REPORT FOR HEALTH SCRUTINY PANEL

6 October 2010

1. What level of involvement does the Department of Social Care, or Commissioned providers have in the provision of End of Life Care?

At a strategic level, there is an End of Life Care Strategy Delivery Group, which exists on Teesside. This is one of 8 theme groups across Teesside. When these groups were established, reflecting the themes in "Our Vision, Our Future, Our NHS" (The North East Strategic document), social care departments were offered only one place on each. The representative on the EOLC group is from Stockton Borough Council. The original intention was that the Local Authority representatives would liaise with counterparts in the other Local Authorities but this does not happen in practice, as there is no forum for the sharing of information.

Prior to the establishment of the Strategy Delivery Group there was a South Tees group, chaired by a representative from Middlesbrough PCT, which involved more operational staff but this no longer meets. I think this is a weakness as there is no forum for Middlesbrough Social Care Department to discuss service improvements / developments.

The Department of Health End of Life Care Strategy was launched in July 2008. In short, the strategy set out a vision and broad parameters to promote high quality care for all adults at the end of life. In the North East a Regional Strategy Development Group consisting of training managers, Sector Skills Councils in Health and Social Care, Colleges, Independent Care Homes and Care Alliances took on a commission from Durham PCT in 2009 to take the National Strategy End of Life Care Strategy further and produce an End of Life Care Learning Pathway. The group had already produced learning strategies on medication and infection control. The group broadened the scope of the national strategy to cover those working within a care associated role or working as volunteers, ancillary workers whose main role or function is not providing direct care but frequently come into contact with those nearing the end of their life.

The group carried out a mapping exercise linking competencies from the national strategy with national Occupational Standards and appropriate qualifications. The competencies included: -

- Communication
- Assessment and Care Planning
- Symptom management, maintaining comfort and well-being
- Advanced Care Planning
- Overarching values and knowledge

With regards to service provision the Department does not commission any specialist services. It relies upon non-specialist providers of domiciliary care and residential/nursing care to provide services for a whole range of needs, which includes people with terminal illness.

There is a big challenge with regard to the personalisation agenda. Many people are choosing to use personal assistants as opposed to services commissioned by Social Care. The training needs of personal assistants are the responsibility of the person who employs them but clearly it is in the interests of the Social Care Department that workers have the required skills and abilities to undertake the work associated with End of Life Care.

2. **To what extent are local services integrated, when people are facing end of life? Is there an End of Life Pathway?**

   There is an End of Life Pathway for NHS Tees. People should be identified in General Practice. Gold Standards Framework meetings are held frequently in GP Surgeries, some involving multi disciplinary meetings that can include Community Matrons, District Nurses, GP's, Practice Staff and Macmillan Nurses.

   The Community Matrons and District Nurses in Middlesbrough are co-located in the same buildings as the Social Workers. Where a need is identified for social care involvement then Community Matrons and District Nurses particularly will refer the person quickly for assessment, care planning and provision of any services.

3. **What are the Department's views on the role played by Nursing Homes in people's experience of EOLC?**

   Nursing home staff in Middlesbrough have all received training in the 'last days of life' component of the pathway. Syringe drivers have been purchased for each home and all have been, or will be, trained in the use of such. This will enable more people to be cared for during the last days of life in a setting that is familiar to them as opposed to hospital for example. In residential care homes, the District Nurses provide any nursing input that is required. Clearly, by their very nature, nursing homes are dealing with a lot of people who require end of life care so they have a significant role to play. If nursing home staff are confident to manage EOLC for people than this will impact upon hospital admissions, hopefully reducing them.

4. **The Panel has already heard that too many people die in hospital unnecessarily which is expensive and usually not people's preferred place to die. In the view of the Department, what can the local NHS do about this? What can the Department do about this?**

   There is an issue about capacity within services. Whilst some specialist NHS services, especially for people with cancer, exist i.e. Macmillan Nurses, Marie Curie Nurses, they are limited in the number of services they can provide to any one individual. The District Nursing out of hour's service is also limited, having only one nurse and one health care assistant on duty for the whole of South Tees overnight.

   The Social Care Department does not commission overnight care specifically, but does purchase care from domiciliary care agencies on a 'spot' contract basis. Additionally, the growth of personal budgets gives people an opportunity to employ their own carer(s). Inevitably, there are discussions between Social Care and the NHS on a regular basis about who should fund such services. Whilst a person may be terminally ill they may not have significant health needs in the early stages of the end of life pathway so the responsibility for funding care lies with Social Care. Towards the last few weeks/days then the funding responsibility may lie with the

NHS. This does present difficulties if a person is using a Direct Payment to pay for care, as the NHS cannot legally purchase care through such an arrangement. The Panel may want to consider the Continuing Health Care Guidance in relation to the funding issues around End of Life Care.

With regard to the future there are some difficult times ahead. The Primary Care Trusts have to make significant savings this financial year and it inevitably means staff losses. Working relationships will be affected by changes. Additionally, the NHS White Paper will lead to commissioning being the responsibility of GP Consortia. It is not yet known what role the Local Authority will have in such arrangements. Ideally we would wish to work with Consortia's to develop and improve services for people on the End of Life Care Pathway.

5. Does the Department feel that services for EOLC are sufficiently 24 hours to meet local need?

This links to the previous point. There are a few services that operate 24 hours a day but they are limited. Care Link can provide planned care during the night but for short spells as it is mainly an emergency response service. Domiciliary Care agencies can provide overnight care on request, either on a 'waking' or 'sleep-in' basis.

If the number of people at any one time to be supported at home is significant then I think services might struggle to meet demand.

6. Is the Department satisfied that frontline staff, including those working for commissioned organisations, are sufficiently trained to deal with issues connected to EOLC?

Following the regional launch of the Learning Pathway, the Strategic Health Authority allocated £700,000 for End of Life Care Training to be co-ordinated by the 4 Care Alliances in the North East. In other areas, the Tees Valley Alliance was given £147,000 to run training linked to the detail covered in the EOLC Learning Pathway. A collaborative venture between Tees Valley Alliance, Local Authorities, the Strategic Health Authority and the 5 local FE colleges is currently providing free training for workers in the adult care sector in Tees Valley (Hartlepool, Middlesbrough, Stockton, Redcar & Cleveland, Darlington). The training will address the need to ensure that frontline care staff, including those working for commissioned organisations, are sufficiently trained to deal with the issues connected to EOLC.

To date 10 courses have been delivered across Teesside by the initiative co-ordinated by the Teesside Care Alliance from the SHA funding. A further 10 dates have just been circulated to run between August and October. According to the Alliance data a total 277 people from across Tees Valley have attended so far. Of these, 42 people from 13 Middlesbrough homes attended. In terms of compliance we will monitor the attendance after the second intake (20 courses) and provide a list of establishments not taking up the offer of free training.

Phil Dyson
Head of Service
July 2010