

# IMPROVING OUT-OF-HOURS HANDOVER OF FRAIL AND VULNERABLE PATIENTS IN THE COMMUNITY SETTING

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## BACKGROUND

Today's NHS demands proactive, responsive care for frail and complex patients. Effective care planning is an essential tool in this process (NHS 5 year forward view<sup>1</sup>). In response to the 2014 admissions avoidance Directly Enhanced Service, 2% of the population of Dorset already have an admissions care plan in place. However, anecdotal discussion established that access to care plans by urgent care clinicians can be limited. This must be addressed, given that 69% of temporal GP access is not provided by the patients' own GP.

**Access to information to allow out-of-hours clinicians to make appropriate and collaborative clinical decisions, in the best interests of the patient, is essential.**

## PROJECT AIM

To ensure best care for frail and vulnerable patients at all times, through improved handover of patient wishes and clinical information between routine and out-of-hours GPs.

## PATIENT STORY

The following patient experience, took place in November 2014. It illustrated to me the need for improvements in the patient journey in the out-of-hours community setting.  
96 year old elderly, gentleman with dementia. Lived with his daughter and son in law (a GP). UCS GP called in to assess what is thought to be a terminal illness, late at night. Family want to avoid admission at all costs in line with pre-existing patient wishes. Existing documentation and practicalities make it very difficult for the visiting GP to enable this choice.

## PROJECT DESIGN

### PLAN

- In December 2015 a project design was drawn up. The aim was to develop a Pan-Dorset Anticipatory Care Plan. The method was followed and the fact finding cycle commenced. Discussions were held with key stake holders: GPs, geriatricians, physio, patients, urgent care clinicians, palliative care clinicians and an IT lead.
- It became apparent, during the fact finding period, that pockets of work developing a unified care plan were already well underway in parts of Dorset, with some duplication. The Dorset CCG Frailty and End of Life Reference Group convened for the first time, identifying the need for mapping of activity relating to the care of patients with frailty in Dorset.

### DO

- Quality Improvement tools (Driver Diagram) and the use of the Pareto Principle led to the the consideration of how data from existing Care Plans is communicated with UCS clinicians: those who temporally cover 69% primary care.

**Figure 1: DRIVER DIAGRAM Considering patients with frailty in Dorset.**

Outcome	Primary Drivers	Secondary Drivers	Interventions
To improve the patient journey of patients with frailty in Dorset.	1. IMPROVED COMMUNICATION Effective, Pro-active holistic delivery of clinical and social care.	1. IT & COMMUNICATION 2. INTERGRATED TEAMS	CARE PLANNING: Single Care Plan, recognised & utilised by all. • Anticipatory/Advanced Care Plan • DNAR discussion and documentation Existing Plans PEACE plan/ SGH MAP RESUS council Dorset SCR C. Plan Durdle Dor document Palliative prescribing UCS SPECIAL NOTE Patient Passport PGH
	2. IMPROVED DELIVERY Improved interface between care organisations involved: (1) 1ary/2ary care (2) clinical and social (3) In-hours and Urgent Care	3. PATIENT IDENTIFICATION & FRAILITY INDICES 4. EDUCATION & TRAINING	• Virtual ward • Hospital at home • Step down beds • Accessibility to necessary services: physio, podiatry phlebotomy, OT SPOA • "Better Together" • Comprehensive Geriatric Assessment • Silver Book • Community Pharmacists • Nursing home education • "Esther" project, Sweden

### STUDY

**Background Data** from 2 surgeries in the locality was collated through a notes audit. This confirmed that 41-43% patient population with an existing care plan made contact with urgent care over a 3 month period.

- The special note which is available on the urgent care IT system was identified as an existing handover baton for palliative patients. Its potential role within the care plan process was considered. Urgent Care GPs were surveyed regarding their use of and access to Care Plans and special notes.

**Figure 3: Urgent Care GP Survey Responses – special message content**

What would you like to see on a special message?	Usefulness Rating (Ave.)
Baseline Functional Status	4.0
Frailty Index Score	2.5
Co-morbidities	4.4
Next of Kin	3.9
Anticipatory Care Plan in place (& details of access)	4.6
Resuscitation Status	4.5
Palliative Care (yes/no) and drugs in place?	4.6

**1 = Least; 4 = most**

Results indicate that readily available information regarding functional status, resuscitation status, existence of current care plans & Next of Kin details would be valued.

**Figure 2: Urgent Care GP Survey Responses (access to care plans)**

Survey uptake (% total Urgent Care GPs)	23%
Refer to Special Note (when available on IT system)	100%
Never refer to admissions avoidance care plan	30%

### ACT NEXT STEPS

- Fellowship continues until March 2017.
- Review of existing special note as incorporated into new Dorset AACCP.
- Discussions with CCG and UCS regarding formulation of special note to automatically reach ADASTRAS UCS system.
- Survey results to influence content of special note design.
- Continued presence on CCG's End of Life and Frailty Reference Group for Dorset
- Presentation of project to date including survey data to RCGP annual conference October 2016.

### LESSONS LEARNT

- Overwhelming sense of isolation at the start of the year.
- Challenging myself to consider the problem: What is the outcome, what change can I make?
- Networking is time consuming but essential: It is NOT time wasted.
- Keep notes and records...
- When QI becomes research...and what that means for my project.