SHARED PURPOSE: BRINGING HEALTHCARE HOME

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The background

A Telehealth hub was set up at Airedale General Hospital for senior nurses to take calls directly from patients thought to be within their last 12 months of life and their relatives. Patients are asked to consent and their health care record is then visible to the nurse. This is provided for 3 CCGs (Airedale, Wharfedale and Craven, Bradford City and Bradford District).

The service was planned with input from health care professionals, patients, carers, CCG representatives and others. The hub nurses are available to take calls 24/7.

The project was planned with input from a member of the Trust's executive team, Consultant in Palliative Medicine as clinical lead (approx. 1/2 day each), a project manager for 30 hours per week and an administrator 15 hours per week.

Problem

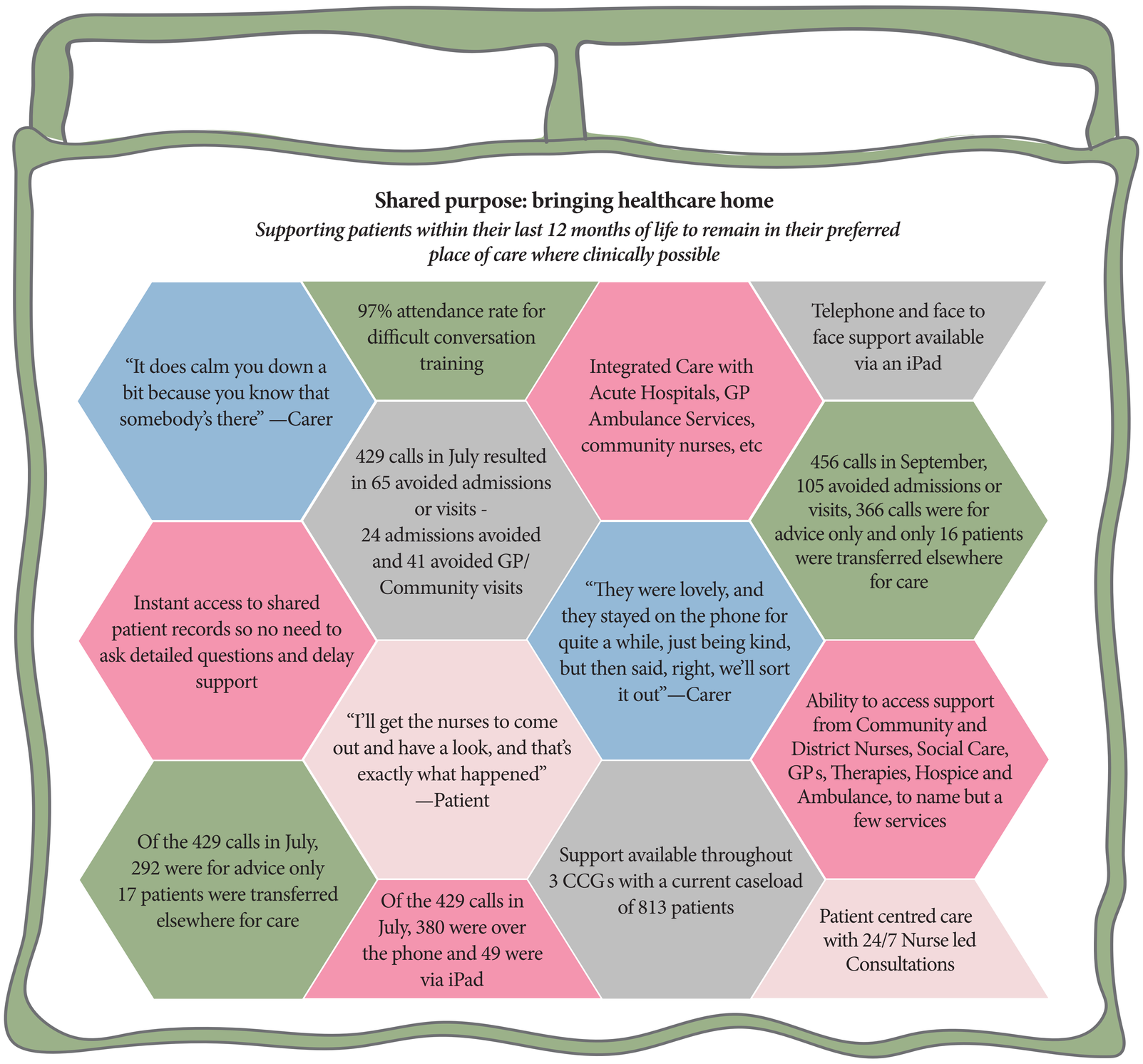
Most people want to spend as much time at home as possible in their last year of life. However, we know that this group of patients spend a significant time in hospital, sometimes these admissions are avoidable if other support options are available.

Patients are particularly at risk of acute admissions to hospital when day time services close. The aim was to provide additional support to patients and their carers in their own homes, reducing the need for acute hospital admission, attendances at A and E and visits from out of hours medical services.

Assessment of problem

Most people say they would prefer to die in their own home, yet the majority die in hospital. If past trends continue, by 2030 inpatient facilities will need to be increased by 20%. With the growing pressure on resources, unless Trusts develop new, higher-quality, more efficient and integrated models of care, these services will be increasingly compromised.

We looked at data around preferred place of death, number of patients achieving their preferred place of death, number of admissions and length of stay for patients who could have potentially been Gold Line patients. When the project was set up, all stakeholders were invited to attend planning events including patient and carer representatives, CCGs, GPs and Community staff.



Intervention

Three workstreams were agreed:

1. Develop an electronic database of all patients thought to be in the last year of life, which includes key information such as the person's wishes.
2. To deliver difficult conversations training to enable staff to support patients in distress
3. To develop a co-ordination hub available 24/7 so patients and carers can call one phone number to access all services they need. Support and advice can be accessed via this number in addition to accessing other support services. 30 mini-iPads were also available to allow some patients to have face-to-face video consultations in addition to the telephone line. This was called the Gold Line to tie in with the Gold Standards Framework, a national programme of care planning for people who may be in the last year of life.

We are happy to show people around the Telehealth hub by prior appointment and discuss the service.

Strategy for change

Gold Line launched in November 2013 for one CCG, the other two joining in March 2014. Formal economic and qualitative evaluation of the service is in progress.

Early evaluation indicates that the service is highly valued by patients, carers and health professionals and by reducing avoidable use of services will prove to be a cost effective intervention.

Measurement of improvement

There are internal and external evaluations being completed at present. We have commissioned qualitative and quantitative data to be analysis by two external companies whilst also evaluating internal benefits of reduced length of stay and reduced admissions.

Effects of changes

We are currently evaluating the outcomes but the feedback we have received from the patients and carers has been overwhelming. The support they have received has allowed them to remain in their preferred place of care, with dignity and an appropriate amount of support to ensure they have the quality of care they need in their most difficult time. Some of these comments have been included in our draft poster attached below.

Lessons learnt

We held a Knowledge Capture event and the main themes were that people felt that having an Executive Lead, Clinical Lead and dedicated Project Management support has pushed this project forward far quicker and further than originally anticipated.

The project has become much larger than anticipated and so we are now looking at how to spread to other specialties and CCGs within our geographical area.

Message for others

Always involve patients and carers in service redesign and ensure you build in clinical lead and project management support and align yourselves with a strong supportive Executive Lead.

Conflicts of interest

Initial funding was through the Health Foundation Shared Purpose project but as we rolled out the support, our CCGs have also commissioned the service for their patients.

Airedale NHS
NHS Foundation Trust