

Jubilee House
Bloxwich Lane
WALSALL
WS2 7JL

22 July 2005

Dear Partner / Stakeholder

Re: Consultation on Palliative Care Strategy

I am attaching a copy of the paper "Palliative Care Strategy for Walsall – An Update" which was approved by the Board of Walsall Teaching Primary Care Trust on 14 July 2005 as a basis for consultation.

As part of this consultation, I should appreciate your comments on the document, and I would also welcome comments from others you may be in contact with, in order to inform the Board's commissioning strategy for Palliative Care.

The documents can be downloaded from our website, www.walsall.nhs.uk for further circulation.

The closing date for submissions is 16 September, and the Board will meet again to consider the results of the consultation on 29 September. All submissions should be returned to Martin Turner, Head of Communications, at this address, or emailed to martin.turner@walsall.nhs.uk.

Questions you may wish to consider include:

- Does the proposed strategy demonstrate service needs clearly, and does it justify the care approach put forward?
- Are the recommendations clear and appropriate?
- Is there a good balance between generalist and specialist palliative care developments?
- Do you think the plans will lead to high quality palliative care services?
- Should other approaches be included, and if so, what evidence would support this?
- What are the strengths, weaknesses, opportunities and threats associated with following the strategy as outlined?

I look forward to hearing your views.

Yours sincerely



Stella Forsdike
EXECUTIVE DIRECTOR – COMMISSIONING AND PERFORMANCE
Enc: "Palliative Care Strategy for Walsall – An update"

WALSALL TEACHING PRIMARY CARE TRUST

REPORT TO: Walsall tPCT Board

REPORT FROM: Dr John Linnane, Deputy Director of Public Health Medicine

SUBJECT: PALLIATIVE CARE STRATEGY FOR WALSALL - AN UPDATE

1.1 Purpose

The tPCT Board is asked to approve the content of this report for consultation.

1.2 Executive Summary

- The Palliative Care Strategy developed in 1996 has delivered an improved quality of care for patients in Walsall. This is most obviously seen by the number of patients with cancer who die at home. This figure of 29% has doubled from the early 90s and now exceeds the national average of 24%.
- Significant policy and practice changes have occurred over the last nine years. The two main changes have been:-
 - the imperative to extend the palliative care and End of Life approach from cancer to encompass other chronic disease areas
 - the extension of the chronic disease management approach to patients with cancer.
- For the immediate future, the NICE guidance on Supportive and Palliative Care provides a comprehensive framework to guide service development and delivery.
- In Walsall there are still a number of gaps in service provision which need to be addressed. These include both generic services as well as specialist palliative care.
- The current accommodation resource for specialist palliative care services is inadequate to address the changing demands of palliative care and specifically the need to provide outpatient and rehabilitation services, education and training and staff accommodation, as well as an inpatient unit.
- We acknowledge the long-term aspiration for a hospice in Walsall. We would be very happy for inpatient palliative care to be provided in Walsall as a result of the fulfilment of this aspiration, provided that it meets the requirements of timescale and quality, and subject to the current provisions of contestability.

1.3 Recommendations

1. Urgent consideration should be given to providing facilities and capacity to develop the community approach further and enable a shift of palliative care services from secondary to primary care.
2. Specialist palliative care beds are required with a likely bed compliment between 6–12 beds although initially a 6-bedded unit is probably sufficient.
3. There is a need to integrate palliative care services to a greater extent with the existing services such as out-of-hours medical and nursing service and the care management approach for non-cancer patients.
4. There is a need to improve End of Life care services in the community and hospital setting.
5. The multi-disciplinary approach to palliative care including Health and Social Care needs to be further developed.
6. Consideration should be given to implementing the Gold Standard Framework as an enhanced service within GMS2.
7. This report should be made available to the Trustees of the Walsall Hospice Appeal to assist in the development of their plans.

**DR JOHN LINNANE
DEPUTY DIRECTOR OF PUBLIC HEALTH MEDICINE
JULY 2005**

**PRELIMINARY UPDATE OF
PALLIATIVE CARE STRATEGY
July 2005**

PRELIMINARY UPDATE OF PALLIATIVE CARE STRATEGY

1. Introduction

The purpose of this report is to provide a preliminary update of the Palliative Care Strategy. The following will be covered in brief:

- Summary of current strategy
- Summary of relevant policy development and initiatives since 1996
- Service developments since 1996
- Revised assessment of need
- Revised development priorities in the light of policy changes, service developments and estimated need
- Further action to be taken to complete revision of the strategy

2. Background

A provisional update of the Palliative Care Strategy has been requested as part of the wider work required to underpin further development of the Estates Strategy. The current Palliative Care Strategy was approved by the former Health Authority in December 1996. Since that time there has been considerable policy development in Palliative Care and related areas together with targeted investment in services. Thus the configuration of services has changed and assessment of need has been refined. In more recent years, the strategic planning for Palliative Care has been increasingly undertaken by the Black Country Palliative Care Network and this update will reflect much of this work.

Further work is required to complete an update of the Palliative Care Strategy. In particular, more detailed planning analysis and modelling is needed looking at the impact of a range of recent policy developments on palliative care requirements as well as discussions and consultation with appropriate stakeholders.

Palliative Care can be defined as:

- '... the active, holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments' (NICE 2004).

Palliative care is based on a number of principles, and aims to:

- Provide relief from pain and other distressing symptoms
- Integrate the psychological and spiritual aspects of patient care
- Offer a support system to help patients to live as actively as possible until death and to help the family to cope during the patient's illness and in their own bereavement
- Be applied early in the course of illness in conjunction with other therapies intended to prolong life (such as chemotherapy or radiation therapy), including investigations to better understand and manage distressing clinical complications

3. Summary of Existing Strategy

The Walsall Palliative and Terminal Care Strategy was developed following a detailed review by a multi-agency group and included the contribution of a Citizens' Jury. The strategy sought to address a considerable shortfall in the provision of Palliative Care services and to rebalance the range of services available, in particular through increasing community based provision. At the time the imminent closure of Goscote Hospital (an annexe of the Manor Hospital and which provided some respite Palliative Care) presented an opportunity for the redirection of resources into alternative service models.

At the time of the review the services in Walsall were typical of many elsewhere in the country in that access to Palliative Care and Specialist Palliative Care was patchy. A high proportion of patients were (and to a large extent still are):

- Dying in an acute hospital as opposed to in their own homes or other community location
- Experiencing differential access to hospice services
- Having less access than desired to 24 hour support in their own homes
- Being supported by carers who needed more advice and information and statutory Support

A summary of the key findings of the review, the estimated level of need for Palliative Care and the level of service provision at that time are shown in Appendix 1.

As a consequence of the review priorities for development, estimated to cost £1.1m, were agreed as follows:

- To improve the quality and amount of Palliative and Terminal Care provided in the community, in order to enable more people to die at home if desired.
- To improve the quality of the palliative care provided at the Manor Hospital
- To create a specialist palliative care unit, based on the concept of a "hospice with a difference"
- To ensure that appropriate arrangements are in place for respite care
- To ensure that hospitals, primary and community care is well co-ordinated, with good discharge procedures

4. Policy Developments Since 1996

A range of policy developments either directly targeted at improving Palliative Care Services or pertaining to related service areas have emerged over recent years and include the following:

- The NHS Cancer Plan (2000) and the establishment of Palliative Care Networks
- Targeted investment in Palliative Care services (2003)
- The Gold Standards Framework (roll out since 2002)
- Building on the Best: Choice, Responsiveness and Equity in the new NHS (2003)
- The new General Medical Services (GP) contract (2003)
- Long term Conditions and Expert patient Programme (2003)
- NICE guideline on Supportive and Palliative Care (2004)
- NSF for Long-term Neurological Conditions (2005)

A brief summary of each is as follows:

4.1 The Cancer Plan

This plan heralded a comprehensive approach to the management of cancer encompassing all aspects of the patient pathway including Palliative and Terminal Care. It saw the

establishment of Cancer Networks and, within these, of Palliative Care networks and Cancer Services Collaboratives with dedicated staff to modernise patient pathways and implement new models of care. Palliative Care networks were required to engage relevant stakeholders, assess needs, appraise the range of services available and tackle inequity in service provision across geographical areas. Walsall (the lead PCT for Palliative Care in the Black Country) has been an active participant within the Black Country Network, which covers a population of 893,600.

4.2 Targeted Investment

Extra investment for Palliative Care was a commitment within the Cancer Plan. Nationally £50m was made available for three consecutive years from 2003/04 (£261,000 for Walsall) with the expectation that it would be recurrent thereafter. The money was specifically intended to tackle inequalities in access to Specialist Palliative Care and to enable the NHS to make a more substantial contribution to the cost of Hospice Care. The resource could be used for inpatient beds, home care teams, hospital support teams, Marie Curie nursing services, outpatient, day care, or bereavement services and staff education.

Plans for use of the money were agreed through the Palliative Care networks and the priorities for investment agreed by the Stakeholder group in Walsall are outlined in the table below:

Table 1
Specialist Palliative Care Funding - Development of Services 2003-2006
Financial Consequences

	£
Sub Total Network Topslice	42000
Consultant/Secretary/Admin	33690
Psychology Services	41170
Lymphoedema Services	67030
Occupational Therapy	32500
Sub Total Local Priorities	174390
Hospice allocations	52000
TOTAL DEVELOPMENT	268390

4.3 The Gold Standards Framework (GSF)

The GSF was launched by Macmillan Cancer Relief in 2002. It provides a systematic approach to optimising the care delivered by primary care teams for any patient nearing the end of life. The aim is to improve the organisation and quality of care in the community so that more patients can be cared for, and ultimately die, in their preferred place of choice. Rollout of the programme has been supported nationally by Macmillan and the Cancer Services Collaborative. The GSF is particularly aimed at improving communication within and between practices, with other teams and with patients and carers. Continuity of care should improve in part as a consequence of advanced planning, including provision of out of hours support.

Within Walsall:

- One GP practice and 1 nursing home have signed up to the GSF
- A GP survey undertaken by the Public Health department in 2003 (with an 86% response rate) identified that a third of practices already undertook most elements of the GSF
- A facilitator has recently been appointed to develop the GSF and Liverpool Care Pathway in both the acute and community sectors

4.4 Building on the Best: Choice, Responsiveness and Equity in the new NHS

This pledged, amongst other things, action to ensure that all adult patients nearing the end of life, regardless of diagnosis, have access to high quality Palliative Care so they can choose to die at home if they wish. The **End of Life Care Initiative** was developed to take this commitment forward and more specifically to support implementation of the GSF, the Liverpool Care Pathway for the Dying and the Preferred Place of Care Plan. Nationally £12m was made available for this initiative.

Within Walsall the money (£70K for the Black Country) was pooled with other Black Country PCTs and combined with other slippage monies to appoint 3 Facilitators across the PCTs and Acute Trusts to support the Pathway implementation. An Audit against the pathway standards has been undertaken in the Manor Hospital and events to launch the approach are planned for July and September this year.

In Walsall:

- A facilitator has been appointed to take forward this work
- An audit has been undertaken on two wards at the Manor Hospital
- A more formal launch is planned for July and September 2005

4.5 The new General Medical Services (GP) contract

This has potentially wide reaching implications but in particular it is noteworthy that the general management of patients who are terminally ill forms an essential service to be provided by all practices. In addition the option to transfer responsibility for the provision of out of hours care to PCTs is of relevance, as is the potential for the development of enhanced services in Palliative Care.

In Walsall:

- The Out of Hours service (Waldoc) has access to Palliative Care drugs and equipment as well as being co-terminous with the Out of Hours District Nurse service
- Resources are available for an Out of Hours Palliative Care Nurse service but despite renewed efforts this has not been achieved so far
- Plans are well advanced to deliver GSF as an enhanced service though this has not been agreed or formally approved by the tPCT

4.6 The NICE guideline on Supportive and Palliative Care

The guideline provides a number of recommendations for the provision of Palliative Care to those with cancer but is equally pertinent to **those with non-malignant disease**. The service model proposed in the guidance recognises that individual patients have different needs at different phases of their illness and that family and carers need support. The vital importance of primary and community services as the mainstay of service provision together with strong partnership working, incorporating the views of service users, underpins the recommendations. Key recommendations include the following:

Table 2
NICE Guidance on Supportive and Palliative Care

National Institute for Clinical Excellence Guidance	Position in Walsall
Improved coordination of care based on multi-disciplinary assessment of need and effective inter-professional communication.	Further work required
Involving patients and carers in developing and evaluating palliative care services	Comprehensive system currently in place including PACT as well as Local Implementation Team representation
Better communication between professionals and patients ensuring that "significant news" is communicated sensitively by appropriately trained staff and is properly documented	Recent training funded by the tPCT for all multi-disciplinary teams at the Manor Hospital
The provision of appropriate and timely information for patients to support their involvement in decision making	New Opportunities Fund award resulting in Cancer Information Service (CISS). Funding of this service has now been picked up by the tPCT
Increased availability of psychological support, including access to assessment and intervention services.	Two Psychologists in post with relatively comprehensive service
Enhancing the social support available to patients through explicit partnerships arrangements between health, social care and voluntary sector services.	Further work required
Improved access to spiritual care givers	Further work required
24 hour, 7 day a week access to general palliative care services to meet physical, psychological, social and spiritual needs, including the provision of equipment.	Dependent on District Nurse cover and links in with out-of-hours arrangements
The need for Specialist Palliative Care services should be assessed and should include as a minimum Specialist Palliative Care inpatient facilities and hospital and community teams. Advice should be available 24 hours, 7 days per week and support should be available to patients in their own homes, community hospitals and care homes	Further work required
Patients' needs for rehabilitation should be assessed and comprehensive rehabilitation services including equipment should be available.	Full Time Occupational Therapist funded at Little Bloxwich Day Hospice.
Access to evidence based complementary therapies should be provided together with information about such services.	Complete and comprehensive service

Implementation of the guideline is being taken forward through the Palliative Care Network and plans are currently being developed with an expected implementation date of September 2007.

4.7 The NSF for Long-term Neurological Conditions

This focuses on the needs of people with long-term neurological conditions and stresses the requirement for personalised care and integrated care planning through partnership working. The aim is to promote the quality of life and independence of people with long-term conditions. The NSF cross references the NICE Palliative Care Guideline and identifies the common specific Palliative Care needs of those with neurological disease such as managing the pain associated with spasticity, providing non-invasive ventilation and managing communication problems.

The NSF is to be implemented over the next ten years through mainstream resources. Initially within Walsall it is envisaged that a local implementation team will take this forward although the NSF recommends the constitution of clinical neurosciences networks in the longer term. Plans are well advanced for joint commissioning around this area with the local authority and a workshop has been organised for July 2005.

5. Service Developments Since 1996

As a consequence of implementation of the agreed strategy and the subsequent policy initiatives outlined above, the following service developments have now taken place:

The following table shows the impact of investment and developments as compared to the baseline position.

Table 3
Summary of Baseline and Current Palliative Care Services in Walsall

Baseline and Existing Palliative Care Services		
	INPATIENT	HOME/DAY CARE SERVICES
Walsall Manor Hospital	0.4 wte Palliative Care Consultant 2 palliative care nurse specialists MDT teams for all unit cancer sites Complex surgery for rarer cancers transferred to cancer centres	
Hospices: St Giles Compton John Taylor Hospice	223 bed days 414 bed days 90 bed days	0.6 Palliative Care Consultant 34 Home/Day care Attendances 0.3 Palliative Care Consultant 339 Home/Day Care Attendances
Walsall Teaching Primary Care Trust		6 specialist (Macmillan) Nurses plus * 2 Oncology Nurses * 2 Lymphoedema Nurses Marie Curie nursing services Little Bloxwich Day Hospice - 72 places/week District Nurse extended night service (part use) Complimentary Therapy Service
Continuing Care/Short Life Expectancy	For 2004/2005 Nursing Home – 16/Home Care 65 funded requests	
Social Services Dept, Walsall MBC	Respite services	Home care services including night sitting

It should be noted that while the tPCT has, year on year, sought to increase investment in hospice care, demand from Walsall has been falling over the last few years.

5.1 End of Life Care

Following the launch of the End of Life initiative by the Department of Health, a strategy group was set up across Birmingham and the Black Country Strategic Health Authority. This group has commissioned a number of reports covering End of Life care. These reports have recently been published along with outline baseline outcome measures for end of life care. Essentially the reports analyse hospital activity for the two years 2001-2003. All hospital admissions for

Cancer
Chronic Obstructive Pulmonary Disease (COPD)
Chronic Renal failure
Heart failure
Dementia
Multiple Sclerosis
Motor Neurone disease

for which the outcome was death, were analysed with regard to source of admission, length of stay and cost to the health economy. The analysis was undertaken at a strategic health authority as well as PCT level. The data for Walsall with regard to cancer and heart failure are presented below. The full dataset is available at Appendix IV.

Table 4
Hospital Finished Consultant Episodes (FCEs) (emergencies) with a diagnosis of Cancer where the outcome was death 2001-2003

Hospital	Total FCEs	% FCEs	Occupied Beds
Manor	1424	82%	52
RWHT		10%	6
Other locations		8%	5
Total	1748	100%	63

Table 5
Hospital FCEs (emergencies) with a diagnosis of Heart Failure where the outcome was death 2001-2003

Hospital	Total FCEs	% FCEs	Occupied Beds
Manor	597	93%	20
RWHT			
Other locations			
Total	643	100%	22

If we look at length of stay for these emergency admissions we can see:

Cancer patients:

- 46% are dead within one week
- 67% are dead within two weeks

Heart Failure patients:

- 51% are dead within one week
- 74% are dead within two weeks

The tables above show that, even restricting analysis to emergency admissions, a significant use of hospital resources occurs to provide essentially terminal care. On average 36 beds are occupied per year at the Manor Hospital providing terminal care for cancer and heart failure patients.

6. Revised Assessment of Need

As specified above the Palliative Care Network has now assumed responsibility for the strategic planning of services for the Walsall population. A needs assessment was undertaken by the network using the methodology recommended by the Department of Health national Palliative Care Development Advisor. Data up to 2002 was available for this assessment.

The demographic profile of the Walsall population used as the basis of the needs assessment is shown in Table 2.

Table 6
Walsall Population Characteristics

	Size	Ethnic Minority
Total Population	246,016	14%
60 – 74 years	35,431	6.4%
75+ years	17,736	1.6%

It is known that those aged 60 years or more have the greatest need for Palliative Care services. However, the greatest indicator of need within a population is the number of cancer and non-cancer deaths. All cancer related deaths and 66% of non-cancer deaths are thought to benefit from Palliative Care services in the terminal phase of their disease.

Table 7
Walsall Cancer and Non-Cancer Deaths 2002

	Number	Number likely to benefit from Palliative Care
Cancer Deaths	658	658
Non-Cancer Deaths	1849	1220
Total Deaths	2507	1878

Deaths from cancerous and non-cancerous diseases are used to estimate the number of potential patients who will each year experience symptoms that would benefit from palliative interventions. Table 4 summarises the number of patients who are likely to experience symptoms within the Walsall population.

Table 8
Estimated Number of Patients in Walsall each year With Symptoms That May Require Palliative Interventions

Symptom	Cancer Patient	Non-Cancer	Total
Pain	553	1120	1673
Trouble breathing	309	819	1128
Nausea or vomiting	336	451	787
Sleeplessness	336	451	787
Mental confusion	217	635	852
Depression	250	602	852
Loss of appetite	467	635	1102
Constipation	309	535	844
Bed sores	184	234	418
Urinary incontinence	243	551	794
Bowel incontinence	165	368	533
Unpleasant smell	125	217	342

It is noted within the network plan that estimation of the number of patients experiencing symptoms will be refined through the use of the Liverpool Care Pathway and Preferred Place of Care tools.

6.1 Place of Death

As recognised in Walsall's original strategy most patients would actually prefer to die at home but most do die in institutions. A survey conducted by the Hospice Movement in 1999 found that almost 60% of patients with terminal cancer would prefer to die at home. Table 5 shows the place of death for Walsall's cancer patients and shows the range across the network population using data for 2000-2002.

Table 9
Place of Death for Walsall Cancer Patients (3yr average 2000-2002)

Deaths	Place of Death					
	Acute Trust	Private Hospital	Hospice	Nursing Home	Home	Other
1968	1066	13	137	147	574	31
%	54%	0.7%	7%	7.5%	29%	2%
Network Range	38-54%	0.2-1%	2.5-16%	4.3-9.2%	29-51%	1-3%
National Comparison					24%	

It can be seen that in comparison to the rest of the network Walsall has the highest proportion of deaths in an acute hospital. It also has the second lowest proportion of patients dying in a Hospice. However, compared with the national picture and particularly taking into account the previous low rates of deaths from cancer at home, the current position in Walsall is a testament to the increased effort and investment in clinical services across the borough. Over the last ten years the number of Walsall patients dying with cancer who are offered the opportunity to die in their own homes has doubled.

6.2 Impact of Household Composition and Deprivation

It is recognised that both household composition and deprivation have an impact on the level of Palliative Care service required by a population. Walsall has 14,966 (14.8%) one person pensioner households, which is consistent with the rest of the network. Within such households it is evident that additional resources will be required when compared to households where there is a potential carer.

Deprivation is the single most important determinant of the need for Palliative Care, after the number of deaths within a population. It has been estimated that the level of resource required in deprived communities may be twice that of affluent areas. Deprivation within the network has been assessed using the DETR Index of Multiple Deprivation. For this measure data is collated on the basis of Super Output Areas (SOAs), which are geographical areas smaller than an electoral ward. The 32,482 SOAs in England are used to rank Local Authorities (LA) through use of a combined score based on the individual SOA scores. The LA ranked as 1 is the most deprived.

Walsall has 819 SOAs and of these 29 fall within the 10% most deprived and 40 fall within the 20% most deprived in England. By way of contrast only 5 of the 819 SOAs fall within the 10% of most affluent SOAs. Thus, whilst having some affluent areas Walsall is largely characterised by high levels of deprivation. Walsall has an average score based on its SOAs of 29 making it the 51st most deprived LA in the country.

The model for estimating resources (see page 26 network plan) uses deaths and adjusts this for deprivation. On this basis Walsall is estimated to require approximately 25% more Palliative Care resources than the average population.

6.3 Estimated Resource Requirement

The network plan estimates the total resource required across the network for some elements of the Palliative Care Service and apportions these on a weighted capitation basis to individual PCTs. The following estimate of required resources for Walsall uses this methodology.

Table 10
Resource Requirements arising from Needs Assessment

Criteria	Resource Required
Specialist Palliative Care Beds	It is estimated that the national provision of Palliative Care beds is 52 per million population and that 50% more beds are required in addition to this to meet the needs of non-cancer patients (i.e. 78 beds per million population). On this basis the network with a population of just under 900,000 would require 70 beds and Walsall would need 28% of these, 18-20 beds. Approximately 10-12 of these would be for cancer patients with the remaining 6-8 beds for patients suffering from non-malignant long-term conditions.
Medical Staffing	The medical staffing required for the 20 inpatient beds would, according to the network plan, be 0.6 WTE consultant and 2 WTE junior doctors. In order to provide consultant support to other hospital services and community and day care services it is calculated that Walsall would require a further 1.4 WTE consultants.
Community Palliative Care Nurses	For cancer care only it is estimated that Walsall requires 6 WTE community nurses
Specialist Palliative Day Care	Whilst NICE guidance does not identify Day Therapy as an essential core service it does recognise that such facilities offer the opportunity for assessment and review of patients needs. The network plan takes the total level of day therapy provided to the network population and apportions this to PCTs on a weighted basis. This methodology indicates that Walsall has 13% higher access than need alone would dictate which is likely to be a reflection of lower levels of access to other services.
Accommodation	While the NICE guidance does not specifically address accommodation requirements, currently in Walsall the existing Day Hospice is severely hampered for space. In order to deliver an effective community service encompassing outpatient, day care and rehabilitation services, as well as providing a focus for education and training, a larger facility is required. This could also provide office accommodation for specialist palliative care staff, as well as provide a possible base for an inpatient unit.

7. Revised Development Priorities

While the NICE guidance which must be implemented by September 2007 provides an overarching context for the development of palliative care services, there are a number of other policy and process developments. These include the introduction of the new GMS contract with the opportunities it provides to develop out of hours palliative care, as well as facilitate the introduction of the Gold Standard Framework (GSF). This is further enhanced by the move to practice based commissioning which is in line with the philosophy of care underpinning the GSF.

Another development of note is the extension of the palliative care approach to a range of other chronic conditions. However, the chronic disease management (CDM)/case manager approach which is currently being promoted for long term conditions, is equally applicable to cancer patients and also affects the provision of palliative care. A key part of this is the provision of rehabilitation services for cancer patients, the development of expert patient programmes for this patient group and comprehensive out of hours services. However, it is illogical to support patients at home by providing a range of community services as well as a case manager in order to prevent inappropriate hospital admissions and then admit these patients to die in an institution be it hospital or hospice.

Linked to this is the recognition that over 60% of patients would prefer to die at home and this aspiration is being taken forward by the End of Life care programme.

In summary there has been a significant development of palliative care thinking and services since the 1996 strategy was approved. In light of this and as a reflection of more recent policy guidance, the current strategy and plan for palliative care should include:-

- Extension of the palliative care approach from cancer care to a wide range of chronic disorders such as heart failure, COPD and chronic renal failure
- Development of a CDM/Case Manager approach for patients with cancer to prevent unnecessary hospital admissions and support patients and carers in their own home.
- Investment and improvement in End of Life care to ensure that the majority of patients who expressed a preference to die at home are supported to have that choice.

8. Further Action to Complete Revision of the Strategy

The draft strategy will be taken to tPCT Board on the 14th July 2005 to approve for consultation. It is envisaged the consultation period will last until early September 2005 with the aim of bringing a finalised strategy to the tPCT Board meeting on the 29th September 2005 for ratification.

9. Conclusion

The Palliative Care Strategy agreed in 1996 has by and large been successfully implemented. More recent guidance has led to the funding of further developments and to the identification of additional priorities for which, if agreed, resources need to be identified.

Since 2000 there has been much more emphasis on extending the palliative care approach and providing palliative care services to non-malignant terminal illness. This, coupled with the need to implement the NICE guidance on Supportive and Palliative Care by September 2007 means that the tPCT needs to continue to invest the range and quality of palliative care services in Walsall.

10. Emerging key issues

- (a) Palliative Care Services in Walsall are scattered throughout the Borough, limited by space available and have a lack of facilities and capacity to develop the community approach further and enable a shift from secondary to primary care.
- (b) There is a need to integrate palliative care services to a greater extent with the existing services such as out-of-hours and the care management approach for non-cancer patients.
- (c) There is a need to invest in terminal care services in the hospital setting.
- (d) Specialist palliative care beds are required with a likely bed compliment of between 6 – 12 beds.
- (e) A multi-disciplinary approach including Social Services needs to be further developed.
- (f) Consideration should be given to implementing the Gold Standard Framework as an enhanced service within GMS2.

Summary of Palliative Care Review and Strategy 1996

Key Issues Identified Through the Review

It was recognised that assessing the level of need for Palliative Care was difficult and that, at the time, there was little robust data reflecting local usage of services. However, in general it was felt that there was an inadequate amount of service and insufficient choice available to Walsall patients.

The consensus was that future services should concentrate upon enabling all patients to receive a high standard of palliative and terminal care in their home with good primary care and specialist palliative team support. It was acknowledged that patients also needed good access to inpatient services in hospital, hospice or nursing home as appropriate.

Through the review there was a recognised need for:

- Increased support and information for carers and increased availability for respite care and bereavement counselling
- Enhanced capacity in Primary Care to provide Palliative Care, partly to be afforded through educational interventions
- Enhanced capacity in Community Services, particularly to establish a 24 hour on call advisory service by Specialist Palliative Care Nurses and improve access to Marie Curie Nurses
- The need to support District Nurses through enhanced education packages
- The need for additional Social Services staff
- Enhanced day Hospice provision (to be subject to a study by UCE)
- The need for improved hospital discharge arrangements with the proposed appointment of a Macmillan Nurse co-ordinator and a GP facilitator, together with increased Palliative Care consultant sessions
- Revision of the provision of Palliative Care from Nursing Homes, in particular to restrict the then diffuse provision of service into fewer nursing homes that could develop greater expertise
- The development of services to meet the diverse cultural needs of the population
- Audit of service provision to be undertaken

Whilst the strategy sought to address the inappropriate dependence on hospital facilities for meeting the Palliative Care needs of patients, it was acknowledged that even with well developed Community and Primary Care services, hospital services would continue to be required for a significant number of patients. There was thus a recognised need to improve the hospital service by possibly concentrating the provision of Palliative care onto fewer hospital wards and by improving the facilities available to carers. Investment in hospital Palliative Care was also required to meet the criteria required for designation of the Manor as a Cancer Unit.

The potential provision of 'a Hospice in Hospital' service formed an important consideration within the review. There was a concern that travelling to St Giles and Compton Hospices presented an access problem for many families and could in part have explained the low access rates typical of Walsall at the time. A range of options for Hospice provision were considered including the following:

- Developing a Hospice within the hospital
- Building a Hospice on the hospital site
- Building a Hospice elsewhere in Walsall
- Increasing the provision from the existing St Giles and Compton providers

Through the review it was noted that the Palliative Care needs of children were to be met through a joint venture between The Acorns Children's Hospice and Rainbow House and this was considered to be appropriate to meet local needs.

Estimated Need for Specialist Palliative Care

An estimate of the need for services was based on the early work of Irene Higginson. Through applying her methodology to the number of cancer and non-cancer deaths in Walsall the following level of need was estimated:

Cancer patients requiring Support Team	180 - 470
Non-cancer patients requiring Support Team	85 – 350
Cancer patients requiring inpatient Hospice Care	100 - 180
Non-cancer patients requiring inpatient Hospice care	50 – 175

Baseline Level of Provision

Existing Palliative Care Services			
	INPATIENT	HOME/DAY CARE SERVICES	COST £000
Walsall Manor Hospital	Approx 35 beds full time Stoma Care nurse Macmillan nurse (job share) Breast Care nurse Oncology Nurse Specialist 3 Chemotherapy nurses		1,050 (Est)
Hospices: St Giles Compton John Taylor Hospice Acorns (children)	360 bed days 610 bed days 180 bed days 120 bed days	0.2 Palliative Care Consultant 70 Home/Day care Attendances 0.2 Palliative Care Consultant 200 Home/Day Care Attendances 50 Day Care Attendances plus community services	225
Walsall Community Health Trust and Voluntary Services		5 specialist (Macmillan) Nurses including * Oncology Nurse * Lymphoedema Nurse Marie Curie nursing services Little Bloxwich Day Hospice - 72 places/week District Nurse extended night service (part use) Aromatherapy Service (pilot scheme)	320
Nursing Home	Palliative and Terminal Care Top up 79 beds available (22 placements 95/96)		52
Social Services Dept, Walsall MBC	Respite services	Home care services including night sitting	41 112
		Total (WHA and WMBC)	1800

Priorities for Development

Priorities amounting to £1.1m were agreed as follows:

- To improve the quality and amount of palliative and terminal care in the community, in order to enable more people to die at home if desired.
- To improve the quality of the palliative care provided at the Manor Hospital
- To create a specialist palliative care unit, based on the concept of a “hospice with a difference”
- To ensure that appropriate arrangements are in place for respite care
- To ensure that hospitals, primary and community care is well co-ordinated, with good discharge procedures

(EXTRACT FROM WALSALL TEACHING PRIMARY CARE TRUST (WtPCT) AND WALSALL METROPOLITAN BOROUGH COUNCIL CONTINUING HEALTH CARE POLICIES – DECEMBER 2003)

PALLIATIVE CARE

Definition

Palliative care is the active total care of patients whose disease no longer responds to curative treatment and for whom symptom control is the accepted option.

All such clients and their families are entitled to assessment and health care service provision by NHS staff who have had additional appropriate training. The explicit aims of the care are to enable the individual to die in dignity and to give maximum choice and if possible, to enable people to die where they wish.

People who are assessed by, ideally, the appropriately qualified Specialist Nurse Clinical Practitioner as having entered the end stage of their terminal disease process i.e. the last few days or weeks of life, and also have health care needs which would meet the criteria for funding, have the right to continue to receive total care that is funded by the NHS in their preferred setting, if at all possible.

NHS funded specialist palliative care e.g. intensive symptom control for people with long term illness, such as muscular dystrophy, multiple sclerosis, chronic heart and respiratory conditions, is available in a variety of settings appropriate to individual need and choice.

Specialist Assessment of Palliative Care Needs

Any patient who requires specialist palliative care in any setting under Continuing Care arrangements must be assessed by the Specialist Home Care Team (Macmillan Nurses) based at Little Bloxwich Day Hospice (telephone 01922 858735) or appropriately trained Specialist Nurses for the specific condition or appropriately trained District Nurses in the community.

If the patient is already in a Care Home with Nursing, assessments by Palliative Care Specialists will determine whether extra support is needed. This could include advice to nursing staff in the Home, regular reassessment of the client, provision of specialist staff time where this is beyond the agreed standard Nursing Home range of work, or provision of specialised equipment free of charge.

Some Care Homes with Nursing are not registered to accept patients who need palliative care. The Care Manager will advise clients and/or their relatives about appropriate Homes to meet their needs.

Total NHS Funding for Clients with Continuing Specialist Palliative Care Needs

Short Life Expectancy i.e. 'end stage' of a Terminal Disease Process

"The person has entered the end stage of a terminal disease process who is likely to die in the very near future (days or weeks) and requires specialist palliative care package as defined by the multidisciplinary team, which will also evaluate the provision of the care. People within this category are likely to be those suffering from cancers or degenerative conditions such as motor neurone disease, multiple sclerosis, muscular dystrophy, chronic heart and respiratory conditions etc."

In addition, clients discharged following acute treatment or inpatient palliative care with a prognosis such that they are likely to die in the very near future (days or weeks), fall within this level of health care needs, as it would be inappropriate to discharge them from NHS care.

In each case, a simple statement from an appropriately qualified Doctor or preferably a Specialist Nurse will be required, confirming that the patient has entered the very final stages of his/her terminal disease process. This will be in addition to the nursing assessment, which will outline the evidence of high dependency, etc, for health care.

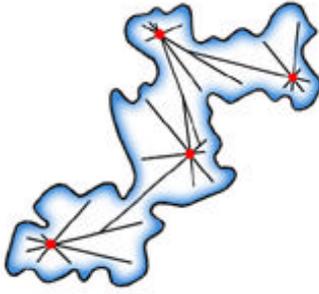
Specialist palliative care and advice is available in the local Hospitals Trust, which can access the specialist community service or hospice-based staff as needed. People in Hospital who are clinically assessed as requiring specialist palliative care should be recorded on the monthly Community Care monitoring data sheets to Walsall Teaching Primary Care Trust. Hospital patients, who are clinically assessed as having entered the end stage of their terminal disease process, and exhibit a high dependency, complexity, unpredictability etc of health care needs will have their care funded in total by Walsall Primary Care Trust, whether they remain in Hospital, return home or go into a Care Home with Nursing.

Palliative Care Patients Requiring Respite Care

Respite 3i states:

"The person is receiving palliative care services at home but the carer(s) or the service user needs a period of respite".

The costs of health care support during this period of respite will be met by Walsall Teaching Primary Care Trust. The Specialist Home Care Team will assess the need and offer the appropriate respite care service to the service user and family.



LOCAL ENHANCED SERVICE FOR THE IMPLEMENTATION OF GOLD STANDARDS FRAMEWORK FOR COMMUNITY PALLIATIVE CARE

Background

All practices are expected to provide essential services and those additional services they are contracted to provide to all their patients. They are also encouraged to provide the Directed, National and Local Enhanced services to the populations they serve. The specification for this service is designed to cover the enhanced aspects of clinical care of the patient, which is beyond the scope of essential services.

The Gold Standard Framework (GSF) in Palliative Care supports primary health care teams in providing the highest standards of generalist palliative care to enable patients in the last stages of their life to achieve the best possible physical, spiritual, and social care in the place of their choice.

Benefits of the GSF include better symptom control for patients, better information and support for carers, better communication and team working within PCTs, less crisis admissions and more confidence in palliative care management in primary care clinicians.

Although much of the GSF is standard general practice co-ordinated and done well, it is acknowledged that there is an additional administrative burden in organising the meetings and recording the assessments. We also wish to promote and incentivise this way of working. Therefore we have proposed the GSF model as a Local Enhanced Service under the New GMS contract. This will reward practices that adopt the model with resources that can be put towards supporting it.

Implementing the Gold Standard Framework in Palliative Care meets targets in the NHS Cancer Plan, the NHS Plan, the NICE guidance for Palliative Care and more recently, the End of Life Initiative. In addition, the Macmillan Community Palliative Care Team has agreed to attend practice meetings where possible to support practice-based learning and critical event analysis.

Service outline

The GSF is a model to proactively manage palliative care in a primary care setting. It is a flexible framework built around regular multidisciplinary meetings that identify palliative care patients, their carers, and their needs. Thereby facilitating planned support and interventions, using available services and resources appropriately, controlling symptoms, avoiding crises and a difficult death. The Primary Health Care Team (PCT) can develop and adapt the model depending on local circumstances to suit the needs of their patients and the needs of the PCT involved.

A variety of 'tools' and resources have been developed & shared by participating PCTs. These can be made available to interested practices, but the use of specific tools is not compulsory so long as the main outcomes are achieved. It is a flexible model aimed at

improving communication and co-ordination of care and we do not wish to create unnecessary paperwork or administration for already busy PCTs.

Service Delivery

All patients in the last 6-12 months of life would receive this service, which would encompass the seven standards of practice based palliative care:

- Practices to maintain a supportive care register to record, plan and monitor patient care. All patients on the register will be assessed and discussed via Primary Health Care Team meetings, at a minimum of monthly intervals.
- Each practice has at least one named palliative care co-ordinator who demonstrates an ongoing commitment to Continuing Professional Development in palliative care and attends at least one appropriate educational event per year. They are also required to attend locality based co-ordinator meetings three times per year.
- Each patient on the register has their symptoms and problems regularly assessed, recorded and discussed according to an agreed protocol.
- Practices will transfer information to out of hours services for palliative care patients.
- The practice is committed to continued learning of skills and information relevant to patients seen using practice-based learning or other tools.
- Carers should be identified and supported. Bereavement support should be planned e.g. practice protocol, visits, notes tagged, others informed.
- Practices should ensure that patients in the last days of their life receive well co-ordinated care without delays in service delivery.

Pricing

The service would be rewarded through quality points as follows:

Palliative care 1	The practice can produce a register of palliative care patients	10 points
Palliative care 2	The practice has at least one named co-ordinator for palliative care	
Palliative Care 3	The practice holds, as a minimum, monthly minuted meetings to discuss palliative care patients	
Palliative care 4	Each patient's concerns, anticipated needs and preferred place of care are assessed and recorded monthly using GSF SCR 1 forms	2 points
Palliative Care 5	Out of hours forms are completed and sent for all palliative care patients and regularly updated	2 points
Palliative Care 6	The practice can demonstrate two educational or critical event minuted meetings supported by specialist palliative care staff. One of these will be practice based and one part of a Walsall-wide education programme.	2 points
Palliative Care 7	Carers details are noted and they are offered support	2 points
Palliative Care 8	Patients in the last days of their life are cared for using an agreed protocol	2 points
Palliative Care 9	Bereavement protocol is developed and documented evidence of support offered to carers	2 points

In order to qualify for any payment under this scheme practices **MUST** achieve Palliative Care 1, 2 and 3 within six months of signing this agreement.

Practices must then aspire to achieve points for palliative care 4 –9 during the following 12 months.

Audit and Verification

The PCT will require each participating practice to provide a folder at the end of the year demonstrating how they have achieved the items above. This should include:

- Monthly copies of their register
- Copies of relevant policies and protocols
- Copies of GSF SCR 1 or comparable forms
- Copies of the out of hours handover forms
- Minutes, including attendance register, of educational events
- Minutes, including attendance register, of monthly meetings

Support

Practices providing this service will be offered support from the tPCT practice development team and palliative care nurse specialist.

Table 1

PCT Name	Walsall tPCT
Discharge Method	(All)
Admission Source	(All)

FCEs Clinical Group	Admission Method			Grand Total
	Elective	Emergency	Other	
Cancer 1	10355	2306	136	12797
Cancer 2	11169	3195	168	14532
Cancer 3	11258	3718	181	15157
Chronic Pulmonary Disease 1	60	2115	14	2189
Chronic Pulmonary Disease 2	114	2811	32	2957
Chronic Pulmonary Disease 3	163	3189	47	3399
Chronic Renal Failure 1 Chronic Renal Failure 2 Chronic Renal Failure 3	340	310	43	693
Dementia 1	501	819	78	1398
Dementia 2	582	1215	100	1897
Dementia 3	20	194	5	219
Heart Failure 1	27	586	14	627
Heart Failure 2	36	928	16	980
Heart Failure 3	21	813	3	837
MND 1	47	1288	11	1346
MND 2	65	1542	18	1625
MND 3	3	19		22
MS 1	4	53		57
MS 2	4	56		60
MS 3	39	44	4	87
	54	108	6	168
	61	143	6	210

Table 2

PCT Name	Walsall tPCT
Discharge Method	(All)
Admission Method	(All)

FCEs Clinical Group	Admission Source			Grand Total
	Home	Other	Care Home	
Cancer 1	12642	152	3	12797
Cancer 2	14336	192	4	14532
Cancer 3	14943	210	4	15157
Chronic Pulmonary Disease1	2166	21	2	2189
Chronic Pulmonary Disease2	2910	44	3	2957
Chronic Pulmonary Disease3	3333	62	4	3399
Chronic Renal Failure 1 Chronic	659	34		693
Renal Failure 2 Chronic Renal	1334	64		1398
Failure 3 Dementia 1	1807	90		1897
Dementia 2	212	7		219
Dementia 3	607	19	1	627
Heart Failure 1	951	27	2	980
Heart Failure 2	834	2	1	837
Heart Failure 3	1336	9	1	1346
MND 1	1608	16	1	1625
MND 2	21	1		22
MND 3	56	1		57
MS 1	59	1		60
MS 2	83	4		87
MS 3	164	4		168
	206	4		210

Table 3

PCT Name	Walsall tPCT
Discharge Method	Dead
Admission Source	(All)

FCEs Clinical Group	Admission Method			Grand Total
	Elective	Emergency	Other	
Cancer 1	58	490	22	570
Cancer 2	67	602	27	696
Cancer 3	72	656	29	757
Chronic Pulmonary Disease 1	2	89	1	92
Chronic Pulmonary Disease 2	4	197	5	206
Chronic Pulmonary Disease 3	7	248	7	262
Chronic Renal Failure 1 Chronic Renal Failure 2 Chronic Renal Failure 3	1	23	2	26
Dementia 1	4	69	9	82
Dementia 2	8	123	12	143
Dementia 3	2	9	1	12
Heart Failure 1	2	49	2	53
Heart Failure 2	2	92	2	96
Heart Failure 3	5	152	2	159
MND 1	8	225	4	237
MND 2	9	266	7	282
MND 3		1		1
MS 2		7		7
MS 3		7		7
		1		1
		2		2

Table 4

PCT Name	Walsall tPCT
Discharge Method	Dead
Admission Source	(All)

ALOS	Admission Method		
	Elective	Emergency	Other
Cancer 1	16.7	13.9	16.4
Cancer 2	16.1	13.1	17.7
Cancer 3	15.7	12.9	16.6
Chronic Pulmonary Disease 1	29.5	10.8	22.0
Chronic Pulmonary Disease 2	19.0	11.3	8.8
Chronic Pulmonary Disease 3	13.0	11.7	10.4
Chronic Renal Failure 1	1.0	22.1	8.5
Chronic Renal Failure 2	8.0	14.1	10.2
Chronic Renal Failure 3	11.9	13.5	13.5
Dementia 1	17.0	22.1	1.0
Dementia 2	17.0	16.0	7.0
Dementia 3	17.0	16.0	7.0
Heart Failure 1	19.2	13.5	4.5
Heart Failure 2	16.6	12.5	5.0
Heart Failure 3	19.0	12.5	29.3
MND 1		6.0	
MND 2		4.6	
MND 3		4.6	
MS 2		2.0	
MS 3		3.0	

Table 5

PCT Name	Walsall tPCT
Discharge Method	Dead
Admission Source	(All)

ALOS	LOS group		Admission Method			
	Under 50d stay		Over 50d stay			
Clinical Group	Elective	Emergency	Other	Elective	Emergency	Other
Cancer 1	14.2	12.4	16.4	62.7	70.7	
Cancer 2	13.9	11.7	17.7	62.7	69.4	
Cancer 3	13.7	11.5	16.6	62.7	68.9	
Chronic Pulmonary Disease 1	29.5	10.0	22.0		80.0	
Chronic Pulmonary Disease 2	19.0	9.6	8.8		77.2	
Chronic Pulmonary Disease 3	13.0	10.0	10.4		71.1	
Chronic Renal Failure 1	1.0	17.5	8.5		70.5	
Chronic Renal Failure 2	8.0	12.4	10.2		70.5	
Chronic Renal Failure 3	11.9	11.5	8.9		61.8	64.0
Dementia 1	17.0	17.3	1.0		61.0	
Dementia 2	17.0	10.6	7.0		76.5	
Dementia 3	17.0	11.0	7.0		68.5	
Heart Failure 1	6.8	10.2	4.5	69.0	92.0	
Heart Failure 2	9.1	9.8	5.0	69.0	83.6	
Heart Failure 3	12.8	10.1	3.8	69.0	81.1	182.0
MND 1		6.0				
MND 2		4.6				
MND 3		4.6				
MS 2		2.0				
MS 3		3.0				

Table 6

PCT Name	Walsall tPCT
DISMETH2	Dead
ADMISORC2	(All)
ADMIMETH2	Emergency

FCEs	LOS						Grand Total
	0 - 7	8 - 14	15 - 21	22 - 28	29 - 50	50+	
Cancer 1	210	106	69	34	58	13	490
Cancer 2	281	122	78	41	66	14	602
Cancer 3	315	130	82	43	70	16	656
Chronic Pulmonary Disease 1	47	19	8	6	8	1	89
Chronic Pulmonary Disease 2	105	45	15	11	16	5	197
Chronic Pulmonary Disease 3	129	59	19	11	23	7	248
Chronic Renal Failure 1	7	4	4	1	5	2	23
Chronic Renal Failure 2	35	10	10	4	8	2	69
Chronic Renal Failure 3	61	16	24	7	10	5	123
Dementia 1	1	3	2	1	1	1	9
Dementia 2	23	10	5	3	4	4	49
Dementia 3	44	18	8	4	10	8	92
Heart Failure 1	75	35	15	9	12	6	152
Heart Failure 2	117	51	20	11	18	8	225
Heart Failure 3	136	60	23	15	23	9	266
MND 1	1						1
MND 2	6	1					7
MND 3	6	1					7
MS 2	1						1
MS 3	2						2

Table 7

PCT Name	Walsall tPCT
Discharge Method	Dead
Admission Source	(All)

OBD	Admission Method						Grand Total
	Los Band			Over 50d stay			
Clinical Group	Under 50d stay		Over 50d stay				
	Elective	Emergency	Other	Elective	Emergency	Other	
Cancer 1	780	5895	361	188	919		8143
Cancer 2	892	6896	478	188	971		9425
Cancer 3	945	7332	481	188	1102		10048
Chronic Pulmonary Disease 1	59	878	22		80		1039
Chronic Pulmonary Disease 2	76	1847	44		386		2353
Chronic Pulmonary Disease 3	91	2405	73		498		3067
Chronic Renal Failure 1 Chronic	1	367	17		141		526
Renal Failure 2 Chronic Renal	32	832	92		141		1097
Failure 3 Dementia 1	95	1356	98		309	64	1922
Dementia 2	34	138	1		61		234
Dementia 3	34	476	14		306		830
Heart Failure 1	34	927	14		548		1523
Heart Failure 2	27	1496	9	69	552		2153
Heart Failure 3	64	2136	20	69	669		2958
MND 1	102	2606	23	69	730	182	3712
MND 2		6					6
MND 3		32					32
MS 2		32					32
MS 3		2					2
		6					6

Table 8

PCT Name	Walsall tPCT
Discharge Method	Dead
Admission Source	(All)

Sum of non-elective tariff	LOS Band		Admission Method			Grand Total
	Under 50d stay		Over 50d stay			
Clinical Group	Elective	Emergency	Other	Elective	Emergency	Other
Cancer 1	£62,425	£574,644	£27,496	£6,251	£15,968	
Cancer 2	£73,418	£676,916	£32,093	£6,251	£15,968	
Cancer 3	£77,801	£711,116	£35,526	£6,251	£21,200	
Chronic Pulmonary Disease 1	£1,368	£75,447				
Chronic Pulmonary Disease 2	£13,124	£185,493	£9,449		£3,123	
Chronic Pulmonary Disease 3	£16,808	£249,714	£12,687		£4,341	
Chronic Renal Failure 1	£1,867	£28,790	£1,867			
Chronic Renal Failure 2	£3,571	£83,370	£7,443			
Chronic Renal Failure 3	£14,496	£134,299	£9,798		£6,337	£1,984
Dementia 1	£3,150	£12,600	£3,150			
Dementia 2	£3,150	£55,520	£6,491		£8,376	
Dementia 3	£3,150	£98,689	£6,491		£10,731	
Heart Failure 1	£5,580	£185,787		£1,858	£2,317	
Heart Failure 2	£9,400	£259,037		£1,858	£2,317	
Heart Failure 3	£18,252	£338,905	£2,878	£1,858	£2,317	£10,503
MND 1		£3,594				
MND 2		£10,249				
MND 3		£10,249				
MS 2						
MS 3						

Table 9

PCT Name	WALSALL TEACHING PCT
Discharge Method	Dead
Admission Source	(All)
Admission Method	Emergency
Provider Code	(All)

Number of Emergency FCEs	Provider									
	BHST	UHB	Dudley Group Hospitals	Wolverhampton Hospitals	Walsall Manor Hospitals	GHH	City GH	Sandwell GH	Other	Grand Total
Cancer 1	1	16	2	46	400	9	2	9	5	490
Cancer 2	2	20	2	58	490	10	3	12	5	602
Cancer 3	2	22	2	62	534	11	3	13	7	656
Chronic Pulmonary Disease 1	1			5	80			3		89
Chronic Pulmonary Disease 2	1			9	181	1	1	4		197
Chronic Pulmonary Disease 3	1			9	229	3	1	5		248
Chronic Renal Failure 1		1		10	11	1				23
Chronic Renal Failure 2	1	1		14	48	4			1	69
Chronic Renal Failure 3	1	1		18	95	6			2	123
Dementia 1				1	7				1	9
Dementia 2				3	45				1	49
Dementia 3				3	86	2			1	92
Heart Failure 1				3	141	5		2	1	152
Heart Failure 2				3	208	9	1	2	2	225
Heart Failure 3				3	248	10	1	2	2	266
MND 1					1					1
MND 2					5			1	1	7
MND 3					5			1	1	7
MS 2					1					1
MS 3					2					2

Table 10

PCT Name	WALSALL TEACHING PCT
Discharge Method	Dead
Admission Source	(All)
Admission Method	Emergency
Provider Code	(All)

Sum of non-elective tariff Clinical Group	Provider									Grand Total
	BHST	UHB	Dudley Group Hospitals	W'ton Hospitals	Walsall Manor Hospitals	GHH	City GH	Sandwell GH	Other	
Cancer 1	£2,816	£35,419		£35,342	£491,499	£6,922	£2,760	£7,764	£8,090	£590,612
Cancer 2	£2,816	£40,731		£43,838	£572,460	£10,263	£2,760	£11,926	£8,090	£692,884
Cancer 3	£2,816	£42,665		£43,838	£606,839	£10,263	£2,760	£11,926	£11,209	£732,316
Chronic Pulmonary Disease 1	£1,368			£3,723	£68,988			£1,368		£75,447
Chronic Pulmonary Disease 2	£1,368			£8,956	£169,986	£2,317	£2,760	£3,229		£188,616
Chronic Pulmonary Disease 3	£1,368			£8,956	£229,865	£2,317	£2,760	£8,789		£254,055
Chronic Renal Failure 1				£12,688	£14,235	£1,867				£28,790
Chronic Renal Failure 2	£1,368			£12,688	£63,525	£5,789				£83,370
Chronic Renal Failure 3	£1,368			£18,021	£115,458	£5,789				£140,636
Dementia 1				£3,150	£9,450					£12,600
Dementia 2				£3,150	£60,746					£63,896
Dementia 3				£3,150	£103,915	£2,355				£109,420
Heart Failure 1				£4,175	£177,896	£6,033				£188,104
Heart Failure 2				£4,175	£251,146	£6,033				£261,354
Heart Failure 3				£4,175	£329,205	£7,842				£341,222
MND 1					£3,594					£3,594
MND 2					£7,267			£1,132	£1,850	£10,249
MND 3					£7,267			£1,132	£1,850	£10,249
MS 2										
MS 3										