Monitor
Making the health sector work for patients

Midhurst Macmillan Palliative Care Service: Sussex Community NHS Trust

The Midhurst Macmillan Palliative Care Service ('Midhurst Macmillan') provides acute-level care at home to patients nearing the end of their lives. Important features are personal case management to co-ordinate all aspects of care, a seven-day service and cross-skilled staff.

Sussex Community NHS Trust is a large community healthcare provider serving a population of about 1 million people. It provides medical, nursing and therapeutic care to over 8,000 patients a day.

Aims

The Midhurst Macmillan consultant-led multidisciplinary team provides hands-on care at home and in other community settings seven days a week. The service is based on the Motala model[1] in Sweden and aims to:

- enable patients with complex needs to be cared for at home
- allow patients to die in the place of their choice
- prevent avoidable admissions to hospital.

Characteristics

- care at home for end-of-life patients
- ability to provide acute level care
- co-ordinating other end-of-life services
- multidisciplinary team
- 7-day service

Midhurst Macmillan differs from traditional hospice models by focusing on care at home and proactively identifying patients earlier in their end-of-life pathways.

Origins

The Midhurst Macmillan Palliative Care Service was set up in 2006 in response to the closure of King Edward VII Hospital and its 20-bed inpatient palliative care unit. The NHS and Macmillan Cancer Support had jointly funded the unit. The hospital's

[1] Beck-Friis B, Strang P. The organization of hospital-based home care for terminally ill cancer patients: the Motala model. *Palliative Medicine* 1993; 7 (2), 93–100.

closure prompted local stakeholders to consult on an alternative solution for palliative care. The local health economy already had good hospice bed provision, so the service focused on developing a more interventionist approach, providing acute-level care at home.

Structure

Multidisciplinary team A single team provides medical, nursing and psychosocial support to its patients.

Community-based Midhurst Macmillan has an administrative base at a local community hospital but provides all care in the patient's home.

7-day care The core service operates between 8:30am and 8:30pm daily. It also provides night-time advice to healthcare professionals and respite care.

Staffing

The team's caseload is around 300 patients a year from a population of 156,000. The team comprises:

- approximately 2 whole-time equivalent (WTE) consultants/associate specialists in palliative medicine
- 0.5 service director/joint clinical lead team leader
- 10 WTE clinical nurse specialists/registered nurses
- 4 WTE healthcare assistants
- 1 WTE counsellor/family therapist
- 1 part-time physiotherapist and occupational therapist
- 1 to 2 WTE administrative staff and volunteer co-ordinator
- more than 70 volunteers.

How patients benefit

Referral from GPs and hospital inpatient wards Midhurst Macmillan encourages referrals soon after diagnosis of a life-limiting condition. Around two-thirds of referrals are from GPs. One-third come from within hospitals, where Midhurst Macmillan staff join multidisciplinary meetings with acute hospital palliative care teams to identify patients who could benefit from the service. The Midhurst Macmillan team also proactively calls acute wards and palliative care teams in local acute hospitals to arrange patients' early discharge.

Palliative interventions the team can provide in or close to a patient's home

- blood/blood product transfusions
- parenteral treatments
- intravenous (IV) antibiotics
- IV bisphosphonates
- fluids
- paracentesis
- spinal analgesia

End-of-life care Midhurst Macmillan accepts referrals for patients over 18 with complex cases of cancer or life-limiting chronic progressive disease. These represent around 25% of end-of-life patients locally. Most Midhurst Macmillan patients have terminal cancer but growing numbers are receiving care for non-cancer conditions, including motor neurone disease, chronic obstructive pulmonary disease, heart failure, multiple sclerosis and other neurological conditions.

Patients are usually seen on the same day. If a patient is in crisis on referral, a clinical nurse specialist treats them in their home on the same day. The clinical nurse specialist also assesses patients not in crisis at home. The team discusses and assesses all patients at daily multidisciplinary team meetings, and allocates support services based on the level of intervention needed.

Clinical staff are allocated to specific patients to enhance care continuity. Each clinical nurse specialist holds a caseload of about 50 patients. In addition, a clinical nurse specialist is able to pick up cases and respond quickly to urgent needs. Clinical nurse specialists do not usually provide hands-on care; this is done by trained nurses or healthcare support workers.

Single assessments Patients are assessed for psychosocial, medical and social needs at the same time. Single assessments help reduce stress and accelerate care planning. Counsellors work with patients and families before and after bereavement.

Enabler: care co-ordination and clear leadership

A clinical nurse specialist co-ordinates care for each patient. This enables staff to build relationships with patients, GPs and district nurses. Relationships are enhanced by the same team seeing patients from diagnosis, with hands-on nursing for more complex procedures in the patient's home.

The Midhurst Macmillan team co-ordinates complex care across a range of providers, placing the patient at the heart of the plan, reducing duplication of effort and covering for other services where necessary.

Working closely with the community Medical and nursing staff visit patients at home. Midhurst Macmillan also supports nursing homes and community hospitals. Skills transfer to staff in nursing homes and community hospitals may benefit patients not directly referred to Midhurst Macmillan.

Consultant presence Consultants visit about 30% of patients. Typically a third of these require a single consultant visit and two-thirds need more frequent visits for specialist medical procedures. Outside these visits consultants are kept updated and provide oversight through weekly multidisciplinary team meetings. The patient's GP remains accountable for patient care but Midhurst Macmillan consultants are able to perform specialist procedures without the GP's prior approval.

Enabler: seven days a week cover

The service operates seven days a week. This allows Midhurst Macmillan to respond to a patient crisis, avoid the patient going into hospital and treat more patients at home.

In addition, Midhurst Macmillan has an increasing bridging role providing care when community nursing teams are not available (eg over the weekend), allowing patients to leave hospital faster.

Enabler: cross-skilled staff

The team treats patients when and where they need it, using competency-based care. Nursing grades or therapy specialisms do not restrict the care that staff can deliver.

A study of the Midhurst Macmillan service notes the importance of flexible working relationships[2] and tasks being performed by the nearest competent professional. Team members are willing to learn from each other.

Midhurst Macmillan also has a large pool of volunteers who fulfil many important roles within the service and support patients through activities such as shopping or gardening.

Access to inpatient beds if necessary If patients require a short-term inpatient stay or procedures that cannot be carried out in their home, inpatient beds are available in local hospices and community hospitals.

Impact

Allowing more patients to die in a place of their choice In 2013, 84% of Midhurst Macmillan patients were looked after and able to die in their preferred place of care. In the UK, for those who expressed a preference reported by their relatives, most people preferred to die at home (81%), although only half were able to.[3]

[2] Noble B et al (2014). Can comprehensive specialised end-of-life care be provided at home? Lessons from a study of an innovative consultant-led community service in the UK. *European Journal of Cancer Care*. ISSN 0961-5423 (in press).
[3] ONS National bereavement survey 2012 www.ons.gov.uk/ons/dcp171778_317495.pdf

Identifying patients early prevents inpatient admissions. Most patients in the Midhurst Macmillan scheme are referred before an inpatient admission, resulting in fewer emergency attendances and over two-thirds fewer inpatient hospital days compared to patients who are referred to a hospice. Most hospice patients have at least two inpatient admissions before referral. Avoiding hospital admissions is a welcome outcome for patients, leading to consistently positive patient feedback.

The scheme may save money. Some evidence suggests this service could cut the total health economy cost of care in the last year of life by 20%.[4] Evaluations indicate the Midhurst Macmillan service is about half the cost of hospice care. Savings are largely due to the earlier referrals to Midhurst Macmillan, particularly if they avoid additional inpatient admissions. However, other parts of the health system incur higher costs as Midhurst Macmillan involves greater co-ordination to provide care with other out-of-hospital services.

More information

Midhurst Macmillan

Sussex Community NHS Trust

healthcareclosertohome@monitor.gov.uk

This is one of a suite of case studies designed to increase awareness of the impact of moving healthcare out of hospital. For more materials see Moving healthcare closer to home

[4] Noble B et al (2014). Can comprehensive specialised end-of-life care be provided at home? Lessons from a study of an innovative consultant-led community service in the UK. *European Journal of Cancer Care*. ISSN 0961-5423 (in press).