

Palliative Care Cancer Pathway Board

Annual Report 2014/15

Pathway Clinical Director: Carole Mula
Pathway Manager: Hodan Noor

Executive summary

To achieve the best possible quality of life for those patients with cancer who have palliative care needs. This may include:

- Those newly diagnosed with cancer
- Those undergoing active anti-cancer treatments
- Those living with on-going cancer
- Those with advanced progressive cancer
- Those approaching the last days of life
- And for those close to them or significant others who have also been affected by cancer.

To help achieve this vision, agreement has recently been approved to have a joint board with the Strategic Clinical Network (SCN) End of Life Care Advisory Group and Manchester Cancer Palliative Care board.

Headlines

1. A number of **resources were developed** in partnership with the SCN to support service providers and commissioners, to ensure that high quality care is focussed on the individual and those close to them in their last days and hours of life.
2. Active input from members of the Manchester Cancer board has been the **revision of the *Pain and Symptom Control Guidelines: Palliative Care (March 2015)***.
3. **Engagement with pathway boards**, Hepato-pancreato-biliary (HPB), Living with and Beyond (LW&BC) and Head and neck to name a few.
4. Manchester Cancer **website hosts (Electronic Palliative Care Co-ordination System (EPaCCS) templates** and training guidelines for primary care on its website.
5. Identified training needs for palliative care nurse specialists and Allied Health Professionals (AHPs) **around acute oncology**.

Challenges

1. The **lack of investment in palliative care** services with a significant lack in resources to meet the current demand.
2. Across Greater Manchester, **only one** of the ten acute Trusts have a **dedicated research programme of activities (PAs)** included in the Consultant's job plan.
3. The transformation / improvements / **re-design of services** need to consider palliative care before changes are made.
4. Improve **oncology team awareness** of the benefit of early integration of palliative care.

Introduction – the Pathway Board and its vision

This is the annual report of the Manchester Cancer Palliative Care Pathway Board for 2014/15. This annual report is designed to:

- Provide a summary of the work programme, outcomes and progress of the Board alongside the minutes of its meetings and its action plan
- Provide an overview to the hospital trust Chief Executive Officers (CEOs) and other interested parties about the current situation across Manchester Cancer regarding palliative care for people with cancer
- Meet the requirements of the National Cancer Peer Review Programme
- Be openly published on the external facing website.

This annual report outlines how the Pathway Board has contributed in 2014/15 to the achievement of Manchester Cancer's four overarching objectives:

- Improving outcomes
- Improving patient experience
- Increasing research and clinical innovation
- Delivering compliant and high quality services.

1.1. Vision

To achieve the best possible quality of life for those patients with cancer who have palliative care needs. This may include:

- Those newly diagnosed with cancer
- Those undergoing active anti-cancer treatments
- Those living with on-going cancer
- Those with advanced progressive cancer
- Those approaching the last days of life
- And for those close to them or significant others who have also been affected by cancer.

To help achieve this vision, agreement has recently been approved from both the Strategic Clinical Network (SCN), End of Life Care Advisory Group and Manchester Cancer Palliative Care Board to form a partnership. This will enhance current close working relationships in to a formal partnership ensure that the two Groups work more efficiently and effectively allowing wider projects with one agreed work plan, thereby improving care for the patients and their significant others.

The first meeting of The Greater Manchester Palliative and End of Life Care SCN's Advisory Group in Partnership with the Manchester Cancer Palliative Care Board took place on the 17/3/15 and was co-chaired by Dr Gomm (SCN) and Carole Mula (Manchester Cancer).

The partnership Board aims to raise the profile and awareness of palliative care to develop a collaborative oncology and palliative care approach to care. This will involve working with and supporting the site-specific Pathway Boards to provide excellent palliative care, ensuring that the views and experience of those who have been affected by cancer are listened to and inform future planning and service developments.

1.2. Membership

Name	Role & Trust
Carole Mula	Pathway Director
Kimberley Steel	Consultant in Palliative Medicine Bolton FT (stepped down due to relocation)
Dr Downes	Consultant in Palliative Medicine Bolton FT
Ashique Ahamed	Consultant in Palliative Medicine CMFT
Iain Lawrie	Consultant Lead Clinician for Specialist Palliative and End of Life Care, PAT
Wendy Allen	Patient Lead
David Waterman	Consultant in Palliative Medicine Stockport NHS FT
Hayes Margaret	Macmillan CNS Team Leader, Palliative Medicine, Tameside
Sophie Harrison	Consultant in Palliative Medicine UHSM
Ursula Haworth	AHP CMFT
Jenny Wiseman	Consultant in Palliative Medicine WWL FT
Phil Lomax	Medical Director St Ann's Hospice & Consultant in Palliative Medicine SRFT
Stephanie Gomm	Consultant in Palliative Medicine SRFT
Julie Whitehead	Pharmacist, East Cheshire NHS Trust
Jennifer Gallagher	Macmillan Palliative Care team Leader WWL FT
Natasha Subherwal	Pharmacist, East Cheshire NHS Trust
Jane Younger	Consultant in Liaison Psychiatry, Christie (stepped down due to relocation)
Elaine Parkin	Quality Improvement Programme Manager – Palliative & End of Life Care, GMLSC SCN
Alice Davies	Macmillan Associate Lead Cancer & Palliative Care Nurse, PAT
Anne-Marie Raftery	Team Leader & Macmillan CNS in Palliative Care The Christie
Fran Mellor	Macmillan Associate Development Manager
Robin Muir	Clinical Psychologist, Bolton FT

The membership of both the SCN Advisory Group and Manchester Cancer Board is currently under review to ensure;

- Inclusive representation from the hospital trusts
- Primary care and community services representation
- Voluntary sector engagement

It is important to note that the lead clinicians for specialist palliative care from across all of the hospital Trusts and the patient representative have historically sat on both the SCN group and Manchester Cancer Board.

Specific leads were identified from the Manchester Cancer Board for research (Dr Iain Lawrie) and Living With and Beyond Cancer (Carole Mula), however, it was not appropriate to appoint a lead for education as the SCN had previously appointed leads for Special Interest Groups (SIGs) and this would have resulted in duplication.

Members of Manchester Cancer Board were actively involved in the SIGs and contributed to the work plan. These SIGs will now formally act on behalf of both the SCN and Manchester Cancer.

SIG	Co-Lead's:
Education and Training	Dr Dave Waterman
Research and Audit	Dr Sophie Harrison and Dr Iain Lawrie
Transforming Care (focus on core metrics)	Robin Gene
Care Coordination (focus on bereavement)	Dr John O'Malley
End of Life Care Plan working group	Dr Dave Waterman

1.3. Meetings

The board have met on six occasions, below are the dates including links to the board minutes;

22nd May 2014

<http://manchestercancer.org/wp-content/uploads/2014/09/Palliative-Care-Pathway-Board-Minutes.pdf>

8th July 2014

<http://manchestercancer.org/wp-content/uploads/2014/09/Palliative-Care-Pathway-Board-Minutes1.pdf>

25th September 2014

<http://manchestercancer.org/wp-content/uploads/2014/09/Palliative-Care-Pathway-Board-Meeting-Minutes.pdf>

27th November 2014

<http://manchestercancer.org/wp-content/uploads/2014/09/Palliative-Care-Pathway-Board-Meeting-Minutes1.pdf>

10th of February 2015

<http://manchestercancer.org/wp-content/uploads/2014/09/Palliative-Care-Pathway-Board-Meeting-Minutes2.pdf>

17th of March 2015

<http://manchestercancer.org/wp-content/uploads/2014/09/Palliative-Care-Pathway-Board-Meeting-Minutes3.pdf>

2. Summary of delivery against 2014/15 plan

No	Objective	Alignment with Provider Board objectives	Tasks	By	Status Green = achieved Amber = partially achieved Red = not achieved
1	Promote the Implementation of the Electronic Palliative Care Co-ordination system (EPaCCS) for End of Life care (EoL)	Patient Experience	Host EPaCCS templates and training guidelines for primary care and secondary care on Manchester Cancer website.	August 2014	Green
			Promote to CCG Cancer Leads the development of EPaCCS and training tools available.	August 2014	Green
			Incorporate EPaCCS information as part of the suite of GP education series	August 2014	Red
			Highlight the importance of integrating EPaCCS into the development of clinical outcomes across Manchester Cancer.	March 2015	Amber
2	Mapping the integration of palliative care (generalist and specialist) service provision into oncology care. To include palliative care involvement across disease specific MDTs, education and training needs, awareness of services, systems and capacity.	Improving survival and outcome	7 day working mapping	March 2015	Green
			MDT attendance mapping	March 2015	Green
			Joint education event with LW&BC	November 2014	Green
			Partnership with the SCN	March 2015	Green
			Joint sub group with LW&BC to identify the needs of people living with cancer		Green

3. Improving outcomes, with a focus on survival

3.1. Information

The Key priorities during 2014/15 for the board was that every person affected by cancer and their relatives/carers in Manchester Cancer;

- Will have their needs assessed
- Their wishes and preferences discussed where appropriate, and an agreed set of actions reflecting the choices they make about their care.
- Including those people, receiving anti-cancer treatments, living with cancer and those in the advanced stages of the disease.
- Every person will be offered a range of physical, emotional, spiritual and social support to improve their quality of life.

3.2. Progress

3.2.1. Partnership Working with SCN

Over the last 12 months, the Manchester Cancer Palliative Care Board has run its meetings back to back with the SCN GM Palliative and End of Life Care Advisory Board, as the majority membership of both groups sat on the SCN group and Manchester Cancer Board. Thus Manchester Cancer has not only progressed with its specific work plan but actively contributed to that of the SCN.

3.2.2. Care in the Last Days of Life

The key focus of the SCN work plan has been around improving care in the last days of life following the publication of *One Chance to Get it Right* (NHS England Leadership Alliance for the Care of Dying People 2014) in response to national review of care of the dying, *More Care, Less Pathway* (Neuberger 2013).

One Chance to Get it Right mandates the implementation of *Five Care Priorities for Dying People* which are fundamental to improve care of the dying. Their use by professionals in all care settings enables those approaching the last few days and hours of their life to receive high quality care that is right for them as an individual. Each priority supports the principle that individual care must be guided by the needs and wishes of the person and those close to them.

Organisations thus have a responsibility to ensure that their staff are trained to be competent in the skills of sensitive communication, have the skills to empathically engage in difficult conversations with a patient's family and those important to them.

The SCN in collaboration with Manchester Cancer and other key stakeholders formed an End of Life Care Plan working group, chaired by Dr Dave Waterman. A number of resources were developed to support service providers and commissioners to ensure that high quality care is focussed on the individual and those close to them in their last days and hours of life. Carole Mula gave specific input to the group as a co-opted member of the Clinical Reference Group for the National Leadership Alliance for the Care of Dying People. These resources include:

- *Principles of Care and Support for the Care of the Dying Patient* - an educational tool to guide clinical staff in the delivery of good care in the last days and hours of life.

- *Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life* - produced in consultation with patients, carers and clinicians and has received over 400 comments that have informed the final care plan. To be used to record and evidence individualised care for the dying person and those close to them; does **not** define a process for care delivery and is **not** a replacement for the Liverpool Care Pathway (LCP). The SCN in partnership with Manchester Cancer are undertaking an audit and evaluation of care of the dying as part of its quality assurance role.
- *Recommended Core Education Standards for Care and Support for the Dying Person in the Last Days and Hours of Life* - provides a basis for commissioners and providers within localities to continue and further develop mandatory education and training to support care in the last days and hours of life. Can be used alongside personal development reviews by managers and individual professionals.
- *Communication Booklet for Care in the Last Days and Hours of Life* - provides families and carers the opportunity to note down any information that is wished to be shared with those involved in providing care. The information will help care staff understand what is important to the person they are caring for and others who are close to them. The Communication Booklet is not aimed to replace face to face communication.

These resources have been shared with all acute trusts, CCGs, and hospices. Organisations wishing to adopt any of these resources need to consider local governance arrangements and adopt a strategic approach to implementation across localities. Implementation will need to be supported with a comprehensive education and training programme to support professionals in the delivery of this care.

<http://www.gmlscscn.nhs.uk/index.php/networks/palliative-and-end-of-life-care/information-for-health-and-social-care-professionals/resource-library>

3.2.3. Pain and Symptom Control Guidelines

A further piece of work led by the SCN advisory group with active input from members of the Manchester Cancer board has been the revision of the *Pain and Symptom Control Guidelines: Palliative Care (March 2015)*. These guidelines are for multi-professional healthcare teams involved in prescribing, advising and administering therapies across all care settings including primary care, hospitals, hospice and nursing homes. These will need approval at local governance and medicines management committees.

3.2.4. Engagement with Cancer Boards

The Manchester Cancer Palliative Care Board has commenced engagement with other Cancer Boards.

- **Hepato-pancreato-biliary (HPB)** – The Palliative Care Clinical Director presented at the HPB Board in Jan 2015. Themes included:
 - Who Provides Palliative Care
 - Supportive Care
 - Quantifying the cancer care pathway

- American Society of clinical Oncology (ASCO) Guidelines
- Evidence that palliative care and when combined with standard cancer care, leads to better patient and caregiver outcomes.
- Earlier integration of palliative care for patients with HPB.

Challenges and Progress made by the Palliative Pathway Board was also discussed (1) in putting the Five Priorities for Care into Action (2) the implementation of the Electronic Palliative Care Coordination System (EPaCCS) (3) Earlier integration of palliative provision into oncology care and how we can work together. The HBP board discussed access to current guidelines on pain and symptom control and referral, admission and discharge via the SCN website (these will be available on Manchester Cancer website once revised versions finalised).

A palliative care champion is to be identified on the HPB board, to develop the profile of supportive/palliative care and explore opportunities for developing a joint nursing role.

It was also raised that HPB is non-compliant for peer review due to a lack of specialist palliative core team member. This has been highlighted with the Lead Clinician for specialist palliative care, Dr Ashique Ahamed. The HPB Board support the mapping of MDT working and presenting this to Manchester Cancer as a risk

- **Head and Neck** – The Pathway Manager has been working with the Head and Neck clinical director to ensure guidelines for referral to palliative care are readily available.
- **LWBC** – The Living With and Palliative Care Pathway Boards set up a joint task group within the 2014-15 work programme, chaired by Katharine Pantelides, to undertake preliminary work that will enable improved outcomes for people living with cancer.

This is in recognition that while the cancer survivorship strategy is focussed upon enhancing recovery after treatment, we may not fully understand or address the needs of those who continue to live with cancer. Also it is important to ensure that people are supported when further anti-cancer treatment is no longer of benefit and that there is a smooth transition into end of life care.

Dr Wendy Makin, Carole Mula and Rachel McMillan (St Ann's Hospice) devised a questionnaire to identify potential gaps and improvements in service relating to palliative patients and those living with cancer. This was distributed to Macmillan and The Christie Information Centres; the centre managers distributed these questionnaires to those people dropping in at the centres who were living with cancer and their carers.

Semi-structured focus group interviews also took place at the Neil Cliffe, The Christie, Wigan and Leigh Hospice and at the Macmillan Trafford Centre.

The data was analysed and recommendations made which include:

- review the use and adaptation of the Recovery Package to ensure it meets the needs of patients who are living with cancer

- ensure there is a process for elements of the recovery package (summary letters, health needs assessment, advance care planning) to be shared with all involved professionals - between hospitals, with GP, community team and hospice
- explore non-clinical models for community-based support for those living with cancer and their carers
- explore the Manchester City Council Macmillan Information & Support Service with a view to developing 'The Case for a Community Based Model'
- develop a psychological support strategy for patients and carers with input from Manchester Cancer Psychological Support subgroup
- develop, with patients and carers, 'Top 10 Tips for Living With Cancer' for cancer professionals as reminders on the areas of focus

These recommendations will be discussed further by the LWBC and Palliative Care Boards for inclusion in 2015-16 work plans (see Appendix 3).

The Living With and Beyond Cancer Board in collaboration with the Palliative Care Pathway Board undertook an education event (25.11.15) which was extremely well attended by all stakeholders across Manchester Cancer.

The aim was to showcase how elements of cancer survivorship and palliative and end of life care are being integrated with the respective cancer pathways in making a difference to patient and carers. Stakeholders also showcased their valuable work through and informative posters and market stalls which generated much discussion.

The event gave stakeholders to opportunity to consider the integration of LWBC and palliative care into their vision for the future.

The Clinical Director presented at the Clinical Directors forum (20.04.15) and highlighted areas specific to palliative that may be addressed in the cancer board's planning cycle to optimise the care and experience of patients with cancer and their carers.

3.3. Challenges

Clinical directors highlighted at the director's forum (16.01.15) their experience of access to specialist palliative care services. Whilst they acknowledged that specialist palliative care intervention hugely improves the patient experience, concerns were raised around the lack of investment in palliative care services with a significant lack in resources to meet the current demand.

The need to identify tangible measures to support the development of specialist palliative services was raised, as there is emerging evidence that supports earlier palliative care intervention improves survival (Bakitas et al 2015, Temel et al 2010). Understanding the complex mechanisms whereby palliative care may improve survival remains an important research priority.

The Christie specialist palliative care and symptom control team is progressing work on measuring the impact of earlier palliative care intervention in specific disease groups.

To reflect this expansion of palliative care services and minimise the fear associated with the terminology of palliative and end of life care, work is on-going to develop;

- An Enhanced Supportive Care model that supports cancer patients, to better suit the changing landscape of cancer care.
- Evidence of improvements in patient experience has increased interest from NHS England Quality, innovation, productivity and prevention (QIPP) team are interested in this work with a view to developing a National commissioning for quality and innovations (CQUIN).

4. Improving patient experience

4.1. Electronic Palliative Care Co-ordination Systems (EPaCCS)

The End of Life Care Strategy (DH 2008) identified the need to improve co-ordination of care, recognising that people at the end of life frequently receive care from a wide variety of teams and organisations. The development of Locality Registers (now Electronic Palliative Care Co-ordination Systems known as EPaCCS) was identified as a mechanism for enabling co-ordination.

By supporting the elicitation, recording and sharing of people's care preferences, and key details about their care, it is anticipated that EPaCCS will improve the quality of care partly through meeting people's expressed wishes and preferences. Early findings from the South West SHA Locality Register pilot showed that the vast majority of people on the register were able to die outside of hospital, and in their preferred place of care.

EPaCCS contributes to increases in the quality of end of life care individuals receive by improving co-ordination and communication across sectors, ensuring that all those involved in care will be aware of the individuals wishes and preferences as recorded in Advance Care Plans (ACPs) as well as treatment care plans.

In the northwest a programme of work led by the SCN has achieved the following;

- Shared common dataset
- Sharing of EPaCCS templates already built and in use in local systems
- Shared information governance (IG) documentation
- Use of common approach to communicate with NWAS and other shared resources

Locally, members of the Manchester Cancer Palliative Care at the board meeting in May 2014 raised support for adherence and usage of EPaCCS within the Greater Manchester area as a potential programme of work for the board.

Based on this agreement the following objectives have been met;

- Manchester Cancer hosts EPaCCS templates and training guidelines for primary care and secondary care on its website.
- An email letter has gone out to promote to Clinical Commissioning Group (CCG) Cancer Leads the development of EPaCCS and training tools available.

Part of the objective for EPaCCS was to incorporate information as part of the suite of GP education series. However, Manchester Cancer core team is in the process of developing an education strategy that will include a model for GP education. In the interim, local CCGs are delivering education on EPaCCS for GP practices.

A further outcome was to highlight the importance of integrating EPaCCS into the development of clinical outcomes across Manchester Cancer. Dr Jac Livsey, Lead for the development of the clinical outcomes database is aware of EPaCCS. Currently this work is focused on gynaecology and lung MDTs which captures whether the patient is in the last year of life and whether the treatment intent is palliative.

There are no immediate plans to communicate information from the MDTs directly to GPs although it is possible that GPs will be able to see the result of their own patients' discussion in the future taking into account information governance. The responsibility for informing GPs of those patients entering the last year of life and subsequent initiation or update of an EPaCCS lies with the consultant who actions the MDT decisions.

Across Greater Manchester, progress has been made across most CCGs to varying degrees with regards to the implementation of EPaCCS.

The Christie is working towards integration into the CCG EPaCCS deployments, which are Graphnet and MIG. Support is required from the localities to add the Christie as part of their local EPaCCS deployments. Initially access will be via view only and will move to integration once the HL7 dataset for MIG is matured.

St Ann's hospice is nearing the point of making a choice regarding which EPR system to procure and is viewing demonstrations from EMIS Web and System One.

4.2. Charities and Support Groups

Charities and support groups provide valuable support to people living with cancer. Across Manchester Cancer area there are numerous organisations providing different services and support depending on the patients / carer's location.

The Board are developing links on Manchester cancer website to enable staff and patients to access relevant information about local and national organisations such as Manchester Lymphoma Association Support Group, Jo's Cervical Cancer Trust, Maggie's Centres and CallPlus.

It is imperative that the organisations listed are reputable and current. This in itself is a big undertaking and support is required to keep this information current.

4.3. Acute Oncology

The Pathway Directors for Acute Oncology (AO) and Palliative Care have met to explore potential opportunities in improving awareness and knowledge of both acute oncology and palliative care amongst those who deliver services for patients with cancer.

A survey monkey was sent to nurse specialists and AHPs working within palliative care to establish their training needs around acute oncology to enable the development of a targeted educational event to improve patient care.

The key areas identified to be included in future educational events include management of neutropenic sepsis and spinal cord compression, clarity of referral criteria including who, when and how to refer.

Increase in GP awareness and A&E departments of AO services and development of alert systems to ensure timely identification and referrals has also been identified.

The need for closer joint working between palliative care and AO services were also highlighted. An education event is planned for 2015/16.

4.4. Macmillan Cancer Improvement Partnership (MCIP)

The Palliative Care Board was approached by The Christie School of Oncology who have been commissioned by Macmillan (MCIP) to provide GP education across North, Central and South Manchester on palliative and end of life care. The content of the training has been identified following a training needs analysis and will be combined with acute oncology topics to deliver a series of half day sessions.

Members of the Board (Dr Sophie Harrison, Dr Iain Lawrie, Dr Ashique Ahamed) have agreed to deliver these half day teaching sessions combining acute oncology and palliative care) with supporting materials in a hand book. These are to commence summer 2015.

The programme needs to be made available across Greater Manchester. It is envisaged that to make best use of resources, that these sessions will be available via podcast.

4.5. Patient Experience Surveys

The peer review measures for specialist palliative care MDT stipulate that organisations should undertake a patient experience survey every two years.

Below are listed a number of recommendations from **patient experience surveys undertaken in the last 12 months**

Trust	Recommendations
PAHT	<p>Development of End Of Life Care (EoLC) standards - launched 19/05/15</p> <p>Development of Volunteers for EoLC</p> <p>Choice of spiritual care for all patients in the last days of life</p> <p>Development of the Butterfly symbol for placing on ward curtains (for privacy & dignity) where situations require sensitive approach.</p>
The Christie	<p>Ensure new editions of specialist palliative care and symptom control booklet are amended to include some blank notes pages</p>

	Redefine the term 'keyworker'
WWL	<p>Improve communication with referring team</p> <p>Introduction of a Personal Care File Referral Pack - to be given to patients on the point of referral and prior to assessment</p> <p>Development of patient information on the role of palliative care nurses</p> <p>Information leaflets regarding service to be given as part of referral pack</p> <p>Health needs assessment to be part of referral pack to enable patients to identify key areas of concern</p> <p>Contact details available as part of the referral pack</p> <p>Discussion regarding future visits</p> <p>Contact details to be given as part of initial assessment and documented in Personal Care File Referral Pack</p> <p>Information leaflets to be left to address needs identified by patients</p> <p>Promoting the Macmillan Palliative service within the organisation</p>

4.6. Members of the Board wish to highlight some of the local developments and innovative projects / achievements relating to cancer and palliative care

Trust	Local developments and innovative projects / achievements
PAHT	<p>Undertaking the National EoLC Transformation Programme across the Trust</p> <p>Development of a New Macmillan Palliative & Supportive Service for North Manchester as part of the MCIP Programme</p> <p>Development of a hospital Statement of Intent</p> <p>Piloting of the Individualised EoLC plan</p> <p>Implementation of the Unified Do Not Attempt Cardio Pulmonary Resuscitation (UDNACPR) form and policy across the trust</p> <p>Successful bid to Macmillan Cancer Support for a team (4 posts for 2 years) to help implement the LW&BC initiative which includes elements of supportive and palliative care including treatment summaries</p> <p>The delivery of the 'HOPE' course to be facilitated several times a year to help patients address problems and concerns they may have. Some of these patients could be palliative.</p>

	Accepted on the e-HNA pilot and to be rolled out across the Trust
The Christie	<p>Successfully implemented a three year CQUIN measuring the impact of earlier integration of palliative care into specific disease groups.</p> <p>NHS England wish to explore this model further as a potential national QIPP for 2016/17.</p> <p>Formed a task and finish group to drive the changes to care in the last days of life</p> <p>Developed The Christie 'Key Priorities for Care in the Last Days of Life'</p> <p>Developed and implemented an An electronic individualised End of Life Care Plan</p> <p>Piloting the SCN communication booklet for carers of dying patients</p> <p>Developed e-lite bite on care in the last days of life to become part of the essential training programme</p> <p>Pilot site for the national specialist palliative care currency</p>
WWL	<p>Developed rapid discharge process and 'statement of Intent'</p> <p>Borough wide introduction of the individualised plan of care</p> <p>Developed patient / relative information at end of life</p> <p>Introduction of Shared decision making process</p>
SRFT	<p>Formed an Executive End of Life Care Task Group to address the key recommendations of the Neuberger Review</p> <p>Direct a comprehensive, systematic approach to promote the individualised care of patients in the last days of life.</p> <p>Developed and communicated the Salford "Principles of Care and Support for the Adult Dying Patient" with supporting Quality Markers, audited monthly as part of the Mortality Review for the team. These will be incorporated into Mortality Review across individual Directorates and Divisions.</p> <p>Developed an electronic individualised End of Life Care Plan</p> <p>Produced and implemented an information and communication booklet across hospital and community settings.</p> <p>Formed a multi-professional Nutrition and Hydration Working Group</p>

	<p>Developed an Eating & Drinking Care Plan for the Last Days of Life; a 'Risk Feeding Protocol' for patients with an expected longer term survival; working group set up to review use of SC fluids in the last days of life.</p> <p>Developed relevant information to support Rapid Discharge to community, care homes or hospice with a carer information leaflet.</p> <p>Updated the End of Life Care education programme</p> <p>On-going development of a network of palliative care link nurses</p> <p>Review of the end of life care standards within the Nursing Assessment and Accreditation System (NAAS)</p> <p>Emergency Admissions Unit (EAU) in-reach project established, involving a dedicated palliative care CNS screening and triaging all admissions to EAU daily (Monday to Friday)</p> <p>Dedicated section of the EPR to record significant conversations with patients. Information is also shared via the EPaCCS</p> <p>Delivered an extensive programme of quality improvement for adults and children in collaboration with the Bereavement Team</p> <p>Used the CODE questionnaire to gain carer bereavement feedback on a sample of hospital deaths in 2014 (analysis is awaited)</p>
<p>Central Manchester CCG</p>	<p>Developed the Macmillan Cancer Improvement Partnership Locally Commissioned Service (LCS) to improve patient experience and deliver a consistent standard of Cancer and End of Life Care across Primary care in Manchester.</p> <p>Registers advance care planning and education was highlighted as domains (3 of the 8 domains) that needed improvement.</p> <p>Quality standards developed to underpin these domains for all GP practices to attain.</p> <p>Cancer and Palliative Care Improvement Facilitators recruited by the 3 Acute Trusts. Quality assurance framework developed guided and supported by a Cancer and Palliative Care Improvement Lead hosted by Central Manchester CCG</p> <p>Developed a mandatory education programme for all practice staff that includes Palliative Care (to be delivered by Manchester Cancer Palliative Care Board members)</p> <p>From go live date of October 2014, 89% of practices have agreed to participate across the City</p>

5. Increasing research and innovative practice

5.1. Information

Specialist Palliative Care research is slow to develop compared to research in Oncology. This is partly due to ethical considerations around involving patients in clinical studies at the end of their lives, together with the absence of dedicated research programme of activities (Pas) included in clinicians' job plans.

Another factor limiting greater palliative care involvement in research is the position of independent hospices in relation to research indemnity cover. The position on this has been unclear and with the lack of dedicated research nurse support, has deterred many local hospices from becoming involved in research activity.

Across Greater Manchester, only one of the ten acute Trusts have dedicated research PAs included in the Consultant's job plan. Where studies relating to palliative care that are National Institute of Health Research (NIHR) adopted are active, some research nurse time is allocated to support the studies, but no areas have dedicated research nurse time purely to support palliative care research studies.

The way forward is to ensure Oncology research programmes not only explore survival but actively integrate supportive and palliative care outcomes such as symptom control, quality of life and patient experience.

5.2. Progress

The nominated Palliative Care Research Lead for the Board is Dr Iain Lawrie; he has been unable to attend any of the Board meetings due to clinical commitments on the day when all meetings have been held, but contributes via e-mail. Dr Lawrie is also the NIHR Cancer Research Network Greater Manchester Cancer Subspecialty Lead for Specialist Palliative Care. There is also a research and audit special interest group (SIG), chaired by Dr Sophie Harrison.

Steady progress has been made across Greater Manchester both in terms of clinical and observational studies:

Two Trusts / three centres in Manchester (Dr Arun Bhaskar, The Christie; Dr Paul O'Donnell and Dr Iain Lawrie, The Pennine Acute Hospitals NHS Trust) participated in a series of three international double blind randomized placebo-controlled parallel group studies of Sativex[®] oromucosal spray, as adjunctive therapy in relieving uncontrolled persistent chronic pain in patients with advanced cancer, who experience inadequate analgesia during optimized chronic opioid therapy.

The Pennine Acute Hospitals NHS Trust is involved in a new study led by Dr Lawrie, but wrongly badged as an Oncology study rather than a Palliative Care study, which is exploring the impact of specialist palliative care interventions alongside conventional oncology treatments. Dr Lawrie is part of the original group who designed the study and gained British Lung Foundation funding (£174,656).

The Christie Specialist Palliative Care Team is involved in a cluster randomised trial of alternative forms of hydration in cancer patients in the last days of life (feasibility study) led by Surrey Clinical Research Centre.

The Pennine Acute Hospitals NHS Trust (Dr Iain Lawrie) is participating in a multi-centre, non-interventional investigation of the relationship between pain intensity numeric rating scale scores and health status, as assessed with the EQ-5D, in patients with cancer-related chronic pain (Commercial study, GW Pharmaceuticals)

The Pennine Acute Hospitals NHS Trust (Dr Iain Lawrie) is participating in an international multi-centre open randomised parallel group trial comparing a two-step approach for cancer pain relief with the standard three step approach of the WHO analgesic ladder in patients with cancer pain requiring step 2 analgesia (TVT)

The Christie Specialist Palliative Care Team (Dr R Berman) participated in two observational studies;

- Can-Talk: A Study to compare usual treatment with a talking therapy to see which is more helpful to improve mood in people with cancer.
- SLT4501: A study to evaluate the effect and tolerability of laxatives for the reversal of constipation caused by opioids.

The SIG group is currently auditing how people who are dying, and their relatives and carers, experience care at the end of life following the recent publication *One chance to get it right* (2014).

Table 1 describes the most recent portfolio research activity across Greater Manchester as reported by the NIHR Portfolio Open Data Platform.

Table 1: Local GM analysis by Trust

Study Design	Acronym	East Cheshire	Pennine Acute	The Christie	UHSM	Grand Total
Interventional	NCRN611 - APD403 in prevention of CINV	8			6	14
Interventional	SCORAD III			3		3
Interventional	TVT Trial		1			1
Interventional Total		8	1	3	6	18
Observational	NCRN - 2991 Relationship between the Cancer Pain Intensity NRS and EQ5D		2			2
Observational	NCRN154 - long term safety of Sativex in patients with cancer related pain.		1	5		6
Observational Total			3	5		8
Grand Total		8	4	8	6	26

5.3. Challenges

The Board have requested that the Research Lead with the Clinical Research Network Greater Manchester Lead provides information on forthcoming recognised national studies specifically relating to Oncology, Palliative and End of Life Care, in order for priority studies for entry into clinical trials to be agreed with Board. This will also ensure professional research nurse support

and national recognition of recruitment. However, the responsibility for involvement, conduct and administration of studies will remain with individual organisations.

Furthermore, the recent establishment of the Experimental Cancer Medicine Team (ECMT) based at The Christie will work with the Board to explore options for recruitment to Phase 1 clinical trials. The patients recruited to these trials will generally have exhausted conventional treatments and other possible trial treatments for their cancer.

6. Delivering compliant and high quality services

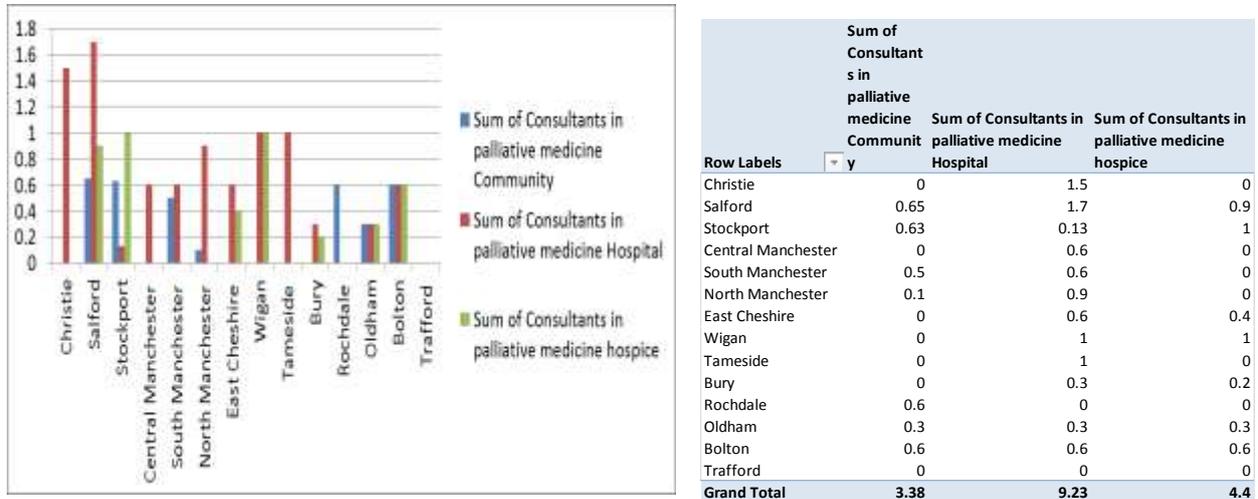
6.1. Workforce capacity

Pathway Clinical Directors have raised concerns around the lack of access to timely specialist palliative care services due to the lack of investment in palliative care services and a significant lack in resources to meet the current demand.

This is also reflected in limited 24/7 access to and provision of a 7 day service for specialist palliative care across Greater Manchester and limited specialist palliative care representation on cancer specific MDTs where specialist palliative care is a core requirement.

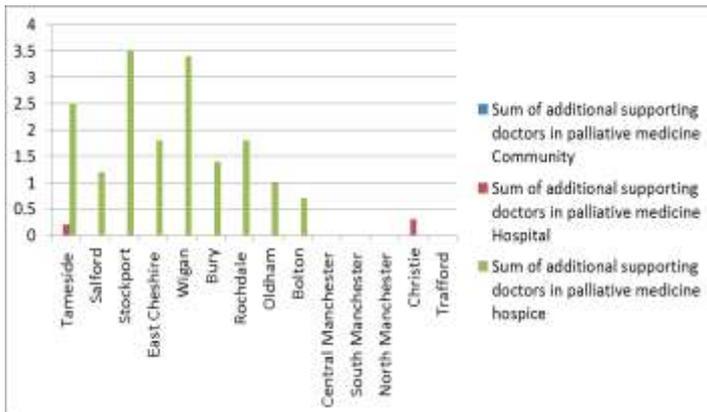
To support these concerns, the Board undertook a mapping of specialist palliative care capacity.

Table 2: WTE of Consultants in Palliative Medicine across Greater Manchester



In some areas, primarily in hospice settings, medical support is provided by speciality doctors and/or GPs with a special interest in palliative care. With this additional medical resource, large gaps for medical support, remain evident particularly across community and hospital settings.

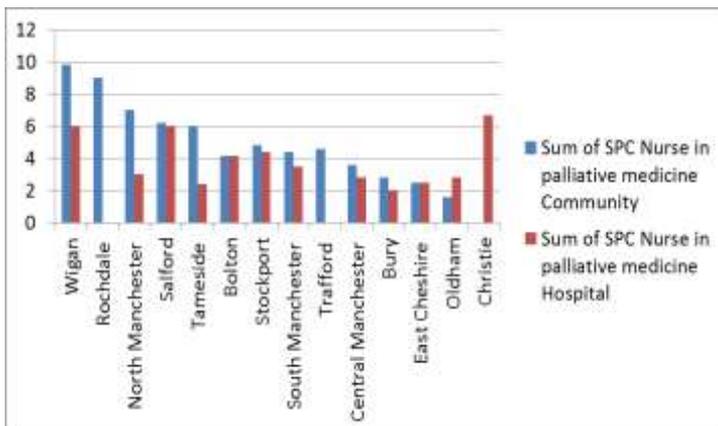
Table 3: WTE of additional Speciality Doctors working in Palliative Medicine across Greater Manchester



Row Labels	Community	Hospital	Hospice
Tameside	0	0.2	2.5
Salford	0	0	1.2
Stockport	0	0	3.5
East Cheshire	0	0	1.8
Wigan	0	0	3.4
Bury	0	0	1.4
Rochdale	0	0	1.8
Oldham	0	0	1
Bolton	0	0	0.7
Central Manchester	0	0	0
South Manchester	0	0	0
North Manchester	0	0	0
Christie	0	0.3	0
Trafford	0	0	0
Grand Total	0	0.5	17.3

Many of the specialist palliative care services are Consultant led, but in some areas the specialist palliative care nurses lead the service. There is also no or limited specialist palliative care nursing access in many areas.

Table 3: WTE of Clinical Nurse Specialist working in Palliative Medicine across Greater Manchester



Row Labels	Community	Hospital
Wigan	9.8	6
Rochdale	9	0
North Manchester	7	3
Salford	6.2	6
Tameside	6	2.4
Bolton	4.15	4.15
Stockport	4.8	4.4
South Manchester	4.4	3.5
Trafford	4.6	0
Central Manchester	3.6	2.8
Bury	2.8	2
East Cheshire	2.5	2.5
Oldham	1.6	2.8
Christie	0	6.7
Grand Total	66.45	46.25

It is evident from this mapping that there is a significant lack of resources in specialist palliative care. Revised national commissioning guidance is soon to be published which will guide future developments.

It is important to note that all of the specialist palliative care services apart from The Christie team also support professionals working in, and patients with, non-cancer diagnoses such as cardiovascular, dementia and renal.

6.2. 7 day working

The Parliamentary and Health Service Ombudsman published a report (May 2015) highlighting some of the investigations into complaints about end of life care. The report highlights cases where:

- New treatments are started, rather than plans being made for a comfortable end to life
- Failure of doctors to recognise or accept that a patient is dying
- Patients suffering unnecessarily because the wrong sort of medication is prescribed or administered poorly
- Palliative care being introduced too late resulting in people enduring a painful, undignified or lonely death and leaving little time for loved ones to say goodbye
- Too many deaths taking place on hospital wards instead of at home (Across Greater Manchester the percentage of deaths occurring in usual residence by CCG during Q3 2013/14 was 40.2 compared with the England national average of 44.5%)

A contributory factor to the above was found to be poor out-of-hours access to palliative care services across the NHS.

The availability of a seven day face-to-face visiting service and 24/7 access to specialist palliative care advice across both the hospital and community settings has been a national recommendation for the last 10 years (NICE 2004; DH 2008; NHS North West 2008; NICE 2011). This is considered to be a minimum level of service. The provision for bed-side consultations in exceptional cases outside the hours of 09.00-17.00 seven days a week is also desirable.

Specialist palliative care seven day working and access to telephone advice is a Specialist Palliative Care Peer Review measure (2012).

An Independent Review of the Liverpool Care Pathway *More Care, Less Pathway* (Neuberger 2013) highlighted the lack of access to specialist palliative care teams outside of office hours and at weekends, to support patients in the last days of life, across both the hospital and community setting.

This lack of access of specialist palliative care has been identified as a contributory factor in the delivery of poor care and poor communication in the last days of life with specific reference to delays in decision-making around the identification and subsequent management of dying patients, poor symptom control, lack of access to equipment, poor family support and the prevention of discharges home to die.

More Care, Less Pathway, recommends, as a core provision, adequately resourced specialist palliative care services (medical and nursing staff), seven days a week with 24/7 access. This is also supported by the subsequent publication of *One Chance to Get it Right* (NHS England Leadership Alliance for the Care of Dying People 2014).

6.2.1. Benefits

a. Patient and carer

- Patients reviewed in a timely manner rather than waiting for review on the next working day.
- Continuation of care, weekends and BH, for patients with complex pain, symptoms, psychological distress and end of life care.
- Clinical staff can access advice and support at all times.
- Patients more likely to be cared for and die in their usual place of residence.
- Reduced length of stay in the acute setting.
- Increase in rapid transfer of care to local services.
- Enhanced opportunities to support family members / significant others regarding the patient's management plan and future care.
- Earlier identification of deteriorating patients and timely decision-making around the identification and subsequent management of dying patients e.g. improved communications, symptom control, timely access to equipment, good family support.
- Carer satisfaction with reduced stress, anxiety and depression.

b. Staff

- 7 day partnership/ joint working with community teams, hospices, GPs, oncology teams.
- Opportunity to provide work based learning over 7 days to promote staff empowerment in dealing with complex situations and/or deteriorating patients.
- Increase in staff confidence.

c. Organisation / potential efficiency savings

- Increase in death in usual place of residence, reduced length of stay in the acute setting, efficiency savings (drugs, investigations and interventions), improved patient experience through optimising symptom control and earlier identification of the dying phase.
- Reduction in complaints around the last days of life

6.2.2. Progress

All the acute Trusts across Manchester Cancer participated in Round 4 of *The National Care of the Dying Audit for Hospitals* (RCP 2014). This audit comprised of:

- An organisational audit that examined key organisational elements that underpin the delivery of care including relevant structures, processes and policies. Organisational KPI 2 measures the provision of 'a face-to-face specialist palliative care service from at least 9am

to 5pm 7 days per week, to support the care of dying patients and their families, carers or advocates’.

- A retrospective case note review of a sample of all patients who died in hospital during May 2013. The standards of care were based on relevant national policy (DH 2008; DH 2009; DH 2012a; DH 2012b, DH 2013, CQC 2010, NICE 2011, GMC 2010) and the questions were informed by the 44 recommendations of the Independent Review of the Liverpool Care Pathway, *More Care, Less Pathway* (Neuberger et al 2013).

The results showed that, nationally, only 21% of sites had access to face-to-face palliative care services 7 days per week, despite a longstanding national recommendation that this be provided; most (73%) provided face-to-face services on weekdays only. Across Manchester Cancer only 2 (17%) out of the 12 Hospitals achieved KPI 2 described in table below.

Table 4: National Care of the Dying Audit Manchester Cancer Results

N.B. Central Manchester University Hospital Trust includes patients who died at the Trafford Division (Hospital)

KPI 2: Access to specialist support for care in the last hours or days of life	Bolton FT	CMFT	Christie FT	East Cheshire FT	Fairfield General	North Manchester General	Royal Oldham Hospital	WWL FT	SRFT	Stockport FT	Tameside FT	UHSM
	2014	✓	x	x	x	x	x	x	x	x	x	✓
2015	✓	x	✓	-	-	-	-	✓	✓	✓	✓	✓
Approximate hospital death per year	1300	2000	250	744	2500			1200	1100	1500	1066	1600

In response to this national audit, the Palliative Care board requested a further mapping to review progress and identify on-going gaps and barriers in services for KPI 2.

A short template was sent for respective Trusts to complete (please refer to appendix 2 Manchester Cancer responses).

6.2.3. Findings

- 100% response rate
- Three providers reported a lack of a seven day face-to-face specialist palliative care service in the hospital(s) and community across.
- The face-to-face service is provided primarily by a single Clinical Nurse Specialist.
- There is no Consultant / medical face-to-face access in any of the areas.
- In some areas, Consultant advice is provided on a telephone advice basis and usually through Hospice advice lines or locally agreed protocols but with no full programme activity recognition. There is limited or no face-to-face medical out of hours visiting available.
- 24/7 telephone advice is provided by the hospices, this service is primarily accessed by generic staff including GPs, district nurses and hospital staff.

6.2.4. Discussion

Although there has been significant progress since the national audit was published, the seven day face-to-face service generally consists of one specialist nurse being available for urgent reviews.

Due to the volume of work and increasing number of referrals, the reviews are mixed with some telephone and some face-to-face contacts.

The service across Manchester Cancer reflects a 'rapid response' service rather than a seven day, 9am - 5pm specialist palliative care service that provides medical and nursing cover to allow assessment, advice and active management.

Some services have one specialist nurse covering both the acute and community setting; other services have a nurse on each site.

There is limited direct access to Medical Consultant advice/support. Some Consultants provide informal support to the specialist nurse.

In most cases, the specialist nurse can access the local hospice for advice; the advice lines are manned by ward nurses, who will escalate the call to the doctor on-call if needed. Note that not all hospices have access to medical support out of hours.

This does not equate to the provision of an equitable seven day service. Furthermore, due to the small number of staff in each specialist palliative care team, weekend working impacts significantly on the Monday - Friday service.

6.2.5. Next steps

To identify with the Trust Leads any short term plans to provide a seven day 9-5 face-to-face specialist palliative care medical and nursing service, potential barriers and any support the Palliative Care Board can provide on their behalf.

The long term vision is to develop an equitable seven day specialist palliative care service staffed to a level sufficient to undertake face-to-face assessments of all people with cancer at home or hospital, 09.00-17.00, seven days a week with 24/7 access to specialist palliative care advice with direct visits where needed. This includes both specialist medical and nursing staff.

6.3. MDT Attendance

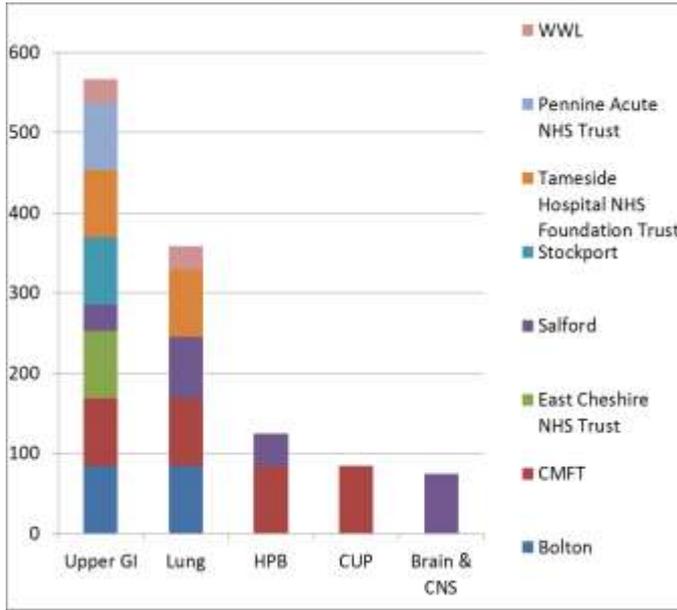
Peer review for a number of disease specific MDTs (AO, CUP, UGI, HPB, lung, Brain & CNS) state that specialist palliative care should be a core requirement. Across Greater Manchester, specialist palliative care representation is variable.

Table 5: Specialist Palliative Care Representation on Disease specific MDTs where this is a core requirement

Core member	Bolton	CMFT	East Cheshire	Salford	Stockport	Tameside	UHSM	WWL	Pennine
CUP	✓ 1 100%			✓ 1 100%	✓ 1 100%		✓ variable		
UGI				✓ 60%			✓ variable	✓ 75%	
HPB				✓ 52%					
Lung			✓ 1 100 %	✓ 8%			✓ variable	✓ 6 3%	✓ 7 5%
Brain & CNS				✓ 12%					

The shortfall in hours calculation is based on 2 hours attendance per week for 42 weeks.

Table 6: Shortfall Capacity in Hours per Organisation



The peer review measures for specialist palliative care are currently under review. However, specialist palliative care MDT is listed for self-assessment from the national team with some organisations requesting internal validation for 2015 with review of the work programme, operational policy and annual report. Areas that are listed for internal validation include The Christie, Pennine Acute (TBC), Wrightington, Wigan and Leigh.

End of Life Care is one of CQC’s new key lines of enquiry. Salford Royal Foundation Trust was inspected in Jan 2015 with the report published in March 2015. The Christie and Wrightington, Wigan and Leigh are scheduled for a visit during 2015/16.

Row Labels	Bolton	CMFT	East Cheshire NHS Trust	Salford	Stockport	Tameside Hospital NHS	Pennine Acute NHS	WWL	Grand Total
Upper GI	84	84	84	33	84	84	84	29	566
Lung	84	84	0	77		84		29	358
HPB		84		40					124
CUP	0	84							84
Brain & CNS				74					74
Grand Total	168	336	84	224	84	168	84	58	1206

7. Appendix 1 – Pathway Board meeting attendance

Name	Role & Trust	22/05 /2014	08/07 /2014	25/09 /2014	27/11 /2014	10/02 /2015	17/03 /2015
Carole Mula	Pathway Director	✓	✓	✓	✓	✓	✓
Kimberley Steel	Consultant in Palliative Medicine Bolton FT	x	✓	x	x	x	x
Dr Downes	Consultant at FT and Bolton Hospice	✓	x	x	x	x	x
Ashique Ahamed	Consultant in Palliative Medicine CMFT	✓	✓	✓	.	✓	✓
Iain Lawrie	Consultant Lead Clinician for Specialist Palliative and End of Life Care, PAT	x	x	x	x	x	x
Wendy Allen	Patient Lead	x	✓	✓	✓	✓	✓
David Waterman	Consultant in Palliative Medicine Stockport NHS Foundation Trust	✓	✓	✓	✓	✓	✓
Hayes Margaret	Macmillan CNS Team Leader Palliative Medicine, Tameside	✓	✓	.	✓	✓	✓
Sophie Harrison	Consultant in Palliative Medicine UHSM	✓	✓	✓	✓	✓	x
Ursula Haworth	AHP CMFT	.	.	✓	.	✓	x
Jenny Wiseman	Consultant in Palliative Medicine WWL FT	x	✓	x	x	✓	x
Phil Lomax	Consultant in Palliative Medicine SRFT & Medical Director St Ann's Hospics	✓	x	x	✓	✓	✓
Stephanie Gomm*	Consultant in Palliative Medicine SRFT	✓	.	✓	.	✓	✓
Julie Whitehead	Pharmacist, East Cheshire NHS Trust	x	x	✓	x	✓	✓
Jennifer Gallagher*	Macmillan Palliative Care team Leader WWL FT	✓	x	✓	x	x	✓
Natasha Subherwal	Pharmacist, East Cheshire NHS Trust	x	x	x	x	x	x
Jane Younger	Consultant in liaison Psychiatry, Christie	x	✓	x	x	.	.
Elaine Parkin	SCN	x	x	✓	✓	✓	✓

Alice Davies	PAT	x	x	x	✓	x	x
ann-Marie Raftery	Team Leader & Mcmillian CNS in Palliative Care Christie	x	x	x	x	✓	✓
Fran Mellor	Mcmillian Associate Development Manager	x	x	x	x	✓	✓
Robin Muir	Clinical Psychologist, Bolton FT	x	x	x	x	✓	✓

*Resigned in March 2015

Appendix 2- Manchester Cancer Response to 7 day working

Area	Is there a seven day 9-5 SPC face to face service in the <i>acute trust</i> ?	Is there a seven day 9-5 SPC face to face service in the <i>community</i> ?	What is the (Macmillan) SPC CNS WTE for the service?		What is the population across the community?	Number of hospital inpatient beds	Number of deaths per annum in the hospital
			Acute Trust	Community			
Bolton	Yes 1 x CNS covering both acute and community		8.3 WTE (Integrated service covering the hospital and community)		Approx. 280,000	Approx. 600	Approx. 1300 pa
Central Manchester	No	No	2.8 WTE	3.6 WTE	216,000	1100 (CMFT) Additional beds in Trafford Division	2000 pa
Trafford	No	No	Covered by CMFT	4.6 WTE			
East Cheshire	No	No	5.0 WTE (Integrated service covering the hospital and community)		191,634	353 (MDGH)	744 (MDGH)
Oldham	No	No (1x CNS available Sat 8.30am - 1.00pm)	2.8 WTE Royal Oldham Hospital, Pennine Acute Hospitals NHS Trust	1.6 WTE plus 0.6 WTE on 6/12	820,000		2500

Area	Is there a seven day 9-5 SPC face to face service in the <i>acute trust</i> ?	Is there a seven day 9-5 SPC face to face service in the <i>community</i> ?	What is the (Macmillan) SPC CNS WTE for the service?		What is the population across the community?	Number of hospital inpatient beds	Number of deaths per annum in the hospital
				contract. Pennine Care NHS Foundation Trust			
Rochdale	No	Yes 1 x CNS (8.00am – 8.00pm)	Rochdale Infirmary, Pennine Acute Hospitals NHS Trust, covered by the Royal Oldham Hospital SPCT on a needs basis				
North Manchester	No	Yes 1 x CNS (8.00am – 8.00pm)	3 WTE North Manchester, Pennine Acute Hospitals NHS Trust				
Bury	No	No	2 WTE Fairfield General Hospital, Pennine Acute Hospitals NHS Trust				
SRFT	Yes 1 x CNS	Yes 1 x CNS	6 WTE		235000	758	1100

Area	Is there a seven day 9-5 SPC face to face service in the <i>acute trust</i> ?	Is there a seven day 9-5 SPC face to face service in the <i>community</i> ?	What is the (Macmillan) SPC CNS WTE for the service?		What is the population across the community?	Number of hospital inpatient beds	Number of deaths per annum in the hospital
Stockport	Yes 1 x CNS	Yes 1 x CNS	4.4 WTE	4.8 WTE	295,000	715	1400 – 1500
Tameside	Yes 1 x CNS	Yes 1 x CNS	2.4 WTE	6.0 WTE Plus 0.6 WTE for nursing homes (not part of 7 day rota)	250,000	524	1066 (2012-2013)
Christie	Yes 1 x CNS	N/A	6.7 WTE	N/A	The Christie treats 40,000 patients across the UK pa	173 beds	240-250 pa
UHSM	Yes 1 x CNS (rota supported by lung and oesophageal CNSs)	Yes	3.5 WTE	4.4 WTE	166,000	900	1600

Area	Is there a seven day 9-5 SPC face to face service in the <i>acute trust</i> ?	Is there a seven day 9-5 SPC face to face service in the <i>community</i> ?	What is the (Macmillan) SPC CNS WTE for the service?		What is the population across the community?	Number of hospital inpatient beds	Number of deaths per annum in the hospital
WWL	Yes 1 x CNS	Yes 1 x CNS	6 WTE	9.8 WTE (employed by hospice)	320,000	531 – across 3 sites	Approx 1200 – 1400

Appendix 3 – Pathway Board Annual Plan 2015/16

The Greater Manchester Palliative and End of Life Care SCN’s Advisory Group in Partnership with Manchester Cancer Board Annual Plan 2015-16

Pathway Clinical Director:	Carole Mula	
Pathway Board Members:	Dr Downes Ashique Ahamed Iain Lawrie Wendy Allen David Waterman Hayes Margaret Sophie Harrison Ursula Haworth Jenny Wiseman Phil Lomax Julie Whitehead Natasha Subherwal Jane Younger Elaine Parkin Alice Davies Ann-Marie Raftery Fran Mellor Robin Muir	Consultant at FT and Bolton Hospice Consultant in Palliative Medicine CMFT Consultant Lead Clinician for Specialist Palliative and End of Life Care, PAT Patient Lead Consultant in Palliative Medicine Stockport NHS Foundation Trust Macmillan CNS Team Leader Palliative Medicine, Tameside Consultant in Palliative Medicine UHSM AHP CMFT Consultant in Palliative Medicine WWL FT Consultant in Palliative Medicine SRFT and Medical Director St Ann's Hospice Pharmacist, East Cheshire NHS Trust Pharmacist, East Cheshire NHS Trust Consultant in liaison Psychiatry, Christie SCN PAT Team Leader & Mcmillian CNS in Palliative Care Christie Mcmillian Associate Development Manager Clinical Psychologist, Bolton FT
Pathway Manager:	Hodan Noor	
Date agreed by Pathway Board:	21 st May 2015	
Review date:	October 2015	

Summary of objectives

Manchester Cancer Palliative Care board have joined resources with The Greater Manchester Palliative and End of Life Care SCN's Advisory Group and developed a joint annual plan. The objectives relevant to Manchester Cancer are below including the alignment with the overall provider board objectives.

No	Objective	Alignment with Provider Board objectives
1	Palliative and End of Life care services to be designed around the patient enabling them to identify their preferences and wishes at end of life and for those wishes to be met regardless of disease, condition or place of care	Improving outcomes
2	Patients and the people who care for them, to be supported by a compassionate, competent, confident and capable workforce	Improving patient experience
3	A unified policy for uDNACPR implemented consistently and safely across the North West	Delivery high quality, compliant, coordinated and equitable services.
4	Evaluation of individualised plan of care and support and related resources	Delivery high quality, compliant, coordinated and equitable services.
9	Meet the requirements of Peer Review	Delivery high quality, compliant, coordinated and equitable services.
10	To optimise the care of patients suffering from acute complications of cancer treatment or from emergencies caused by the disease process itself	Improving outcomes
11	Wider Manchester Cancer Pathway Board Engagement with palliative and end of life care services and initiatives	Improving outcomes

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
1. Palliative and End of Life care services to be designed around the patient enabling them to identify their preferences and wishes at end of life and for those wishes to be met regardless of disease, condition or place of care	1.1 Electronic Palliative Care Co-coordinating Systems (EPaCCS) at level A or level B in place across GM. (Joint deliverable with CCGs)	1.1.1 Encourage localities to have a EPaCCS locality group via support from project manager	Jan-June 2015	SCN – Stephen Burrows Elaine Parkin
		1.1.2 Established Network Implementation group (NIG)	Jan 2015	SCN – Stephen Burrows Elaine Parkin
		1.1.3 Collation of Network data to present to the North West operational Group	March 2015 ongoing quarterly	SCN – Stephen Burrows Elaine Parkin
		1.1.4 Localities to have a EPaCCS locality group with an EPaCCS implementation plan (link to 1.1.1)	Jan-Mar 2015	Locality -
		1.1.5 Representation at the GM EPaCCS Network implementation group (NIG) which meets every two months. (link to 1.1.2)	Jan 2015	Locality -
		1.1.6 Submission to Stephen Burrows of EPaCCS dashboard (link to 1.1.3)	March 2015	Locality -
		1.1.7 Communication Brief on EPaCCS and on who is their local EPaCCS Lead to all pathway boards	2016/16	MCB – Carole Mula Hodan Noor

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
		1.1.8 Include EPaCCS data set in the development of CWP	2015/16	MCB – Carole Mula Hodan Noor
		1.1.9 Communicate the findings and recommendations from the living with and palliative care focus group interviews and questionnaires with the GM SCN Advisory Group	2015/16	MCB – Carole Mula Hodan Noor
2. Patients and the people who care for them, to be supported by a compassionate, competent, confident and capable workforce.	2.1 An education delivery plan to support the guidance and principles in supporting excellent end of life care in all care settings underpinned by multi-professional education and training funding (MPET)	2.1.1 Coordination of an investment proposal which will reflect the Service Level Agreement with Health Education North West (HENW).	June 2015	SCN – Kim Wrigley
		2.1.2 Impact assessment/evaluation of previous MPET investment in order to influence future funding from HENW	January 2015	SCN – Kim Wrigley
		2.1.3 Provision of a network audit recording tool that will collate information to report on a North West basis to HEENW	2015/16	SCN – Kim Wrigley
		2.1.4 Establish and sustain the work programme of the Education and Training Special Interest Groups SIG's Revision of education standards	2015/16	SCN – Dr David Waterman and Abdul Amin Education Training SIG

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
		2.1.5 Coordinate a review and publish the revised symptom control guidelines after approval of the Greater Manchester Medicines Management Group	May 2015	SCN – Clinical Leads
		2.1.6 Commissioning of a comprehensive programme of Communication skills training	2015/16	SCN – Kim Wrigley
		2.1.7 Commissioning of a scoping exercise of Specialist Palliative Care Resources across the SCN	May 2015	SCN – Kim Wrigley
		2.1.8 Coordinate MDT Discussion and submit to the network a locality wide MPET plan (link to 2.1.1)	2015	Locality - Palliative and End of Life Care Lead Commissioner
		2.1.9 Provide information to support an Impact assessment/evaluation of previous MPET investment in order to influence future funding from HENW (link to 2.1.2)	January 2015	Locality - Palliative and End of Life Care Lead Commissioner
		2.1.10 Evaluate MPET funding using the North West template and submit to the network (link to 2.1.3)	2015/16	Locality - Palliative and End of Life Care Lead Commissioner
		2.1.11 Locality membership and support to the work programme of the SIG Evaluation of education standards across SCN (link to 2.1.4)	2015/16	Locality -
		2.1.12 Revision of locality pain and symptom control guidelines (link to 2.1.5)	March 2015	Locality -

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
		2.1.13 Support Co-ordination of locality attendance to a comprehensive communication skills training programme available across GM via The Maguire Unit at The Christie (link to 2.1.6)	2015/16	Locality -
		2.1.14 Cascade training packages available to boards. Ensure education on palliative care is included in pathway board education programme	February 2016	MCB – Carole Mula Hodan Noor
		2.1.15 Pathway Director to deliver presentation to Manchester Cancer Directors Forum on findings from the audit on the individualised end of life care plan and related resources.	December 2015	MCB – Carole Mula Hodan Noor
		2.1.16 Report on specialist palliative care 7 day working to be presented at the Manchester Cancer CEO Cancer Board and actions to be agreed. (link to 2.1.7)	March 2015	MCB – Carole Mula Hodan Noor
2.2 Service improvement programmes to support best practice		2.2.1 Network scoping report of Facilitator role in localities taking forward Quality improvement palliative and end of life care programmes	Mar - Sept 2015	SCN – Elaine Parkin
		2.2.2 Increase the numbers of care homes accessing the GSF or Six steps programme with sustainability plans in place (link to 2.2.1)	Mar - Sept 2015	Locality -
		2.2.3 Increase the number of domiciliary care staff accessing the six steps programme (link to 2.2.1)	Mar- Sept 15	Locality -

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
3. A unified policy for uDNACPR implemented consistently and safely across the North West	3.1 An established North West Policy for uDNACPR	3.1.1 Develop a baseline survey of the uptake of a unified DNACPR policy across GM.	Feb 2015 - May 2015	SCN – Kim Wrigley
		3.1.2 Complete baseline assessment (VIA survey monkey) of the uptake of a unified DNACPR policy across GM.	June 2015	Locality - Palliative and End of Life Care Lead Commissioner
		3.1.3 Safe implementation via a coordinated locality approach (link to 3.1.1)	April 2015- March 2016	Locality -
		3.1.4 Cascading the policy once developed to ensure awareness and implementation.	June 2015	MCB – Carole Mula Hodan Noor
4. Evaluation of individualised plan of care and support and related resources	4.1 Audit report on the implementation of the SCNs resources in response to one chance to get it right (2014)	4.1.1 Establish and sustain the work programme of the Research and Audit Special Interest Group (SIG)	2015/16	SCN Dr Sophie Harrison Abdul Amin Research and Audit SIG group chair
		4.1.2 Audit report on the implementation of the SCNs resources in response to 'One chance to get it right' (2014) (link to 4.1.1)	2015/16	Locality

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
		4.1.3 Virtual education session to raise awareness of 5 care priorities for the care of last days of life. To be included as an agenda item.	December 2015	MCB – Carole Mula Hodan Noor
5. Raise awareness of and enable conversations around death and dying with the public and professionals both in health and social care	5.1 A North West agreed model for end of life care	5.1.1 Revision and publication of the North West End of Life Care Model with update to reflect Spiritual Care	June 2015	SCN – Elaine Parkin
		5.1.2 Produce and share via an event a resource to support palliative and end of life care commissioning priorities in line with the needs of people from BAME communities	June 2015	SCN – Elaine Parkin
		5.1.3 Raise Dying Matters at senior level with NHS England. Distribution of Dying Matters Materials	May 2015 onwards	SCN – Elaine Parkin
		5.1.4 Promotion of the North West EoLC model 2015 updated to reflect the 5 priorities for care for the dying person: One chance to get it right (2014) (link to 5.1.1)	Feb 2015	Locality –
		5.1.5 Support the national dying Matters awareness campaign 2015 (Link to 5.1.3)	May 2015	Locality -
		5.1.6 Engage with network resources to support the discussions in local BAME communities (link to 5.1.2)	June 2015	Locality -

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
6. Coordination and breakdown of data on deaths in usual place of residence (DiUPR) from the National Intelligence Network.	6.1 Ongoing reporting, benchmarking and dissemination of locality specific data.	6.1.1 Quarterly report of DiUPR data at the GM Advisory Group	Q2 by 30 Dec 2014, Q3 by 28 Feb 2015, Q4 by 30 Jun 2015	SCN – Abdul Amin
		6.1.2 Analyse local data and share information at the GM Advisory group (link to 6.1.1)	Q2 by 30 Dec 2014, Q3 by 28 Feb 2015, Q4 by 30 Jun 2015	Locality -
7. Address good practice for Care Coordination in palliative and end of life care	7.1 Via the work programme of the care coordination SIG develop scoping and resources to support work in bereavement	7.1.1 Establish and sustain the work programme of the Care Coordination Special Interest Groups (SIG)	2015/16	SCN – Dr John O’Malley and Elaine Parkin Care Coordination SIG
		7.1.2 Locality membership and support to the work programme of the Care coordination SIG (link to 7.1.1)	2015/16	SCN – Dr John O’Malley and Elaine Parkin Care Coordination SIG

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
8. Increase the uptake and implementation of the National Acute Hospitals Transform Programme	8.1 Increase in the Levels of implementation of Transform increasing across the network	8.1.1 Establish and sustain the work programme of the Transforming Care Special Interest Groups (SIG)	2015/16	SCN – Steve Gene and Elaine Parkin Transforming Care SIG
		8.1.2 Locality membership and support to the work programme of the Transforming Care SIG (link to 8.1.1)	2015/16	Locality -
9. Meet the requirements of Peer Review	9.1 All localities to provide a 7 day specialist palliative care service	9.1.1 SCN to develop an action plan to support localities once the national position is clear regarding the Specialist Palliative Care measures	2016	SCN –Kim Wrigley and Elaine Parkin
		9.1.2 Localities to access patient and carer experience e.g VOICES, CODE, bereavement questionnaires, National hospital audit of the care of the dying, NWAG audits and evaluation of the individual plan of care	2015/16	Locality -
		9.1.3 Manchester Cancer to develop an action plan to support localities once the national position is clear regarding the Specialist Palliative Care measures	2016	MCB – Carole Mula Hodan Noor
		9.1.4 Access to palliative care nurse specialist over 7 days in place across Greater Manchester with the provision of activity data and evaluation of 7 day service	2015/16	MCB – Carole Mula Hodan Noor

Aim/objective	Deliverables	Outcome/Measure of success - SCN/Manchester Cancer/Locality	Timescale	Lead
10. To optimise the care of patients suffering from acute complications of cancer treatment or from emergencies caused by the disease process itself	10.1 An education delivery plan to support best practice in managing patients with palliative and acute oncology needs	10.1.1 Delivery of education to acute oncology CNS's, Specialist palliative care CNS's and AHPs on palliative care and acute oncology scenarios	2015/16	MCB – Carole Mula Hodan Noor
		10.1.2 To encourage staff to attend training	2015/16	Locality -
11. Wider Manchester Cancer Pathway Board Engagement with palliative and end of life care services and initiatives	11.1 Increase in the level of engagement with palliative and end of life care initiatives	11.1.1 Palliative and end of life care reflected in Cancer Pathway Boards' Annual Plans	2015/16	MCB – Carole Mula Hodan Noor
		11.1.2 Proactive engagement with the identified champions from the cancer board	2015/16	MCB – Carole Mula Hodan Noor

Appendix: Manchester Cancer Provider Board objectives

1. Improving outcomes, with a focus on survival

We aim to:

- have a cancer survival rate for all cancers one year after diagnosis that is consistently higher than the England average for patients diagnosed beyond 2012
- have a one-year survival rate higher than 75% for patients diagnosed in 2018
- narrow the gap with Sweden's one-year survival rate from 12% (now) to 6% for patients diagnosed in 2020
- approach Sweden's one-year survival rate by 2025, and
- have greater than 70% of cancer patients diagnosed in 2020 survive at least five years

2. Improving patient experience

We aim to:

- improve year-on-year the patient experience across the region (as measured by the National Cancer Patient Experience Survey), and
- have the best performance in core patient experience questions of any major city area in England by 2015

3. Increasing research and innovative practice

We aim to:

- increase the proportion of patients involved in clinical trials from 30% to more than 40% by 2019

4. Delivering high quality, compliant, coordinated and equitable services

We aim to:

- support our specialist commissioning colleagues to deliver compliance in the four historically non-compliant specialist cancer surgery services (oesophago-gastric, hepato-pancreato-biliary, gynaecology and urology) by December 2015, and
- maintain regional compliance with the national cancer 62-day waiting time target.