Community-based palliative care teams

A retrospective cohort study in Canada reported that use of specialist community-based palliative care teams was associated with fewer hospital admissions and more deaths at home among terminally ill people.

Overview: Palliative care is defined as the active holistic care of people with advanced, progressive illness (NICE 2012). Palliative care can be provided by generalist or specialist teams in the community or in hospitals or hospices. Community-based palliative care teams typically involve a group of interdisciplinary healthcare professionals – palliative care doctors, nurses and GPs – who provide integrated palliative care to patients in their homes. These teams manage symptoms, provide education, coordinate care and provide additional or enhanced support and care.

Community-based palliative care teams can improve symptoms and quality of life for patients with advanced illness (Bakitas et al. 2009), and many patients prefer to receive care at home (Higginson and Sen-Gupta 2000). This approach may also reduce the risk of hospitalisation and help people to die at home.

Current advice: NICE guidance on improving supportive and palliative care for adults with cancer advises that commissioners should ensure that an appropriate range and volume of specialist palliative care services are available to meet the needs of the local population. These services should, as a minimum, include specialist palliative care inpatient facilities and hospital and community teams. Specialist palliative care advice should be available on a 24-hour, 7-days a week basis. Community teams should be able to provide support to patients in their own homes, community hospitals and care homes.

NICE is currently preparing guidance on care of the dying adult.

New evidence: Seow et al. (2014) did a retrospective cohort study to assess the effect of specialist community-based palliative care teams on risk of hospitalisation and dying in hospital. This Canadian study compared patients treated at home by 1 of 11 specialist community-based palliative care teams with matched patients who received usual community-based palliative care.
The specialist community-based palliative care teams comprised a core group of palliative care doctors, nurses and general practitioners. Members of these teams collaborated to provide integrated palliative care to patients in their homes (symptom management, education and care) and were available 24/7. Patients on usual care received community-based palliative care (mostly nursing and personal care) from a number of service providers with little coordination between them, and the providers may not have been contactable at evenings and weekends. These patients may have separately received home visits from a general practitioner. The primary outcomes were hospital or emergency department visit in the last 2 weeks of life, and dying in a hospital inpatient unit.

A total of 3109 patients received specialist palliative care over the 2 year period studied; these people were matched to 3109 patients who received usual palliative care. Participants had an expected prognosis of less than 6 months, and around 80% in each group had cancer. The specialist palliative care teams studied varied in size and composition. Compared with people who received usual palliative care, people who received specialist palliative care were less likely to be admitted to hospital (relative risk [RR]=0.68, 95% CI 0.61 to 0.76, p<0.001) or the emergency room (RR=0.77, 95% CI 0.69 to 0.86, p<0.001) in the last 2 weeks of life. People who received specialist palliative were also less likely to die in hospital (RR=0.46, 95% CI 0.40 to 0.52, p<0.01).

Limitations of this study include that participants were matched with propensity score matching, which cannot adjust for unmeasured factors such as patient preference for hospital care. The study took place in Canada and participants were mostly cancer patients, which may limit the generalisability of the findings. In addition, 2 of the 11 specialist palliative care teams did not have a significant effect on outcomes compared with usual care.

Commentary: “Existing evidence shows that community-based specialist palliative care teams improve symptom control and quality of life, increase satisfaction with care, and provide better outcomes for families (Higginson et al. 2003, Abernethy et al. 2008). This paper complements these findings by showing that the teams can also reduce emergency department attendances, hospital admissions and hospital deaths of people considered to be in the last 6 months of life.

“These findings reinforce NICE guidance that commissioners should ensure availability of specialist palliative care in the community. This does not just mean telephone advice to professional carers, but direct access by phone or home visits for patients and families, both within and outside office hours. These were the features that were associated with reduced use of acute services in this study.

“The UK already uses specialist palliative care teams similar to those shown to be effective in this study. But specialist palliative care in the UK remains on average only 25% funded by the NHS, the remainder coming from charitable sources. Better provision, which this paper suggests would be of benefit to the healthcare sector as a whole, would need a specific share of any shift of resources into the community.

“This research is probably the best evidence yet that specialist palliative care teams in the community can reduce use of acute services and hence both save money and prevent patients being exposed to care settings that most of them do not wish to enter. However, there would need to be new investment in specialist provision in the community if change is to be driven further.” – Dr Nigel Sykes, Consultant in Palliative Medicine, St Christopher’s Hospice, London

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