

June 2010

MACMILLAN END OF LIFE CARE NEWSLETTER

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End of Life Care

Newsletter

A new primary care collaboration

Welcome to this special newsletter to coincide with the Macmillan Primary Care Conference, and focusing specifically on end of life care within primary care.

The publication is the result of a collaboration between Macmillan Cancer Support and the National End of Life Care Programme – which itself emerged from widespread enthusiasm at last year's conference for closer working between the two organisations.

As a result the first afternoon of this year's conference will be devoted to the latest developments in end of life care. These include an update on the End of Life Care Strategy, Royal Marsden's innovative Hospital2Home scheme, locality register pilots and the ambitious e-learning for end of life care project.

Overall the annual Macmillan Primary Care Conference provides the opportunity for members of the community to network, share innovations and learn about cancer in primary care across the UK. The event is hosted by the Macmillan GP Advisers Team, and is open to Macmillan GPs and primary care cancer leads, other primary care colleagues and Macmillan Cancer Voices together with Macmillan service teams.

Within this newsletter we aim to share the latest news from the conference, to showcase the work in practice and provide information

about a range of useful programme resources.

The issue contains, for example, details of a new pocket guide on what to do in the immediate aftermath of a patient's death, how busy GPs in the North of England are managing to combine palliative care training with their workload and why the Dying Matters coalition is targeting the next phase of its campaign specifically at GPs.

What is the EoLC Programme?

The National End of Life Care Programme works with health and social care services across all sectors in England to improve end of life care for adults by implementing the Department of Health's End of Life Care Strategy.

The Programme aims to support all people to have access to high quality end of life care services regardless of diagnosis and recognises that the principles and practice will be applicable to all patients with end of life care needs.

During the course of the conference we will be:

- Seeking to spread the word about e-learning for end of life care training modules
- Reporting on progress with the eight end of life care locality register test sites, which will be testing out different approaches over the next year
- Discussing the framework for social care at the end of life
- Updating knowledge about the latest programme support tools for implementation

What is Macmillan Cancer Support?

Macmillan has had a strong programme of work in primary care since the development of the Macmillan GP role in 1994.

The key focus of the role has been to produce recognisable improvements in the quality of cancer and palliative care provided by primary health care teams within the local health economy and in line with both national and Macmillan priorities. The Macmillan GPs also influence national activity in primary care.

Our overall aim is to:

- Influence and raise the profile of cancer and palliative care in primary care
- Develop cancer services in primary care and improve equitable access for people living with cancer in the community
- Raise standards of cancer care and palliative care services in primary care
- Improve awareness and early diagnosis of cancer by influencing both GPs and the general public about signs and symptoms of cancer.



Anita Hayes
Deputy Director,
NEoLCP

Rosie Loftus
Macmillan
GP adviser



Why talk about it?

Talking about death doesn't bring death closer. It's about planning for life.

Dying Matters targets GPs as key influencers

The national Dying Matters Coalition is working with the support of the Macmillan GP community to enlist the support of GPs in helping to raise public awareness about issues surrounding death and dying.

The decision follows research showing that GPs are trusted by a significant proportion of the public who wish to discuss future plans about dying and death. At the same time a recent survey shows that many GPs require more support in initiating discussions with their patients about effectively planning for their death.

The key aims of the new initiative are to raise the profile of the coalition among GPs and their staff and patients, support doctors in their consultations with patients and pilot communication materials that will help GPs discuss these issues with patients.

The first phase is a pilot involving 20 practices with a high level interest in palliative care. If this is successful it will be followed by a 'targeted opt-in' focused on GPs who have shown a willingness to engage with the Dying Matters campaign. The initiative would then be promoted nationally.

The next stage of the coalition's work will also involve targeting people aged between 55 and 75 following a UK-wide survey that showed that only 29% of the public talk about their wishes surrounding death and dying. The main reason given is that death seems a long way off. But as people get older they are more likely to say that other people don't want to talk about their death.

- The Dying Matters Coalition was set up by the NCPC and now has over 7,000 members. For more information see www.dyingmatters.org

Advance care planning – new guide

A basic patient guide on advance care planning is available from the National End of Life Care Programme.

Planning For your Future Care: A Guide explains in simple language the wide range of issues which can be covered through advance care planning as well as giving advice on how to develop written plans and decisions.

The guide spells out how people can talk with relatives, friends or their nurse or doctor to ensure their wishes are respected when they are no longer able to speak for themselves and the services and support they want are in place at the end of their life.

If as part of advance care planning people choose to make an advance decision to refuse treatment, the guide recommends they seek the advice of an experienced healthcare professional. It also explains that such decisions must be put in writing and signed.

The National End of Life Care Programme guide was produced with Nottingham University and the NCPC and is available from www.endoflifecareforadults.nhs.uk/eolc



Talking about death and dying

More than 50 nurses and GPs from the Medway area attended a highly successful session in March aimed at tackling some of the difficult practical issues around death and dying.

The hour long event, entitled 'How do we talk about death and dying?', was held in a Thai restaurant in Rochester. It included presentations on DNACPR decisions as well as handover for out of hours services and when to break bad news and how to talk about it.

Participants were enthusiastic about the event with everyone agreeing it had been useful and relevant. A number of the evaluation comments referred to the importance of 'being upfront about the inevitable' and ensuring that nursing and residential homes were fully aware of the issues.

'I went away feeling we need to hold more of these meetings,' said organiser and Macmillan GP Facilitator TA Bui. 'None of us are really brought up to talk about death and dying. Doctors and nurses want to make people better and perhaps we were not really trained much on death and dying. But maybe we should focus more on the importance of planning for a "good death".'

Another doctor confessed he just didn't know where to start when it came to talking about dying. 'Some people are just not sure how to tackle this. It seems so basic but actually it takes a lot of skills and confidence to do it,' said Dr Bui.

Another problem was time. 'We are all so busy with our work and sometimes you think where do I start? How do I say that without upsetting the patient and their family?'

Dr Bui was planning a further session for GPs and nurses on death and dying issues in May, probably in smaller groups to facilitate open discussion, and expects to run further events at a later date. More details from tashum@blueyonder.co.uk

Booklet spells out what to do after death

A new pocket guide for health professionals on what to do in the immediate aftermath of a patient's death has already had a positive reaction from local GPs in Lambeth and Southwark.

What to do after death guidance, produced by the Modernisation Initiative End of Life Care Programme and NHS Lambeth and Southwark, highlights the tasks that doctors and nurses are expected to carry out if they are present immediately after a patient dies in the community.

It covers, among other things, the certificate of cause of death, when to inform the coroner, when to contact a funeral director as well as disposing of medication and equipment. It also addresses more unusual issues such as an organ donation request or dealing with a patient who has HIV or an implanted cardioverter defibrillator.

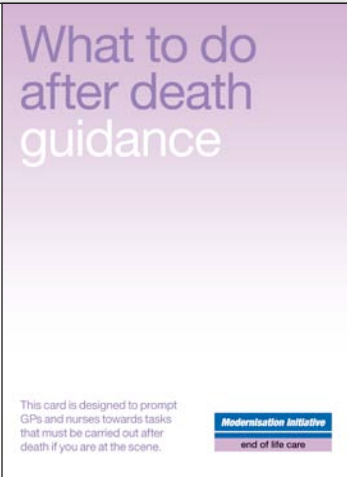
Dr Cathy Burton, Macmillan GP adviser and clinical cham-

panion with the Modernisation Initiative, said the booklet was the result of feedback from last year's LCP pilots indicating that a number of GPs and nurses felt ill-prepared to deal with some of the issues following a death.

The booklet involved input from a range of experts, including Dr Burton. It was published in March and has been distributed to all GPs, OOH services and community nursing teams in the area.

Dr Burton said feedback from GPs had been enthusiastic – even before the official launch. 'When we showed a group of GPs a dummy copy earlier in the year they were extremely keen to get their hands on it!'

Together with colleagues she has also produced a leaflet for patients about the Gold Standard Service for those with life-limiting conditions. The two-page leaflet was circulated



to all Lambeth GSF practices in February and will be evaluated before wider dissemination.

For details and copies of What to do after death guidance see www.gsttcharity.org.uk/projects/eolc.html or email mlendoflife-care@gstt.nhs.uk



Health Department's community guide lists high impact changes

A new guide to end of life care in the community offers a range of highly practical ways in which professionals can make a tangible difference.

The Department of Health's Transforming Community Services guide lists a number of high impact changes that experts agree have the greatest potential to improve care and boost quality. It also identifies the key skills needed by staff and contains an action plan.

The guide has four central ambitions: getting the basics right; making everywhere as good as the best; delivering evidence-based practice and supporting people to lead high quality community services.

The high impact changes include identifying patients approaching the end of life at an early stage; providing all patients with a care plan and a key worker or case manager and ensuring care is available 24 hours a day.

The guide also includes a range of

activities that have been proved to be effective as well as a number of case studies of good practice. In addition it highlights the different skills and characteristics that practitioners need and provides a checklist to help them put the guide into action. One suggestion is that the organisation does an audit of how well it measures against basic requirements and the high impact changes to identify priorities for improvement.

The guide is aligned to the national end of life care quality markers for good practice.

Seventeen primary care trusts and community organisations

are currently piloting new approaches to end of life care as part of the Department of Health's TCS Innovation Awards.

Torbay Care Trust, for instance, is developing a training programme for care homes while Portsmouth City PCT plans an expert carers programme targeting young carers who do not have access to local services. West Kent PCT is testing out a self-referral scheme for supported discharge.

Transforming Community Services: Ambition, Action, Achievement. Guide for Transforming Services for end of life care is available at www.dh.gov.uk/tcs



Palliative care course appeals to busy GPs

Around 400 GPs from the North of England Cancer Network area have benefited over the past 10 years from a unique palliative care course that enables doctors to combine learning with their busy clinical workload.

The distance learning course, Practical Palliative Care for General Practitioners, is run by Teesside University and involves participants in 2-3 hours work a week over nine months. It eventually leads to a diploma and GPs can earn about 30 CPD credits.

The main elements of the course are a series of topic-based assignments on issues such as pain, nausea and vomiting and non-malignant diseases, followed by a week-long attachment to a local hospice and finally a 4,000-word case study based on the care of an individual patient.

All students are also trained in syringe driver techniques and are assigned an individual mentor to provide help, support and advice.

One of those mentors, Dr Kavi Sharma, Macmillan GP Advisor for Northern England, says evaluation shows that GPs are more confident in palliative care as a result of attending the course and more likely to employ the right resources.

He also feels that working as a mentor has taught him a lot. 'I have learnt from the students but also from my fellow mentors. It just gives you the opportunity to be more critical of the work you do.'

Although the course was set up specifically for Teesside GPs it now includes all GPs within the Cancer Network and has also been franchised to other parts of the country such as Hull, Cumbria and Leicestershire. In addition some GPs from remote areas such as the Scottish Isles have been able to take advantage of the course.

For more information contact: Course Director John McPhee, email: jmcphee@hartlepool-hospice.co.uk

New palliative care template for doctors

A new palliative care review template which helps GPs focus on the key elements of end of life care is now available to all practices in Camden and Islington.

The standardised data entry template is the brainchild of Patrick McDaid, GP Principal and Macmillan Palliative Care GP Facilitator for Camden and Islington. Audits of practices had revealed a big demand for suitable templates in end of life care and Patrick's template builds on the one previously developed by Macmillan Cancer support's GP community. The new template for EMIS LV and PCS clinical systems was launched last year and is more closely tailored to end of life care than previous templates. It combines the Macmillan palliative care template and the GSF SCR1 (register record and prompt sheet). All codes used are national Read Codes and anomalies have been addressed. For instance, it replaces GP out of hours service notified of Cancer Care Plan (9e00) with GP out of hours handover form completed (9e2).

It is too early yet to say how many practices have taken advantage of the new templates, says Dr McDaid (pictured). But he plans to audit all practices over the next year to get a more detailed picture.

The biggest hurdle in achieving good end of life care is the reluctance of many GPs to discuss these issues with patients in the first place. 'But if they overcome that this (template) is a very quick evidence-based checklist, has a logical flow and should streamline the process of going through the various things they might consider. With the EMIS PCS version, for each entry you might click on, a brief description appears as your mouse hovers over it. As EMIS LV can't do that I produced a very useful handout of the read codes plus the description.'

So far the new template is only used in Camden and Islington but Dr McDaid suggests it could easily be exported elsewhere since it follows the national codes and is consistent with the GSF. "The plan



is to update this a little further, with the support of Macmillan, and get EMIS and other GP Computer system suppliers to disseminate it."

Anyone with a N3 Connection can access these EMIS Tools by going to www.camdenpct.nhs.uk » Services » Palliative Care and scrolling down to EMIS Tools. Or contact Dr McDaid on mcdaid@nhs.net

GMC's new end of life care guidance

Doctors are to receive new guidance to help them make complex decisions at the end of life. For the first time, the General Medical Council has provided guidance on topics including advance care planning, responding to a patient's advance requests for treatment and decisions involving infants and children.

It also covers doctors' responsibilities after a patient has died and how they should approach conversations about organ and tissue donation. See: www.gmc-uk.org/end_of_life_care

H2H: helping patients get the right care in the right place

The Royal Marsden's innovative Hospital2Home service has enabled four in five patients to achieve their preferred place of death, report Clare Smith and Julia Riley

The Department of Health End of Life Care Strategy, published in 2008, advocates that everyone approaching the end of life should be offered a co-ordinated care pathway tailored to their needs.

The Royal Marsden Hospital2Home service, which was highlighted in the Department of Health's first annual report on end of life care, is an example of how this coordinated care can work in practice.

Set up in 2007, it aims to empower patients to make choices that allow the right care to be delivered at the right time, in the right place and by the right person.

So far it has enabled more than 80% of its patients to achieve their preferred place of death. The deaths at home or in a hospice have been significantly higher than the national average while many fewer are dying in hospital.

The Royal Marsden Hospital2Home service uses a case conference in the patient's home to provide a collaborative approach between the patient, informal carer, the Royal Marsden Hospital and community providers of end of life care to promote discussion of patient preferences and early risk assessment of the patients current and anticipatory problems.

The Hospital2Home (H2H) service was established in October 2007 by Dr Julia Riley and the palliative care team at the Royal Marsden Hospital after an audit of hospital admissions found that a large number of emergency admissions were not for problems related to oncology treatment but in fact for palliative symptom control.

The clinical team consists of the lead clinician, Dr Riley, and three H2H specialist sisters. These specialist sisters are palliative care nurses employed and trained solely to organise and chair case conferences.

The aim of the service is to ensure that through better identification, co-ordination, advance planning and communication more patients die in their preferred place (most commonly home) and the number of inappropriate hospital admissions for these patients is reduced.

Currently the service is available to any Royal Marsden Hospital patient over the age of 18 approaching the end of life (prognosis likely to be less than one year) for whom there is no further active anti-cancer treatment available.

Upon referral to the service the patient is allocated to one of the three H2H specialist sisters. This nurse will then accompany the patient (and their carer) through the remainder of their journey from referral to case conference.

The first part of the service is a consultation in the hospital between the specialist sister, patient

and carer. This is a separate assessment from any other oncology or palliative care contact. The purpose is to draw up a patient-led agenda to provide the basis for a case conference. This usually includes current symptoms, psychological, spiritual, social issues as well as future anticipated problems.

The H2H specialist sister then organises a suitable date, time and place for a case conference with the community teams. This is usually in the patient's home and currently the average time from the patient's discharge to the case conference is three working days. The patient, carer, GP, district nurse, community palliative care nurse and H2H specialist sister all attend.

As a result of the case conference a care plan is drafted with a responsible professional for each item and the H2H specialist sister circulates this to all those attending, including the patient if they wish.

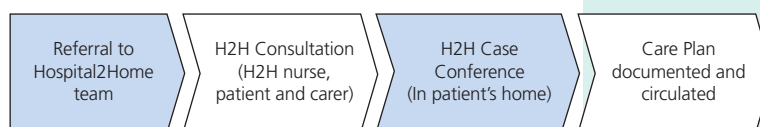


Figure 1: The Hospital2Home service model

To date there have been 166 case conferences and 146 patients have died. Sixty four (44%) have died at home, fifty seven (39%) have died in a hospice, sixteen (11%) in a hospital and eight (6%) in a nursing home. The deaths at home or in a hospice are significantly higher than the national average (18%, 4% respectively for all diagnoses), with fewer dying in hospital.

It is not always appropriate to discuss preferred place of death with patients and this is the case for 7% of people referred to the H2H service. So preferred place of death was only documented in 136 out of 146 of these patients with 113 of these dying in either their first or second choice location. This translates to 83% of patients achieving their preferred place of death.

The data so far indicates that the Hospital2Home service is a manageable scheme with case conferences attended by 82% of GPs, 88% of community palliative care teams and 94% of district nurses. It is achieving its primary aim of increasing the number of patients dying in their preferred place while also providing an environment for shared learning between the acute trust and community teams which will improve end of life care for others in the future.



Dr Clare Smith, Dr Julia Riley

The Royal Marsden NHS Foundation Trust
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Social care framework for end of life care to be unveiled

Margaret Holloway tells Andrew Cole how the new framework could transform the way social care's 1.5 million staff respond to clients at the end of their lives

Social care is often seen as the poor relation when it comes to its contribution to end of life care. But many in the field are optimistic that the new Framework for Social Care, to be launched in July, could change all that.



Margaret Holloway: 'Quality of life also means quality of dying'

The work to formulate a new vision for social care's central role in providing high quality end of life care has been led by Margaret Holloway, Professor of Social Work and Social Care Lead with the National End of Life Care Programme.

Her appointment to the Programme last autumn was a reflection, she says, of a growing recognition that without fully involving the social care workforce, the effectiveness of end of life care would be seriously limited.

That is partly because end of life care can extend over a long timeframe. And the fact that many people, such as the frail elderly or those with long-term conditions, have had contact with social care offers an opportunity to plan for end of life care at an early stage.

'For people to be kept central in that process we need to be able to engage with their concern and plan much earlier than we perhaps have thought necessary in the past.'

Unfortunately in recent years the social work role in adult services has been going in the opposite direction. 'Increasingly social workers feel they're not able to undertake a counselling role or develop an ongoing relationship with people because of the other care management demands. So we face a huge awareness raising task to make it clear this is part and parcel of their work.'

The framework seeks to set out a vision of end of life care that is relevant to all 1.5m workers in social care and which can also inspire them.

'One of the purposes of the framework,' says Margaret, 'is to sketch out that vision and find a way of engaging people with it. It should provide a focus and structure. We can then roll out the framework and develop the structures and tools to help us deliver that.'

The framework will cover a number of key issues. One of the most important will be raising awareness of, and clarifying, social care's key role in end of life care – both within the workforce itself as well as other sectors and the general public.

Education and training will also be critical. 'It is very important to focus on identifying all the skills that this workforce already has which need to be brought into play in terms of end of life care,' she says. 'Sometimes

this will be a confidence-raising process to help them understand that it is appropriate to have a conversation with people about end of life care issues. It will also mean further developing people's skills in some areas.'

A large steering group from right across social care and beyond has been involved in developing the framework. One objective will be not only to make end of life care a specialist social work pathway but to ensure it is an integral part of training at both qualifying and continuing levels.

Another key plank of the framework will be gathering evidence of what works well and identifying existing good practice. It is expected the framework will contain a number of case studies of good practice around the country and in different specialties.

But the fundamental message, in Margaret's view, is about the vital role of social care – including palliative care social work – in ensuring high quality end of life care. 'It involves understanding that quality of life also means quality of dying,' she says. 'These are not two separate things.'

The framework must also be closely integrated with other initiatives such as the Department of Health's End of Life Care Strategy as well as developments in social care itself such as the transformation agenda that is currently being rolled out.

Personalisation is a key part of that agenda and Margaret sees end of life care as a good example of how that can be developed. 'We should not have a template of the good death,' she says. 'It should be what is a good death for this person? This is something that affects everybody. We are all service users when it comes to this.'

The social care framework should be available online at the start of July. It will be followed by an intensive programme of dissemination, involving an implementation network, regional road shows and conference appearances. A series of test sites, funded by the Programme, will then pilot different approaches recommended in the framework.

'This has got to involve everybody in the social care workforce,' says Margaret. 'It's no good getting commissioners on board if frontline staff haven't got the confidence to deliver it.'

She believes the new framework will help achieve a 'more flexible, personalised approach to end of life care which takes account of the individual in their wider family, community and cultural context.

'By the time somebody arrives in a hospital or hospice bed it's too late to suddenly start asking what pathway this person would have wanted to follow. Social care has a big role in starting the conversation early on.'



• information@eolc.nhs.uk

Ten top tips for palliative care

Drs Prue Mitchell, Lucy Thompson, Angela Steele, Jonny Rae and Charles Champion-Smith, who are all UK Macmillan GPs, offer a helpful list of dos and don'ts

SYMPTOM CONTROL

1. Make an accurate diagnosis

Good palliative care is based on an accurate diagnosis of the cause of symptoms such as pain or vomiting. Don't fall into the trap of just treating the 'cancer pain' with opiates, or the 'cancer vomiting' without thinking of the cause.

Is the pain due to metastases which might need radiotherapy? Is the vomiting due to hypercalcaemia, gastric compression, UTI or drugs?

2. Strive for excellent pain relief

Good pain relief requires regular dosing rather than a vague direction 'as required'.

Start cautiously, using 4-hourly morphine mixture, adjusting the dose to prevent pain breakthrough. Once the dose is established consider swapping to a slow release preparation.

If pain is unrelieved (three or more doses of breakthrough analgesia or reports of moderate or severe pain on three occasions over 24 hours) increase the baseline analgesia dose by 30-50%

3. Always prescribe for breakthrough pain

Calculate the doses accurately. For acute pain in someone already on an opiate, ordinary doses of diamorphine will do very little. The usual breakthrough dose is about 1/6th the daily total analgesic dose, so needs updating as analgesia requirements increase.

4. Plan for what might happen

- Increased or new symptoms
- Inability to take oral medication
- Urinary retention
- Spinal cord compression

Give the patient and carer clear information (preferably in writing) about what to look out for and what to do. Ensure appropriate drugs are already prescribed – maybe in a Just in Case box - and equipment such as a syringe driver or urinary catheter pack is at the home or easily available.

Discuss with family and friends how to get care and help at different times. Specifically advise that calling 999 is very seldom appropriate and may result in resuscitation, transfer and admission.

Try and prepare family and carers for the final days and hours of life. Consider using the Liverpool Care Pathway booklet *Coping with Dying – understanding the changes which occur before death*. (see http://www.mcpcil.org.uk/liverpool_care_pathway)

5. Breathlessness

Acute breathlessness is often accompanied by panic or fear. Sublingual lorazepam ('off-label' use), 0.5mg

to 1mg, can be quick and effective. For chronic breathlessness low-dose morphine, using a fan or opening the windows and simple relaxation exercises can help. Asking the patient to tell you about their fears may allow you to give reassurance.

COMMUNICATION AND ORGANISATION OF CARE

6. Record patients' wishes as an anticipatory care plan

This allows people to exercise a degree of control and involvement in their care. Knowing that wishes about place of care and advanced decisions about resuscitation have been recorded and passed on is a great relief to many.

Ensure everyone involved in a patient's care knows of any care plans, highlight them in practice records and communicate key points to those giving care out-of-hours in a handover form.

If you are seeing a patient you don't know make an effort to find out about, and take note of, things such as advance care plans.

7. Establish open communication with patient and family

Avoid giving exact prognoses – you will almost always be wrong! Talking in 'days', 'weeks' or 'months' can give patients and families some indication but always remind them of the unreliability of even these predictions. It is better to say 'we will do our best' than to make a promise you can't keep.

Talk to patient and family together whenever possible. This helps discussion and means everyone is told the same thing. Consider joint visiting with the specialist palliative care nurse.

8. Be willing to ask difficult questions

Ask about patients' fears and concerns. 'Are you frightened?' can be a useful question that allows fears and anxieties to be discussed. Don't give empty reassurances. 'Don't worry' is dismissive and inappropriate for someone dying of cancer; it closes down the opportunity for someone to express deeper fears.

9. Be willing to ask for help

Specialist palliative care nurses and consultants will offer advice and help readily. In most areas this is available 24 hours a day. The BNF has a good chapter on palliative prescribing. MIMS also has a section while the LCP and local guidelines include symptom control algorithms.

10. Work as a team

Include the family and your local pharmacist in this. Share problems, support each other and review the care you have given. Don't forget to recognise when you have done a great job together. If things haven't all gone well think about how they could be better next time.

E-learning package offers training and support for all staff

Nearly all health and social care staff need training of some sort in end of life care. A new e-learning package aims to offer just that

A hugely ambitious new e-learning programme on end of life care is currently being rolled out across the NHS and social services. It offers the training and support that many practitioners have been crying out for - and it's all free!

The package, called e-ELCA (End of Life Care For All) and launched in January, will eventually offer 130 interactive learning sessions to all NHS and social care staff – including GPs and other community staff – whose work brings them into contact with people nearing the end of their lives.

The project has been developed by e-Learning for Healthcare (e-LFH) and the Association for Palliative Medicine and is led by the National End of Life Care Programme and the Department of Health.

The learning sessions, which typically take between 20 and 30 minutes to complete, are divided into four core modules covering advance care planning, assessment, communications and symptom management. A fifth module covers integrated learning.

Some sessions provide basic information to people new to this area. More experienced staff can develop their knowledge. In each case the worker gains a certificate on completion of the session.

Around 120 individual learning sessions are currently available to staff working for NHS organisations signed up to the National Learning Management System (NLMS). Up to 12 of these sessions are available to anybody, including members of the public.



Dr Bee Wee (right): sessions are easy, fun and free

If you are a GP or work in a GP practice you will be able to access e-ELCA later this year when e-GP will be upgraded to the same learning management system used by the new resource. Those who want to access e-ELCA earlier should contact e-LFH who will consider applications on a case-by-case basis.

Commenting on the new approach Dr Bee Wee, national clinical lead for e-ELCA, said: 'These interactive sessions are created by experts at the sharp end for all those at the coal face. Most are easy, many are fun - all are free.'



The e-ELCA website is at www.e-elca.org.uk
The sessions open to anyone are available at www.endoflifecareforall.com

Resources

NATIONAL END OF LIFE CARE PROGRAMME

The Programme has a range of resources which can be found at www.endoflifecareforadults.nhs.uk

It has also launched an intelligence network and website that brings together data on where people die in England and what affects their care. See www.endoflifecare-intelligence.org.uk

MACMILLAN CANCER SUPPORT

Main website: www.macmillan.org.uk

www.be.macmillan.org.uk – the information arm of Macmillan Cancer Support - has a range of resources:

End of life

- www.be.macmillan.org.uk/be/s-314-end-of-life.aspx

About Macmillan services

- www.be.macmillan.org.uk/be/s-202-about-macmillan-services.aspx

Toolkits

- www.be.macmillan.org.uk/be/s-209-toolkits.aspx

www.be.macmillan.org.uk/be/s-198-financial-support.aspx

Financial support

- www.be.macmillan.org.uk/be/s-198-financial-support.aspx

Macmillan also has a virtual learning environment, **Macmillan Learn Zone**

- www.learnzone.macmillan.org.uk

END OF LIFE CARE TOOLS

Liverpool Care Pathway

- www.mcpcil.org.uk/liverpool-care-pathway

Gold Standards Framework

- www.goldstandardsframework.nhs.uk

DOCUMENTS

End of Life Care Strategy, DH (2008)
• <http://tiny.cc/5a712>

End of Life Care, National Audit Office (2008)
• <http://tiny.cc/qszk5>

The differences between general care planning and decisions made in advance, National End of Life Care Programme (2010)
• <http://tiny.cc/jl55s>

End of Life Care principles and competences for the health and social care workforce, National End of Life Care Programme, DH, Skills for Care and Skills for Health (2009)

- <http://tiny.cc/vk1oi>

Improving supportive and palliative care for adults with cancer, NICE (2004)

- www.nice.org.uk/nicemedia/pdf/csgspexecsummary.pdf

USEFUL LINKS

National Council for Palliative Care

- www.npcp.org.uk

Marie Curie Cancer Care

- www.mariecurie.org.uk

Help the Hospices

- www.helpthehospices.org.uk

Palliative Care Wales is the main access point for palliative care news/advice/medication advice and download point for the Welsh community DNA CPR

- www.wales.pallcare.info