ANNEX E

DPH Chairman's Report

Welcome to the Dover Park Hospice's 32nd AGM.

Time flies. At our last AGM, I mentioned that we were entering an exciting transitionary period as an organization, and physically as we prepare to move into our new premises at the Integrated Care Hub (ICH). There have been substantial changes in the health financing and delivery landscapes and DPH has been at the forefront of some of these, contributing to the national agenda.

We have now been in the ICH for almost one year, and the capitation-based/ fixed funding per patient Integrated Palliative Care Pilot (IPCP) DPH is leading with Tan Tock Seng Hospital (TTSH) is now well underway. It is thus timely for me to step down and I am now making my last report as your Chairman. It has been an honour and privilege to serve with all of you.

A Busy 2023-2024

We have increased our Bed Occupancy Rate (BOR) to approximately 80%, grown our Home Care to island-wide coverage of TTSH patients, and worked on deepening the programs in Day Care. We are taking many more non-cancer patients, and are performing new interventions on the ward, such as ventilator care, blood transfusion, and peritoneal dialysis.

Secondly, we have pushed ahead with the Integrated Palliative Care Pilot (IPCP) brokered by MOH between DPH and TTSH which aims to do away with the administrative burden of care transitions from acute care into DPH, and to allow our patients to freely move across our own three services in accordance with clinical need and personal family situations.

Thirdly, we have refreshed the executive team with a new Director of Nursing (DON) who has brought with her experience and skills that complemented the Medical Director (MD). The executive team have done an excellent job handling the transition to ICH, expansion and deepening of our services, while caring for DPH staff. The Intermediate and Long-Term Care (ILTC) sector manpower attrition rate at the end of 2023 was between 11%-15%. Our fellow hospices were around 12%. Despite the changes, DPH's rate was only 11%.

Care Innovation and Evolution in Our New Home in the ICH

Our physical co-location in the ICH has already given us early gains.

From November 2023, our laboratory test turnaround time dropped from 2 days to 2 hours. Radiology (X-ray and ultrasound) is merely a short elevator ride down. Blood transfusion units are a mere walk away, across the Linkbridge.

Admissions flow smoothly across the same Linkbridge from any TTSH ward, saving our patients a wait and an uncomfortable ambulance ride. Indeed, on 30th October 2023, the very day we moved our inpatients from our old site, our MD took the first patient from TTSH A&E into DPH.

Our larger physical footprint in the ICH can accommodate up to 100 beds, of which 30 are set aside for a unique co-management model called PISCES (Palliative Integrative Supportive Complementary Empowering Spiritual). PISCES is not a test of space. It is a change in the care model – how acute care should transition patients to a palliative approach whilst not withdrawing support or involvement.

A larger Day Care space created the opportunity to increase the impact of social interventions such as art and music therapy, connection-based therapies such as Namaste Care or pet-assisted sessions, the marking of patients' important milestones such as birthdays, and fulfilling last wishes e.g. marriage ceremonies. These are low-cost high-impact actions that can transform the experience of dying.

A much larger Sky Garden gave our therapists and social workers many more green pockets of quiet space to work deeper with our patients and their families on psychosocial and emotional needs, away from the noisy street level, and cooled by breezes. These are the interventions that give caregivers strength to carry on, and may well have prevented a suicide.

A closed-loop medication management system has been implemented in our wards in ICH, reducing the risk of accidental harm. Our ward staff are fully-trained in using Automated Dispensing Cabinets (ADC). We are the only hospice in Singapore on par for medication safety practice standards with the acute hospitals. This will be presented at the upcoming 2nd Singapore Palliative Care Quality Improvement Conference (29 & 30 August 2024).

In partnership with Respiree, a local start-up for remote monitoring devices, our team has developed the ability to detect significant changes in patients' breathing patterns that may influence how we treat these. Many wearables measure respiratory rate, but ours measures tidal volume, a metric of much greater clinical value in palliative care. The team has won a prestigious National Medical Research Council (NMRC) Grant, which historically has not gone to hospices, to research this area.

ANNEX E

The Integrated Palliative Care Pilot (IPCP)

The IPCP runs from Oct 2023 to May 2025 inclusive of an evaluation period during which the National Healthcare Group's (NHG's) Health Services & Outcomes Research (HSOR) team will analyse the impact of this pilot.

This pilot offers us a per-member-per-month (PMPM) subvention rate of $2,800 per patient regardless which of our three services the patient requires.

In tandem, early rollout of the more generous means test and the national rollout of increased Medishield claim amounts for hospice care have given us much needed fuel for growth.

The outcomes sought are:

1. Quality of care, measured by symptom control, unplanned A&E visits, and percentage of patients who die out of hospital
2. Earlier access to care, measured by the transfer wait time from TTSH to DPH, and days from referral to DPH Home Care first contact.
3. Utilization and siting of care, measured by the workload of each palliative care setting, U-turns to acute hospital, and utilization of PISCES.
4. Patient Preferences, measured by the number of actual visits of patients under DPH or TTSH Palliative Medicine department.

Since we began, 70% of DPH's Home Care patients have had their wishes fulfilled – they died at home (the national average is 26%). Since November, total patients referred to DPH by TTSH have grown from an average of 85 per month (Jan – Oct 23) to 95 per month (Nov 23 – Mar 24), with 80 % of TTSH referrals going to Home Care (from 67 to 73 per month) and shorter time to admission.

Many Hands Make Moments Matter

Many different groups of people contribute toward palliative care.

Our staff now number 171, up from 158 at the end of 2022. Volunteers in 18 groups contribute monthly, offsetting 11,614 hours of work in 2023.

New hands have stepped forward, who want to make a difference together with us. Two examples are Willing Hearts, who deliver delicious meals pro bono, and two taxi drivers who buy snacks for nurses. Another example is the collaboration of two charities (DPH and Hao Ren Hao Shi) to organize a meal and shopping outing to Suntec City for 50 people comprising patients and their families.

It is heartening to see that the community spirit of “just do it” among staff and contributors alike is still alive and well.

Continuing Good Governance

Our Governing Council has continued its good work supported by a well-rounded set of sub-committees representing all aspects of enterprise and governance areas.

We will continue to refresh and renew our Governing Council membership with passionate members with different experiences and expertise.

Education That Meets Specific Needs

The Palliative Care Centre for Research and Education (PalC) has continued to be sensitive to the knowledge needs of our sector. For example, the inaugural run of the Managing Burnout and Building Resilience course, curated and led by Dr Mervyn Koh is tailored to healthcare workers facing immense work pressure.

In FY23/24, PalC successfully engaged a total of 276 participants through 10 specialized courses. This participation underscores the sustained demand for high-quality palliative care education within our professional community.

This is apart from an achievement of hosting its inaugural ethics webinar symposium "Translating Ethics into Humanistic Care”, which drew an impressive 104 attendees. The event allowed a unique exploration of the intersection between ethical principles and compassionate patient care, solidifying PalC's role as a leader in advancing ethical discourse and practice within the palliative care domain.

The other landmark achievement is PalC’s involvement in developing the postgraduate programme, MSc in Holistic Palliative Care (HoPE). Initiated three years ago, it is meant to address the urgent need for academically upskilling healthcare professionals in end-of-life care. This programme is a collaboration among DPH, Nanyang Technological University’s (NTU’s) Lee Kong Chian School of Medicine (LKCMed) and NHG offering a world first flexible and stackable learning pathway from Graduate Certificate to full Master’s degree. It has just been launched in August 2024 with 30 inaugural students.

Clinical Attachments and International Field Visits

A total of 158 local healthcare professionals completed their clinical attachment stints at DPH, including medical doctors, nurses, allied health professionals, and medical students. Additionally, DPH hosted field visits for healthcare professionals from

countries such as Beijing and Thailand, reflecting our expanding influence in palliative care education and our commitment to sharing best practices in the region.

Workload and Patient Demographics

In FY23/24, we admitted 414 inpatients (370 in FY22/23) with an average length of stay (ALOS) of 28 days (26 in FY22/23). Of these, more than 70% were from the lowest two tiers of income groups of the National Means Test (NMT) (58% in FY22/23). Their average age was 76 years (74 in FY22/23).

Home Care managed 865 patients (745 in FY22/23), with an ALOS of 85 days (74 in FY22/23). Their average age was 81 years (80 in FY22/23). The lowest two tiers of the NMT represented 66% (55% in FY22/23) of workload.

Day Care looked after 32 patients (38 in FY22/23) across all three programmes: Compassion, IMPACT and Dignity. The average duration of enrolment in daycare was 95 days (105 in FY22/23), and average age was 79 years (77 in FY22/23), of which 81% were from lower income families (53% in FY22/23).

As we diversify and increase the pathologies that we can manage, as well as going upstream to ensure palliative care is started timely, we may need to discern which of our services and programmes are best suited to different patient needs and progression over time.

Generally, the trends seem to show that patients have increased in age, ALOS and percentage requiring more financial assistance, except for Day Care enrolment duration which had shortened. The eldest patients were in our Home Care service, and the highest percentage of needy patients were in Day Care. These factors may continue to drive frailty, complexity and the need for fundraising over the next few years. Subvention may need to be reviewed annually or bi-annually to give realistic forecasts of adequate funding.

Financial Performance

For the financial year ended 31 March 2024, DPH reported a net surplus of $12.76 million (FY22/23: $686K) which was largely due to receiving a legacy donation of $13.42 million and contributions of $2.44 million from fund investments this year.

DPH continued to receive substantial government funding via the Community Silver Trust (CST) and Community Care Salary Enhancement (CCSE) Schemes which contributed to offsetting the cost of digital innovation and manpower.

DPH also benefitted from generous and supportive donors through its fundraising activities.

Operating expenditure increased from $19.49m million in FY22/23 to $22.76 million this year. The main contributors were higher ICH rental, increased housekeeping costs, and rising manpower expenses.

During the financial year, DPH engaged with the Ministry of Health (MOH) on the new Integrated Palliative Care Programme and its enhanced subsidy framework. As of the report date, the formal agreement for this new care model has not been finalized. DPH continued to apply the existing subsidy framework for financial reporting. The financial impact of adopting the new care model and the enhanced subsidy will be assessed and adjusted upon the finalisation of the agreement in financial year ending 31 March 2025.

Management continues to exercise prudence in financial management.

Challenges Ahead

As we continue to grow, there will be new financial and operational challenges ahead. Increasing the size and scope of Home Care and Day Care are all financial risks, given that we currently do not charge patients for these services. It is therefore vital to ensure that the IPCP gives good insights as to how much subvention ought to be provided to offset this, if MOH requires that we continue in the same manner.

The increased need for fundraising will be yet another challenge. We can no longer rely on event-based and ad hoc fundraising. We must attempt to secure dividend-like funds which will be very helpful for monthly cashflows.

In terms of operations, the larger ICH gross floor area (GFA) comes with its own price. Many operating costs are bundled together and negotiated by ALPS for the whole building. There are some that we can still separate and save on, for example, the good work done by the executive team in negotiating reasonable deals for security and food supplies. We must continue to seek savings and refine our procurement practices.

Clinically there will always be the temptation of mission creep. Becoming bigger is not a mission. Delivering moments that matter, delivering excellent clinical care and honouring personhood and dignity, are the mission and what we strive to do every single day.

Other risks we face include data and cyber security, which are global concerns and I am grateful to Gim Leng for concentrating on these areas going forward.

Ensuring DPH secures our fair share of talent is an ongoing effort, and a critical priority for the Governing Council. It will be crucial for DPH to navigate partnerships and long-term collaborations to protect our pipeline of staff and have access to shared resources in leadership development and talent management.

Conclusion

Much has been achieved and yet, there is still much to be done. Many more patients deserve a good death, and many more families need bereavement support and closure.

I am confident that the incoming Chairperson, supported by our committed Governing Council and Management will guide DPH into an even stronger position in the years ahead.

Thank you.

A/Prof Jeremy Lim
Chairman
32nd Governing Council