“If somebody had explained to us, not necessarily what was going to happen, but what was available to us, you just felt … into the abyss.”

Carer interview prior to new model of care

**UNMET NEED, prior to new model of care**

Patients for BSC from diagnosis. Fife figures, 2012 (n=103)
- 54% were diagnosed in acute hospital, 38% died there. 77 patients who had acute hospital admissions utilised 1079 bed days
- 72% seen by palliative care service before death, but timing of this variable, often close to death.
- Support and anticipatory care planning inconsistent and poorly communicated between health services, and health and social care.

**MEDIAN SURVIVAL 73 DAYS FROM MDT DIAGNOSIS**

**ACHIEVEMENTS: the first 15 months**

- 246 patients for BSC with lung cancer, their families and carers have been supported under the new model of care.
- Comprehensive palliative care assessments took place in all care settings, most commonly in patients’ own homes.
- Acute hospital admissions in BSC patients still common, with 70% occurring out of hours. Length of stay reduced, with total bed days for sample of 99 patients 32% lower than in 2012 (reduction from 1079 to 624 days).
- Fewer patients are dying in acute hospital, compared with 2012 (23.2% versus 38.2%, p=0.021)

**WHAT ARE WE DOING DIFFERENTLY?**

- Providing good palliative care, but earlier and more consistently = ‘Proactive Best Supportive Care’
- **Early identification**: robust referral pathways for comprehensive palliative care assessment for all patients with lung cancer who are for BSC
- **Prompt assessment** at home, in acute hospital or new outpatient clinic. Discussing and recording an immediate action plan, preferences for future care, DNACPR where possible.
- **Patient/carer/family engagement and support**: action plan given to patient along with lung cancer and palliative care service information pack. Weekend helpline piloted
- **Improved inter-professional communication**: comprehensive letter available on clinical portal within 2 working days of patient first assessment, sharing patients’ understanding and plan with wider healthcare teams. eKIS consent and prompting for GPs.
- **Increased responsiveness**: additional nursing and medical resource in the community to facilitate timely assessments as patients deteriorate/needs evolve. E-alert generated when patients admitted to acute hospital, prompting palliative care review.
- **Directing wider resources more appropriately**: cancelling secondary care clinics where not beneficial, supporting decision-making in acute hospitals for BSC inpatients.

**KEY POINTS and WHAT NEXT?**

- **Best Supportive Care** has become consistent, proactive care for patients in Fife with incurable lung cancer
  - Key elements: robust identification of patients, comprehensive palliative care assessment and care planning and care coordination and follow-up
  - Joint working with allied health professional and social care colleagues extends the breadth of services and support and enables more effective communication. This is integrated health and social care in action.
  - Discussions about sustainability and transferability of the new model of care are ongoing. Might the concept of ‘Proactive Best Supportive Care’ be usefully extended within and beyond cancer?