

Testing a WISer approach to community palliative care

Renfrewshire Macmillan Palliative Care Project Team

Background

The team were asked to “redesign delivery of palliative care services through integration of supportive and palliative care approaches into mainstream primary & community care service provision”, recognising that many people in Scotland who could benefit from palliative and end of life care (PEOLC) do not currently receive it. The Strategic Framework for Action on PEOLC aims to ensure that by 2021 everyone who needs palliative care will have access to it.

Redesign aim

To promote equal opportunities for holistic person centred assessment, access to services and support via the introduction of a model of care that identifies and streams people with palliative care needs offering a proactive, coordinated, integrated model for palliative or any complex care that is fit for the future.

The redesign sought to improve consistency and reduce variability in community palliative care in all settings and all conditions, testing ways to develop the vision of a consistent response, so that no-one is missed, that gives people with palliative care needs, and their families, the opportunity to identify and discuss their concerns as well as plan ahead, should they wish to do so. Following engagement with local staff and public (climate surveys, palliative care timeline and an Open Space Event) we used the intelligence gained to design and test potential redesign options.

The focus was on developing a 'standard response' for those on a GP practice palliative care register who have new or changing palliative care needs, In September 2016 we started testing the redesign model. The GP practice was asked to categorize patients with any condition who are on the palliative care register as being Red, Amber or Green:

- Red** - Those who have had sustained irreversible decline or sudden severe irreversible decline – may be expected to live for weeks
- Amber** - Those whose condition is deteriorating (due to irreversible causes) and whose need for palliative care is clearly changing - may be expected to live for months.
- Green** - Those, whose condition and their need for palliative care is not currently changing, may also be expected to live for six months or more.

The practice then shares their **AMBER** and new palliative care patients list with the **Weekly Integrated Standard (e) Response (WISer) palliative care meeting**, a new integrated weekly forum of health and social care professionals. Named service representatives attend for 1 hour maximum from community nursing, rehabilitation and enablement service, care at home, social work, specialist

palliative care and crucially administration staff, to facilitate coordination of care and resource allocation to help pro actively meet changing palliative care needs and the needs of the carer. Patients are discussed and allocated to the appropriate service so that they can be pro actively assessed and a person centred holistic assessment and care planning can take place. The carer will also be identified and a direct referral to the new adult support worker team at the Renfrewshire Carers Centre will be discussed and made with the carer's agreement. Thus opening the door for Advance Care Planning (ACP) should people wish to do so.

Outputs

Service Redesign- WISeR palliative care

In all streams there is an emphasis on holistic, person centred assessment, using the Concerns Checklist, electronic Concerns Checklist Resource (eCCR) and About Me and My Care (see below). This model pulls together all aspects of the project work redesigning delivery of palliative care services through integration of supportive and palliative care approaches into existing mainstream primary & community care service provision. **This redesign is implemented within existing local structures and with existing local clinical staff.** The WISeR model promotes new ways of working for existing staff providing a common language and forum to identify changing needs and work in an integrated, proactive, person centred way. In return for the relatively small investment of the required administrative support the potential impact on outcomes for patients and on integrated working could be transformational.

*“It’s the kind of work that the Scottish Government’s Strategic Framework of Action for Palliative and End of Life Care wants others to replicate”
(Improvement advisor Health Improvement Scotland).*

There are 3 main outputs from the project all of which underpin WISeR palliative Care, for further information please contact a member of the project team (contact details at the end).

- **About Me and My Care** - a pack for patients and carers to help with coordination of care
- **Electronic Concerns Checklist Resource** - an electronic information and signposting tool
- **Palliative Care Training Calendar** - a tool to help staff find and access training.

We have started work on what a ‘standard response’ could be for those people identified as ‘stable’ (green) but on the register with a focus on social support, building resilience and early access to community based and third sector services. For people identified as being in the last stages of life (red) service responses are already well established within GP, community nursing and specialist services.

Evaluation Methodology and outcomes

We used focus groups and observation to evaluate the work to date, with all doctors in the GP practice (n=6), and all professionals who attend the WISeR palliative care meeting (n=5) taking part. Overall the response from all professionals involved is overwhelmingly positive recognising that this way of working delivers outcomes:

- **Improved /increased access to assessment and services for patients and carers**

“knowing you can pass holistic needs over to others and they will be taken care of makes a big difference to us” Participating GP

- **Time savings benefits for GPs initially**

“Time saving for the doctor as you can feel confident you are passing their (the patient and their family) needs on and these will be dealt with” Participating GP

*“getting things sorted in an hour saves me time in the long run chasing things up”
WISeR member*

- **Crisis prevention**

“we have already proved that this has prevented crisis, it is helpful that we are getting all this information” WISeR member

- **Improved communication**

“the big positive is that it is an MDT approach in a service where they (other services) don’t talk to each other routinely. Getting to know each other and what others do is a huge bonus for staff and patients” WISeR member

- **Improved integrated working and problem solving**

“I am no longer in a bubble with lots to deal with for this patient, you are all there and its the wider team” WISeR member

We did not formally evaluate from a patient or carer perspective, however observation of the WISeR palliative care meeting did show that the improvements in information sharing, joint working and problem solving resulted in quicker, earlier interventions for patients and that carers were directly linked to the carers centre when previously professionals would not have been so proactive. From this it is not unreasonable to conclude that this way of working can improve outcomes for patients and carers however this will require further investigation.

“I think a lot of things have been dealt with quicker rather than waiting month to month for GSFS meeting. Things which are not particularly urgent maybe lying waiting for these meetings, and can be dealt with quicker through WISeR. Weekly meeting picks things up quicker” WISeR member

Recommendations

Recommendations for roll out have been made to ensure local momentum is not lost on this valuable work. Further developments and wider-scale testing are required to confirm results to date and evaluate the impact on patients and carers as well as staff.

Conclusions

The Renfrewshire Macmillan Palliative Care project has successfully met its aim. This work had been undertaken during a time of enormous change in health and social care services. The formation of Renfrewshire Health and Social Care Partnership presented the opportunity for us to embrace the integrated approach at the heart of our redesign. This innovative new model champions pro active, integrated working with patients and carers as partners in the care, working towards the right help at the right time:

“Not just what services can provide, but what individuals themselves want and what those around them want”

Health and Social care delivery plan Scottish Government 2016

This approach has the potential to ensure Renfrewshire Health and Social Care Partnership and NHS GGC fulfil the Scottish Governments aim that palliative and end of life care is available for all who need it by 2021:

Commitment 1

Support Health Care Improvement Scotland in providing HSCPs with expertise on testing and implementing improvements in the identification and care co-ordination of those who can benefit from palliative and end of life care.

*Strategic framework for action on palliative and end of life care 2016-2021
Scottish Government 2015*

Project Contact

For further information please contact Susanne.Gray@ggc.scot.nhs.uk

References

- The Healthcare Quality Strategy for NHS Scotland Scottish Government 2010
- Strategic framework for action on palliative and end of life care 2016-2021 Scottish Government 2015
- Health and Social care delivery plan Scottish Government 2016
- National Clinical Strategy for Scotland Scottish Government 2016

