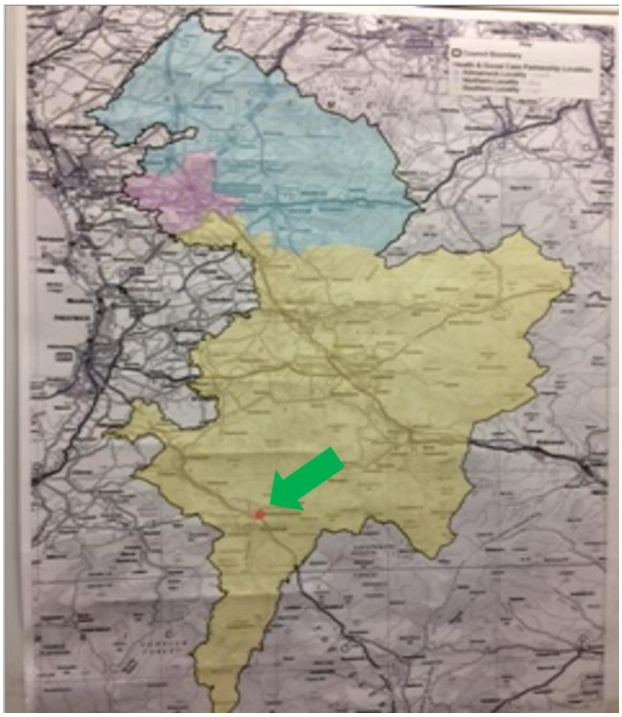
East Ayrshire: An Alternative Place for Palliative Care

A local story

A generalist palliative care bed in a nursing home has been tested over almost two years with the intention to improve access to general and specialist palliative care and prevent admission to an acute hospital. The purpose of this bed was for when a person is finding it difficult to be supported at home, or the person has needed to be admitted to hospital, but preferred their place of care to be closer to home, family and friends.

This initiative was led by the local GP and supported by the local District Nurses, Social Worker, Care Commissioning officer for care homes, Ayrshire Hospice Specialist Palliative Care Community Nurse, Hospital Specialist Palliative care Nurse, Ayrshire Hospice Education team, Senior Manager for East Ayrshire Health & Social Care Partnership (EA HSCP) and the Associate Improvement Advisor for EA HSCP. The chosen private nursing care home -Glebe House is a 44 bedded unit. This was after consultation with stakeholders based on the application proposal from the care home manager. The testing of this model was initially agreed for 6 months and later extended to 12 months.



Picture of the 3 localities in EAHSCP. The Care home is situated in the southern locality

Glebe house offered the palliative care room as a dedicated en-suite bedroom facility, with plenty of space to accommodate family and friends. The home offer a holistic approach accommodating the person's spiritual, emotional and/or social support needs. The care home and local staff received additional education that and included pain and symptom management, anticipatory care planning and cardiopulmonary resuscitation. As this was a new model referral and admission criteria were developed by the stakeholder group. A process for sharing of information was agreed. Since electronic systems were not linked to the care home it was essential that everyone involved was committed to good communication.

20 people have accessed the service, some repeatedly. There has been a 6.6% decrease in hospital stays and over a 50% decrease in bed days and average length of stay. It is likely that permanent funding will be granted by (EA HSCP) based on the work to date. A key success factor was the initiative lead locally by GPs.

East Ayrshire deliver their service by:

Identification and referral criteria • Clinical judgement making use of assessments including Support Team Assessment Schedule (STAS) and Eastern Cooperative Oncology Group (ECOG) Score • Known history of patient, key information summary (KIS) • Conversations with patient/carer • Current level of needs including reason for treatment/admission and whether this can be delivered in the nursing home • Eastern Cooperative Oncology Group (ECOG), Support Team Assessment Schedule (STAS) , ACP discussion / CPR discussion	Approach taken by team • Practice have monthly multi-disciplinary palliative care meeting • They discuss present patients on Palliative Care register and potential patients • They categorise these patients • identify those for JIC (just in case) boxes • Discuss with patients openly regarding palliative care including early discussion of options for future care and support • Resources can be found on the LWiC webpages.	People receive the range of palliative care interventions and was the palliative bed was used for the broader needs of people not just the very end of life. Key enablers have been palliative care training to care home staff and primary care MDT engagement Training, raising awareness and changes in practice relating to: • Symptom management of advance disease • Pain assessment and basic pain management principles • End of life care planning / symptom management • DNACPR and Advance/Anticipatory care planning

Staff groups involved

- Senior Manager for East Ayrshire H&SCP
- District Nursing
- Social Work
- GP from Dalmellington Practice/Practice Manager
- NHS Specialist Palliative care x 2 (Ayrshire Hospice & Ayr Hospital)
- Education (Ayrshire Hospice)
- Local Associate Improvement Advisor support
- Care Home Commissioning

Operational Data

Year 1 2016/17, the bed was occupied for a total of 162 days (£430 x162 = £69,660), Overall 45% use
Year 2 2017/18, the bed was occupied for a total of 172 days (172 x £430 = £73,960), Overall 47% use

GP Practice	**2016/17**	**2017/18**	**% Change**
Hospital stays	61	57	6.6 % decrease
Bed days	992	400	59.7 % decrease
Average length of stay	16.3 days	7.02 days	56.9 % decrease
Compared to neighbour GP Practice with similar practice population			
Hospital stays	92	79	14 % decrease
Bed days	936	743	21 % decrease
Average length of stay	10.2 days	10.6	4 % increase
Data from NHS A&A LIST analysts Oct 2018			

Conclusion

Over the course of two years there were changes in key care processes, contributing to reductions in hospital stays, hospital bed days and average length of stays. This included training on palliative and ACP and the creation and use of the care bed. Additionally people receive a range of palliative care interventions and the care bed was used for the broader needs of people and not only at the very end of life.

- Training of staff on palliative and ACP
- 334 total bed days /prevented hospital admissions
- Anticipatory Care Planning increased (44 bed care home)
- Improved person centred care
- Film / interest and visits from other boards