Dundee Enhanced Community Palliative Care: Right Care, Right Time, Right Place

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Background

•The majority of people express a preference to be cared for and to die in their own homes.
•The physical and psychosocial aspects of end of life care can be challenging in the home environment and may lead to potentially avoidable and unwished hospital admissions.
• This can be detrimental to patient and carer experience at a critical life stage, and creates avoidable cost for the NHS.

Aims

1. To reduce potentially avoidable hospital admissions for people who are at or near the end of life.
2. To improve transitions of care between inpatient and community settings for people who are at or near the end of life.

Method

•A service development project commenced in March 2023 within the Dundee Specialist Palliative Care Service.
•Supported by funding from the NHS Tayside Unscheduled Care Board.
• Recruitment of new roles within the existing Specialist Palliative Care MDT in Dundee: a Band 7 Community Palliative Care Clinical Nurse Specialist (CNS), a Speciality Doctor (0.6WTE) , two Band 3 Community Health Care Support Workers (HCSW) and a Clinical Fellow in Ninewells Hospital.

Key Interventions

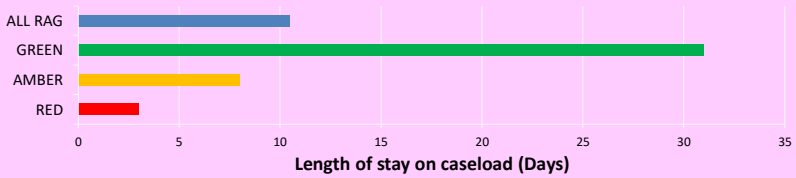
A. Urgent assessment	•All new referrals and existing patients on caseload triaged daily to RED/AMBER/GREEN category •Same day review offered to all new RED referrals (weekdays) •Daily review for existing patients on RED caseload (weekdays)
B. Rapid Response	•Early access to senior decision maker for complex referrals/uncertainty around admission/urgent prescribing need •Specialist Physiotherapy, Occupational Therapy and Day Services Outreach Support
C. Integrated Care	•Daily virtual huddles and weekly MDT - includes Social Work and Marie Curie managers (weekdays) •HCSWs provide personal care/respite interventions – mainly at end of life •Building links with other community and acute services: includes a new pathway for paramedic delivery of community based palliative care in Tayside •Patient journey mapping across inpatient and community settings
D. Discharge Without Delay	•Early review by Hospital Palliative Care Team (HPCT) for all community patients admitted to Ninewells Hospital •Ninewells HPCT participation in weekly community MDT •Proactive HPCT presence at the 'front door' of Ninewells Hospital

Results: March to August 2023

•There were ***232*** *new referrals to the Dundee Community Palliative Care Service:*
•***177*** *completed care episodes have been evaluated*

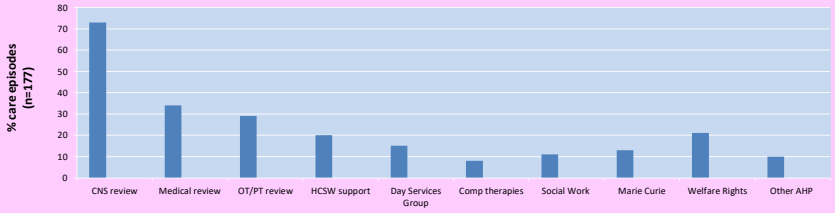
A. Urgent Assessment: ***A high level of urgent need has been identified*** *within new referrals and the existing caseload:* ***19%*** *of new referrals are* ***RED*** *and* ***53%*** *of patients are on the* ***RED*** *caseload at some point during their care episode*

Median total length of stay *on community caseload is* ***11 days***



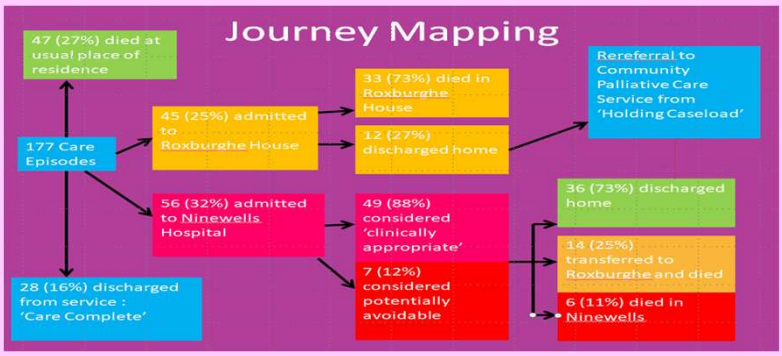
B. Rapid Response: *Average time to first in person review was within* ***1 day*** *for all* ***RED*** *and* ***AMBER*** *referrals and contact was made within 3 days for GREEN referrals*

C: Integrated Care: *A range of MDT interventions have been delivered and coordinated by the Dundee Community Palliative Care Service*



D. Discharge Without Delay: *Journey mapping shows that one third of care episodes include an admission to hospital, but* ***the majority of these were considered clinically appropriate*** *and most patients were subsequently discharged back home*

Only 6 patients (from 177 care episodes) died in Ninewells Hospital



Carer Feedback: What helped the most?

The variety of specialisms and the integration with GP, District Nurses and Roxburghe House

The speed you all came to help

I appreciated the call on Mondays to see how the weekend had been

Someone always on the end of the phone...having a main contact to call

Summary

•There is early evidence that this project has promoted the delivery a highly responsive Community Palliative Care Service in Dundee, with favourable patient outcomes and carer feedback; there are a small number of **avoidable** hospital admissions and a **very small number of hospital deaths** in patients who are known to the service.
•Specialist palliative care services must develop integrated models of care delivery which align to patient journeys across inpatient and community settings, and work in partnership with other acute and community services.
•Investment in Specialist Palliative Care Services may reduce the cost associated with avoidable hospital admissions at, or near, the end of life.