Workforce Development and Training

Exploring barriers to a universal approach to End of Life Care

Contents

Introduction

Engaging Communities Staffordshire (ECS) is an independent, community interest company that delivers Healthwatch Staffordshire, Wolverhampton, Walsall and Solihull.

ECS is primarily concerned with engagement with local communities surrounding the provision of healthcare in Staffordshire, the wider West Midlands region and beyond. The company provides a subscription service for partner organisations to conduct regular research and insight gathering that can help them improve their service design and delivery. We develop practical recommendations to improve services, replicate good practice, and improve service user experience, based on robust evidence collected from the voice and experience of service users and staff.

Our reports are designed to be transparent, clear, and easily accessible that create sustainable improvements in the delivery of services.

Engaging Communities deliver the contracts for Healthwatch in Staffordshire, Wolverhampton, Walsall and Solihull. This work is part of our Healthwatch Staffordshire contract delivery following a public consultation in 2015.

Background

After a public consultation, End of Life Care (EoLC) emerged as a priority area for Healthwatch to focus their work in 2017. Our local intelligence around EoLC suggested there were discrepancies in the way care was delivered across different parts of the County and the wider Midlands Region. We are also aware that the Director of Public Health in Staffordshire has focused on End of Life (EOL) for his annual report this year. As a result, an EOL Advisory Group was developed with a sample of local service providers from St Giles Hospice Care, Beth Johnson Foundation, Douglas Macmillan Hospice, Alzheimer's Society Staffordshire and Shropshire, Donna Louise Trust and University Hospitals of North Midlands (UHNM), led by Engaging Communities (ECS) and Healthwatch Staffordshire.

This project set out to explore the barriers to a consistent, holistic approach to EoLC through multi-disciplinary collaboration in Staffordshire, Walsall, and Wolverhampton. This included looking into the experiences and opinions of EoLC professionals, staff, and service users. Three workstreams were devised which the group considered to be primary issues that needed consideration. These included Advanced Care Planning, Workforce Development and Pre/Post Bereavement Support.

As part of the objectives of the Workforce Development workstream, a Task & Finish group was set up to identify the barriers to a consistent, holistic approach to EoLC within Staffordshire, Wolverhampton, and Walsall with regards to workforce development and training.

The end of life care or palliative care workforce's aim is to provide care to patients with a life-limiting prognosis. They provide holistic care that involves, but is not limited to: management of symptoms, provision of social care support, as well as provision of psychological, social and spiritual support (Thompson, 2007). Research into the EoLC workforce reported concerns around varying skill levels and comfort around EoLC, listing the lack of appropriate and adequate education and training as a key issue (Shipman et al., 2008).

This report intends to identify the skills and experience of the EoLC workforce, what systems and processes can be put in place for effective multi-disciplinary collaboration, and what the training and developed needs are to help the workforce.

Plan & Methodology

This report is underpinned by the following research questions, and will be structured to reflect the findings against these questions. A discussion of the methodology justification and quality assurance for research design is also provided.

Research Questions

1.   What are the skills and experience of the EoLC workforce?
2.   What are the barriers to effective multi-disciplinary collaboration?
3.   What systems and processes can be put in place for effective multi-disciplinary collaboration?
4.   What training and development needs to be in place to help staff do their jobs effectively?

Methodology

This study used questionnaires as the main data collection method, which were sent out to End of Life education trainers in the various hospices and hospitals within Staffordshire, Walsall, and Wolverhampton. This research was led and completed by Engaging Communities Staffordshire (ECS)/Healthwatch Staffordshire, with input and support from Douglas Macmillan Hospice and University Hospitals North Midlands (UHNM).

The report also includes an overview of background research, using current, unpublished research specific to organisations, as well as published academic reports.

Quality plan

ECS has a responsibility to ensure that the research it undertakes and creates is of high quality and aligned to best practice across the industry. Research ultimately provides the evidence on which sound decisions should be made, which is why it is important to state up front how quality was ensured during this project. The Research and Insight team underpins its research activities by applying the Market Research Society Codes of Conduct (MRS, 2014). ECS are a company partner of the Market Research Society.

During this project ECS adhered to a strict data protection policy that ensured that:

- Everyone handling and managing personal information internally understood they were responsible for good data protection practices;
- There was someone with specific responsibility for data protection in the organisation;
- Staff who handled personal information were appropriately supervised and trained;
- Queries about handling of personal information would have been promptly and courteously dealt with had they been received;
- The methods of handling personal information are regularly assessed and evaluated;
- Necessary steps were taken to ensure that personal data was kept secure at all times against unlawful loss or disclosure.

ECS have firm guidelines for data storage, data retrieval, data security and data destruction. There is also a strict process in place should a data breach occur (which includes containment and recovery, assessment of ongoing risk, notification of breach, evaluation and response). To further ensure the quality of the final report, an internal peer review process was initiated to ensure that the report is fit for purpose before submission. Where data is not robust it was suppressed to prevent disclosure.

Findings

What are the skills and experience of the EOLC workforce?

As a recognised medical specialist job, palliative care requires the equivalent of 4 years specialist medical training (National Institute for Health and Care Excellence NICE, 2017) for clinicians. Equally, specialist training for psychological support, spiritual and religious care, and other areas of speciality are needed to tailor to the wide-ranging needs of people with a palliative condition. In this section, we have highlighted some of the skills and experience recommended for clinicians, psychological support staff, and spiritual and religious care staff, to be able to deliver high quality care. It is important to note that some of these skills and experience differ for different levels and positions within each of the palliative care sectors. Detailed descriptions into each of the various competencies can be found in the relevant organisation handbooks.

Clinical staff (Heath Carers & questionnaire findings)

- Advanced and highly developed communication skills to deal sensitively with information of their medical diagnosis.
- Personal credibility of a clinician or nurse, such as safe, competent delivery of symptom management.
- Able to work proactively and take responsibility for their own work. This includes taking responsibility for any negative consequences of decisions or information divulged to patients
- Able to be adaptable and resilient in the face of death and other highly emotional issues.
- Be able to work empathetically and be able to show compassion for patients, carers and their families who are involved in their care.
- Strong desire and interest to improve quality of life for patients with a palliative diagnosis and be able to work to improve care in the area.
- Awareness of different cultures and behaviours associated with death and a palliative diagnosis.
- Strong decision-making skills under stress
- Able to work ethically and under the guidelines to provide a high quality of care.

Through the questionnaire, it was also reported that skills and experience such as knowledge of advance directives, advance care planning, supporting difficult conversations, knowledge of the progression of different forms of conditions as per the speciality area and the potential impact on life skills, emotions and relationships, could be useful.

Psychological support

- Advanced communication skills that allow the individual to communicate honestly and compassionately.

- Ability to understand emotional context and appreciate what meaning it has for the patient, rather than for themselves.

- Ability to conduct and undertake psychological screening, assessment and intervention skills.

- Reflecting, and summarising on feelings and emotions of the patient/carer.

- Have the ability to recognise when they have reached the boundary of their competence.

- Able to recognise and react accordingly to presentations of risk and suicide.

- Be able to remain calm and be able to undertake assessments when risk and safeguarding are concerned.

- Are able to maintain confidentiality and the lines where confidentiality will need to be breached.

Spiritual and Religious Care (as identified by Marie Curie.)

- Awareness of nature of spirituality and ability to demonstrate this awareness within a palliative setting. Staff should be able to recognise that spirituality needs to be acknowledged, and should be able to describe and evidence what it means to have spiritual and religious needs.

- Awareness of various religious needs and are able to demonstrate this awareness within a palliative setting. This also requires recognition of spiritual and religious needs that are unmet. This requires the individual to be aware of complex and complicated spiritual, religious and ethical issues.

- Able to build relationships with different people such as patients and their carers. Staff should be able to actively listen and be able to show empathy. They should be able to discuss with patients/carers about their concerns at a pace that is comfortable for them. They should also be able to discuss, explore and deal appropriately with conflicts in patients/carers or within families.

- Able to recognise their own personal limitations and boundaries. This would require the staff member to look at training and development needs as well.

- Able to develop a plan for spiritual and religious care based on needs. This would involve being able to maintain confidentiality while carrying out the plan.

- Able to work closely with the multi-disciplinary team (MDT) involved in the patient's care and recognise when there is a need to refer patients and carers on to other members of the MDT

While much of the findings above are based on requirements identified by the different organisations, many of these skills and experience overlap with The National Occupational Standards (NOS). The NOS was developed to provide a framework that focuses on what an individual working in palliative care needs to be able to do. Details of the framework applies across the National Health Service, local government, and independent sector organisations, both private and voluntary (Skills for Care, National End of Life Care Programme, & Skills for Health, 2012).

Even when equipped with all of the skills listed above, organisational, personal, and other environmental barriers make it difficult for palliative staff to be able to use their skills to provide a high level of care. The following section looks into these barriers.

What are the barriers to effective multi-disciplinary collaboration?

Results of our questionnaire, as well as an intensive literature review, revealed the 4 key barriers listed below that prevent effective multi-disciplinary collaboration
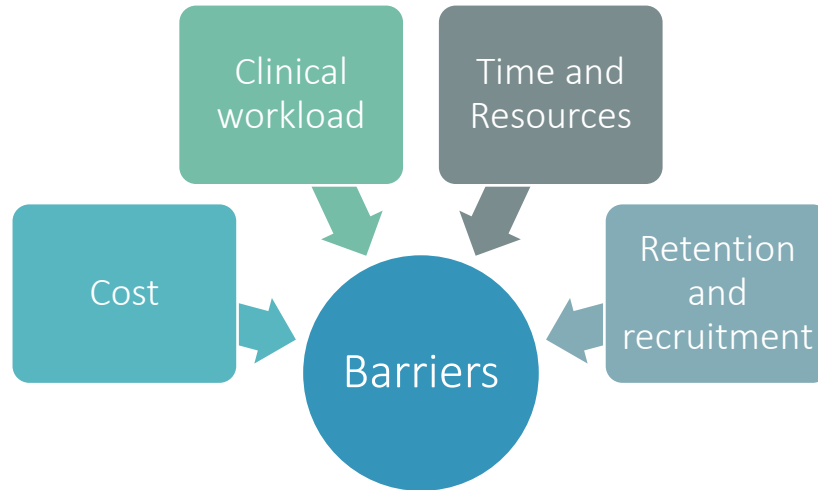
Retention and recruitment

There are currently major issues across the country relating to staff retention and recruitment, which has a direct impact on the ability to provide and sustain EoLC training. The specialist palliative workforce is low and health professionals with expert knowledge in palliative services are limited (Census, 2014). In addition, with many of the older staff members approaching retirement, the lack of staff makes it difficult to not only release other staff members for training but also to retain highly skilled professionals.

Findings from the questionnaire reported that finding the right people who deliver the right training at the right time can be a challenge. The lack of retention of skilled staff mean more investment into resources such as paying for agency staff and using more of managerial time for recruitment and training of new staff, all of which are extremely time-consuming and resource reliant for an already struggling system.

Now that many CCGs have been provided with funding to care for routine patients as well as palliative patients, the switch from dying patients to routine clinical work can place additional stress on staff. GPs and District Nurses who may not have any formal support in place to deal with dying patients are the more likely targets for this (Burt, Shipman, Addington-Hall, & White, 2005). Nurses reported that retention was a hard task to achieve when there is a lack of support or supervision, increased used of agency staff rather than permanent staff, when there is a lack of a good senior

leadership, as well as when they have a sense of not being valued (Burt, Shipman, Addington-Hall, & White, 2005).

After interviewing 80 managers and 180 employees of high retention companies in the adult social care sector, results of the research conducted by Ekosgen (2013) revealed that the main factors for retention as reported by managers were good communication and provision of training, as well as providing their staff with autonomy and flexibility. Research into pay cuts reported that, in most cases, pay is not said to have had a significant impact on turnover, and pay was described by employees as being 'important' but not the main factor for retention of staff (Ekosgen, 2013).

Clinical workload

1/3 of hospices are NHS funded, although over the last few years, this funding has remained stagnant and in some hospices, reduced (Robinson, 2017). An independent review of palliative care funding in England also reported that the NHS has substantial differences in the amount spent on specialist palliative care across the sector (National Audit Office, 2008). The report showed that this difference ranged from £186 to £6,213 per death, despite most specialist palliative care spending less that £1,000 per death (Hughes-Hallet et al., 2011).

The cost of training staff members is currently unaffordable due to the reduction of funding across health sectors. In the questionnaire they were provided, palliative education leads reported that the cost of external courses affect an already dwindling budget. The reduction in funding pots across the county mean that health services have less money to put towards training needs. However, reviews into training costs also report that palliative care offered by trained palliative care staff is cheaper than if the care was delivered by generalist or untrained hospital staff (Simoens, 2010). Therefore, funding needs to reflect 'need' (National Audit Office, 2008) and redirecting the funding into training palliative care staff can save money in the future.

Staff workload

Palliative care generally can be very time consuming work that is very demanding. Bureaucratic and administrative requirements, alongside work with other patients, increases stress levels for staff (Burt et al, 2005).

In addition to physical workloads, palliative care staff have high emotional workloads as the care demands high emotional resilience (Meier and Beresford, 2006). Nursing staff particularly, are more likely to feel the stress of caring for the dying (Wakefield, 2000). According to Vachon (1998), such continuous exposure to grief can lead to "grief overload". After the loss of a patient, if grief is not given the option to be expressed (as it often is), it can feel burdening and staff may experience burnout (Meier and Beresford, 2006; Rokach, 2005) due to the lack of support currently available

(Wenzel et al., 2011; Montgomery, 1998). However, researchers are quick to point out the emotional stressors alone are not enough to lead staff members to burnout or to future withdrawal from the industry (Debsiens & Fillion, 2007). It is stated that organisational factors, as well as other factors like a heavy workload (Cohen et al., 2001), in addition to the pressures of the job, can contribute to the burnout staff members may feel.

Without being able to fulfil individuals' need for support and psychological release, staff members may not feel interested to undertake any kind of development or training. Education leads report in the questionnaire we provided that sometimes perceptions of what learning is (or isn't) can prevent staff from making the most of opportunities that are provided. Additionally, due to their workloads, staff may also not have the time to commit to training needs. This commonly results in cancellations or dropouts for training in order to prioritise service delivery (The Democratic Society, 2015).

Time and resources

There are a myriad of reasons behind why staff taking on training is useful and valuable, for both the service and staff who work in palliative care. Research shows that managers who are supportive of non-mandatory training for staff members are able to empower staff, which can increase job satisfaction of employees (Ekosgen, 2013). However, in spite of knowing this, the lack of resources and time to undertake training and development make it difficult for services.

Despite the fact that study leave is permitted for staff to take each year, staff shortages and high workloads make it difficult for services to release their staff to take on training. Findings from our questionnaire revealed that education trainers report that it is always a "balancing act between delivering care, managing rotas & skill mix, and releasing staff for face to face training".

Results from the questionnaire also highlighted practical issues, such as the lack of resources, that make it difficult to provide for development needs. Not all services have the space to work with groups or to conduct one-to-one sessions in an environment which is physically stretched or which is not always appropriate to the task. Additionally, even when space is not a concern, access to IT to optimise e-learning opportunities are not available as they may be used for service delivery.

What systems and processes can be put in place for effective multi-disciplinary collaboration?

According to the World Health Organisation (WHO), three key measures are the main foundations for developing quality, effective palliative care. These are reported by WHO (2007, p.6) as:

- a government policy to ensure the integration of palliative care services into the structure and financing of the national health-care system
- an educational policy to provide support for the training of health-care professionals, volunteers and the public
- a drug policy to ensure the availability of essential drugs for the management of pain and other symptoms and psychological distress, in particular, opioid analgesics for pain relief.

However, these measures can only be effectively carried out if the policies have in place strong systems and processes that enable the three measures to be carried out; these would have to be able to work across multiple disciplines and agencies while also being very responsive.

Review of systems currently in place

Currently, the Electronic Palliative Care Co-ordination Systems (EPaCCS) allow for the recording and sharing of patients' care preferences at EoL. EPaCCS was first piloted in 2009 and was later rolled out across England in 2010. In a survey conducted in 2014 regarding the impact and efficacy of EPaCCS, the results from clinical commissioning groups (CCGs) across England reported that EPaCCS was beneficial overall for communication and information sharing. However, the survey also showed that social care only had access to records in 3 cases, suggesting that system interoperability is one of the main concerns (Public Health England, 2013). A further review conducted in 2016 highlighted that EPaCCS still lacks the ability to work across sectors effectively. While findings do emphasise the benefit of having EPaCCS for EOL, they also report that "technology in isolation is not guaranteed to bring benefits, which means that it is very important that healthcare teams work together and provide services that are in the best interests of the patient and family" (p.64). The report also highlighted that for EPaCCS, the ability for the system to "report on progress and outcomes remains generally very poor" (Whole Systems Partnership, 2016, p. 64)

An updated system could perhaps look at tying in social care, social work, ambulance services, and psychological services sectors etc. to ensure that all of the individuals involved in the care of a dying patient has access to selected information. Data protection policies may still be adhered to by providing password protected accesses to relevant services, ensuring that key information is only passed to other services on a need to know basis.

Changing the processes: International initiatives

It has been well documented that the majority of patients prefer to die at home, and preferred to be cared for at home. Providing a specialist care team within the home can not only help to care for patients early in their illness, it also increases patient satisfaction with the care they receive while reducing costs of care at EoL (Brumley et al, 2007). However, the lack of specialist staff able to do this are dwindling, and therefore providing care at home has become increasingly difficult in England. However, two countries who struggled with similar issues with a palliative care workforce have created programmes using trained volunteers to help to ease the difficulty.

In Argentina, the Palliative Care Programme of the Medical Federation of Buenos Aires (FEMEBA) Foundation has been providing palliative care in San Nicolas through informal methods. They use a range of trained volunteers who assess and update the course of a patient's treatment. They also help to educate family members about using various medications and treatment issues that arise. The team work with a qualified medical team and are supervised by them, and work to the WHO guidelines (Wenk et al, 1991).

Similarly, in Kerala, India, the Neighbourhood Network in Palliative Care (NNPC) uses volunteers who can spare 2 hours a week to care for the ill in their area. These volunteers are enrolled into a rigorous training programme, which provides them with a clear structure; following this, they can form teams in their own community areas. These volunteers are used to identify people in need of palliative care across even the most unknown communities, and they work together to identify the needed interventions. These interventions are then carried out by the team of clinicians and nurses they work with. The teams also provide home visits and follow-up care, as well as undertaking fundraising and awareness raising activities (Kumar, 2007).

The process of EoLC is currently a very medical one within the UK, and managed entirely by a stretched palliative care workforce. The use of volunteers in these 2 cases highlight how time constraint issues can be managed without needing the use of a workforce for selected palliative care issues. Equally, they bring palliative care management back to the public, therefore allowing communities to feel like death and dying are not medicalised and can be managed within themselves (Russell, 2017).

What training and development needs to be in place to help staff do their jobs effectively?

The National End of life Care programme highly recommends that education and training should be; regularly reviewed by training providers; underpinned by the EoLC competencies; and included as part of qualifications or credits. According to the report published by Skills for Care, Skills for Health and National End of Life Care Programme (2012), training and education providers should:

- Address what people who use end of life services say they want from health and social care providers.
- Reflect what employers want their workforces to be able to do.
- Provide a framework to assess end of life care skills and competencies.
- Support the commissioning of education and training to address workforce development needs (p.9).

Most training that is currently offered tend to be academically-focused, intending to provide staff with clear theoretical understanding of different areas of work as listed above. Training programmes that are academically structured tend to struggle to create a programme where ethical, psychological, and spiritual aspects are the most important part of care (Bolognesi, Brighi, Muciarelli, & Biasco, 2013). Therefore, palliative care training programmes need to change their focus to these key aspects, which are important to patients. The key areas regarding the training and development that needs to be in place to help palliative staff do their jobs effectively, aside from an academic focus, have been listed below.

Spiritual Care training

Research into spiritual care training recognises that not all professionals who work in palliative care feel ready or prepared to respond to patients who have religious or spiritual needs. In order to provide comprehensive care, these needs and concerns need to be addressed alongside physical health needs (Wasner et al, 2005). Particularly for hospice nurses, the lack of knowledge and confidence to address these issues are reported to one of the significant stressors (Power & Sharp, 1988).

Research by Vachon (2001) recommends individual work by palliative professionals, using meditation or any exploration with their own spirituality, to increase their ability to understand and empathise with the need for meaning that the patients they care for may have. Evaluative research into a spiritual care programme for palliative care professionals reported that since the training, professionals presented with significant improvements that has been sustained over time in attitudes towards their care work, spiritual welfare, and ability to cope with own losses and bereavement. The

course, known as 'Wisdom and Compassion in Care for the Dying', intended to help participants to empathise and recognise the different areas of dying and death that families and the dying person faces. The course requires participants to be involved in an, "*in-depth reflection on one's own fear of death, learning first hand both the needs and the hopes in dying. The participants learn techniques of active and compassionate listening, and how to recognise and address the causes of emotional and spiritual suffering. Practical exercises are presented to enable the participants to connect with disturbed or cognitively impaired patients, to learn how to deal with unfinished business, and to be able to support mourners. Furthermore, non-denominational spiritual practices such as contemplation and meditation are introduced, which can help the participants apply and experience the benefits of spiritual care for themselves, and learn how to integrate these techniques for calming the mind and deepening compassion in their professional work.*" (p. 100)

Communication Skills training

It is no secret that communication about palliative conditions and EoL is one of the hardest aspects of palliative care for clinicians and palliative professionals. Lack of training in communication can contribute to stress and burnout in palliative professionals (Fallowfield, & Jenkins, 1999; Taylor et al., 2007) and research shows that experience alone does not improve communication skills (Cantwell & Ramirez, 1997). Communication skills need to go beyond the basics, however many training programmes struggle to provide these competencies due to the academic requirements that take precedence in medical training (Back, 2007).

An Advanced Communication Skills Training (ACST) Programme for Senior Health Care Professionals in Cancer Care is currently offered as a training course in the NHS and hospices across the UK. A review of the programme reported that nurses who undertook the training showed improvements not only in their communication skills but also in their confidence and anxiety levels. Furthermore, it found an increase in their patients' satisfaction levels. This programme not only looks at academic knowledge that may be lacking for nurses (such as skills to assess patients' physical, psychological, sexual, social and spiritual issues as well as history-taking skills) but also used practical methods (role-plays conducted over 3 days) that presented different scenarios for the nurses to practice with. The results of nurses' confidence levels were also seen 3 months after the training (Wilkinson et al, 2008).

Resilience and stress management training

According to Hospice UK, workplace stress contributes to 30% of sickness absence from work and costs the NHS around £300 million per year. Aside from personal stress and burnout, workplace stress can also affect how well staff work with their patients, and can result in them making more mistakes

(Ros Taylor, 2014). Hospice UK maps out a clear flow chart for the different levels of staff, and the training that needs to be provided for these groups of workers:

	Senior leaders	Team leaders	Individuals
Source of stress	Challenging and changing external environment. Scarce resources. Increasing demand for care.	Lack of clear and shared goals, values and processes. Lack of time available for reflection and support by the team.	Distressing nature of the work – dealing daily with suffering, death and dying. Excessive workload. Lack of clear roles and responsibilities.
Risks if not addressed	Low staff morale, turnover and sickness. Reduced quality of patient care. Organisational reputation.	Team conflict, inefficiency, low morale and staff absence (sickness, turnover), poor patient care.	Unhappiness, stress, physical and mental ill health, (depression, anxiety) burnout.
Primary intervention	Good communication with staff: explain, consult and listen. Reward and thank. Monitor staff satisfaction and stress levels through surveys and sickness and absence data. Staff wellbeing strategy and policies in place.	Maintain consistent and strong leadership. Proactively meet with staff and demonstrate 'active listening'. Good management practice, eg team meetings, objective setting and appraisal. Clinical supervision. Allow time to attend, eg Schwartz Rounds.	Learn how to care for self, mentally and physically. Agree protected clinical supervision time. Plan work schedule and liaise with team members to help ensure clinical supervision time. Find someone with whom one feels safe to share concerns/ debrief.

	Senior leaders	Team leaders	Individuals
Secondary intervention	Provide access to and resources for management training, clinical supervision, organisational reflective time, resources for mindfulness, resilience etc, training.	Strong and supportive leadership. Team debrief. Group clinical supervision. Robust assessment of what is causing stress and inform executive of implications. Solution focused.	Find a safe place/ person for debrief and reflection. Seek support from line manager – be clear what support would help. Consider and offer possible solutions. Maintain own wellbeing, eg nutrition/hydration / rest. Meditation, relaxation, resilience techniques.
Tertiary intervention	Clear policies and support available for those suffering physical or mental ill health.	100% completed appraisals. All managers received management (and other) training.	Uptake of training and practice in the above.
Measures for success – are we improving?	Improvement in absence, sickness, stress levels using a recognised scale for measuring stress.	100% completed appraisals. All managers received management (and other) training.	Uptake of training and practice in the above.

Aside from training staff to combat stress and develop resilience, Hospice UK also recognises that primary interventions are still required in such a high-pressured system. Organisations who are committed to helping their workforce maintain their welfare need to ensure that stressful situations do not occur too often, and should equip managers and staff, including volunteers, to deal proactively when stress is identified in a staff member (Hospice UK, 2015). Provision of psychological support for staff members, regular supervision that includes elements of sharing stressful or difficult days, check-in sessions by managers, and immediate psychological first aid, are some ways to help staff members to deal with their workplace stress.

While there are many areas in addition to those listed above that can be looked at to ensure that the training is able to meet the needs of patients, the lack of specialist staff makes it difficult to carry out any training that has been prepared. According to a report by the Agency for Heathcare Research and Quality in the United States, the lack of specialist staff can be combated by specialist training provided to every clinician providing medical care for patients who have long-term or serious medical conditions, so that they become acquainted with the core principles and practices of palliative care (Agency for Heathcare Research and Quality, 2012). However, other research argues that this could be problematic as it could push the responsibility of basic symptom management and support to other professionals, which could only further divide an already fragmented system (Quill & Abernethy, 2013). However, the research does not completely deny the positives of training generalist clinicians. Many areas of specialist palliative care can be carried out by existing specialist or generalist clinicians who do this on a day-to-day basis in different settings anyway, and so there may still be a way to use generalist clinicians without pushing complete responsibility of palliative care onto them (Quill & Abernethy, 2013). According to Quill and Abernethy, this would mean the implementation of a care model merging, primary palliative care and specialist palliative care, so that they can co-exist (2013).

Conclusions

The palliative workforce is one that is in crisis and requires key changes to survive. Clinicians and palliative care staff are limited by barriers such the difficulty of retaining and recruiting staff, the ever-increasing case load that makes it difficult to undertake training, the cost of training, and the lack of resources.

However, the current training and development itself can also be problematic. The workforce needs to be trained beyond the basics of academic knowledge of palliative care, as the needs of patients gets more diverse. Furthermore, the increasing expectation on the smaller workforce to take on a larger workload also requires certain specialist training. Spiritual care training, communication skills training, as well as resilience and stress management training, can be very helpful for staff members to not only meet the needs of a diverse patient pool but to also feel more psychologically supported in their work.

As much as such initiatives can support the palliative workforce to feel more supported, the lack of staff will be an ever-present problem if not dealt with. Mid-term solutions such as using generalist staff whose roles are similar to those of specialist palliative staff, and have both staff groups working together to merge their workloads, may help to increase efficacy and reduce duplicity.

Aside from training and development, the processes and systems that support the palliative care staff are key to any successful palliative programme. While EPaCCS has been incredibly beneficial for EoLC overall, the system is still not able to effectively work across sectors to include other organisations involved in the care of patients, due to data protection issues and lack of communication. A new system, or updated versions of the current system, that can be accessed by all relevant people involved in the care of patient will enable more effective communication and better joint working that will improve the patient experience.

Recommendations

- **Improvements to current system.** The current system used to record and disseminate information about EoL plans needs to be updated and shared so that all who are involved in a patient's care, including social workers, carers, ambulance services etc. are able to access the records. Use of password protection, providing different access websites as well as a carer portal, can help to mitigate data protection issues while still enabling joint working.
- **Training beyond the academics and theory.** Training staff needs to not only concentrate on theoretical underpinnings, but to also focus on what staff members need immediately. Provision of training that is beyond just the academic focus, such as spiritual care training and resilience

and stress management training can help staff to better perform their role. Use of more interactive methods such as role playing or shadowing will enable staff to learn on-the-job and in a more hands-on manner.

- **Being able to release workforce to attend training.** There should be a push to provide training on ACP for every GP, which would save money in the future by preventing wastage in how people are cared for towards the end of their lives. Other options will be to use locums, a more effective rota system, use of volunteers for non-medical activities, as well as recognition and added value for staff who do training outside of work hours, are possible methods that may be able to achieve this outcome.

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