Clinical Senate
15 December 2017
<table>
<thead>
<tr>
<th></th>
<th>01</th>
<th>Chair’s Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>02</td>
<td>02</td>
<td>An update on current events in Cardiff and Vale University Health Board (Len Richards, Alun Tomkinson, Anna Kuczynska and Sue Morgan)</td>
</tr>
<tr>
<td>03</td>
<td>03</td>
<td>Ongoing work in the UHB on Sepsis (Paul Morgan)</td>
</tr>
<tr>
<td>04</td>
<td>04</td>
<td>E-referrals and the impact on prioritisation and demand/capacity management (Jeff Turner)</td>
</tr>
<tr>
<td>05</td>
<td>05</td>
<td>Virtual Fracture Clinic (Susan Allen and James Lewis)</td>
</tr>
<tr>
<td>06</td>
<td>06</td>
<td>Breaking the rules for better patient outcomes (Rebecca Aylward)</td>
</tr>
<tr>
<td>07</td>
<td>07</td>
<td>Palliative Care (Darren Cousins)</td>
</tr>
</tbody>
</table>
Chair’s Introduction

Graham Shortland, Medical Director
An update on current events in Cardiff & Vale University Health Board

Len Richards, Chief Executive Officer
Alun Tomkinson, Clinical Board Director, Surgery
Anna Kuczynska, Clinical Board Director, PCIC
Sue Morgan, Director of Operations and Delivery, PCIC
Cardiff and Vale University Health Board

Clinical Senate

- General Update
- Feedback from Canterbury Visit
  - Anna Kuczynska
  - Alun Tomkinson
  - Sue Morgan
  - Len Richards
General Update

• Relationship with Welsh Government:
  • Targeted Intervention

• Delivery Against KPI’s:
  • Continued improvement against most KPI’s
  • Improvement in financial position 2017/18
  • Patients still wait too long – 52 week+ waits
  • Patients still wait too long – 12 hour+ waits ED

• Great examples of patient-centred care
Canterbury District Health Board

One of 20 DHBs in New Zealand
Planning, funding and providing health and social care
Population 530,000
Workforce 10,300
Tertiary Centre South Island

10 years ago
• Aging population & rising demand
• Challenging financial situation
• Not able to staff hospitals - needed a new way of working
• Poor integration
• Poor information
Learning from Canterbury

- Vision – consistent and compelling vision
- Clinical engagement and empowerment
- Culture – permissive and accountable
- Patient centred – system wide

“It should be seamless for the person...they have no sense of having been passed from one organisational structure to another...the services are just organised around them”.
OUR MISSION

We provide leadership to the transformation of the Canterbury Health System in collaboration with system partners and on behalf of the people of Canterbury.

OUR APPROACH

Within our alliance framework we will act in good faith to reach consensus decisions on the basis of ‘best for patient, best for system.’

Our person-centred approach includes:
- Taking a patient-centred, whole of SYSTEM APPROACH to make health and social services integrated and sustainable;
- FOCUSING on PEOPLE, their FAMILIES and communities, keeping them at the centre of everything we do;
- Enabling CLINICALLY-LED service development;
- Making the best use of our resources and capacity to achieve IMPROVED HEALTH OUTCOMES for our population.

STRATEGIC OBJECTIVES

of the CANTERBURY HEALTH SYSTEM

The vision that underpins our leadership decisions:

- People take greater responsibility for their own health.
  The development of services that support people/whānau to stay well and take greater responsibility for their own health and wellbeing.

- People stay well in their own homes and communities.
  The development of primary care and community services to support people/whānau in a community based setting and provide a point of ongoing continuity, which for most people is general practice.

- People receive timely and appropriate complex care.
  The freeing-up of hospital based specialist resources to be responsive to episodic events and the provision of complex care and support and specialist advice to primary care.
Clinical Engagement and Empowerment

- Canterbury Clinical Network
  - Alliance

- Health pathways

- Data that is live and accessible

- Key programmes
PURPOSES

Our purpose is to lead and guide our Alliance as it seeks to improve health outcomes for our populations, as outlined in the Agreement. We aim to provide increasingly integrated and co-ordinated health services through clinically-led service development and its implementation within a ‘best for patient, best for system’ framework.

In the first instance, our priority is to implement the Canterbury Clinical Network Implementation Plan.

PRINCIPLES

The foundation of our Agreement is a commitment to act in good faith to reach consensus decisions on the basis of ‘best for patient, best for system’. As a leadership team we will conduct ourselves and undertake our leadership role in a manner consistent with the Alliance principles, set out in the Agreement. These include:

We will strive for **equitable health outcomes across our population** through accessible, culturally appropriate services;

We will support **clinical leadership**, and in particular **clinically-led service development**;

We will conduct ourselves with honesty and integrity, and **develop a high degree of trust**;

We will promote an **environment of high quality, performance and accountability, and low bureaucracy**;

We will strive to resolve disagreements co-operatively, and wherever possible achieve consensus decisions;

We will adopt a **patient-centred, whole-of-system approach** and make decisions on a **Best for System** basis;

We will seek to make the **best use of finite resources** in planning health services to achieve improved health outcomes for our populations;

We will balance a focus on the highest priority needs in our communities, while ensuring appropriate care across all our rural and urban populations;

We will adopt and foster an open and transparent approach to sharing information; and

We will actively monitor and report on our alliance achievements, including public reporting.
Health pathways

• Pathways constructed by Teams of Clinicians

• Multiple Multidisciplinary Clinical Teams

• Span 2°, 1° care, social care

• Builds Trust and Shared Purpose

• Same goal – “best for patient, best for system”

• Built inside web based FRAMEWORK

• Visible to all with Feedback access for all
Example of a Pathway

Acute Exacerbation of COPD

Red Flags

- Respiratory failure e.g., cyanosis, oxygen saturation < 85%, confusion
- Drowsiness
- Sepsis

Management

Practice Point

Consider community management as New Zealand has one of the highest rates of admission to hospital with exacerbations of COPD.

1. If red flags, request acute general medicine assessment (or acute respiratory assessment if under the current care of a respiratory physician) unless the patient is being treated palliatively and symptoms can be managed in the community.

2. Decide whether the patient can be managed in the community:
   - Consider Acute Demand support for home-based care or admit to the observation unit.
   - If the patient is unable to manage at home despite supports, consider hospital admission.

3. Use increased dose of bronchodilators.

4. If increase in sputum purulence, and increase in sputum volume or breathlessness, give antibiotics. If unresponsive to initial antibiotic choice:
   - Consider resistant or resistant organisms.
   - Arrange sputum testing.

5. Start oral prednisone if:
   - Moderate to severe exacerbation.
   - Worsening in spite of antibiotics and increased bronchodilators.

6. Consider and treat co-existing conditions e.g., heart failure, pneumonia.

Follow-up

About 1 week after exacerbation:

1. Review severity status and long term management.
2. Reassure that recovery to reach baseline may take around 30 days.
3. Review medications and inhaler technique.
4. Complete or revise an Acute Plan.
5. Complete a COPD Action Plan (Blue Card) and Advance Care Plan, if not already done.

7. If frequent attender to hospital (> 2 admissions per year), refer for integrated respiratory nurse assessment.

Information

- Clinical Resources
- Patient Information
- References

Page Information

Information about this HealthPathways document (16624):

- Document Owner: Respiratory Team (see Who’s Who)
- Last Updated: July 2017
- Next Review: February 2020
- Keywords: 

Note: Only the electronic version is controlled. Once printed, this is no longer a controlled document.

Send Feedback  Expand all  Email this page  Log out

Have you read the disclaimer?  © 2008-2017 Cardiff & Vale University Health Board
Data – Live and Accessible
For information, not performance

• 'Signals from noise'
• Interactive data set
• Linking data across multiple providers
• Currently: St John's ambulance, ED and inpatient data
• In the future: labs, radiology, community mental health, specific programmes (e.g. ADMS, CREST)
DRIVES CLINICAL ENGAGEMENT

• Data for Information
• Easy understandable
• Live (updates every 15 mins)
• Interactive
• Meaningful feedback
• Trusted
Data – Live Interactive
For information, not performance

ED: older people and ambulance (on pre-quake trend)
Data – Live Interactive
For information, not performance

COMMUNITY FALLS PREVENTION
In the first four years, compared with expected (75+):
1862 fewer ED attendances
553 fewer fractured NOFs
32,008 fewer NOF bed days
211 fewer deaths at 180 days

Fewer ED attendances for a fall (75+)

Fewer admissions for # NOF

Agreed price (IDF) $815 per rehab bed day
$8.714M costs foregone in last 12 months
Cost: 6 Physios ($650K pa)

Fewer bed days for # NOF

Fewer deaths at 180 days post # NOF
Key Programmes
Culture

- Best for patient, best for system
- One health system, one budget
- High trust, low bureaucracy
- Skills and leadership development:
  - Reinforce vision
  - Enable change
  - Servant leadership
  - Permissive and accountable
Ongoing work in the UHB on Sepsis

Paul Morgan, Sepsis Lead
E-referrals and their impact on prioritisation and demand/capacity management

Jeff Turner, Transformation Clinical Lead
Welsh Patient Referral Service (WPRС)

• Systems & processes allowing the electronic transfer of referrals from primary care to WCP for prioritisation

• Gastroenterology directorate – 3^{rd} adopter within UHB (implementation January 2016)

• Divided into 2 principal pools:
  – Hepatology
  – Luminal gastroenterology (includes dyspepsia – only accessible to secondary care)
Impact on ‘zero priority’ referrals

Fall in % of zero priority referrals from 20 to 8.5%
Prioritisation form in WCP

<table>
<thead>
<tr>
<th>Clinical Priority</th>
<th>USC</th>
<th>Clear Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastro Pool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic (Manual)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspepsia Outpatients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuroendocrine Tumours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspepsia Virtual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coeliac</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic Radiation Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR R HEWETT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR C THOMAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR C SWIFT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR SUNIL DOLWANI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR CLARE TIBBATS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR A HAWTHORNE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR D DURAI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR J GREEN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR JEFFREY TURNER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopy - Procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OGD - Nurse endoscopist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OGD +/- dilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OGD +/- stent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other procedure (outline below with slot value)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barrett’s surveillance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexi Sig - Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy surveillance - PH/IBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopy - Preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phosphate enema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Klean prep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other prep (outline below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moviprep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senna/citramag (Age&lt;70; eGFR&gt;60 within last 3/12)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
System adaptable to clinical needs
Quarter 3: Gastroenterology WPRS data

Prescribed bowel prep for lower GI endoscopy procedures
DEMAND
Referrals from primary care

Overall percentage of referrals returned (‘rejected’) has increased from 11.4 to 13.1%
Prioritisation category of GP referrals

Clinician vetting: 84% no change to GP priority, 12% upgraded & 4% downgraded
Endoscopy waiting list additions

NICE suspected cancer (NG12) publication date
Endoscopy demand

• Increased demand – specifically of USC category:
  – NICE suspected cancer lowered the threshold for referral from a
    positive predictive value of 5 to 3%
• Increased number of patients requiring diagnostic (endoscopic)
  investigation
• WPRS facilitated ‘direct to test’ endoscopy referrals
Cluster / practice referral variance
(referral ratios according to practice size)

Numerically number of referrals received varied between 29 - 189
Variation in clinician vetting

Supported updated directorate job planning document with different sessional allowance for consultants in each pool.
Variance in OPD & diagnostics conversions

Consultant OPD & endoscopy conversion rates

[Bar chart showing conversion rates for various procedures and consultants]
CAPACITY
1 year WPRS

• 6303 referrals received and actioned by clinicians

• Clinic appointments requested for 2822 patients referred from primary care:
  – 89% Luminal gastroenterology
  – 11% Hepatology
Outpatient clinics

Hepatology
- Pooled: 229
- Consultant specific: 79
- Sub-specialty specific: 3

Luminal Gastroenterology
- Consultant specific: 2209
- Sub-specialty specific: 165
- General luminal: 137
- Dyspepsia: 414
- Other: 1795
Dyspepsia (demand vs capacity)

- Demand: 414 patients
- Defined capacity: 252/year (specialist nurse)

Consultant led Dyspepsia VC:
- Appropriate patient selection (consultant joined WPRS dyspepsia pool)
- Increased activity
- High discharge and low diagnostics conversation rates
- Positive patient feedback
Developments

• Coeliac disease virtual clinic:
  – Specialist nurses & secretary using electronic test requesting (WRRS)

• IBD self management:
  – Reduce number of face to face follow ups
  – Increase new patient capacity
Variance in ‘rejection’ of referrals

% Referrals Accepted by Actioning Consultant  % Referrals Rejected by Actioning Consultant
‘Rejected’ referrals

• 17% (n = 83) of Hepatology referrals returned:
  – 69% abnormal blood/radiology results
  – 31% other (e.g. patient admitted in interim)

• 5% (n = 313) of Luminal Gastro referrals returned:
  – 73% advice given
  – 19% avoidable (info on portal, under active FU for symptoms etc)
  – 8% other
Opportunities

• Pathway / advice for common referrals:
  – Abnormal radiology advice sheet under development for clinical portal (linked from PCIC page)
  – Normocytic anaemia / weight loss ?cause guidance
  – Faecal calprotectin

• Further education:
  – Abnormal LFT (pathway already exists on clinical portal)
Gastroenterology Directorate

The Gastroenterology Directorate was formed in 2014 and is sat within the Medicine Clinical Board. Departments are based at both University Hospital Llandough and University Hospital of Wales, providing inpatient, outpatient and endoscopy activity. This page aims to provide:

- Clinical guidance for common GI presentations
- Up to date information regarding endoscopy waiting times
- New developments within the Gastroenterology Directorate

Condition management guidance (pathways)

The following pathways provide guidance on the management and investigation of common gastrointestinal presentations:

- **Dyspepsia pathway**
  Guidance in the management and investigation of patients with Dyspepsia

- **Iron Deficiency Anaemia (IDA) pathway**
  Guidance in the management and investigation of patients with an IDA

- **Abnormal liver function test (LFT) pathway**
  Guidance in the management and investigation of patients with abnormal LFTs

New developments

WPRS was commenced within the directorate in January 2016, to improve the speed of processing and traceability of referrals received. GPs are now able to direct referrals through WCCG to both Hepatology (Liver) and Gastroenterology (includes endoscopy). We may correspond with you using this system to obtain further information regarding referrals to guide our prioritisation, as well as sign posting you to the guidance available on this page to support the management of patients.

In March 2016, the Gastroenterology e-advice service was launched to provide non-urgent guidance regarding the management of patients with dyspepsia and gastro-oesophageal reflux. We aim to provide a response within 5 - 7 days.

Please note that the agreed UHB referral route via the WCCG. Faxed and paper referrals are no longer accepted and will be returned.

Cardiff and Vale UHB – Gastroenterology – LFT (Liver Function Test) Pathway

Version 1.0 - Review Date: March...

N.B. The agreed UHB referral method is via WCCG. Faxed referrals are no longer acceptable.
Outpatient clinic capacity

• Hepatology demand from primary care referrals: 26 patients/month

• Capacity: 48 patients/month (based upon consultant activity for 42 weeks/year)

• Existing hepatology workforce adequate to manage OPD demand
New kid on the block: E-communication

<table>
<thead>
<tr>
<th>WAP ID:</th>
<th>822774</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Received:</td>
<td>03/11/2017</td>
</tr>
<tr>
<td>NHS Number:</td>
<td></td>
</tr>
<tr>
<td>D.O.B.</td>
<td></td>
</tr>
<tr>
<td>Specialty:</td>
<td>ENT</td>
</tr>
<tr>
<td>Consultant:</td>
<td></td>
</tr>
<tr>
<td>Waiting List:</td>
<td></td>
</tr>
</tbody>
</table>

**CAV INTERNAL REFERRAL**

Medical in Confidence

This is a summary message for a CAV internal referral

**Patient Detail**

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Patient's Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Home Telephone</td>
</tr>
</tbody>
</table>

**Referral From**

<table>
<thead>
<tr>
<th>Consultant/Practitioner</th>
<th>Specialty</th>
<th>Hospital Site</th>
<th>Date Referral Sent</th>
<th>Urgency of Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR. JEFFREY TURNER</td>
<td>GASTROENTEROLOGY</td>
<td>University Llandough Hospital</td>
<td>03/11/2017</td>
<td>URGENT SUSPECTED CANCER</td>
</tr>
</tbody>
</table>

**Referral To**

<table>
<thead>
<tr>
<th>Consultant/Practitioner</th>
<th>Specialty</th>
<th>Hospital Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>DR. CONSULTANT ENT</td>
<td>EAR NOSE AND THROAT</td>
<td>University Hospital of Wales</td>
</tr>
</tbody>
</table>

**Details of Referral**

Presenting Complaint: New mass in pharynx

Dear ENT,

The patient was admitted to Ward 1 with malaise whilst on warfarin. The patient had an OGD which revealed a gastric ulcer.

Whilst intubating the patient, the endoscopist noticed a large mass in his pharynx.

Discussed with ENT reg on call. Advised to make an USC referral for urgent ENT review.

On questioning, the patient has been experiencing difficulty swallowing and a change in voice.

Many thanks
WPRS

• Reduced zero priority referrals
• Quantify workload (job planning)
• Manage variation in 1ry/2ndry care
• Inform development of guidance / pathways (reduced demand)
• Demand-capacity planning:
  – Supports workforce planning
  – Speciality vs pooled
  – Methods to help manage capacity (VC clinics)
Thanks

• I,M&T team

• Gary Williams

• Andrew Nelson
Any Questions?
Virtual Fracture Clinic

Susan Allen, Transformation Clinical Lead
James Lewis, Consultant Orthopaedic Surgeon
What is the **Virtual** Fracture Clinic?

- Right Patient
- Right Clinician
- Right Clinic
- Right Time for their injury
WHY?

DR JAMES LEWIS
Why – do we need virtual fracture clinic

- Emergency Medicine attendances increasing
- Fracture clinic patients increasing
- Present set up is not fit for purpose
- Clinics over run by hours
- No time to teach trainees
- General orthopaedic surgeons seeing specialist work
- Huge stress on consultants
- Staff finding it difficult to care for patients properly

Part of Transformation
Solution

Part of Transformation
Savings they quote

In 2015 they saw 5,000 in their virtual fracture clinic (100 per week) and made a saving of £318,784 per annum.
Evidence from **Brighton**

5 year’s experience

- 57% less follow ups
- Adapted Glasgow pilot to their needs – more physiotherapist lead
- *They went live within 4 months of the project starting*
- Receptionist time less to make & register patients in outpatients
- Secretarial staff less as fewer patient letters to type
- Reduced cars to hospital site & parking. Less hospital transport needed
- Reduced patient/driver’s time off work to attend appointments.
Achieved by...

- **Knowledge** of what works & does **not** work e.g. ED discharges & Ortho 7/7 working....
- **Products** – on line/apps: videos (27 professional) for patients, paperless/paper information sheets specific to injury, electronic referral form, means to capture data, accurate performance figures, PROMS.
- **Care** – standardise what patients receive, minimize clinician variation. Less imaging & plastering.
- **Rehabilitation** – addressed & subsequently reduce returns & complications.

Part of Transformation
What works?

- **Paperless referral form** from ED (Takes 2 minutes to do)
- **Boots** - all stable lower limb injuries. Less plaster tech time in hours/nurse time out of hours
- **Business card** with dedicated named person/phone to deal with issues
- **All** information send out from virtual fracture clinic – paperless/paper
- **Physiotherapist** deciding who needs to be followed up to their clinics
- **Orthopaedics surgeons** deciding which specialist clinic patients need
- **No** extra work for **Emergency Staff**

Part of Transformation
Patients

82 year old Gardener

28 year old footballer

Part of Transformation
Action – Technology & Finances

Technology-complicated

- Numerous systems doing amazing things often in isolation
- We need joined up technology which will grow with us

Finances - complex

- Labour costs will reduce
- Technology we need to invest
We do **not** have a PLAN

- **A** = Buy in a product
- **B** = Make use of existing

**Cost** needs to weigh up:
- Time
- Expertise
- Energy
- Staffing
- Equipment
- Imaging
- Clinic space
- Parking
- Targets
Action - Finances

- Realistic
- Inclusive of all hidden cost:
  - Paper & postage
  - Labour – redistribute & reduce
  - Clinics
  - Electronic reduce printing
  - Boots – streamline types
  - Plaster of Paris - reduce
Results

Patient-focused

Cost Effective

Evidenced based

Part of Transformation
Summary of the virtual fracture clinic
Decision → Action → Results

- We need to work smarter *not* harder
  - Embrace a *cultural* change

- Use what’s available already - *labour*
  - *Invest* in technology which is fit for purpose & *grow* with us
  - Balance savings with vital technology needed to go forward

- Collative working by EVERYONE to make change happen = TRANSFORMATION

- Remember *Major Trauma* is only just around the corner- need resources & *investment*
Any Questions?

THANK YOU
Breaking the Rules for Better Patient Outcomes

Rebecca Aylward, Transformation Clinical Lead
We are caring professionals. But are we being over-caring to the point that we do everything for our patients, without attempting to encourage them to do what they can do themselves and supplementing it with our help?
Older people in hospital can be more at risk of:

- Reduced bone mass and muscle strength
- Problems with blood pressure control
- Reduced mobility
- Confusion due to changes in environment
- Demotivation

When an older person comes to hospital and lies in bed, it can effect their wellbeing and physical functioning. Known as **Deconditioning**
Reconditioning can take twice as long as deconditioning; if it has taken one month to get to this low level of function, it may take two months of hard work to return to their original level.

It is often said that for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs, in people over 80 years old.
We need to manage the expectations of relatives and carers about enhanced supervision.

Rumours reported about staff being sacked if a patient falls and they are meant to be under supervision. Lots of anxiety from staff about their accountability and responsibility for a patient who falls.
One of the redesign principles of Transformational changes in health care delivery
seeing things differently may mean that I change my view
Weekly Bank and Agency Spend 1:1 Specialing

UHW

MEDIAN

26/03/2017 26/04/2017 26/05/2017 26/06/2017 26/07/2017 26/08/2017 26/09/2017
Framework is user friendly and works well

Good to categorise patients to look at their exact needs. We don’t want the patient to feel we are watching them. Manages staff numbers better.

When patients are engaged in activities it leaves time for the nurse to get on with caring for other’s needs - leaves time for nurses to carry out personal care.
Physiotherapy Lead Nancy Maisey explains “There has been an increased focus on preventing deconditioning, and promoting independence within the health board. Running exercise groups is one way of us working towards increasing activity levels on the wards. We are currently collecting data to evaluate the impact, the patient experience, and its sustainability”.

The classes run 2-3 times a week on several of the medical wards at Llandough Hospital. The staff experience of the exercise clubs has been positive, and patients have reported feeling the benefits of attending the class. The team would like to acknowledge the Health Charity who have kindly supported the bid for equipment provision on West 2 ward.
Physiotherapist Louise Strick explains,

“The patients really enjoy the energetic classes, but it’s also an opportunity for patients to socialise with each other and have a little fun!”
We aim to further improve the physical ward environment of care; focusing on activities, promoting independence and preventing deconditioning to improve patient outcomes.
Any Questions?
Palliative and End of Life Care

Darren Cousins, Transformation Clinical Lead
Aims of Transformation

Improve the experiences of patients and families who pass through our services including,

• Increase the number of patients who die in their preferred place of death

• Reduce the number of avoidable hospital admissions

• Reduce hospital length of stay
IHI Triple Aim

- Improving the patient and provider experience of care.
- Improving the health of populations.
- Reducing the per capita cost of health care.
Growth in household projections are not uniform across Wales

Number of households in Wales in 2014

Projected number in 2034

Identifiable spending on health
Spending in the four countries of the UK per head, 2003/04-2014/15

England  Scotland  Wales
Northern Ireland  UK

Note: Health spending is measured as public spending on 'health services', and includes all spending on the NHS in the UK, but excludes administrative costs. It also includes medical research, devolved administrations and local government spending on health.

The Health Foundation
© 2016
Achievements in Palliative Care Services:
- (>90%) of patients referred for uncontrolled symptoms reviewed by SPCT within 48 hours including weekends/BH
- Welsh EOLC Acute Hospital Audit (2015) demonstrated consistent high level care was delivered
- Process improvements in Fast Track CHC discharge process from 30 to 8 days with discharge within 24 hours for patients in the last days of life
- Development of a bespoke Hospice at Home HCSW team to support patients dying at home
- Delivered degree module in EOL care to huge percentage of generalist nurses in hospital, community and care home areas
Welsh Data Sets

- ONS data suggests that 52.8% of CVUHB patients die in hospital from all causes

- The preferred place of death is 81% (Voices Survey) in their own homes 8% Hospice; 7% Care Home; 3% Hospital

- During 2015 there were 66,000 admissions in Wales in the last year of life (average 2 per person), 77% were emergencies (All Wales Data)

- City Hospice data suggests that patients with an Advance Care Pathway (ACP) in place are less likely to be admitted than those without. Data shows where there is no ACP in place this results in greater likelihood of hospital deaths
Out of Hours Audit

• Three consecutive weekends sampled to examine the impact of palliative/EOL care needs on out of hours GP services at Cardiff & Vale

• 19.71% of 208 patients seen by the OOH service were classed as “palliative”

• Collectively these 41 patients required an average of 22.3 minutes each (average triage phone consultation 7.9 minutes and average home visit time was 14.41 minutes)

• The home visit time is likely an underestimate because the start time is sometimes entered retrospectively, triage calls can be up to 28 minutes long and home visits up to 51 minutes

• In this sample the most common GP action was giving medication (including PRN), followed by verifying death (expected and unexpected), giving advice or abscess drainage.

Source Calum Davies PCIC
Clinical Case
Mrs M.R. 93 year old lady: lives with her daughter/independent/mobile with stick

Day 1: Painful ischaemic toe:
- SB Vascular team: antibiotics/progressive gangrene/ team decision too high operative risk/ withdraw active treatment/comfort-based care only

Day 8: Palliative Care referral:
- Same day assessment
- Discussions re situation/acceptance of patient/daughter including prognosis 1-2 weeks max
- Patient wishes to go home to die: daughter worried may not cope but daughter agrees to try
- Stabilisation of pain control complicated and requires some days: improves with titration of opiate/Ketamine combination in syringe driver, ongoing breakthrough prn injections required, poor oral intake meds
- Planning required for discharge:
  - Paperwork: Fast-track CHC 2/community drug chart/TTH with all anticipatory end of life(EOL) prn medication/syringe driver prescription/DNACPR
  - Equipment: hospital bed/mattress/glide sheets/commode/delivery time to suit daughter
  - Community healthcare resource: DNs contacted re capacity to mx syringe driver/MC Hospice at Home contacted/ Community Palliative Care Service/GP

Day 14: Pain improving:
- DC agreed with daughter for Monday to avoid Friday discharge, daughter anxious but agrees. Understands GP and Community Specialist Palliative Care team will be overseeing care.

Day 15: Patient dies in hospital
Target areas for improvements:

- Have in place a clear clinical pathway for palliative care
- Reduce length of stays
- Improve information sharing challenges between primary and secondary and third sector care
- Need for flexibility in the workforce numbers to meet urgent sudden changes in condition
- Better flexibility to discharge unstable patients home with improved infrastructures
- Improve opportunities to work with families in preparing them for the care roles at home
- Review of resources to support population increase and progressively older population and cancer incidence
Clinical Aims

• Engage all HB cross-cutting areas in contributing to improvements in Palliative and EOL care
• Identify whole system change/transformation areas to achieve best outcomes for patients and families
• Maximise use of digital technology across whole service
• Develop new systems that improve the patient journey through the services
IHI Triple Aim

- Improving the patient and provider experience of care.
- Improving the health of populations.
- Reducing the per capita cost of health care.

Adaptation of the Institute for Healthcare Improvement's Triple Aim
Any Questions?
Closing Remarks

Graham Shortland, Medical Director