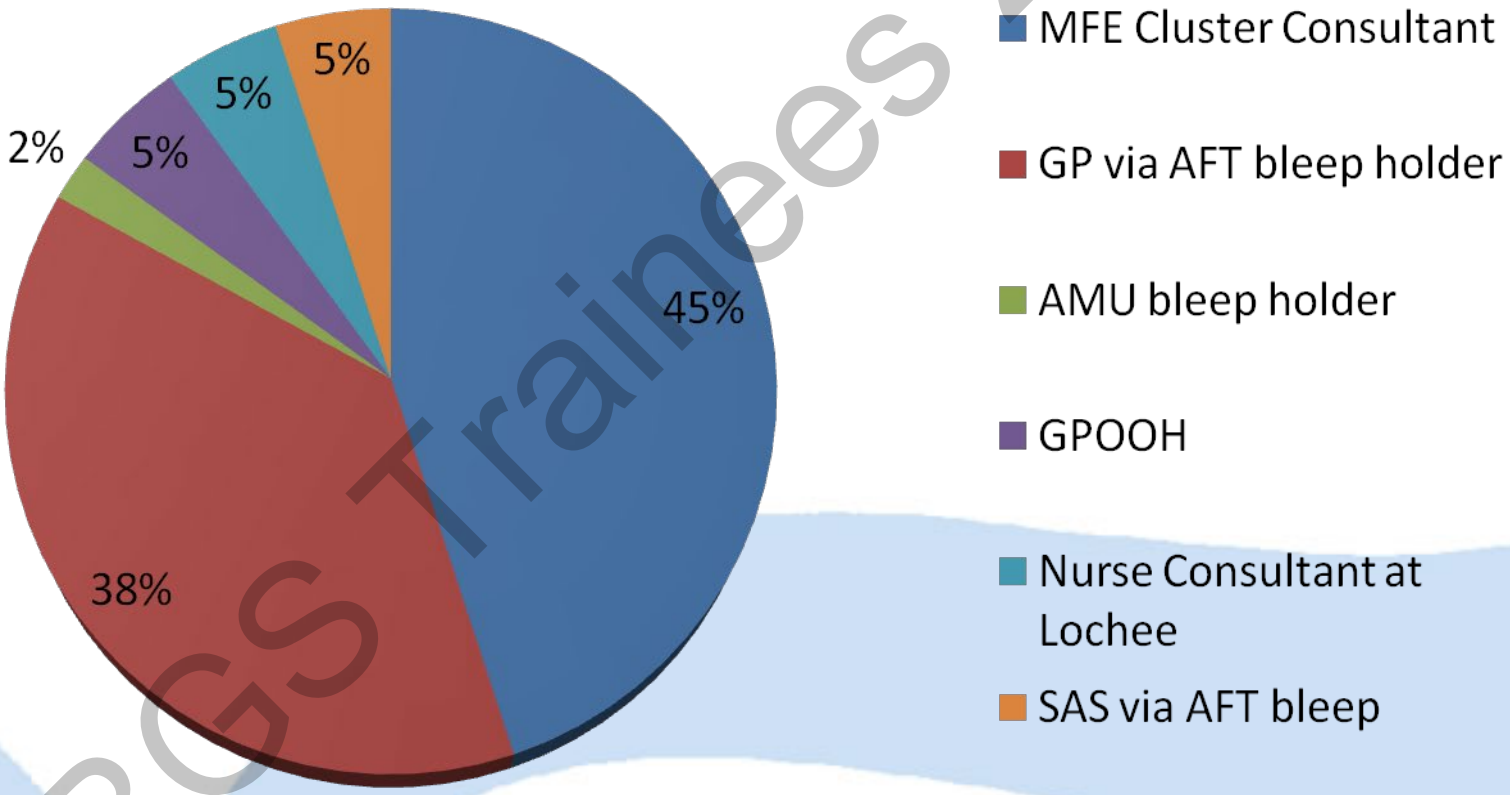
DECSA results

- 70% of patients referred to DECSA managed at home
- 20% of patients admitted to Hospital after initial assessment by DECSA team
- 10% of patients admitted to Hospital whilst under DECSA care
- 40% of referrals to Red Cross - emergency Carers (including overnight sitter service)

N DECSA Referrals



Source of DECSA Referrals



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Case Presentation

Mrs C

- 92 yr old lady
- Referred to ECS (Amber)
- Functional decline, recurrent falls
- Multiple Missed appts
- PMH – IHD, T2DM, HTN, LVSD,
- SH – lives alone, MoW, mobilises with stick, community alarm
- No POC

Mrs C

- **Initial ECS assessment:**
  - mildly confused
  - mild ankle oedema
  - constipated
  - non-compliance of meds
  - BP 175/80 no postural drop

- **Management plan**
  - pharmacy tech – venalink
  - PT/OT referral
  - GP prescribed laxido

Mrs C

- **Day 5 – visit by ECS nurse:**

  - More confused – disorientated
  - Agitated
  - Sons concerns wandering
  - Fall ? Head injury
  - Pyrexial Temp 37.8C
  - Urinary frequency

- ECS nurses struggling – phoned for step up to DECSA team

Mrs C

DECSA review with 1 hour:

- Patient remained confused
- Temp 37.9C
- Tender suprapubic area
- Constipated on PR
- Bladder scan – urine retention (600ml in bladder)

Plan:

- Catheterised
- Urine sent for C+S
- Commenced on oral Pivmecillinam

Mrs C

Plan:

- Red cross team for urgent care
- Sitter service overnight
- Phosphate enema
- Bloods – CRP 120, WCC 13.8, eGFR 50
- Diuretics witheld
- Red cross carers pushed fluid intake
- POA informed of decline – USA

Mrs C

Progress:

- Day 4 – less agitated but remained confused
- CRP 70 renal function improving
- Bowels moving daily
- Catheter removed
- Voiding well
- Red cross team reduced to x4 POC
- CTB – SVD nil else
- Son over from USA

Mrs C

Progress:

- Day 7 – less confused
- Antibiotics completed
- Compliance of meds improved with venalink
- CRP 30 renal function baseline
- PT continue to see improvement in mobility
- OT – equipment. Handrails toilet and showed, bedside commode

- Patient discharged back to ECS/GP to discuss at MDT – progress and ongoing cognitive decline

Challenges for DECSA!

- **New patient assessment takes 3hrs!**
- Poor mobile signal RVH
- Limited to Dundee city
- Poor IT systems linking GP to hosp care
- Access to Red Cross care variable
- Transport for patients for investigations
- Lack of Pharmacy time
- No weekend or PH working at present
- Acute changes to meds difficult – venalink
- Deaths – who certifies, who issues cert
- Training staff – training ANPs
- No PT or OT in team (rely on CRT)
- Changes to Primary Care urgent care

Future plans for DECSA

- Offices to co-locate with ECS team (ward 3 RVH)
- Develop IT systems
- DECSA patients step up to BBU & RVH
- Increased Pharmacy time (level 3 polypharm review)
- Closer links with radiology and diagnostics.
- Possible use intravenous antibiotics / diuretics
- GP trainees / MFE trainees / FY trainees on team

Summary

- Dundee Community MFE:

- Locality/ Cluster model
- Early Intervention / ECS
- Community MDTs in GP practices
- MFE teams aligned to GP practices / clusters
- DECSA – similar to H@H, rapid response team
- DECSA – MFE Consultant led

“I love being at home it's much better than hospital”