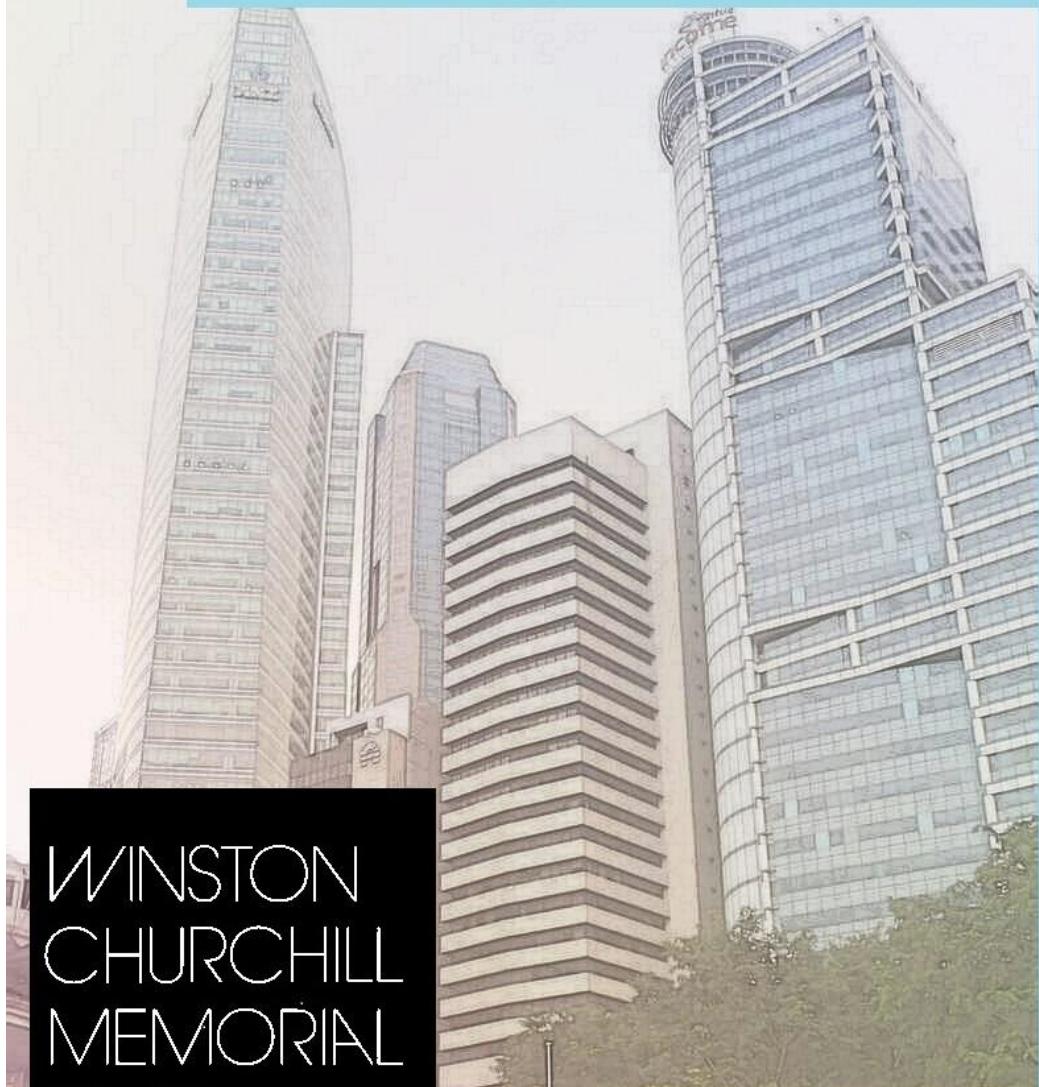


Caregiver Training..... The Way Ahead?

Ann-Marie Todd 2016



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Glossary

EoL/EoLC	End Of Life /End of Life Care
HPCT	Hospital Palliative Care Team
HCA	HCA Hospice Care
yCG	Young Caregiver Team at HCA Hospice Care
SGH	Singapore General Hospital
PCOC	Palliative Care Outcomes Collaboration

Personal Profile

I am a doctor currently working in Palliative Medicine with NHS Tayside. I am based at Cornhill MacMillan Centre, Perth which is a Specialist Palliative Care unit providing symptom and EoLC for the people of Perth & Kinross. I am part of a multidisciplinary team providing inpatient care, day care, outpatient clinics and am also involved in providing a hospital liaison advisory service to the adjacent acute hospital.

My interest in Palliative Medicine began back in medical school and following some initial years in General Practice gaining insight into the challenges of managing patients in the community, I began concentrating my focus & career in specialist palliative care.

I am married with two teenage sons who help keep me focused on achieving a healthy work-life balance!



Executive Summary

Project Aims

1. Evaluate the Palliative Caregiver Training Workshop, identify key components and whether these are applicable and appropriate to replicate in the U.K
-to achieve this, meet with the relevant professionals currently implementing the workshops and identify barriers and identify appropriate settings and facilitators.
2. Evaluation of the role of Palliative Care providers in educational establishments: Identify the concepts shared and the age groups targeted. Identify barriers to sharing palliative care concepts to children in a educational establishment setting. Identify the structures in place to ensure appropriate psychological support.
3. Identify the assessment tools used by a Hospital Palliative Care Team to evaluate their input. Observe current practice of a busy hospital team and identify similarities and differences to my own role. Identify any practice that would be transferrable to my own clinical situation.

Summary of Key Findings

Caregiver Training Workshops have a well established role within Palliative Care provision in Singapore. Although Palliative Care in Singapore only became a recognised medical subspecialty 10 years ago, the development and expansion of the Caregiver Programme in recent years reflects the worldwide goal within Palliative Care groups to undertake Advance Care Planning and help patients achieve their preferred place of death. Caregiver Workshops address the concerns and training needs highlighted by carers in the U.K and are a model that is transferrable to the U.K with minor modifications, accounting for cultural differences.

Educational establishments in Singapore have welcomed the inclusion of age appropriate Palliative Care concepts. At primary school age these concepts are broad and directed towards introducing the concept of 'Caring for others'. In Secondary School

Groups, there is the introduction of the specific needs of a population facing progressive illness and exploring with them how they can help and interact with this group of patients through voluntary work.

Summary of recommendations

1. Assess national initiatives for carer support and caregiving training across the U.K.
2. Implement Caregiver Training Workshops-locally and nationally to help address burden and concerns expressed by carers involved in caring for family members approaching EoLC.
 - Local- establish a working group to develop introduction of such a Workshop and source funding.
 - National- disseminate knowledge gained through this Fellowship with stakeholders involved in carer support and Palliative Care provision throughout the U.K to enable others to consider provision of Caregiving Workshops in their area.
3. Evaluate the current provision in Education regarding the concepts of 'demonstrating care to others' as well as moral and social responsibility. Continue to consider whether Palliative Care providers could have a formal role in Education provision and whether this may have an impact on facilitating communication around End of Life Care issues over the longer term.
 - Share the work undertaken in Singapore by the yCG team with those currently working in Education to understand the current provision and assess development opportunities.

Introduction

"You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die"

Dame Cecily Saunders 1918-2005

The Palliative Care community is continually challenged in striving to meet the needs and preferences of people as they approach death. Many patients express a wish to receive care at home towards the end of life and there is evidence that highlights the associated challenges in achieving this.

The aim of specialist Palliative Care services has always been to improve the quality of life by controlling physical symptoms, providing psychological support, and addressing spiritual and social needs.

It is estimated that if every person approaching the End-of-Life has one member of their family or a friend caring for them, in the U.K 0.5 million people are carers for someone at the End-of-Life in any given year. However, in recent years, the implications for the family who seek to support the patient in their wish for care at home have become more apparent. Studies have identified the physical, psychological and emotional burden those caring face: In a survey undertaken by the Princess Royal Trust 61% of 1066 carers reported feeling 'physically drained' and 20% reported back injury.

A study published in 2014 exploring the burden experienced by carers when involved in caring for a family member at home at the end of life, found that the number describing severe burden increased to 2/3 in the week prior to death.

In my current role within a Specialist Palliative Care Unit providing inpatient care as well as providing support in the community, we became aware of the concerns families described when considering supporting a patient who expressed a wish for end of life care at home. Their concerns mirrored those highlighted in a survey undertaken on behalf of MacMillan Cancer support in recent years: The YouGov survey highlighted 22% carers had dealt with specific healthcare tasks like administering medicines & pain relief. 1

in 3 felt their lack of knowledge could result in the person they cared for being admitted to hospital. Marie Curie also reported that many carers have the responsibility of medicines administration placed on them and the same report uncovered hidden, often overlooked pressures relatives face when caring.

A nursing colleague and I began to explore how other Palliative Care Services support carers and could we learn from them. Was a training workshop for carers an initiative we could introduce locally? Having heard about the work being undertaken in Singapore in that area and was there a national need for carer training to help facilitate care towards End of Life at home given the concerns in providing care that had been highlighted by families?

We began to look at Palliative Care services in Singapore because of the demographics (ageing population), epidemiological trends (increased burden of life limiting chronic diseases) and resultant pressure on health care systems. A visiting Palliative Care consultant to NHS Tayside some years previously had also provided us with an invaluable insight into the similarities and differences between the UK and Singapore, as well as being able to suggest contacts within local agencies who would be able to provide us with valuable insights.

Project Aims & Objectives

1. To identify the similarities & differences between Palliative Care provision in Singapore and the UK.
2. To observe the Palliative Care Caregiver Workshops provided by HCA Hospice Care and identify the benefits and challenges of providing the service. Is the caregiver training workshop model transferrable to the UK?
3. To observe the work currently being carried out in schools within Singapore by the Young Caregivers Team (yCG)- is this an area of development that could be replicated within the UK.
4. To observe the Palliative Medicine Multidisciplinary Team/Hospital Palliative Care Team at the National Cancer Centre. An advisory Hospital Palliative Care service to Singapore General Hospital- identify the tools used to evaluate the team's input into patients' symptoms and also observe practice- are there lessons to be learned in the way the team works in Singapore and can be transferred to the Hospital Palliative Care Team I work with in the UK?
5. Disseminate my findings with the local team in which I work and other agencies nationally.

Approach & Methodology

In order to formulate this report it was important to gain an appreciation of current practice in Singapore, the challenges in service provision and whether the cultural differences between the UK and Singapore would impact on the introduction of similar workshops here. Observation and evidence from the teams visited have been used to support the conclusions made in this report. The teams visited were selected through research of currently offered services within Palliative Care and the link that already exists between NHS Tayside and individual physicians within Palliative Medicine in Singapore.

Following the award of my Winston Churchill Travel Fellowship, a three week visit to Singapore was arranged allowing time to be divided between HCA Hospice Care and the National Cancer Centre Palliative Medicine Department.

Report Overview

Singapore has a population of 5.4 million people, very similar to that of Scotland. However, the geographical area of Scotland is 10 times bigger than that of Singapore. In 1965, Singapore became an independent country having been a British Colony prior to this. It was around this time that Palliative Medicine was becoming an established specialty in the U.K with Dame Cecily Saunders (who is widely credited as the founder of the modern hospice movement) opening St Christopher's Hospice in 1967.

In Singapore, Palliative Care began in the mid 1980's to meet the needs of patients dying at home. There was no formal hospice and the first team worked out of a university lecturer's apartment, providing care in patient's homes. No doctors were trained in palliative care and there were limitations on the kind of care and setting where care could be provided. However, over the past 25 years Palliative Medicine has developed rapidly to meet the complex and multiple needs of patients with progressive and advanced illnesses. Provision of Palliative Care in Singapore has mirrored that elsewhere and now extends to patients who have malignant and non-malignant conditions. Palliative Care is offered in hospitals, hospices and at home. Palliative Care providers in Singapore recognised that due to an ageing population it would be essential to structure the health care system to deliver palliative care efficiently to an increasing number of patients facing progressive illnesses and disability towards the end of life.

Home Hospice Care

The structure of inpatient hospice care and the role of hospital palliative care teams in Singapore are very similar to those within the U.K. However, the Home Hospice organisations in Singapore provide community based Palliative Care covering roles traditionally covered in the U.K by District nurses and Community MacMillan Teams. The majority are charitable organisations comprising of multidisciplinary teams of doctors, nurses and social workers who provide care to patients 7 days a week.

I spent time with **HCA Hospice Care** Singapore's largest Home Care charity, which was founded in 1989 as Palliative Medicine was developing in Singapore. **HCA** provides a free home hospice service to approximately 40,000 patients per year. At any given time **HCA** usually has 800 patients registered. In addition to a central hub, **HCA** has four satellite centres spread across the island. Each centre has a team of specialist Palliative Care nurses who hold their own caseload. They work Monday-Friday 8.30-5pm and Saturday/Sunday/Public Holidays 9-3pm on a rotational basis. During weekend hours telephone advice is usually given but there is the capacity for a home visit if necessary. Outwith these hours there is a senior doctor/consultant on call to provide medical advice to patients, carers and other medical professionals.

Each team will hold a weekly multidisciplinary team meeting with the Medical Director, senior doctor and social worker. Each nurse will have the opportunity to discuss complex symptom control issues of patients on their caseload and a management plan is agreed. The need for a joint medical/Nurse visit to a patient's home is also highlighted at this weekly team meeting. As in the U.K, the patient's GP or family doctor will still have overall medical responsibility for the patient and therefore advice is communicated to the GP following each team meeting if necessary.

During my time at **HCA** I observed that the Medical Director used these weekly team meetings as an opportunity for case based learning and education. Each nurse would select at least one case where there were issues to be discussed and using an established framework present an overview of the patient. This model ensured on-going education, team discussion and often-healthy debate! The structured approach was essential to the smooth running of each meeting as well as ensuring all salient points in the patients care were included.

Palliative Caregiver Workshop

Within each **HCA** satellite centre, there is a home hospice care training area which is used to demonstrate to patients and their families a model of a suitably equipped home that can cater to their daily needs. This is also where the **HCA Palliative Caregivers Programme** is based. On most Saturdays throughout the year, a Caregivers Workshop is available for families/carers to attend. It was this workshop that formed the original aim for my visit.

In Singapore there is a focus to provide End Of Life Care at home, if this is the patients preference. Given that the majority of patients who wish to die at home achieve this, I wanted to investigate whether the Caregivers Workshop was pivotal to this or were there other factors?

Families of patients who have stated EoLC at home as a preference are invited to attend the next available workshop. The majority of the families attending the workshops I observed had relatives in hospital who were about to be discharged home for EoLC. It is not uncommon in Singapore, to have employed 'Helpers' at home. These roles are often filled by helpers/carers who live in the family home. If a family has employed a Helper they will attend the workshop as the expectation is such that they will provide many of the physical caregiving tasks.

Each workshop was facilitated by one of the HCA Palliative Care nurses. This was in addition to their day to day nursing role and those nurses with a passion for education or carer support often viewed this role as a privilege. The aim was to have at least 3 families attend a workshop and on average 13-15 people attended. Having workshops available weekly meant families requiring support/training to facilitate caring for a relative at home, were able to access one fairly quickly. The workshops were first introduced in 2005. Each workshop covers the same common educational themes but there is flexibility to allow each facilitating nurse to tailor the session to the needs of those attending.

Each session, which ran over an entire afternoon included an overview of the service provided by **HCA**, ensuring each family knew how to access advice when required both in & out of hours. There was an opportunity to share information about who they represented and the illness their relative had, if they felt able to do so. That gave

the nurse an opportunity to highlight specific information which may be of particular relevance to them.

Each workshop covered the same themes;

*Care of the caregiver

*Communication/ Sharing concerns

*Basic infection control/Hand washing techniques

*Symptom Management-

*Pain

*Nausea/Vomiting

*Constipation/Diarrhoea

*Oedema/Abdominal Distension

*Breathlessness management

*Medication Management

*Nutrition/Hydration

*Personal Hygiene/Bathing Techniques

*Transfers/ Manual Handling

*Massage/Importance of touch

*Emergencies- Sudden Breathlessness, seizures, bleeding, spinal cord compression

Following a refreshment break the latter part of the afternoon was spent practising transfer/manual handling techniques with the available equipment in the demonstration area. Each workshop would often end with an opportunity for those attending to participate in a time of relaxation. Each family represented at a workshop was given a guidebook to take home which contained written information and photographs of the topics covered in the workshop.

The objective of the workshop is to help caregivers cope physically and emotionally with the care of their relative at home.

Evaluation of training has shown that more than 70% of those trained were able to cope with the physical and emotional aspects of caregiving.



Demonstration of manual handling techniques during HCA Caregivers Workshop

Culturally, there are significant differences between the U.K and Singapore. As a society Singaporeans view the importance of helping achieve someone's 'last wishes' in terms of place of death as significant. There is a general expectation that families will provide care towards EoL and employers are accepting of this. During the workshops I attended the 'privilege of providing care' was talked about and the choice you have in the manner you view care provision. The opportunity to 'provide care for those who once provided care to you' is key to the education shared in schools by the yCG team.

The depth of information shared during the workshops, particularly in the symptom management section, was similar to that I have observed being taught to junior medical staff in the U.K. The nursing staff who facilitated each workshop felt this was appropriate and did not feel it led to inappropriate interventions by family members. They felt it was useful for people to have information they

could reflect back on when symptoms subsequently developed and resulted in improved communication between team and family in the patient's home. Any concerns or issues which were highlighted for a particular family during a workshop were relayed to the lead nurse involved with that particular family resulting in continued ongoing support. The **HCA** team had originally run the workshop over two sessions but found that attendance was reduced on the second session. They felt that reflected time pressures rather than disengagement or distress related to the workshop content.



HCA Hospice Care Headquarters

Young CareGiver Programme

As in many other countries, family structure has changed significantly in Singapore over the past few decades. Whereas it was commonplace for extended families to live together, that is no longer the case. Due to changes in working environment and expectations families now more commonly live as a single unit and grandparents/extended family may live some distance away.

When **HCA** were searching for premises for a satellite office in 2004, they were approached by the local mayor for the area in which they were searching. He offered office space in exchange for an outreach service to children and young people in the area to introduce the concept of social responsibility. The Young CareGivers Programme was born (**yCG**) with the aim of nurturing children/teenagers/young adults to be good caregivers and to help them develop into socially responsible adults who are mindful of the needs of an ageing population with increasing care needs.

A small team, augmented by volunteers, facilitate workshops in schools and colleges. The team begins working with children around age 10 and engages them in games, role-play, video watching and discussion. The aim is to instil empathy, introduce an understanding of the need to care and also demonstrate simple ways to show care to older individuals.

Following the workshops, schools are given the opportunity to visit a **HCA** daycare facility and interact with the patients attending. The older students from secondary schools and colleges are encouraged to plan a programme that will promote interaction between patients and students. They will sometimes plan an outing for the day-care patients, taking into account the mobility & access issues that an illness may create. Following each session, a debrief is conducted to ensure any issues that may have arisen are addressed. These sessions reflect part of the national school curriculum which is called Value-in-Actions. The yCG programme was awarded the President's Volunteerism and Philanthropy Award for Social Impact in 2013.

During my time in Singapore I was able to observe the delivery of a programme in a Primary School and also the visit of a secondary school group to the daycare facility at HCA headquarters. Each of these programmes was supported by selected volunteers many of whom had a background in education.

The primary school had 5 Grade 3 classes and the programme was delivered simultaneously to all classes. The programme consisted mainly of games to highlight the differences between children and older people. As the time for discussion came the children were enthusiastically engaged and there was no hesitation from them in contributing their ideas. A short video was shown, that demonstrated the work of a Palliative Care Day Unit facility. Throughout the session, the teaching staff observed those children who may need additional support due to family situations/recent bereavement. Parents had also been given an opportunity to highlight issues to the class teacher before the team's arrival. Most schools in Singapore have a School Counsellor who is available to support the children if this is needed.

The Day Care facilities across HCA welcome input from Secondary school groups who have engaged with the yCG team. I was able to join with a Balloon Modelling club from a local school who visited HCA headquarters: Twenty young people and their teachers visited with balloons in abundance. They introduced themselves and initially appeared very hesitant at the situation they found themselves in. However, they were then encouraged to sit alongside the patients and create a balloon gift for them. Flowers, crowns, dogs and swords provided the required icebreaker. Observing the hilarity as patients competed with each other as to who would return home with the most balloons had the effect of easing any initial discomfort the students had when they arrived. A few patients who appeared disengaged at the start of the session were quickly included and conversation quickly followed between students and patients. During the second part of the afternoon the students had brought snacks to share with the patients. Day Centre staff had opportunity to review the planned food prior to the students' arrival to ensure the appropriateness for those with particular dietary needs. The students then provided each patient with a gift to remind them of their visit.

Before they departed the students had an opportunity to reflect on the afternoon with a facilitator from the yCG team. A few commented how socially awkward they felt when talking initially to the patients. Many had grandparents or elderly relatives with whom they had regular contact but reflected how it can be difficult to initiate conversation with strangers. A few commented that prior to their visit they had worried about talking to patients who were approaching the end of their life for fear of upsetting them or being

upset themselves. This was acknowledged and students were given the opportunity to complete an evaluation of their visit which included the option of sharing any concerns that the visit had highlighted. The yCG team follow up on these visits and the schools involved ensure support for those students who require it.



HCA Day Care-Balloon Modelling Club visit

There is a general acceptance across Singapore that the elderly population are referred to as 'Aunties & Uncles'. This is seen as a term of endearment and I was aware of this in both community and hospital settings and was used by nursing and medical staff, regardless of grade or seniority.



Balloon Gifts given to patients from school group

Hospital Palliative Care Team; National Cancer Centre

Singapore's National Cancer Centre is home to the Department of Palliative Medicine. The Palliative Medicine teams based there provide an advisory service to the wards of Singapore General Hospital which is situated on the same campus. Three teams, each comprising of a Consultant, a registrar and/or staff grade, junior doctor and an Advanced Practitioner Nurse receive referrals from the wards across the hospital. Two teams cover the medical and surgical wards and the third team is based on the Oncology ward. SGH provides care for over 1 million patients per year and it is owned by the government.

In Singapore, the government ensures affordability of healthcare within the public health system through a system of compulsory savings from payroll deductions, subsidies and price controls. There is a nationalised health insurance plan known as *Medisave*. The patient chooses a level of subsidy at the time of each healthcare episode. A key principle is that in general, medical services are not free of charge, regardless of the level of subsidy. The intention is to reduce the over utilisation of healthcare services. Approximately 80% of Singaporeans obtain their medical care within the public health system.

This healthcare system is clearly different to that in the U.K. However, the issues I became aware of, occur whether the patient is located in the U.K or Singapore. The symptoms, concerns and fears experienced by patients are the same. Similarly, the issues and politics experienced by the **HPCT** teams are the same experienced by my own: they are reviewing patients at the invitation of another hospital team, who have their own priorities for planning care for each patient. The differences I witnessed were related to the size of the **HPCT** caseload and the cultural influences in providing care. Each **HPCT** had on average 20 patients on their caseload at any given time. The **HPCT** I work with typically has 4 or 5, reflecting the differences in size of the hospitals.

At **SGH** patients were reviewed twice each day if changes had been suggested to medication during the morning review. I wanted to find out about the tools used by the teams to evidence the benefit of their input. The teams used the **PCOC** system to monitor patient outcomes. This tool is widely used in Palliative Medicine to systematically measure and benchmark patient outcomes. It includes information on patient demographics as well as information relating

to whether patient is stable, unstable, deteriorating or terminal. Scores related to a patient's dependency and performance status are also included. Colleagues across Palliative Medicine in Tayside are in the process of introducing a modified PCOC tool to streamline patient based assessments. This should enable audit work to be carried out to evidence the input of a **HPCT**.

A significant difference in Singapore I observed was the emphasis placed on trying to facilitate the patient's preferred place of death quickly if deterioration was identified. It was not unusual to arrange discharge of a patient the same day for **EOLC** at home. The home hospice team (often **HCA**) would meet the patient at home later the same day to ensure a management plan/ equipment was in place and family were supported with telephone numbers provided for out of hours contact if needed. In my own workplace we typically achieve discharge for **EOLC** at home over a number of days. This reflects the time taken for drug organisation/provision, communication with Primary Healthcare Team, organisation of necessary equipment and transport. The District Nursing teams and Community MacMillan Nurse Teams in the U.K would typically fulfil the role provided in Singapore by home hospice nursing staff.



National Cancer Centre, Singapore

Conclusions

"What is the use of living, if it be not to strive for noble causes and to make this muddled world a better place for those who will live in it after we are gone"

Winston Churchill in Dundee October, 1908.

Whether in U.K or Singapore, those working in Palliative Medicine share the World Health Organisation definition of Palliative Care as a goal of the care they provide: "An approach that improves the quality of life for patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." The goals of care do not differ between countries. However, the cultural differences between the U.K and Singapore have resulted in different ways to achieve that goal. I returned from Singapore certain that we could learn lessons from each others practice.

Caregiver Training Workshop:

Given the current focus in the U.K of striving to achieve a patient's preferred place of care & death, we need to identify barriers to achieving this. My main aim for travel to Singapore was to clarify whether we could replicate the Caregiver Training Workshop and would this reduce the burden & address the training needs carers currently experience. Given the combination of information on symptom management, practical demonstration of safe transfer techniques and carer support in each workshop, a similar programme in the U.K would address the issues highlighted in various studies regarding carer burden. I was surprised at the depth of medical information given during each workshop and questioned whether this was appropriate for non medical participants. I had opportunity to question carers following participation in a workshop and consistently they voiced that the information given was helpful. They did not view it as overwhelming and reflected that they felt more equipped to care. This is supported by the evaluation of participation in Caregiver Workshops by HCA. The information

given during the workshops was also provided in a booklet given to each participant and the home hospice nurse for each family represented followed with a home visit after a workshop. The Home Hospice nurses found that by attending a training workshop their communication with families was easier and information could be targeted in a focused manner. Published studies have recently highlighted that Breathlessness management for patients with this distressing symptom is more effectively managed if shared with carers as well as with the patients themselves. The Caregiving Training Workshop in Singapore had recognised this association prior to publication of these studies.

Although a resident carer/help is relatively commonplace in Singapore they were not the focus of the training workshops I attended and family member attendance was far greater. In the U.K social care provision is different to that in Singapore and there are differences across the country but patient need is the same leading to consideration that social care professionals involved in palliative care provision should have training in various aspects of care with a particular focus for the specific needs a patient approaching EoLC may have.

Young Caregiver Team:

Prior to my visit to the yCG team in Singapore I had no exposure to the introduction of caregiving/social responsibility to children & young people. The work I observed has given rise to questions as to what is the current provision within the U.K educational system in relation to social responsibility? Is there a role for the Palliative Medicine Community within education to share information? Since my return to the U.K informal discussion with those who are currently involved in teaching has led me to belief that the concepts of caregiving/need to show care is broadly covered in the curriculum under the heading of ‘Personal & Social Education’ but the specifics of topics covered vary across the country. I am aware that a few Palliative Care Units undertake work in their local schools to promote the work they undertake. These are generally units funded by charitable organisations rather than the NHS. This highlights the differences across the U.K in Palliative Care Unit funding organisation. Within England & Wales Palliative Care Units are generally funded by charitable organisations and in Scotland the majority of units are funded and supported by the NHS. This variability in organisational structure will lead to challenges in

equitable community involvement. However, variability should not be a barrier to work in this area.

National Cancer Centre:

Having the opportunity to observe the practice of another individual or team in a similar role is always beneficial. I was reminded that a patient's symptoms and concerns were the same whether they lived in Tayside or Singapore. I was surprised but reassured that the frustrations for the **HPCT** are also very similar. This undoubtedly reflects the similarity of people the world over. As a specialty we are using the same tools for the assessment of patients worldwide. The **PCOC** tool originated in Australia and Singapore's proximity therefore leads to a great deal of collaborative working.

Recommendations

• Local

1. Implementation of Caregiver Training Workshops:

Following dissemination of this report, support from the team in which I currently work and NHS Tayside, I plan to implement Caregiver Training Workshops locally. Funding for Caregiver Workshops will need to be sourced to cover staffing and materials. Selection of staff with a particular passion for carer support/ education was key to the success of the programme in Singapore and that would be the same within the U.K. Formation of a local working group would be key to oversee the issues of funding, workshop content, recruitment of families and publicity to local healthcare professionals and other agencies who may be engaged with families who could benefit from attendance.

In Singapore the attendance at a Caregiver Workshops was often just prior to a patients discharge home from the acute hospital setting or when a patient had begun to deteriorate at home. There is an argument for careful review of the timing of attendance at a workshop; early enough to allow informed choices to be made in terms of care choices but also at a stage in the patient's illness for discussion to be relevant.

2. The role of Palliative Care Units in Young People's Education:

Explore with NHS Tayside and local Education authorities as to whether there is a role for Palliative Care providers to be involved in the curriculum topics within 'Personal & Social Education'. If Palliative Care teams were involved in Educational provision in the U.K from a relatively early age, as in Singapore, it may lead to an increased awareness of the role of Palliative Care, the issues around EoLC and lead to social acceptance of conversation about End Of Life Care Issues generally. Some Palliative Care Units which rely on public support for funding have a more visible presence in the community and in local schools. As a specialty we could look to build on existing

relationships within the community and reviewing opportunities local young people have to become involved in the work we do.

•National- Rest of UK

Both the Caregiving Training Workshops and the role of Palliative Care within Young People's Education are important considerations across the U.K. In addition to sharing my report with the various Palliative Medicine professional bodies, I plan to share this report with national organisations & charities with a particular focus for carer support, those involved in Young People's Education and also the Scottish Government.

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