

BRINGING HEALTHCARE HOME

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- Led by Airedale NHS Foundation Trust, supported by partner organisations, including Airedale, Wharfedale and Craven Clinical Commissioning Group and Sue Ryder Manorlands.
 - Project that ran across Airedale, Wharfedale, Craven and Bradford.
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INTRODUCTION

Most people say they would prefer to die in their own home, yet the majority die in hospital. Recognising this, Bringing healthcare home was a project designed to improve the quality of care for end-of-life patients.

In Bradford and Airedale, an electronic palliative care coordination system has been developed to record key information, including patients'

preferences for care for those identified as being in the last year of their life. All of these patients are offered 24-hour access to clinical opinion and support in their own home via a telephone helpline or video consultation.

WHY DID THEY DO THIS PROJECT?

There is a growing recognition that the care of people approaching the end of life needs to be improved, and that people need to be better supported at home during this time. The majority of people would prefer to spend the last year of their life at home, but in reality most patients at the end of their life spend a significant amount of time in hospital, and two out of three patients die there.

The national End of Life Intelligence Network reports that currently in England 58% of people die in NHS hospitals, with around 18% of deaths occurring at home, 17% in nursing and residential care homes, 4% in hospices, and 3% elsewhere.

If these trends continue, inpatient facilities will need to be increased by 20% by 2030 to meet the demand. With growing pressure on resources, hospital trusts need to develop new, higher quality, more efficient integrated models of care.

A significant proportion of hospital admissions are potentially avoidable. By providing extra support to patients, families and carers in their own home, the number of avoidable hospital admissions and visits from medical services can potentially be reduced.

WHAT DID THEY DO?

Bringing healthcare home has involved working with patients with advanced cancer or with long-term conditions and thought to be in their last year of life.

The project team started by looking at existing end-of-life pathways and assessing the gaps in services and barriers to their implementation. Following stakeholder events involving patients and carers, three work streams were identified:

Palliative care coordination

A central electronic register of patients thought to be in their last year of life was set up. Key information, including the future care wishes of these patients, is included in a template held within the electronic health records of these patients.

Communication skills training

Health care staff underwent training in communication skills so that they would feel competent and confident in having sensitive conversations with patients in their last year of life. This enabled staff to start conversations around death and dying with patients, and to deal with patients or carers in distress.

Telephone helpline

A 24 hour, seven day a week telephone support line (Gold Line) was set up for patients identified to be in their last 12 months of life, and their carers. The calls are answered by senior nurses who can assess, advise and support patients and carers, as well as having access to a range of services which they can coordinate on behalf of the patient. These nurses have had training in palliative care and communication skills.

To explore the potential additional benefits of telemedicine, 30 iPads were offered to a proportion of these patients to enable them to have face-to-face video consultations.

WHAT IMPACT DID THEY SEE?

In early 2015, the Gold Line had a caseload of around 950 patients (and their carers) from three Clinical Commissioning Groups with a population of 500,000. Gold Line currently takes around 500 calls a month from patients over the phone or using iPads.

The project has provided high-quality, coordinated care for a large number of people facing the last year of their lives, and their carers. Reports suggest significant reductions in the use of primary and secondary care services following the implementation of the Gold Line service. Analysis has shown that 13% of patients who were registered with Gold Line and died between 1 April 2014 and 31 March 2015 died in hospital. This is significantly lower than the national average of 58% dying in hospital.

Over 300 staff and volunteers have received communication skills training on how to support patients and carers in distress.

Having to tell their story ‘over and over again’ has been described by carers as one of the most draining parts of caring for someone in their last year of life. The electronic register set up via this project has enabled access to patient records by hospital staff, GPs and community nurses so that they can give advice and treatment when required, without the patient or carer having to give their details to a number of different people.

WHAT DID THEY LEARN?

Changes in scope

The original objective was to set up a discreet project to help patients in the last year of their life to remain at home where possible. However, following stakeholder consultation and patient and carer feedback, the team found that the project was much more complex and so the scope was changed.

For example, it soon became clear that the actual identification of the cohort of patients needed to be in place first; as the foundation on which to build all other services. In addition, it was soon recognised that support for professionals was needed in having sensitive conversations with the identified patients.

Keeping stakeholders informed

Due to the nature of this project, gaining stakeholder buy-in was not difficult, but ensuring that all stakeholders were fully informed every step of the way was more challenging as the messages needed to be open and informative while being appropriate for the audience. As a result, two overarching project group meetings were arranged each month; one to support the strategy and direction of the project, and the other to identify any operational issues.

Passion and engagement

The project attracted a number of health care staff who have experienced personal loss, and, as such, the level of passion and commitment has been unparalleled, and has clearly been a factor that has driven the project forward. However, there were also obstacles that needed to be overcome, in particular with ensuring the various clinical teams were properly engaged.

WHAT ADVICE WOULD THEY GIVE TO OTHERS?

Take time to plan and design

Many projects are rushed in the planning stages. Take time to think about what changes would have the most beneficial impact on the service, and what measures need to be in place to show if this change has been of benefit or not.

Ensure strong leadership

A strong executive lead and dedicated clinical leadership has been critical to the success of this project. Strong executive support has allowed the delivery of the project to run a lot more smoothly than most projects, and the clinical leads have increased the ability to gain clinician buy-in from the outset.

Fully consider patient and carer impact

Patient and carer representation ensured that the project team fully considered their perspectives and that they were aware of the impact the project could have on the lives of patients and carers.

Use appropriate and up-to-date technology

Engaging with the most appropriate technical partner has also meant that the project could offer the most suitable use of up-to-date technology possible for maximum impact and ease of use for patients and carers.

A shared IT system is a major enabler

The shared IT system across primary and secondary care that was in place was a major enabler for joined-up care.