Enhanced End of Life Care Support

Stockport CCG

The challenge
The CCG identified that in its area there were gaps in end of life care (EOLC) provision, in particular domiciliary care. The district nursing service also had capacity issues. Combined, this meant that 70% of expected deaths were occurring in a hospital environment, rather than in a patient’s preferred place to die which was the home.

The solution
An integrated EOLC support model was developed consisting of a team of district nurses from health and Assistant Practitioner staff from social care working together. This dedicated team focusses on EoLC for people in the last weeks of life whose preferred place of care is at home or in a care home. The teams are co-located, undertake joint assessments, deliver clinical tasks and maintain responsibility for the patients on the caseload, with the on-going lower level clinical tasks and domiciliary support being delivered by the Assistant Practitioner including emotional and psychological support as well as support for a person’s social needs. Daily contact meetings are jointly attended, and care planning and 2 weekly reviews are undertaken jointly. Caseloads are held by District Nurses who undertake initial triage assessment and allocate cases to the appropriate Assistant Practitioner to deliver low level clinical tasks.

Care is coordinated and tailored to the needs of the individual and contact and communication links are maintained with the patient and their family and support could be accessed by a series of planned visits as well as on an ad hoc basis so that crisis, carer breakdown and hospital admission is avoided.

The service was initially piloted in one locality in December 2013, then expanded into other localities before being made borough wide by the end of November 2014. The service is expected to maintain a caseload of approximately 400 people at any one time.

The impact
Since commencement of the service 92% of patients are now able to die at home – their preferred place. This is a significant increase on the 30% able to do so pre-service.

Other examples of the positive impact of the service include:
- Carers are supported and feel confident that their loved one can be cared for at home
- Patients are accessing appropriate care and support at the time of need
- Fragmentation of care is reduced
- Care is coordinated pulling in specialist advice responding to need
- Staff feel more positive about service quality
- Reduction in unplanned admissions and attendances from hospital leading to cost savings.

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