Evaluation of Yorkshire & the Humber end of life care development programme for care homes

Final report

March 2014

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Evaluation of Yorkshire & the Humber End of Life Care Development Programme for Care Homes, Final Report, March 2014
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- Supplement 3 – Championing end of life care. Case studies from the Yorkshire and the Humber Skills for Care and health authority end of life care training project for residential care managers and end of life care champions (supplement 3 is available as a paper copy)
- Supplement 4 – Programme plan
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1. Executive summary

1.1. Introduction

In 2011, Skills for Care was commissioned by Yorkshire and Humber Strategic Health Authority (Y&H SHA)[1] to develop and deliver a learning and development programme in end of life care skills, which focused on care home managers and 'champions' across the Yorkshire and the Humber area. End of life care (EoLC) 'champions' are members of care staff who are specifically designated to promote better quality end of life care in their workplace. The programme included care homes with and without nursing services.

Other activities in the specification included setting up a support network and developing resources for managers and champions, as well as raising awareness of end of life care service quality issues with commissioners and regulators of care home services.

This report provides the background to the project, and supplement 1 contains an analysis of surveys undertaken by managers and champions who completed the learning and development programme. Progress on the other workstreams is also included in the main body of the report, and views from a wide range of stakeholders and case studies demonstrating how the programme developed, and the learning taken forward, can be found in supplements 2 and 3.

An interim report published in September 2013 identified some early benefits of the programme, which are still relevant:

- raised awareness of end of life care across sectors
- more integrated working between health and social care workers
- the potential to work more closely with the Yorkshire Ambulance Service on sharing information and reducing the pressures on accident and emergency departments.

Since the interim report, a national consultation has taken place to inform the government's response, expected in 2014, to the recommendations from the Neuberger review, *More Care, Less Pathway – A Review of the Liverpool Care Pathway* (Neuberger 2013). Changes in policy and guidance around end of life care will significantly influence future learning and development programmes involving care workers in care homes and domiciliary care settings. Skills for Care contributed to the consultation, and with established programmes and resources focussed on end of life in place will be able to quickly respond and modify content if required.

In addition, a number of relevant reports have also been published including:

- the Francis Report
- the Cavendish Report on health care assistants and social care workers
- the Berwick Review into patient safety within hospitals
- the Keogh Report regarding the quality of care and treatment provided by 14 hospital trusts in England

[1] The SHA was abolished in March 2013 and the strategic leadership for the programme transferred to Health Education Yorkshire and Humber.

- the Ann Clywd Report about the investigation of complaints received by hospitals.

Their impact on national policy, service improvement and inspection is now becoming more widely understood.

In particular, the Cavendish Report's recommendation 5 calls for Health Education England, with Skills for Health and Skills for Care, to develop proposals for a rigorous system of quality assurance for learning and development, which links funding to outcomes, so that money is not wasted on ineffective courses. Recommendations 207 to 213 of the Francis Report also specifically cover healthcare support workers and make linkages across to the Cavendish Report especially around the 'Certificate of Fundamental Care' (Cavendish recommendations 3, 15).

The recommendations from the care homes EoLC development programme will be invaluable in helping Skills for Care and services within Yorkshire and the Humber respond to these reviews and changes in policy and guidance.

1.2. Background

Improving the quality of end of life care services in care homes was identified as a priority to enable the then Y&H SHA to meet the national End of Life Care Strategy (2008), the 2010 End of Life Care Quality, Innovation, Productivity and Prevention (QIPP) and the 'Better for Less' agendas. The area covered by the Y&H SHA has nearly 1700 care homes with just over 50,000 registered places. To achieve quality and efficiency improvements in services, care home managers need to have the right knowledge, skills and behaviours to embed good end of life care into practice. For changes in services and behaviours to become a reality it is also necessary to develop a critical mass of knowledgeable and skilled workers to act as end of life care champions.

As a result, following a recommendation from the End of Life Care Pathway Leadership Board in 2011, the Y&H SHA commissioned Skills for Care to develop and deliver a sustainable and flexible development programme aimed at adult services within care homes. The programme comprised four main workstreams:

1. A development programme aimed at care home managers and champions, including developing a resource guide for care home workers containing all the links to resources needed to achieve quality improvements and measures.
2. Establishing local networks for managers and champions to reduce isolation and increase peer support and shared learning.
3. Developing end of life care knowledge and understanding for commissioners and regulators of care. This would be critical in ensuring there is a link between learning and development and meeting the standards and requirements for registration with Care Quality Commission (CQC).
4. Extending the use of e-learning to complement the development programme and support cascading knowledge and learning to other care home workers.

1.3. Aims of the programme

The overall aim of the programme was to achieve outcomes that improve the care experience for residents, their families and the workers looking after them, by increasing:

- the number of people who have advance care plans in place
- the number of people who die in their preferred place

- the number of people entered on an end of life care pathway
- the number of allocated key workers.

A further expectation of the programme was that workers would be able to facilitate an increase in the number of residents who could be treated within care homes and avoid inappropriate hospital admissions. It was also anticipated that care homes would benefit by seeing an improvement in the ability to demonstrate compliance with commissioner and regulator measures and CQC inspections, as well as a reduction in the number of complaints.

1.4. Summary of the Managers' and Champions' Development Programme evaluation

511 care homes comprising some 19,600 places have participated in the programme, which involved 516 managers and 489 champions. This analysis is based on responses from 137 managers and 73 champions who completed both pre- and post-programme surveys. The personal commitment made by care home managers and champions should not be underestimated, and many had to undertake training in their own time.

Encouragingly, the vast majority of respondents rated the programme as either very or quite important in terms of helping them improve practice, knowledge and skills. This was mainly identified in the areas around:

- confidence in delivering end of life care
- better understanding of how to support clients and raise this topic
- dealing with families
- improving paperwork and documentation
- improving workers' skills in general and
- better liaison with district nurses, GP and other healthcare workers.

The full analysis can be found in supplement 1.

Workers' skills, attitudinal impact

- Managers were asked about their workers' knowledge and skills in relation to end of life care. They generally rated their workers' skills higher after the learning and development, indicating change is happening in the right direction.
- 61% of champions were new to their champion role.
- Just over a quarter of managers have cascaded the learning to 81–100% of their workers. However, cascading of information was still continuing.
- The survey included a list of knowledge and attitude statements about managers' and champions' views on end of life care. It was found that these changed in a positive direction for all the statements, which is an excellent finding and confirms the positive impact of the programme.

Policies and procedures

After the learning and development programme, a higher proportion of managers responded that their care home had policies, procedures and end of life registers in place than before.

Use of resources

- e-ELCA e-learning modules had been accessed by over a quarter of managers (29%) and almost a third (32%) of champions, leaving the majority of participants still to access this resource.
- 'Achieving success in end of life care: A guide to delivering quality standards across Yorkshire and Humber care homes' (2012) was more widely read—by almost six-in-ten champions (57%) and over three-quarters of managers (76%).

Networks

The majority of champions and managers agreed to some extent that a strong network of support had been built up in the areas. Just over half of managers (55%) and around a third of champions (35%) attended end of life care or other relevant networks.

Assessment of monitoring data

Statistics on the situation in care homes in the area were gathered, mostly relating to the previous 12 month period, in both stages 1 and 2. Important changes in the period to note were:

- the proportion of residents with advance care plans in place rose from 34% to 45%
- the proportion who died with a specified place of preference rose from 46% to 72%. This 26-point rise is a 38% increase
- the proportion who died in their preferred place remained constant at 88%
- after the programme, a significantly higher proportion of managers stated they looked into why any resident died in a place other than their place of preference compared with before (69% to 79%).

More detailed analysis of these figures by area is available, but should be viewed with caution because of lower sample sizes.

Other learning and development, challenges and further steps

Almost three-quarters of champions (71%) had not accessed other relevant learning and development, whereas the response of managers was a bit more mixed, with some stating both they and some of their workers had. Where other training had been attended, this was generally rated as important in terms of helping them improve practice, knowledge and skills around end of life care. While this only applies to a minority, the impact of the additional training on the overall positive change seen in the report's findings should not be disregarded.

Respondents gave examples of challenges they had encountered in trying to improve their end of life care. These usually fell into the categories of dealing with family members, GPs, resistance by or shortage of workers, and updating paperwork.

Many respondents also commented on not having encountered challenges up to this point. In terms of next steps, managers generally felt that continued networking and good communication of all parties, and continued learning and development and refresher courses were important in sustaining the programme in future.

Conclusions from the managers' and champions' learning and development

Overall, the evaluation shows evidence of a positive impact made by the managers' and champions' learning and development programme, particularly in terms of impact on

workers' knowledge, skills and confidence. Further, the evidence shows that the project objectives, as set at the beginning of the project, have been largely achieved.

Comments from managers and champions

- "I enjoyed this programme and feel that it has had a positive effect of how I and my colleagues approach end of life care." *(Champion)*
- "It was interesting and rolling out to more people will be beneficial." *(Champion)*
- "I feel I have gained more knowledge and understanding towards end of life care and applying it in-house." *(Champion)*
- "Should be expanded, it's great." *(Champion)*
- "Loved the course and gained a lot from it." *(Manager)*
- "The training has been brilliant for all staff at all levels in raising awareness for end of life care." *(Manager)*
- "It was a useful and worthwhile undertaking, raising awareness and hopefully care standards." *(Manager)*
- "The end of life programme has highlighted to the management and staff the need for continuous end of life care." *(Manager)*
- "I have thoroughly enjoyed this programme and the support and help from the End of life care trainers has been amazing." *(Manager)*
- "General improvement in end-of-life care. Easier access and availability of training. Improved access to anticipatory drugs. A greater understanding of DNRs, resulting in very few if any hospital admissions. People dying in peace and quiet, with families present. Obviously I am only commenting on the impact in a care home." *(Manager)*

Comments received that gave rise to learning points for future work included:

- "Need further assistance as some things were not quite clear." *(Manager)*
- "I gave a lot of time to working through the workbooks and have had nothing back." *(Champion)*
- "We did not complete this training as we were doing everything that was being trained."
- "Enjoyed (it) but still not received notification as to whether or not I was deemed to have achieved the award, or if there is work outstanding? Very poor organisation in general, I was not aware on commencing training that it was a written project, nor do I feel we were given enough time to complete this considering we were not expecting it and work full time etc., we were told that the timescale was short as we were the last cohort but this seems hardly fair." *(Champion)*
- "Unable to complete the course as we had no one at the end of life stage, we were disappointed that we could not do the course." *(Champion)*

1.5. Summary of views from stakeholders

The views from all stakeholders are detailed in full within supplement 2. Of those who responded to the online survey, 100% supported the statement '*Ongoing and recognised education and training in end of life care must be embedded in normal practice of care home staff'*. Members of the programme board and steering group were asked if the project was worthwhile, and their overall view was that the successes outweighed initial weaknesses. Raised awareness of the end of life care stakeholder map, changing attitudes and priorities around the role of care homes and the contribution they can make to

improving services, as well as strengthened integrated working through the development of cross-sector networks, were highlighted as the main successes for the project.

If the project were to be undertaken again the following were identified as the main areas where lessons had been learned:

- A cross-section of stakeholders should be brought together at the start of the process to achieve 'buy in'—commissioners and CQC are key to future sustainability and must recognise end of life care as a priority, otherwise all other efforts will be lost.
- Stakeholders leading the project must be knowledgeable and know what works and what has not worked before, and recognise the importance of integrated working to sustain developments.
- Time must be spent to do the groundwork, identify a baseline and understand the population and the care homes and other services that serve them. Do not underestimate the complexity of provision.

1.6. Recommendations

The recommendations have been drawn from the evaluation of the individual workstreams, and views of stakeholder groups engaged with the care home project. They are targeted to local authorities and clinical commissioning groups to support further development of end of life care commissioning plans. These recommendations should support driving up quality in the delivery of end of life care, improve integrated working and contribute to potential reduction in inappropriate admissions to hospitals from care homes.

End of life care networks and engagement of health and social care

- End of life care networks must be recognised by, and communicate with, local authorities (LAs), clinical commissioning groups (CCGs), strategic clinical networks and continue actively to support care homes.
- The networks should bring together all key stakeholders to provide strong leadership for end of life care, share good practice and work through challenging issues. They need to agree actions that fall within the remit of their member organisations to achieve service improvements in end of life care.
- Membership should be extended to community care providers (domiciliary care providers and personal assistants), health care professionals, hospices and community settings as well as commissioners, if not already involved.
- Current issues should be expanded to include hospital admissions and discharges, nutrition, dementia and medication, a continuance of localised end of life care training and developing new champions.

Learning and development in care homes and domiciliary and community settings

- All social care workers, including healthcare assistants, social workers and assessors should be required to attend learning and development based on the level 2 unit Understand how to work in End of Life Care (EOL 201), and this should be included as a requirement within local workforce strategies.
- Care home managers to achieve a level 5 unit Lead and Manage End of Life Care Services (EOL 501).
- Workers who want to undertake elements of units but not undertake formalised assessment (to achieve a qualification) should also be supported. Encouraging

workers to complete units to obtain a qualification is desirable but, except for mandatory requirements, it should be recognised that not all workers want, or are given the time, to follow this route.

- Integrated learning and development provision should be encouraged by engaging a cross-section of health and social care organisations, and established training providers, in design and delivery.
- Hospices and community palliative care teams should be supported to enable them to continue to make a significant contribution to learning and development by delivering content and act as expert assessors.
- e-ELCA (the end of life e-learning programme) should be actively promoted and integrated into traditional training and work-based learning. It is a valuable resource but physical resources need to be available in care homes and protected time to learn agreed.
- Skills for Care must review the resource guide annually to keep it updated, and consider making hard copies available.
- A development programme for workers in community settings, based on the care homes programme, should be developed.

Contract compliance

- Contract arrangements and quality frameworks should include end of life care, with a standard requirement for each person in receipt of care to be given the opportunity of recording their wishes and preferences through an advance care plan.
- Monitoring arrangements by all NHS and local authorities ought to include end of life care as a priority.
- Improved accuracy in recording individuals admitted to NHS services from care homes is needed to ensure that monitoring of services can justify funding against improved outcomes.
- Contracts with end of life care providers should include a requirement that all workers are trained in end of life care as detailed in 1.6.2 above.

Regulation

- The Care Quality Commission (CQC) to include end of life care as part of their inspection regime, and for CQC to ensure inspectors are trained to inspect end of life care provision in all settings.
- Skills for Care is recognised as being well placed to provide assistance for care homes who are identified by the CQC's end of life care inspection procedure as not meeting outcome 4 of its *Essential Standards of Quality and Safety* (CQC 2010).

Integration of health and social care

- Local authorities and CCGs should make greater use of integrated services and learning and development in line with national policy. Networks have a key role in ensuring integration of end of life care services through their diverse membership.
- Increasing opportunities to combine learning and development of community-based workers in health and social care would enable a greater understanding of each other's roles and contribution in delivering quality end of life care services.

- More discussion is needed with Health Education Yorkshire and the Humber, and commissioners, to make learning and development opportunities and funding available for registered nurses in care homes and community settings.
- More needs to be done to raise awareness and improve recognition by GPs, community matrons, district nurses, ambulance workers and out of hours (OOH) services that workers in residential care homes, with appropriate learning and development , can deliver good quality end of life care including clinical care currently provided by health care assistants (HCAs). This should contribute to reducing inappropriate hospital admissions, provide continuity of care for individuals, and improve use of resources.

2. Yorkshire and the Humber end of life care development programme for care homes

2.1. Introduction

The project to deliver the care home development programme across Yorkshire and the Humber started in November 2011 and finished in March 2014 following a three month evaluation. This report contains background information on the project, evaluation of surveys from those who have undertaken the learning and development programme, views from a wide range of stakeholders, and progress on other workstreams to enable the work to become embedded into normal practice.

Due to baseline data not being readily available about the care homes, the numbers of deaths in the care homes, and the number of hospital admissions from care homes, the development programme could not progress to the original planned timeframe. Data had to be collected which resulted in additional work for Skills for Care before the main project could start.

Considerable effort was also needed by the project team to raise awareness, establish relationships and secure engagement from care homes and other stakeholders in the area. This work took place at a time of significant change within NHS organisations and among their personnel, and the effort required to maintain continuity and ensure the programme progressed should not be underestimated.

Improvements in end of life care services, and changing behaviours and practice in care homes, are dependent on working across sectors and organisations, so it has been important within the programme to develop networks that reflect integrated working across localities. Continuing these networks, and their support and recognition by commissioners and regulators, is key in taking forward the benefits identified in the development programme and forms a major recommendation within this report.

Overall the views from stakeholders involved in the project and the results of the evaluation of those who attended the programme, would indicate that the success of the project outweighed the initial weaknesses. Comments from stakeholders expressing views relating to these issues and others can be found in supplement 2 ‘Stakeholder Consultation’, and summarised within section 2.5.9 of this report.

2.2. National context

Where people die, and their preferences for where they die, are important indicators of the quality of their end of life care. Many sources now indicate that over 60% of people state their preferred place of care, and death, is at home; however, over 50% of people still die in hospital (Gomes Calanzani Higginson 2011, NEoLCP 2012). These national figures indicate that more work has still to be done to reduce the numbers of people who die in hospital and increase the numbers who die in their preferred place.

The Public Health England EoLC Intelligence Network estimates that in England during 2011 around 88,000 people died in care homes (18% of total deaths). A report published in November 2013 (PHE NEoLCIN 2013) showed that the proportion of people dying at home

or in care homes increased from 38% in 2008 to 44% in 2012, reflecting the preferences of many to stay at home to die.

For ageing people with complex needs, a care home is often their final home, and their preference to be cared for by workers known to them and to die in surroundings they are familiar with should be met where possible. 27% of people live in care homes for more than three years, with the average period from taking up residence in a care home to death being 15 months (NEoLCIN 2012). The same report shows that 16% of people resident in care homes in their last week of life die in hospital and not the care home.

The national End of Life Care Strategy (DH 2008) highlighted that people approaching the end of life require care in a variety of different settings, and emphasised the need for high quality 'seamless' integrated health and social care that should include allowing more people to choose where to die. It raised awareness that many care home residents die after emergency admissions to hospital just days or even hours before their death. This showed that there was a need for more coordinated working between the NHS and social care to support care home workers to reduce hospital admissions by providing good quality end of life care in care homes.

To support improvements in care homes the National End of Life Care Programme produced *The route to success in end of life care – achieving quality in care homes* (NEoLCP 2010) based on the six steps of the end of life care pathway[2] which highlighted the key levers for rapid service improvement based on findings from expert reference groups.

NICE introduced a quality standard (NICE 2011) in end of life care that defines clinical best practice. This provides specific concise quality statements, measures and descriptors that define high quality care, intended for the public, health and social care professionals, commissioners and service providers. It covers all settings and services in which care is provided by health and social care workers, including care homes, and applies to all adults approaching the end of life. This includes adults who die suddenly or after a very brief illness.

In 2013, the National End of Life Care Programme and Skills for Care produced a follow-up progress report *Improving End of Life Care in Care Homes – Progress, Challenges and Best Practice* (NEoLCP 2013) that outlines how the care home sector has responded positively to the challenges. It demonstrates examples of real innovation and excellence by making use of the wide range of resources now available to support workforce development in end of life care. Many of the case studies show that ensuring managers and workers have the confidence, skills and abilities to actively support people to live and die well are the critical building blocks in supporting service improvements. The report also suggested that managers and workers in care homes play an important role in leading by example in championing dignity and compassion at the end of life. Many other useful references to

[2] 'End of life care pathway' usually refers to the six steps outlined in the national EoLC strategy (DH 2008) and not the integrated pathways for the dying used in the last days of life such as in the Liverpool Care Pathway (LCP).

work undertaken with care homes, including case studies and websites containing more information, can be found within the report.

Skills for Care's approach to end of life care is based on its 2012 joint publication with Skills for Health and the NHS National End of Life Care Programme, *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* (SfC SfH NEoLCP 2012). This is also the basis for the national qualifications in end of life care, which are outlined in Skills for Care's guide to end of life care qualifications (SfC 2013a).

Since the Yorkshire and the Humber care home development programme's interim report in September 2013, a national consultation has taken place to inform the government's response to the recommendations from the Neuberger review, *More Care, Less Pathway – A Review of the Liverpool Care Pathway* (Neuberger 2013). It is likely that the response will be published in spring 2014 and changes in policy and guidance around end of life care will significantly influence future learning and development programmes involving workers in care homes and domiciliary care settings. Skills for Care contributed to the consultation, and with recognised programmes and resources focused on end of life care established, will be in a strong position to respond quickly and modify content if required.

In addition, a number of relevant key reports have been published including:

- the Francis Report
- the Cavendish Report on health care assistants and social care workers
- the Berwick Review into patient safety within hospitals
- the Keogh Report regarding the quality of care and treatment provided by 14 hospital trusts in England
- the Ann Clywd report about the investigation of complaints received by hospitals.

Their impact on national policy, service improvement and inspection is now becoming more widely understood.

In particular, the Cavendish Report's recommendation 5 calls for Health Education England, with Skills for Health and Skills for Care, to develop proposals for a rigorous system of quality assurance for learning and development , which links funding to outcomes, so that money is not wasted on ineffective courses. Recommendations 207 to 213 of the Francis Report also specifically cover healthcare support workers and make linkages across to the Cavendish Report especially around the 'Certificate of Fundamental Care' (Cavendish recommendations 3, 15).

The lessons learnt from the care homes EoLC development programme will be invaluable in helping Skills for Care and services within Yorkshire and the Humber respond to these reviews and changes in policy and guidance.

2.3. Developments in Yorkshire and the Humber

In response to the national EoLC strategy (DH 2008), each SHA developed its own plans to improve end of life care services. In addition, the national End of Life Care Quality, Innovation, Productivity and Prevention (QIPP) initiative was introduced by the Department of Health in 2010 to identify how services could be redesigned to achieve the twin aims of improved quality and efficiency. SHAs were required to respond to this initiative and put

plans in place to reduce the number of hospital deaths and increase the number of deaths in people's usual place of residence by 2015 to achieve national performance measures. Other performance measures included reducing the length of stay in hospitals that ended in death.

This highlighted the need for integrated service improvement plans across health and social care to ensure that care in the community and home settings had the capacity and quality of services in place to respond to these changes. Although national organisational change resulted in the QIPP initiative ending in March 2013, many of the integrated local and regional plans put in place by SHAs (also abolished in March 2013) to increase quality and efficiency continue through the work of Health Education England and clinical commissioning groups (CCGs). In relation to this programme, Health Education Yorkshire and the Humber now work closely with Skills for Care and the care homes programme.

The Y&H SHA's End of Life Care Pathway Leadership Board commissioned a study (Y&H SHA 2010) to look at where investment could make a significant impact against the QIPP and 'Better for Less' agendas. In the report the quality and commitment of care home managers and leaders was highlighted as a significant driver for embedding quality improvements in care homes. Where managers were committed and enthusiastic about improving care standards for residents there was a greater likelihood that the quality of care would be improved and sustained. A report (SfC NMDS-SC 2013) based on September 2011 data held on the National Minimum Data Set for Social Care (NMDS-SC) showed that within the 2,518 records held for establishments providing or organising adult social care in Yorkshire and the Humber the turnover rate for registered managers was 14.3%, where the average for England was 11.4%. Therefore a further factor in ensuring long term sustainability was the development of a critical mass of knowledge and skilled workers to become end of life care 'champions' and promote better quality end of life care in their workplaces.

Investment was prioritised to raise the quality of care provided in care homes through a learning and development programme. A trained and knowledgeable workforce should enable more residents to receive end of life care within their own home environment and reduce avoidable hospital admissions, as well as enabling those admitted to hospital with complex medical needs to be discharged more quickly to their care home when their condition has stabilised.

Yorkshire and the Humber has nearly 1700 care homes with around 50,000 registered places. The study found that data on the number of care homes actually involved in learning and development was limited, but estimated that approximately 38% had some involvement. There were significant differences in the range of activities and staff providing learning and development around end of life care across the area. Evaluation of the programme tended to focus on the actual training delivered and measuring the skills and knowledge gained, but only limited evaluation of changes in behaviour and outcomes was available.

The study highlighted many useful suggestions for taking forward a learning and development programme, but also suggested a wider developmental programme to include

commissioners and regulators of end of life services. These were grouped and four main strands recommended to the SHA:

1. A development programme aimed at care home managers and champions—including developing a resource guide for care home workers containing all the links to resources needed to achieve quality improvements and measures.
2. Establishing local networks for managers and champions to reduce isolation and increase peer support and shared learning.
3. Developing end of life care knowledge and understanding for commissioners and regulators of care—this would be critical in ensuring there is a link between learning and development and meeting the standards and requirements for registration with the Care Quality Commission (CQC).
4. Extending the use of e-learning to complement the development programme and support cascading knowledge and learning to other care home workers.

In 2011 the Y&H SHA commissioned Skills for Care to develop and deliver a development programme aimed at adult services in care homes with and without nursing services. The original programme plan can be found in supplement 4.

Skills for Care, the sector skills council for adult social care in England, was well placed to deliver this programme as it had the expertise to develop a well-designed and properly evaluated and accredited learning and development course based on national qualifications for care home workers. This approach would resonate with employers, commissioners and regulators in care home services, and would contribute to improvements in commissioning specifications and evidence of compliance with regulatory standards.

2.4. Aims of the programme

The overall aim of the programme was to achieve outcomes that improve the care experience for residents, their families and the workers looking after them, by increasing:

- the number of people who have advance care plans in place
- the number of people who die in their preferred place
- the number of people entered on an end of life care pathway
- the number of allocated key workers.

A further expectation of the programme was that workers would be able to facilitate an increase in the number of residents who could be treated within the home and avoid hospital admissions. It was also anticipated that care homes would benefit by seeing an improvement in the ability to demonstrate compliance with commissioner and regulator measures and CQC inspections, as well as a reduction in the number of complaints.

2.5. Programme findings

This section outlines the findings from each of the workstreams and the arrangements put in place by Skills for Care to take the programme forward.[3] It was initially agreed to target 800 care homes across the area; however, only 511 care homes (64%) put forward managers and champions for the programme.

[3] Updates on the project can be found on the Skills for Care website http://www.skillsforcare.org.uk/endoflifecareinyh/

2.5.1. Governance

- A project manager was appointed in November 2011.
- A programme board chaired by Skills for Care was established with representation from the SHA, primary care trust (PCT) and a local authority. Since April 2013 members of the SHA have moved to Health Education Yorkshire and the Humber (HE YH) and the local clinical commissioning group (CCG), however they have remained on the programme board
- A project steering group chaired by the PCT was set up, comprising a wide range of stakeholders which now includes representation from HE YH, the CCG, a commissioning support unit, Yorkshire Ambulance Service, a care home association, local authorities and community end of life specialists. There was an initial delay in identifying the correct membership and establishing the governance arrangements. The chair remained the same but now represents a CCG.

2.5.2. Delivery of the Managers' and Champions' Development Programme

During 2011, Skills for Care invited tenders from training providers to deliver the development programme for managers and champions across 800 care homes. The range of care homes awarded to each education provider was determined by the number of local authority areas and the proportion of care homes within each of those areas.

The development programme commenced in March 2012. The models of delivery varied between training providers. Initially the managers' programme was planned to be a total of four days, consisting of two training days and two days of work-based assessment. The champions would attend a two-day programme, one training day and the other day undertaking work-based assessment. The training sessions element of the programme ended in May 2013 with Craven College, Aspect Training and Dove House Hospice continuing to work with care homes until the end of September 2013 to finish work-based assessments.

The contracts were awarded to the following providers:

Training provider	Areas covered	Contracted nos. of care homes for development programme	Actual nos. of care homes participated in development programme
Dove House Hospice and Hull College	Hull East Riding	 **Total = 83**	l 23 39 **Total = 62 (75%)**
Aspect Training	Sheffield, Doncaster Rotherham	60 42 42 **Total = 144**	30 25 30 **Total = 85 (59%)**
Leeds Care Association and Definitive Training	Leeds Bradford	75 75 **Total = 150**	70 31 **Total = 101 (67%)**
Barnsley and South West Yorkshire Foundation Partnership Trust	Barnsley	 **Total = 40**	 **Total = 36 (90%)**
Craven College	North Yorkshire and York Kirklees, Calderdale Wakefield	144 156 **Total = 300**	113 60 **Total = 173 (58%)**
Grimsby Institute	North East Lincolnshire and North Lincolnshire	 **Total = 83**	27 27 **Total = 54 (65%)**
	Overall Totals	**800**	**511 (64%)**

Following completion of the development programme, a workshop was held with training providers at which the disappointing participation rate was discussed. It was agreed that it had been a good opportunity to offer the level 3 and 5 unit awards (SfC 2013b), but the reality was that the percentages undertaking the required assessment to achieve the units and an award were low. Only 20% (103) of managers and 21% (104) of champions had completed a unit.

Trainers felt the participation rate could be improved by focusing on changes in practice, with gaining an award as an additional opportunity. The format may have deterred care homes from sending workers due to the personal and time commitment required in gaining a qualification, e.g. recording in workbooks and work-based assessments.

Some of the other reasons put forward by the training providers were:

- More foundation activities were needed to raise awareness, improve collaboration and buy-in earlier in the process, so that when training providers were marketing the course a level of awareness existed among the care home community.
- Detail on what the course was about, who it was aimed at and the commitment required, should have been more widely explained in the early stages so that care homes understood the benefits and their interest was engaged (many were wary that it was free!).
- Although all providers had a marketing plan, mail shots and emails did not appear to be very effective. Phone calls, which are time consuming, were more successful than mailshots and emails, however it was often difficult to find the right person to talk to.

- The initial message was unclear as to who the actual awarding organisation was going to be, and there was a delay before the awarding body was ready to deliver the units and enable people to register.
- Releasing care home workers to attend learning and development is an ongoing issue; some care homes initially signed up to attend but on the day no one turned up. Many managers and champions had to undertake learning and development in their own time. High workforce turnover within care homes dilutes the impact of learning and development and also needs addressing.
- To achieve engagement from care homes employers it was a majority view that commissioners and regulators must support the programme.

Common features

The development programme was based on two end of life care units, 501 and 3048 (Ofqual 2013), and each training provider was given the flexibility to design delivery of the content.

It was important that both a manager and a champion from each care home were recruited to attend the development programme. With the manager undertaking learning and development it was considered more likely that other workers would be encouraged to participate, and greater benefits for the care home workers and residents could be achieved, as well as contributing to future sustainability. Requests from local authorities and health colleagues regarding particular care homes who may have needed support with end of life services were considered by Skills for Care when approaching care homes.

All training providers had a similar marketing plan, which included:

- sending emails to care homes,
- joint flyer with each training provider
- a flyer posted out
- emails from local authorities and health colleagues
- phones to care homes
- websites and local e-news
- information given at forums.

Skills for Care also designed flyers and updates that were sent regularly to all care homes. Local authorities and end of life care colleagues were also asked to send out information.

Delivery of the programme

To see if any one model of delivery showed significant benefits over others, each training provider was asked to provide information on the content and format of their course. The models adopted are summarised below:

a) Dove House Hospice and Hull College – a combined two-day programme for both managers and champions with one-and-a-half days taught as one group and half a day for managers and champions to spend time separately in their own groups. Work-based assessment was completed by Hull College requiring managers and champions to write an assignment and answer questions within the work place. Dove House Hospice also delivers learning and development to social care employers.

b) Aspect Training (sessions delivered by two palliative care nurses) – two separate programmes, with two days for managers and one day for champions. Work-based assessments were based on managers and champions completing a work book for each unit. Aspect Training assessed the managers and champions at the workplace, where they were observed and asked questions to test their knowledge and check competence.

c) Leeds Care Association in partnership with Definitive Training – combined two days for both managers and champions. All completed an action plan to take back into the workplace. Two workshop events were held where managers and champions were invited to listen to speakers and take part in discussion. Work-based assessments were based on managers and champions completing a work book for each unit. Managers and champions were observed and asked questions to test their knowledge and check competence. In Leeds the programme was supported by the end of life care facilitator for care homes with nursing.

d) Barnsley Metropolitan Borough Council in partnership with South West Yorkshire Foundation Partnership Trust (SWYFPT) – two separate programmes with two days for managers and one day for champions. A trainer who had expertise in leadership delivered the managers' session. Work-based assessments were based on managers and champions completing a workbook for each unit. Managers and champions were observed and asked questions to test their knowledge and check competence. Additional support was given to those managers who requested it individually.

Anecdotal evidence and discussions with the training providers once learning and development had ended showed that the integrated delivery model in Barnsley with two organisations in partnership has appeared to embed end of life care across the local area and in practice, as colleagues work together. The care homes used SWYFPT as a resource for learning and development and advice before the project and greater numbers are now using this service.

e) Craven College – supported by two palliative care hospice nurses delivering a combined programme with managers attending for two days and champions for the first day only. Work-based assessments were based on the managers and champions completing a workbook for each unit. Managers and champions were observed and asked questions to test their knowledge and check competence. The training provider felt the use of the local authority commissioners to promote the sessions was helpful.

f) Grimsby Institute – initially delivered the programme to managers and champions separately with three days for managers and two days for champions. It was a very full three days for managers with speakers from the hospice and the funeral services, which Grimsby Institute felt worked very well. They reviewed this after six months as one of the difficulties was gaining the commitment from managers to attend a three day programme. As a result, managers and champions combined to attend two learning and development days. Work-based assessments were based on managers and champions completing a workbook for each unit. Managers and champions were observed and asked questions to test their knowledge and check competence.

Lessons learned

Feedback from training providers and stakeholders suggested that, in future, workers who want to undertake elements of units but not undertake formal assessment (to achieve a qualification) should also be encouraged and supported and this may increase the numbers attending learning and development. Encouraging workers to complete units to obtain a qualification is desirable but, except for mandatory requirements, it should be recognised that not all workers want, or are given the time, to follow this route.

No one model stands out as offering significantly greater benefits; however, engagement with hospices and integrated delivery of the programme would appear to be beneficial. Local variations in future will be dependant of the resources available and networks will need to take a lead in determining the most effective model of learning and development within their areas.

2.5.3. Summary of the effectiveness of the managers' and champions' learning and development

This section summarises the final findings of the evaluation of the manager and champion learning and development delivered between March 2012 and September 2013. The evaluation reviewed the overall usefulness and impact of the programme on the 511 care homes across Yorkshire and the Humber who took part. 516 managers and 489 champions attended and this analysis is based on responses from the 137 managers and 73 champions who completed both the pre- and post-programme surveys.

The full evaluation can be found in supplement 1. This report builds on the findings summarised in an interim report, published in September 2013 http://www.skillsforcare.org.uk/Document-library/Skills/End-of-life-care/Endoflifecareinterimreport-September2013.pdf

Overall rating of programme

Encouragingly, the vast majority of respondents rated the programme as either very or quite important in terms of helping them improve practice, knowledge and skills. In terms of which elements of the programme were most important, almost two-thirds of managers (63%) and over half of champions (57%) felt it was a combination of some or all of the elements. Respondents gave examples of how they had applied learning from the programme to improve practice in their care home. This was mainly felt in the areas of confidence in delivering end of life care; better understanding of how to support residents and raise this topic; dealing with families; improving paperwork and documentation; improving workers' skills in general; and better liaison with district nurses, GP and other healthcare workers.

Use of resources

The e-ELCA e-learning modules had been accessed by over a quarter of managers (29%) and almost a third (32%) of champions, leaving the majority of participants still to access this resource. The resource guide by comparison was more widely read, by almost six-in-ten champions (57%) and over three-quarters of managers (76%).

Workers' skills

Most champions in the sample were new to their "champion" role – just over six-in-ten (61%) stated they had no experience being an end of life care champion. Managers were asked about their workers' knowledge and skills in relation to end of life care; they generally rated their workers' skills higher after the learning and development, indicating change is happening in the right direction. However, it was also evident that the cascading of information was still continuing, with just over a quarter of managers having cascaded learning and development to 81–100% of their workers.

Policies and procedures

The programme had a positive impact on end of life care policy and strategy, with a higher proportion of managers responding that their care home had these in place when comparing pre- and post-programme results. The same was found for the end of life care register; the proportion of managers stating their care home had this in place increased as well.

Attitudinal impact on managers and champions

The survey included a list of knowledge and attitude statements concerning managers' and champions' views on end of life care. It was found that these changed in a positive direction for all the statements, which is an excellent finding and confirms the positive impact of the programme. The full list of statements and their ratings can be found in supplement 1.

Networks and participation

The majority of champions and managers agreed to some extent that a strong network of support had been built up across the areas. Just over half of managers (55%) and around a third of champions (35%) attended end of life care or other relevant networks.

Other learning and development, challenges and further steps

Almost three-quarters of champions (71%) had not accessed other relevant learning and development, whereas the response of managers was a bit more mixed, with some stating both they and some of their workers had. Where other learning and development had been attended, this was generally rated as important in terms of helping them improve practice, knowledge and skills around end of life care. While this applies only to a minority, the impact of the additional learning and development on the overall positive change seen in the report's findings should not be disregarded.

Respondents gave examples of challenges they had encountered in trying to improve their end of life care, which usually fell into the categories of dealing with family members and GPs, resistance by or shortage of workers, and updating paperwork. Many respondents also commented on not having encountered challenges up to this point. In terms of next steps, managers generally felt that continued networking and good communication of all parties, and continued learning and development and refresher courses were important in sustaining the programme in future.

Assessment of monitoring data

Statistics on the situation in care homes in the area were gathered, mostly relating to the previous 12 month period, in both stages 1 and 2. Important changes in the period to note were:

- the proportion of residents with advance care plans in place rose from 34% to 45%
- the proportion who died with a specified place of preference rose from 46% to 72%; this 26-point rise signifies an increase of 38%
- the proportion who died in their preferred place remained constant at 88%
- after their learning and development, a significantly higher proportion of managers stated they looked into why any resident died in a place other than their place of preference, compared with before (69% to 79%)

More detailed analysis of these figures by area is available, but should be viewed with caution because of lower sample sizes.

Additional comments

- "Gave me a greater understanding of residents' wishes and how far I can go in fulfilling them." (Manager)
- Made me more aware, improved my practice." (Champion)
- "I feel I can talk to more people regarding EoLC, more people are aware of what is involved." (Champion)
- "Have improved confidence and knowledge for use in the workplace." (Champion)
- "Up to date knowledge and standards, staff in general are very pleased that clients have a choice where they want to die, especially as often staff have cared for the clients for a long while." (Manager)
- "Has helped to raise the standard and quality of End of Life Care at [care home], and raised everyone's awareness." (Manager)
- "A strong reminder of the need for quality end of life care, excellent course." (Manager)
- "The study days and the resources given have helped to improve our planning and ability to discuss sensitive subjects. Has raised confidence and awareness and have been able to pass this on to colleagues." (Champion)
- "The manager and champion training was very good and the network has proved helpful. Will access the e-learning to help other members of staff to enhance their practice." (Manager)
- "I enjoyed meeting other managers and exploring other care homes way of working during EoLC. I felt this was beneficial to see at what stage our care was at in comparison." (Manager)
- "All elements were important. However the focus on management of EoLC has been a huge benefit to me and to my staff." (Manager)
- "Although I have been involved for 20 years I have a greater understanding of relevant issues." (Manager)

2.5.4. Managers' and champions' networks

Networks are currently in place to share best practice, learn from each other, provide support to care homes with specialist workers' input and look at other issues raised when caring for people at the end of life. Subjects such as dementia care and nutrition care are often the focus of small events or workshops. Key facts:

- 17 networks currently exist
- 158 managers and 91 champions who have undertaken the programme have represented their care home at a network forum
- 267 additional care homes attend the networks who have not had workers complete the programme

- overall, 425 care homes are engaged with the networks
- 162 community matrons, end of life care facilitators, discharge co-ordinators, performance and contract managers from the NHS and local authorities have been involved.

Networks contributing to this evaluation have highlighted the following areas that have proved useful for managers and champions, and others, to discuss:

- Issues with inappropriate hospital admissions shared with the discharge co-ordinator invited to attend the network.
- Lack of communication and relationship between care homes and GP practices or out of hours services, resulting in residents being admitted to hospital using the ambulance service instead of being cared for in homes.
- Concerns have been raised about communication difficulties between care home workers and ambulance crews.
- Information provided with the individual on admission to hospital from a care home being lost once the individual is transferred to a ward.
- Issues where individuals returning to a care home from hospital with a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) notice in place and it has not been discussed with the individual or their family.
- Sharing difficulties and how to support workers who find it difficult to talk to residents about their wishes at end of life.
- Difficulties in developing advance care plans when people are entering residential care at more advanced stages – raising the need to establish or develop advance care plans earlier, when the person is still being supported at home.
- Inviting specialist speakers and experts in using end of life care tools and resources
- Sharing good practices that managers and champions have implemented, and use of communication and audit tools.
- Opportunities for clinicians and EoLC facilitators to raise issues and ask questions of the care home managers.

Feedback indicates that these networks, and the support they offer, will be key for continuing development and providing leadership in end of life care service improvements. Some of the networks exist jointly with other local authority forums; and in Barnsley the network meeting is held following the Care Home Employer forum and generally has a good attendance. Both of these models could be a way of ensuring future engagement and sustainability. Networks will have to expand their remit to include learning and development for champions now that the development programme project has ended.

2.5.5. Resource guide - *Achieving success in end of life care: A guide to delivering quality standards across Yorkshire and Humber care homes* (2012)

The resource guide includes information on the EoLC strategy, quality markers, care quality commission standards, the six steps pathway as well as links to other end of life care resources. It was first published in March 2012, and 2000 hard copies of the guide were produced. It is still available to download on the Skills for Care website with access to the supporting documents. Memory sticks containing a copy of the guide and all the supporting documents are available.

Hard copies were provided to all managers and champions who attended the development programme. A copy was made available to all Care Quality Commission inspectors, NHS and local authority commissioners and contract compliance officers.

As part of the evaluation managers and champions were asked to complete a questionnaire on whether they found the guide useful. The questions included rating the various components, and if managers had made any changes within their care home, whether they were aware of changes in residents' experience, or workers' improved knowledge of end of life care from using the guide.

Outcomes

Feedback about the guide came from 23 managers, seven from care homes with nursing, 16 from care homes without nursing and a community clinical nurse specialist. The majority of people stated that they found the guide very or quite useful. Comments received from managers were all positive and included:

- "We have used the guide to check that we are on the right path."
- "Following using the guide we have looked into accessing bereavement training for our staff."
- "Helped to establish requirements and what we needed to do develop and maintain."
- "Helped me focus on how the different markers reflect in regards to other legislation—helped feel how they come together."
- "Structured information and guidelines, useful resource."
- "Excellent guide which is user friendly and facilitates the knowledge and awareness of EoLC and dying."
- "The guide is very useful to know what standards are expected and ways to meet them. Also the guide helps to explain things better surrounding end of life and has brought about awareness within our home."
- "Handy as a reference tool, in plain English. Able to be used by senior carers confidently."

Some managers have made changes resulting in benefits for residents and it has improved workers knowledge and awareness.

- "We are now more familiar with DNACPR, Advance Care Plans and "This is me' resources."
- "Have introduced end of life care with confidence, working in partnership with GPs to ensure good EoLC."
- "Able to communicate how the work we provide can be done in a way that meets the different standards."
- "Gather end of life information from residents on admission."
- "Look at the individuals differently."
- "Developed an audit for care of the dying and their relatives."
- "We have talked to residents about the fact that we have been involved in the training, and more discussions about end of life care are happening more naturally."
- "Yes it has been used in supervision sessions and staff meetings."

- "It has assisted some staff and strengthened their confidence in discussing end of life with residents and families."
- "Developed in depth care plans."
- "Established an end of life group within the care home."

The feedback from the managers, and the other health and social care professionals, has shown that the resource guide is considered a very useful, accessible and relevant document for care homes. Sharing the document as part of the development programme gave managers and champions the opportunity to use it within the sessions. Additional copies have been requested by the Care Quality Commission.

The guide will need to be regularly reviewed, especially when the changes to national policy and guidance change because of national reviews. Given the often poor quality IT access and equipment locally, care homes have requested that hard copies are also made more readily available.

2.5.6. Work with the Care Quality Commission (CQC)

Over the period of the project, five sessions were held with CQC inspectors. The first in September 2012 was to raise awareness of the care home development programme and discuss end of life care issues facing care homes. The four follow-up sessions during 2013 were to find out if inspectors were aware of improvements and changes within care homes.

Fifty people from four CQC teams attended the sessions in 2013 and feedback focussed on four areas:

1) Have there been any changes or improvements in end of life care, including how it is delivered and managed by the care home manager?

- There was a mixed view from the inspectors. Some inspectors said clearly no improvement, while others felt the managers who had attended the programme were more aware of what should be in place, such as learning and development for workers, advance care plans and recording residents' wishes.
- Good practice was very dependent on the care home owner, manager, workers and environment.
- Some improvement was noted in Bradford, Harrogate, York and North Yorkshire.
- Inspectors in North Yorkshire did raise concerns that they felt people were being admitted to hospital unnecessarily by care homes and out of hours GPs.

2) Has there been any increase in the number of advance care plans, end of life care pathways or keyworkers?

- Some inspectors felt that there were more advance care plans in place in the care homes, with wishes being recorded, e.g. regarding music and family. Other inspectors felt that plans were held in residents files but not fully completed.
- In Barnsley, more keyworker roles were noted and improved relationships between care homes and GPs.

3) At the first session some inspectors raised issues with there being too many DNACPR forms, Is this still an issue?

- This varied across the area; in some care homes all residents have a DNACPR form, while others have few residents with one.
- Improved levels of detail in the completion of DNACPR forms were noted. GPs were notifying residents, with clear documentation in the file.
- Clarification was sought by one inspector about who should sign the form, as a care home manager had completed one and signed it. Confirmation was given that it was a clinical decision and should be completed and signed by a doctor or appropriately trained health professional.

4) Have you observed any improvements in bereavement services offered to family or friends or other residents?

- Some improvements—not all inspectors would ask if they have bereavement services in place, or if the home has followed up with family members regarding the quality of service that had been provided by the care home.
- Some homes do have 'Dying Matters' leaflets in place about bereavement services.

CQC uses the number of deaths in care homes as part of their inspection regime and, where high numbers are reported, investigating inspectors have found evidence of expected deaths.

CQC inspectors were supportive of the work undertaken by Skills for Care but it was still early days to expect significant changes, although inspections indicate that the confidence of care home managers in delivering quality end of life care was growing. A relationship has been established with Skills for Care, and CQC will continue to work with Skills for Care regarding future support needs of care homes who are not compliant with CQC inspection outcomes.

2.5.7. Work with commissioners and contract compliance officers

The initial sessions with commissioners and contract compliance officers took place during September 2012, and it was agreed that further events should take place in 2013 to follow up on progress.

The aim of the sessions was to engage with those who were responsible for commissioning and monitoring services across health and social care to raise awareness of end of life care issues in care homes. Views from stakeholders closely involved with the programme have indicated that these sessions should have taken place at the start of the project and not mid-point. Commissioners supporting the project from the start might have improved engagement and commitment from other health and social care organisations, as well as improving the number of managers and champions involved in the programme.

Four sessions were held across the YH area with attendance from the majority of the local authorities and NHS commissioners. All completed an action plan for their area to be reviewed at local meetings and at the events held in 2013. Local areas differed in how they commissioned, contracted and monitored end of life care.

Sharing of learning and practices appeared to support the areas who felt they needed to develop and improve their practices. Two local authorities requested additional support to

be given to other colleagues in the LA on what is a 'good death'. This was actioned with the same offer made to all LAs if required.

Follow-up events in May, June and July 2013

Commissioners and contract compliance officers were invited to a series of events with the managers and champions who had completed the development programme. The South Yorkshire event was a full-day session held in partnership with Barnsley Metropolitan Borough Council, the other three events were half-day sessions hosted by Skills for Care. A good mix of health and social care professionals attended all the events. All 15 local authorities attended with some representation from the CCGs. There was limited attendance from GPs, which reflects the difficulties of engaging with GPs generally throughout the project.

At each event, care homes were able to share their experiences of delivering end of life care with other health and social care professionals, highlighting examples of joint working and evolving good practice. Commissioners and contracts officers gave updates on progress with the action plan, prompting some local authorities to review their framework or end of life care procedures.

All were asked to complete a survey giving them the opportunity to express their views on the project, the speakers and overall usefulness of the event. The majority of the respondents stated that they were either very satisfied or satisfied with the event.

The sessions that had a high rating were:

- listening to a care worker talk about her experience of caring for someone at end of life
- the presentation from Yorkshire Ambulance Service
- listening to care home managers talk about their experience (Millfields in Wakefield and Elmwood in Leeds).

The majority mentioned it was a good opportunity to network with others and take ideas back into their workplace to improve their end of life care practices. These included reviewing documentation, the importance of care planning, attending local networks and looking at learning and development for all workers.

Progress has been made by local authorities in how they contract and monitor the care homes. Some local authorities have started to include end of life care in their quality frameworks and in the contracting arrangements. Local authorities have also included end of life care as part of their workforce strategies offering the levels 2, 3 and 5 end of life care units (SfC 2013b, Ofqual 2013) to care homes and other care providers. Two local authorities have contracted the end of life care learning and development out to the local hospices.

2.5.8. Extending e-learning (e-ELCA)

Mechanisms exist for care home workers to access the end of life care e-learning suite of sessions (e-ELCA) through a token on NMDS-SC. A resource guide exists to help people get started.[4] Information on e-ELCA can be found at www.e-lfh.org.uk.

The e-ELCA sessions have now been mapped to the Qualifications and Credit Framework end of life care modules and units, and should now provide further opportunities to disseminate learning from the programme as well as being included in future course content and delivery. A full list of e-ELCA sessions and their learning outcomes can be found within supplement 5.

In January 2014 figures on NMDS-SC showed that only 70 care homes and 114 care home workers across YH had registered and accessed e-ELCA. Poor uptake of e-ELCA hampers the cascade to all care home workers even if it is recognised as a valuable resource, but in most care homes it will only be accessible if physical resources are made available and protected time for learning is agreed.

2.5.9. Views from stakeholders

Stakeholder feedback was gathered using a two-stage process which consisted of a preliminary qualitative stage (depth interviews by telephone) with members of the programme board and steering group, followed by an online survey to the wider stakeholder audience. The approach was iterative, and survey questions were based on responses given in the qualitative consultations.

The sample comprised 11 consultations in the qualitative stage, and 47 responses in response to the online survey, representing a response rate of 42%. This is a robust sample for analysis. The full report on the stakeholder consultation can be found within supplement 2.

Members of the programme board and steering group were asked to identify three factors for success if other areas of the country wanted to take the development programme forward. The three most common responses were:

- Bring together cross-sector stakeholders at the start of the process to achieve 'buy in' from health and social care at senior levels and have resources committed and available. Commissioner and CQC support is key as they have 'teeth' to drive change through contracts and regulation. Win hearts and minds!
- Have a knowledgeable cross-sector stakeholder group leading the project who are not afraid to take a risk and have the experience to know what works and what has not worked before.
- Spend time at the beginning doing the groundwork and understand your population and care homes; prepare a comprehensive needs assessment and recognise that one model may not fit all across a locality. Set the baseline using standardised reliable data and undertake analysis throughout the project, and do not be afraid to make changes based on the analysis. Engage with other services to collect data

[4] Using the NMDS-SC Online www.nmds-sc-online.org.uk click on the 'create an account' button. A token is a code number to input on NMDS-SC that allows access to material on the e-ELCA site.

such as that held by ambulance services on call outs and see ambulance services as key players.

Some members of the programme board did express concern that although having 511 care homes engaged with the project was encouraging, this did only represent around two thirds of the 800 care homes targeted through £1.3m funding made available. It was therefore difficult to quantify the true unit cost to build an evidence base for future investment. Due to a lack of baseline data on the number of individuals from care homes admitted to hospital and who subsequently die, it was not possible to undertake a return on investment analysis, which was disappointing.

The wider stakeholder group were also asked their views on lessons learned and over three-quarters agreed that more work to scope out the project should have been undertaken at the beginning, and seven out of ten agreed that care homes should have been informed earlier in the process. A similar proportion agreed that, at the beginning, lack of current local knowledge and the wider relationships was a weakness. Further lessons learned raised by the stakeholders varied considerably, with the only common theme emerging being around flexibility in the programme, in terms of who could attend the sessions and qualifications. Of those who responded to the online survey, 100% supported the statement '*Ongoing and recognised education and training in end of life care must be embedded in normal practice of care home staff'.*

While acknowledging that information on costs and return on investment is not robust, the evaluation highlights clear service improvements, raised awareness, improved integrated working and improved levels of confidence in care home workers. Combined with establishing networks and a commitment from commissioners to support the development, significant added value to the quality of end of life care across Yorkshire and the Humber has been achieved and successes outweigh weaknesses. This has provided a good foundation on which to build.

3. Recommendations

The recommendations have been drawn from the evaluation of the individual workstreams and views of the stakeholder groups engaged with the project. They are aimed at local authorities and clinical commissioning groups to support further development of end of life care commissioning plans. These recommendations should support driving up quality in the delivery of end of life care, improve integrated working and contribute to a potential reduction in inappropriate admissions to hospitals from care homes.

End of life care networks and engagement of health and social care

- End of life care networks must be recognised by, and communicate with, local authorities (LAs), clinical commissioning groups (CCGs), strategic clinical networks and continue actively to support care homes.
- The networks should bring together all key stakeholders to provide strong leadership for end of life care, share good practice and work through challenging issues. They need to agree actions that fall within the remit of their member organisations to achieve service improvements in end of life care.
- Membership should be extended to community care providers (domiciliary care providers and personal assistants), health care professionals, hospices and community settings as well as commissioners, if not already involved.
- Current issues should be expanded to include hospital admissions and discharges, nutrition, dementia and medication, a continuance of localised end of life care training and developing new champions.

Learning and development in care homes and domiciliary and community settings

- All social care workers, including healthcare assistants, social workers and assessors should be required to attend learning and development based on the level 2 unit Understand how to work in End of Life Care (EOL 201), and this should be included as a requirement within local workforce strategies.
- Care home managers to achieve a level 5 unit Lead and Manage End of Life Care Services (EOL 501).
- Workers who want to undertake elements of units but not undertake formalised assessment (to achieve a qualification) should also be supported. Encouraging workers to complete units to obtain a qualification is desirable but, except for mandatory requirements, it should be recognised that not all workers want, or are given the time, to follow this route.
- Integrated learning and development provision should be encouraged by engaging a cross-section of health and social care organisations, and established training providers, in design and delivery.
- Hospices and community palliative care teams should be supported to enable them to continue to make a significant contribution to learning and development by delivering content and act as expert assessors.
- e-ELCA (the end of life e-learning programme) should be actively promoted and integrated into traditional training and work-based learning. It is a valuable resource but physical resources need to be available in care homes and protected time to learn agreed.
- Skills for Care must review the resource guide annually to keep it updated, and consider making hard copies available.

- A development programme for workers in community settings, based on the care homes programme, should be developed.

Contract compliance

- Contract arrangements and quality frameworks should include end of life care, with a standard requirement for each person in receipt of care to be given the opportunity of recording their wishes and preferences through an advance care plan.
- Monitoring arrangements by all NHS and local authorities ought to include end of life care as a priority.
- Improved accuracy in recording individuals admitted to NHS services from care homes is needed to ensure that monitoring of services can justify funding against improved outcomes.
- Contracts with end of life care providers should include a requirement that all workers are trained in end of life care as detailed in 1.6.2 above.

Regulation

- The Care Quality Commission (CQC) to include end of life care as part of their inspection regime, and for CQC to ensure inspectors are trained to inspect end of life care provision in all settings.
- Skills for Care is recognised as being well placed to provide assistance for care homes who are identified by the CQC's end of life care inspection procedure as not meeting outcome 4 of its Essential Standards of Quality and Safety (CQC 2010).

Integration of health and social care

- Local authorities and CCGs should make greater use of integrated services and learning and development in line with national policy. Networks have a key role in ensuring integration of end of life care services through their diverse membership.
- Increasing opportunities to combine learning and development of community-based workers in health and social care would enable a greater understanding of each other's roles and contribution in delivering quality end of life care services.
- More discussion is needed with Health Education Yorkshire and the Humber, and commissioners, to make learning and development opportunities and funding available for registered nurses in care homes and community settings.
- More needs to be done to raise awareness and improve recognition by GPs, community matrons, district nurses, ambulance workers and out of hours (OOH) services that workers in residential care homes, with appropriate learning and development , can deliver good quality end of life care including clinical care currently provided by health care assistants (HCAs). This should contribute to reducing inappropriate hospital admissions, provide continuity of care for individuals, and improve use of resources.

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NICE 2011	*End of life care for adults QS13* (2011, Nat.Inst.for Health & Care Excellence) www.nice.org.uk/QS13
Ofqual 2013	*The Register of Regulated Qualifications*, online resource (201) Understand how to work in end of life care http://register.ofqual.gov.uk/Unit/Details/A_503_8085 and (501) Support individuals at the end of life http://register.ofqual.gov.uk/Unit/Details/T_601_9495 and (3048) Lead and manage end of life care services http://register.ofqual.gov.uk/Unit/Details/T_503_8134
PHE NEoLCIN 2013	*What we know now 2013 New information collated by the Public Health England National End of Life Care Intelligence Network http://www.endoflifecare-intelligence.org.uk/home*
SfC 2013a	*National end of life care qualifications in social care A guide for employers and learners* (2013, Skills for Care) Download from http://www.skillsforcare.org.uk/developing_skills/endoflifecare/endoflifecare.aspx
SfC 2013b	Skills for Care. Units and qualifications in end of life care. Accessed via Skills for Care's online skill selector at http://skillselector.skillsforcare.org.uk/search-results.aspx?q=end%20of%20life%20care
SfC NMDS-SC 2013	Yorkshire and the Humber Local Education and Training Board Report 2013 – From the National Minimum Dataset for Social Care (NMDS-SC)
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Additional information

Skills for Care end of life care units and qualifications: http://skillselector.skillsforcare.org.uk/search-results.aspx?q=end%20of%20life%20care

National Council for Palliative Care, *Dying Matters* website: http://dyingmatters.org/

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