## End of Life Care Home Facilitators

### Version Control Log

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<th>COMMENT</th>
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Marie Roberts, EoLC Trainer, SRFT  
Steve Gene, ADNS, Palliative & EoLC, SRFT  
Victoria McLoughlin, Palliative & EoLC Practice Development Lead, SRFT  
Anne Mitchell, Lead EoLC Facilitator, SRFT | Draft                   |
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<th>Final</th>
<th>Andrea Lightfoot, Service Improvement Manager</th>
<th>Service and Finance approved version to ICJC</th>
</tr>
</thead>
</table>
Table of Contents

1 Executive Summary

2 Strategic Context
   • Purpose
   • The service
   • Health / service needs
   • Problem / Opportunity
   • Current situation

3 Service Description
   • Purpose
   • Objectives
   • Applicable local standards
   • Scope
   • Out of Scope
   • Risks (business and operational)
   • Anticipated outcomes
   • Stakeholders
   • Strategic alignment

4 Non-financial option development
   • Benefits criteria
   • Impact of the local community and environment
   • Options
   • Recommended option
   • Risk assessment

5 Financial option appraisal
   • Quantitative analysis
     o Full costs analysis
     o Incremental cost analysis
   • Qualitative analysis
   • Assumptions

6 Recommended option
   • Recommended option
   • Economic case
   • Value For Money

7 Service Management arrangements
   • Leadership
   • Project Plan
   • Monitoring
   • Reporting
   • Benefit realisation plan
   • Post service evaluation
   • Communication Strategy
8. **Conclusions and recommendations**
   - Conclusions
   - Recommendations
   - Service responsibility
   - Business Case sign-off
**Section 1 Executive Summary**

**Purpose**

“Good end of life care should mean that people are treated with dignity and respect and, where possible, in their preferred place of care. Some people receive high standards of care in their final weeks, days and hours, but others do not. Organisations responsible for the care of people approaching the end of their life need to improve the planning and delivery of services particularly support in the community. There is scope to make these improvements by using both existing and planned additional resources more efficiently and effectively.”

(National Audit Office, 2008).

The provision of end of life care is becoming increasingly complex, with people living longer and the incidence of frailty and multiple conditions in older people rising. Information on peoples’ wishes is often not captured or shared and a lack of services to support them at home may lead to unplanned and unwanted admissions to hospital.

Frontline staff often lack training in delivering basic end of life care. Only a small number of doctors and nurses receive pre-registration training in end of life care and there is a lack of formal training for staff working in care homes. Positive experiences of care are often linked to being treated by staff that understand, appreciate and empathise with the end of life situation.

The End of Life Care Homes team has expanded the Six Steps training and education programme to include a coaching model for frontline staff in the care home setting, supporting nurses and carers delivering end of life care at the point of need. This provides guidance, direct ‘hands-on’ support and advice to care home staff enabling them to anticipate, plan and deliver optimal end of life care for individual residents.

The facilitators work collaboratively with other services e.g. GP’s and District Nurses, to expedite safe and appropriate rapid or fast-track discharges for care home residents nearing the end of life from hospital to care home by attending weekly multi-disciplinary team meetings (MDT) and monitoring attendance or admission of residents to hospital and supporting residents and ward staff with discharge and the care home to receive the returning resident.

Staff facilitate the development of positive, supportive working relationships between care home staff, Salford Care Homes Practice (plus other GP’s), district nurses, Community Macmillan Nurses and other service providers by co-ordinating ‘joined up’ working and ensuring timely and appropriate referrals to other services. They support nursing home staff to manage residents’ symptoms at the end of life, including the safe administration of end of life care medication, in collaboration with GP’s and District Nurses when necessary.

They actively disseminate and embed national guidance, clinical and quality standards in how end of life care is delivered locally, across the region and nationally through education and training in both formal and informal settings.

Regular support visits and the use of the coaching model has enabled residents to achieve their preferred place of death (PPD) and receive high quality care which is delivered by staff who have undertaken appropriate training in all aspects of end of life care. Early identification of deterioration and discussing preferred place of care and death has supported both hospital and community teams to support both expedited and rapid discharge (home to die) and avoid hospital admissions as appropriate.
The Service and Finance Group is asked to review the information outlined in this business case and approve the recommendation (option 3) to commission and recurrently fund this service at a cost of £113,070 for salary costs (subject to any cost of living increases), plus an additional one off payment for equipment and training of £1,508, to continue to develop and provide a local strategy of support to care homes, patients, their families and carers.
Section 2 Strategic Context

Purpose

“Palliative and end of life care requires collaboration and cooperation to create the improvements we all want .... Health and Social care are equal partners in this endeavour. Cross-organisational collaboration is vital to design new ways of working that will enable each community to achieve these ends. These systems must reach out beyond the usual networks of organisations and communities to call upon contributions, ideas and actions from a wider spectrum of people. We need integrated health and social care systems that work with people, as well as for people.”

(Ambitions for Palliative and End of Life Care, 2016).

“I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s).”

(National Voices and the National Council for Palliative Care (NCPC) and NHS England, 2015).

The National Palliative and End of Life Care Partnership recently identified 6 key ‘Ambitions’ for Palliative and End of Life Care (A National framework for Local Action 2015-20):

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and well-being
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

It is acknowledged that population projections show that people are living longer, such that by 2033, 27.5% of the population will be aged over 65, 14.6% over 75 and 5.7% over 85 therefore patients will need more in terms of health and social care.

There are currently 32 elderly care homes in Salford with a combined bed capacity of 1,568. Average life expectancy for care home residents is under one year (Thomas & Paynton, 2013) and national data demonstrates increasing numbers of care home residents are dying in their usual place of residence (UPoR). In Salford, in 2015, the number of deaths in care homes was 368, an increase of 9% compared to 340 deaths in 2014 (ONS, Primary Care Mortality Database, 2016). It is therefore essential that end of life care (EoLC) in care homes is delivered by a competent, confident workforce trained and supported to consistently deliver a high standard of care.

In 2013, Salford CCG commissioned two band 6 care home trainer posts on a fixed term for two years, to support the substantive band 7 lead end of life care facilitator in the delivery of the ‘Six Steps to Success in Care Homes’ programme. The team had a target to achieve an increase in the number of care homes completing the training programme each year to ensure that at least 91% of care homes complete the training programme.

The ‘Six Steps to Success Programme’ is a workshop style training programme developed by the Greater Manchester and Cheshire Cancer Network, the Merseyside and Cheshire Cancer Network and the Cumbria and Lancashire End of Life Care Network with support from the National End of Life Care Programme. It enables care homes to implement the structured organisational change required to deliver the best end of life care. The leadership Alliance for the Care of Dying People (2014) stated that all clinicians involved in the care of the dying patients and their relatives or carers should have a specific standard set and the
need to develop training resources or programmes for continuing professional development was highlighted as well as improving the confidence of care home staff to make end-of-life care decisions based on patient preference and choice and improve the quality of care provided.

The primary aim of the team has been to create a skilled end-of-life care workforce within the care home setting. The Department of Health’s end-of-life care strategy published in 2008 recognised the need to improve the quality of care provided to residents approaching the end of their life. Although many of the care home staff are enthusiastic about improving the care they provide there are still more patients dying in hospital after an emergency admission.

Until July 2013 the End of life care training programme for care homes was led by a band 7 End of Life Care Facilitator who delivered education and support around end of life care issues to all care homes (nursing and residential) across Salford however this has now evolved into a wider team (see The Service below).

The Service

The End of Life Care trainers continue to deliver the ‘Six Steps to Success’ Programme. The role of the team has evolved since October 2015 and all Salford Care Homes have now engaged with the programme. Each home has a nominated facilitator/trainer assigned to the home. The team now comprises of a band 7 Lead End of Life Care Facilitator (substantive) and three band 6 End of Life Care Trainers (fixed term to March, 2017). The team continues to deliver education and support to 32, (2 homes have closed since the programme was first introduced), nursing/residential homes across Salford in relation to end of life care issues. Every home has been given the opportunity to attend formal education sessions; all 32 homes have engaged and are at various points of learning within the programme.

Since November the team has implemented a 1:1 coaching model in that they work alongside the nurses and carers in the care home setting at the point of need as well as continuing the formal education and training sessions. Coaching is gaining momentum in many organisations and is seen to enable the highest form of learning. Literature suggests that coaching can lead to increased staff confidence and motivation, and can change traditional cultures and behaviours and increase the skills and competence of staff (Narayanasamy, 2014).

The service aims to:

- Provide a co-ordinated facility to guide, support and advise care home staff (at the point of need), enabling them to anticipate, plan and deliver optimal, culturally sensitive end if life care for individual residents
- Work collaboratively with other services, e.g. district nurses, GPs and hospital palliative care services to expedite safe and appropriate rapid or fast-track discharges for care home residents nearing the end of life from hospital to care home
- Develop supportive working relationships between care home staff, Salford Care Homes Practice, (plus other GPs), district nurses, community Macmillan nurses, social care, safeguarding and continuing healthcare and other service providers by co-ordinating ‘joined up’ working and ensuring timely and appropriate referrals to and from other services
- Maintain strong integration with the hospital and community specialist palliative care teams to ensure the appropriate use of end of life care documentation, e.g. uDNACPR, individualised end of life care plan, EPaCCS, statement of intent
- Sustain the commitment to six steps formal workshop education programme as well as the support and expectations visits
• Ensure appropriate on-going relevant data collection to inform performance monitoring and improved patient outcomes
• Increase clinical support for care home staff to maintain residents wishes to remain in the home by supporting the implementation of mortality review meetings
• Support nursing home staff to manage residents symptoms at the end of life, including safe administration of end of life care medication, in collaboration with GPs and district nurses when necessary
• Contribute to ensuring that an equitable standard of healthcare is delivered to all Salford residents by supporting care home staff to deliver a high standard of end of life care using the tools and processes available in community, hospital and hospice settings, e.g. Advance Care Planning (EPaCCS), End of Life Care Plan and Royal's Alliance Bereavement Model
• Disseminate and embed national guidance, clinical and quality standards in how end of life care is delivered locally, across the region and nationally

The end of life care homes team, as part of the wider Salford Royal Palliative Care Service received a CQC rating of ‘outstanding’ from its inspection of community and hospital end of life care in January 2015.

Health / service needs

Health needs assessment for existing services

There are four steps involved in this process:

Extent of the issue

The proportion of long term care home residents who died in a care home increased from 61% in 2004 to 71% in 2013 (the place of residence on their death certificate is a care home). Care home deaths in England increased from 16% in 2004 to 22% in 2013.

Two in five people with dementia die in hospital, indicating that the trend towards increasing hospital deaths for people living with dementia has reversed. A pattern of increasing hospital deaths for people with dementia in England began to reverse in 2006. Less than 5% of dementia patients died at home or in a hospice. Care home bed provision has been found to be the key to this trend reversal.

The number of centenarians (people aged 100 or more) deaths has increased by 56% in the last ten years, between 2001 and 2010. Most died in a care home or in a hospital. ‘Old age’ was stated on 75.6% of death certificates. Centenarians have a high risk of death in hospital from pneumonia.

Only 20% of patients diagnosed with organ failure (heart, lung, liver or kidney) or dementia, either requested or were identified for palliative care before dying, compared to 75% of cancer patients.

The National Survey of Bereaved People (VOCES – Views of Informal Carers – Evaluation of Services, 2013) reveals that:

• Only 32% of deceased people expressed a preference of where they would like to die. Of those who did, reported preferences for place of death were:
  – Home 79%
  – Hospice 8%
  – Care home 8%
  – Hospital 3%
  – Other 2%

• Only half of the deceased who wanted to die at home actually died there
• About one third who wanted to die at home, died in hospital
People’s preferences of place of care and place of death change can vary significantly over their final months with fewer people wanting to die at home, reducing from 91% to 75% to 63% in the final year, months and days before death respectively.

(National End of Life Care Intelligence Network; What we know now: 2014)

Frontline staff require ongoing education and training combined with a coaching ‘hands on and face to face’ approach to delivering high quality basic end of life care; there has previously been a significant lack of co-ordinated and ongoing formal training for staff working in care homes.

Current Services
The Care homes End of Life Care team is based at Sandringham House and consists of:
- 1 band 7 end of life care home facilitator (substantive post funded by SRFT)
- 3 band 6 end of life care trainers (fixed term until March 2017)

Gap Analysis
There are key considerations specific to the end of life care education, training and competence of care home staff:
- Frequent staff turnover can lead to recurrent loss of basic end of life care expertise and resources in care homes, significantly impacting on continuity and co-ordination of care for end of life care residents and carers
- Availability of care home staff competent in initiating advance care planning conversations with residents and carers is adversely affected by staff turnover and requires continuous attention and educational leadership.
- Advance care planning (ACP) also involves complex decision making that requires sensitive discussion in end of life care, e.g. Deprivation of Liberty Safeguards; Statement of Intent to avoid inappropriate coronial involvement in expected deaths, creation of Unified Do Not Attempt Resuscitation orders to avoid inappropriate CPR; the outcomes of these interventions requires regular comprehensive review and are part of delivering safe end of life care
- Avoidance of inappropriate hospital attendances/admissions requires clear and up to date advance care plans; the process of ACP requires consistent review and structured analysis of outcomes for residents and carers

Clinical and cost effectiveness
The Care Home facilitators actively in-reach into the hospital by identifying residents who have been admitted and establishing whether an advance care plan (ACP) has been undertaken in the care home previously. Once the team is at full capacity it is hoped that through in-reaching into the hospital and supporting enhanced and rapid discharge (home to die) the team will be able to further increase the number of bed days saved in the future.

Problem / Opportunity
Care home staff has previously been unaware of the supportive services they can access on behalf of residents (and themselves) and have struggled to manage residents end of life care needs effectively. With the support of commissioners, significant work has been undertaken over a period of years to enhance the quality, safety and reliability of end of life care in Salford care homes.

What has become evident over that time is that educational support alone is not enough to guarantee consistently high quality co-ordinated care. The introduction of reliable systems, processes and channels of communication for care home staff and direct education/coaching support has paid dividends in terms of staff confidence and competence. The ongoing interventions of the end of life care home team provides the opportunity for care home staff to continuously improve, measure and own the end of life care they deliver for their residents and carers.
22% of homes require the full support from the district nursing team; these homes have been unable to complete the Six Steps programme and do not feel confident in delivering end of life care.

**Current Situation**

The end of life care home team has specifically played a pivotal role in integrating wider health and social care services with the care homes. They have built robust working relationships with these services consequently care home staff are much more likely to refer to the wider multi-disciplinary team for support when caring for a resident.

The 1:1 coaching model continues to enable the team to improve the care and support delivered to the residents and their families at the point of need thus improving workforce confidence and competence of improved care. The use of end of life care support tools are more likely to be used to support the holistic care provided to residents approaching the end of life when the care home trainers/facilitators are involved in the residents care.

Since the 1:1 coaching model was implemented there has been an increase in the number of referrals to the service from other healthcare professionals allowing the team to follow up and ensure resident’s needs are continuously met regardless of setting with a co-ordinated approach. These referrals have continued to increase and are received for three main reasons:

- Resident support
- Support for families
- Staff coaching – this includes support and guidance with symptom management

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<th>April to June 2016</th>
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<tr>
<td><strong>Reason for referral</strong></td>
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<tr>
<td>Number of referrals</td>
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(There may have been more than one reason for referring to the team i.e. resident support and nurse coaching).

Developments in the SharePoint system (secure electronic data repository) will enable the team to establish a system for monitoring and conducting advance care planning discussions and enable residents to be cared for in their preferred place of care. The team are continuing to address collaborative ways of ensuring systems are in place to support advance care planning in the future.

The Six Steps training programme continues to be requested by care homes and promoted by other health care professionals to improve practice. Commitment from the care homes has increased and they are accessing a variety of end of life and bereavement care training and education sessions. The team has sought ways to reach all staff, providing bespoke in house training both during the day and evening as well as the formal sessions which have been well received by the nurses and carers.

Historically, nearly all nursing homes were as dependent as the residential homes on the district nursing service for providing all care and symptom management to residents approaching the end of life. Currently, 78% of nursing homes are either completely independent of the district nursing service or are working towards independence and require minimal support with the administration of medication, i.e. syringe pumps for pain and symptom control.

A Survey Monkey was developed and sent out to care home staff and managers. This survey was set up to not only have user feedback regarding the service, but to illustrate the competency of the current workforce in the team to deliver the training. A snapshot of responses can be found in appendix 1.
Section 3 Service Description

For coaching to be successful the nurses must want to engage and an opportunity to engage must arise…

(Narayanasamy, 2014).

Purpose

The service will strive to deliver a skilled, flexible, responsive service to support care home and nursing home staff to provide measurable high quality end of life care in accordance with national, network and local standards. Support is provided in a caring non-judgemental manner in agreement with care home staff, residents and family members.

The service will ensure the provision of high quality care in the most appropriate setting to reduce hospital attendances/admissions, promote quality of life, and facilitate timely discharges and co-ordinate complex end of life care packages. A key aim will be to actively support the preferences and choices of care home residents (and their carers) for preferred place of care and death.

The service has achieved successful engagement with all the care homes across Salford, (approximately 1,568 residents). With the continuation of the service, integration can occur in voluntary and social care organisations including domiciliary care (as identified in the Route to Success guidance, National End of Life care Programme 2011).

The service has evolved from a primary focus on delivering an identified education programme (i.e. Six Steps) to a service encompassing coaching, advocacy and in-reach. Direct referrals for care home residents (and their carers) are received via a single dedicated telephone number and on request of service referral documentation. Referrals originate from professionals across the partner agencies of the Integrated Care Organisation. The End of Life Care facilitators received a total of 34 referrals in quarter 1 (April to June 2016).
**Education and training**

The national End of Life Care Strategy (2008) identifies that in order for care home staff to deliver good end of life care they must receive end of life care training and support. The facilitators deliver several teaching sessions in a variety of settings. Many homes struggle to release staff to attend formal training therefore the facilitators have developed training and education sessions that can be delivered on site. The flexible autonomous working of the team permits training to be delivered at times suitable for the home including late evenings to capture night staff.

The care home facilitators support all homes regardless of their involvement in the Six Steps education programme; this has enabled the team to build relationships with the care homes and it is recognised that through continuous support, the care homes choose to go through with the training.

The types of formal training delivered include:

- The monthly Six Steps workshops (programme takes 10 months to complete)
- McKinley T34 syringe pump training
- Symptom management (joint teaching with the Macmillan nurses)
- Six Steps ‘Champions’ day (full day)
- Six Steps overview session (2 hours)
- Oral health
- District nurse updates on the cluster care homes to strengthen collaborative working

The Six Steps programme has been attended by all of the care homes in Salford; however, due to the high turnover of staff some homes have required increased support from the care home facilitators. As a result the team commenced a tenth cohort of training in January 2016. A further cohort has been provisionally booked for January 2017 in anticipation of the posts receiving substantive funding. This is for care homes previously taught who have requested extra training for new staff to ensure they can sustain the principles of the ‘Six Steps’ within their home.

65% of Salford homes have successfully achieved accreditation first time resulting from attendance at monthly workshops and engagement with the frequent expectation visits by the team. 21% of homes required two attempts or are currently attending the programme on their second attempt. 12.5% required three attempts or are currently attending for their third time. There are 8 homes attending the latest cohort; of these homes, 5 will not complete due to poor attendance at the workshops. This is due to staff being on duty and not able to be released; therefore the need for formal training continues to be required.

In addition to the programme, care home staff are also invited to attend Salford Royal’s ‘in-house’ education and training (attended by health and social care staff from across Salford, promoting integration of working across services). The end of life care facilitators support the teaching within the trust and deliver on the Introduction to End of Life Care study day, bereavement study day, Sage and Thyme communications skills training and Enhanced Communication Skills training for nurses band 6 or above, from the community, hospital and care home settings. They also support the learning disability team to deliver education and training on their bereavement study day.

Following completion of the programme care homes will have between one and three ‘Six Steps Champions’ to ensure sustainability. From the start of the programme in 2012, 78% of homes completed and have been awarded the Six Steps award. 88% of these homes have continued to maintain the Six Steps principles within their home and a portfolio of evidence to support this. The remaining 22% of homes have been offered to either attend cohort 10 or receive coaching support via increased input from the care home team.
Between April and June 2016, 32 care homes engaged in the Six Steps education sessions and 13 attended the Six Steps Champion day.

**Assessment, accreditation and continuous quality improvement**

Care homes are required to complete a yearly portfolio of evidence to ensure that end of life care skills and standards are maintained. This is evaluated by the practice development lead in Palliative and End of Life Care, district nurses, community Macmillan nurses and the end of life care facilitators.

Successful homes are awarded with the Six Steps award, presented at a celebration event, supported and attended by the NHS Funded Care team, safeguarding team, Hospice at Home, Macmillan nurses, hospital development team and members of the integrated care programme.

On completion of the programme each care home has a 12 weekly expectation visit from a facilitator to monitor progress and commitment to continuous improvement. The focus is predominantly on the training and education of the Six Steps programme and the principles of care that are being embedded in the home. The expectation visit documentation was written in partnership with Salford City Council Extra Care and Review Team in Salford. This ensures that post programme, the staff continue to develop the principles of good care and enables them to build on the knowledge and skills attained on the programme and put these skills into practice. The visit gives clear guidance to care homes in order to continuously benchmark high quality care.

**1:1 direct coaching and support**

Appendix 2 demonstrates the increased number of support visits to the care home employees for residents and families in the last year of life and end of life care (January to March 2016).

The following table shows the number of visits by the facilitators to the care homes in quarter 1. These include palliative care register meetings to identify those who may be in the last 12 months of life, facilitation of advance care planning discussions (ACP), supporting and educating the staff when caring for patients at the end of life – improving the quality of care, symptom management and meeting spiritual, religious and cultural beliefs along with support for the family.

<table>
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<tr>
<th>Visits</th>
<th>April 2016</th>
<th>May 2016</th>
<th>June 2016</th>
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<tbody>
<tr>
<td>Total number of visits to the care homes by the trainers</td>
<td>94</td>
<td>85</td>
<td>92</td>
</tr>
<tr>
<td>Average numbers of visits per care home per month</td>
<td>2.93</td>
<td>2.65</td>
<td>2.87</td>
</tr>
<tr>
<td>Number of WTE in the team supporting the visits</td>
<td>3.6</td>
<td>2.6</td>
<td>2.6</td>
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In quarter 4 there were a total of 88 deaths. 75% of those deaths were in the care homes setting and 81% of those were supported by the team. At this point the team had 3.6 WTE.

There were a total of 102 care home deaths in quarter 1, 2016; of these 58.8% of residents died in the care home setting. 32 (53%) of these residents were directly supported by the care home facilitators, with some residents requiring multiple visits for patient and family support or educational coaching for care home staff regarding symptom managements or principles of care. There was a total of 81 support visits for residents who were in the last
days of life. The number of WTE was reduced in these months to 2.6 which demonstrates the impact of losing just one member of staff.

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<tr>
<th>Visits</th>
<th>April 2016</th>
<th>May 2016</th>
<th>June 2016</th>
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<tr>
<td>Total number of visits by the End of Life Care facilitators for patients who are approaching their end of life</td>
<td>19</td>
<td>25</td>
<td>37</td>
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**Advance care planning and advocacy**

Advance care planning (ACP) plays a vital role in identifying where the residents preferred place of care (PPC) and death (PPD) is; it has been identified that the systems and processes for establishing this information has previously been difficult to monitor/measure. The end of life facilitator in partnership with elderly care consultants and the Care Homes practice, GPs and advanced nurse practitioners have developed an electronic ‘SharePoint’ system to document and record ACP, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders and Statement of Intent information ensuring appropriate support is provided to all Salford care home residents across 24 hours.

The end of life care homes facilitators attend regular register meetings in care homes and will continuously collect and record the SharePoint information, simultaneously educating staff on how to identify residents who are deteriorating and potentially entering the end of life phase. This in turn will directly support the ACP process and increase the number of residents achieving their preferred place of death (PPD). See appendix 3.

The care home facilitators support the rapid discharge of residents back to their care home. Aside from the key outcome of supporting achievement of the residents PPD, this does result in bed savings for Salford Royal as a trust. In the period April to June 2016, a total of 158 bed days were saved.

**In-reach to acute care**

The following table details the number of A&E attendances and the number of admissions by care home residents in their last 12 months of life, since the intervention of the care home facilitators:

<table>
<thead>
<tr>
<th>A&amp;E attendances by residents in last 12 months of life</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17 (to Sept)</th>
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<tbody>
<tr>
<td></td>
<td>775</td>
<td>548</td>
<td>173</td>
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### Admissions by residents in last 12 months of life

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17 (to Sept)</th>
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<tbody>
<tr>
<td></td>
<td>628</td>
<td>400</td>
<td>149</td>
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### Outcomes

To ensure the resident receives the right care in the right setting the facilitators refer patients to other services. The right care must be provided in the right place and at the right time by a competent workforce, (NICE, 2015). Safeguarding and NHS Funded Care teams support the end of life care home facilitators and advocate attending the Six Steps training to care homes that have previously had safeguarding concerns related to end of life care. This has in turn, supported 100% engagement of all the homes.

### Objectives

- To continuously improve the quality of end of life care in Salford care homes through education and training, coaching and direct 1:1 support for staff
- To continuously improve the quality of end of life care in Salford care homes through engaging care home staff in measuring the quality of care they provide
- To continuously improve the quality of end of life care in Salford care homes through engaging relatives, families and carers in evaluating care provided
- To improve collaborative integrated working with all partner agencies
- To reduce inappropriate and avoidable hospital admissions and attendances
- Facilitate timely discharges in order to return patients to their usual place of care
- Support greater proportion of residents to die in their usual place of residence through active engagement in advance care planning and in-reach to acute care

### Applicable local standards

The service will ensure the outcomes outlined in the Salford Residential Care Specification are adopted by care homes:

- **Outcome 4**: Service users are discharged from hospital care at the appropriate time
- **Outcome 24**: Service users shall be helped to be as comfortable and pain-free as their condition and circumstances allow
- **Outcome 25**: Service users end of life needs are provided with dignity and in accordance with the wishes of the service user
- **Outcome 37**: The ageing, illness and death of a service user is handled with respect and according to the individuals expressed wishes
- **Outcome 54**: Family and friends are involved in care planning and care giving. They feel valued and welcomed. They are supported to maintain relationships with their loved ones

### Scope

- **Timeframe**: The end of life care home facilitators have been funded since 2013. Funding is due to cease for the band 6 posts on 31st March 2017; recurrent funding is required to make these posts permanent from April 2017
- **Department**: The team are part of Salford Royal NHS Trust’s Palliative Care directorate and are based within the Salford Care Homes practice at Sandringham House.
- **Service**: End of life care home facilitators
- **Function**: To deliver the ‘Six Steps to Success’ education and training programme and provide direct 1:1 practical support to staff through coaching working alongside nurses, care support workers and carers in the care home setting as well as providing other formal education and training. Resident and carer advocacy through advance care
planning care co-ordination and communication across partner agencies is a key role. Supporting continuous quality improvement for end of life care across Salford care homes is an essential underpinning element of the service.

- **Technology and / or equipment**: The service currently runs with good IT systems and keeps detailed records.
- **Workforce implications**: The team comprises of 1 band 7 lead end of life care lead facilitator (substantively funded) and 3 band 6 care home facilitators

**Out of Scope**

The service will only provide a facility to Salford care homes and nursing homes, delivering support to patients registered within Salford.

**Risks (business and operational)**

- Rapid care home staff turnover poses an ongoing challenge; continuity of education, training, coaching and advocacy is essential. It will not be self-sustaining
- If the 3 band 6 facilitator posts are not made substantive the service will be reduced to education and training alone; significant progress and momentum will be completely lost
- Continuous quality improvement for end of life care will not be achieved through education alone, it requires full and ongoing engagement of care home staff in measuring the outcomes of the care they provide

**Anticipated Outcomes**

- To continue to deliver the Six Steps programme to all care homes within Salford as a quality improvement and benchmarking initiative for end of life care
- Promotion of safe, effective end of life care in care homes through direct 1:1 coaching of staff and support to residents and carers (monitored through incidents and complaints)
- To expedite timely discharge of care home residents from hospital through active in-reach to acute care (emergency department, emergency assessment unit and ward areas, thereby supporting achievement of preferred place of care and death)
- To function as a reference point for communication and care co-ordination by taking direct referrals for residents and carers
- To act as advocates for care home residents with life-limiting illness, demonstrated by the range of end of life care supportive mechanisms initiated
- To directly support the end of life care work of the Care Homes Practice and the Community Elderly Care Consultants
- To develop a quality assurance framework for the provision of high quality end of life care in care homes, underpinned by local, Network and national standards, guidance and end of life care tools

**Stakeholders**

General Practitioners
Community nursing teams
Community and hospital specialist palliative care teams
Advanced nurse practitioners
Practice nurses
Emergency care practitioners
Care home staff
Care home residents and families
NHS Funded Care
Safeguarding team
Hospice at Home
Macmillan nurses
Coronial services
Learning disability teams
Counselling and bereavement services
Dementia nurses
Community geriatricians

**Strategic alignment**

The end of life care home facilitators education/training/advocacy model for Salford aligns to:

- NICE Quality Standards/Statements (QS13) End of Life Care for Adults (2011)
- NICE Guidance (NG31) care of Dying Adults in the Last Days of Life (2015)
- Ambitions for End of Life Care – A National Framework for local Action 2015-2020

The current strategic direction for end of life care is set by the above and can be encapsulated by the ‘Ambitions’ summarised below:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and well-being
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

### Section 4 Non-financial Option Development

**Benefit criteria**

<table>
<thead>
<tr>
<th>BENEFIT CRITERIA</th>
<th>DESCRIPTION</th>
<th>WEIGHTING (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC1:</td>
<td>Delivery of safer end of life care for care home residents and carer(s) through direct advocacy (advance care planning, pain and symptom control – plus focussed Safeguarding, Social care and Coronial liaison work)</td>
<td>25</td>
</tr>
<tr>
<td>BC2:</td>
<td>Continuous quality improvement in resident and carer experience of end of life care through staff education, training, 1:1 coaching and outcome measurement</td>
<td>25</td>
</tr>
<tr>
<td>BC3</td>
<td>Improved achievement of resident end of life care preferences and choices through co-ordination of care and communication across all partner agencies of the Integrated Care Organisation</td>
<td>25</td>
</tr>
<tr>
<td>BC4</td>
<td>Improved patient flow through direct in-reach to urgent care and inpatient areas Salford Royal (e.g. Emergency Dept. and Assessment Units, Elderly Care, Orthopaedics)</td>
<td>25</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Impact on the local community and environment

The service will aim to continue its implementation of the education, training, coaching and advocacy model to develop a skilled end of life care workforce within the care home setting.

The impact this would have over the longer term would be:

- Reduction in the length of stay for end of life care home residents who have been admitted to hospital
- A competent and confident care home workforce will be developed, who feel actively supported to deliver end of life care within the care home setting
- Increased staff confidence and motivation in providing high quality end of life care through on-going engagement with the Six Steps programme
- Strong trusted relationships with care home staff impacting positively (literally) on the environment for end of life care in care homes
- Care home staff can build on the knowledge and skills attained and put these skills into practice
- An increase in the number of residents cared for in their place of choice through expedited and rapid discharge back to the care home
- Ensuring that the resident receives the right care in the right setting by a competent workforce

Options

Option 1: do nothing, posts no longer funded beyond March 2017 and service will cease.

Option 2: fund one additional band 6 post plus 1 band 4 administrator – the admin would support some of the essential outcome measurement recording and presentation (plus educational preparation).

Option 3: continue with the funding of three band 6 end of life care facilitators to deliver the Six Steps training programme as well as providing coaching support to care home staff and in-reach to acute care to improve the standards of care for dying patients. The additional facilitator time provided by all 3 band 6’s will ensure the outcome measurement recording, presentations and preparations are delivered and guarantee that all staff will be actively present in the homes to coach/educate/support residents and carers.

<table>
<thead>
<tr>
<th>Benefit criteria</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Score</td>
<td>Weighted score</td>
<td>Score</td>
<td>Weighted score</td>
</tr>
<tr>
<td>BC1 25</td>
<td>7</td>
<td>175</td>
<td>27</td>
</tr>
<tr>
<td>BC2 25</td>
<td>3</td>
<td>75</td>
<td>24</td>
</tr>
<tr>
<td>BC3 25</td>
<td>7</td>
<td>175</td>
<td>27</td>
</tr>
<tr>
<td>BC4 25</td>
<td>4</td>
<td>100</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>525</td>
<td>98</td>
</tr>
</tbody>
</table>

Recommended option

The options appraisal was scored by 5 members of the Service Improvement Team at the CCG. Option 3 was the preferred and recommended option based on the identified benefits and weighting of scores. This would enable the continuation and further development of the following implications:
<table>
<thead>
<tr>
<th><strong>Patients</strong></th>
<th><strong>Staff</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent end of life palliative/care provided to residents in their final days/weeks of life by staff who are coached by the facilitators</td>
<td>Increased awareness for staff being guided to provide excellent end of life care to residents, families and their carers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other clinical services</strong></th>
<th><strong>Implications to other stakeholders</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Joined up services, practitioners working together in a more integrated way</td>
<td>No issues – links with all stakeholders involved in the residents care to meet EoLC needs in their final days/weeks of life</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Continuity of service</strong></th>
<th><strong>IT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Careful management of the service will ensure that this does not affect continuity of the service. Continuity of the service will be supported by making the 3 band 6 posts substantive, this will ensure cover for sickness/absence and annual leave</td>
<td>The facilitators will be required to follow robust processes to record patient information, adhering to Salford Royal policies and procedures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>IT Governance</strong></th>
<th><strong>Estates</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Governed by Salford Royal policies</td>
<td>No issues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Facilities</strong></th>
<th><strong>Telephony</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No issues</td>
<td>No issues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Transport</strong></th>
<th><strong>Corporate risks register Etc.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No issues</td>
<td>In place at Salford Royal</td>
</tr>
</tbody>
</table>

**Risk Assessment**

<table>
<thead>
<tr>
<th><strong>Probability of Risk</strong></th>
<th><strong>Impact of Risk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High</strong> increasing ageing population</td>
<td><strong>High</strong> people are living longer with multiple conditions and complex needs. Increasing numbers of people are being admitted to care homes where they require end of life care</td>
</tr>
</tbody>
</table>

**Medium** lack of on-going engagement from the care home owners/staff following completion of the training | **High** – residents, families and their carers will not be supported as professionals are not equipped with the skills or confidence to provide support |

**Medium** poor uptake of training, staff not able to attend the sessions offered due to commitments in the workplace | **High** – residents, families and their carers will not be supported as professionals are not equipped with the skills or confidence to provide support |
Section 5 Financial option appraisal

Quantitative Analysis – Financial costs and benefits

The following table outlines the full costs for each option, which include employers on-costs and is costed at mid-point on the relevant bands:

<table>
<thead>
<tr>
<th>Option</th>
<th>Details</th>
<th>Salary cost (est.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Post ceases</td>
<td>£0.00</td>
</tr>
</tbody>
</table>
| 2.     | 1 band 6 nurse & 1 x band 4 admin (full-time)  
1 x keyboard and monitor  
1 x facilitator course fees | £64,156 |
| 3.     | 3 x band 6 nurses (full-time)  
3 x keyboards and monitors  
2 x facilitators course fees | £114,578 |

Full Cost Analysis

In addition to the salary costs, the three band 6 facilitators will require monitors and keyboards for their laptops, totalling £348. Two facilitators will be required to attend a facilitator’s course at a cost of £580 each.

Incremental Cost Analysis

Depending on recruitment there may be incremental rises for the band 6 posts. One existing staff member is mid-point on the scale.

Cost / benefit analysis

The End of Life Care Home Facilitators has contributed to a reduction in A&E attendances and non-elective admissions for people in the last twelve months of life in care homes since 2014/15. In 2016/17 (based on 6 months data) there is forecasted to be 429 less A&E attendances and 330 less non-elective admissions than in 2014/15. Based on average costs this reduction represents potential savings to the system of £111,540 in A&E activity and £759,000 in non-elective acute internal medical admissions.

Qualitative Analysis – Non-Financial Benefits

Feedback from care home staff, families and carers has shown that the support provided has been excellent, (see appendix 4).

Assumptions

It is assumed that if funded, the post holders will stay in post at the top of band 6 at a fixed cost, with no changes to the banding.

Section 6 Recommended option

Recommended option
Option 3 has been recommended. This option will ensure that there continues to be a service that will ensure care home staff, residents, families and their carers are trained and coached in order to recognise the support needs at the end of life. Ultimately the continued aim is to:

- Help care home staff to be trained in all aspects of end of life care for residents
- Apply an innovative approach to end of life care support by training and coaching staff with the skills and confidence to cope with residents entering their last days of life
- Help care home staff to meet the initial direct support needs for palliative and end of life residents
- In-reach work would increase
- There will be more working within EAU
- Expansion to domiciliary care establishments
- The team could take part ownership of the Six Steps Programme (nationally) due to recognition of the work done

**Economic Case**

If approved funding for these posts will sit within the main provider contract with Salford Royal against the community services budget. Evidence for any financial gains for this service can be measured by looking at the reduction in the number of A&E attendances from care homes plus the number of emergency admissions to hospital and early discharges. There is also the potential for longer term benefits of this service to patients who are end of life, i.e. improvements in their care and treatment, delivered by competent staff that have been educated and coached by the care home facilitators.

**Value for Money**

A return on investment can be quantified by potential savings from patients not needing to attend A&E or be admitted and if continued, the service will meet potential gaps in service provision, be an example of best practice and raise the quality of end of life care for the care home population of Salford.
### Leadership

- CCG, Andrea Lightfoot, Service Improvement Manager and Dr Tin Aye, Clinical Lead for End of Life Care
- SRFT, Steve Gene, Assistant Director of Nursing, Palliative & End of Life Care; Marie Roberts, End of Life Care Trainer for Care Homes; Anne Mitchell, Lead End of Life Care Facilitator for Care Homes, Victoria McLoughlin, Palliative and End of Life Care Practice Development Lead

### Project Plan

<table>
<thead>
<tr>
<th>Stage</th>
<th>Nov 2016</th>
<th>Dec</th>
<th>Jan 2017</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan 2018</th>
<th>Feb</th>
<th>Mar</th>
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<tbody>
<tr>
<td>1. Ratification of Business Case:</td>
<td>CBC 29th</td>
<td>S&amp;F 3rd</td>
<td>Bi-monthly review LTC 9th May</td>
<td>Bi-monthly review LTC 11th July</td>
<td>6-monthly review LTC</td>
<td>Bi-monthly review LTC 14th Nov</td>
<td>Annual Review LTC 13th Mar</td>
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<tr>
<td>- Recommendation at Community Based Care Commissioning Group (CBCCG)</td>
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<td>- Agreement at Service and Finance Group</td>
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<tr>
<td>2. Development of service specification</td>
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<tr>
<td>3. Long Term Conditions Commissioning Group</td>
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<tr>
<td>- Bi-monthly contract reviews by LTC as required for any 1st year of a new contract</td>
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<tr>
<td>- 6-monthly review of progress/outcomes</td>
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<td>4. Annual Evaluation</td>
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</table>
**Monitoring**

Prior to commencement of substantive funding of the three band 6 posts, outcome measures will be agreed, KPI's developed and subsequent monitoring of a service specification.

**Reporting**

Progress of the first year of the permanent service will be monitored by the Service Improvement Team with exception reporting to the Long Term Conditions Commissioning Group as required.

**Benefit realisation plan**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Qualitative</th>
<th>Quantitative – Cash releasing (£s)</th>
<th>Quantitative – Non-cash releasing</th>
<th>Disbenefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing skills, competency and confidence of care home staff</td>
<td>✓ Training delivered at a high level to increase awareness, demonstrated by positive outcomes (experience, satisfaction, preferences and choices, bereavement care and follow up, e.g. CODE questionnaires)</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Provision of a high quality training and coaching service that is equitable and meets the needs of staff, residents, their families and carers</td>
<td>✓ Bespoke training and coaching support provided to care home staff, to benefit residents, families and carers. Evidence of staff engagement through evaluation and accreditation of evidence portfolios</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Improved awareness of end of life</td>
<td>✓ Care home staff having the</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Benefit</td>
<td>Type</td>
<td>Target</td>
<td>Data Source</td>
<td>Responsible person</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>-------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Increasing skills, competency and confidence of care home staff to deliver high quality end of life care to residents</td>
<td>Q (Qualitative)</td>
<td>Via annual reporting</td>
<td>Data collection by the service</td>
<td>Service Improvement Manager</td>
</tr>
<tr>
<td>Provision of a high quality training and coaching service that is equitable and meets the needs of staff, residents, their families and carers</td>
<td>Q (Qualitative)</td>
<td>Via annual reporting</td>
<td>Data collection by the service</td>
<td>Service Improvement Manager</td>
</tr>
<tr>
<td>Improved awareness of end of life procedures for residents in their last days/weeks of life</td>
<td>Q (Qualitative)</td>
<td>Via annual reporting</td>
<td>Data collection by the service</td>
<td>Service Improvement Manager</td>
</tr>
<tr>
<td>Increase in the number of advance care plans and timely reviews</td>
<td>Q (Qualitative)</td>
<td>Via annual reporting</td>
<td>Data collection by the service</td>
<td>Service Improvement Manager</td>
</tr>
</tbody>
</table>

**Post Service Evaluation**

The service will be responsible for the collection of quarterly outcomes data and activity data as well as the production of progress reports. Progress reports will be monitored through the LTC Commissioning Group with an annual report submitted.
**Communication strategy**

If recurrent funding is agreed, commissioners will work with the service to agree a communications plan.

**Contingencies**

No contingencies are required as if recurrent funding is agreed, the service will continue as currently provided.

## Section 8 Conclusions and Recommendation

**Conclusions**

There are 3 possible options:

**Option 1**: do nothing, posts no longer funded beyond March 2017 and service will cease.

**Option 2**: fund one additional band 6 post plus 1 band 4 administrator – the admin would support some of the essential outcome measurement recording and presentation (plus educational preparation).

**Option 3**: continue with the funding of three band 6 end of life care facilitators to deliver the Six Steps training programme as well as providing coaching support to care home staff and in-reach to acute care to improve the standards of care for dying patients. The additional facilitator time provided by all 3 band 6’s will ensure the outcome measurement recording, presentations and preparations are delivered and guarantee that all staff will be actively present in the homes to coach/educate/support residents and carers.

**Recommendations**

Following the options appraisal option 3 was clearly the preferred option.

**Service Responsibility**

The responsibility of the service will be that of the post holders and they in return will report to the service improvement manager at the CCG. As the service is already in existence there will be no new implementation plan required.

**Business Case approval and sign-off**

The business case will be presented to the Long Term Conditions group. If approved by this group, this will then be presented to the Service and Finance Group for final sign off and approval.
APPENDIX 1

Care Home Staff Survey

Do you feel your knowledge and skills in end of life care has been improved following the end of life care facilitators coaching?

![Pie chart showing responses to the first question.]

As a result of the facilitators input do you feel the patients and families care was improved?

![Pie chart showing responses to the second question.]

Care Home Managers Survey

How often do you or your staff engage with the End of Life facilitators?

![Pie chart showing frequency of engagement]

- At least weekly
- Monthly
- Less often

Do you think taking part in the Six Steps Programme has improved the end of life care in your organisation?

![Pie chart showing response to the question]

- Yes
- No

Comments:

- The service that they provide to all of our staff is invaluable, without them we wouldn’t have the knowledge that we have now.
- To continue to be there for us as a residential home, we often get missed with professionals the end of life team give confidence to my team.
- I would like to see the service continue at increased or current strength hand on hear the support from the team enhances care delivery at a particularly difficult time for residents and relatives and without this end of life care would be nowhere near it is now. I have worked in other areas and nowhere does it as good as Salford.
- To continue the support and training they give to care homes along with keeping care homes up to date with new legislation. Assist and advise care providers with changes in documentation and in all areas of end of life care.
## APPENDIX 2

<table>
<thead>
<tr>
<th>Time period</th>
<th>Number of visits to the home</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2013</td>
<td>25</td>
<td>Commencement of funding.</td>
</tr>
<tr>
<td>1 x lead facilitator</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July – Dec 2013</td>
<td>86</td>
<td>The first 6 months of 2 x care home trainers included the induction period and learning of the programme.</td>
</tr>
<tr>
<td>1 x lead facilitator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 x care home trainers</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Jan – May 2014</td>
<td>105</td>
<td>The trainers were fully trained and had engaged further care homes. Cohorts 5 &amp; 6 commenced team responsible for more homes.</td>
</tr>
<tr>
<td>2 x care home trainers</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Jun – Sep 2014</td>
<td>72</td>
<td>The trainer worked over the contracted hours to support the service as much as possible.</td>
</tr>
<tr>
<td>1 x care home trainer</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Oct – Sep 2015</td>
<td>397</td>
<td>12 months of data</td>
</tr>
<tr>
<td>2 x care home trainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Oct – Dec 2015</td>
<td>209</td>
<td>This is the level of support given to the care homes when nearly at full capacity.</td>
</tr>
<tr>
<td>1 x p/t lead facilitator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 x care home trainers</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Jan – Mar 2016</td>
<td>277</td>
<td>This is the level of support given to the care homes when nearly at full capacity.</td>
</tr>
<tr>
<td>1 x p/t lead facilitator (3 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 x care home trainers</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Apr – June 2016</td>
<td>271</td>
<td>The lead facilitators have not been able to fulfil the entire band 7 role in order to continue the support to the care home staff and residents.</td>
</tr>
<tr>
<td>1 x lead facilitator</td>
<td></td>
<td></td>
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<tr>
<td>1 x care home trainer</td>
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<td></td>
</tr>
<tr>
<td>1 x p/t care home trainer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 x care home trainer (until 1st May)</td>
<td></td>
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</tr>
</tbody>
</table>
Preferred Place of Death (PPD)
Salford care home residents with ACP
QTR 1. 2016 (n=66)

- Did not achieve their PPD: 7.60%
- Achieved their PPD: 92.40%
APPENDIX 4

I believe that the service given by the end of life team is invaluable to the care homes practice, the patients and staff and the care homes. The team are always willing to go above and beyond in their jobs roles to ensure that the patients achieve the best possible end of life care. Each member of the team is passionate and committed to their job. I have received regular positive feedback from the homes when I visit and also bereaved relatives. They have been incredibly supportive to me over the last 12 months and I have really enjoyed working with you all.

Their facilitator role needs to be continuous. The homes that have been trained in 6 steps will always need ongoing support due to the high turnover of staff and also the use of bank staff. In addition, there are homes that are in difficulty and need ongoing help to try and maintain a safe and high quality standard of care. In addition to supporting staff, there will always be patients and families that need specialist support at the end of life and I believe that the team is best placed to offer this service. Our intermediate care services are yet to have end of life training and this is vital to ensure that patients that die in temporary placements can still get high quality care. The sharepoint site that the team have set up provides a massive resource of useful information for the care homes and this will need constant upkeep to ensure its usefulness.

There is still lots to do and achieve within the team. I believe that there is massive potential for the team to continue and expand their hospital in-reach service. The high turnover of patients means that there are always going to be ACP’s to complete and families to support and care for. There are research opportunities for the team including review of admissions and deaths in hospital at end of life, and looking at preferred v’s achieved place of death. There is also an opportunity to provide bereavement support to the homes and relatives as well. Finally, I would like to see the team develop their clinical duties and provide specialist palliative care services to the care home residents.

Dr Louise Butler, Consultant Ageing & Complex Medicine (Community)

I have been a district nurse in Salford for many years and have supported residential and nursing homes in their deliverance of end of life care. Although this is a valuable exercise and beneficial to the patient at that time it is often impossible for the staff to get continued support, training and advice. Since the introduction of the end of life care home training team in Salford we have felt an increase in the knowledge, skill and confidence that the care home staff possess and this is due to the time and efforts of the care home trainers. Not only can they support the resident, staff and their family at a very challenging time they can also provide ongoing mentorship and encourage the staff to reflect on their experiences and identify future learning needs. The way they support staff is invaluable and we have found that the care for the residents has been much more seamless and interventions executed in a more timely manner, for example the prescribing of anticipatory medication, statements of intents, DNAR forms/discussions and identification of symptoms.

The team are a great asset to any care home in Salford and their skills and knowledge has relieved the pressure off the district nursing teams across the city.

I believe that investment in care homes should be a high priority of any clinical commissioning group as they care for some of our most vulnerable members of society. In order to change practice, embed education and maintain a level of skill and competence that is required the care home trainer role is vital and I hope to see the team expand in the future.

Rachel Moorhouse, District nurse team leader, Walkden integrated care team
I am a District Nursing Sister working across Salford and I regularly provide end of life care within residential and nursing home settings.

Since the End of Life Care training team has been in place, I have found that residential and nursing home staff have become much more proactive in relation to planning for a patient who is approaching end of life. The staff are more confident at approaching a patient’s GP to initiate advance care planning discussions, involving patients and their relatives to ensure that they are involved in any decision making.

Nursing home staff are now also more aware of what patients should have in place when they are approaching end of life i.e. Statement of Intent (if appropriate), DNA CPR, Anticipatory End of Life Care medication, End of Life Care Plan.

Prior to input from the End of Life Care training team, District Nurses were often called in to nursing homes to manage crises in symptom management. At this stage, the patients’ often had end of life care drugs in place, but had not been started on the End of Life Care Plan. This resulted in very lengthy visits for District Nurses, while end of life care discussions were held with patients’ families and GP visits were arranged to complete the necessary documentation.

In recent months, I have visited one particular nursing home where staff have received input from the End of Life Care trainers and have been very impressed by how well they have prepared for patients who are approaching end of life. I have visited to administer sub cut medication/ set up a syringe driver and on each occasion all the prescribers’ authorisation sheets have been in place and the End of Life Care Plan has been fully completed by the nurse at the nursing home in conjunction with the patient’s GP. The care home and nursing home staff are in an ideal position to complete this as they have often built up good relationships with patients and their relatives and having received in training from the End of Life Care trainers, they now feel more confident to have difficult conversations.

It is very beneficial for District Nurses when End of Life Care Plans have been completed as it is then possible to gain a holistic picture of the patient. When visiting nursing homes, I have seen evidence within patients’ End of Life Care Plans that they are being regularly reviewed in terms of their nutrition and hydration, pressure area care, mouth care and bladder and bowel management. I recently witnessed one of the nursing home managers stressing the importance of this to staff, demonstrating how input from the End of Life Care trainers has influenced a positive change in practice.

With these changes in place, District Nursing time is then freed up to focus on medication administration and effective symptom management.

Ruth Garside, District Nursing Sister 9.10.16