Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board –3 July 2013

Subject: End of Life and Palliative Care Framework for Manchester

Report of: Director of Public Health

Summary

The Board will today have received the Strategic Outline Case for Living Longer, Living Better and be informed that one of the priority groups and associated care models relates to “Adults and children that are at the end of their lives”. This report which covers the work of the End of Life and Palliative Care Group for adults in Manchester, chaired by the Director of Public Health, is therefore very timely. The nature and provision of End of Life and Palliative Care for children is different from that of adults and requires a separate scoping exercise and planning which will be considered in a future paper.

Recommendations

The Board is asked to:

1) Note local, regional and national guidelines for provision of high quality end of life care;
2) Note and consider the discussions and findings of the Manchester End of Life and Palliative Care Working Group;
3) Consider the most appropriate strategy to improve palliative / end of life care for Manchester residents and support the development of an options appraisal for increased provision in the north of the City in particular ;
4) Provide leadership and support for a strategy to enable Manchester to become a social, clinical and academic centre of excellence for palliative and end of life care.

Board Priorities Addressed:

3) Moving more health provision into the community
4) Providing the best treatment we can to people in the right place at the right time
8) Enabling older people to keep well and live independently in their community

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Contact Officers

Name: Dr. Petula Chatterjee
Position: South CCG Lead GP
Telephone: 07802-270131
E-mail: petula.chatterjee2@nhs.net

Name: Dr Denis Colligan
Position: North CCG Macmillan GP
E-mail: deniscolligan@nhs.net

Name: Dr Amanda Myerscough
Position: Central CCG Lead
E-mail: Amanda.myerscough@nhs.net

Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

1. Introduction

1.1 End of life care has been defined as 'care that helps all those with advanced, incurable illness to live as well as possible until they die. It enables the needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support'.

1.2 Palliative care, as defined by the World Health Organisation in 2002, is "… an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."
"You matter to the last moment of your life and we will do all that we can, not only to help you die peacefully, but to live until you die."
(Dame Cicely Saunders)

1.3 End of life and palliative care is a crosscutting area of care which incorporates urgent care, planned care and all patients with a life-limiting illness. It requires cooperation between a wide number of health, social, statutory and voluntary organisations that provide care for people at the end of life. It relates to care given in the last year(s) of life in all settings (home, acute hospital, residential/care home, nursing home, intermediate care, hospice, prison or other institution) and across health and social care.

1. 4 The proposed national key indicators for end of life and palliative care:

KP1 Record deaths in usual place of residence
KP2 To reduce the number of hospital admissions of 8 days or more that end in death
KP3 A reduction in unplanned admissions in the last year of life

provide the context for Manchester's key outcomes that are to:

1) Reduce the number of hospital admissions of 8 days or more that end in death;
2) Reduce unplanned admissions to hospital in the last year of life;
3) Improve patient choice regarding the nature and place of their care;
4) Enable more patients to be cared for in their preferred place of care;
5) Increased the number of people dying in their preferred place of care.

NHS Improving Quality- Strategic Intent [2013] highlights the completion of the existing commitment to increase deaths in the usual place of residence to 47% by 2015. Greater Manchester has been actively working in reducing number of hospital deaths since 2008

1.5 Both commissioners and providers in Manchester have recognised for some time that, although there are some excellent examples of good practice in the city, service provision is not equitable and far too many people still die outside their preferred place of care.

1.6 Over the past year, a small working group has been looking at some of the challenges facing Manchester, culminating in a summit at the Etihad Stadium on 27 March 2013 involving a wide range of key stakeholders. The outputs from the summit have informed this report and the detail is provided in Appendix 1

1.7 The End of Life Care Profile for Manchester Local Authority is attached (Appendix 2) and the ONS Data for 2011 for Manchester highlight that in term of place of death:

- 23.75% occurred at home
- 60% occurred in Acute Hospitals
- 3.2% occurred in Hospices
- 6.76% occurred in Care Homes
- 6.29% occurred in other settings

2. Implementing best practice

2.1 Diagram 1 (page 6) is a generic, non disease-specific, linear representation of a patient's journey. Timelines will vary according to the specific disease. It highlights areas of responsibility for any particular stage of a patient's health. These areas of responsibility have altered over time (e.g. more diagnostics and End of Life care are undertaken in Primary Care).

2.2 In order to enable people in Manchester to achieve the best quality of life at the end of their lives and achieve a peaceful death in the place of their choice, national recommendations and initiatives provide the starting point for consideration of a new Manchester Framework;

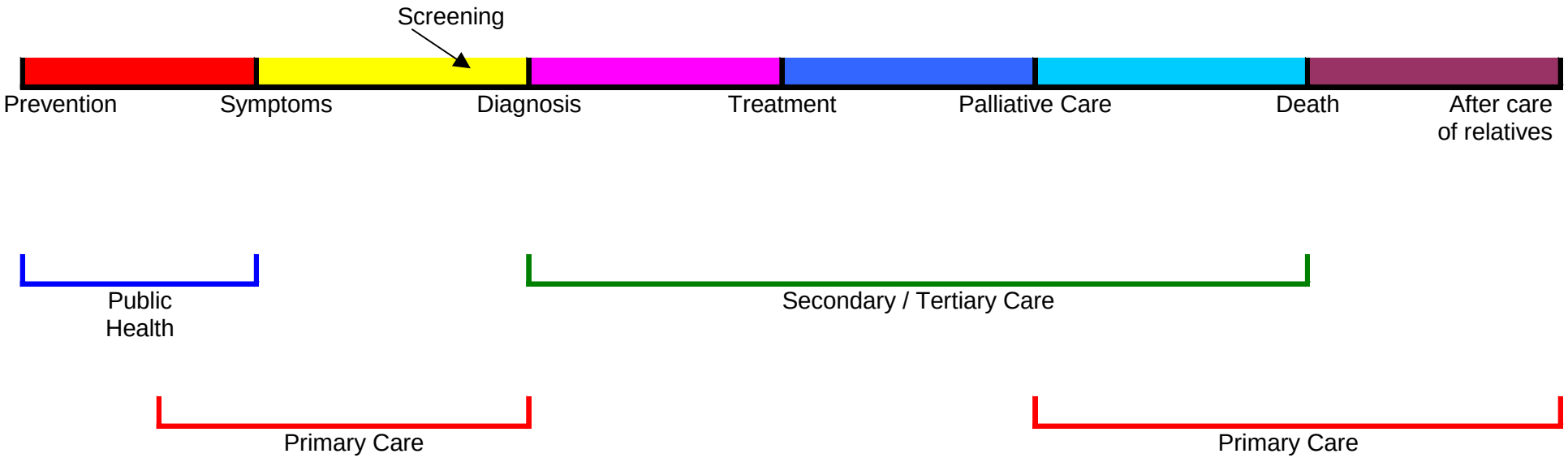
2.3 Gold Standards Framework (GSF)
The GSF is a programme to support and help patients and their family to cope with their illness and associated treatment. It enables the development of a practice-based system to improve organisational quality of care for patients in the last year of life in the community. It helps the patient get the best benefit from their treatment and live as well as possible with the effects of their condition. The patient will be a priority patient for all care providers and on a register held by their GP and community teams involved in their care to work effectively, communicate and provide the best possible standard of care and support.

2.4 Liverpool Care Pathway (LCP)
The Liverpool Care Pathway (LCP) is a pathway document that specifically supports doctors and nurses to provide appropriate care for those in the last days / hours of life and their families. It was developed to transfer best practice in hospice care to all settings addressing the care required in the last days / hours of life.

2.5 Preferred Priorities for Care (PPC)
The PPC is a form of advance care planning to initiate and document discussions about death and dying with patients and carers. To support this, Manchester has developed a patient-held booklet that can be transferred with the patient between services to ensure the patients wishes can be acted upon if required and possible. The booklet offers patients support in communicating their needs around death and dying.

Diagram 1

PATIENT PATHWAY



3. Current Programmes and Provision in Manchester

The following programmes highlight the work of some of the main providers of end of life and palliative care in Manchester.

3.1 Hospices in Greater Manchester

Current provision includes:

- St Ann's Hospice (3 sites) - Little Hulton, Heald Green, and the Neil Cliffe Centre (Supportive out-patients) at Wythenshawe (activity data in Appendix 3)
- Springhill Hospice, Rochdale
- Dr Kershaw's Hospice, Oldham
- Bury Hospice, Bury

3.1.2 Hospices provide a range of Specialist Palliative Care for adults who have a life-limiting illness, who have complex needs and who require assessment and management by the multi disciplinary team. They do not provide long-term residential or nursing care where there are no specific Specialist Palliative Care needs.

3.1.3 Hospices provide a wide range of services but generally can be grouped under the following headings:

In Patient Care

- complex symptom control (e.g. intractable vomiting, complex pain)
- complex psychological and/or spiritual need (e.g. severe anxiety and depression)
- complex social need (e.g. crisis intervention)
- rehabilitation assessment following radiotherapy, chemotherapy, surgery or other palliative interventions
- care of the dying patient with Specialist Palliative Care needs

Day Therapy

- Supportive Outpatients
- Specialist Palliative Medical Out Patients
- Lymphoedema Management Service

Community Services

- 24 hour Advice Line for professionals, patients and carers
- Outreach Complementary Therapy Service
- Hospice At Home (not in Manchester)
- Community Specialist Palliative Care Team (not employed by Hospice in Manchester)

3.1.4 It is important to note that hospices provide different services across Greater Manchester and this is often based on historic developments and specific commissioning investment.

3.1.5 All hospices aim to help people maintain their dignity and have the best quality of life. Each service provided will have unique referral criteria but it is important to note that the rehabilitative element of assisting individuals to cope with a life-limiting illness and its treatments runs through them all.

3.1.6 Inpatient and Community provision by hospices is undoubtedly an essential part of end of life care. However, the hospice at home approach is also an important component that currently is not available for Manchester residents.

3.1.7 Hospice at Home is:

- To assist with end of life care where the preferred place of care is home (including care homes or other long-term care facilities)
- To provide or support crisis intervention
- To support rapid discharge from hospital / hospice

3.1.8 A previous pilot of a Hospice At Home service in North Manchester was not continued. In other clinical Commissioning Groups (CCGs) there is evidence to show that Hospice At Home services support patients in their preferred place of care and death.

3.2 Macmillan Cancer Improvement Programme

3.2.1 The pan-Manchester Macmillan Cancer Improvement Programme to redesign pathways of care builds on Macmillan's previous £12million investment in Manchester over the last eight years and aims to deliver more patient centred and coordinated support from the point of diagnosis all the way through treatment and beyond.

3.2.2 Phase one of the programme focuses on primary, community and supported, palliative and end of life care across all cancers. £2.35 million has been committed by Macmillan to implement Phase one including £1 million to improve supportive, palliative and end of life care. This has been agreed in a specific funding agreement with North, Central and South CCGs with South CCG being the lead organisation.

3.2.3 The supportive, palliative and end of life care framework aims to establish a proactive patient pathway for all patients with potential and existing palliative care needs extending to end of life care. It will achieve this thorough a variety of activities some of which will be to help Primary Care in supporting patients through the use of the Gold Standard Framework, palliative care registers, carers' registers and palliative care review meetings all of which are managed in General Practice. To improve the quality of out of hours provision the Macmillan out of hours palliative care training programme will be delivered to all providers.

3.2.4 Macmillan has committed just over £500,000 of the £1 million to North Manchester to develop the existing Consultant-led community supportive / Specialist Palliative Care team to improve access to Specialist Palliative Care, earlier referral from GPs and strong partnership working with and including

GPs. The approach involves District Nurses, other social and health care professionals and, importantly, volunteers.

3.2.5 Adoption of the principles of this model will result in extending the choice for patients, clinicians, families and carers facilitating, as part of an integrated specialist community palliative care service more patients to be able to die at home or their preferred place, and reduce the number of deaths in hospital. This is supported by a recent economic review.

3.2.6 Macmillan is keen to ensure that the investment being made is consistent with an overall strategy for improving palliative and end of life care across the City of Manchester. The support of the Manchester Health and Wellbeing Board will be crucial in achieving this.

3.3 Work in Care Homes.

3.3.1 Education and Training in End of Life Care is crucial with the increasing number of people being cared for in Manchester Care Homes suffering from long term conditions. This requires ongoing education and training to take account of staff turnover. There are currently 95 Care Homes in Manchester.

3.3.2 The Gold Standards Framework (GSF) in Care Homes education programme recognises the majority of people in Care Homes are in the last year of life. For this reason Care Homes hold GSF Registers and the staff work through a system of identifying at which stage of life a resident is, to proactively plan with them their care needs and reduce the number of hospital admissions. Manchester has 95 care homes and 4 GSF homes.

3.3.3 The National End of Life Care Programme released a series of materials [Routes to Success] describes best practice in different care settings. The Routes to Success in End of Life –achieving best practice in Care Homes [2010] led to the development of the North West Six Steps to success End of Life Care Home Programme. 14 Care Homes in Manchester have completed this programme.

3.3.4 Provision of Social Care is crucial in providing End of Life Care. Work is nearly complete on the Six Steps to Success in Domiciliary Care. This education programme for social care staff will also contribute to people remaining in their usual place of residence in their last days of life.

4. The key role of Clinical Commissioning Groups

4.1 Each CCG in Manchester has prioritised End of Life Care in their commissioning plans and is implementing a number of End of Life care initiatives

4.2 Manchester CCGs are also collaborating to developing an Electronic Palliative Care Co-ordination System (EPaCCS) to ensure key information about an individual's preferences for care at the end of life are recorded and accessible to those services providing that person's care. This will allow more people to

be supported to die in the place of their choosing and with their preferred care package.

4.3 North Manchester initiatives

- Community and hospital teams are developing 7 day working to improve access to review and advice for palliative care patients. End of Life care Facilitator working with nursing homes
- Development of a verification of death policy to support people dying in their own home by speeding up the verification and certification of death process.
- Nursing and residential care homes undertaking the Transform Programme Nursing home project - intensively supporting nursing homes undertaking the GSF programme
- Working with funded nursing care and Continuing Health Care colleagues to develop key checks when placing patients for end of life care in care homes.

4.4 Central Manchester initiatives

Central CCG has developed an End of Life (EOL) care pathway as part of its Quality and Productivity indicator targets, to encourage all GP practices to follow a best quality care pathway. Each practice should have a GSF lead, ensure all patients in the last year of life are placed on their GSF register recorded using the agreed Clinical Read codes.

4.5 Each practice will work with appointed EOL facilitators to establish an EOL register on the EPaCCS system.

- Development of a community nursing supportive care pathway for patients on the GSF register
- End of Life Care for Residential Homes Project to improve end of life care for residents. The residents will be on the supportive care pathway which will take into account their Preferred Priorities for Care.
- End of Life Care Facilitator in post
- Six Steps to Success programme underway
- One nursing home has completed GSF programme and awaiting accreditation with a further 2 homes currently undertaking programme.
- End of Life Care Facilitator providing educational support for GP practices and DN teams around end of life care and education to nursing home teams. Support is provided to staff as they deliver end of life care to residents. An audit of the Liverpool Care Pathway use in community teams is in progress
- 6 Steps to Success programme underway
- 5 nursing homes have undertaken the GSF programme.

4.6 South Manchester initiatives

- Priority to develop an integrated team based model across health and social care, with GP based/neighbourhood teams to enable teams to work in a more cohesive way, while ensuring improved communication the primary care team. This rapid access team will build upon the existing provision to provide an intensive support package of care at home

- Development of a community nursing supportive care pathway for patients on the GSF register
- Development of the key worker role to help patients and their family navigate their end of life care pathway and local services. The key worker will co-ordinate services on behalf of the patient and ensure their care is seamless.
- End of Life Care Facilitator to be appointed.
- Practices engaging in the Quality and Productivity (QP) programme to improve review of patients on the Cancer registers and to extend the use of Palliative Care Registers to all diseases. These registers/meetings will help to identify key workers within the Primary Care Teams and support patients at appropriate times in their journey
- Central Manchester Foundation Trust has been working on a programme of work to develop the provision of end of life care at home. A training and support package for residential homes which has seen the percentage of deaths at home increase from 45% to 94%. The team will also be designing a multidisciplinary hospice at home type model.

5. Outputs from of the End of Life/Palliative Care Summit held on 27.3.2013

5.1 Recurring themes from across the three localities included:

- A strong need to improve the standard of care for patients approaching end of life, with uniformity across the city
- Improvement in timely and appropriate communication across all sectors
- Increased and improved education for all individuals caring for patients with palliative and end of life needs
- Increased choice for Preferred Priorities for Care (PPC) for all patients

5.2 All Manchester patients need a better service offer built around their needs but there are particular gaps in the north of the city and parts of the central locality.

5.3 The challenge in funding, developing and managing such services is recognised and can only happen with the full support of commissioners, including CCGs, the City Council and specialist Continuing Care Commissioners.

5.4 A Hospice at Home service could be commissioned from a provider who already has experience in providing this services but it is important that it is "branded" as, for example, North Manchester Service (or similar for the other localities).

5.5 There is a need for inpatient and day therapy services on a relatively small scale and need for this in North Manchester is arguably greater than for other areas as the infrastructure needed to support palliative care patients at home is often lacking.

5.6 There was unanimous support for an even greater focus on developing Hospice at Home Services and a good debate about the challenge of "building" and developing more specialist in-patient provision in the current economic climate.

5.7 The summit did not provide all the answers but it did give a strong steer to further work on Hospice at Home provision, giving priority to the north of the City. It has since been suggested that a feasibility study is undertaken and commissioned by the End of Life/Palliative Care group that not only looks at Hospice at Home but a range of other options, given the commitment of local care providers, Macmillan and The Pennine Acute Hospitals NHS Trust in particular**.** Macmillan has made a financial commitment, via a Macmillan Cancer Improvement Programme, for the proposed delivery of a community specialist palliative care service within the north of the city.

6. Recommendations:

The Board are asked to

- Note local, regional and national guidelines for provision of high quality end of life care;
- Note and consider the discussions and findings of the Manchester End of Life and Palliative Care Working Group;
- Consider the most appropriate strategy to improve palliative / end of life care for Manchester residents and support the development of an options appraisal for increased provision in the north of the City in particular ;
- Provide leadership and support for a strategy to enable Manchester to become a social, clinical and academic centre of excellence for palliative and end of life care.

Appendix 1 Summit outputs
NORTH

General Discussion

What about a hospice in North Manchester?

- North Manchester patients have least access to transport and travel exhausts the patient
- Something with the 'ethos' of hospice care
- North Manchester General Campus – Potential for accommodation
- Hospice at home pilot 12 years ago.
- Geographical gap but building is costly to run. Community based provision is potentially more sustainable.
- Hospice buildings have reduced beds and specialised area of work
- Maybe North Manchester needs both hospice at home and specialised inpatient beds. Small, focused physical unit, supported by predominantly community service may be better.
- Specialist cover in community is 1 session / week. Not enough capacity to offer cover widely.
- Patient cohort in Rochdale and Bury is different. Need to look at level of need and plan accordingly (use of out of area hospices is not designed for Manchester patients). Aim high for resource
- Effect on care homes. Would Care Home residents still have access to end of life care?
- Facility may not address cultural attitudes
- Social infrastructure in North Manchester is so poor. Lots of people alone in deprivation. Both inpatient and community resources are needed.
- Challenge – Reducing % of death in hospital is laudable but lots of North Manchester patients don't want to die at home.
- Sheffield. Comparable population, much better model
- Three considerations:
  1. Complexity of population
  2. Nursing home system
  3. Community – HUB and spoke from unit.
- Think big; understand own community but who holds the ring?
- Competition, rivalry + tendering. Is there an argument for formal collaboration?
- Salford – Amalgamation of teams + 7 day working, rapid response etc
- Look for commitment from all organisations
- Running a hospice = ongoing costs + management – challenging + consider impact on Greater Manchester. Fundraising will be challenging
- Good palliative care starts early
- Risk of building a facility on top of a system that doesn't work

<u>Key messages for plenary</u>

1.) North Manchester patients are not the same as those from Bury, Rochdale etc. We need a service built around their needs that included both hospice at home and inpatient beds. There is tangible support from Pennine Acute Trust.

2.) Mustn't underestimate the challenge in funding, developing and managing such a service or network of services. Its impact on existing services in Manchester + Greater Manchester must also be assessed.

3.) We can't do this without formal collaboration and detailed involvement of commissioners, local authority, Specialist Continuing Care Commissioners as these are the contractual levers we have available.

SOUTH

General Discussion

1.) What works well and can we extend further across the health and social care economy

- Able to give more support to people to at home – move dying at home (e.g. Most practices now have palliative care meetings)
- Care homes now have better skills in supporting people
- Have a framework but still work in progress

2.) What are the major opportunities for change and improvement

- System doesn't support continuity integration or individual preference – not joined up, several pathways

3.) What doesn't work at the moment and needs fixing

- Need much better communication, coordination and trust across organisations.
- Need to bring hospitals into the Transform Programme, Gold Standard Framework (GSF), Liverpool Care Pathway (LCP)
- Need to see these things through
- Changing the mindset / culture with hospitals – very fragmented approach to end of life care. - Need hospital staff to think differently regarding Primary Care
- Funding flows – PBR, QOF, CQUINS works against what's needed.
- Need to factor in care homes. Provision for non cancer care need to be addressed.
- 25% cancer, 75% non malignant – 90% of palliative care is for cancer
- What has to be put in place for people to die at home?

4.) What needs to change to better support patients with end of life care needs

- Advance Care Planning – complex e-learning need
- Need to factor in dementia – cancer models aren't working well for stroke, heart failure, etc
- Palliative care needs to be part of medical education and training – embedded in the curriculum

- Integrated partnership with Social Care and Health and Wellbeing Board, CCG Patch configuration
- Multidisciplinary approach needed- IT Strategy, video conferencing. Principle needs to be established. Between hospitals and Primary Care, Primary Care worker to hold it together.

Key Messages for plenary

1.) What is working well, what could be improved?

- Current standards GSF and LCP – needs to be seen through
- MDTS – expanded down to Primary Care
- Improved communication
- Advanced Care Planning
- Needs more choice

2.) Opportunities for change

- Development of Health and Wellbeing Board
- Social Care integration
- Different ways of commissioning and funding flow

3.) What needs to change?

- Look at Care Programme Approach, identification of key worker – Advocacy role – using risk factors
- Extending undergraduate education to include Palliative Care
- Imbalance Cancer vs. Non Cancer Palliative Care (egg. Dementia, stroke)
- IT Strategy – video conferencing

CENTRAL

General Discussion

1.) What works well?

- Collaborative working across Acute Trust
- Community Palliative Care across Manchester
- District Nurses and Specialist Palliative Care and GPs
- GP 80% regular audited
- Each practice has an allocated Macmillan Nurse
- Care Homes
- District Nurses and Care Mangers supporting residential homes
- 2013 Living Longer Living Better - opportunities

2.) Challenges and Opportunities

- Has the cash worked?
- Moving services into the community – impact on care

- Message about the changing role of staff
- Working closely with local communities
- Developing relationships with communities across 3 CCGs
- Communication + Infrastructure
- Having a key worker, as people can't navigate system.
- District nursing team stretched
- Have an implementation plan that can overcome the bureaucracy
- ACP – Advanced Care Plan – need to do more on this
- Palliative Care should be available sooner
- 3rd sector full cost recovery could train staff
- Crisis intervention out of hours rapid discharge and out of hours
- General Staff Education
- Better integrated and coordinated care and workforce development.

Key messages for plenary

1.) One way of working. Spanning long term conditions. (E.g. Healthcare assistants, district nurses, 'a navigator model'.)

2.) Communications and service development

- Information in real time that is informative.
- Local practices staying in touch, set the scale re timescales for key workers.
- Communication on a local level and support for people in own home
- Support for people in own home.
- Issue re not being able to serve people who are in poverty.

Appendix 2 End of Life Care Profile for Manchester Local Authority

National end of life care INTELLIGENCE NETWORK

NHS National End of Life Care Programme

National End of Life Care Profiles for Local Authorities

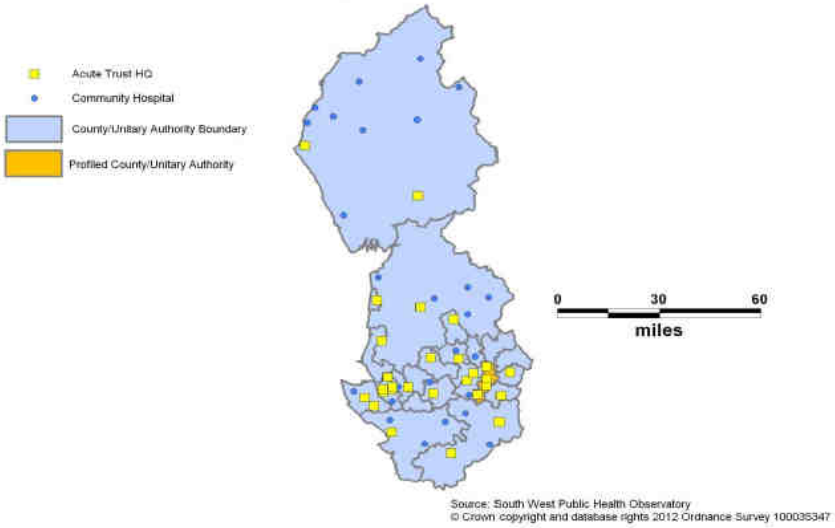
Manchester

Introduction

This end of life care profile provides a snapshot of this upper tier local authority's position compared to England and its Strategic Health Authority (SHA). It can be used to benchmark and review the local authority's position over time. Commissioners and providers of end of life care can use the profile when discussing service need. If you would like to see how this local authority compares with others, then please use the End of Life Care Profiles interactive tool on the National End of Life Care Intelligence Network website: **www.endoflifecare-intelligence.org.uk/profiles.aspx**

Local authority population: 498,779
SHA population: 6,969,638

Acute hospital trusts and community hospitals in NHS North West



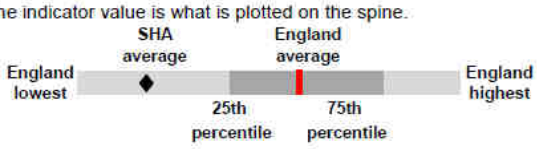
Note: Based on the best available data from the following sources: NHS Connecting for Health, Organisational Data Service, May 2012 and Community Hospitals Association, December 2011, with some modifications by the NEoLCIN. Mapped sites are shown in: ***List of Acute Hospital Trust HQs and Community Hospitals***

How to read the indicator spine chart

See the spine chart on the next page. This summarises the local authority position compared to England.

- Each indicator is numbered. Each number corresponds to a definition on the next page. The definitions give you more information about the indicator and its data source. More detailed definitions are given in the **Indicators Metadata Guide.** It is especially important to read these for the social care indicators, which are included in these profiles for the first time.
- The two columns immediately to the right of the indicator name give **i)** the underlying number for that indicator, from which **ii)** the 'indicator value' (highlighted in grey) is calculated. The indicator value is what is plotted on the spine.

- **Significantly lower than England average**
- **Not significantly different from England average**
- **Significantly higher than England average**
- **Significance not tested**



- On the spine, the light grey bar shows the range of values found in England. The dark grey sections mark out the range within which the middle half of the observed values lie (25th to 75th percentile).

End of Life Care Local Authority Profile - Manchester

Indicator spine chart

Domain	Indicator	LA number	LA indicator value	England average	England lowest	England range	England highest
Population	1. Percentage aged 65+ (persons)	50,506	10.4%	16.3%	7.0%		25.1%
	2. Percentage aged 65+ (males)	21,718	8.7%	14.5%	6.3%		23.0%
	3. Percentage aged 65+ (females)	28,788	12.2%	18.0%	7.7%		27.1%
	4. Percentage aged 75+ (persons)	25,062	5.2%	7.8%	3.4%		12.7%
	5. Percentage aged 75+ (males)	9,718	3.9%	6.3%	3.0%		10.8%
	6. Percentage aged 75+ (females)	15,344	6.5%	9.3%	3.8%		14.5%
	7. Percentage aged 85+ (persons)	7,477	1.5%	2.2%	0.9%		4.0%
	8. Percentage aged 85+ (males)	2,400	1.0%	1.5%	0.7%		2.8%
	9. Percentage aged 85+ (females)	5,077	2.1%	3.0%	1.0%		5.2%
	10. Percentage increase in population aged 85+ (projected to 2033)	12,200	63.2%	142.1%	24.5%		233.7%
	11. Percentage of resident population who are Black and Minority Ethnic	74,806	19.0%	9.1%	0.7%		60.6%
	12. Percentage resident in urban settlements	485,266	100.0%	81.1%	0.0%		100.0%
	13. Percentage resident in the most deprived quintile	295,989	61.0%	20.0%	0.0%		89.7%
Deaths	14. Crude death rate (persons) as a percentage	3,806	0.8%	0.9%	0.4%		1.3%
	15. Crude death rate (males) as a percentage	1,902	0.8%	0.9%	0.4%		1.4%
	16. Crude death rate (females) as a percentage	1,904	0.8%	0.8%	0.4%		1.4%
	17. Percentage of deaths aged 75+ (persons)	2,142	56.3%	66.7%	50.2%		75.3%
	18. Percentage of deaths aged 75+ (males)	865	45.5%	58.6%	42.2%		69.1%
	19. Percentage of deaths aged 75+ (females)	1,277	67.1%	74.2%	59.3%		82.4%
	20. Percentage of deaths aged 85+ (persons)	1,028	27.0%	36.2%	23.1%		46.4%
	21. Percentage of deaths aged 85+ (males)	330	17.3%	26.2%	14.8%		36.0%
	22. Percentage of deaths aged 85+ (females)	699	36.7%	45.5%	31.2%		55.4%
Place of death	23. Percentage of deaths in hospital*	2,402	63.1%	54.5%	42.2%		70.2%
	24. Percentage of deaths in own home	774	20.3%	20.3%	15.9%		27.2%
	25. Percentage of deaths in hospice*	124	3.3%	5.2%	0.1%		12.6%
	26. Percentage of deaths in care home	416	10.9%	17.8%	3.7%		32.1%
Cause of death	27. Percentage of deaths from respiratory disease (underlying cause)	593	15.6%	13.8%	11.2%		17.8%
	28. Percentage of deaths from respiratory disease (mentions)	1,463	38.4%	34.2%	27.9%		41.3%
	29. Percentage of deaths from cancer (underlying cause)	987	25.9%	27.7%	23.1%		31.4%
	30. Percentage of deaths from cardiovascular disease (underlying cause)	1,076	28.3%	29.6%	25.3%		35.3%
	31. Percentage of deaths from liver disease (mentions)	221	5.8%	3.8%	2.6%		6.7%
	32. Percentage of deaths from renal disease (mentions)	196	5.2%	5.8%	3.6%		8.2%
	33. Percentage of deaths from Alzheimers, dementia & senility (mentions)	455	12.0%	17.3%	7.9%		26.9%
Deaths in hospital	34. Percentage of terminal admissions that are emergencies	1,754	92.0%	89.7%	76.1%		97.0%
	35. Percentage of terminal admissions aged 85+	561	29.4%	37.8%	27.5%		49.4%
	36. Percentage of terminal admissions that are 8 days or longer	985	51.7%	48.8%	37.6%		57.8%
	37. Average number of bed days per admission ending in death	28,776	15.0	12.9	8.0		16.0
Care homes	38. Number of care homes per 1,000 population aged 75+	106	4.2	4.4	1.2		8.2
	39. Number of care home beds per 1,000 population aged 75+	2,984	118.3	114.1	35.7		169.6
	40. Percentage of care homes achieving Gold Standard Framework	1	0.9%	1.6%	0.0%		14.7%
Social care (SC)	41. Persons (aged 65+) discharged from hospital per 100,000 aged 65+.	450	896	425	47		2,715
	42. Average user experience score (max. score 24), persons aged 65+	3,070	18	19	17		20
	43. Persons (65+) receiving Self Directed Support (per 100,000 aged 65+)	3,455	6,879	2,935	238		7,619
	44. Delayed transfers of care: persons (all ages) (per 100,000 aged 65+)	409	814	568	21		2,026
	45. Delayed transfers of care: days (all ages) (per 100,000 aged 65+)	10,065	20,040	15,956	239		60,629
	46. Persons (65+) with completed assessment (per 100,000 aged 65+)	1,710	3,405	5,054	1,343		11,209
	47. Persons (65+) with care package delivered (per 100,000 aged 65+)	465	926	3,186	768		8,683
	48. Carers (65+) who received social care support (per 100,000 aged 65+)	1,145	2,279.7	2,003.3	400.6		5,977.1
	49. Persons (65+) who received social care support (per 100,000 aged 65+)	3,650	7,666	6,297	4,819		20,543
	50. Persons (65+) entitled to Carer's Allowance (per 100,000, aged 65+)	2,510	4,997.5	3,470.1	946.7		9,194.4
SC Expenditure (Avg annual £'000s per 100,000 aged 65+)	51. Gross residential and nursing care (£'000s per 100,000 aged 65+)	£36,480	£72,633	£59,849	£33,157		116,154
	52. As indicator 51, less NHS section 256 (£'000s per 100,000 aged 65+)	£34,180	£68,054	£57,239	£32,754		£115,930
	53. Home care (£'000s per 100,000 aged 65+)	£35,323	£70,330	£25,766	£12,518		£92,012
	54. Direct payments (£'000s per 100,000 aged 65+)	£2,616	£5,209	£3,420	£273		£15,457
	55. Day care or day services (£'000s per 100,000 aged 65+)	£3,696	£7,359	£4,246	£793		£21,608
	56. Meals (£'000s per 100,000 aged 65+)	£1,021	£2,033	£905	£0		£7,497

*Notes: The totals for males and females combined may not equal the 'persons' total, due to rounding. * It is not possible to distinguish between hospital deaths and deaths in specialist palliative care units/hospices that are based in hospitals, so hospital deaths may be an over-count and hospice deaths an under-count.*

Indicator notes and definitions

1. Percentage of persons who are aged 65 and over, average annual for 2008-10. ONS
2. Percentage of male population who are aged 65 and over, average annual for 2008-10. ONS
3. Percentage of female population who are aged 65 and over, average annual for 2008-10. ONS
4. Percentage of persons who are aged 75 and over, average annual for 2008-10. ONS
5. Percentage of male population who are aged 75 and over, average annual for 2008-10. ONS
6. Percentage of female population who are aged 75 and over, average annual for 2008-10. ONS
7. Percentage of persons who are aged 85 and over, average annual for 2008-10. ONS
8. Percentage of male population who are aged 85 and over, average annual for 2008-10. ONS
9. Percentage of female population who are aged 85 and over, average annual for 2008-10. ONS
10. Percentage increase in the population aged 85 and over, projected to 2033, 2008-based national population projections. ONS
11. Percentage of resident population who are BME, 2001. NCHOD
12. Percentage of residents in urban settlements (population over 10,000), average annual for 2008-10. ONS
13. Percentage of residents in the most deprived quintile average annual for 2008-10. DCLG.
14. Crude death rate (persons) as a percentage, average annual for 2008-10. ONS
15. Crude death rate (males) as percentage, average annual for 2008-10. ONS
16. Crude death rate (females) as percentage, average annual for 2008-10, ONS
17. Percentage of all deaths that are aged 75 and over, average annual for 2008-10. ONS
18. Percentage of male deaths that are aged 75 and over, average annual for 2008-10. ONS
19. Percentage of female deaths that are aged 75 and over, average annual for 2008-10. ONS
20. Percentage of all deaths that are aged 85 and over, average annual for 2008-10. ONS
21. Percentage of male deaths that are aged 85 and over, average annual for 2008-10. ONS
22. Percentage of female deaths that are aged 85 and over, average annual for 2008-10. ONS
23. Percentage of all deaths that occur in hospital, average annual for 2008-10. ONS
24. Percentage of all deaths that occur in own home, average annual for 2008-10. ONS
25. Percentage of all deaths that occur in a hospice average annual for 2008-10. ONS
26. Percentage of all deaths that occur in a care home, average annual for 2008-10. ONS
27. Of all deaths, percentage that die from respiratory disease as the underlying cause of death, average annual for 2008-10. ONS
28. Of all deaths, percentage that die from respiratory disease listed as either the underlying cause of death or as a contributory cause of death (mentions), average annual for 2008-10. ONS
29. Of all deaths, percentage that die from cancer as the underlying cause of death, average annual for 2008-10. ONS
30. Of all deaths, percentage that die from cardiovascular disease as the underlying cause of death, average annual for 2008-10. ONS
31. Of all deaths, percentage that die from liver disease listed as either the underlying cause of death or as a contributory cause of death (mentions), average annual for 2008-10. ONS
32. Of all deaths, percentage that die from renal disease listed as either the underlying cause of death or as a contributory cause of death (mentions), average annual for 2008-10. ONS
33. Of all deaths, percentage that die from Alzheimer's disease, dementia or senility listed as either the underlying cause of death or as a contributory cause of death (mentions), average annual for 2008-10. ONS
34. Percentage of hospital admissions ending in death (terminal admissions) that are emergencies, 2010/11. HES
35. Percentage of hospital admissions ending in death (terminal admissions) that are aged 85+ and over, 2010/11. HES
36. Percentage of hospital admissions ending in death (terminal admissions) with a stay of 8 days or longer, 2010/11. HES
37. Average (mean) number of bed days per admission that end in death, 2010/11. HES
38. Number of care homes per 1,000 population aged 75 and over (average 2008-10). CQC data extract Feb 2012 and ONS
39. Number of care home beds per 1,000 population aged 75 and over (average 2008-10). CQC data extract Feb 2012 and ONS
40. Percentage of care homes achieving Gold Standard Framework (GSF). GSF data extract Feb 2012 and CQC extract Feb 2012.
41. Persons (aged 65+) discharged from hospital for rehabilitation, per 100,000 aged 65+. From NI 125, Q3 2010-11, HSCIC. & ONS.
42. Average user experience score (aged 65+), (max score 24) From NI 127, 2010/11, HSCIC.
43. Persons (65+) receiving Self Directed Support, per 100,000, 65+. From NI 130, 2010/11, HSCIC. 2010, ONS.
44. Delayed transfers of care: persons (all ages), per 100,000, 65+. From NI 131*, 2010/11 HSCIC. 2010, ONS.
45. Delayed transfers of care: days per month (all ages), per 100,000, 65+. From NI 131*, 2010/11 HSCIC. 2010, ONS.
46. Persons (65+) with completed assessment, per 100,000, 65+. From NI 132*, 2010/11 HSCIC. 2010, ONS.
47. Persons (65+) with care package delivered, per 100,000, 65+. From NI 133*, 2010/11 HSCIC. 2010, ONS.
48. Carers (65+) who received social care support, per 100,000, 65+. From NI 135, 2010/11 HSCIC. 2010, ONS.
49. Persons (65+) who received social care support, per 100,000, 65+. From NI 135, 2010/11 HSCIC. 2010, ONS.
50. Persons (65+) entitled to Carer's Allowance, per 100,000, 65+. Aug 2011, DWP caseload. 2011, ONS.
51. Residential and nursing care, average annual gross expenditure (£'000s per 100,000, 65+), 2010/11 HSCIC. 2010, ONS.
52. Residential and nursing care, average annual gross expenditure less NHS Section 256 (£'000s per 100,000, 65+), 2010/11 HSCIC. 2010, ONS.
53. Home care expenditure (£'000s per 100,000, 65+), 2010/11, HSCIC. 2010, ONS.
54. Direct payments expenditure (£'000s per 100,000, 65+), 2010/11, HSCIC. 2010, ONS.
55. Day care/day services expenditure (£'000s per 100,000, 65+) 2010/11, HSCIC. 2010, ONS.
56. Meals expenditure (£000's per 100,000, aged 65+) 2010/11, HSCIC. 2010, ONS.

Abbreviations

BME - Black and Minority Ethnic, **CQC** - Care Quality Commission, **DCLG** - Department for Communities and Local Government, **DH** - Department of Health, **DWP** - Department of Work and Pensions, **GSF** - Gold Standard Framework, **HES** - Hospital Episode Statistics, **NCHOD** - National Clinical and Health Outcomes Knowledge Base, **NI** - National Indicator, **HSCIC** - Health and Social Care Information Centre, **ONS** - Office for National Statistics, **SC** - Social Care, **SPC** - Specialist Palliative Care.

* Discontinued National Indicator

End of Life Care Local Authority Profile - Manchester

Place and cause of death

Source: ONS Mortality Data 2008-10

	All causes	Underlying cause of death			Causes mentioned on death certificate			
		Cancer	Cardiovascular disease	Respiratory disease	Alzheimer's/ Dementia/Senility	Liver disease	Renal disease	Respiratory disease
Home	774	273	220	80	35	54	20	188
Care home	416	75	132	62	204	2	17	160
Hospital	2,402	505	705	444	210	157	157	1,095
Hospice	124	117	2	2	0	3	1	7
Total	3,806	987	1,076	593	455	221	196	1,463

Notes: i) 'Underlying cause' of death is the main cause of death recorded on a death certificate. 'Causes mentioned' include the underlying cause and any contributory causes recorded. We have selected the most common underlying causes of death and the most common 'mentioned' causes that are demanding of end of life care. ii) While an individual will have only one recorded underlying cause, they may have more than one contributory cause recorded. iii) Numbers are annual averages.

How to interpret your profile

- Be open about what the profile might be telling you.
- Focusing on individual indicators can be misleading, consider the full range of indicators.
- Read the notes on the indicator spine chart to aid interpretation.
- Understanding the context is essential: use the demographic and geographic information at the beginning of the profile to provide context.
- Triangulate the information in the profiles with information from other sources. For example, End of Life Care Quality Assessment (ELCQuA) tool, the local Joint Strategic Needs Assessment, a clinical or organisational audit.
- Recognise the limitations of the data (see the **Indicators Metadata Guide** on the National End of Life Care Intelligence Network
- This is the first time these profiles have been produced and, despite our best endeavours, some of the data may be out of date, incorrect or missing. Please send us your comments about the data (see 'Feedback' at the end of this profile).
- Use the profiles to identify further questions that may need to be asked.

Related resources

The National End of Life Care Intelligence Network (NEoLCIN) coordinates statistical information and commissions research on end of life care. It also brings all this data together in one place, enabling commissioners and people working in end of life care to use it to plan, deliver and improve end of life care services. For more information please visit the NEoLCIN website at **www.endoflifecare-intelligence.org.uk**

- **End of Life Care Profiles** provide data and statistics on end of life care, by PCT and Local Authority areas in England broken down by age, gender, place of death and cause of death. Available in both PDF and Instant Atlas formats.
- **Resources** includes information on research, links to other sources of information and publications produced by the NEoLCIN and other organisations.
- **Data sources** provides a guide and links to key sources of data relating to end of life care.

We are currently developing PDF profiles for Acute Trusts in England. These will be made available on the NEoLCIN website in due course. Please **sign up to email alerts** to keep up-to-date with developments.

The **National End of Life Care Programme** works with health and social care services across all sectors in England to improve end of life care for adults by implementing the Department of Health's End of Life Care Strategy. Its website **(www.endoflifecareforadults.nhs.uk)** is designed to support health and social care staff working, in any capacity, with people nearing the end of life. It has information on policy and strategy, education and training, research and evaluation and commissioning, as well as case studies, information on care pathways and care settings, news, publications and events.

Feedback

Please let us know:

- If the data is incorrect due to the sources we are using.
- How the profiles have assisted you in identifying changes in policy/practice.
- How we can improve the profiles.
- If you have suggestions for other indicators that we could include in future.
- Any other comments you may have.

Email us at:
information@neolcin.nhs.uk

www.endoflifecare-intelligence.org.uk

Appendix 3

% Activity for Manchester
St Ann's Hospice
April 2011 – March 2012

		In Patient Stays	Day Care Attendances	Out Patient Attendances
St Ann's Hospice Heald Green	Total	414	1508	961
	Manchester	121	642	214
	% of activity	29%	43%	22%
St Ann's Hospice Little Hulton	Total	271	1204	1454
	Manchester	17	38	30
	% of activity	6%	3%	2%
Neil Cliffe Centre	Total	-	-	2024
	Manchester	-	-	992
	% of activity	-	-	49%
Springhill Hospice		10		

% Activity for Manchester
St Ann's Hospice
April 2012 – March 2013

(this is our most recent data and thought it would be most useful)

		In Patient Stays	Day Care Attendances	Out Patient Attendances
St Ann's Hospice Heald Green	**Total**	**377**	**1602**	**1098**
	Manchester	**113**	**673**	**259**
	% of activity	**31%**	**42%**	**23.5%**
St Ann's Hospice Little Hulton	**Total**	**292**	**1250**	**1493**
	Manchester	**17**	**25**	**29**
	% of activity	**5.82%**	**2%**	**1.9%**
Neil Cliffe Centre	**Total**	**-**	**-**	**2215**
	Manchester	**-**	**-**	**1158**
	% of activity	**-**	**-**	**52.2%**
Springhill Hospice				