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## *How to use this publication*

This publication brings together some of the most up to date developments and thinking in the field. It can be used to provide an overall view, but each section also stands alone to enable readers to understand a particular aspect of palliative and end of life care for people with dementia

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# A Primary Care Approach: The Jenner Health Centre Practice

This is an initiative developed by Dr Gillie Evans at the Jenner Health Centre Practice in Whittlesey, Peterborough in which a named GP has been aligned to an individual care home. The approach has developed more widely and a draft Service Level Agreement (SLA) is currently being agreed to extend the arrangement across Peterborough PCT.

Dr Evans is the named GP for The Gables, a specialist BUPA home for the elderly mentally ill, for people with dementia and many with challenging behaviour problems. All fifty beds at the home are now covered by Dr Evans who is supported by Sally Jacks, a Registered General Nurse at The Gables.

The project operates within an overall structure. The Palliative Care in Dementia Group was started jointly by Dr Evans and Dr Janet Squire, consultant in palliative medicine, and based at the Sue Ryder Thorpe Hall Hospice in Peterborough. The Group has multidisciplinary membership including a clinical psychologist, a dietician, a speech and language therapist, a consultant in medicine for the elderly and a consultant psychogeriatrician. This Group provides a forum for discussion and enables access to specialist advice. Education is an essential part of the project with constant formal and informal learning.

The project is underpinned by an audit of emergency hospital admissions from six care homes in Whittlesey both in GP hours and out of hours over the period of

a year. The audit demonstrated that in GP hours 75% of those admitted had been visited and assessed. For out of hours services this proportion dropped to 25%. The audit showed there was a correlation between length of stay in hospital and assessment. Patients who had been visited and assessed by a GP had a longer length of stay and a more appropriate admission.

Key features of the project include:

- a regular GP 'ward round' at the care home
- use of a modified end of life care pathway
- development of Advance Care Planning
- training for the use of syringe drivers
- training and support to staff for the use of a pain assessment scale
- significant event meetings which are attended by all staff disciplines including activities and administrative staff at the care home
- a practical session with relatives to discuss a range of issues including pain assessment, appropriateness of hospital admission and the end of life care pathway. Regular time is also available for individual discussion between the family and the GP
- development of a set of guidelines and protocols
- introduction of a formalised 'allowing a natural death' decision on an individual patient basis

A draft SLA is being discussed with the PCT for GP practice care home alignment. The agreement will stipulate standards of care including the commitment of a named GP from the practice to the care home, use of the Gold Standards Framework and end of

life care planning. Choice is preserved within the arrangement as most, but not all, practices within the PCT have engaged with the agreement and all care home residents have the option to remain with their existing GP.

### *Key points*

- *GP alignment to a care home improves continuity and quality of care for people with dementia; the approach is person-centred*
- *the project was 'kick started' by a GP but a wider model of care has now been developed with commissioners*
- *a draft SLA has been formulated by the local PCT.*

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## *A Partnership Approach within a Local Area: the Croydon Project*

This article has been written by Dr Victor Pace, Consultant in Palliative Medicine, St Christopher's Hospice, London.

Despite the fact that dementias are life-limiting illnesses, we still know very little about what happens to patients and their families when the illness reaches an advanced stage. There is now widespread agreement that general palliative care principles should be followed in the care of these patients and families, but does specialist palliative care have a role to play, and if so, how? This is what the Palliative Care in Dementia Project in Croydon, run by St Christopher's Hospice and funded by a grant from the King's Fund, hopes to help clarify. It runs over three years.

The project itself began with the appointment of Sharon Scott, a highly experienced Clinical Nurse Specialist in palliative care, to support patients, families and professionals dealing with advanced dementia. Her role is advisory, supportive and educational. She is backed up by a palliative medicine consultant (myself). We did not want to add yet another layer of care to an already complex web. Instead, we work to a large extent through existing care professionals, teaching them and guiding them to provide effective palliation. We assess and follow up patients and families ourselves, but then work with the person's primary professional carers who are already in place, sometimes also involving services of which perhaps the families or