Welcome

Dr Ros Taylor MBE, 
Clinical Associate Hospice UK, 
Medical Director St Giles Hospice 
@hospicedoctor

#HospiceLearning @hospiceuk @APMPostTweets
MANAGING SUFFERING & UNCERTAINTY

We find ourselves on different sides of a line that no-one drew...

Leonard Cohen

Dirty words in palliative care!

- Care Home
- Hospice
- Specialist
- Morphine
- Palliative
- Death
certain community services are fragmented

certain family structures are changing

certain loneliness is increasing

certain illness trajectories are becoming less certain

certain not enough people are planning ahead
**baby boomers like certainty and control**

**numbers of people needing palliative care**

**what matters**

**symptom control**

**24/7 responsive information**

**new conversations and new actions**
certain
dearth has
disappeared

certain
medicine is doing
too much….

medicine today
Preoccupation with the body
…..ignores the mind
…..deserts the spirit

event-centred care?
- Treat each event as a discrete reversible episode without taking into account trajectory
goals of care conversations
what matters to you if time is short?

We can see the future.....

Dr Kieran Sweeney
a hesitation to be brave....
That’s the research…..
But what is the reality?

Evidence from studies
6 MONTHS = 24 weeks
48 days = 6+ weeks

Routine referral
UK to palliative care

Key results
Shorter duration of palliative care as you get older
Non-cancer - half the number of days as cancer
Variation by location
Develop new partnerships

Palliative Care

Co-morbidity
Frailty
Dementia
Cancer

Geriatric Care

8760 hours

In India they train families

Social network

Professional network

Patient network

Conversations

Individuals Society

Society Individuals

The Departure Lounge
Individuals

Society

Society

Individuals

Actions

 Conversations

certain
people are anxious about dying

The existential slap…

What It's Like to Learn You're Going to Die

Palliative-care doctors explain the "existential slap" that many people face at the end.

The Atlantic

managing death anxiety

BUILD SELF ESTEEM and CONNECTION

connected
The Royal Marsden

The town that’s found a potent cure for illness - community

George Monbiot

Frome in Somerset has seen a dramatic fall in emergency hospital admissions since it began a collective project to combat isolation. There are lessons for the rest of the country

@GeorgeMonbiot

Asset Based Community Development

New public health in palliative care
recognise the social nature of illness and dying
recognise local wisdom in communities
loss is universal and affects everyone

A.Kellehear

Too few
Too late

How to support more people

Critical points on journey
Light touch between
Digital
Partner
Know your data
Coach carers
Compassionate Neighbours

event-centred care
family-centred care
network-centred care
“To allow people the deaths they want, end of life care must be radically transformed...”

Dying for Change
Charles Leadbeater
Jake Garber

Dance me through the panic till I’m gathered safely in...
Leonard Cohen

Wasting a dying person’s time is wrong
Prof Rob George
St Christopher’s Hospice London

The Hospice Movement or Monument?

Uncertainty.....
safe in uncertainty
Barry Mason

From organ-centred to network-centred care
Have braver conversations
Build on assets
Key Issues in 2016

1. Hospice strategy
2. Sustainability
3. Junior doctor posts
4. 24/7 cover and advice
5. Specialist v generalist
6. Personal resilience
7. Pharmacy issues
8. Consultant gaps
9. Revalidation
10. Assisted dying

Yesterday

Updates, resources, and responses to common current concerns

Dr. Amy Proffitt, Vice President, APM

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Today!

Updates, Resources, and Responses to Common Concerns

Dr. Amy Proffitt, Vice President, APM

Key themes

WorkForce
The Association for Palliative Medicine (APM) has compiled the 2019 palliative medicine workforce report to summarise the current workforce situation for the specialty extracted from 3 distinct sources (RCP census 2017, September 2018 palliative medicine SAC Data collection and the 2018 APM Workforce Survey).

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of consultants (WTE)</th>
<th>Number of STR (WTE)</th>
<th>Number of SAS (WTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>517</td>
<td>179</td>
<td>449</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>20</td>
<td>7</td>
<td>26</td>
</tr>
<tr>
<td>Scotland</td>
<td>49</td>
<td>15</td>
<td>32</td>
</tr>
<tr>
<td>Wales</td>
<td>36</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>TOTAL</td>
<td>622</td>
<td>212</td>
<td>529</td>
</tr>
<tr>
<td>Female / Male</td>
<td>475</td>
<td>147</td>
<td>180</td>
</tr>
<tr>
<td></td>
<td>76%</td>
<td>24%</td>
<td>85%</td>
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<td></td>
<td>15%</td>
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<td>15%</td>
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</tbody>
</table>

The data indicates that over the next 10 years approximately 207 consultants in palliative medicine, representing 33% of the workforce, are likely to exit the workforce due to retirement.

In the last two years fewer than 35 STR per year completed their training (CCT holders) whilst an ongoing demand of between 50 and 60 consultant vacancies.

The specialty must stand firm in claiming an increase of training numbers to compensate for on-call gaps and current and future dearth of CCT holders particularly in regions that struggle to recruit consultants at AACS.

The current recruitment of just over 30 NTNs is too low given that existing funding may sometimes be left unused due to lack of pooling of funding in some deaneries.

1. A review of the formula to define palliative medicine requirements of Consultant and SAS is needed. The existing commissioning recommendations are not clearly distinguishing the needs related to population size from those of acute hospitals.
We would rather recommend a population-based figure in line with the Ireland recommendations of 2.2 WTE per 100,000 population or with Australia 1.5 WTE per 100,000 population, two countries with a comparable specialty development

- currently stands at 0.8

2. Recommendations for establishing 7 Day working in line with the best level of service.
3. Growing the contribution of SAS doctors to the workforce.
4. Continue supporting smart working with multi-disciplinary teams and providing support to nursing colleagues facing increasingly complex patients to be managed in the community and kept at home whenever possible and desirable. It should go hand in hand with outpatient and community work including requesting appropriately targeted investigations and interventions away from hospitals. It is key to sustain the independent sector and community services for this (Impact of SoT)
5. Influencing retirement age by offering highly flexible working to discourage early retirement.
6. Finally, almost doubling CCT output by increasing to 60 new trainees appointed nationally every year to meet the growing demand in the right regions to rebalance the offer according to regional needs (dropped by 42016-2017).

End of life and palliative care: the policy landscape

- The projected growth in size of the UK population, the demographic shift in age, and the resulting changes in the future demographics of dying, were amongst the factors that prompted the Academy of Medical Sciences to embark on a major programme of work exploring both public and policy perspectives on death and dying in 2019.
- The key themes that emerged from the workshop, were system fragmentation;
- need for patient and public involvement at all levels (notably faith and cultural perspectives);
- value for money of interventions;
- the lack of research funding;
- and the requirement for appropriate metrics.

http://tools.england.nhs.uk/images/OLCatlas/atlas.html#
Models of 24/7 care


- Palliative medicine is at a turning point in terms of delivering new service models with the advent of Shape of Training and a changing population. We are called upon to champion the model of integrated care between community and hospitals to deliver on the GMC recommendations of increasing care in the community. We should not underestimate the important role of the charitable sector in providing high quality care in specialist centres which are increasingly integrated with NHS service provisions.

Key Issue
Medical Leadership Role

**CEO perspective**
Dr Heather Richardson, Joint Chief Executive, St Christopher’s

**Medical Director Perspective**
Dr Mike Stockton
Consultant in palliative medicine. Director of Medicine St. Gemma’s Hospice, Leeds

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Welcome

- All about getting the best for patients and other people who seek our help
- A demanding role
  - ongoing change in the internal and external landscape
  - changing parameters of what is considered “best”
  - multiple expectations from a wide variety of stakeholders
  - multi faceted; decisions have significant ripples
The landscape for decisions and actions

Key priorities

Key actions

Doing the job well....

Final thoughts

- hospice care is very challenging currently
- our role is complicated
- shared leadership is key
- agility is vital

WE HAVE A LOT TO PLAY FOR, BUT WE MUST BE STRATEGIC IN FOCUS AND ADEPT OPERATIONALLY.
WE NEED EACH OTHER...
Introduction

- Variation
- Scale
- Scope
- Structure
- Ambition and expectation
- Job planned sessions

Palliative Medicine jobs often contain leadership roles

One person's experience and view

Past

- 10 years as Medical Director at St Gemma’s Leeds
- Informal
- No formal training, development or career path
- Locked structure, clarity of role and responsibility
- Low volume, complexity and accountability
- Hospices able to operate more independently
- Managed to combine clinical work (IPU and community), education, research, with a smaller medical team
- Possibly reflected the Hospital Medical Director role

Medical Director Role

4 PA’s, 6 Direct Reports

<table>
<thead>
<tr>
<th>OPERATIONAL &amp; MANAGEMENT</th>
<th>STRATEGIC &amp; LEADERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of medical and pharmacy teams</td>
<td>Hospice Leadership Team</td>
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<tr>
<td>Recruitment</td>
<td>Board of Trustees</td>
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<tr>
<td>Line management</td>
<td>CCG matters</td>
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<tr>
<td>Performance management</td>
<td>Strategy &amp; Innovation</td>
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<tr>
<td>Medical availability, across 24/7</td>
<td>Transformation &amp; Project leadership</td>
</tr>
<tr>
<td>Communications</td>
<td>Medical service development</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>Academic Service development</td>
</tr>
<tr>
<td>Recruitment</td>
<td>City and Regional representation</td>
</tr>
<tr>
<td>Skills, training and development</td>
<td>National roles</td>
</tr>
</tbody>
</table>

Present

- Key drivers
- Role: diverse and complex
- Responsibility: regulation, governance and accountability
- Integral part of the whole system: providers, CCG, ICS, Universities
- Recognition of MD's value and importance

Achievements

- Professor of Palliative Medicine:
  - Academic Unit of Palliative Care, University of Leeds
- University Teaching Hospice

Leeds Palliative Care Network:

- Leeds Clinical Senate
- Leeds Informatics Board

Future

- Structure
- Role clarity and consistency
- Training and support
- More available
  - Business managers
  - Deputy roles
  - Regional leads and shared functions
- Mentoring the next generation
- Doctors as CDO’s

- Systems leadership
  - Transformation change
  - Unique position and role
- Integration and collaboration
- VUCA
- Pensions issue

Final Thoughts...

- No magic or secret way to success
- Open, honest, authentic and caring adults
- People who understand and are kind
- Imagination
- Determination and Resilience
- Accountability
- Strategic thinking
- Political acumen
- Courage to do the right thing
Refreshment Break

Group Discussion: Medical Leadership Challenges and Solutions

Key Issue
Ongoing MD Support, place for online network?

Prof Max Watson,
Project ECHO Project Director, Hospice UK,
@DrMaxWatson

Ongoing MD support, place for online network?

Overview
WHY?
HOW?
WHAT?
WHEN?
WHO?
Ongoing MD support, place for online network?

WHY NOT?
- Time
- Too many meetings
- Confidentiality
- Because we’re not worth it.

HOW? A proposal.
- A 60-90 minute online group.
- Our curriculum
- Expert speaker in the area
- Discussion
- Trained Facilitation
- Dedicated IT
- Dedicated Admin
- Private online resource library

SOFTWARE
- ECHO is based in the "cloud"
- The software which we connect with is ZOOM
- ZOOM encrypts
- ZOOM is free to Project ECHO hubs
  - Candidates join the meeting using the password sent by your ECHO administrator

WHAT could curriculum be?
- Update on the latest information
- Facilitated discussion of issues people are facing
- Solutions that have been tried
- Sharing of resources

WHEN
- 9 Sessions for a trial year. Monthly minus July, August and Easter.
- 2 alternating times Tuesday or Thursday
- Lunchtime, Early morning, or Evening
WHO?
Invite to Hospice MDs Across the UK (Curriculum dates and times)
Can join individually or in local clusters if prefer
If sign up will get access to software, online repository, presentations and videos of sessions, certificate of attendance for CPD
Supported by HUK and APM

www.hospiceuk.org

WHEN
2 alternating times on Tuesday / Thursday
Lunchtime, Early morning, or Evening

www.hospiceuk.org

Questions?

“So... where do you see yourself in 5 minutes time?”

www.hospiceuk.org

Lunch
12.45-13.15

www.hospiceuk.org

Key Issue
Sharing Survival Strategies
Roundtable discussion & Feedback

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Key Issue: Shape of training - Facilitated sharing of different perspectives

SAC and APM perspectives

Dr. Polly Edmonds, Consultant and Honorary Senior Lecturer in Palliative Medicine joint with King’s College Hospital, Palliative Care Clinical Service
Dr. Aoife Gleeson, Consultant in Palliative Care and Honorary Senior Lecturer, Cardiff University & Ymgynghorydd Meddygaeth Liniarol

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Shape of Training and the new Palliative Medicine curriculum

Dr Polly Edmonds
Vice Chair Palliative Medicine SAC

Why do we have trainees?

• Work to standard curriculum
  – Consistency in knowledge and skills
  – Quality control
  – Education and training fundamental to palliative care

• Succession planning: we need to train people to be consultants to lead services
  – NICE guidance (2004); commissioning requirements; specialty recognition

• Rotation through placements and settings allows training units to learn from practice elsewhere and gives trainees range of experiences and role models

• Trainee involvement in quality improvement, research and innovation ensures that training units are engaged, up to date and forward looking

• Most (but not all) training posts in hospices are centrally funded
  – Provide valuable service provision and on call
  – Balance with demands of training

• Trainees can be challenging – but involvement in training very rewarding; investment in the future!

Why is Training Changing?

• Current workforce not configured to best meet current and projected population needs

• Significant workforce challenges include:
  – Filling medical registrar posts
  – Consultant participation in acute take
  – Increasing ‘silo’ specialist working does not take account of complex multi-morbidity
  – Need to re-create ‘generalists’

• Population changes: growing number of people with multiple co-morbidities, ageing population, health inequalities & increasing patient expectations

• Patients and public need more doctors who are capable of providing general care in broad specialties across a range of different settings

The New Training Pathway for Physicians

The physician training pathway

Dual Accreditation with Internal Medicine

• Majority of medical specialties will dual train with Internal Medicine (IM)

• Integrated Internal Medicine training programme, where competence and expertise (both clinical and non-clinical) is incremental

• Internal Medicine curriculum will span entirety of the programme i.e. ‘years 1-3’ and ‘4-7’
  – IM stage 1 curriculum approved by GMC - December 2017
  – First intake of new Internal Medicine trainees - August 2019
  – First intake into specialty training (dual accrediting specialties) - August 2022

• UKSTSG designated Palliative Medicine as a group 1 (dual accrediting) specialty in January 2017

Shape of Training: Report from the UKSTSG 2017

• Three areas where clear requirement for more ‘generalists’
  – Provision of care for unscheduled patients in hospitals
  – Provision of continuity of clinical care in acute hospitals
  – Development of more doctors who can work at the boundary between primary and secondary care and who can support more work in the community

• It’s not all about acute take!
Opportunities
- All trainees in Internal Medicine will have training in palliative and end of life care – enhanced reach
- Increased opportunity to influence decision-making across range of settings by having same training pathway as other medical specialties
- Changing population demographics mean that traditional models of palliative care service delivery are evolving; need to further develop non-acute models of care delivery
  - Commissioning based on patient pathways / whole system approach
- Many examples already of innovative models of service delivery in response to population need… Will dual trained palliative medicine consultants facilitate ‘one system’ working across care settings?
  - “Front of house” models of earlier Palliative Medicine involvement in EDAMUs
  - Increased confidence of all physicians in managing uncertainty, supported by Palliative Medicine
  - Improve interface between acute and non-acute settings Community role in appropriate admission avoidance
  - Ability for hospices to take medically unstable patients
  - Enhanced cross specialty joint working and decision making, e.g. with geriatricians, community heart failure and respiratory teams and across acute/community interface

Challenges
- Impact on service
  - Impact on 7-day palliative care: may require shift to consultant delivered services
  - Impact on service provision
  - Impact on delivery of specialty on call rota
- Impact on workforce planning and recruitment
  - Potentially reduces options for applicants from non-MRCP routes
  - Potential for impact on recruitment, especially outside London
  - Potential for type of doctor we are training and the posts they may want to take up
  - Potential for ability to achieve CESR – only option will be for dual accreditation CESR
  - Concern for current trainees re: two tiers of consultants in future and appointability
- Impact on training
  - Less time to achieve training requirements (as overall training time unchanged)
  - Less experience across care settings
  - Less experience of specialty on call and ‘holding/managing’ problems out of hours
  - Academic training
  - Quality and specialty immersion: No additional funding or training time
  - Integration of IM training into specialty training
- Impact on specialty: how to retain core skills that are unique to palliative care and continue to provide ‘holistic’ whole person care

Current Situation
- Phase 1 of new curriculum submission – the Purpose
  - Statement – approved by the GMC Curriculum Oversight
  - Group January 2019
  - SAC asked to develop models for implementation in response to concems re impact on service and workforce
- Full new curriculum submission anticipated by end 2019 / early 2020 to allow time for approval by GMC
- Extensive specialty consultation on new curriculum
  - APM
  - Interested consultants
  - Virtual trainee group
  - SAC including trainee representatives
  - APM trainee representatives

Our New Palliative Medicine Curriculum
(August 2022)
- Curriculum learning outcomes amended to reflect change from competence assessments to high level learning outcomes (HLOs)
- Rebalancing of clinical/presentations to better represent the patient population seen in palliative care (retaining knowledge and skills to manage cancer patients but enhancing knowledge and skills to support people with a wide range of life limiting illnesses, including frailty, dementia, organ failure and multi-morbidity)
- Health promotion at the end of life (public health) – significant additions to the new curriculum to reflect emerging evidence to support the positive outcomes of community engagement, development and health promotion at the end of life
- Recognition of emerging importance to palliative care services of supporting transitional care for teenagers and young adults
- Recognition of new discipline of supportive care in cancer
- Focus on managing patients in non-acute settings
- Recognition of challenges of access and of meeting the needs of hard to reach groups

Minimising the Impact on Service and Workforce:
Potential Implementation Models

- Model 1
  - Internal Medicine trainees provide backfill
- Model 2
  - 25% increase in number of PM trainees
- Model 3
  - Hybrid of models 1 and 2

In Summary

- Shape of Training is happening
  - Status quo is not an option – need to focus on skills required for palliative medicine physicians of future
- Potential workforce and service implications recognised
  - GMC COG has requested work on options for implementation with JRCPTB
- New Palliative Medicine curriculum developed - consultation and work on equality impact assessment underway
  - First trainees will start new curriculum in August 2022
- Local training leads exploring how to ensure palliative care training opportunities within Internal Medicine are realised
Key Issue: Shape of training - Facilitated sharing of different perspectives

SAC and APM perspectives

Dr. Aoife Gleeson, Consultant in Palliative Care and Honorary Senior Lecturer, Cardiff University & Ymgynghorydd Meddygaeth Liniarol

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Key Issue
Managing on call 24/7 - what others are doing

Prof Matthew Makin, Medical Director of Supportive Care UK and Pennine Acute Hospitals Trust

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Discussion Plan

- The challenge of providing 24/7 provision of Specialist Palliative Care/Medicine
- Solutions
- Governance arrangements
- The Future

“... There are two certainties about life: we are all born and we all die. Everything else in between is variable. No one would countenance having areas in England with no maternity services, or only rudimentary midwifery without access to NHS obstetric care in the event of a complication”

Baroness Ilora Finlay

Access to Palliative Care Bill [HL]: Second Reading in the House of Lords at 10:06 am on 14th June 2019.
Solutions

SCUK can:

- Provide full OOH second on call consulta days per year inc. Bank holidays.
- Bolster existing rotas providing 1 in 2, 1 in 3 etc.
- Provide ad hoc support to cover vacancies, annual leave or sickness.

How can we do this?

- We have 8 senior consultants who support our on call rota:
  - Professor Matt Makin
  - Dr. Rasha Al-Qurainy
  - Dr. Neil Nijhawan
  - Dr. Declan Cawley
  - Dr. Laura Edwards
  - Dr. Jonathan Martin
  - Dr. Adam Hurlow
  - Dr. Esther Waterhouse

- 24/7 telephone call handling service.
- Use of Encrypted emails for submission of clinical reports.
- Robust Governance - Monthly Quality assurance meetings to review advice, discuss and report on any incidents.
- Quarterly consultant forums to discuss best practices.
- Dedicated business support team led by CEO and Lead Operational nurse.
Scenario 1
Hospice
3 sites plus Community Advice line
Aim:
To provide 24/7 access to specialist advice 365 days p.a.
Current staffing:
Senior palliative nurses. First 24 hour cover by OOH GP
onsite plus 7 days a week. Community advice line
supported by Senior executives.
Requirements:
Second on call consultant support 5pm-9am plus 24 hr
weekend cover.
SCUK solution:
Provision of Consultant support OOH 365 days a.m. Inc.
Bank holidays. Mobilised within 1 week.

Scenario 2
NHS Trust
6 Acute Hospital settings
Aim:
To launch a 7/7 day week specialist palliative care service.
Current staffing:
Senior palliative nurses (Band 6/7) 7 days a week.
Requirements:
Second on call consultant support 0830-1630 Saturdays.
SCUK solution:
Provision of Consultant support. Mobilised within 48 hours.

Scenario 3
Hospice
18 inpatient beds
Aim:
To provide 24/7 access to specialist advice 365 days p.a.
Current staffing:
2 part time consultants. Palliative consultant/Medical Director
vacancy.
Requirements:
Second on call consultant support Friday 5pm-9am
plus 4 weeks annual leave OOH support.
SCUK solution:
Provision of Consultant support. Mobilised within 1 week.

Conclusion
• There are Gaps in 24/7 Specialist Palliative Care
  Consultant Advice
• Leads to Clinical Risk in Hospice/Hospital/Community
  settings
• SCUK can offer bespoke solutions
• Reliable/Consultant Led /Strong Governance

Further Questions
• What about the Ethics of using Independent Providers for
  Palliative Care
• The risks of remote advice
• Are there situations SCUK wouldn’t offer support

Key Issue
Gathering of key anonymous data and Hospice MD perspectives
Completion of MD information summary questionnaire
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Palliative Care; Walking an old path in new shoes.

Dr Amy Proffitt
Consultant in Palliative Medicine
Vice President APM

Palliative care - a “journey”

- Where are we now?
- Where are we going?
- How will we get there?
- What will we need to achieve this?
- How will we know we did achieve this?

- Undoubtedly we have come on leaps and bounds since 1967

A ‘need-supply’ and ‘requirement-distribution mismatch’

need explosion

- The need of the hour is to provide an unbiased, equitable and evidence-based palliative care to those in need irrespective of the diagnosis, prognosis, social and economic status or geographical location

- BUT HOW?
**Summary**

- Hold the values of Palliative medicine and our beginnings at the fore.
- Understand our Culture and resources.
- Build transitions/transformation/research and education with a Patient centred/ Colleague centred approach.
- Be SMART.
- Be Savvy and Evolve
- Be Leaders
Have courage

Thank you

Have a safe journey home

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