AGENDA ITEM No. 11

NORTH LANARKSHIRE COUNCIL

COMMITTEE REPORT

To: SOCIAL WORK (OPERATIONS AND SERVICES) SUB COMMITTEE	Subject: PALLIATIVE CARE : JOINT HEALTH AND SOCIAL WORK PROTOCOL
From: DIRECTOR OF SOCIAL WORK	
Date: 24 FEBRUARY 2004 Ref: GS/	

1. PURPOSE OF REPORT / INTRODUCTION

This report advises Committee of the production of a Joint Protocol to ensure fast track access to palliative care services for people at the end stages of life. It has been produced and agreed jointly with NHS Lanarkshire and South Lanarkshire Council Social Work Resource.

2. BACKGROUND

2.1. Palliative Care is defined as:

- **"....the active care of patients whose disease is not responsive to curative treatment. The goal of palliative care is the achievement of the best quality of life for patients and their families" (World Health Organisation,1990).**

2.2. Lead responsibility for ensuring palliative care services are in place lies with the Health Service. Provision has commonly been associated with specialist care within a hospice, but palliative care is delivered in a range of settings, including hospital, day facilities, residential settings and at home.

2.3. Representatives from Social Work in both North and South Lanarkshire Councils are involved with NHS Lanarkshire in planning and developing palliative care services, with the aim of achieving a number of goals. This includes:

- maximising the quality of life of people who require palliative care, ensuring that they are supported and cared for in a place of their choice.
- ensuring that palliative care is available for people who have non- cancer related needs.
- providing integrated multi-agency support services to individuals and their carers.

2.4. In recognition of the fact that Palliative care services to people at the end stage of life are variable throughout Lanarkshire, the Health led Palliative Care Planning Group recommended that work should be undertaken to produce a jointly agreed protocol to improve and speed up the provision of appropriate support and services.

3. PROPOSALS/CONSIDERATIONS

3.1. The Joint Protocol (Appendix 1) outlines the background, scope and remit of the initiative, while also providing a flow chart and practice guidance.

3.2. People in hospital who are deemed no longer to require in patient treatment are the focus of the Joint Protocol. Key individuals or teams and the role they should play in ensuring a speedy, appropriate and co-ordinated process are identified in the document.

3.3. The Joint Protocol serves to reinforce existing practice, rather than proposing major changes and is designed to ensure that the relatively small number of people requiring a fast track service are prioritised appropriately.

3.4. A plan for implementation is now being developed, and this will incorporate the assessment process as it relates to people at the end stages of life, ensuring a level of high quality care in a location that is most appropriate for the level of need.

3.5. The production of the Joint Protocol is one of a range of developments which aim to improve the lives of people with life limiting illness. Other initiatives include:

- The proposed development of a Managed Clinical Network (MCN) for palliative care. (A Managed Clinical Network refers to a process of bringing together health professionals and other stakeholders to ensure co-ordinated and equitable provision of high quality effective services.)
- The establishment of a Cancer Care Steering Group by NHS Lanarkshire
- The Citizens Advice Bureau in conjunction with Macmillan Cancer Care has developed a benefits advice service.
- An NHS Lanarkshire Cancer Information Web Site has been established to enable carers, service users, professionals and others to access vital information in relation to cancer.

3.6. Future plans for improving services and support for people with palliative care needs and their families and carers include the establishment of a *Maggie Centre* at Wishaw General Hospital and the production of palliative care guidelines for Lanarkshire.

4. FINANCIAL/PERSONNEL/LEGAL/POLICY IMPLICATIONS

4.1. The Joint Protocol has no direct financial, personnel or legal implications for the Department as it is designed to reinforce existing practice, rather than requiring additional resources for implementation. It will be included within the range of Departmental policies and procedures.

5. RECOMMENDATIONS

5.1 Committee is asked to:

(i) note the development of the Joint Health and Social Work Protocol for Palliative Care (Appendix 1)

(ii) otherwise note the contents of this report

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Director of Social Work
February 2004

For further information on this report please contact Susan Taylor , Manager, Community Care (Adult Services) (TEL: 01698 332071) or Gordon Simpson, Senior Officer (Carers) (TEL: 01698 332265)

Appendix 1

JOINT HEALTH AND SOCIAL WORK PROTOCOLS

HOW TO ACCESS PALLIATIVE CARE SERVICES QUICKLY IN LANARKSHIRE

1 AIM OF AGREEMENT

The aim of this agreement is to aid the statutory agencies in Lanarkshire (NHS Lanarkshire, and South Lanarkshire Council) to work North Lanarkshire Council collaboratively to fulfil their respective responsibilities for palliative care. Through the provision of fast-track assistance, patients will be cared for and supported to die in the place of their choice. This agreement focuses on people who are in hospital or hospice where a decision is taken that they no longer require inpatient care in these settings, or where that decision can clearly be foreseen.

2 DEFINITION OF PALLIATIVE CARE

Until recently the concept of specialist palliative care has been limited to care delivery within a hospice environment or by specialist palliative care teams to patients in hospital. There are now growing numbers of specialist palliative care teams based in the community with a remit to help support and maintain people at home/care home through integration of the specialist team and the primary healthcare team.

Specialist palliative care should be recognised as being part of the palliative care approach. The concept of palliative care is an approach to which all should contribute. It is a whole person approach to care for someone who is coming to the end of his or her life. The following definitions are provided for clarification.

"**Specialist** Palliative Care is the active total care of patients with progressive, far advanced disease and limited prognosis, and their families, by a mulit- professional team who have undergone recognised **specialist** palliative care training. It provides physical, psychological, social and spiritual support, and will involve practitioners with a broad mix of skills."**1** These patients will have complex needs including symptom control, palliative rehabilitation and specialist end of life care.

"**Palliative care** is the active total care of patients and their families by a multi-professional team when the patient's disease is no longer responsive to curative treatment."**2** Care delivery with a palliative approach is a core skill that every health care professional, in whatever setting, should possess if dealing with patients with incurable progressive disease.

1 Tebbit 1999 as cited by CSBS "Clinical Standards Specialist Palliative Care June 2002", NHS Scotland
2 CSBS (2001) "Clinical Standards Specialist Palliative Care June 2002", NHS Scotland

3 REMIT OF PROTOCOL

This protocol seeks to address the needs of people with a life limiting physical illness. The primary illness is most often due to cancer, or less commonly neurological disease, or other life threatening illness (such as chronic heart failure, renal failure and respiratory failure)and the individual will have reached the end stage of their disease. The protocol does not seek to address the needs of patients whose primary illness is dementia.

4 PROVISION OF PALLIATIVE CARE IN LANARKSHIRE

Specialist Palliative Care and Palliative Care are provided in a variety of settings within Lanarkshire with an emphasis on giving choice to patients, their families and carers where possible.

Specialist palliative care is delivered and/or organised by:

- St Andrew's Hospice - inpatient care, day care and hospice social workers to all areas of Lanarkshire and a specialist palliative care homecare team* providing a service to Airdrie & Coatbridge
- Strathcarron Hospice - inpatient care, day care and a specialist palliative care homecare team* providing a service to Cumbernauld & Kilsyth
- Hairmyres District General Hospital
- Monklands District General Hospital
- Wishaw District General Hospital
- Macmillan Palliative Care Nurses - hospital and community based
- East Kilbryde & Hamilton LHCC – Overnight Palliative Care Nursing Service*
- Strathclyde Hospital - Dalziel Centre (social daycare and specialist palliative care clinics) and Specialist Lymphoedema Service
- Kello, Lady Hume & Lockhart Community Hospitals – Specialist Palliative Care Liaison Nurse providing advice and support
- Community Pharmacy Network – out of hours access to specialist palliative care drugs
- Beckford Lodge – Bereavement Service to all of Lanarkshire

(*Referred to as the Specialist Community/Hospice Outreach Team within the document)

Specialist palliative care teams work in partnership with those providing generalist palliative care to ensure that patients' and families' complex needs are met. Often this care will be provided within the individual's home.

Palliative care is delivered and supported by:

- Primary Health Care Services – GPs , community nurses, OTs, SLTs
- Marie Curie Overnight Nursing
- Blantyre Health Centre - The Haven (counselling and communication centre)
- Crossroads Palliative Care – Care Attendant Schemes (Blantyre, East Kilbride & Larkhall)

- Care Homes
- Local authority social worker services, home care services and OT services
- Lanarkshire Cancer Care Trust Volunteer Driver Service
- Carers

5 AGENCY RESPONSIBILITIES

NHS Lanarkshire has responsibility for funding **specialist** palliative care for those with complex needs, in whatever setting, after an individual has been referred by the General Practitioner/Hospital Consultant and assessed by the specialist palliative care team as requiring specialist palliative care.

Palliative care services are provided and funded by **NHS Lanarkshire, North Lanarkshire Council and South Lanarkshire Council** in settings appropriate to patients' care needs. Those patients who do not require specialist palliative care and wish assistance in obtaining a care home placement remain the responsibility of the relevant local authority. (For the purposes of access to state benefits via completion of the DS1500, the terminology used by the Benefits Agency is "Terminally Ill")

To ensure the provision of suitable fast track assistance, an individual from each agency should assume lead responsibility (LHCC/Local Social Work Team). **Should disputes arise, including funding responsibilities, these should not delay patients' placement.** Key individuals should be identified by each of the agencies to resolve such disputes.

Where a mix of health and social need is evident it will be appropriate to determine the patient's needs through a Single Shared Assessment. This is a holistic approach to assessment, avoiding duplication of work and making appropriate use of staff skills and expertise. A lead person will be identified to complete the assessment, the results of which will be accepted by fellow professionals.

Protocols across Lanarkshire are in place for the sharing of information across agencies to allow appropriate services to be put in place.

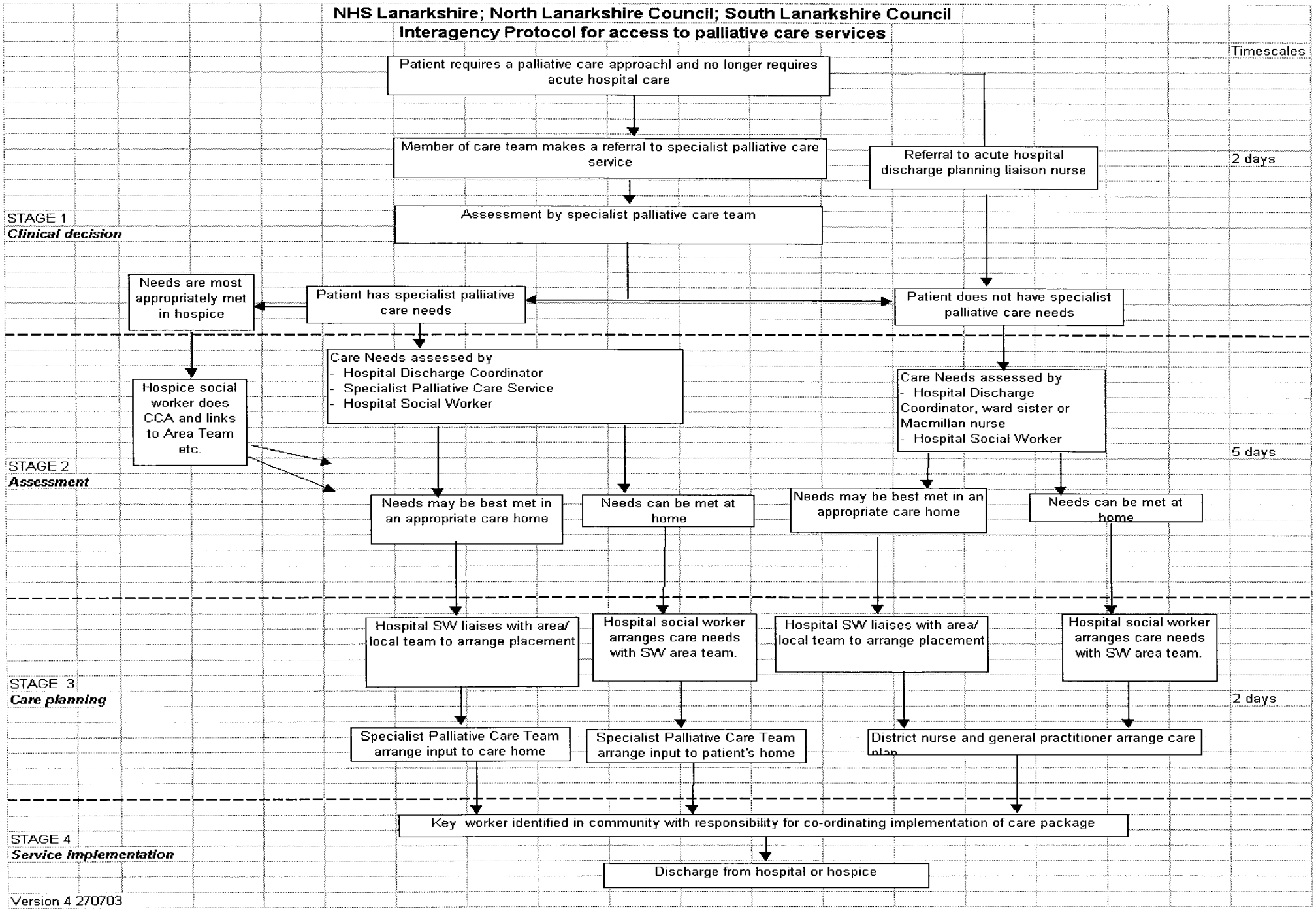
Agency responsibilities are summarised in the following table.

1.1 Type of Care	*1.2 Location of Care*	*1.3 Funder*
Admission to hospital	NHS bed	NHS Lanarkshire
Discharge from acute hospital with specialist palliative care needs	Hospice	NHS Lanarkshire in partnership with the voluntary sector
Discharge from acute hospital with specialist palliative care needs	Care Home with palliative care registration or utilising specialist palliative care elements	NHS Lanarkshire for specialist care elements (e.g. Specialist Community /Hospice Outreach Team) and the relevant local authority for non specialist elements
Discharge from acute hospital with specialist palliative care needs	1.3.1 Individual's home	NHS Lanarkshire for specialist care elements (e.g. Specialist Community/Hospice Outreach Team) and the relevant local authority for social work, homecare and OT services as required
Discharge from acute hospital with non specialist palliative care needs	Care Home	Relevant local authority and NHS Lanarkshire for appropriate general palliative care input from the relevant professionals
Discharge from acute hospital with non specialist palliative care needs	Individual's home	NHS Lanarkshire for palliative care professional input and the relevant local authority for social work, homecare and OT services as required

It is recognised that there will be occasions where patients with specialist palliative care needs require more intense general supportive care. This may require admission to Hospice, Hospital or Care Home facilities or increased support within the family home to provide a break for the carer and/or the patient.

6 ACCESS TO SERVICES

In line with respective responsibilities, the statutory agencies seek to provide appropriate care in suitable settings, while recognising that patients' and their families'/carers' wishes are a priority. Access to services is summarised in the flow chart detailed over.


NHS Lanarkshire; North Lanarkshire Council; South Lanarkshire Council
Interagency Protocol for access to palliative care services
Timescales
Patient requires a palliative care approachl and no longer requires acute hospital care
Member of care team makes a referral to specialist palliative care service
Referral to acute hospital discharge planning liaison nurse
2 days
STAGE 1
Clinical decision
Assessment by specialist palliative care team
Needs are most appropriately met in hospice
Patient has specialist palliative care needs
Patient does not have specialist palliative care needs
Hospice social worker does CCA and links to Area Team etc.
Care Needs assessed by
- Hospital Discharge Coordinator
- Specialist Palliative Care Service
- Hospital Social Worker
Care Needs assessed by
- Hospital Discharge Coordinator, ward sister or Macmillan nurse
- Hospital Social Worker
5 days
STAGE 2
Assessment
Needs may be best met in an appropriate care home
Needs can be met at home
Needs may be best met in an appropriate care home
Needs can be met at home
Hospital SW liaises with area/ local team to arrange placement
Hospital social worker arranges care needs with SW area team.
Hospital SW liaises with area/ local team to arrange placement
Hospital social worker arranges care needs with SW area team.
STAGE 3
Care planning
2 days
Specialist Palliative Care Team arrange input to care home
Specialist Palliative Care Team arrange input to patient's home
District nurse and general practitioner arrange care plan
Key worker identified in community with responsibility for co-ordinating implementation of care package
STAGE 4
Service implementation
Discharge from hospital or hospice
Version 4 270703

6.1 *Discharge From Acute Hospital To Hospice - with specialist palliative care needs*

STAGE ONE Hospital Consultant or Care Team/Hospital Discharge Co-ordinator, with the Consultant's permission, refers patient to the Hospital Specialist Palliative Care Service to determine care needs.

Hospital Specialist Palliative Care Service assesses patient and determines that there are specialist palliative care needs which would most appropriately be met within a hospice. The patient is referred for hospice care.

STAGE TWO The patient is admitted to a hospice, where the Hospice Liaison Social Worker undertakes a Community Care Assessment and liaises with Social Work Area Team as appropriate. At this stage, if a carer is involved, they should be advised of their right to an independent assessment.

Should a patient wish to be discharged to the community following appropriate symptom control, the process listed at 6.5 should be followed by the Hospice Co-ordinator.

6.2 Discharge From Acute Hospital to a Care Home with Palliative Care registration or utilising specialist palliative care supports– with specialist palliative care needs

STAGE ONE Hospital Consultant or Care Team/Hospital Discharge Co-ordinator, with the Consultant's permission, refers patient to the Hospital Specialist Palliative Care Service to determine care needs.

Hospital Specialist Palliative Care Service assess patient and determine that there are specialist palliative care needs

STAGE TWO Hospital Discharge Co-ordinator/Specialist Palliative Care Service/Hospital Social Worker undertake a comprehensive care needs assessment. This may be addressed via a single shared assessment. At this stage, if a carer is involved, they should be advised of their right to an independent assessment. It is deemed appropriate for the patient to be transferred to a care home with palliative care registration or utilising specialist palliative care supports.

STAGE THREE Hospital Social Worker liaises with Social Work Area Team to identify and arrange placement.

Hospital Specialist Palliative Care Service liaises with the Specialist Community/Hospice Outreach Team or Community Macmillan nursing service, G.P. and District Nurse to arrange appropriate specialist service input to the care home

STAGE FOUR A key worker is identified in the community who will have responsibility for co-ordinating implementation of the agreed care package. The patient is then discharged from hospital or hospice.

6.3 **<u>Discharge From Acute Hospital to Individual's Home</u> – with specialist palliative care needs**

STAGE ONE Hospital Consultant or Care Team/Hospital Discharge Co-ordinator, with the Consultant's permission, refers patient to the Hospital Specialist Palliative Care Service to determine care needs.

Hospital Specialist Palliative Care Service assess patient and determine that there are specialist palliative care needs

STAGE TWO Hospital Discharge Co-ordinator/Specialist Palliative Care Service/Hospital Social Worker undertake a comprehensive care needs assessment. This may be addressed via a single shared assessment. At this stage, if a carer is involved, they should be advised of their right to an independent assessment.

It is deemed appropriate for the patient to be transferred home.

STAGE THREE Hospital Social Worker liaises with the Area Team Social Worker to determine the individual's care needs and organise an appropriate care package.

Hospital Specialist Palliative Care Service liases with the Specialist Community/Hospice Outreach Team or Community Macmillan nursing service, G.P. and District Nurse to arrange appropriate specialist input to the patient's home

STAGE FOUR A key worker is identified in the community who will have responsibility for co-ordinating implementation of the agreed care package. The patient is then discharged from hospital or hospice.

Should the patient require access to inpatient specialist palliative care services these can be accessed via the Community/Hospice Outreach Team Co-ordinator or the Community Macmillan nursing services.

6.4 **<u>Discharge From Acute Hospital To Care Home</u> – with non specialist palliative care needs**

STAGE ONE Hospital Consultant or Care Team, with the Consultant's permission, determine the patient's medical and nursing needs (this may not involve referral to the Hospital Specialist Palliative Care Service) and refer the patient to the Hospital Discharge Co-ordinator. It is determined that there are no specialist palliative care needs

STAGE TWO Hospital Discharge Co-ordinator/Ward Sister/Hospital Social Worker undertake a comprehensive care needs assessment. This may be addressed via a single shared assessment. At this stage, if a carer is involved, they should be advised of their right to an independent assessment. It is deemed appropriate for the patient to be transferred to a care home.

STAGE THREE Hospital Social Worker liaises with Social Work Area Team to secure funding and appropriate placement.

District Nurse and G.P. arrange care plan.

STAGE FOUR A key worker is identified in the community who will have responsibility for co-ordinating implementation of the agreed care package. The patient is then discharged from hospital or hospice.

Should the patient require access to specialist palliative care services these can be accessed via GP/Macmillan Nurse/Community (District) Nurse.

6.5 <u>Discharge From Acute Hospital To Individual's Home</u> – with non-specialist palliative care needs

STAGE ONE Hospital Consultant or Care Team, with the Consultant's permission, determine the patient's medical and nursing needs (this may not involve referral to the Hospital Specialist Palliative Care Service) and refer to the Hospital Discharge Co-ordinator.
It is determined that there are no specialist palliative care needs

STAGE TWO Hospital Discharge Co-ordinator/Ward Sister/Hospital Social Worker undertake a comprehensive care needs assessment. This may be addressed via a single shared assessment. At this stage, if a carer is involved, they should be advised of their right to an independent assessment. It is deemed appropriate for the patient to be transferred home.

STAGE THREE Hospital Social worker liaises with Social Work Area Team to determine the individual's care needs and organise an appropriate care package.
District Nurse and G.P. arrange care plan.

STAGE FOUR A key worker is identified in the community who will have responsibility for co-ordinating implementation of the agreed care package. The patient is then discharged from hospital or hospice.
Should the patient require access to specialist palliative care services these can be accessed via GP/Macmillan Nurse/Community (District) Nurse.