Community Specialist Palliative Care
A New Way of Working

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DEMOGRAPHICS

The population of Doncaster is estimated at 300,000. It has a higher level of deprivation than the national average, with some areas rating the most deprived in England. Health and wellbeing in Doncaster is not improving as fast as the rest of the country and as a consequence, the life expectancy for both men and women is significantly lower than the average for England (DMBC 2012). Locality Health Profile data for Doncaster (DH 2012) indicates that the main cause of death is cancer, followed by cardiovascular disease. The borough has significantly higher statistics for early deaths caused by heart disease, stroke and cancer.

Place of Death Doncaster rates higher than the national average for people dying in hospital. Nationally the number of people dying in their usual place of residence has risen from 38% in 2008 to 44.5% today (NHS England 2014). The figure for deaths in the person's own home for Doncaster mirrors the national average; however less people are dying in care homes. The number of deaths within St John's Hospice is also lower than the average for England.

RDASH ST JOHN'S HOSPICE SERVICES INCLUDE:

RDASH Wider Team
We work very closely with the District Nurses

BACKGROUND

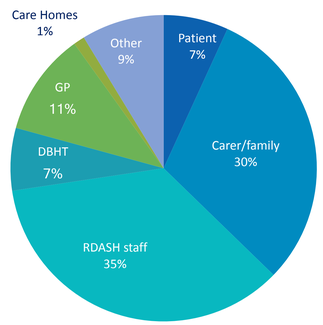
The Community Specialist Palliative Care Team (CSPCT) in Doncaster was based on a traditional model of working 9-5 Monday to Friday. There was no service provision for community Specialist Palliative Care (SPC) at weekends and bank holidays. Referrals to hospice services would come to the individual service meaning that different departments within SPC could be seeing the same patient without each knowing, causing a duplication/triplication in workload.

Working with Doncaster Commissioning Group we developed a service specification to integrate the palliative and end of life patient pathway to include both palliative and specialist palliative care. The specification reflects recommendations in national guidance and standards to meet the needs of the Doncaster population.

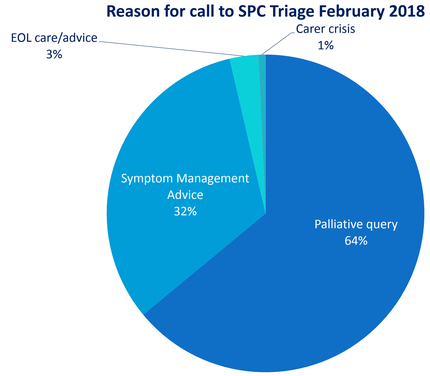
We have transformed the way we work by developing a single point of access triage system for all hospice service referrals, 7 day admissions to the hospice inpatient unit and a responsive Community Specialist Palliative Care Team working 7 days a week.

SERVICE DATA

Source of call to SPC Triage February 2018



Reason for call to SPC Triage February 2018



THE COMMUNITY SPC TEAM

Band 7 8 WTE	• We have 11 Clinical Nurse Specialists (CNSs) within the team, working a mixture of full and part-time.
Band 5 1.8 WTE	• We have 2 Band 5 staff nurses that work alongside the CNSs and also arrange Enhanced Support visits.
Band 3 3.2 WTE	• We have 7 Band 3 Healthcare Assistants that work in our Enhanced Support Team . They support people at home for day shifts and / or night shifts. • We have the capacity and flexibility to increase hours to meet the needs of the patient and their family.

SPC TRIAGE

Specialist Palliative Care Triage is a 7 day CNS led service that is based at the hospice and staffed 08:30-16:30 Monday – Sunday. All referrals to hospice services come via Triage, the referrals are reviewed by a band 7 CNS and signposted to the most appropriate service for that individual in a timely manner. This also includes when a patient requires admission to the hospice inpatient unit.

Triage is pro-active with the resources available, for example if an admission is required, but a bed is not available, Triage will send a band 7 CNS to review the patient and their symptoms the same day and arrange Enhanced Support cover until admission is available (see case study below).

Triage is staffed by admin support and a band 7 CNS on a rota basis. This model was developed to ensure that both patients and professionals could get timely advice and have a voice at the end of the phone, at a time that it is needed the most.

Patient / Relative / Professional → Triage / Band 7 CNS → Referral Actioned to the Most Appropriate Service

PATIENT CASE STUDY

Mr X was a 76 year old gentleman with Non-Small Cell Lung Cancer. He had bilateral pleural effusions with a Rocket drain insitu requiring drainage 3 times weekly for symptom management of breathlessness. His past medical history included throat cancer 20 years ago and advanced Alzheimer's disease.

Mr X was referred to the CSPCT for symptom management and psychological support. Mr and Mrs X were very close and he had good support at home. Following discussions it was evident that Mr X had planned for the future and had expressed that he wanted to die at home. Mrs X found such conversations distressing but understood her husband's prognosis. Plans were in place for end of life care at home.

Rapid deterioration occurred; Mr X became very breathless, agitated and distressed. Mrs X called SPC Triage for advice. The Triage nurse had immediate access to his records, offered reassurance on the phone and stated she would send a CNS out to assess Mr X.

CNS visited, Mr X had deteriorated and appeared to be nearing the end of life, he was very agitated and breathless. Mrs X was both exhausted and distressed by the deterioration and by seeing Mr X unsettled. She was upset and felt guilty but asked if he could be admitted to the hospice for end of life care, as she was unable to cope.

CNS felt that this may be a safe option and rang Triage to enquire about the capacity to admit. Triage informed the CNS that there was no capacity as the hospice was now full. Triage arranged for our Enhanced Support Team to be involved, they arranged for a Healthcare Assistant to provide 24 hour cover for the subsequent 48 hours until a bed in the hospice became available. A CNS visited daily and the family were also supported by the 24 hour District Nursing Team.

The CNS palliated symptoms, commenced a syringe driver and supported the family.

Mr X settled and over the following 2 days became more comfortable, Mrs X felt supported and no longer wanted Mr X admitted to the hospice for end of life care. Mr X died 72 hours later, with his wife by his side and at home.

References: Department of Health (2012) *Health Profile – Doncaster.* London, DH: Doncaster Metropolitan Borough Council (DMBC) (2012) *Doncaster Health and Wellbeing Strategy 2013 – 2016.* Doncaster, DMBC: NHS England (2014) *Actions for End of Life Care 2014 – 16.* Leeds, NHS England.