

Agenda Item	P1/009/19	Date: 30th January 2019
Subject /title	Palliative and End of Life Care Strategy 2018-2023	
Author	Dr A Coackley and Dr D Monnery	
Responsible Director	Sheila Lloyd, Director of Nursing & Quality	
Executive summary and key issues for discussion		
Executive Summary		
<p>Death and dying is something that will affect us all. Improving the quality and accessibility of palliative and end of life care should be a priority for everyone. The needs of people of all ages who are living with incurable illness, death and bereavement; their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.¹</p> <p>In 2008 there was recognition that some people experience excellent palliative and end of life care but many do not.² Ten years on there is still an urgent need to improve outcomes including people’s experiences and the quality of care wherever they are.¹ We have to focus on the individual and those important to them and healthcare organisations must lead the way in improving the delivery and experience of care.</p> <p>In 2015 the National Palliative and End of Life Care Partnership published the Ambitions document ¹ which provides a national framework for local action. The framework outlines six national ambitions and the foundations and building blocks required to deliver high quality palliative and end of life care.</p> <p>The six national ambitions are:</p>		
<ol style="list-style-type: none">1. Each person is seen as an individual2. Each person gets fair access to care3. Maximising comfort and wellbeing4. Care is co-ordinated5. All staff are prepared to care6. Each community is willing to help		
<p>Our 2015-2018 strategy focused on these ambitions and our 2018-2023 strategy will continue with this work, addressing each ambition with details of goals and the actions required for success.</p>		
Our Vision		
<ul style="list-style-type: none">✓ Every Clatterbridge Cancer Centre (CCC) patient is supported in making an informed decision about their care and treatment, based on information which is sensitively communicated by a knowledgeable and compassionate multi-professional team.✓ Each patient receives the care and support to live well until they die and to have a dignified death in the place of their choice. People that are important to them are involved and supported to the extent they would wish.✓ Patients have 24/7 access to specialist palliative care services which meet their holistic needs and the needs of those important to them, regardless of where they live.✓ Patients receiving palliative treatment under the care of The Clatterbridge Cancer Centre are able to access Enhanced Supportive Care services either locally or from the centre to support them throughout their treatment. This will involve coordinated multi-professional care to meet physical, psychological, social and		

spiritual needs. We will work in partnership with colleagues across the region in delivering this service.

- ✓ Patients admitted to The Clatterbridge Cancer Centre receive consultant led specialist palliative care which relieves symptoms and maintains dignity and comfort, providing support during and after treatment.
- ✓ Patients who die in The Clatterbridge Cancer Centre receive, safe, compassionate, effective and evidence-based care. People important to the patient receive the information and support they need in a sensitive and easily accessible way, including bereavement care.

This strategy is tabled for discussion and approval for ratification at a Trust strategy.

BAF Risk Reference

This strategy does not have its own BAF risk associated with it, but adds assurance with regards to the following existing BAF risks:
1.3, 1.4, 4.3, 5.5, 7.12

Link to CQC Regulations

Regulation 9: Person-centred care

Resource Implications

The delivery of this strategy will clearly require investment in the workforce. Some of this predicted expansion is detailed in the timescale/ action plan at the end of the strategy. In addition, a cost vs benefit summary is provided in table 7 which demonstrates greater financial benefit from greater service expansion. However, the exact level of expansion required is not currently known as discussions with our partners across the region about the delivery model for Enhanced Supportive Care are still ongoing. Therefore, business cases to support additional workforce will follow when exact requirements are known.

Key communication points (internal and external)

- CCC has developed an ambitious 5 year Palliative and End of Life Care Strategy to support the wider Trust strategy and Transforming Cancer Care Initiative.
- The strategy is grounded in national ambitions and local needs and strives to improve the quality of palliative and end of life care including the addition of robust KPIs.
- This strategy when implemented will ensure equal access to Enhanced Supportive Care services across Cheshire and Merseyside and make CCC leaders in Palliative and End of Life Care regionally and beyond.

<p>FOI exemptions must be applied to specific information within documents, rather than documents as a whole. Only if the redaction renders the rest of the document non-sensical should the document itself be redacted.</p> <p>Application Exemptions:</p> <ul style="list-style-type: none"> • Prejudice to effective conduct of public affairs • Personal Information • Info provided in confidence • Commercial interests • Info intended for future publication 	<p>Please tick the appropriate box below:</p> <table border="1"> <tr> <td style="text-align: center;">✓</td> <td>A. This document is for full publication</td> </tr> <tr> <td></td> <td>B. This document includes FOI exempt information</td> </tr> <tr> <td></td> <td>C. This whole document is exempt under FOI</td> </tr> </table> <p>IMPORTANT:</p> <p>If you have chosen B above, highlight the information that is to be redacted within the document, for subsequent removal.</p> <p>Confirm to the Trust Secretary, which applicable exemption(s) apply to the whole document or highlighted sections.</p>	✓	A. This document is for full publication		B. This document includes FOI exempt information		C. This whole document is exempt under FOI
✓	A. This document is for full publication						
	B. This document includes FOI exempt information						
	C. This whole document is exempt under FOI						

Equality & Diversity impact assessment		
Are there concerns that the policy/service could have an adverse impact because of:	Yes	No
Age		✓
Disability		✓
Sex (gender)		✓
Race		✓
Sexual Orientation		✓
Gender reassignment		✓
Religion / Belief		✓
Pregnancy and maternity		✓
<p>If YES to one or more of the above please add further detail and identify if full impact assessment is required.</p>		
Next steps		
Appendices		
The strategy is included as an appendix for your review.		

Strategic Objectives supported by this report

Improving Quality	✓	Maintaining financial sustainability	
Transforming how cancer care is provided across the Network	✓	Continuous improvement and innovation	✓
Research	✓	Generating Intelligence	✓

Link to the NHS Constitution

Patients		Staff	
Access to health care	√	<i>Working environment</i> Flexible opportunities, healthy and safe working conditions, staff support	
Quality of care and environment	√	<i>Being heard:</i> <ul style="list-style-type: none"> • Involved and represented • Able to raise grievances • Able to make suggestions • Able to raise concerns and complaints 	
Nationally approved treatments, drugs and programmes	√		
Respect, consent and confidentiality	√		
Informed choice	√	Fair pay and contracts, clear roles and responsibilities	
Involvement in your healthcare and in the NHS	√	Personal and professional development	√
Complaint and redress		Treated fairly and equally	√

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Date: 21.1.19

Dear Members of the Board,

It is our pleasure to present to you the final draft of the Palliative and End of Life Care Strategy 2018-2023.

This strategy is ambitious and has been developed in response to key national, regional and local drivers. It will significantly improve the quality of care and experience for patients with palliative care needs treated here at the Centre.

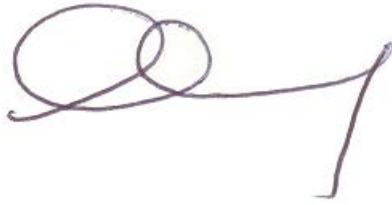
There has been extensive consultation with a range of stakeholders including patients and this has facilitated the development of a comprehensive range of Key Performance Indicators. These will help us to demonstrate effective implementation of the strategy and ensure that we address the current gaps in service provision.

There is a detailed action plan with timescales for delivery and provisional costings for the workforce expansion required. These will of course require submission of the relevant business cases for future approval. Currently there are regional discussions with local specialist palliative care providers and other stakeholders about the delivery of Enhanced Supportive Care across Cheshire and Merseyside. The outcome of these discussions will have a direct impact on the level of expansion required by CCC and so the current figures are only provisional.

We believe that this strategy will enable us to achieve our vision of ensuring our patients receive the best possible Palliative and End of Life Care and will establish CCC as a regional and national leader in this important area of care.

Kind regards.

Yours sincerely

A handwritten signature in purple ink, consisting of two overlapping loops followed by a long horizontal stroke and a vertical line at the end.

Dr Alison Coackley
Consultant in Palliative Medicine

A handwritten signature in black ink, featuring a stylized 'D' with a horizontal line through it, followed by a long horizontal stroke.

Dr Dan Monnery
Locum Consultant in Palliative Medicine

Palliative and End of Life Care Strategy

2018-2023

“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 Cicely Mary Saunders DBE

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Executive Summary

Death and dying is something that will affect us all. Improving the quality and accessibility of palliative and end of life care should be a priority for everyone. The needs of people of all ages who are living with incurable illness, death and bereavement; their families, carers and communities must be addressed, taking into account their priorities, preferences and wishes.¹

In 2008 there was recognition that some people experience excellent palliative and end of life care but many do not.² Ten years on there is still an urgent need to improve outcomes including people's experiences and the quality of care wherever they are.¹ We have to focus on the individual and those important to them and healthcare organisations must lead the way in improving the delivery and experience of care.

In 2015 the National Palliative and End of Life Care Partnership published the Ambitions document¹ which provides a national framework for local action. The framework outlines six national ambitions and the foundations and building blocks required to deliver high quality palliative and end of life care.

The six national ambitions are:

- 1. Each person is seen as an individual**
- 2. Each person gets fair access to care**
- 3. Maximising comfort and wellbeing**
- 4. Care is co-ordinated**
- 5. All staff are prepared to care**
- 6. Each community is willing to help**

Our 2015-2018 strategy focused on these ambitions and our 2018-2023 strategy will continue with this work, addressing each ambition with details of goals and the actions required for success.

Our Vision

- ✓ Every Clatterbridge Cancer Centre (CCC) patient is supported in making an informed decision about their care and treatment, based on information which is sensitively communicated by a knowledgeable and compassionate multi-professional team.
- ✓ Each patient receives the care and support to live well until they die and to have a dignified death in the place of their choice. People that are important to them are involved and supported to the extent they would wish.
- ✓ Patients have 24/7 access to specialist palliative care services which meet their holistic needs and the needs of those important to them, regardless of where they live.
- ✓ Patients receiving palliative treatment under the care of The Clatterbridge Cancer Centre are able to access Enhanced Supportive Care services either locally or from the centre to support them throughout their treatment. This will involve coordinated multi-professional care to meet physical, psychological, social and spiritual needs. We will work in partnership with colleagues across the region in delivering this service.
- ✓ Patients admitted to The Clatterbridge Cancer Centre receive consultant led specialist



palliative care which relieves symptoms and maintains dignity and comfort, providing support during and after treatment.

- ✓ Patients who die in The Clatterbridge Cancer Centre receive, safe, compassionate, effective and evidence based care. People important to the patient receive the information and support they need in a sensitive and easily accessible way, including bereavement care.

1. Introduction

Death and dying is something that will affect us all. Improving the quality and accessibility of palliative and end of life care should be a priority for everyone. The needs of people of all ages who are living with incurable illness, death and bereavement, their families', carers and communities must be addressed considering their priorities, preferences and wishes.¹ Death should not be seen as a failure but poor care most certainly is. Good end of life care must be accessible, responsive, effective and personal and everyone must experience good care.

In 2008 there was recognition that some people experience excellent palliative and end of life care but many do not.² Ten years on there is still an urgent need to improve outcomes, including people's experiences and the quality of care, wherever they are.¹ We have to focus on the individual and those important to them and healthcare organisations must lead the way in improving the delivery of care.

In 2015 the National Palliative and End of Life Care Partnership published the Ambitions document¹ which provides a national framework for local action. The framework outlines the six ambitions, foundations and building blocks that are required to deliver high quality palliative and end of life care. This framework was used in our 2015-2018 strategy and remains at the heart as we build on our work over the next five years. Appendix 3 details key developments following our 2015-2018 strategy

The purpose of this 2018-2023 strategy is to outline how The Clatterbridge Cancer Centre will:

- Ensure that it delivers the best possible care to patients and carers,
- Work with a range of professionals and organisations to deliver that care and
- Provide leadership to local communities and linked services on the quality of palliative and end of life care across Cheshire and Merseyside.

2. Background

We have a rapidly ageing society in which the changing patterns of illness mean that many more of us will live longer and experience the debilitating effects of long-term conditions. Every year there will be more deaths and more of us will experience the harrowing challenges of death, dying and bereavement. In England approximately half a million people die each year equating to approximately 1% of the population. That number is expected to rise by 17% between 2012 and 2030. The percentage of deaths occurring in the group of people aged 85 years or more is expected to rise from 32% in 2003 to 44% in 2030.²

The landscape of cancer care is also changing rapidly. Advances in treatment mean there are an increasing number of patients living with cancer at different stages of their illness. They may be actively receiving anticancer therapy, or be off treatment - either in remission, cured or living with advancing disease. Many patients, especially those with progressive disease, will require the help of healthcare professionals with expertise in managing a range of problems- either associated with



cancer itself, or as a consequence of anticancer treatment.³

Preferences for where people would like to die were summarised in the 2008 National End of Life Care Strategy.² Most people would prefer to be cared for at home, as long as high-quality care can be guaranteed and as long as they do not place too great a burden on their families and carers. Currently about half of all deaths occur in hospitals and 1 in 10 patients in hospital will die during their admission. Almost 1 in 3 will have died a year later, rising to 1 in 2 for the older age groups. Despite a wish for people to die in the place of their choice, most people will continue to die in hospital for the foreseeable future.

As more people will die at an older age they will be more likely to have complex needs, multiple co-morbidities and an increased need for more care and support. The role of the hospital in the planning and delivery of palliative and end of life care is of major significance. Many patients die in hospital and hospital admission provides an opportunity to identify those who may be approaching death and arrange the care that people, their families and those important to them will need.

Provision of high quality end of life care is challenging. People have different needs, the clinical course in the last weeks and days of life is often unpredictable, and health care professionals must be adequately trained and supported. We need good coordination between the many, and often confusing, health and social care services required by each individual.

The families and those important to the person who has died also need support. This includes good quality communication during the patient's illness but also at the time of death and beyond, including access to timely bereavement support.

3. Local Context

The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) is one of the leading cancer centres in the UK, providing highly specialist cancer care to a population of 2.3m people across Cheshire, Merseyside and the surrounding areas, including the Isle of Man. The Centre provides world-class clinical services and care with academic excellence and research & development into pioneering drugs and therapies.⁴

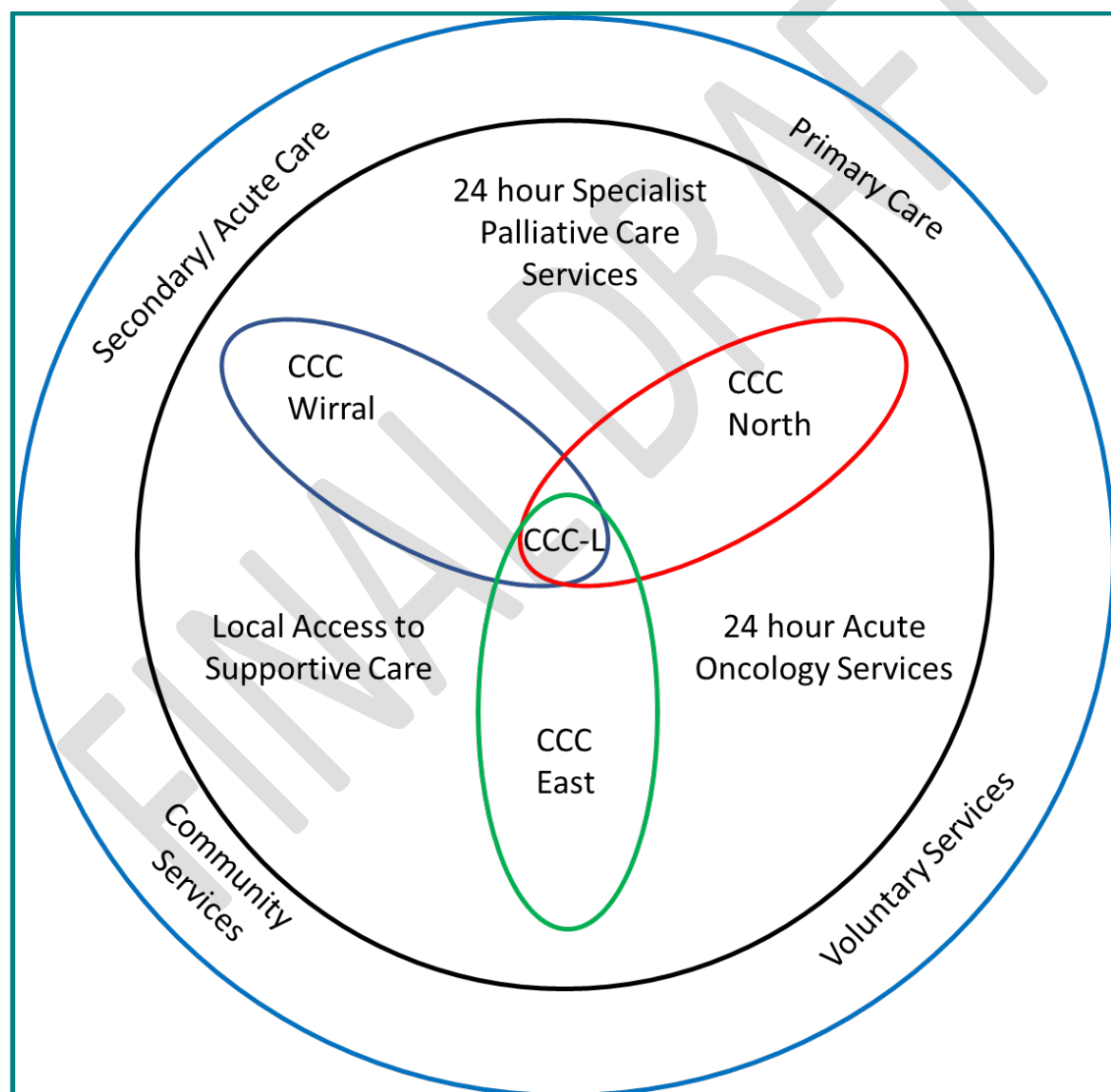
The Clatterbridge Cancer Centre is currently based in Wirral, Merseyside supported by a £17m radiotherapy treatment centre in Aintree, Liverpool. It also operates specialist chemotherapy clinics in seven of Merseyside's acute hospitals and delivers a pioneering Treatment at Home service⁴ as well as a newly developed treatment in the workplace service. However, change is on the horizon. From 2020, the Centre, in line with the Transforming Cancer Care initiative, will be based in Liverpool, adjacent to the Royal Liverpool University Hospital. The new Centre will accommodate more inpatients, including the addition of Haemato-oncology beds which will bring a younger and more complex cohort of patients. In addition, The Clatterbridge Cancer Centre will provide more services closer to patients' homes

through three regional 'hubs' (see Figure 1).

The challenge with delivering cancer care over this much larger scale is that supportive care also needs to be available on the same scale. Whilst CCC may not be the sole provider of this care, it is essential that all providers work together in a

coordinated and fully accountable way. Providers may include CCC, local specialist palliative care services, local acute oncology services, other supportive specialties and voluntary organisations. The challenges inherent with this increase in scale are key drivers for this strategy document.

Figure 1 The future multi-site model for palliative and supportive care delivery



CCC has a unique and innovative Cancer Rehabilitation and Support Team (CReST) which incorporates a wide range of healthcare professionals including: occupational therapists, physiotherapists, consultants in psychological medicine, lymphoedema specialist nurses, clinical nurse specialists, dieticians, information advice worker, benefits advisor, social worker, family support worker, chaplains, counsellors and a specialist palliative care team. The unique team approach to delivering supportive care provides real benefits to patients, families, carers and staff and must continue to be available, supported and promoted in any new model of care delivery.

Many of the patients being treated by the Centre are receiving palliative

treatment and need help with physical, psychological, social or spiritual difficulties. The Clatterbridge Cancer Centre has a responsibility and commitment to contribute to high-quality care for patients in the palliative phase of their illness and in their last hours and days of life with appropriate support to their families and those close to them. This may be directly or through partnership and collaboration with other services and teams across Cheshire, Merseyside and beyond.

The specialist palliative care team provide an integrated approach with other healthcare professionals within the Centre and work very closely with palliative care providers across the network in a range of settings (see Figure 2).

Figure 2 Providers of palliative and end of life care across the Cheshire and Merseyside Network



3.1 The Hospital Specialist Palliative Care Team at The Clatterbridge Cancer Centre

Within the Centre there is a specialist palliative care team and Table 1 gives details of the makeup of the team including core and extended members. The team provides an advisory service to other healthcare professionals within the Trust and direct clinical care to people in outpatients, inpatients and those receiving treatment at the Centre. There are over 500 referrals per year with a significant number being inpatients (60% in 2017-18) and a growing demand for outpatient services (126% increase in the last 12 months). The Enhanced Supportive Care (ESC) service has expanded from 43 new referrals in 2016-17 to 143 new referrals in 2017-18. The inpatient unit at the Centre will care for between 70-90 dying patients every year. 50% of referrals require input for symptom control with 24% needing psychological support. Over 90% of patients are seen within one day of referral.

The team have a significant role in delivering education and training, both to professionals within the Trust and externally and actively participate in research, audit and quality improvement activities.

Table 1 Core and extended members of the CCC Specialist Palliative Care Team

Core Members	Extended Members
Clinical Nurse Specialists (4.6 WTE)	Specialist Registrar (0.4 WTE)
Supportive and Palliative Care Team Co-ordinator (0.5 WTE)	
Social Worker (1.0 WTE)	
ESC Co-ordinator (1.5 WTE)	
Administrative Clerk (0.2WTE)	
Consultant in Palliative Medicine (1.0 WTE)	
Locum Consultant in Palliative Medicine (1.0 WTE)	

The Clatterbridge Cancer Centre Specialist Palliative Care Team works as per the hospital palliative care teams model set out in the Royal College of Physicians 'Designing Services' advice.⁵ We work with a range of other clinical teams to support the care pathway of patients admitted to hospital. Referrals are made by the medical team, ward nursing staff or directly from the patient and family. Examples of reasons for referral include:

- assessment of the patient in Triage or CDU (Clinical Decision making Unit) where early input can enable early discharge to community or hospice services especially for end-of-life care
- support to patient and/or carers at time of diagnosis of a life-limiting condition

- assessment of complex physical, psychological, spiritual and social situations, especially when disease is progressive, but there is uncertainty around prognosis or when the focus of clinical management shifts from supportive care alongside proactive medical intervention to palliative and end-of-life care
- support with intractable problems associated with patient, family and staff distress
- support of the dying patient and those important to them

The team is a consultant-led, multi-professional team including consultants in palliative medicine, palliative care nurse specialists, a social worker, allied health professionals and the chaplaincy team.

The team usually 'works alongside' in an advisory capacity although some may share in prescribing for pain and symptom management. All healthcare professionals should have, and retain, responsibility for ensuring good palliative and end-of-life care for the patients they look after.

The specialist palliative care service is provided 7 days each week. At weekends, palliative care nurse specialists are supported by palliative medicine physicians through on-call. Health care professionals have access to a 24 hour telephone advice line service.

4. Key Drivers

This strategy is underpinned by local, regional and national drivers which are summarised in Table 2.

5. Links to the Trust Vision

Our strategy supports the Trust vision in a number of key ways:

- ✓ This strategy reinforces the Trust values of improving care and achieving excellence. It is essential that CCC staff are instilled with the values of achieving excellence in care for patients with incurable disease. We reinforce these values through mentorship, role modelling, CPD opportunities and education. The continued presence of a consultant led team which works effectively with others in the new clinical model will develop this further.
- ✓ We will develop and deliver a palliative care research strategy to reflect Trust plans to increase research undertaken and highlight more qualitative outcomes. We will explore the patient experience and disseminate lessons learnt to make us leaders in how to deliver care beyond our region.
- ✓ We will strive to integrate more closely with local partners. The new clinical model presents opportunities to work with others to support patients across the region through our Enhanced Supportive Care service including the Merseyside and Cheshire Health and Care Partnership.
- ✓ We will focus on exploring ways in which high quality care can be delivered across the region, closer to patients' homes in partnership with others.

Our strategy sets out the vision and actions needed to deliver the best supportive care for patients being treated at CCC and the new sector hubs. Providing the best cancer care needs us to deliver the best supportive care. The two are inextricably linked.



Table 2 Key local, regional and national drivers underpinning our 2018-2023 strategy

Driver	Details
Key outcomes from national strategy ^{1-2, 6-20}	Our services need to meet the key national outcomes regarding quality of palliative and end of life care and maintenance of patients' safety during a vulnerable stage of their lives. Any changes to the way in which our service is delivered must be underpinned by these values.
Internal reviews	The Specialist Palliative Care Team is actively involved in quality assuring our services including participation in local audit and actively encouraging patient feedback through validated methods such as the Care of the Dying Evaluation (CODE), the End of Life Care Audit and National Audit of Care at the End of Life (NACEL). ²¹ Results feed directly into this strategy as the lessons learnt influence on-going service improvement.
External reviews	The 2017 Care Quality Commission report for 2017 ²² gave the Centre an overall rating of 'outstanding' and rated end of life care services as 'good'. We are determined to address the areas for improvement set out in their report including: <ul style="list-style-type: none"> • Delivering a 7-day service • Delivering comprehensive trust-wide end of life care training • Delivering AMBER care and advance care planning • Delivering on the Gold Standards Framework accreditation scheme • Demonstrating active involvement in complaint and incident handling involving end of life care
Transforming Cancer Care	The challenges posed by the forthcoming Transforming Cancer Care initiative require palliative and end of life care to be available across a larger geographical area with stronger links to local palliative and supportive care services to maintain quality of care.
Haemato-Oncology	The Clatterbridge Cancer Centre, Liverpool will host inpatient beds for Haemato-oncology which the current centre does not. Haemato-oncology patients are frequently younger and have more complex needs than other oncology patients so our service needs to be responsive to this and meet the needs of these patients on both an inpatient and outpatient basis.
Shape of Training Review ²³	The Shape of Training Review will change how doctors train from 2020. Junior doctors may have less exposure to palliative care and we need to ensure that our education is effective in developing their knowledge and skills. This will ensure that the next generation of doctors can deliver safe and effective palliative and end of life care wherever they work.
Emerging Evidence	The Clatterbridge Cancer Centre Specialist Palliative Care Team is actively involved in the regional Cheshire and Merseyside clinical audit and guideline development process which reviews key palliative and end of life care topics, ensuring that care is delivered in line with the strongest evidence base. We need flexibility in our practice and systems to ensure that we can always change in response to new evidence. This includes clinical care e.g. symptom control and services such as bereavement care.
Enhanced Supportive Care	CCC is actively involved in the delivery of Enhanced Supportive Care. Currently this is part of a national pilot evaluated by a CQUIN. Our local evaluation has demonstrated a wealth of benefits for patients and the healthcare system including reduced unplanned admissions and 30-day chemotherapy mortality. In future this service needs to be available for all patients diagnosed with incurable cancer and this will place extra demands on our clinical capacity. We need streamlined systems, expansion of our workforce and up skilling of the wider workforce to make sure we meet the needs of all patients.

6. Alignment with the Cheshire and Merseyside Palliative and End of Life Care Programme Board Plan

Our strategy aligns with the Cheshire and Merseyside Palliative and End of Life Care Programme Board Plan in a number of ways:

- Our developments in advance care planning, supportive conversations and closer integration with local teams via our regional model will help patients live well before dying with peace and dignity, supported by care which is personalised, high quality and equally accessible to all.
- Our education plan will create skilled workforce
- Our audit, quality improvement, patient involvement and research plan will enhance patient experience across the region.
- We outline the workforce required to deliver a sustainable seven day service within CCC.
- Our commitment to standardised critical appraisal of mortality reviews for patients dying within CCC will lead to improvements in care and experience for patients and those important to them
- Our model for delivery of Enhanced Supportive Care will contribute to regional discussions on service rollout.
- We plan to adopt EPACCS thus supporting electronic transfer of patient information to all relevant healthcare professionals across settings and localities

7. Vision for CCC- Our Six Ambitions

Our vision is that:

Every Clatterbridge Cancer Centre (CCC) patient is supported in making an informed decision about their care and treatment, based on information sensitively communicated by a knowledgeable and compassionate multi-professional team.

This will ensure they receive the care and support to live well until they die and to have a dignified death in the place of their choice and that those important to them are involved and supported to the extent the patient would wish.

Every patient has access to specialist palliative care services which meets their holistic needs and the needs of those important to them regardless of where they live.

This vision is aligned with the six ambitions for palliative and end of life care at The Clatterbridge Cancer Centre which are outlined in Figure 3. The ambitions are written from the perspective of the person who is nearing the end of their life. However, the ambitions also apply to carers, families, those important to the dying person and where appropriate, to those who have been bereaved. These ambitions should be applicable to everyone irrespective of whether the end of their life is predictable, unpredictable, sudden or gradual.¹



Figure 3 Our ambitions for palliative and end of life care at The Clatterbridge Cancer Centre¹



The 2018-2023 strategy will address each of these ambitions and detail the actions which will be crucial for their delivery. Each ambition is supported by foundations and a number of key 'building blocks'. We have provided in depth description of the foundations in this document. Further description about each building block can be found in the 2015-2018 Palliative and End of Life Care Strategy.²⁴

8. How Do We Deliver on Our Ambitions?

8.1 Foundations

This strategy reaffirms a commitment to the eight foundations outlined in the 2015-2018 strategy. These remain as relevant as ever in the changing landscape of cancer care. The foundations are illustrated in Figure 4 and expanded upon in Table 3. They each require specific actions to make sure we deliver effective and safe palliative and end of life care.

Figure 4 Eight foundations for the delivery of high quality palliative and end of life care at The Clatterbridge Cancer Centre

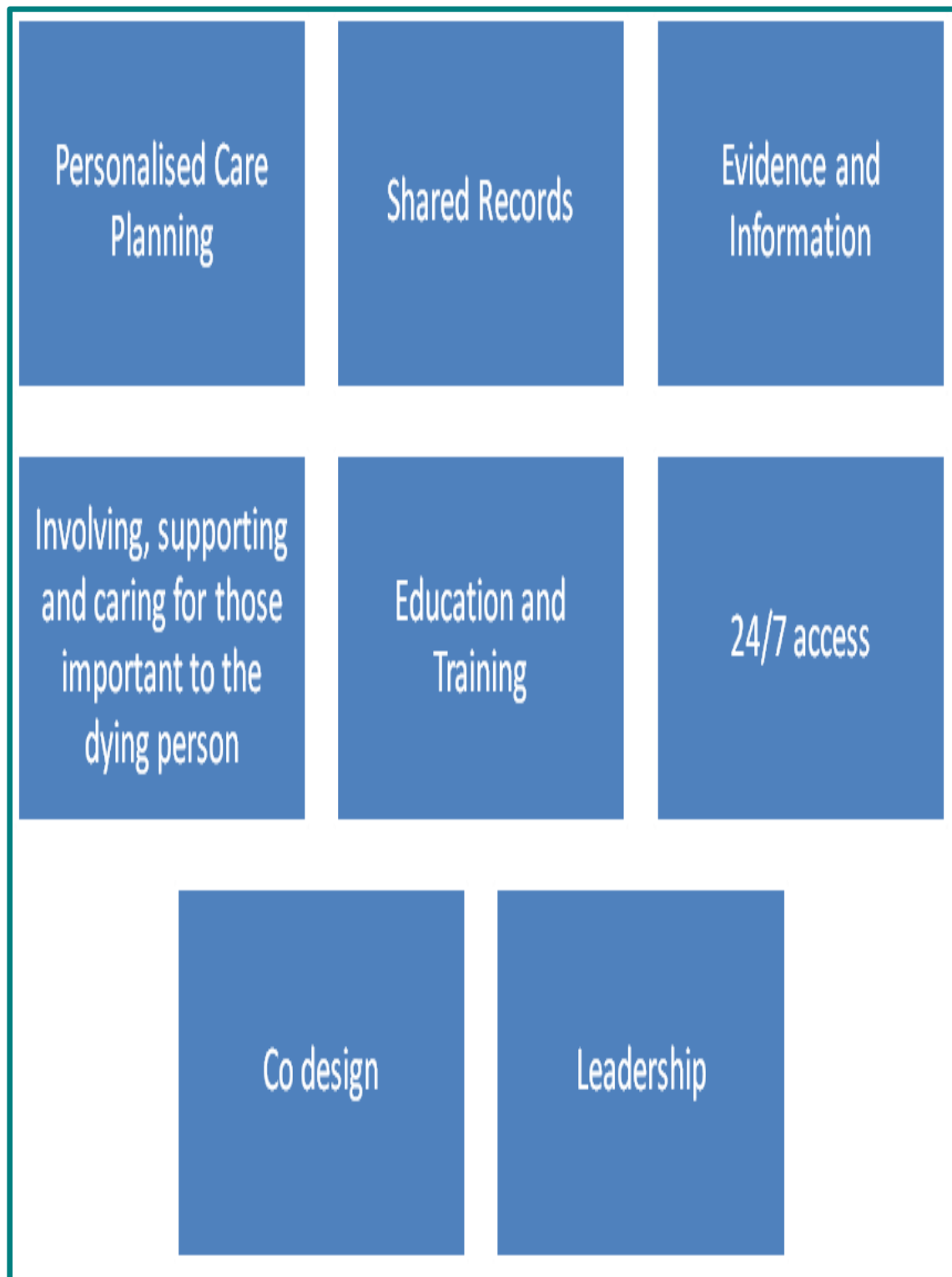


Table 3 Description of the eight foundations and actions required for the delivery of high quality palliative and end of life care at The Clatterbridge Cancer Centre.

Foundation	Actions Required
<p>Personalised Care Planning</p> <p>Patients will always have access to opportunities for informed discussion about their care and the option to plan for the future. These conversations will include those important to the patient if the patient wishes this. It is vital that opportunities to open these discussions following changes in the patient's condition are recognised by the healthcare professionals delivering care, wherever that care is received. Triggers for discussions to be offered include:</p> <ul style="list-style-type: none"> ✓ Acute admission to hospital ✓ Development of acute illness from which the patient may not recover ✓ Diagnosis of incurable illness ✓ Deterioration in condition ✓ Patient expresses a wish to discuss the future ✓ Discharge from hospital following a complex clinical course in which prolonged illness may follow <p>Care plans will include the patient's preferences for care including preferred place of care and, where appropriate, death. Discussion should include who the patient wishes to be consulted about their care in the future should they lose capacity to make decisions for themselves and the option to appoint a Lasting Power of Attorney for health or complete an ADRT. Conversations and plans should be regularly reviewed.</p>	<ul style="list-style-type: none"> • Re-launch the AMBER care bundle within CCC to ensure that those patients with an uncertain outlook are identified early and offered personalised conversations at the right time. • The Serious Illness Care Programme UK within CCC should expand to deliver training to registrars, consultants and specialist nurse roles so that all patients are offered the opportunity to have a conversation about their individual priorities and goals. These conversations should be recorded and made available to other professionals involved in their care. • Training in advance care planning should be introduced. • CCC should endorse and work with community partners through the Gold Standards Framework (GSF) or End of Life Care Registers to ensure that patients recognised to be in the last 12 months of life are highlighted to other service providers and ensure that the patients' wishes are known between settings.

<p>Shared records</p> <p>Patients' care plans will be available across settings at all times so that they can be accessed by the right professional at the right time to assist them to deliver the right care for that patient, in accordance with their wishes. Electronic systems should be developed to enable sharing of this information sharing in a robust and confidential way.</p>	<ul style="list-style-type: none"> • CCC should adopt EPACCs (Electronic Palliative Care Coordination System) to allow digital information sharing about a patient and their priorities and preferences for care. • CCC should liaise closely with local partners including GPs and community services to enhance information sharing including GSF and End of Life Care registers and that these are regularly updated.
<p>Evidence and information</p> <p>The care we give patients and those important to them will always be underpinned by the best quality and strongest evidence. This involves participating in data collection projects and ensuring that practitioners remain up to date in their practice. Education in Palliative and End of Life Care at CCC will be regularly reviewed to ensure that the content and format of delivery is in line with the strongest evidence.</p>	<ul style="list-style-type: none"> • CCC should continue to participate in regional and national audits and evaluations collecting anonymised data to improve service delivery • CCC should participate in local, regional and national research projects in palliative and end of life care to develop the evidence to support practice • Education in palliative and end of life care should be peer reviewed to ensure content and format of delivery is in line with best practice. Mandatory training in end of life care should continue to be supported within the Trust for all professionals with a patient facing role
<p>Involving and supporting those important to the dying person</p> <p>CCC will deliver high quality care for those important to the patient. This care should run alongside patient care through the entirety of their cancer journey and continue after death with bereavement care. The needs of children and adults with additional needs will always be met, and the support they need will be available regardless of where they live. This will require strong links with local services and appropriate signposting or/ referral.</p> <p>The team caring for a dying person must assess and address the needs of those important to the patient or escalate to those who are better placed to deliver this care.</p>	<ul style="list-style-type: none"> • Training in assessment and emotional/spiritual support for those important to the dying person should be available for all professionals in the trust directly involved in delivering patient care. • Bereavement policies should be up to date, evidence based and regularly reviewed to ensure that they meet the needs of people who have lost loved ones. • Healthcare professionals who have contact with bereaved persons should be familiar with tools for assessing bereavement risk, safeguarding procedures and escalation routes for those considered at high risk for adverse bereavement reactions. • A replacement Family Support worker should be employed within the Trust

<p>Education and Training</p> <p>CCC will ensure that all healthcare professionals are competent and up to date in the knowledge and skills required to deliver non-specialist palliative and end of life care.</p> <p>CCC must also ensure that their Specialist Palliative Care team remains up to date with their training needs to be able to support those patients with more complex needs.</p>	<ul style="list-style-type: none"> • Training in palliative and end of life care suitable for non-specialist delivery should remain mandatory for all staff at CCC with a patient facing role. • The Trust should support communication skills training for all staff with a clinical role. • Education and training should be rigorously evaluated to ensure achievement of suitable learning outcomes and best practice. • CCC should continue to support the training of a specialty registrar in Palliative Medicine. • Expand training numbers for GP trainees so that the medical workforce of tomorrow has a solid foundation in the management of patients approaching the end of their lives. • The trust should continue to support the professional development of our specialist palliative care team including attendance at conferences and courses to further our knowledge and improve our practice. • CCC should explore the commercial opportunities inherent within education design and excellence of delivery. This could include regional access to simulation training, training in Serious Illness Care Programme UK for primary and secondary care providers, and advanced symptom control courses.
<p>24/7 Access</p> <p>CCC will ensure that patients receiving care within our hospital have access to expert symptom control advice 24 hours a day, seven days a week.</p>	<ul style="list-style-type: none"> • Continue to support 7 day working with CNS cover • Review current provision of 24 hour telephone advice to healthcare professionals • Review input of specialist palliative care input to Triage and new Clinical Decisions Unit
<p>Co-design</p> <p>CCC will ensure that the views and opinions of people who are using our services and professionals who are delivering care are recognised and acted upon, including in the design of care systems.</p>	<ul style="list-style-type: none"> • Respond positively to feedback from staff and patients, including a proactive attitude to management of complaints • Develop palliative care input to mortality review processes so that lessons can be learnt about care at the end of life, whether or not it has resulted in incidents or complaints. • Involve patients and members of the public in service design • Act in a timely manner on any areas for improvement highlighted in patient feedback. • Elicit patient feedback through an annual survey.

<p>Leadership</p> <p>Clinical leadership will be at the centre of the design and development of the service within CCC. Close collaboration with CCGs and the Cheshire and Merseyside Health and Care Partnership will help to ensure that our future goals for service delivery are achievable across a wider geographical area.</p>	<ul style="list-style-type: none"> • The palliative and end of life care strategy will be available to the Board so that support from the top can be developed. • The role of the CCC specialist palliative care team within the new structure of care delivery in the Transforming Cancer Care initiative should be discussed at cancer alliance level and then the STP, to ensure regional support for the support of patients across a multi-site model. This should include the expansion of Enhanced Supportive Care in collaboration with our regional partners and local palliative care providers. • Clinical leads in palliative care will be involved in the strategic planning of services
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9. Who will we Work with to deliver on Our Ambitions?

9.1 Internal

To improve inpatient and outpatient care and experience, we need to work closely as a team and with other teams within CCC to ensure that we are always delivering the specialist support that is needed by patients. Our goals for education and development will need support from all Directorates and Site Reference Groups.

9.2 External

Much of our focus over the next five years will be how we work best with others outside our organisation. This is particularly relevant because of the geographical challenges posed by a multi-site model of care and the need to ensure that Enhanced Supportive Care and Palliative Care are available to all patients who need it in a timely and coordinated manner.

Not all of this care will be delivered by CCC in isolation. We need to foster strong links with local palliative care

and supportive care services to ensure we work together to meet the needs of patients. The delivery of care needs to align with regional strategy delivered within the Cheshire and Merseyside Sustainability and Transformation Plan (STP) and with shared responsibility with our partners in the Cancer Alliance. We will require support from the Cheshire and Merseyside Health and Care Partnership, Cancer Alliance and regional partners. Our care delivery needs to be in line with national strategy from NHS England.

It is important that we also take a more active role in the support of external non-specialist palliative care providers. We need stronger links with primary care which will include education and training strategies to ensure they are empowered and supported to deliver care when specialist intervention is not required. As technology advances to make communication links between primary, secondary and tertiary care more robust, we need to explore ways of using these improvements to enhance the care that we deliver.



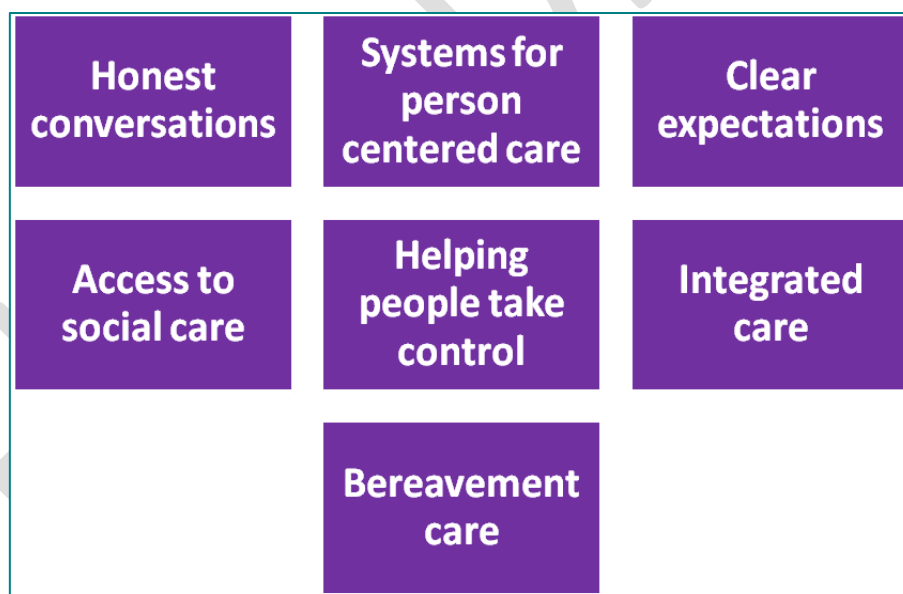
10. Our Ambitions

Ambition 1: Each person is seen as an individual

Ambition 1
Each person is seen as an individual

• I and the people important to me have opportunities to have honest and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible

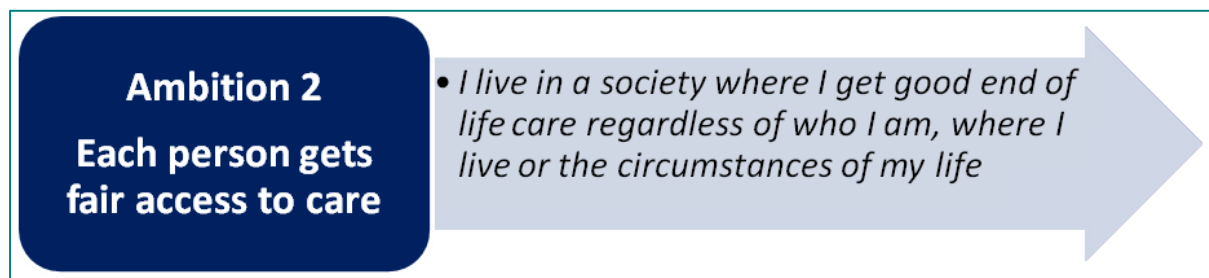
Building Blocks Underpinning Ambition 1



Ambition 1. What do we need to do?	How do we do it?
Facilitate honest conversations about the patient's condition and facilitate any wishes they have to make plans for their on-going care	<ul style="list-style-type: none"> • Re-launch and embed AMBER care to improve recognition of when a patient might deteriorate and die • Deliver mandatory training on recognising the dying patient • Expand the Serious Illness Care Programme UK to train those with direct clinical care responsibilities how to facilitate and record important conversations about patients' goals and priorities for the future • Adopt Advance Care Planning processes to allow formal care plans to be created which record the patients' wishes for on-going care that follow them between care settings.
Ensure that all people looking after that patient know what their priorities are, regardless of where they receive their care	<ul style="list-style-type: none"> • Adopt Advance Care Planning processes mentioned above • Liaise closely with other caregivers in other settings using systems such as Gold Standards Framework or End of Life Care Register to coordinate care • Embed electronic information sharing processes through the use of the Electronic Palliative Care Coordination System (EPACCs) to facilitate the sharing of this information
Ensure that those important to the dying person are listened to and have their needs addressed, including after the death of their loved one	<ul style="list-style-type: none"> • Support advanced communication skills training for all senior clinical staff, including the delivery of mandatory advanced communication skills training for all band 6 nurses. • Deliver mandatory training on how to support carers/ those important to the patient • Support the creation of a new role within the team to combine additional social worker responsibilities with family support work and advance care planning facilitation • Ensure those who have contact with bereaved persons have access to up-to date and evidence-based bereavement support information and that they are familiar with it. • Ensure those who have contact with bereaved persons can undertake a bereavement risk assessment and escalate those at high risk to the Trust social worker for follow up.
Maintain and develop CReST (Cancer Rehabilitation and Support Team) to ensure that the supportive care needs of patients within CCC are met by an integrated service which can meet the holistic needs of patients throughout their cancer journey.	<ul style="list-style-type: none"> • Allow opportunities for CReST on-going integration within the new CCC structure, including co-location and opportunities for coordination including multidisciplinary meetings, joint patient reviews and joint clinics.



Ambition 2: Each person gets fair access to care

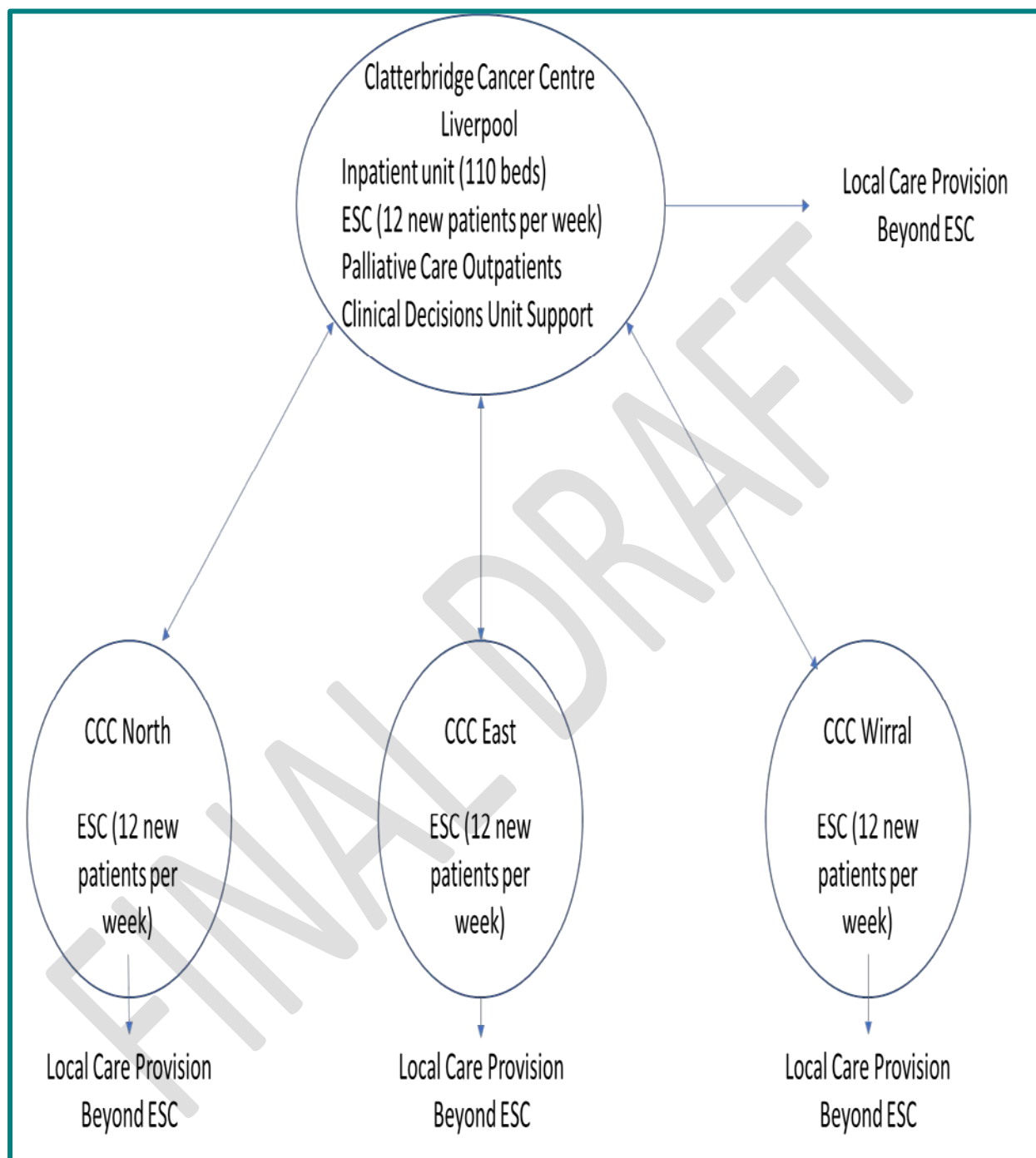


Building Blocks Underpinning Ambition 2



Ambition 2. What do we need to do?	How do we do it?
Ensure Palliative and End of Life Care at CCC is high quality and evidence-based	<ul style="list-style-type: none"> • Participate in local, regional and national clinical audit projects to highlight and share best evidence. • Participate in local, regional and national research projects to ensure emergence of best evidence for palliative and end of life care. • Continue to be actively involved in the production of NICE accredited clinical guidelines. • Disseminate evidence-based practice through mandatory training to all staff with clinical contact with patients approaching the end of life • Respond positively to patient feedback and complaints by acting to solve problems and disseminate lessons from errors and incidents • Involve patients and public future care system design • Develop a research portfolio to aid the evidence based development of our services in liaison with Research and Innovation. • Ensure that the Palliative Care research strategy links with the Trust research strategy in key areas in which we are specialists, i.e. the delivery of care, the improvement of the patient experience, communication and qualitative patient experience. • Undertake more research into how we can best care for patients and disseminate research outcomes to all departments so that themes can be replicated throughout the patient's cancer journey.
Ensure access to specialist palliative care and Enhanced Supportive Care is available across sites within the new clinical model	<ul style="list-style-type: none"> • Obtain support from the Board for a new multi-site clinical model for Enhanced Supportive Care. • Work closely with the Cancer Alliance and Cheshire and Merseyside Health and Care Partnership to develop a plan for delivery of ESC across the multi-site model. • Support professional development within the team so that we have the right skills and capacity to deliver high quality palliative care and enhanced supportive care to a larger cohort of patients across a larger scale (see figure 5). Note that to deliver an expanded ESC service, other supportive services within CCC and across the region will also require expansion.
Ensure strong links with other providers to ensure that the care of patients is not affected by movement between care settings	<ul style="list-style-type: none"> • Develop closer working with regional partners and local palliative care teams to ensure seamless care for patients.
Develop Patient Reported Outcome Measures (PROMS) to ensure that the care we give meets the needs of patients	<ul style="list-style-type: none"> • Further develop the use and analysis of IPOS (Integrated Palliative care Outcome Scale) to demonstrate patient outcomes from inpatient and outpatient palliative and end of life care services and use this data to develop services.

Figure 5 Potential patient flow through ESC in the new clinical multi-site model.



The model illustrated in Figure 5 demonstrates potential patient flow through CCC Liverpool and regional ESC delivery within the sector hubs in the new clinical model. 3500 new patients will be eligible for ESC every year. Assuming a 60% uptake of this service (which reflects current ESC uptake rates) this will result in 2150 new patients per year accessing ESC services. These patients may not need to be seen at CCC hubs. There is potential for these patients to be seen by local specialist palliative care teams. Care wherever it is delivered, must be multidisciplinary with standardised outcome measures to ensure equality of service wherever the patient is seen. This will require further discussion with colleagues across the region as part of the Cheshire and Merseyside Palliative and End of Life Care Delivery and Oversight Group. Given the variable demands on services across the region it is likely that the model of delivery will look different between the hubs.

Projected Workforce requirements

For the current standard of care to be delivered across all hubs by CCC staff, the following numbers would be needed to maintain the service as well as inpatient services and 7-day clinical cover:

3.0 WTE Consultants (Currently 1)

1.0 WTE specialty doctor (Currently 0)

7.0 Clinical Nurse Specialists
(Currently 4.6)

1.0 WTE Social worker (Currently 1)

1.0 WTE mixed roles social worker, responsible for family support and advance care planning facilitation
(Currently 0)

4.0 WTE Admin (Currently 2)

Some of this work may be taken up by local teams reducing the need for CCC service expansion, however this discussion on a regional footprint is due to start October 2018 so current estimates of full service expansion requirements are not available.



Ambition 3: Maximising comfort and wellbeing

Ambition 3 Maximising comfort and wellbeing

My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

Building Blocks Underpinning Ambition 3

**Recognising distress
whatever the cause**

**Skilled assessment
and symptom
management**

**Addressing all
forms of distress**

**Priorities for care of
the dying person**

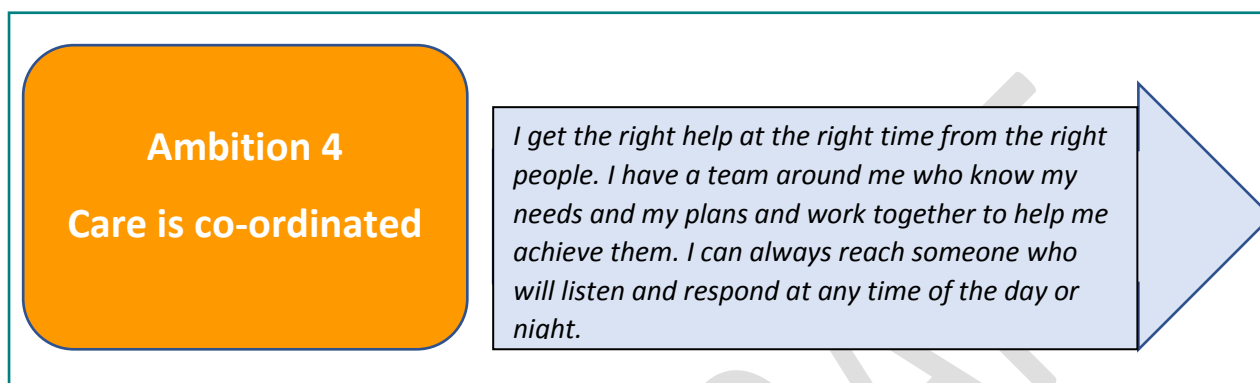
**Specialist palliative
care**

**Rehabilitative
palliative care**

Ambition 3. What do we need to do?	How do we do it?
Ensure all clinical staff are able to support patients' care with the End of Life Care and Communication Record (EOLCCR)	<ul style="list-style-type: none"> • Deliver mandatory training in end of life care and use of the End of Life Care and Communication Record • Regular audit of use of the End of Life Care and Communication Record and feedback results to clinical staff. • Regular debriefs with ward staff after a patient has died, with reviews of documentation to ensure lessons are learnt in real-time
Ensure all staff who have clinical contact with dying patients are skilled in assessing symptoms including psychological, spiritual and social distress and managing non-specialist needs	<ul style="list-style-type: none"> • Deliver mandatory training in symptom assessment/management for all clinical staff who care for patients approaching the end of life • Deliver mandatory training in assessment of non-physical symptoms such as psychological and spiritual distress for all clinical staff. • Develop the Link Nurse Programme to ensure that key nurses on the inpatient wards are trained in the more complex aspects of palliative and end of life care and that new information is cascaded reliably.
Ensure 24/7 access to specialist palliative care advice	<ul style="list-style-type: none"> • Ensure 24/7 consultant level specialist palliative care advice remains available and all clinical healthcare professionals know how to access it • Support 7 day working
Maintain the structure of CReST (Cancer Rehabilitation and Support Team) to ensure that the supportive care needs of patients are met by an integrated service throughout their cancer journey.	<ul style="list-style-type: none"> • Allow opportunities for on-going integration of CReST within the new CCC structure, including co-location and ample opportunities for coordination including multidisciplinary meetings, joint patient reviews and where needed joint clinics.
Ensure that the Specialist Palliative Care Team continues to work in the most effective and coordinated way and always has access to consultant level support	<ul style="list-style-type: none"> • Maintain a physical space for the specialist palliative care team within the new CCC building in Liverpool to ensure that private discussions about patients continue to be feasible and team members are easily accessible to other professionals seeking support in a known location. • Ensure the Palliative Care MDT continues to operate effectively, including use of digital technology to allow inter-site seamless communication • Ensure ongoing professional development of members of the Specialist Palliative Care Team by supporting applications for further training and specialisation
Build strong links with Haemato-oncology to ensure that patients receiving haemato-oncology treatment have access to specialist palliative and supportive care throughout and beyond their treatment.	<ul style="list-style-type: none"> • Work actively as part of both inpatient and outpatient Haemato-oncology MDTs to offer support in the symptomatic management of inpatients receiving treatment • Provide outpatient services so that patients can access supportive care alongside their treatment • Liaise closely with Haemato-oncology specialists to recognise the holistic needs of patients throughout their haemato-oncology journey • Deliver education and training on supportive management within Haemato-oncology, highlighting services provided by

	<p>the CCC Specialist Palliative Care Team and CReST</p> <ul style="list-style-type: none"> Use feedback from haemato-oncology patients to inform the on-going development of a palliative and supportive care service which meets their holistic needs.
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Ambition 4: Care is coordinated



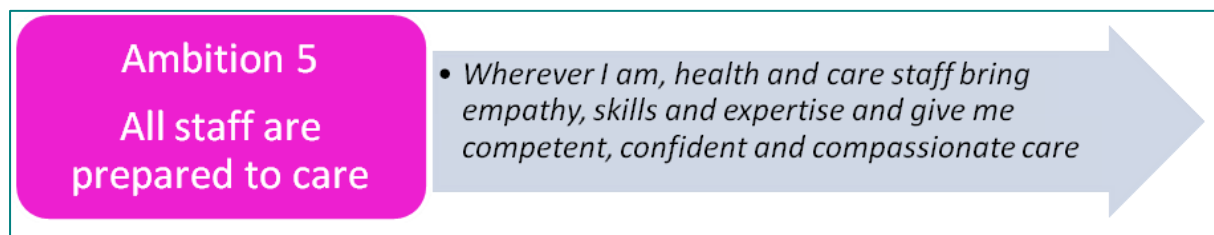
Building Blocks Underpinning Ambition 4



Ambition 4. What do we need to do?	How do we do it?
Ensure holistic care is coordinated across settings	<ul style="list-style-type: none"> • Adopt Advance Care Planning processes to allow formal care plans to be created which record patient wishes for on-going care that follow them between care settings. • Explore developing more robust use of the Holistic Needs Assessment to better inform coordinated holistic care. • Liaise closely with other caregivers in other settings using systems such as Gold Standards Framework or End of Life Care Register to coordinate care • Embed electronic information sharing processes Electronic Palliative Care Coordination System (EPACCs) to facilitate the sharing of this information • Develop systems for closer working with regional partners and local palliative care teams to ensure seamless care for patients when they complete treatment at CCC and require on-going holistic supportive and palliative care closer to home.
Ensure the presence of robust rapid discharge systems	<ul style="list-style-type: none"> • Ensure all clinical staff are aware of the rapid discharge process, to be used when patients wish to be discharged home to die. • Regularly audit rapid discharge processes and disseminate lessons learnt. • Ensure that as part of the rapid discharge process, referrals to local teams and thorough clinical handover are conducted every time.
Ensure 24/7 access to specialist palliative care advice	<ul style="list-style-type: none"> • Ensure 24/7 consultant level specialist palliative care advice remains available and all clinical healthcare professionals know how to access it • Support 7 day working in the future • When changing care setting, ensure that local teams are aware of the change and ensure the patient and those important to them know who to contact in their new care setting for support and advice
Explore links with specialist palliative care services at the Royal Liverpool and Broadgreen University Hospitals including the Academic Palliative Care Unit and develop systems of working to avoid duplication and to ensure seamless care as patients move between settings	<ul style="list-style-type: none"> • Develop clear pathways in partnership with the Specialist Palliative Care Team at the Royal Liverpool University Hospital to facilitate the establishment of criteria and operational process to support patient transfer between care settings • Develop strong systems of communication to ensure patients moving between care settings receive coordinated seamless care • Explore opportunities for developing a referral process to the Academic Palliative Care Unit • Explore opportunities for collaboration between sites including areas of quality improvement and research



Ambition 5: All staff are prepared to care



Building Blocks Underpinning Ambition 5



Ambition 5. What do we need to do?	How do we do it?
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Ensure all staff have the knowledge and skills required to deliver competent empathic care suited to their level of clinical responsibility	<ul style="list-style-type: none"> • Mandatory training for all eligible staff in delivering care for patients approaching end of life specific to their level of contact with these patients and the roles they play in the patient journey • Develop the Link Nurse Programme to ensure that the right knowledge, skills and attitudes to deliver high standard end of life care is present on all the wards and can be disseminated widely by these champions. • Ensure that CPD opportunities in palliative and end of life care are available for all to access and encourage those who are interested to participate.
Ensure that the professional culture within CCC is always one of valuing quality of End of Life Care for inpatients.	<ul style="list-style-type: none"> • Maintain a robust consultant input to IPU and CDU • Maximise opportunities for “on the job teaching” and shadowing for junior doctors and nurses • Use Link Nurses to disseminate the importance of high quality end of life care through role modelling • Offer feedback opportunities on care given and use facilitated reflection to embed the importance of high quality care.
Ensure staff maintain their resilience to be able to deliver compassionate care for every patient every time	<ul style="list-style-type: none"> • Provide regular debriefs following the deaths of patients. • Support good practice. • Feedback praise from patients and those important to them. • Support clinical supervision for all staff, with the option for additional clinical supervision after complex or distressing clinical situations. • Ensure on-going availability of specialist palliative care team to support non-specialist colleagues in complex situations
Ensure that education to support staff to deliver skilled and compassionate care is evidence based, high quality and delivered in the most effective way	<ul style="list-style-type: none"> • Regular reviews and evaluation of education delivered in palliative and end of life care including review of learning outcomes, how we demonstrate these are being achieved and using peer review to ensure adequate delivery • Use technology where possible to supplement training or improve the education process, e.g. by using tools such as e-ELCA and simulation. • Encourage continued use of the tiered approach to end of life care training where all staff are trained appropriately to their level of interface with patients. We have a robust framework for the development of staff at all levels and this must continue.
Ensure all staff with clinical responsibilities are aware of key legislation surrounding care for patients approaching the end of life	<ul style="list-style-type: none"> • Mandatory training for all clinical staff in the application of the Mental Capacity Act, safeguarding and equality commitments.
Using Technology to help deliver care	<ul style="list-style-type: none"> • Pilot the use of telehealth within Enhanced Supportive Care to overcome geographical barriers to patients accessing service

Ambition 6: Each community is prepared to help



Ambition 6

Each community is prepared to help

I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways

Building Blocks Underpinning Ambition 6

**Compassionate
and resilient
communities**

**Public
awareness**

**Practical
support**

Volunteers

Ambition 6. What do we need to do?

How do we do it?



Involve communities in care design	<ul style="list-style-type: none"> • Encourage communities and patient/carer groups i.e. People's Voice to contribute their views on future care design
Develop a body of enthusiastic volunteers to help support care	<ul style="list-style-type: none"> • Explore the option of a programme to allow volunteers to help in care delivery and the support of patients receiving palliative and end of life care
Allow communities to support our work	<ul style="list-style-type: none"> • CCC should contribute to improving public awareness of the work we do, including palliative and end of life care so that they may offer support where they can to facilitate high quality care across a wider geographical area
Share our vision with our communities	<ul style="list-style-type: none"> • CCC should contribute to Dying Matters coalition work

11. Key Performance Indicators

Key Performance Indicators are measures that quantify the level of performance for a

particular aspect of health service provision. They present indicative information only and



must have a clear relationship to the objectives of the service.

We have developed a range of key performance indicators that will help to demonstrate effective implementation of this strategy. Tables 4 and 5 detail the key operational and strategic performance indicators.

KPIs 1-5 have high priority. They are present in national strategies and represent areas

which have been highlighted through local quality improvement processes as requiring development within CCC.

It is likely that these KPIs will be developed and refined further over the next 12-18 months and will form a dashboard of measures, integrated with other partner organisations, to ensure quality care across settings.

Table 4 Key Operational Performance Indicators

KPI Description	Numerator	Denominator	Data Sources	Exclusion
1. Proportion of patients who have an expected death at CCC and who have with a completed End of Life Care and Communication Record*.	Total number of patients who have an expected death at CCC with a completed End of Life Care and Communication Record.	All patients who have an expected death at CCC	End of Life Care Audit	None
2. Proportion of staff attending mandatory training in End of Life Care*.	Total number of eligible staff attending mandatory training in End of Life Care.	All eligible CCC staff	L and D data	None
3. Proportion of inpatients in last 12 months of life offered Advance Care Planning discussions	All patients who die within 12 months of discharge having being offered Advance Care Planning discussions during their most recent admission	All patient who die within 12 months of their most recent admission to CCC	Trust electronic data and audit	Patients who die from non-cancer diagnoses.
4. The proportion of patients dying in hospital, who were not admitted for end of life care, with a completed AMBER care bundle	All patients dying in hospital AND who were not admitted for end of life care with completed AMBER Care Bundle	All patients dying in hospital who were not admitted for end of life care	Trust electronic data.	None.
5. Proportion of patients admitted to CCC within the last 12 months of their life who have a GSF notification sent to their GP on discharge	All patients who had an admission to CCC within the last 12 months of their life who had a GSF notification sent to their GP when they were discharged.	All patients who had an admission to CCC within the last 12 months of their life	Trust electronic data	None
KPI Description	Numerator	Denominator	Data Sources	Exclusion
6. Proportion of patients receiving	Total number of people receiving palliative care	All patients receiving	Trust electronic	None



palliative care input with completed IPOS scores*	input with at least one set of completed IPOS scores	palliative care input at CCC	data	
7. Proportion of inpatient deaths reviewed as part of the mortality review process*.	Total number of inpatient deaths at CCC reviewed using structured judgement review	All inpatient deaths at CCC	Clinical case record, agendas for Mortality Surveillance Group	None
8. Proportion of patients with incurable disease offered a serious illness conversation	Total number of patients with incurable disease who are offered a serious illness conversation	All patients with incurable disease receiving treatment at CCC	Meditech report: serious illness conversations	Patients receiving radical treatment
9. Proportion of patients with incurable disease offered referral to Enhanced Supportive Care (ESC)*	All patients with incurable disease offered referral to ESC	All new patients diagnosed with incurable disease	Trust electronic data	None
10. Proportion of bereaved family/carers who have a completed bereavement risk assessment*	All completed bereavement risk assessments for the family/carers of patients who die at CCC	All patient deaths at CCC	Bereavement Audit	None
11. Proportion of patients receiving palliative treatment and/or their families offered referral to the Family Support Worker	All patients or their loved ones who are offered a referral to the family support worker.	All patients receiving palliative treatment at CCC	Audit	None.
12. Proportion of patients dying at CCC who do so as their preferred place of care/death.	All patients who die at CCC with an expressed Preferred Place of Care/Death as CCC.	All patients who die at CCC.	Trust electronic data and end of life care audit	Patients declining to nominate a preferred place of care/death
13. Survey of bereaved persons using the Care of the Dying Evaluation (CODE) completed every two years*	CODE evaluation completion	Years between CODE evaluations	CODE evaluation	None
14. Proportion of eligible staff who received communication skills training in past two years	All eligible staff who have received communication skills training in the last 2 years	All eligible staff	L and D held data	Trainers /Facilitators

Table 5. Key Strategic Performance Indicators

KPI Description	Numerator	Denominator	Data Sources	Exclusion
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1.The proportion of patients receiving care from CCC who achieve their Preferred Place of Death (PPD)	All patients who have received care at CCC who die in their Preferred Place of Death (PPD)	All patients who have received care at CCC who die.	Trust electronic data.	None.
2. Proportion of patients dying at CCC whose care at the end of life is supported by the End of Life Care and Communication Record which demonstrates that there was*: <ul style="list-style-type: none"> Assessment and management of physical, psychological social and spiritual needs High quality communication with the patient and their family/carers Assessment and management of the needs of the family and carers including their psychological and spiritual needs Where possible the priorities of care, outlined by the patient, were identified and met 	All patients dying at CCC who die with the aforementioned need met	All patients who die at CCC	Trust electronic data, audit, surveys, CODE, NACEL, Friends and Family test	None

* Systems for implementation already exist for these KPIs and baseline measures are available

12 Action Timeline

Table 6 outlines the timeline for implementation of our strategy. All actions should be implemented in the first three years. Years Four and Five are reserved for error-adjustment, impact analysis and exploring further areas for development highlighted during implementation.

Table 6 Provisional Implementation Timeline

Timeline	Action	Requirements	Associated KPI(s)
Year 1	Contribute to development of a	Developed through	1-5, 14,



To be completed by 5 th January 2019	robust comprehensive Supportive Care strategy which works in conjunction with the Palliative and End of Life Care Strategy	existing resources	
	Robust measurement of Key Performance Indicators		
To be completed by 1 st April 2019	Form a working group to implement and embed the AMBER Care Bundle across the Trust, with delivery of all training and provision of electronic resources to support effective use	Will need additional resources plus development of IT systems. Need for additional allocated time for mandatory training and enforcement of attendance with support from senior management	
	Deliver key elements of intermediate communication skills including skill in supportive conversations as part of mandatory training for all nurses		
	Re-launch the Gold Standards Framework for patients identified as being in the last 12 months of life		
	Extend mandatory training sessions to facilitate teaching on symptom control for all clinical staff		
	Train clinical staff in completing bereavement risk assessment		
	Deliver education and training to all staff who deliver the "day after death service". Training to include updated bereavement policy, and how to escalate those people with a high bereavement risk		
	Deliver and evaluate consultant-led specialist palliative care in the new Clinical Decisions Unit (CDU)		
	Recognition of dying to be made part of mandatory training in palliative and end of life care for all clinical staff		
	Deliver debriefing sessions on		

	each wards following the death of a patient and use as an opportunity to discuss quality of documentation in the End of Life Care and Communication Record		
	Support robust link nurse education to ensure that the most up to date standards of palliative and end of life care are disseminated across all inpatient areas		
	<p>Re-launch Advance Care Planning processes to include inpatients and outpatients</p> <p>Recruit a second Social Worker with a shared role for family support (Cost £47,956 per year) (1 WTE).</p> <p>Recruit a substantive consultant in palliative medicine (business case submitted) (1 WTE)</p>	Investment needed to maintain current care quality during increasing demand and patient complexity. A single consultant and social worker are both single points of failure. Lack of Advance Care Planning means we are failing to ensure that each patient gets the end of life care they want and need.	3, 9,
	Recruit a specialty doctor in Palliative Medicine to assist delivery of Enhanced Supportive Care to more primary tumour sites (1WTE)	Essential for the delivery of expected service demands in 2019 and beyond. Numbers of Esc referrals per year could increase to 2150 per annum when the service is open to all tumour groups. Should be adopted in next financial year with priming funding sought to bridge the gap.	
	Recruit additional Clinical Nurse Specialists (2WTE) in palliative care to assist in the delivery of expanding inpatient and outpatient services; supporting delivery of 7 day working and specialist input to the CDU. Each CNS is costed at £47,956 each	Two additional Clinical Nurse specialists needed to maintain and expand service including CDU. Existing seven day service is at risk because of limited flexibility in the system to cover for absence, sickness and annual leave. In 2017/2018 only 44% of weekends were fully	

		covered.	
	Ensure appropriate and adequate administrative and coordinator support to facilitate clinical and non clinical work of the team in delivering this strategy	Will require further resources post end of CQUIN in April 2019	
Year 2 To be completed by 1 st April 2020	Re launch the AMBER care bundle for all inpatients	See Year 1	4, 7, 8, 9, 13 14
	Embed Serious Illness Care Programme UK within the Trust	Funding for infrastructure of Programme	
	Deliver key elements of intermediate communication skills and having supportive conversations as part of mandatory training for all nurses and mandate advanced communication skills training for band 6 nurses and above	Deliverable within the resources defined for year one provided that systems are responsive with sufficient managerial support to produce change.	
	Expand GP trainee numbers rotating through CCC by widening the scope of their training to include more outpatient and supportive/palliative care experience	Protected time for CNS's to undertake audit and evaluations should be protected and trust managerial support will be required to create working systems for shared patient care across settings when moving to the new hub and spoke model of care delivery.	
	Develop a simulation training schedule and teaching content to be delivered four times per year by our specialist palliative care team		
	Specialist Palliative Care representation should be present within the Mortality Surveillance Group with structured judgement reviews of all inpatient deaths		
	Explore a regional model for the delivery of Enhanced Supportive Care in collaboration with local supportive and palliative care teams		

	<p>Recruit further supportive and palliative care team members as determined by the outcome of the regional discussions about Enhanced Supportive Care models and move to the new multi- site clinical model</p> <p>Deliver mandatory training in palliative and end of life care for all medical staff with annual updates</p> <p>Develop robust processes for CReST collaboration within the Liverpool hospital including opportunities for shared working, regular meeting and shared care of inpatients and outpatients</p> <p>Specialist palliative care team to be involved in four regional audits per year with author representation on all NICE accredited regional guidelines</p> <p>Return to tiered approach to mandatory training in palliative and end of life care to ensure appropriate delivery of training to non-clinical as well as clinical staff</p> <p>Specialist Palliative Care should join the Haemato-oncology MDT and liaise closely to lead the supportive care for patients</p> <p>Develop referral pathways for patients to their local palliative care teams when their care at CCC has ended.</p>		
<p>Year 3</p> <p>To be completed by 1st April</p>	<p>Adopt EPACCs (Electronic Palliative Care Coordination System) to facilitate digital information sharing about patients, their priorities and preferences for care</p>	<p>Achievable within resources outlined in year 1 with support from other teams e.g. clinical education, research/innovation</p>	<p>All</p>

2021	Evaluate commercial opportunities for simulation training and advanced symptom control teaching delivered at CCC		
	Develop a research portfolio in collaboration with Research and Innovation focusing on qualitative research into caring		

Actions in red address outstanding recommendations from the 2016 CQC Inspection.

Table 7 Cost Benefit Summary from Strategy Implementation

Cost of Delivery	Benefits of Delivery
<p>The current cost of the specialist palliative care team at CCC which includes current admin provision, CNS provision, 2 consultants and 0.4WTE registrar is £652,000 per year</p> <p>Capital investment required for workforce expansion required to deliver services regionally includes the following roles in addition to current provision:</p> <ul style="list-style-type: none"> • Expansion of inpatient and outpatient Clinical Nurse Specialist capacity (2 CNS) • A second social worker with responsibility for family support • A band 7 CNS with responsibility for AMBER care, Advance Care Planning and education facilitation • A specialty doctor to allow more outpatient clinic capacity <p>Total: £238,055 per year</p> <p>NB: A third full time consultant in Palliative Medicine may be required to deliver ESC for all tumour groups on a regional footprint once CCC moves to</p>	<ul style="list-style-type: none"> • High quality patient care throughout their cancer journey including at the end of life for patients who die at CCC • Regionally coordinated care with seamless transition between services • Robust systems for delivering care in line with patients' preferences and goals • A research active palliative care services which actively contributes to the Trust's research agenda • Comprehensive provision of education for all appropriate staff covering communication skills and clinical skills required for excellent palliative and end of life care • Psychological support for patients and those important to them; a service which they have told us is currently lacking • Earlier recognition of uncertain recovery from AMBER care bundle,

<p>Liverpool. This will add cost of £112,803 to the above but would be depend on services provided by other localities across the region.</p> <p>Potential total: £350,858 per year</p> <p>Including cost of current service provision: £1,002,858 per year</p>	<p>leading to increased supportive care and communication to ensure that patients and those important to them have the opportunity to express their preferences and contribute earlier to treatment decisions</p> <ul style="list-style-type: none"> • Greater family and carer support provided by a second social worker including delivery of Trust-wide education on how to support patients with complex psychological needs and bereavement support needs. • Increased knowledge and achievement of patients' preferred place of care • Improved quality of life for all patients accessing the Enhanced Supportive Care Service • A reduced 30-day post chemotherapy mortality for patients attending ESC (80% statistically significant reduction in our study) • A reduction in wasted chemotherapy from deferrals for patients attending ESC (60% statistically significant reduction in our study) • A 22 to 35% reduction in unplanned admissions regionally for patients attending ESC (which will increase in line with expansion to more patient cohorts) <p>Current regional cost saving from unplanned admission avoidance alone is a minimum of £278,357 per year (equivalent to unplanned admission with no investigation or treatment costs added).</p> <p>If ESC were resourced to cover all primary tumour groups, this cost saving would</p>
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	<p>grow to £738,531 based on an expected 22% reduction in unplanned admissions as seen from our current service provision.</p> <p>This cost saving does not include reduction in wasted chemotherapy, as this is not easily costed due to variation in regime price.</p> <p>Specialist palliative care within CCC is not currently commissioned. This contract is under renegotiation with the commissioners. The Christie NHS Foundation Trust's Palliative Care Service is commissioned on the following terms:</p> <p>£174.63 per out-patient attendance</p> <p>£48.90 per day for in patient activity</p> <p>If this were applied to CCC with an expanded ESC service and inpatient activity, total income would be £417,891.52</p> <p>Total minimum cost benefit from service investment, including expansion of the ESC service is calculated as:</p> <p>Commissioned income + Unplanned admission avoidance</p> <p>£417,891.52 + £738,531</p> <p>Total £1,156,422.52</p>
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13. Next Steps

This strategy will align with the CCC Supportive Care 2018-2023 strategy so that we continue to work closely with our colleagues in the wider supportive care team. Liaison with other professionals through the Site Reference Group for Supportive and

Palliative Care will ensure that we work towards joint goals and regularly measure our progress against both strategies.

We have much work to do in liaising with our regional colleagues to ensure that high standards of care and equality of access to care are met within the new clinical model. This



includes inpatient and outpatient care,

Further work within the Cheshire and Merseyside Health and Care Partnership will help us to clarify our future model of delivery and pilot joint ways of working. This will ensure that

all patients receive the best care wherever they live.

We will form an action plan of SMART (Specific, Measurable, Achievable, Relevant and Time-bound) objectives to cover all action points highlighted in this strategy. Each objective will have named leads to ensure that it is led by the most appropriate people and groups within the organisation.

In collaboration with our colleagues in Research and Innovation, we will develop a research agenda, outlining key research themes for 2018-2023, potential funding streams and potential research partners.

Finally, in order to provide robust measurement of our performance, we will be submitting our proposed Key Performance Indicators to the Trust Board so that the delivery of palliative and end of life care at CCC is measured and monitored in the most effective way.

14. Acknowledgements

Many professionals across the Trust are involved in the delivery of palliative and end of life care for patients, families and those important to them. Their comments and support during the development of this strategy have been warmly welcomed.

and ESC delivery and coordination.

Input and feedback from the various Site Reference Group Chairs and their members has also been extremely valuable.

15. References

1. National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care. A national framework for local action. 2015-2020. Available from: <http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf> [Last accessed 1st July 2018]
2. Department of Health. End of Life Strategy. Providing high quality care for all at the end of life. July 2008. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136431/End_of_life_strategy.pdf [Last accessed 1st July 2018]
3. Department of Health. Living with and beyond cancer: Taking action to improve outcomes. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181054/9333-TSO-2900664-NCSI_Report_FINAL.pdf [Last accessed 2nd July 2018]
4. The Clatterbridge Cancer Centre NHS Foundation Trust. Available from <http://www.clatterbridgecc.nhs.uk/about-centre/mission-aims-and-values> [Last accessed 1st July 2018]

5. Royal College of Physicians. Designing Services: Palliative medicine services: Hospital palliative care. 2018. Available from: <http://www.rcpmedicalcare.org.uk/designing-services/specialties/palliative-medicine/services-delivered/hospital-palliative-care/> [Last Accessed 2nd July 2018]
6. Leadership Alliance for the Care of Dying People One Chance to Get it Right. –June 2014. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf [Last accessed 1st July 2018]
7. DOH Fourth Annual Report on the End of Life Care Strategy (October 2012). Available from: <https://www.gov.uk/government/news/end-of-life-care-strategy-fourth-annual-report> [Last accessed 1st July 2018]
8. Department of Health One Chance to Get it Right. One Year On. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/450391/One_chance_-_one_year_on_acc.pdf [Last accessed 1st July 2018]
9. NHS England Five Year Forward View. October 2014. Available from: <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf> [Last accessed 1st July 2018]
10. NHS England Transforming End of Life Care in Acute Hospitals Route to Success “How to guide” revised December 2015. Available from : <https://www.england.nhs.uk/wp-content/uploads/2016/01/transforming-end-of-life-care-acute-hospitals.pdf> [Last accessed 1st July 2018]
11. Commissioning Guidance for specialist palliative care. How to deliver commissioning objectives. December 2012. Available from: <http://www.ncpc.org.uk/sites/default/files/CommissioningGuidanceforSpecialistPalliativeCare.pdf> [Last accessed 1st July 2018]
12. The Mid Staff Foundation NHS Trust Public Enquiry. Executive Summary, Available from: <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf> [Last accessed 1st July 2018]
13. Independent Review of the Liverpool Care Pathway. More Care Less Pathway. A review of the Liverpool Care Pathway... July 2013. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf [Last accessed 1st July 2018]
14. NHS England Actions for End of Life Care: 2014-2016. Available from: <https://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf> [Last accessed 1st July 2018]
15. House of Commons 2015 Health Committee End of Life Care. Fifth report of session 2014- 2015. Available from: <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/805/805.pdf> [Last accessed 1st July 2018]
16. Parliamentary and Health Service Ombudsman 2015. Dying Without Dignity: Investigations by the



parliamentary and health service ombudsman into complaints about end of life care. Available from: <http://www.ombudsman.org.uk/reports-and-consultations/reports/health/dying-without-dignity> [Last accessed 1st July 2018]

17. The Choice in End of Life Care Programme. What's Important to Me. A Review of Choice in End of Life Care. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407244/CHOICE_REVIEW_FINAL_for_web.pdf [Last accessed 1st July 2018]
18. NICE Quality Standard for End of Life Care. 2011 Available from: <https://www.nice.org.uk/guidance/qs13> [Last accessed 1st July 2018]
19. National Institute for Health and Clinical Excellence. End of life care for adults. Quality Standards QS13, <http://guidance.nice.org.uk/QS13> (2011) [Last accessed July 2018]
20. Care Quality Commission. Service Framework for End of Life Care. 2016. Available from: <https://www.cqc.org.uk/sites/default/files/20170629-IH-end-of-life-care-core-service-framework.pdf> [Last Accessed 2nd July 2018]
21. Royal College of Physicians. End of Life Care Audit – Dying in

16. Appendix 1: Definitions of palliative and end of life care

End of life

Patients are 'approaching the end of life' when they are likely to die within the next 12 months. This includes

Hospital: National report for England 2016. Available from: <https://www.rcplondon.ac.uk/projects/outputs/end-life-care-audit-dying-hospital-national-report-england-2016> [Last Accessed 2nd July 2018]

22. Care Quality Commission: Clatterbridge Cancer Centre 2017. Available from: <https://www.cqc.org.uk/location/REN20> [Last accessed 1st July 2018]
23. Shape of Training: Securing the future of excellent patient care 2013. GMC. Available at: https://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf [Last accessed 1st July 2018]
24. The Clatterbridge Cancer Centre NHS Foundation Trust. Palliative and End of Life Care Strategy 2015-2018. 2015. (Unpublished- Available on Request)

patients whose death is imminent (expected within a few hours or days) and those with: a) advanced, progressive, incurable conditions; b) general frailty and co-existing conditions that mean they are expected to die within 12 months; c) existing conditions if they are at risk of dying from a sudden acute crisis in



their condition; d) life-threatening acute conditions caused by sudden catastrophic events.

In General Medical Council guidance the term 'approaching the end of life' also applies to those extremely premature neonates whose prospects for survival are known to be very poor, and to patients who are diagnosed as being in a persistent vegetative state (PVS) for whom a decision to withdraw treatment may lead to their death.

Palliative care

The World Health Organisation has defined palliative care as follows:

Palliative care is an approach that improves the quality of life of patients and their families facing the problem 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.

Palliative care provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient's illness and in their own bereavement; uses a team approach to address the needs of patients and their families; enhances quality of life and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended

to prolong life, and includes those investigations needed to better understand and manage clinical complications.

Palliative care can be provided by a range of health and social care staff and may be done alongside treatment intended to reverse particular conditions

17. Appendix 2: Definitions of specialist palliative care

Specialist palliative care

Is the active total care of patients with progressive advanced disease, their families, carers and those important to them. This care is provided by a multi-professional team who have undergone recognised specialist palliative care training. It is a diverse discipline delivered across primary, secondary and tertiary care and funded by the NHS and the voluntary sector.

The care provides physical, psychological social and spiritual support. Specialist palliative care will include care in hospices, inpatient beds, community service, hospital



advisory teams, outpatients and day therapy

There are no nationally agreed criteria for accessing specialist palliative care but a common theme is that of

complexity. Frequently those with the most difficult and complex problems some of whom will be younger people, will require specialist palliative care provided by multi-professional teams of individuals who have had specialist training.

Specialist palliative care teams also act as major sources of advice, support and education to others involved in providing care

Specialist palliative care experts have played an important direct or supportive role in helping people to fulfil their wishes and preferences.

They can help to support faster and more effective discharges from hospital and reduce unplanned crisis admissions with a better trained workforce and deliver dignity in care.

Specialist palliative care professionals are used to the concept of integrated care, bridging the gap between settings and influencing care in different environments.

18. Appendix 3: The 2015-2018 Palliative and End of Life Care Strategy

Key developments as a result of the 2015-2018 strategy

- ✓ Increased engagement with data collection to inform judgments on quality of our service e.g. The Care of the Dying Evaluation (CODE), the National Audit of Care at the End of Life (NACEL) and the Specialist Palliative Care Patient and Carer Survey.
- ✓ The development of a successful Enhanced Supportive Care (ESC) service to deliver the most effective supportive care to patients undergoing anticancer treatment. This involves the wider MDT in



delivery of coordinated outpatient care.

- ✓ The development of a framework for mandatory training in end of life care for all patient-facing staff
- ✓ The development of a seven day service to improve access to specialist palliative care.
- ✓ Collaboration with regional partners in establishing an evidence base to inform clinical practice and standardise high quality care across the region.
- ✓ The development of the Serious Illness Care Programme UK- a system level intervention designed to improve the care of people with a serious illness by optimising the timing, frequency and quality of serious illness conversations. It facilitates clinicians and patients to have structured meaningful conversations about a patients' goals and priorities.
- ✓ The adoption of robust clinical audit procedures, both locally and regionally to ensure that physical, psychological, spiritual and social care needs of patients and those important to them are met in an effective and responsive way.
- ✓ The development of the "Day after Death Service" to deliver tailored initial bereavement care to all loved ones of patients who die at CCC and signpost access to local services.
- ✓ The adoption of the Integrated Palliative Care Outcome Scale (IPOS) delivering patient centred outcome measures to inform service delivery and change.
- ✓ A continued commitment to working as part of a coordinated MDT, delivering holistic care to patients and those important to

them, wherever they are in their cancer journey.

- ✓ A continued commitment to delivering personalised care at the end of life, facilitated by robust and regular audits of the documentation of care.
- ✓ Maintaining close working relationships with hospice and community teams to facilitate patients accessing their preferred place of care whenever possible and ensuring equality of access to services when patients are discharged from CCC, wherever they live.

Key Areas still to be developed

Some key development areas highlighted in the 2015-2018 strategy are yet to be fully achieved. They are prioritised in this strategy and include:

- ❖ Advance Care Planning processes to enable patients to plan for the future based on their own identified needs and goals.
- ❖ Embedding AMBER Care Bundle to facilitate early conversations and treatment decisions in partnership with the patient and those important to them when the clinical trajectory is uncertain.
- ❖ Implementation of the Gold Standards Framework to ensure that patients approaching the end of life are identified to all healthcare professionals involved in their care, and that access to appropriate services is available and coordinated between settings.
- ❖ The use of appropriate technology to coordinate care,



including access to medical records across settings.

FINAL DRAFT