Palliative and End of Life Care Education and Training Strategy

Meeting the education and training needs of all of the health & social care workforce involved in the end of life care of patients and the care of their carers

“How people die remains in the memory of those who live on.”

Dame Cicely Saunders

February 2015
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Foreword

While progress has been made in improving end of life care across the country since the publication of the EOLC Strategy in 2008, recent criticism about the use of the Liverpool Care Pathway for the Dying Patient and concerns around general care in hospitals and other care settings have highlighted the need for continued education of the health and social care workforce around the care of dying people. This strategy sets out to recommend the skills and competencies required by anyone caring for people at the end of life.

Dying is a normal part of the life course, however modern society has an expectation that death can be avoided (almost) at all costs. Our healthcare system is also designed to promote life at all costs and as a result when a person is facing a life limiting illness, they, their family and the professionals around them may not have experienced death before and they may not be fully equipped to deal with the necessary difficult conversations, or the uncertainty that the future may hold. Sadly, those reaching the end of their lives, either as a result of frailty and/or old age or as a consequence of the final stages of an illness, such as cancer, dementia, chronic obstructive pulmonary disease, chronic heart disease and/or a number of these co-morbidities, need to be afforded the same skilled and competent team of health and social care givers regardless of where they are cared for and whether or not the care provider is salaried or a volunteer.

End of life care needs to be delivered by people who are competent, confident, caring and compassionate, who feel supported in their role regardless of their professional status in the care delivery team. The care giver needs to feel valued in the delivery of their unique contribution to the care of the person reaching their end of life. This strategy focuses on the non-specialist palliative care workforce who are responsible for the majority of care for people in their last year of life; however consideration also needs to be given to the specialist palliative care workforce as they will be likely to provide care, support and advice to patients and families and non-specialists as well as providing much of the education and training. This strategy does not seek to address public education around death and dying, but local authorities and public health teams may wish to make links with Hospices and other specialist palliative care providers to develop strategies for public awareness.

This end of life care education and training strategy intends to set a direction for Community Education Provider Networks and care provider organisations in order to ensure they have staff who are competent, confident and compassionate in delivering good quality end of life care. The challenge for commissioners and providers is to recognise the need for education and training in end of life care in order to ensure people with life-limiting illness receive the best possible end of life care and those who are left behind after their death feel supported during a distressing time.

Dr Nav Chana
Clinical Adviser, Health Education South London
Executive Summary

The strategy has been developed following consultation with service users, health and social care professionals, commissioners, organisations involved in delivering education and those responsible for assuring the standards of education that are provided. It is endorsed by Health Education South London.

The recommendations from the Cavendish report (Cavendish, 2013), More Care, Less Pathway (DH, 2013), the Francis report (Francis, 2013) and One Chance to Get It Right (DH, 2014) have been considered and included in the training priorities included in this strategy.

This strategy aims to ensure that the health and social care workforce in South London have the skills and confidence to deliver holistic, compassionate care for dying people and their families regardless of where they are cared for. Implementation of the strategy will help to ensure incremental improvements and spread of high quality end of life care to all those who need it, regardless of pathophysiology, place of care or other characteristics which may have an impact on access to care.

The focus of the strategy is on the training of all grades and disciplines of generalist\(^1\) and specialist staff who come into contact with dying people regularly. The strategy focuses on five themes for development within training:

- Communication skills
- Assessment
- Advance care planning
- Symptom management, comfort
- Family support, bereavement

Local training needs analysis will identify the training and skills development that should be commissioned by Community Education Provider Networks (CEPNs) and provider organisations; to support health and social care organisations to ensure staff have the right competencies, skills, attitudes and demonstrate compassion; Specialist Palliative Care and/or Education Providers should be appropriately commissioned\(^2\) to ensure they have the necessary capacity to deliver education and training and to provide ongoing support to all those health and social care staff who are involved in the delivery of end of life care.

Any education delivery and skills development should be evaluated to demonstrate impact and value for money. This strategy includes some examples of programmes that are available and some new training which is in development. For further advice it is recommended that CEPNs and Care Organisations should liaise with their local education providers and Specialist Palliative Care Teams to explore opportunities to meet the training needs of their workforce.

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\(^1\) For the purposes of this strategy, the term generalist refers to care providers who are not specialist s in Palliative Care, however they may be specialist in other areas e.g. cardiology, dementia, respiratory medicine.

\(^2\) Services may be commissioned locally and/ or regionally by individual provider organisations, CEPNs, CCGs, HESL etc.
Introduction

Palliative and end of life care involves care to all those with any advanced, progressive, incurable illness. The aim of palliative and end of life care is to enable each individual to live as well as possible until they die; ensuring that the patient and family have their needs identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

The stages of the dying process are illustrated below, with care continuing beyond death to include last offices, care of the body, preparing for the funeral and bereavement support. Everyone who comes into contact with dying people and their families, regardless of care setting and/or role, needs to have an appropriate level of knowledge, and skills to provide competent, compassionate, sensitive care during the final phase(s) of a person’s life.

Timeframes in the dying process

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<th>The End of Life</th>
<th>The Dying Phase</th>
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<td><strong>At risk of Dying</strong> in 6-12 months but may live for years</td>
<td><strong>Months</strong> 2-9 months</td>
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<td>Disease(s) Relentless Progression is less reversible. Treatment benefits are waning</td>
<td>Changes Underway Benefits of treatment less evident, harms of treatment less tolerable</td>
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(Department of Health, 2013)

A workforce that is skilled and confident in the provision of palliative and end of life care underpins the development of reliable, responsible and sustainable services for people with 

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3 See Appendix 1: End of Life Care Pathway
life-limiting disease. The development of robust and appropriate education provision for palliative and end of life care is therefore vital to ensure high quality care for these people.

This strategy, in relation to the training of staff involved in palliative and end of life care of adults and children, has been created in recognition of this need. It will focus on the role of specialist palliative care practitioners and other experts in delivering education and training such as end of life facilitators and Macmillan GPs and outline the behaviours, attitudes, competencies and skills of health and social care staff who care for dying people and their relatives. The strategy outlines the training needs of Volunteers, Health & Social Care Assistants, Registered Health Care Professionals and Ancillary Staff who work in any care setting where dying people receive care. It builds on the education and training strategy drafted for SE London as part of the Marie Curie Delivering Choice Programme (SE London Palliative & End of Life Care Network, 2008); for more detail see Appendix 2.

This document aims to set out an education & training strategy which has been developed in partnership with service users, professionals from health and social care settings, commissioners of care, organisations involved in delivering education and those responsible for assuring the standards of education that are provided. The strategy has been endorsed by Health Education South London and the Health Innovation Network⁴ and aims to set out the long term vision for end of life care education and training to inform the prioritisation and planning of training for South London.

As different organisations will wish to implement this strategy according to their own individual priorities and education and training is funded through a number of different routes (e.g. CPPD, HESL support, ad hoc funds for specific projects, charitable grants, professional organisations and individuals); this strategy should help inform the overall plan from which they can identify existing resources or seek additional funding if required/appropriate.

The national context - motivation for change

Health services in South London serve a population of approximately 3 million people and have an incidence of approximately 19,000⁵ deaths per annum. In line with the rest of the country, over half of these people will die in hospital, despite the fact that when people are asked about their preferred place of care the majority of people will state a preference to be cared for at home or in a hospice (Gomes B et al, 2013).

Nationally, the proportion of deaths in the usual place of residence (DIUPR, deaths in own home or a care home) continues to increase and correspondingly the proportion of deaths in hospital is falling. The DIUPR figure for England was 43.7% in 2012, up from 37.9% in 2008 (Public Health England, 2013).

London has the widest variation for deaths at home. Sutton (15.9%) has the lowest percentage of home deaths while the City of Westminster has the second highest percentage (24.9%) in England (Public Health England, 2013).

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⁴ The Health Innovation Network is the Academic Health Science Network for South London.
⁵ National End of Life Care Intelligence Network gives crude death rate at 0.63% of London population (National End of Life Care Intelligence Network, 2013)
An economic evaluation found evidence that implementing Electronic Palliative Care Co-ordination Systems (EPaCCS) affected place of death, with an extra 90 deaths occurring in the usual place of residence per 200,000 population each year above the underlying increase in rates experienced across England (Ipsos MORI Social Research Institute, 2011). People under hospice care are more likely to have had a conversation about their preferences for care in advance and to have their wishes met.

The majority of people die in hospital and it is important that quality end of life care is provided in all settings. Analysis of hospital care and local authority-funded social care services provided in the final 12 months of life for over 72,000 deaths in England found that 89.6% had some hospital care in the final year (Bardsley M, 2012). London has the highest percentage of deaths in hospitals (61%) and the lowest percentage of deaths in care homes (11.8%) (Public Health England, 2013).

The main causes of death can be broadly divided into 4 groups; cancer, organ failure, dementia/frailty and sudden death. Advances in treatment and demographic changes are already beginning to have an impact on the causes and complexity of death/dying, with more people suffering with one or more long term condition and frailty/dementia becoming more predominant. It is predicted that nationally, the death rate is likely to increase by 17% by 2030 (Department of Health, 2008); this is an additional 3,200 deaths per annum in S London. People who receive Specialist Palliative Care are more likely to die at home than those who do not; people over 85 and those with a non-cancer diagnosis are less likely to access Specialist Palliative Care, although this is increasing (National Council for Palliative Care, 2012).

The quality of care for people who are dying in hospital as well as in the community is particularly important; The National Cancer Patient Experience Survey Programme, undertaken by Quality Health on behalf of NHS England, highlights the progress that has been made with treatment of cancer, but also raises concern about a lack of progress on improving the patient experience, particularly for Londoners (Quality Health, 2013). The National Survey of Bereaved Relatives reported that relatives of people rated hospital Doctors and Nurses less well at ensuring that their loved ones were treated with dignity and respect, with hospice staff ranking highest (Office for National Statistics, 2014). Londoners who die in hospital following an emergency admission also have a longer length of stay than the National average. Recent events related to the withdrawal of the Liverpool Care Pathway have anecdotally had a negative impact on care. Specialist Palliative Care teams have responsibility for implementing new guidance about the care of dying people and this includes providing training for generalists much of which is already underway. All commissioned training should be evidence based, coordinated and evaluated, demonstrating impact and cost effectiveness.

Population projections suggest that the numbers and proportions of people from black, Asian and minority ethnic (BAME) groups will continue to increase and they will represent a larger proportion of older people. People from BAME groups are more likely to have unmet needs and/or disparities in palliative and end of life care (Calanzani N, 2013).
The National Health Service has gone through turbulent times over the last 5 years, and hospital scandals have highlighted shocking reports of poor care in services such Mid Staffordshire Hospitals NHS Trust and the Winterbourne Care Home. This has resulted in the public and government demanding more from its health and social care professionals, managers and commissioners, and holding them to account for care which falls below the expected standards of care in the 21st Century. The Francis Report (Francis R, 2013) highlighted the issues that can occur when a hospital places a greater focus upon finance than upon patient care, with too great a degree of tolerance of poor standards and of risk to patients, along with a failure to build up a positive culture, in nursing in particular, but also within the medical profession.

The report recommends that organisations should:

- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do;
- Ensure that the public are protected from those not fit to provide such a service;
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system;
- All health and social care support workers must undergoing fundamentals in care training before being allowed to care for patients;

The nursing profession came in for heavy criticism and was aimed at directors, managers and clinical nurses and highlighted the poor education and training of health care assistants. For some, these recommendations require a major shift in attitudes to care delivery; education and training should give staff an opportunity to explore and embed these skills.

The Nursing and Midwifery Council has updated the Code of Conduct for nurses and midwives to highlight the importance of delivering fundamental care to dying people so that they can expect to receive the high standard of care afforded to any other person needing nursing care. In response to the report More Care, Less Pathway (Department of Health, 2013); the Nursing and Midwifery Council (NMC) has incorporated its fundamental care
standards into its draft revised Code which is currently out for consultation (Nursing & Midwifery Council, 2014).

“Anyone training to be a nurse in the UK is required to demonstrate that they can deliver care safely, competently and with compassion. Following the publication of More Care, Less Pathway in 2013 we published our standards for competence to make the public aware of the fundamental standards of care that a nurse is expected to be able to deliver. In addition, as part of the review of our Code, we have incorporated these standards into the draft to make sure that all nurses registered in the UK, regardless of where they trained, understand what the public expect from them.” Jackie Smith, NMC Chief Executive and Registrar, 2014

The recent Cavendish Report (Cavendish, 2013) provided an independent review into healthcare assistants and support workers in the NHS and social care settings; healthcare assistants (HCAs) make up around a third of the caring workforce in hospitals, and research suggests they now spend more time than nurses at the bedside. It is cited that 60% of patient contact is delivered by non-registered staff. Healthcare assistants have no compulsory or consistent training and a profusion of job titles; this confuses patients, who often assume that everyone is a nurse, and it makes life difficult for some nurses, who are not always sure which tasks they can safely delegate. Some HCAs are now doing jobs that used to be the preserve of nurses, even doctors. The health care system should see healthcare assistants as a critical, strategic resource; yet many HCAs feel undervalued and overlooked.

The NHS has tended to treat HCAs and the registered nurses who supervise them as separate workforces. Health and social care staff should, through development and education, have the opportunity to enter new bridging programmes so that they may acquire the skills and qualifications to progress into professional training such as nursing, or one of the allied health care professions. There is overwhelming evidence that care outcomes improve when all staff feel valued as part of strong, self-reinforcing teams.

Cavendish goes on to say that the social care support workforce dwarfs that of the NHS. By helping people to live independently, frail and vulnerable people can be supported in their own homes and the strain on the NHS is reduced. Staff turnover rates of 19% a year in care homes and up to 30% a year in domiciliary care can negatively impact on the quality and continuity of care. For workers in this sector, “I’m only a carer” is too common a refrain. The phrase “basic care” dramatically understates the role fulfilled by this staff group. Helping an elderly person to eat and swallow safely, bathing someone with dignity and without hurting them, communicating with someone with early onset dementia; doing these things with intelligent kindness, dignity, care and respect requires skill as well as considerable maturity and resilience. Like healthcare assistants, social care support workers are increasingly taking on challenging roles, and having to look after more frail elderly people, yet their training is hugely variable. Some employers are not meeting their basic duty to ensure that staff are competent; the Cavendish report proposes minimum standards of competence before staff can work unsupervised, in the form of the “Certificate of Fundamental Care”.

The report also highlighted the challenge for managers and social care staff of navigating the sea of vocational qualifications and training courses which have developed in response to
changing systems of government funding. Lack of faith in the system has led to costly
duplication, as employers develop their own in-house courses, and retrain new staff
irrespective of what training they have had elsewhere. The report calls for a rigorous quality
assurance mechanism for training courses and vocational qualifications.

“Despite the pressures, charities, hospices and other social care organisations are
pioneering some of the most innovative approaches to person-centred care. The NHS has a
great deal to learn from them about responding to individual needs, and values based
recruitment.” (Francis, 2013).

London is particularly challenged around recruitment and retention of health and social care
professionals. High staff turnover and recruitment problems necessitate ongoing training
opportunities for all staff.

The Chief Nurse uses the “6 Cs” to articulate the elements which apply to all delivering care
regardless of professional background and job title (NHS, 2012). The 6 Cs are used as the
foundation of good quality care and provide the pillars to support good end of life care.

The recommendations of the Francis and Cavendish Reports and the Chief Nurse’s 6 Cs,
translate easily to all areas of care especially end of life care. The NHS core values (NHS,
2013) embed much of the recommendations of these reports cited above; end of life care
education and training should aim to embed these values.

Recent guidance relating to end of life care

Until the last decade, end of life care typically had a low profile within the NHS and was often
been a low priority in terms of service improvement for both commissioners and providers.

In July 2008, the first ever National End of Life Care Strategy was published (Department of
Health, 2008); it aimed to promote high quality care for adults at the end of life. The
development of the end of life care workforce formed one of its chapters.

With regard to development of workforce, the key messages within the End of Life Care
Strategy were:

• For a cultural shift in attitude and behaviour related to end of life care within the health
  and social care workforce. Death is inevitable and does not necessarily constitute a
  failure of care
• For a focus on the resolution of the major deficiencies in the knowledge and skills of staff groups who come into frequent contact with people at the end of their lives, rather than on an expansion in the workforce

• That programmes to enhance training for medical undergraduate/postgraduate and other pre-registration students will take longer to demonstrate benefits for people approaching the end of life, but are of equal importance in the long-term

• Those staff delivering any aspect of end of life care have a personal responsibility to ensure they have the necessary skills and competencies to enable them to deliver high quality end of life care

Since the strategy was published, significant headway has been made, with a gradual increase in the number of people dying in their place of choice and an increased focus on advanced care planning; however recent reports suggest that there is still more to be done (Public Health England, 2013).

One of the tools championed in the strategy “The Gold Standards Framework” has been widely adopted, particularly in primary care and care homes and Electronic Palliative Care Coordination Systems (EPaCCS) such as Coordinate My Care are improving communication across care settings, particularly out of hours (Ipsos MORI Social Research Institute, 2011).

Following reports of concerns voiced by many patients’ families and some professionals, the Minister Norman Lamb set up an independent review of the Liverpool Care Pathway (LCP), another of the tools championed in the strategy. The review panel, chaired by Baroness Neuberger, published a report More Care, Less Pathway in July this 2013 (Department of Health, 2013). It recognized that people had peaceful and dignified deaths where the LCP was used properly, but that there were so many examples where it was not used well that it recommended phasing out the use of the LCP within 6-12 months.

The National Care of the Dying Audit of Hospitals (Royal College of Physicians, 2014) highlighted that the quality and provision of care for people dying in hospitals varies significantly. While every patient has different needs, and some will need more pain relief than others for example, there should be no variation in the quality and provision of services, or training in the care of people dying in hospitals. The audit shows that major improvements need to be made to ensure better care for dying people and better support for their families, carers, friends and those important to them. Hospitals have a responsibility to provide high quality care for people in their final days of life, and support for families, carers and those close to them. A small proportion of acute trusts across South London have access to face-to-face specialist palliative care services, 7 days per week (Murtagh F, 2012), despite a longstanding national recommendation that this be provided; most of the remainder provide face-to-face services on weekdays only or a six day service.

The RCP audit highlighted that nationally, mandatory end of life care training in acute hospitals was only required for doctors in 19% of trusts and for nurses in 28%.

82% of Trusts had provided some form of training in care of the dying in the previous year; 18% had not provided any.
Based on its findings, the report makes 10 key recommendations aimed at driving up the quality of care for dying people across all trusts. The recommendations reflect key themes in the evidence base on care for dying people and those in the Neuberger Review. The recommendations are also in keeping with the work of the Leadership Alliance for the Care of Dying People, a partnership of organisations brought together to produce a system-wide response to address the issues raised by the Neuberger Review (Department of Health, 2014) (See below).

The report specifically recommended that “education and training in care of the dying should be mandatory for all staff caring for dying patients. This should include communication skills training and skills for supporting families and those close to dying patients”.

The National Coalition aimed at changing public attitudes to death, dying and bereavement “Dying Matters” report a reluctance of the public and professionals to talk about dying and plan ahead - despite this, 80% of the public believe all adults should be required to have a will to avoid disputes after they have died and 90% of the public agree that all healthcare professionals should receive compulsory training in how to talk sensitively to people who are dying and their families (Public Health England, 2013).

In June 2014, the report produced by the Leadership Alliance for the Care of Dying People published their response to More Care, Less Pathway; the report, One Chance to Get It Right (Department of Health, 2014) outlines the following priorities of care:

When it is thought that a person may die within the next few days or hours:

1. This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person’s needs and wishes, and these are regularly reviewed and decisions revised accordingly.

2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.

3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

**Strategic Aims & Vision**

This strategy aims to ensure that the health and social care workforce in South London have the skills and confidence to deliver holistic, compassionate care for the dying and their families regardless of where they are cared for. Implementation of the strategy will help ensure incremental improvements and spread of high quality end of life care to all those who need it, regardless of pathophysiology, place of care or other characteristics which may have an impact on access to care.
Specifically, the strategy aims to:

- Promote the development of a well trained workforce, leading to improvements in the overall quality of EoLC, including increases in patient choice, the quality of communication with patients & carers, and increased levels of patient & carer satisfaction, by improved communication between care givers.

- Contribute to the development of a culture within the health & social care workforce in which death will not be regarded as a failure and a good (expected) death is seen as a successful care outcome.

- Ensure a full range of education and training opportunities relating to end of life care are available across South London, to enable the health and social workforce to be confident and competent in delivering care to dying people and their families.

- Ensure training and education is offered to all groups of staff including non-registered staff, volunteers, and those who predominantly deliver social care.

- Provide opportunities for staff to develop their careers with clear opportunities for progression into more technical/skilled and/or senior roles.

- Increase the choices available and improve the experience of care for dying people and their relatives by having a more competent workforce across all care settings.

- Improve staff morale due to increased confidence in knowledge and skills in end of life care reflected in staff survey and reduced attrition.

- Enable those responsible for end of life education and training commissioning to procure appropriate training from suitable education providers in a systematic and strategic manner.

- Ensure that those involved in the delivery of end of life care education and training have the skills, knowledge and capacity to meet the challenges set out above.

- Develop consistent standards for education training delivery across South London and to share learning more widely.

- Develop networks and relationships with and between specialist palliative care providers who provide ongoing guidance & support for health and social care staff delivering end of life care.

- Support the development of competencies and/or recognise existing competencies which have been evaluated and have currency and transferability across health and social care settings, avoiding duplication of training.

Outcomes

In order to support the delivery of this strategy, the following outcomes should be locally measured and demonstrated:

- The number of health and social care staff (by staff group, care setting and Clinical Commissioning Group) who have the appropriate knowledge and skills to provide high quality end of life care when caring for dying people and their families has increased.

- The availability and consistency of palliative and end of life care training has increased for all disciplines.
End of life care training is embedded in training curricula at all levels and for all staff groups

End of life care training is delivered & assessed by staff who are competent in palliative/end of life care

A change in practice demonstrated through patient satisfaction surveys and audits

Staff morale is improved due to increased confidence in knowledge and skills in end of life care reflected in staff surveys and reduced attrition/turnover

Commissioning education provision

On 1 April 2013, there was a major reorganisation of the National Health Service and the changes set out in the Health and Social Care Act (2012) came into force. New clinical commissioning groups (CCGs) took responsibility for allocating resources to secure high quality services, with the freedom to commission services from any service provider which meets NHS standards and costs; these could be NHS providers, social enterprises, voluntary organisations or private sector providers. CCGs are supported by NHS England who allocate resources and commission certain services such as primary care.

The establishment of Health Education England (HEE) and Local Education and Training Boards (LETBs) from 1 April 2013 was intended to ensure that education, training, and workforce development could drive the highest quality public health and patient outcomes, and achieve good value for money. HEE were given the responsibility to provide national leadership and oversight on strategic planning and development of the health and public health workforce and to allocate education and training resources.

It is critical that education commissioning is led by the care needs of the population and is locally managed to meet the needs of employers. Under this new system there is more emphasis on local knowledge and employers have a greater say in developing their workforce. The Local Education and Training Board (Health Education South London, or HESL) is supporting healthcare providers and clinicians across South London to take greater responsibility for planning and commissioning education and training.

The national strategy identifies one of the most pressing tasks as defining the core principles and competencies required by each staff group when they deliver care. As illustrated in the following diagram, agreeing and establishing competencies for care is vital to ensuring that the correct training is available to develop a skilled and knowledgeable workforce; the workforce also need to understand and appreciate their limitations and understand where further support and help can be accessed when caring for dying people and their families.

Commissioners and providers of education and training should encourage Skills for Care and Skills for Health to develop competencies which have currency/ recognition and transferability across health and social care settings and for those individuals who acquire them to have transferability across health and social care settings. Where new programmes
are developed locally, these should be shared with national agencies to avoid duplication and drive improvement elsewhere.

Figure 2

To support health and social care organisations to ensure staff have the right competencies, skills, attitudes and demonstrate compassion; Specialist Palliative Care and/or Education Providers should be appropriately commissioned\(^6\) to ensure they have the necessary capacity to deliver education and training and to provide ongoing support to all those health and social care staff who are involved in the delivery of end of life care.

This will not be a quick fix and will require successive years of investment to educate, train and support existing and new staff. Education and training programmes must be locally or regionally commissioned, developed and delivered to ensure the workforce are confident to deliver competent, compassionate end of life care.

Releasing care professionals from practice across all settings to teach on accredited education is a major resource issue, as their priority if often to deliver clinical care. Specialist palliative care providers, dedicated end of life care staff (e.g. Macmillan GP leads) need to be appropriately commissioned to deliver education, training and support programmes in order to ensure health and social care staff, are confident, competent and have the right attitudes to deliver compassionate care. This will ensure the recommendations outlined in the Francis and Cavendish Reports are implemented in a coherent and cost effective manner.

\(^6\) Services may be commissioned locally and/or regionally by individual provider organisations, CEPNs, CCGs, HESL etc.
All commissioned care providers are expected to invest in education and training to ensure they have a competent workforce in necessary areas of clinical practice; this is funded through a variety of means including their own investment in mandatory training, and investment in direct and indirect Continuous Professional and Personal Development (CPPD) from Health Education South London. In addition, HESL have invested in the commissioning and delivery of education based on local needs through the new Community Education Provider Networks (CEPNs) and Strategic Networks. The membership of CEPNs can include, although is not limited to, GP surgeries, community pharmacies, community dentists, community optometry, community service providers, acute providers, voluntary sector and higher education institutions. Some of the key benefits of CEPNs can include:

- multi-professional education;
- streamlining educational governance and commissioning arrangements;
- real-time primary and community workforce data;
- enhanced clinical and educational outcomes through the use of peer review.

Most importantly, where CEPNs have been established, education and training can be more closely tailored to the needs of local communities and more easily aligned to service priorities.

One of the greatest challenges to developing the local healthcare workforce is the need to ensure appropriate provision for groups that have traditionally received less training once they have qualified. Community nurses, community pharmacists and emergent practitioner groups (such as care navigators and health champions) are among these groups. CEPNs offer an opportunity to support the development of these groups while seeking to expand capacity and capability for more established professional groups.

Workforce planning and education commissioning is not currently integrated between health and social care service planning and strategic commissioning intentions, and as many people at the end of life will also be relatively “high” users of social care, it is important that this is explored. Education investment is not always adequately aligned to service need and future development and educational outcomes are often of variable quality and fail to meet the needs of employers; this strategy seeks to set some standards around quality of education and training delivery.

Health Education South London has outlined a number of priorities for the education they commission (see Appendix 3), and end of life care education and training should be designed with these priorities clearly in view.

The South London Palliative Care Oversight Group will provide HESL with expert advice to support decision-making in regard to allocation of funding for training for specialist palliative and end of life care across all sectors and care settings.

Education & training programmes should only be commissioned where the quality and effectiveness of the programme has already been demonstrated, or in the case of new programmes; an evaluation and dissemination of this is planned. A number of such
programmes exist already and HESL have invested in the delivery of these as well as in the development of some new models of education and training (see Appendix 4). It is desirable that all commissioned training and support programmes be accredited/ kite marked as being effective and fit for purpose.

Specific guidance on commissioning end of life care education is to be found in One Chance to Get It Right (Department of Health, 2014), see appendix 5 & 6 for further details.

**Care Providers**

South London has an extremely diverse range of providers involved in the care of people at the end of life. These range from tertiary centres, district general hospitals, urgent care centres and community hospitals to community and homecare providers, primary care, hospices and care homes. There is also a vast range of voluntary sector providers providing advice, support and advocacy generally or for specific groups. Local Authorities provide a significant amount of domiciliary care directly and indirectly through private and not for profit agencies and increasingly, citizens are choosing to “purchase” their own care directly from organisations and individuals.

Appendix 7 gives an overview of the range of organisations involved in providing care across S London.

**Workforce**

As well as there being a broad range of providers of care/ employers; there is an incredibly wide range of staff roles involved in the delivery of care for dying people. The workforce includes: doctors, nurses, physiotherapists, occupational therapists, dieticians, speech and language therapists, social workers, care managers, chaplaincy teams, pharmacists, psychological support staff, ambulance staff/ paramedics, complementary therapists, health and social care assistants and ancillary staff such as ward clerks, GP receptionists and clinical administrators, commissioned hospital transport staff and care workers.

Of these, the specialist palliative care workforce is relatively small; approx. 5,500 nationally when compared to the total number of health and social care professionals and non-registered staff who deliver end of life care, which is estimated to be 1.3 million across health care (Health Education England, 2014).

Specialist staff working in palliative and end of life care have a clear role in teaching, supporting and modelling good practice, however in order to meet the challenge of training the large number of staff who comprise the ‘non-specialist’ end of life care workforce, education and training should be appropriately purchased through a variety of core and ad hoc education commissioning.

In recent years, a model of ‘high facilitation’ has been used in care homes, nationally and in South London, to support improvements in the skills and confidence of care home staff. When sustained over longer periods of time, this has succeeded in supporting more people
to remain in their care home, with improvements in the quality of care and reduced hospital admissions. The relatively ‘weak’ context of care homes requires such an approach (Hockley J, 2006) and it is reasonable to draw comparisons between the context in care homes and that of other sectors such as domiciliary care and some hospital wards.

The solution proposed within the national end of life care strategy is to segment this workforce into three groups, as illustrated below.

This strategy outlines the suggested minimum levels of skills and knowledge for Groups B and C. In order to achieve the aims of this strategy; the group with the greatest training needs is those who come into contact with dying people regularly, although it is not a core part of their role and often who have received little if any training in this area.

With regard Group A, specialist training and education is provided through universities, hospices and other specialist providers; the Mental Health and Psychological Support Pathway Group of the London Cancer Alliance is currently reviewing the training available regarding “Advanced Communication Skills” which remains a requirement for Cancer Peer Review, and the needs of the Specialist Palliative care workforce will be reviewed as part of this.

Figure 3: End of Life Care Workforce Groupings

Work in specialist palliative care and hospices who essentially spend the whole of their working lives dealing with end of life care

Frequently deal with end of life care as part of their role

Work as specialists or generalists within other services who infrequently have to deal with end of life care
**Group A:**
Staff working in specialist palliative care and hospices who essentially spend the whole of their working lives dealing with end of life care. This includes: Physicians in palliative medicine, palliative care nurse specialists & allied health professionals, hospice pharmacists, senior palliative care pharmacists, chaplaincy teams, social workers & all health & social care staff working in specialist palliative teams or hospices

**Group B:**
Staff who frequently deal with end of life care as part of their role. This includes: Secondary care staff working in A&E, acute medicine, respiratory medicine, and care of the elderly, cardiology, oncology, renal medicine, long term neurological conditions, intensive care, hospital chaplaincy teams & social workers and some surgical specialities. Primary care staff including GPs, district nurses, practice nurses, community matrons, some care home staff, ambulance staff and community based carers

**Group C:**
Staff working as specialists or generalists within other services who infrequently have to deal with end of life care. This includes: Other professionals working in secondary care or in the community, for example, care home staff and extra care housing staff, day centre and social care staff not involved in hospices, as well as domiciliary care and prison services staff

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**Underpinning principles for end of life care education and training**

This education and training strategy seeks to ensure that the principles of good general care are reflected throughout; however it is important to be explicit about the following principles when developing and delivering training:

- An active, holistic and compassionate approach to care that ensures respect for and dignity of the patient and family including their spiritual needs
- Partnership in care between the patient, family, health and social care professionals
- Regular and systematic assessment of patient/ carer/ family needs incorporating patient consent at all times
- Advance care planning/ risk stratification in accordance with patient preferences
- Patient choice about place of care and death
- Anticipation and management of deterioration in the patient’s state of health and well-being
- Recognition of the process of dying
• Understanding of the bereavement process and bereavement care expertise
• Sensitivity to personal, cultural and spiritual beliefs and practices
• Effective coordination of care across all teams and providers of care (in statutory, voluntary and independent sectors) who are involved in the care of patient and family

To ensure providers and commissioners have the appropriate workforce across health and social care; that all staff are confident and competent to deliver holistic, compassionate end of life care for their patients; and to meet the needs of their carers and family, there is a need to identify and address gaps in workforce capacity.

Training needs analysis

When undertaking a training needs analysis, commissioners, CEPNs and providers of end of life care education and training should consider that such education and training is not delivered in isolation - it is core to long term conditions such as stroke, dementia, Motor Neurone Disease, Chronic Obstructive Pulmonary Disease, Heart Failure and Cancer. Training needs analysis should address the five priority areas – communication skills, assessment and care planning, Advance Care Planning, symptom management and family support/bereavement for all levels of staff who frequently deal with end of life care as part of their role.

Each provider of care should consider how they will release staff for training and education and where employed/contracted, how their Specialist Palliative Care staff will be supported to have the capacity to fulfil their responsibilities to implement this strategy. Board member leads for end of life care are responsible and accountable for working with all stakeholders within their organisations to ensure that end of life care is improved, and that staff are adequately trained.

Suggested questions regarding End of Life Care for inclusion in training needs analysis:

• Would you be confident that your workforce could communicate competently with patients and carers to support them with Advance Care Planning?
• Would you be confident that your workforce can assess and plan care to minimise pain and other symptoms for people with life limiting illness?
• Would you be confident that your workforce has the skills to offer high quality bereavement support?

Programme design and delivery

Once training needs have been identified, commissioners and providers should work together to determine the current level of education and training provision in order to inform a gap analysis across the sector/local area:
• Identify gaps in end of life care education provision and begin by addressing priority areas

• Explore existing good practice or design, pilot and evaluate appropriate education packages to meet the needs of all staff across all care sectors, including care homes, acute, primary and voluntary sector service providers

• Promote the development of “core” training packages and implement innovative methods of delivery

• Provide training in communication skills (at a level appropriate to the practitioner) for all staff across all sectors

• Ensure that content of courses encompasses all aspects of the end of life care pathway and staff are equipped and enabled to support their own needs and those of team members when delivery of care is challenging

In many cases this can be delivered through higher education providers, CEPNs or Strategic Networks delivering training commissioned by HESL.

Education programme priority areas

In order to achieve the aims of this strategy; the group with the greatest training needs are those who come into contact with dying people regularly, although it is not a core part of their role, often they will have received little if any training in this area. The focus should therefore be on Group B (page 18) initially, and then on Group C.

To ensure the workforce work using a multi-professional team approach and are confident and competent to deliver compassionate care; education, training and support should broadly be developed and delivered around the following five themes of high quality person-centred end of life care.
1. **Communication Skills:** Staff need to be confident and competent to discuss ethical concerns and decisions made when the patient lacks capacity. Staff understand the importance of communicating with and supporting family members and friends as well as the dying person. Where appropriate, registered professionals are competent in discussing issues related to DNACPR, artificial hydration and nutrition etc.

2. **Advance Care Planning/Risk Stratification:** Staff are comfortable talking about issues related to prognosis, preferences for care and place of care, the use of advance decisions to refuse treatment/lasting power of attorney. Staff understand the importance of discussing issues with carers in relation to do not attempt resuscitation and refusal of treatment. Staff understand the mechanisms for documenting and sharing these discussions with the wider health and social care team (e.g. use of Coordinate My Care).

3. **Assessment and Care Delivery and Planning:** Staff are able to recognise, assess and understand the changing care needs of the dying person in their individual social and cultural context. They are confident and competent in assessment of need and

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7 Adapted from "Developing end of life care practice: A guide to workforce development to support social care and health workers to apply the common core principles and competences for end of life care" (Skills for Care, 2012)
prioritising care. Staff have an understanding of the services and professionals available and are able to participate in multi-professional discussions. Staff understand the need to gain consent for all aspects of care and assess mental capacity and take this into account as part of their assessment. Staff are able to provide information and support for family members following death and through bereavement.

4. **Symptom Management: Comfort & Wellbeing**: Staff are competent in assessing symptoms and providing advice and treatment for relief of symptoms including the use of syringe pumps and other equipment (where appropriate). Staff are aware of specialist services who can support them and the patient with advice around controlling symptoms and more complex interventions for social, psychological, spiritual and cultural needs.

5. **Support for Families including Bereavement Care**: Staff understand the importance of supporting families, friends and informal caregivers of the person who is dying and are skilled at managing care in the immediate after death period and throughout bereavement.

For each area of training, competencies should be developed based around four groupings of staff to ensure delivery of education, training and support at the appropriate level according to the necessary skill set of each workforce group.

1. Volunteers
2. Health and Social Care Assistants/ Non Registered Workforce
3. Registered/Professional Health/ Social Care Workforce
4. Medical Staff

Where possible multi-professional education and training should be provided as this is how care is delivered, and it gives staff an opportunity to gain a better understanding and appreciation of each other’s roles and responsibilities, plus a recognition of each person’s unique contribution in the patient pathway.

As highlighted in the Cavendish report (Cavendish C, 2013), there should be a greater consideration of the robustness of the assessment of learning and competence for all levels of staff and where individuals fail to meet these standards, they should be supported to develop or removed from practice.

A number of new developments and existing programmes are underway to address the end of life care training needs of the workforce. A selection of these are listed on page 23-30.

**Education providers**

A wide range of providers deliver end of life care education in south London, including Universities, Colleges, NHS Palliative Care Teams and Hospice providers. Historically, Hospices have been somewhat under-utilised as education providers with little strategic planning around capacity for commissioning of education.
All acute hospitals, community providers and Hospices are engaged in pre-registration education to a certain degree and most are involved in providing practice placements for post graduate medical training; however the capacity of the sector to provide specific palliative care programmes has not been assessed as a whole. Recent inclusion of Hospices into the allocation of CPPD funding is a positive step, and data relating to the use of this will help to inform HESL about workforce, skills and capacity in the future. Greenwich and Bexley Community Hospice is currently participating in the project to agree the quality of practice placement standards across south London.

In the past, care homes and private hospitals have had to privately commission small packages of bespoke education, and other education has been provided free with the aim of supporting more people to remain in their place of choice and prevent attendance at Emergency Departments and/or Hospital admission. The needs of this sector should continue to be assessed as part of the big picture. Some care homes are now positioning themselves to become “teaching care homes” and centres of excellence; the benefits of this approach should also be evaluated.

Examples of existing programmes and new developments

There are a number of well-established end of life care training programmes available in south London, as well as some recent developments. Those featured below are examples of the range of courses available, and the list is not exhaustive.

Generic courses

Gold Standards Framework for Care Homes

The GSFCH© training programme is a widely used and well-evidenced quality improvement programme with an accreditation process for quality assurance. GSF is a nationally recognised marker of excellence endorsed by the Department of Health and Care Quality commission.

The programme aims to improve the quality and experience of care for care home residents and their carers, improve coordination and collaboration for integrated cross boundary care and improve cost effectiveness, decreasing hospitalisation, enabling more people to die where they choose.

GSFCH is provided by St Christopher’s Hospice and care homes undergoing training are supported by all adult Hospices in south London.

QELCA©

The QELCA© programme integrates a work-based learning experience with facilitated classroom reflection and the model is designed to be delivered by specialist clinicians who
have undertaken the QELCA “train the trainers” programme.

The programme, originally designed to be delivered by hospice nurses to senior nurses working in acute hospitals is now being provided by a number of south London Hospices to multi-professional senior staff working in the full range of care settings. The course is provided over five days, using the hospice setting as a learning resource, participants are offered a first-hand experience of observing and being alongside specialists as they deliver expert care to dying people and their families. In addition to the practice experience, learners will participate in classroom discussion and reflection facilitated by experienced palliative care professionals. The programme then continues with six months of facilitated action learning sets so that action plans for self, team and organisation can be supported in practice and learning can be consolidated.

QELCA© (Quality End of Life Care for All) was designed by St Christopher's Hospice and evaluated, in partnership with the NHS National End of Life Care Programme and Help the Hospices and seeks to role model end of life care to participants, equipping and empowering them to deliver better care to patients on their return to practice. There is evidence that the course motivates participants to introduce care for self and their teams into their organisations and to lead change in culture.

Development of Assistant Practitioners in End of Life Care

Working with Skills for Health and Skills for Care, a set of common core requirements for End of Life care linked to occupational standards have been developed to support the new role of “Assistant Practitioner”. This role and the associated training package are being developed to help improve the care of people approaching the end of life. In a project led by South London Hospices, the role will be piloted across south London with support and funding from Health Education South London.

Review and development of nationally accredited vocational qualifications

Traditionally end of life care has been viewed as a specialist area of work; in reality it incorporates all elements of the daily lives of people nearing the end of their lives. A quality experience of social care is now seen as pivotal to those individuals at the end of their lives.

Skills for Care have produced a number of resources to support those working in adult social care to develop their skills and knowledge in this area. The National End of Life Care Programme, in partnership with Skills for Care and Skills for Health have developed guidance on “Developing End of Life Practice, a guide to workforce development to support social care and health workers apply the common principles and competencies for End of Life Care (Skills for Care, 2012). The challenge of training and assessing such a large part of the workforce is large, improved care and experience for people approaching the end of life will only be improved if this part of the workforce’s contribution is valued and their development fully supported.
Working with the South London Hospices Education Collaborative, St Christopher’s Hospice is leading on the development of a Certificate of Fundamental Care for Health and Social Care Support Workers. A model for working with a local Further Education provider is being developed.

Transforming End of Life Care

The course is taught by a variety of members of the specialist palliative care team and the hospital chaplain. The course is being formally evaluated by academic colleagues in order to inform future developments.

This two day course, developed by Guy’s and St Thomas’s NHS Foundation Trust, provides multi-professional education for all staff working in acute and primary care. The course covers specific aspects of end of life care (the last days of life, managing uncertainty, symptom management, prescribing, family and bereavement, culture and spirituality, discharge processes, communication skills and ethics and the law) and aims to improve self-perceived confidence and competence in these areas. Course content is based on National and local policy and guidance and integrates knowledge of organisational and community clinical practice covered by the service.

Developing volunteers to support people with long term conditions or who are at the end of life and their carers

Hospices have a long history of involving volunteers to supplement the paid workforce in a wide variety of roles. In south London, hospices are increasingly utilising trained volunteers to support the paid workforce to deliver care and support. Roles range from advocacy and befriending roles to more practical support and “hands on” care.

A project has been established by the South London Hospice Education Collaborative to further explore the roles that volunteers can fulfil and to develop a standardised, accredited training programme for patient-facing volunteers in order to add value to services for people at the end of life.

Training will be adaptable to ensure that “specialist” training can be incorporated for specific roles. Once developed, this training will be available to other health and social care providers to enable them to take forward their own volunteer projects.

Training for Coordinate My Care

Coordinate My Care (CMC) is a clinical service that coordinates care and aims to facilitate people to achieve their choices and improve their quality of life. The CMC service is introduced to a patient by a clinician who has a clear understanding of the person’s medical, nursing and social history to create a record of their personalised care plan. The person is asked to provide consent to have the details of their care plan entered onto the CMC IT system and subsequently shared with care providers who have a legitimate reason to
access this information.

Throughout the last three years, CMC has acted as an enabler to embed End of Life Care across London and training projects related to its roll out have been many and varied.

For 2014/15 it is planned to further embed CMC in other EoLC education initiatives to build upon those elements that have been successful in previous years, coordinate training providers to meet local need and avoid duplication.

An example of a previously successful approach is Richmond CCG, who commissioned the Difficult Conversations training to GPs across the borough. This was highly respected training which rather than be seen as a standalone module, was seen as a building block for EoLC competency with CMC acting as an enabler to record and share information.

Going forward, training will be broken down into modules supported by uniform training packages, delivered by palliative care experts, so that HESL can confidently commission training that delivers improved outcomes for dying people and their families.

It is proposed that CMC training is divided into three stages:

1. Awareness
2. Using CMC (including how to create/update a record with a patient)
3. Support once you’re using CMC – may be provided 1-1 or in small teams

And that where possible, training for stages 1 & 2 are incorporated into other programmes.

The European Certificate in Essential Palliative Care (ECEPC)

This is an eight week distance learning course delivered by eight Hospices across the UK, Eire and Malta and coordinated centrally by Princess Alice Hospice, Esher.

Since its inception in 2000, the course has been successfully completed by over 2,000 doctors, nurses and allied health professionals seeking greater knowledge of the holistic care of people at the end of their lives.

The course material is delivered in the form of a course handbook and supported by a Virtual Learning Environment. Candidates are assigned a facilitator to support them in the production of a reflective portfolio and undertake a written exam and viva.

Communication skills

Sage and Thyme

The SAGE & THYME ® model was developed by clinical staff at the University Hospital of South Manchester NHS Foundation Trust (UHSM) and a patient in 2006. It was designed to train all grades of staff how to listen and respond to patients/clients or carers who are distressed or concerned. It places published research evidence about effective
communication skills within a memorable structure for clinical practice.

‘SAGE & THYME’ is a mnemonic which guides healthcare professional/ care workers into and out of a conversation with someone who is distressed or concerned. It provides structure to psychological support by encouraging the health worker to hold back with advice and prompting the concerned person to consider their own solutions.

SAGE & THYME is designed for foundation level communication, suitable for any member of staff (e.g. medical secretary, outpatient clerk, nurse, physiotherapist, doctor, social worker, student) and for any specialty. It is suitable to be used with patients and carers, students, colleagues and children – anyone who is distressed or concerned – inside and outside of health and social care.

A number of organisations in South London are accredited to deliver SAGE & THYME training.

Connected – National Advanced Communications Skills

The importance of good communication in cancer care has been highlighted in successive reports, and this course was established by the National Cancer action team to enhance senior healthcare professionals’ abilities to deal with challenging communication situations.

The course, which is facilitated by nationally accredited trainers, includes discussion of the research evidence surrounding communication in cancer care, interactive exercises and role-play in small groups with actors. Participants practise skills and receive positive and constructive feedback in a safe and supportive environment.

The agenda for the course is set by the participants in response to their personally identified learning needs. Participants are expected to take part in all aspects of the course.

A number of organisations in South London have accredited facilitators for Advanced Communications Skills training.

Difficult Conversations©

Difficult Conversations© is a standardised, highly interactive workshop that uses simulation and discussion to draw on the experiences of the participants. It’s a unique appraisable course developed to empower health and social care professionals to facilitate ‘difficult conversations’ with patients/service users around end of life care, cancer and long term conditions. Developed in partnership with RCGP, RCN, British Geriatric Society, Dying Matters and Macmillan Cancer Support, it links with specialist palliative care providers in each locality to signpost to local experts in palliative care.

In addition, there is a train the trainer programme available, where key individuals can be identified from within the community to train and be certified in Difficult Conversations© as an official facilitator. This is targeted at experienced trainers.
Miscellaneous

Schwartz Center Rounds®

Schwartz Center Rounds are a practical tool that health and care providers can use to improve the culture of their organisation and support staff.

The Point of Care Foundation is the sole licensed provider of training and support to organisations wishing to run Schwartz Center Rounds in the UK.

Rounds are in use in a number of organisations across the UK including some Hospices and can be helpful to improve multi-professional communication across THE WHOLE care team.

More information is available on www.pointofcarefoundation.org.uk

Shaping the Strategy

The London Cancer Alliance held an end of life care education stakeholder event in June 2014 where the End of Life Care Education and Training Strategy was shared with stakeholders for comments and feedback. At the event, there was general support for the strategy, with further suggestions to reflect the overarching approach to the care of dying people and their families, embedding holism, compassion and dignity as central to care delivery. Training should stress the importance of cultural sensitivity; a patient and family focus and also include something on assertiveness so the workforce is confident to escalate any problems, concerns or gaps in skills/knowledge.

In addition, participants felt that, where possible, education should be delivered in a multi-professional manner to reduce the tendency for silo working, integrated between health and social care (being aware of the differences in language used) and including support of people who are bereaved as well as “self-care”. Attention to the emotional burden of caring for dying people and how to increase resilience was felt to be very important to include as part of any course or intervention which focuses on end of life care. QELCA© provides an example of how this aspect can be incorporated in training courses.

Training should reflect the pathway approach to care, including recognition of the process of dying. Education and training should be “blended” and include observation, role modelling and reflection.

All Health and Social Care staff regardless of their status and grade should be viewed as an integral part of the “MDT” with a valid and valued contribution to the care of dying people. The strategy should consider how it will impact/support difficult to reach staff i.e. those working in home care where access to education and training may be limited.

As already identified in the general principles, it was felt that education and training programmes should be accredited/kite marked so those involved in the direct care of people, managers and commissioners are confident that the products are fit for purpose and provide value for money. It was suggested that an education and training “passport” should
be developed to enable staff to move from one setting to another and not have to repeat similar modules where they are deemed competent. An approach such as this is currently being explored for Foundation Year Doctors working in south London.

**Mandatory End of Life Care Training**

As part of the discussion, the suggestion of mandatory end of life care training was raised in several groups. As the Care Quality Commission increases its focus on the quality of end of life and palliative care within organisations, this is likely to be something that organisations consider implementing.

**Public Education around Death, Dying and Bereavement**

The importance of educating the public about death and dying was raised as part of the discussions at the stakeholder event. While this is an important issue, this strategy does not seek to address this; the National Coalition Dying Matters provide further guidance on raising public awareness of death and dying. [www.dyingmatters.org.uk](http://www.dyingmatters.org.uk)

**Priority groups**

As resources are limited and the strategy will take time to fully implement, stakeholders were asked at the event in June to vote on who they felt were the priority staff groups to be targeted for training:

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<thead>
<tr>
<th>Priority Group</th>
<th>Votes</th>
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<tbody>
<tr>
<td>GPs</td>
<td>28</td>
</tr>
<tr>
<td>Hospital Doctors - all grades</td>
<td>18</td>
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<tr>
<td>Care Home Staff</td>
<td>18</td>
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<tr>
<td>Hospital Registered Nurses</td>
<td>14</td>
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<tr>
<td>Hospital Health Care Assistants</td>
<td>12</td>
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<tr>
<td>Community Nurses</td>
<td>11</td>
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<tr>
<td>Home Care /Housing Staff</td>
<td>11</td>
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<tr>
<td>Social Workers</td>
<td>10</td>
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<tr>
<td>Other community professionals (health)</td>
<td>8 (not named)</td>
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<tr>
<td>Hospital Ancillary Staff, Porters, A&amp;C, Housekeepers etc.</td>
<td>6</td>
</tr>
<tr>
<td>Practice Staff</td>
<td>1</td>
</tr>
<tr>
<td>Allied Health Professionals including Chaplaincy</td>
<td>1</td>
</tr>
</tbody>
</table>
Implementation

The success of this strategy will be judged on its implementation which should be locally driven by Commissioners, Community Education Provider Networks, Care Providers and Education Providers.

Significant investment has been made by Health Education South London to support the delivery of training for health care staff in end of life care, but without the commitment of employing care organisations who will also use their CPPD resources, support the release of staff and support culture change, education and development will not have the significant impact that is needed.

By carrying out thorough training needs analysis, targeting high priority groups and working with specialist palliative care, end of life care and education providers to develop/commission training to meet learners needs, not only will organisations be able to develop their workforce to be more confident and competent in end of life care; there will also be improved communication between specialist and generalist providers and improvements in the care pathway for people facing the end of their lives.
References


NHS, 2013. The NHS Constitution: NHS.


Skills for Care, 2012. *Developing end of life care practice: A guide to workforce development to support social care and health workers to apply the common core principles and competences for end of life care*: Skills for Care/Skills for Health/National End of Life Care Programme.
Appendix 1: End of Life Care Pathway

(The Department of Health, 2008)
Appendix 2: Findings from Phase 1 of the Marie Curie Delivering Choice Programme in South East London (2008)

The Phase I investigation for the Delivering Choice Programme highlighted various issues and barriers to the education and development for professionals, which were categorized under the following headings:

- Recognition of palliative care patients and the dying phase/Identification of their needs
- Communication Skills/Breaking Bad News
- Patients with LTC needing palliative care
- Palliative Care Knowledge and Skills
- Utilising appropriate specialist resources i.e. Palliative Care Team
- Preferred Priorities of Care (PPC)
- Care Homes
- Attendance and access to Education and Training sessions/events
- Support/Advice/Information for families and carers
- Continuing Health Care Funding

Further detail on each of these issues is available from the full report.

It also outlined the findings and topics for further training for two professional groups that are critical in delivering care in the community (GPs and DN’s).

General Practitioners (GPs)

106 GPs responded to questions related to their training needs in palliative care including specific topics that they would like refreshing or further training on. Answering the question if they would like further training in palliative care, 84% of the respondents answered that they would benefit from further training in palliative care. The topics that were highlighted for further training include:

- Breaking bad news
- Addressing end of life issues with patients and family
- Dealing with psychological issues
- Addressing social needs
- Spiritual care
- Cultural aspects in palliative care and issues related to ethnic groups
- Dealing with palliative care emergencies
- Symptom management: Pain management; dealing with patients symptoms other than pain: nausea; itching
• Medicines management: - new approaches and update on current drug management; Update on syringe drivers
• Review of current clinical care and modern advances; Keeping abreast of developments
• Advanced directives
• Advice on Benefits
• Update on communication
• How to help young children in bereavement situation

District nurses (DNs)

41 DNs responded to the questionnaire. The respondents scored themselves of their ability in managing a list of physical symptoms [score: zero (not effective) to ten (very effective)]. The respondents scored around average for managing physical symptoms such as fatigue;

![Graph showing average responses for physical symptoms]

sleep changes; and breathlessness.

Further questions in understanding their training needs in addressing psychological, social and spiritual issues showed that approximately half of them would have benefited from further training on dealing with psychological, social and spiritual issues.

| Effectiveness in addressing patient and family concerns regarding psychological issues | 29% felt they were average in this area | 44% felt they would benefit from training in this area |
| Effectiveness in addressing patient and family concerns | 29% felt they were average in this area | 54% felt they would benefit from training in this area |
regarding social/relationship conflict issues

Effectiveness in addressing patient and family concerns regarding spiritual issues

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37%</td>
<td>Felt they were average in this area</td>
</tr>
<tr>
<td>56%</td>
<td>Felt they would benefit from training in this area</td>
</tr>
</tbody>
</table>

63% of the respondents answered that they will benefit from training on cultural aspects in palliative care and issues related to ethnic groups.

The following were highlighted as areas where additional training would be beneficial:

- Symptom control and updates on managing nausea, fatigue, vomiting, breathlessness, pain, constipation; spinal cord compression, titration of analgesia; agitation; bladder retention; Sleep disturbance; Dry mouth/appetite; problems with profuse bleeding; anxiety/agitation
- Blood result interpretation
- Update on new medications and drug available
- Psychological support
- Counselling; Dealing with family carers not accepting diagnosis; how to deal with relatives; answering difficult questions; how to advice patients;
- Managing: All types of cancer including symptom control after Chemotherapy; heart disease; end stage heart failure; Lymphodoema; MND, HIV, CCF; COPD; Parkinson’s, MS, Renal failure
- Respiratory training

Care Homes

A survey was also undertaken with care home managers about palliative care training within care homes. 31 care home managers responded to the survey. 97% of the respondents felt that their staff would benefit from further training in palliative care.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have any staff in the care home received training in palliative care and end of life care?</td>
<td>18 (58%)</td>
<td>13 (42%)</td>
</tr>
<tr>
<td>Do you feel that staff would benefit from more training in palliative care?</td>
<td>30 (97%)</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

The following were highlighted as areas where additional training would be beneficial:

- Symptom control, keeping a person comfortable & pain free; recognising changes in patient;
- Use of syringe driver for pain control

<table>
<thead>
<tr>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 (97%)</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>
• Physical disabilities i.e. M.S, muscular dystrophy, stroke and diabetes
• End of life for frail elderly people and mental health.
• Cancer, Parkinson, Dementia, CCF and COPD, renal failure; Alzheimer’s disease and Dementia; liver disease
• How to deal with depression, Parkinson's disease and confusion
• Basic physiology for metastatic disease
• Communicate bad news and communication with relatives; listening skills, working with families; counselling and bereavement
• How to approach relatives and patients regarding the advanced directive
• Ethics surrounding "not for resuscitation" instructions
• How staff could implement GSF and how to explain GSF to family
### Appendix 3: Health Education South London Priorities

<table>
<thead>
<tr>
<th>To achieve a workforce that:</th>
<th>Our focus will be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Works effectively as a key enabler of system change, engaging with local communities and providers of services</td>
<td>• Maintaining and enhancing multi-professional leadership</td>
</tr>
<tr>
<td>• Has the ability to manage change and ensure the quality of training is maintained</td>
<td>• Developing productive relationships between staff, students and patients</td>
</tr>
<tr>
<td>• Retains and supports its good people during major change programmes, using their skills to empower patients to inform that change</td>
<td>• Developing workforce planning systems to reflect the demand on all providers of care</td>
</tr>
<tr>
<td>• Shows continuous improvement based on contribution to and the application of the most up-to-date clinical evidence, and feels empowered to innovate at all levels and professions</td>
<td>• Enhancing the quality of supervision and learning for all our learners, and supporting the development of all staff providing NHS funded services in South London</td>
</tr>
<tr>
<td>• Enables social mobility, increasing participation from those who might not otherwise consider further education, and is representative of the community it serves</td>
<td>• Ensuring workforce development programmes enable staff to work effectively within different settings and across organisational boundaries</td>
</tr>
<tr>
<td>• Demonstrates the highest potential to develop and deploy the skills, attributes and behaviours patients need</td>
<td>• Ensuring effective collaboration with our Academic Health Science Network to design and spread innovation</td>
</tr>
<tr>
<td>• Represents value for money by translating investment in education and training into productive careers representative of the direction of health and social care</td>
<td>• Attracting and developing a diverse workforce that reflects the diversity of our population</td>
</tr>
<tr>
<td>• Always has the patient’s interest at heart by acting in line with the NHS Constitution’s values</td>
<td>• Promoting best practice in recruitment to programmes across our network of members</td>
</tr>
<tr>
<td>• Works in an integrated and supportive environment that values individual and collective contributions</td>
<td>• Targeting the use of CPPD funding to support the workforce’s career planning and development and Lifelong Learning</td>
</tr>
<tr>
<td>• Has the skills, attributes, values and behaviours to promote wellbeing and to provide high quality care needed by patients</td>
<td>• Embedding the NHS’s values in staff from the point of recruitment and throughout their working lives</td>
</tr>
<tr>
<td>• Is trained and educated to reflect the way it increasingly operates: in multi-</td>
<td>• Developing clinical and educational trainers and supervisors to ensure high quality learning environments for all staff and learners</td>
</tr>
<tr>
<td>• Maintaining and enhancing multi-professional leadership</td>
<td>• Supporting HEIs and employers to embed the NHS Constitution’s values across their organisation</td>
</tr>
<tr>
<td>• Developing productive relationships between staff, students and patients</td>
<td>• Developing community based education</td>
</tr>
<tr>
<td>• Developing workforce planning systems to reflect the demand on all providers of care</td>
<td></td>
</tr>
</tbody>
</table>
disciplinary, inter-professional teams and in community-based roles encompassing prevention of ill-health, and promotion of re-ablement, recovery and rehabilitation

- Is trained and educated through quality-assured outcomes-based learning methods that fit with the way our students, trainees and staff learn best
- Has clear and visible, values-driven leadership at all levels and in all professions
- Recognises the importance of, and is equipped to enable, patient education and empowerment

<table>
<thead>
<tr>
<th>provider networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fostering placements that provide opportunities for all learners in community and hospital learning environments</td>
</tr>
<tr>
<td>Integrating quality assurance processes across all areas</td>
</tr>
<tr>
<td>Prioritising leadership development across all domains</td>
</tr>
<tr>
<td>Creating environments in which opportunities for inter-professional learning are maximized</td>
</tr>
<tr>
<td>Embedding principles of patient empowerment in all programmes of learning</td>
</tr>
</tbody>
</table>
## Appendix 4: EoLC Training Commissioned by Health Education South London

<table>
<thead>
<tr>
<th>Provider</th>
<th>Staff Group</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenwich &amp; Bexley Community Hospice <a href="http://www.communityhospice.org.uk">www.communityhospice.org.uk</a></td>
<td>Registered Nurses – Band 6+ Older age settings (hospital, community, care homes)</td>
<td>Improving EoLC for Older People</td>
</tr>
<tr>
<td>Southwark CEPN</td>
<td>All groups of health and social care professionals, including healthcare assistants and care home staff,</td>
<td>To develop a CEPN around multi-professional community workforce development in palliative and end-of-life care.</td>
</tr>
<tr>
<td>King’s Health Partners</td>
<td>multi-disciplinary sessions</td>
<td>Transforming End of Life Care</td>
</tr>
<tr>
<td>Princess Alice Hospice</td>
<td>to pre qualified H&amp;S care professionals</td>
<td>Sage &amp; Thyme</td>
</tr>
<tr>
<td>St Christopher’s Hospice <a href="http://www.stchristophers.org.uk">www.stchristophers.org.uk</a></td>
<td>Healthcare Assistants and Social Care Support Workers</td>
<td>Development of QCF level 3 diploma in LTC and EoLC</td>
</tr>
<tr>
<td>S London Hospices Collaborative</td>
<td>Volunteers</td>
<td>Developing a training package for patient facing volunteers working in end of life care and dementia</td>
</tr>
<tr>
<td>S London Hospices Collaborative</td>
<td>Assistant Practitioners (band 4)</td>
<td>Development and implementation of assistant practitioner role</td>
</tr>
<tr>
<td>S London Hospices Collaborative</td>
<td>Band 6 and above Multi Professional</td>
<td>Quality End of Life Care for All (QELCA)</td>
</tr>
<tr>
<td>St Raphael’s Hospice</td>
<td>Home care and care home staff</td>
<td>Quality Improvement in End of Life Care: Bringing the 6 Cs to the End of Life Care of people in Nursing Homes, Residential Homes and their own homes</td>
</tr>
<tr>
<td>Lewisham &amp; Greenwich NHS Trust</td>
<td>Multi-disciplinary hospital staff</td>
<td>Improvement in end of life care provision in the acute setting</td>
</tr>
</tbody>
</table>
Other Commissioned Education

<table>
<thead>
<tr>
<th>Provider</th>
<th>Staff Group</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greenwich &amp; Bexley Community Hospice</td>
<td>Care Home Staff</td>
<td>Gold standards framework (care homes) High Facilitation and intensive support</td>
</tr>
<tr>
<td>St Christopher’s Hospice</td>
<td>Care Home Staff</td>
<td>Gold standards framework (care homes) High Facilitation and intensive support</td>
</tr>
</tbody>
</table>

Appendix 5: Recommendations for Education, Training and Professional Development

(Taken from One chance to get it right pages 31-33)

1. The issues raised by the review panel’s report require substantial action on education, training and professional development. It is clear from the report that some staff caring for dying people do not have the skills and knowledge required to deliver care to high standards; and in some cases, they are not putting into practice the values that underpin such care.

2. Particular members of the Alliance have specific responsibilities for ensuring that initial training for particular groups of staff equips them to carry out their roles effectively. This document describes action Alliance members have taken and will take to ensure this happens. Individual providers of health and care are responsible for ensuring their staff have the experience and competence they need to do their jobs well. This includes making time and other resources available for staff to undergo professional development. Staff themselves have responsibilities to ensure that they have the necessary skills to do their jobs and to keep those skills up-to-date. This document also describes action Alliance members have taken and will take to support service providers and individual health and care staff to deliver their responsibilities in relation to education and training on caring for dying people.

Training for Doctors

1. Many of the competencies that are needed to deliver effective care for people in the last few days and hours of life are generic: i.e. they are also relevant to caring for other people. The Shape of Training Review, which reported to the GMC on 29 October 2013, stressed that future postgraduate curricula would need to encompass the generic

8 including post-graduate training required for qualification.
professional capabilities that all doctors should possess (or be able to develop) to ensure the delivery of good quality care across all specialties. The GMC is working with the Academy of Medical Royal Colleges to identify what these are. They will include some fundamental areas of practice such as the need to communicate effectively, empathise, lead, follow and be diligent and conscientious as well as those more related to end of life care, such as partnership and teamwork.

2. Further support for doctors’ ongoing professional development is available through a document being produced by the Specialty Advisory Committee for Palliative Medicine of the Royal College of Physicians, the Joint Royal Colleges Postgraduate Training Board and the Association for Palliative Medicine of Great Britain and Ireland. This outlines how physicians training in a range of medical specialties can gain the required competences in palliative care. (Panel recommendation 10 refers to training for doctors.)

Ongoing education and training for all health and care staff

3. Alliance members are clear that all staff who have contact with dying people must have the skills to do this effectively and compassionately. This includes clinical and support staff (e.g. porters, reception staff and ward clerks.) Those organisations that deliver such care have the prime responsibility for ensuring that the people they employ are competent to carry out their roles effectively, including facilitating and funding ongoing professional development, where this is appropriate. The Alliance’s Implementation Guidance for Service Providers and Commissioners includes advice to help those organisations ensure they are carrying out their responsibilities to ensure staff have the necessary training and skills in this area. This advice includes desired characteristics of programmes of education and training for staff that care for people in the last days and hours of life. The desired characteristics include taking an educational approach which employs evaluation methods that can demonstrate achievement of outcomes and, ideally, extend beyond the immediate end of the training course or event. The Alliance is creating a mechanism for sharing practice, and enabling evidence of its effectiveness, to be shared. The Alliance intends that those who fund, commission or provide training for health and care staff should use the ‘desired characteristics’ it has developed and its mechanism for sharing good practice, to help them develop specifications for specific training, education, professional development and learning packages that include care in the last few days and hours of life.

On content, the Alliance’s advice includes that such education and training cover:

- Specific attention to the topics of nutrition and hydration: assessment, discussion and shared decision-making with the person (where possible), and those important to them and other health and care team members.

- Symptom management: assessment, communication and shared decision-making wherever possible about use of medication (including route of delivery), physical measures (including repositioning) and safe and accurate prescribing.

- Communication skills, including empathy and recognising emotional response to stress and distress, discussing uncertainty, conversations about limits of treatment including ‘Do
4. Alliance members consider there is scope for those arranging training for health and care staff who care for dying people and their families to make greater use of Health Education England’s e-Learning for Health e-learning programme on end of life care (e-ELCA). e-ELCA\(^9\) is a library of over 150 highly interactive sessions of e-learning on end of life care, which aims to provide a resource for enhancing the training and education of health and care staff involved in delivering end of life care to people. The sessions are arranged in four core modules (advance care planning; assessment; communications skills; and symptom management, comfort and wellbeing), with three additional modules (social care, bereavement and spirituality) and one 'integrating learning' module which helps to consolidate and apply understanding in different situations.

5. Despite its high regard, soundings taken by the Alliance suggest that the use of e-ELCA to support education and training remains patchy in some parts of England. The Alliance notes that the breadth of e-ELCA can make it difficult for busy practitioners to make choices and that its potential to be used as part of a blended approach to learning is not fully realised. Hence, it will seek to provide guidance on factors that maximise the effectiveness of e-ELCA. GMC will consider the possibility of including information about e-ELCA in its wider work to enable doctors to identify and access learning opportunities on end of life care; and its work to promote its guidance on *Treatment and care towards the end of life: good practice in decision-making*, 2010\(^{10}\).

6. Individual Alliance members are keen to run joint education and training days throughout England to support care in the last few hours and days of life. For example, the RCGP, Marie Curie, Macmillan and the GMC are exploring the possibility of a collaboration to deliver one-day educational workshops on excellent personalised care and symptom control in 2014. The RCP is also considering plans to produce a toolkit on care for people in the last few days and hours of life to identify current problems and suggest ways of improving quality.

7. Training for the assessment and meeting of spiritual needs of dying people, their relatives and carers in any setting can be accessed from chaplaincy departments. Training can support the use of a variety of approaches, including FICA (the acronym FICA refers to: F - Faith and Belief, I - Importance, C - Community and A - Address in Care). Further details of this are at Annex I.

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\(^9\) Further information on end of Life care for all (e-eLca) is available at: www.e-lfh.org.uk/projects/end-of-life-care

\(^{10}\) Available at: www.gmc-uk.org/end_of_life.pdf_32486688.pdf
Assessment and evaluation of training, education and learning to support health and care staff caring for dying people.

8. The Alliance has produced Implementation Guidance for Service Providers and Commissioners. This states that education and training programmes for care in the last hours of life should take an educational approach which includes how to apply learning to practice and evaluation methods that can demonstrate achievement of outcomes and will, ideally, extend beyond the immediate end of the training course or event. (Panel recommendation 22 refers.)

9. Health Education England will work with stakeholders to influence training curricula as appropriate, although the content and standard of clinical training is ultimately the responsibility of the professional bodies. Education and training of the existing workforce is primarily an employer responsibility. (Panel recommendation 35 refers.)
Appendix 6: Recommendations on desired characteristics of education and training programmes for care in the last days of life

For use by those who commission, fund or procure such programmes for health and care staff involved in care of the dying person. One chance to get it right, pages 103 – 104, DH 2014

As a minimum, such education and training programmes should include:

Learning Objectives

These are high level objectives as they need to be adapted to suit the programme, its duration and format, and its intended learners. Depending upon role they should focus from awareness to application to complex assessment and decision-making. They should include:

By the end of the training programme, learners are able to:

- Describe how to assess and act upon the needs of a dying person: physical, psychological, emotional, social, spiritual, cultural & religious.
- Explain how to address the dying person’s comfort, specifically in relation to food, fluids and symptoms.
- Discuss how to approach and implement individualised care planning including shared decision-making.
- Demonstrate how to communicate about dying with the person, and those who are important to them.
- Describe how to assess and act upon the needs of the dying person’s family and those important to the person.
- Describe the importance of and act upon maintaining own and team resilience through reflective practice and clinical supervision.
- Demonstrate understanding of how Mental Capacity Act should be applied when the dying person lacks capacity.
- Demonstrate understanding of the impact of loss and grief, including how to support individuals who are bereaved.

Additionally, for clinicians:

- Describe how to recognise that dying may be imminent, assess reversibility, make appropriate decisions and plans for review, and communicate uncertainty

Content

- Assessing the person whose condition has changed, including how to gather information from that person and those important to them, and other health and care team members, make professional judgements about the potential reversibility of the condition (and if so, whether or not reversing the condition is the right thing to do) and take appropriate action, including seeking senior advice or second opinion if necessary.
Assessing and discussing the physical, psychological, emotional and social needs of the dying person.

- Assessing and discussing the spiritual and/or religious needs of dying patients, and those important to them.
- Specific attention to the topics of nutrition and hydration: assessment, discussion and shared decision-making with the person (where possible), and those important to them and other health and care team members.
- Symptom management: assessment, communication and shared decision-making wherever possible about use of medication (including route of delivery), physical measures (including repositioning) and safe and accurate prescribing.
- Assessing and addressing the needs of those important to the dying person, including in bereavement.
- Communication skills, including empathy and recognising emotional response to stress and distress, discussing uncertainty, conversations about limits of treatment including ‘Do not attempt cardiopulmonary resuscitation’ (DNACPR), withholding and withdrawing treatment, preferred place of care and death, etc.
- Clarity in verbal and written handovers between professionals, and across shifts/duty periods and settings (e.g. community and hospital care) to ensure consistent care and communication with the person and those important to them.
- An appreciation that caring for people in the last days of life is not just about ‘doing’ or ‘fixing’ things. It is concerned with supporting the person and those that are important to them during the dying period.

Educational approaches

- Employer commitment to ensure the delivery of appropriate end of life education programmes to health and care workers.
- Employee commitment to attend and implement learning from end of life education programmes.
- Explicit learning outcomes which include how to apply learning to practice, and supports implementation of advice from the Leadership Alliance for the Care of Dying People.
- Teaching methods which include some element of experiential learning, and encourages reflective practice as part of continuing professional development, and life-long learning.
- Evaluation methods which can demonstrate achievement of outcomes and ideally extend beyond the immediate end of the course/training event.
Key Facts:

• **12** Health and Wellbeing Boards
• **12** Clinical Commissioning Groups
• **12** Local authorities
• **12** Healthwatch organisations
• **7** Higher Education Institutes and Universities including two medical schools
• **31** education and training placement providers
• Estimated **60,000** plus NHS workforce
• **504** surgeries across South London
• **9** Acute Trusts
• **2** Mental Health Trusts
• **9** Community Healthcare providers
• **7** Hospices
• **Hundreds** of other voluntary and community sector organisations
Appendix 8: South London End of Life Care Education and Training Strategy; Stakeholder Feedback from the 18th June 2014 London Cancer Alliance Event

Comments on the Strategy and the 3 priorities from each of the 4 groups:

- There should be an education and training passport in relation to the 4 cornerstones
- Education should be delivered in a multi professional manner to prevent, minimise silo working, should be integrated and reflect the pathway approach to care
- All Health and Social Care staff regardless of their status and grade should be viewed as an integral part of the “MDT” with a valid and valued contribution to the patient/persons care.
- Patient Centred Care must include the family & Carers
- The 4 Cornerstones language needs to change to reflect overarching themes – holism, compassion, dignity
- Cornerstones need to include recognition of process of dying, care of the dying patient and include bereavement or another cornerstone
- The strategy must consider how it will impact/support difficult to reach staff i.e. those in social care setting where access to education and training
- All staff must be mandated to have end of life care skills or mandate certain groups
- Staff should include how it will support staff in relation to the emotional burden of caring
- Education and training for the public around the 4 cornerstones, dying matters approach
- Education and training should be blended but not e-learning
- There should be a passport of education and training undertaken so allows transfer of prior learning across care settings
- Education and training programmes, courses should be accredited/kite marked so those involved in the direct care of people, managers and commissioners are confident the products are fit for purpose and value for money
- Communication should be culturally sensitive; family focused and also include something on assertiveness so the workforce is confident to escalate to a more senior person of the “MDT” for advice and support i.e. SCA has the confidence to ring a GP for advice
- Raised that some staff have limited communication skills (including ancillary staff and support workers) the recruitment process should include an assessment of communication, which should be at a certain level in terms of verbal and written skills.
- Language differences between health and social care- care planning means differing things to different people! E.g. Advance Care Planning