# St Luke's Community Complexity Framework

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# Outline

- Where we started
- Evolution of St Luke's Complexity Framework and day to day use
- Service evaluation of "red" visits
- Future plans:
  - Capturing the expertise here today
  - Collaborating

# Where we started

- **Recognised issues**:
  - Limited medical time and resource in an integrated team
  - Variance in skill set and knowledge
  - “siloed” professional approach
  - No method of describing rapid changing complexity
  - Communication: describing the problem, relevant information and management plan
  - Mixed approach to communicating as an MDT or between individuals/teams
  - Didn’t have equitable access to seven days service

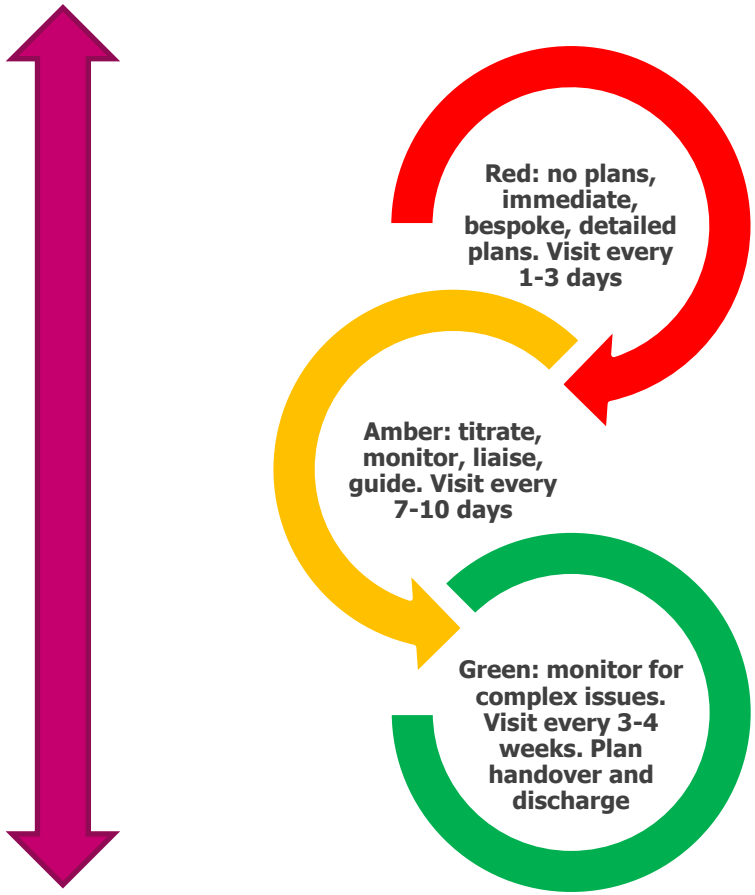
# Evolution of St Luke's CF

- **Early CF development**:
  - Combined learning from discussion of medic roles, RR trial and team agreement on what appeared to be most complex SPC situations
  - Initial focus complex therapeutics, palliative emergencies and ACP
  - SBAR handovers
  - Daily board round
  - 7 day working
- **Organisational change**:
  - New MDT
  - Implementation of IPOS and Phase of Illness (OACC suite of measures)
  - Early version of CF incorporated into new MDT and board round
  - Implementation of eShift
  - Use of delegation through eShift
  - Morning huddle and afternoon board round
  - Flexible diaries
- **Starting to evaluate**:
  - Marie Curie Research bid process
  - Service evaluation of Medic RR visits

# St Luke's Complexity Framework

- Describes how we case find and case manage complex palliative situations at home
- Used by all Community team members
- From each **face-to-face** assessment, to MDT discussions
- **Case find:**
  - Use PROMs/phase during our specialist holistic assessment
  - Agreed "red flag" complex situations not usually managed by GP/DN alone at home
- **Case manage:**
  - Immediate face-to-face management plan
  - Agreed when we reassess, discuss and how we facilitate care at home
- High to medium to low complexity (RAG)

# Flow through framework



# Highly complex patient

- **Referral**: 27 year old man with rectal cancer, pain, been to GP in surgery, referred for pain control, on maintenance Methadone for substance misuse. Routine referral
- **Phone**: mum confirmed prefer visit at home, sleeping downstairs
- **Face-to-face**: (CF starts here)
  - Fungating rectal tumour, unable to sit, stand or sleep
  - Septic, discharge
  - "Active" substance misuse….poor prescribed medicine understanding
  - Couldn't read/write
  - HIV positive

# Case find

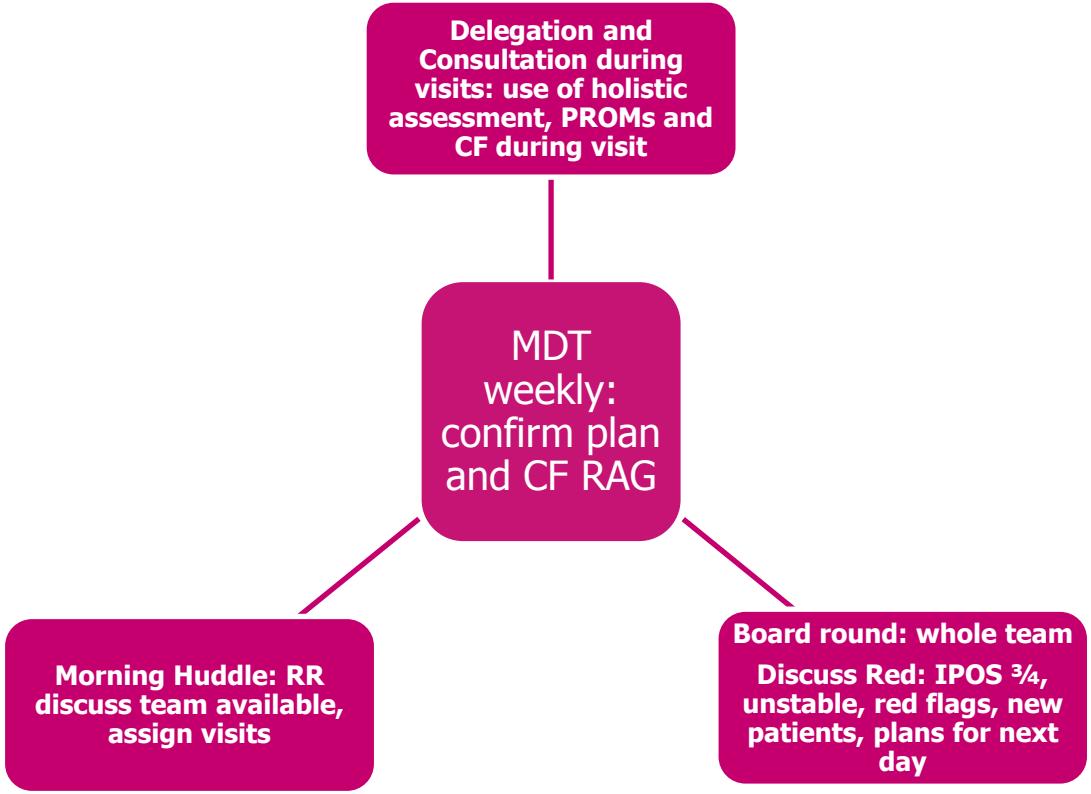
- **Case find:**
  - Unstable
  - High IPOS scores
  - Red flag(s):
    - Complex medications, substance misuse
    - Multimorbidity
    - Palliative care emergencies: high risk of bleed from tumour, septic, bowel obstruction
    - Complex psycho social issues

# Case manage

**Case Manage**: "Red"

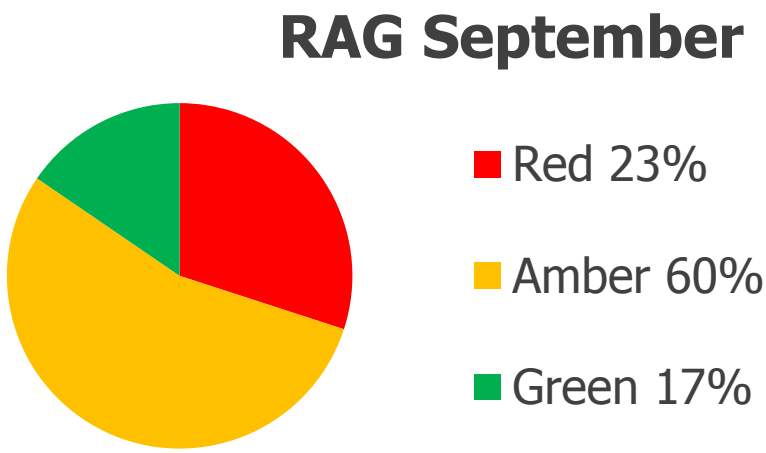
- Immediate
  - Symptom control and plan
  - Established expectations and ceiling of treatment
  - Escalate and discuss with senior team member
- In the house:
  - Specialist prescribing
  - Support with medicines management
  - Liaison: GP, District nurses, substance misuse, local pharmacist, social worker, infectious diseases
- Same day
  - Urgent same day letter
  - Board round, huddle
- Ongoing:
  - Daily visits
  - facilitation of admission

# Day to day use of Complexity Framework



# Operational detail: September

- Number on caseload: 445
- Referrals/month: 167 (99 routine/68 urgent)
- Total visits/month: 542
- RR visits/month: 181
- Visits/day: up to 30



# Team diaries: flexible and responsive

- Outlook diaries: RAG rating on patient name
- Role and skill specific (e.g. more planned Green visits for Band 5s)
- Medic for RR not “pre-booked”
- Diaries reviewed as a Zone team/RR
- Influenced and adjusted each day by patient/family need and team pressures

# Senior team members: integrated and expert

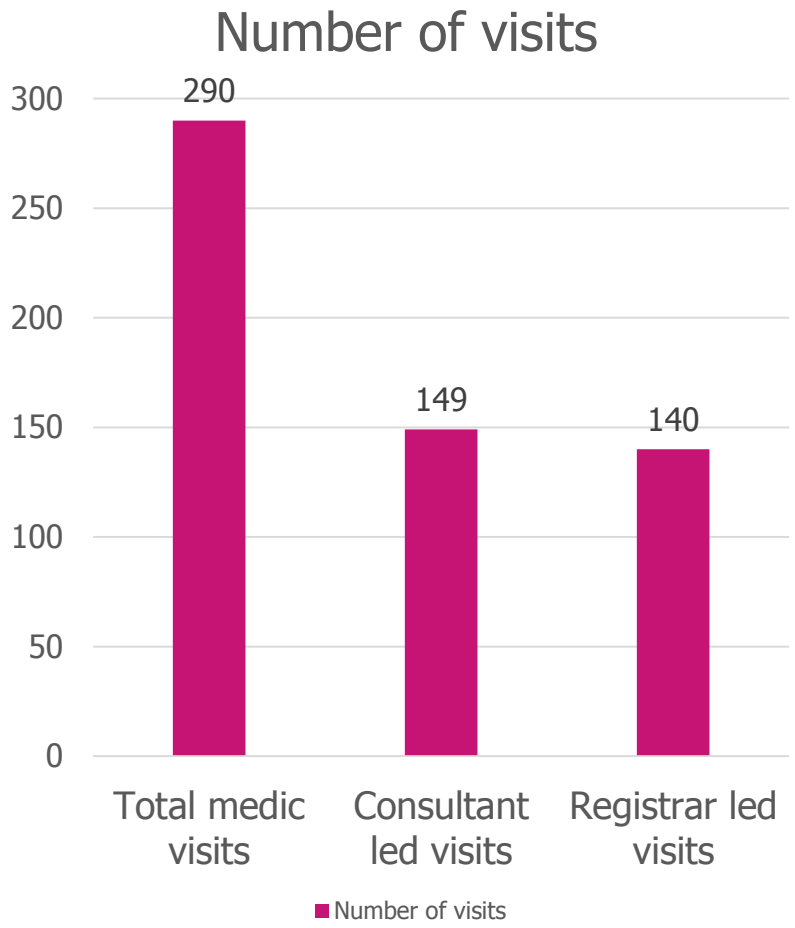
- RR visiting: on the day/next day, highly complex, often joint visits
- Lead MDTs ( x2/week)
- Delegation
- Present at morning huddle and board round
- Available for escalation and consultation during the day

# Outcomes of using St Luke's CF

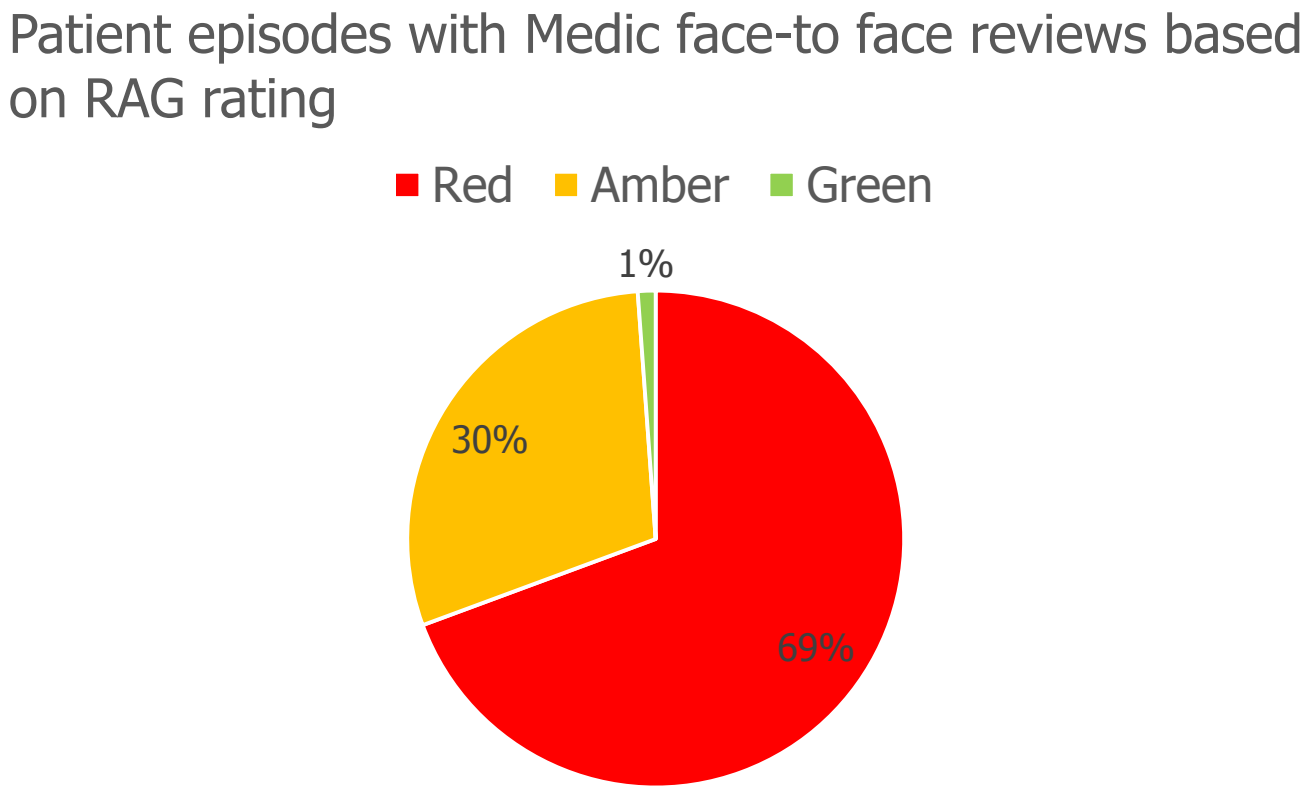
- **Patients and families**:
  - Have the most complex situations for patients and carers managed by the most senior team members
  - Rapidly assess, individually manage, treat, reduce complexity and improve symptoms and communicate that with all involved
  - Achieve PPOD
  - Avoid unplanned emergency admissions
- **For the clinical team**:
  - We are able to respond flexibly, educate and role model for all team members
  - Agree and deliver on clinical standards with aim of directly improving patient and carers experience
  - We debate and re-adjust dependant on team pressures
  - We liaise more widely with our own Hospice team and with other teams at home and in the hospitals
  - We think about and reflect on complexity at home

# Service evaluation (Dr Rachel Parry, SPR)

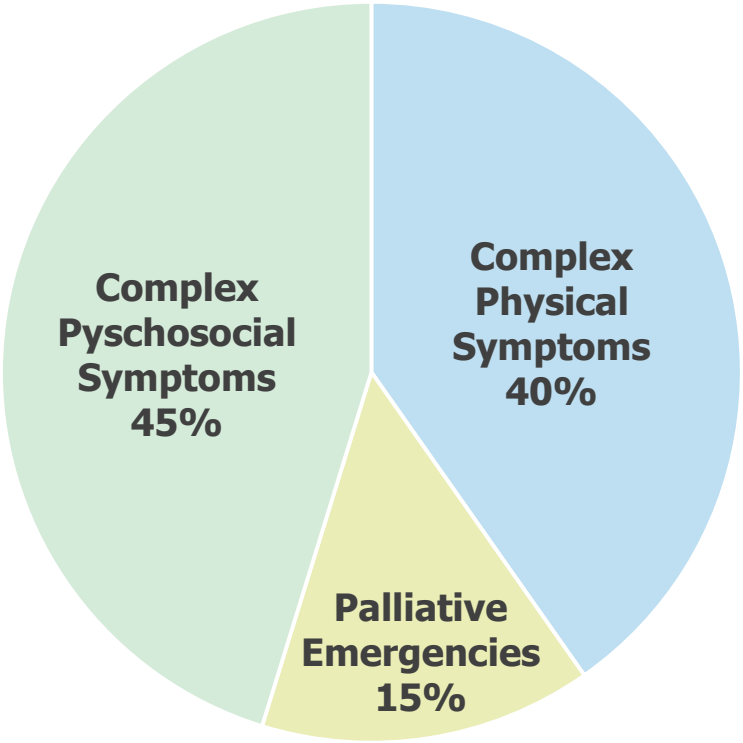
- Between April 2015 and March 2016
- Total of 290 medic RR visits
- 83% malignant diagnosis
- Medic availability in this period:
  - Consultant 2.5 DCC PAs
  - Registrar 4.5 DCC PAs



# Does the medic see the most complex patients?



# Which highly complex problems do the medics deal with?



| | Percentage of workload | | No. of patients | Percentage of patients |
|---|---|---|---|---|
| Complex physical symptoms | 40% | Complex **physical symptoms** not responding to first line treatment | 49 | 28% |
| | | Complex **neuropathic pain** requiring two or more non-opioid agents | 22 | 13% |
| | | **Methadone or ketamine** patients | 16 | 9% |
| | | **Complex opioid management** of two or more background agents | 6 | 3% |
| | | Medic assessment following a **procedure** | 4 | 2% |
| Palliative care emergencies managed at home | 15% | **Acute deterioration** with no previous escalation plan | 23 | 13% |
| | | **Palliative care emergency** for management at home only | 12 | 7% |
| Complex psychosocial symptoms | 45% | Complex **family and social circumstances** needing a medical assessment | 49 | 28% |
| | | Complex **Advance Care Planning** e.g. LPA, Best Interests, declining discussions | 36 | 21% |
| | | Complex **psychological symptoms** requiring a medical assessment | 24 | 14% |

# Future

- Use expertise, learning, experience here today to look at the concept of a CF in the Community
- Use this expertise to update and refine the current version
- Plan further research and pilot

# Complexity has been described: how do we respond?