Coventry and Warwickshire partnership Trust (CWPT)

CWPT is the lead provider in Coventry for community services, providing 24 hour service 365 days a week with one single point of access. Care is provided by dedicated teams allocated to GP clusters thus allowing full MDT working across the community service pathway. Within Coventry management of long term conditions and palliative care is provided within an integrated care model and within the pathway palliative care is integrated with district nursing, community matrons, family support etc. These services are fully integrated and care is provided by locality MDT teams with named Macmillan nurses.

Access to palliative care service is based on specialist need and not limited to cancer diagnosis. Patients with any long term condition who identified as being in the palliative stages of their condition can access services equally to those of a cancer diagnosis including bedded facilities for symptom management of end of life care.

District nursing teams specialist nurses and community matrons have received training around the use of preferred place of care documentation, (documentation from the C.A.S.T.L.E. web site is utilised) GPs are encouraged through their monthly integrated team meetings to consider patients who may be SPICT positive and not known to the community services pathway.

All qualified nurses within the pathway received specialist raining in Long term conditions including palliative care and symptom management. Training is mandatory initially a 1 day course then annual half day updates. (Contact Yvonne Brown as ab below or Rachael Lee for more information Rachael.lee.@covwarkpt.nhs.co.uk)
Long term Conditions and in particular palliative care is included within the competencies for all bands of staff within Community Services Pathway. (contact Helen O'Callaghan for further information helen.ocallaghan@cwpt.nhs.co. uk)

Access to any element of the service is via the single point of access.

Community matrons, District nursing Sisters and Macmillan Nurses can also access up to 24hour care through the family support service for patients in the end stage of life. Myton Hospice or palliative care beds at Stoneleigh Nursing Home can also be accessed through the Macmillan Nursing team and are available for all conditions in the palliative stages for either symptom management of end of life care. Funding for Stoneleigh nursing Home Palliative care bed is funded through health via the Continuing Health Care Fund.

Integrated team meetings

These are held monthly rather than the standard set within QOF of 3 monthly allows for opportunity for full MDT approach to care, improves communication and facilitates a proactive approach rather than reactive approach to care.

In addition to palliative care patients this meeting is utilised to discuss patients with a long term Condition at risk of admission to hospital utilising the EVOLVE data with representation from GPs, Practice Nurse, District Nurse, Community Matron and Macmillan Nurse

All patients on the pathway services who are in the palliative stages of their condition, new referrals from palliative care services at UHCW/Myton Hospice, and any patient considered to be S.P.I.C.T. positive are discussed

Breathlessness MDT meetings

Also occur monthly and are held at the local hospice. The meetings are attended by :-

Dr. Alison O'Conner—Palliative care consultant for the community

Representation from Macmillan team and Community matrons

Dr Colin Gelder Respiratory consultant and one of the C.O.P.D. nurse specialists (tele 02476237005)

Heart Failure Nurse Specialist - Gill Tanner (available via bleep through UHCW switchboard 02476964000)

Dr Sarah Maclaran Palliative care consultant UHCW/Myton Hospice (contact 02476 841 916 Dolores Towers medical secretary)

Any member of staff in acute or community services are able to bring along cases for discussion re management of

Contacts

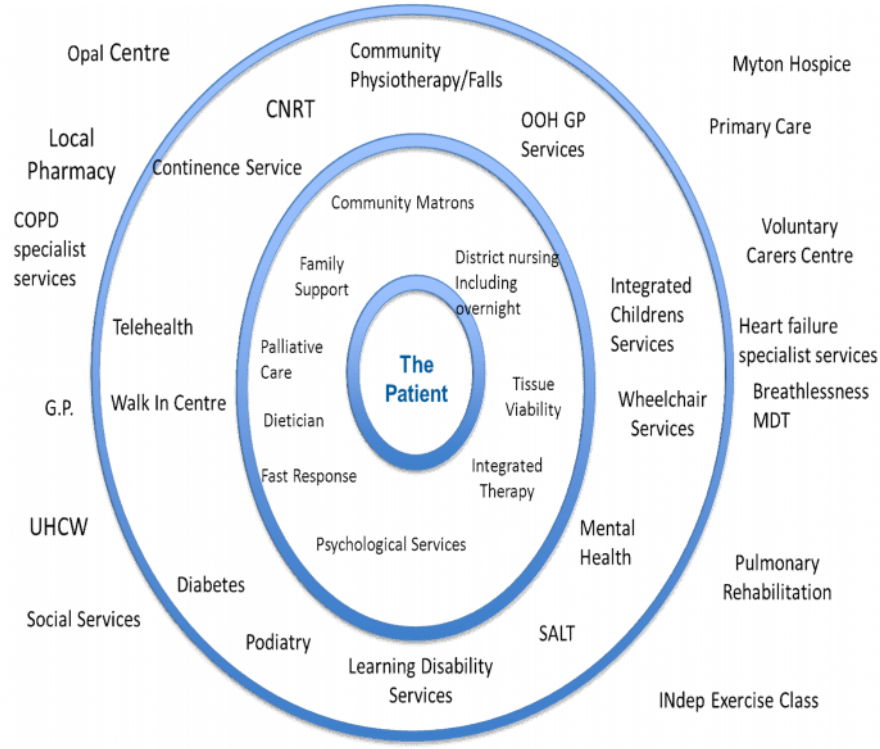
Yvonne Brown Community Matron 07818561739 yvonne.brown@covwarkpt.nhs.co.uk

Annette Bird District nursing Sister 07818561832 annette.bird@covwarkpt.nhs.co.uk

Jo Drewett Clinical Lead for Palliative care 07990661595 jo-sarah.drewett@covwarkpt.nhs.co.uk

Alice OConner Consultant palliative care CWPT alice.oconner@covwarkpt.nhs.co.uk

Integration of Acute and Community Services



Patient Story

Bob's Story

- Referred into CSP via heart failure CNS
- End stage heart failure – SPICT positive
- Preferred place of care initiated by district nursing and Macmillan nurse
- Widower lives with Sister in Law
- Bed downstairs has carers 4 times a day.
- Supported by district nursing team
- Reviewed by palliative care OT
- Reviewed by palliative care team
- Symptom management i.e. breathlessness discussed at breathlessness MDT and monthly Integrated team meetings at GP surgery
- Admitted to hospice for symptom management
- Later admitted to hospice for end of life care