

**AGENDA MANAGEMENT SHEET**

**Name of Committee**                      **Health Overview and Scrutiny Committee**

**Date of Committee**                      **23<sup>rd</sup> May, 2007**

**Report Title**                                      **Draft Terms of Reference for the Review of Palliative Care**

**Summary**    The following report provides suggested terms of reference for the scrutiny exercise of Palliative Care. It includes a suggested reporting timetable culminating in a final report to this committee June 2008. This committee is now asked to agree panel members for this scrutiny exercise, scope, methodology and resources

**For further information please contact:**

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**Would the recommended decision be contrary to the Budget and Policy Framework?**                      No.

**Background papers**                                      None

**CONSULTATION ALREADY UNDERTAKEN:-**                      Details to be specified

- Other Committees                       .....
- Local Member(s)
- Other Elected Members                       Cllrs Jerry Roodhouse, Anne Forwood, Marion Haywood
- Cabinet Member                       Cllr Bob Stevens .....
- Chief Executive

- Legal  Sarah Duxbury.....
- Finance
- Other Chief Officers  David Carter, Graeme Betts, Marion Davis
- District Councils
- Health Authority
- Police
- Other Bodies/Individuals

**FINAL DECISION Yes**

**SUGGESTED NEXT STEPS:**

Details to be specified

- Further consideration by this Committee
- To Council
- To Cabinet
- To an O & S Committee
- To an Area Committee
- Further Consultation  .....

## Agenda No

# Health Overview and Scrutiny Committee 23<sup>rd</sup> May, 2007.

## Draft Terms of Reference for the Review of Palliative Care

## Report of the Performance and Development Directorate

### Recommendations

That the committee agrees the terms of reference for the review of 'Palliative Care with specific reference to:

- Panel Members
- Scope
- Methodology
- and Resources

### 1. Introduction

1.1 The aim of this scrutiny exercise is to review the services and care being provided for patients/clients who have been diagnosed as being near the end of their lives in Warwickshire.

### 2. Recommendation

2.1 That the committee agrees the terms of reference for the review of 'Palliative Care' with specific reference to:

- Panel Members
- Scope
- Methodology
- and Resources

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20 April 2007

# Draft Terms of Reference for the Scrutiny of Palliative Care

## 1. Aims and Objectives

The aim of this scrutiny exercise is to review the services and care being provided for patients/clients who have been diagnosed as being near the end of their lives in Warwickshire. Taking into account the following:

- The services provided by the NHS, Local Authority (Social Care Arrangements, Voluntary Sector and Hospice Movement)
- How the services providers above work together
- The support offered to users, carers and families
- To support 'Dignity in Care' campaign introduced by the Minister for Care Services Ivan Lewis in November 2006, which aims to place dignity and respect at the heart of caring for older people
- To consider the needs of children and adolescents

A successful outcome from this review would be:

- A better understanding of palliative care provision
- To understand the relationship between palliative care and health
- To understand what service providers do to meet the needs of those affected and their families
- To ensure that service providers provide a flexible, appropriate, clinically effective and accessible service in response to the needs of those affected and their families.
- To take into account equity of access to services in line with the social inclusion agenda.
- To support 'Dignity in Care' 10 point plan
- To provide a detailed analysis of current services and arrangements for the care of patients/clients at the end of their lives
- To suggest recommendations where there could be service improvement and improved working arrangements between service providers
- To identify issues where there is financial challenge and suggest areas of sustainable funding where appropriate.

## 2. History of Palliative Care

The word "hospice" originates from Roman times and throughout the early centuries the religious community ran establishments dedicated to the care of the sick and dying. These early hospices took a very holistic approach to care and focussed on the specific needs of the dying individual. Following religious suppression these places declined and it was not until the late 19<sup>th</sup> century that the old idea of hospice began to revive.<sup>1</sup>

Much of the theory and structure of modern hospice care in the UK can be credited to Dame Cicely Saunders, who observed the need for the spiritual and psychological

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<sup>1</sup> Robbin J, Moscrop J, (eds), 1995, "Caring for the dying patient and the family", Chapman & Hall: London (3<sup>rd</sup> Edition), p246

care of dying patients whilst working as a hospital nurse. Following qualification as a doctor in 1957, Saunders interviewed many terminally ill patients and created the concept of “total pain”. She also made the important clinical observation that “constant pain needs constant control”. These two features of pain relief and control are an essential part of modern hospice medicine.<sup>2</sup>

Using her wide experience in the field of caring for terminally ill patients, she opened St Christopher’s Hospice in 1967 (the start of the modern hospice movement). These combined the accomplishments of modern medicine with the more traditional holistic approach.

### Changing Role of Doctors in Palliative Care

Traditionally nurses were the main healthcare providers in the palliative care setting, this remains true today. However the role of doctors in palliative care has changed significantly over the last 40 years.

Originally doctors were reluctant to work in palliative care, because it was considered an inferior branch of medicine and training was seen as “lacking in credibility”. Most care teams at that time had one doctor who worked on a part-time voluntary basis. They usually had an area of speciality, which related to terminal care such as clinical pharmacology, but it was not directly related to palliative care. The role of the doctor was to advise nurses on more complicated areas of drug treatment and provide reassurance to patients who were reluctant to take care advice from nurses alone.<sup>3</sup>

However, in 1987 palliative care was recognised by the Royal College of Physicians as a speciality and since then the number of consultants and doctors in palliative care training schemes has increased dramatically. Now doctors in the palliative care sector work as an integrated part of a multi-professional team.<sup>4</sup>

### **3. Scope**

In order to achieve the aim set out in paragraph 1, this review will invite representatives from the following services to support and contribute information and advice:

- NHS – PCT & Acute Services
- Local Authority – Adult Social Care and Children’s Services
- Voluntary Sector – Carers, Support Services, etc.
- Independent Sector - Hospices

The review will consider how working arrangements between different services and service providers contribute to meeting national standards, best practice and related national policy

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<sup>2</sup> Milcevik N, 2002, “The Hospice Movement: History and Current Worldwide Situation”. Archive of Oncology, volume10(1), p29-32

<sup>3</sup> Dunlop R.J., Hockley J.M, 1990, “Terminal Care Support Teams: The Hospital-hospice interface” Oxford University Press: New York, p31-34

<sup>4</sup> <http://www.rcplondon.ac.uk/specialty/Palliative.asp> , 2007

The review will consider current practice, but will be informed by data and trends where these suggest changing patterns in how where care is provided.

Key areas for consideration will include:

- OOH's access to advice, support and crisis management
- Patient pathways for accessing palliative care
- Training to staff (NHS, Local Authority Services, voluntary organisations and Private)
- Multidisciplinary team (MDT) working & joint commissioning arrangements
- Pain control and symptom management
- 'Dignity in Care' 10 point plan
- Psychological, spiritual and social support that could be culturally sensitive
- Patient choice –facilities available or stay at home
- Information and communications for patients and their families
- Support to carers and access to respite
- Individualised person centre care planning and support
- Perceived role and impact of the single assessment process
- Palliative care of children and adolescents

#### **4. Panel**

To be decided

#### **5. Methodology**

To be decided

#### **6. Resources**

To be decided

#### **7. Timetable**

<i>Activity</i>	<i>Timescale</i>
Draft Terms of Reference presented to Health and Scrutiny Committee	23 <sup>th</sup> May 2007
Finalise Terms of Reference presented to Health Overview and Scrutiny Committee and agree Panel membership, Methodology and Resources	5 <sup>th</sup> September 2007
First Meeting of Panel	October 2007
Carry out scrutiny	October 2007 – May 2008
Report to Panel	May 2008
Report to full committee	June/July 2008