# Dorset Integrated Care System: Development of an innovative service to meet local population need

## What is this case study about?

This case study shows how the **Hospice at Home service based at the Macmillan Unit for East Dorset** and the **Community Night Nursing Team** are working together to improve Palliative and End-of-Life Care (PEoLC) provision at night within the Dorset Integrated Care System (ICS). This illustrates the Sue Ryder and sector partners recommendation:

"Each ICS should look to develop or implement innovative services or specific roles in response to challenges and to meet local population health need."


## The night service partnership in Dorset

The Community Night Nursing Team in Dorset were struggling to meet demand and severely challenged in recruitment and retention.

The new Hospice at Home service, run out of a hospice within the University Hospitals Dorset Trust, joined forces with the Community Night Nursing Team to provide tailored support to patients under specialist palliative care. Patients are triaged by a 24/7 helpline. The partnership aims to increase capacity and quality of care at night.

## What makes the night service partnership work?

- **Trust:** The partnership was set up with sensitivity and respect between the two teams and framed as a source of mutual support for working towards a shared goal.
- **Culture:** A willingness to do things differently, and overcome barriers to doing so – such as enlisting the support of the Chief Pharmacist in getting sign off for the Hospice at Home staff to single check drugs, thus speeding up the process of getting medication to patients.
- **Flexibility:** While there are clear boundaries to the roles of the two teams, there is flexibility to this, recognising that patient needs can change quickly at the end of life.

## What difference has the night service made?

### A difference to the workforce:

- ✓ **Improved staff wellbeing and morale:** Nursing staff feel better supported by having access to advice from specialist palliative care colleagues, and staff burn-out has reduced through additional capacity in the service.
- ✓ **Improved recruitment and retention:** Improved service reputation and being part of a collaborative service has attracted more staff to apply to the Community Night Nursing Team. Vacancies have reduced by 80%.

### A difference to patients and families:

- ✓ Better **quality of care** for patients with complex palliative care needs, as the Hospice at Home service can provide specialist care to these patients.
- ✓ Patients are more likely to be able to **stay in their homes**.
- ✓ **Shorter wait times** at night for palliative and other patients, as the Community Night Nursing Team has been able to increase the number of patient visits per shift.

### A difference to the system:

- ✓ **Improved capacity** within the system means more patients can be seen.
- ✓ **Reduced pressure** on ambulance service and reduced emergency admissions, because both palliative and non-palliative patients can access care and support overnight.
- ✓ Positive impact on **social care**, as avoided admissions mean that social care packages do not have to be stopped and started.

# East Dorset's top tips for effective partnership working

- ✓ **Establish relationships:** Think about informal as well as formal ways to build the partnership. The Community Night Nursing Team have an open invitation to pop into the hospice for a cup of tea when they are out on shift, and this is reciprocated at the Integrated Urgent Care Hub.
- ✓ **Establish boundaries and roles:** Hospice at Home focus on patients with complex palliative care needs, while the Community Night Nurses manage those with less complex needs and other patients requiring overnight nursing care.
- ✓ **Get buy-in from the wider team by emphasising impact:** Make sure everyone understands that they are part of a team that has one chance to get it right for the patient at end-of-life, and to avoid hospital admission. Ensure out of hours GPs are on board.
- ✓ **Get the right management team in place:** Particularly when designing and implementing the service, get the right size team with the right skills and experience in place. Dorset found their team of four management staff, two from each service, provided a good mix of different perspectives and challenge, while still enabling quick decision making.
- ✓ **Get the practicalities in place:** Both teams have access to patient records, enabling all clinicians to have a shared understanding of patients' evolving needs. The teams are co-located within the Integrated Urgent Care Hub, which has helped enable effective communication and collaboration.

> **"Staff feel enabled to be caring as they should be caring again."**
>
> Louise Pennington, Lead Nurse Palliative Care, University Hospitals Dorset

> **"The Hospice at Home team provide clinical support, but also an emotional element which is key to staff wellbeing."**
>
> Holly Taylor-Brown, IUCS Clinical Manager Visiting Services, Dorset Healthcare University NHS FT

## Governance at a glance

- Initially a **small group** of two members from each service met weekly to review and troubleshoot; they now meet monthly.
- New **policies, procedures and training** were developed to enable the service to be delivered.
- A **quality improvement approach** is used to regularly review effectiveness of the service (for example, assessing impact on staff wellbeing via the quarterly staff survey, monitoring patient complaints and concerns and implementing change in response, and tracking achieved preferred place of care and death).

**For more information** about this case study or the recommendations for commissioning and delivering better end-of-life care, contact john.kemp@sueryder.org.

## Palliative and End-of-Life Care: best practice case studies

Sue Ryder and sector partners working in PEoLC have developed Key recommendations for commissioning and delivering better end-of-life care within Integrated Care Systems.

This case study from Dorset is one of a series showcasing how ICSs around the country are implementing some of these recommendations:

- ✓ **Well-functioning collaboratives**
- ✓ **Local solutions to workforce challenges**
- ✓ **Engagement with patients, families & communities**
- ✓ **Measuring population need for PEoLC**
- ✓ **Using data effectively**