Shaping the Future

Workforce

End of Life Care Area Workforce Report
1. Introduction

End of Life Care (EoLC) is “care for those approaching the end of life, their family and carers, from identifying people who are approaching the end of life right through to care for the bereaved”\(^1\).

In July 2008 the Department of Health launched the first comprehensive strategy for End of Life Care in England. The aim of the strategy is to provide equal access to high quality End of Life Care for all patients who require such treatment.

The workforce delivering End of Life Care falls into three major categories (or tiers):

- **Group A – Specialists**: staff who primarily spend their time delivering End of Life Care, for example Specialist Palliative Care (SPC) consultants and SPC nurses. This workforce requires considerable growth and further development in the knowledge and skills required in caring for people at the end of their lives.
- **Group B - Practitioners**: staff groups who frequently provide aspects of End of Life Care such as practitioners that work in health and social care (e.g. care home staff).
- **Group C - Wider workforce**: staff who are infrequently involved with delivering End of Life Care such as dermatologists.

2. Demand drivers

There are a number of drivers which have impacted on End of Life Care workforce demand, including:

2.1 Need to develop a new model of care

Traditional models of EoLC centre on SPC. Access to SPC is still largely by people with cancer and there is inequitable access for people with other diagnoses. Over the last few years there has been an increasing recognition of the EoLC needs of people with diagnoses other than cancer and a need to develop new models of care heralded most recently by the publication of the EoLC Strategy.

2.2 Numbers of deaths per annum

There are 33,000 deaths per year in South Central a year. 60% of these deaths occur in acute hospitals with an average of 18 days spent in acute hospitals in last year of life. Around £90 million is spent per year on End of Life Care in South Central, much of it reactive and not planned spending.

After 2015 the death rate is projected to rise steeply with an increase of 17% by 2030. Of these, 40% will be in those aged over 85. Using existing models of care, 20% more institutional beds would be required.

---

2.3 Policy
The need to provide patients with greater dignity and respect, and ensure round the clock access to palliative services is available in line with High Quality Care For All - NHS Next Stage Review Final Report².

There is also a commitment in the End of Life Care Strategy³ and in the Next Stage Review, to
- raise awareness of, and change attitudes towards, death and dying.
- deliver an integrated service based around a care pathway.
- develop the infrastructure, including workforce, to achieve these outcomes.

The Transforming Community Services work also focuses on EoLC and the 70% of people who would choose to die at home. New models of care will focus on enhancing community services to meet this choice whilst ensuring acute care remains sensitive to the needs of those at the End of Life. The importance of this has been reflected in the National Audit Office review which showed that 40 per cent of patients who died in hospital did not have medical needs which required them to be in an acute setting, and could have been cared for elsewhere.

2.4 South Central End of Life Care Clinical Improvement Programme
The South Central Clinical Improvement Programmes are currently in development by the Board of Commissioners, building on the work of the clinical pathway groups.

The SHA’s vision is to improve choice and quality of EoLC in South Central, as well as bringing cost savings for the health economy. The EoLC pathway is intimately related to the work of Long Term Conditions and Acute Care in particular. It is hoped that service evolution for EoLC will not be isolated but will fit coherently and potentially synergise the evolution of services for Long Term Conditions and Acute Care.

Priorities within the programme include:
- Promoting active membership by stakeholders of Primary Care Trusts' EoLC groups. The groups should include representation from the acute sector, social care and particularly care homes. The ratio of deaths to places in care homes with nursing in South Central is around 13% below that for England as a whole. If this ratio could be brought up to the England average then it is probable that around 450 deaths would be transferred from hospital to care home. This change will require ongoing support, training and access to expert advice.
- Ensuring that EoLC is considered as part of planning for other clinical pathways and when implementing policies such as the National Dementia Strategy, the Carers Strategy, at a local level.
- Maximising workforce training and education. To ascertain, at PCT level, the training that is already in place as well as any gaps that exist, will help formulate proposals for using the SHA training monies. Setting up sustainable systems such as a community of practice is likely to be beneficial.

• Improved identification of people nearing the end of life. PCT EoLC groups should consider how this can best be achieved across sectors and settings of care.

3. Workforce supply

It is difficult to quantify the contribution made specifically to the End of Life Care area by the wider End of Life Care workforce. However, a key workforce within EoLC is the Specialist Palliative Care (SPC) workforce, including SPC consultants and SPC nurses. They in particular have the knowledge and skills to be able to help with the development, support and expert advice resource for the general EoLC workforce.

3.1 Specialist palliative care nurses

According to data collections carried out in 2005, 2007, 2008 by the National Council for Palliative Care, the NHS Workforce Review Team and the Information Centre for Health and Social Care (across all staff groups in both the statutory and voluntary sector), approximately 75% of the SPC nursing workforce are within the voluntary sector. A small proportion of medical and AHP staff are funded by the voluntary sector.

Nationally, there was an overall increase in the number of nurses within SPC between 2005 and 2008, as shown in Table 1, below.

<table>
<thead>
<tr>
<th>Year of data collection</th>
<th>Specialist palliative care nurses FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>5103</td>
</tr>
<tr>
<td>2007</td>
<td>5233</td>
</tr>
<tr>
<td>2008</td>
<td>6155</td>
</tr>
</tbody>
</table>

Table 1: FTE of SPC nurses in England from 2005-2008

To meet the planned change in the roles of SPC staff, i.e. moving away from direct care to being an expert resource and trainer, more staff at higher grades may be required. There has been a large increase in band 5 nurses (1553 in 2007 to 2037.4 in 2008, although this may be because of more accurate reporting). However, the vacancy rate has increased in higher grades between 2007 and 2008 with 21% of vacancies reported amongst band 8 posts. This may also be related to more posts being advertised at this grade to meet the changing demand.

34% of SPC nurses in England are recorded as being over 50, highlighting the risk of a potential retirement bulge in the next ten years. It should be noted, however, that SPC staff tend to retire later and often begin working in this setting later in their career.

Based on ‘Cast’ modelling, the Workforce Demand and Supply Modelling 2009-2010 document produced by South Central SHA to inform the non–medical education commissioning plan does not currently identify supply and demand imbalance concerns in this area of the workforce.

3.2 Specialist palliative care consultants

An overall increase in the number of SPC consultants in England was observed between 2005 and 2008, as shown in Table 2, below. There has been an increase in training numbers

---

4 Sources: NCPC, WRT, IC
and palliative medicine consultants have now been taken off the National Shortage Occupation list, overseen by the Migration Advisory Committee.

<table>
<thead>
<tr>
<th>Year of data collection</th>
<th>Specialist palliative care consultants in England, FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>234</td>
</tr>
<tr>
<td>2007</td>
<td>207</td>
</tr>
<tr>
<td>2008</td>
<td>268</td>
</tr>
</tbody>
</table>

Table 2: FTE of SPC consultants from 2005-2008

According to the Information Centre census 2008, the following numbers of palliative care medical staff were employed in South Central SHA in September 2008 (Table 3):

<table>
<thead>
<tr>
<th>Role</th>
<th>Headcount</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Specialty doctor</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Associate specialist</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Staff grade</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Registrar group</td>
<td>18</td>
<td>17</td>
</tr>
<tr>
<td>Senior house officer</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Foundation year 2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>House officer and foundation year 1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospital Practitioner/ Clinical Assistant</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Other staff</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3: Palliative medicine staff in South Central in September 2008

4. Workforce priorities and recommendations

The following list highlights priority areas in which the workforce must be developed in South Central to achieve improved outcomes:

4.1 Group A - Specialists

The role of SPC is changing in line with both the national and local PCT EoLC strategies to more of an expert advisory and education resource, SPC needs to be supported in this.

SPC providers will want to review their service and workforce plans in light of the EoLC agenda and the need to meet the 24/7 expert advice and support required as part of the NICE Supportive and Palliative Care Guidance. This may involve the need for more higher grade staff.

If this is the case SPC providers will want to discuss the need for further workforce development with their PCT/Local Authority EoLC group.

Given this changing role SPC will need to be commissioned for providing this education, training, support and expert advice role.

5 Sources: NCPC, WRT, IC
6 Source: IC census, 2008
4.2 Group B - Practitioners
This group across all levels of staff and professions will be the main focus of EoLC training and education. It is vital that this occurs across health and social care, joining up the training will provide the greatest collective benefit.

PCT/LA EoLC groups will want to consider their population needs and therefore the areas of greatest need in terms of workforce development. Given the large numbers a model of cascade training will be required by using for example train the trainer or link nurse systems. Formal education is a small part of this the emphasis will need to be on practice based learning which has been shown to be effective.

Much EoLC is carried out by unregistered health and social care workers. Increasing their skills, harnessing resources to help with this such as e-learning, competences, communities of practice, support networks and communication skills work will be essential. Examples of good practice are available for example see Building on Firm Foundations7.

EoLC tools are useful and all areas should be using the Liverpool Care Pathway or equivalent. But it should be remembered these are only tools and not the answer in themselves so tools should only be introduced with a training and education package and access to expert advice and support as necessary.

It is good practice to carry out a post death review to debrief, learn from the experience and provide support for staff. There is no set format but it should include all of the staff affected including catering, cleaning, porters etc. For examples of formats see Care to Learn8 which has a post death review template or After Death Analysis tool9. Staff support mechanisms should be in place in all settings.

4.3 Group C - Wider Workforce
EoLC will be included in pre-registration training but for this group of staff who care infrequently for those at the End of Life it will be important that they are aware of the EoLC tools available to help them when necessary. They will also need to know how to access expert advice and support as required. Given the work on public awareness of EoLC, public health and health social marketing staff will need to have an understanding of EoLC.

4.4 Quality
Planning and evaluation should be informed by EoLC quality markers and the experiences of EoLC service users and their families/carers.

5. Workforce Strategy Alignment

The table below identifies the links between the themes and vision set out in the NHS South Central Shaping the Future Workforce Strategy 2010 to 2015 and the Staying Healthy workforce priorities.

---

8 The National Council for Palliative Care (200x) Care to Learn, online: www.ncpc.org.uk/training
9 NHS (2009) After Death Analysis tool, available online: http://www.goldstandardsframework.nhs.uk/GSFCareHomes/ADA.htm
<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Vision</th>
<th>Alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Share the journey: engage patients, carers and staff</td>
<td>Patients, carers, staff and the general public all need to be engaged and play their part in ensuring the NHS continues to provide excellent health care within a sustainable framework.</td>
<td>4.2 Group B - Practitioners 4.4 Quality</td>
</tr>
<tr>
<td>2. Plan and Prepare: Manage the Change</td>
<td>To respond to the challenge and scale of both the forecast increase in demand for health care services, and the reduction in spending on public services we must actively plan the workforce and prepare intelligently to manage the change.</td>
<td>4.1 Group A - Specialists</td>
</tr>
<tr>
<td>3. Integrate and align: design a joint future</td>
<td>To maximise the effectiveness of our workforce planning we need to integrate and align our actions, taking a system wide perspective on the future workforce requirements to deliver the emerging service models.</td>
<td>4.1 Group A – Specialists 4.2 Group B - Practitioners</td>
</tr>
<tr>
<td>4. Tighten up business: drive up quality and value</td>
<td>To drive up quality and value, and reduce waste and variation in the way we deploy the workforce in NHS South Central, we need to implement excellent human resource management across all health sector employers.</td>
<td>4.2 Group B - Practitioners</td>
</tr>
<tr>
<td>5. Step up flexibility: develop the workforce</td>
<td>To develop a more flexible workforce that can assimilate new skills rapidly and work in new and innovative ways, by targeting skills development and developing new employment models.</td>
<td>4.1 Group A – Specialists 4.2 Group B - Practitioners 4.3 Group C – Wider workforce</td>
</tr>
<tr>
<td>6. Be accountable: focus leadership</td>
<td>To enable the service changes that need to be delivered we need a culture of accountability at all levels, and leadership that is focussed on delivering the best health care system in the world.</td>
<td>4.1 Group A – Specialists 4.4 Quality</td>
</tr>
</tbody>
</table>
6. Next Steps

The content of the 'Next Steps' section is to be confirmed.