The Marie Curie
Palliative Care Institute
LIVERPOOL

WHAT IS THE LCP?

HEALTHCARE PROFESSIONALS

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The Royal Liverpool and Broadgreen University Hospitals NHS Trust
Marie Curie Cancer Care Devoted to Life
University of Liverpool

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GENERAL LCP OVERVIEW

The Liverpool Care Pathway for the Dying Patient (LCP)
Over the past few years a major drive has been underway to ensure that all dying patients, and their relatives and carers receive a high standard of care in the last hours and days of their life. The Specialist Palliative Care Team at the Royal Liverpool and Broadgreen University Hospitals NHS Trust and the Marie Curie Hospice, Liverpool developed the Liverpool Care Pathway for the Dying patient (LCP). This is an integrated care pathway for the dying. The Framework is one of the key programmes within the Marie Curie Palliative Care Institute Liverpool University (MCPCIL).

The LCP was recognised as a model of best practice in the NHS Beacon Programme (2001). It was then subsequently incorporated into the Cancer Services Collaborative project and the National End of Life Care Programme (2004-7). It was recommended in the NICE guidance on supportive and palliative care for patients with cancer (2004) as a mechanism for identifying and addressing the needs of dying patients. It was recommended in the Our Health, Our Care, Our Say white paper 2006 as a tool that should be rolled out across the country. It is recommended in the End of Life Care Strategy DH 2008.

Best practice in care of the dying should be seen as the norm not the exception in our society driven by patient and carer expectations with generalists and specialists working together to inform and respond to the national agenda.

The LCP Framework incorporates:
1 Aim
To improve care of the dying in the last hours / days of life

2 Key Themes
To improve the knowledge related to the process of dying
To improve the quality of care in the last hours / days of life

3 Key Sections

Initial Assessment
Ongoing Assessment
Care after death

4 Key Domains of Care
Physical
Psychological
Social
Spiritual

The LCP therefore provides a useful template to guide the delivery of care for the dying to complement the skill and expertise of the practitioner using it. Once commenced the goals of care prompt staff to consider the continued need for invasive procedures and whether current medications really are conferring benefit. The clinician has the opportunity to follow the LCP guidance or to record the reason for decisions to determine a plan of care that deviates from this pathway. Using the LCP in any environment requires regular assessment and involves continuous reflection, challenge, critical decision-making and clinical skill.
We continue to believe the LCP is a means to empower health professionals by winning time in the climate of “busyness” to enable best practice in the last hours / days of life. The LCP is a vehicle through which best quality of care for the dying is made measurable, explicit and visible. It is valued because of the positive impact on the patient, carer and staff and it can therefore bring about a change in the culture of an organisation.

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Professor Mike Richards, Chair, End of Life Care Strategy Advisory Board commented in the foreword of the final Report of the National Audit that:

> **"How we care for the dying must surely be an indicator of how we care for all our sick and vulnerable patients. Care of the dying is urgent care; with only one opportunity to get it right to create a potential lasting memory for relatives and carers."**

End of Life Care Strategy July 2008

> **"Good PCT's will want to ensure that the particular needs and wishes of all people who are dying should be identified and addressed.**
> **The LCP provides a well-established mechanism for achieving this. PCT's are therefore strongly recommended to ensure that the LCP is adopted and its use audited in all locations where people are likely to die"**

Although the LCP was originally developed for the care of cancer patients in the acute environment it has been adapted and disseminated across all generic care settings irrespective of diagnosis.

The LCP provides guidance on key aspects of care including:

- Symptom Control
- Comfort measures
- Anticipatory prescribing of medication
- Discontinuation of inappropriate interventions
- Psychological and spiritual care
- Care of the family (both before and after the death of the patient)

Implementation of the Liverpool Care Pathway in a new setting involves a number of key steps:

- Training of health and social care professionals
- Baseline reviews and analysis
- Implementation and reflective practice
- Benchmarking of care provision within a National Audit Process

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NCDAH / NATIONAL INFLUENCE

National Audit Care of the Dying – Hospitals (NCDAH)

The first National Care of the Dying Audit – Hospitals (NCDAH) was undertaken by the MCPCIL and the Royal College of Physicians supported by Marie Curie Cancer Care & the Department of Health UK. This assessed the quality of care given to 2672 patients who died across 94 hospital trusts in 118 hospitals in 2006 / 07.
The quality of care for each patient had been documented through the use of the LCP. Each hospital provided information on up to 30 patients. Over half of the patients reported did not have cancer.

The audit enabled trusts to benchmark their performance against national findings on a range of domains, including:

- Physical comfort of the patient
- Psychosocial & spiritual aspects of care
- Communication
- Information giving & receiving
- Following appropriate procedures

The results / reports from this audit can be viewed on the web site (www.mcpcil.org.uk)

The second round of this national audit will commence July 2008.

The recently published End of Life Care Strategy UK recommends the LCP or similar framework be used in all expected deaths wherever people die. **(Department of Health (2008) End of Life Care Strategy – promoting high quality care for all adults at the end of life. DH. London)**

The LCP Continuous Quality Improvement Programme should reflect the organisations goals, performance management and governance framework in support of best practice in care of the dying

Over the past decade teams working with the LCP have used the document to guide care for patients dying of conditions other than cancer. Importantly the audit was not confined to cancer patients, 55% of cases had a non-cancer diagnosis.

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NON-CANCER / SPECIALITY AREAS

Non Cancer / Specialty Areas

There is a 4 phased approach to demonstrate transferability into a non cancer sub speciality area / non cancer patient cohort as outlined below;

Key Requirements for all projects:

- A specialist palliative care team who have implemented the LCP within the generic environment
- A specialist palliative care team with the resource to implement the LCP in the sub-speciality areas
- Sub-speciality areas with the capacity to engage in the LCP programme

PHASE 1 (Local)

Induction Model - Local Pilot / Single site non cancer sub speciality area / non cancer patient cohort, a local project led by MCPCIL

PHASE 2 (Local or National)

Dissemination Model to 4 – 6 sites (This may be a local dissemination or a national dissemination depending on the clinical arena and potential for national support)

PHASE 3

National Dissemination Model - Advertise a National Meeting

PHASE 4

National Evaluation Model

The National Meeting agreed consensus and proposes a National Benchmarking programme in line with National Audit Programme.

There are programmes within these phases for the following:

- Renal Failure
- Cardiac Failure
- Intensive Care Units (ICU)
- Paediatrics
- Dementia *(hope to begin at end of 2008)*
- Neurological care *(hope to begin at end of 2008)*

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International LCP Programme

The LCP Central Team UK is currently working with a number of Palliative Care leads in several countries around the World regarding the development, implementation and dissemination of the LCP.

2000 - 2005

Since 2000 we have been working at an international level with a group of Specialist Palliative Care colleagues to determine the most appropriate level of liaison and learning related to the LCP.

2005 - 2007

Based on evaluation of the first 5 years learning we have developed an interim collaborative plan which is outlined further in this document for international colleagues within Specialist Palliative Care who are eager to work with us at this current time.

2008 - Current

We are currently working with our visiting Educational Fellow at the Marie Curie Palliative Care Institute Liverpool to further develop an educational toolkit to enable valid, reliable, measurable and, sustainable dissemination of the LCP to our International colleagues both English and non English speaking with the support of the Palliative Care services within individual countries. We intend to develop a model of continuous quality improvement that supports those countries that may not have robust Specialist Palliative Care service provision.

It is important to maintain the integrity of the LCP Framework and enable collaboration with colleagues within English and non-English speaking countries. Learning in support of a continuous quality improvement Framework and the development of the research and development agenda in care of the dying will be enhanced if it is agreed that the goals on the LCP remain unchanged. This process will support future potential benchmarking models.

To this end the LCP Central Team UK have developed a translation guidance based on EORTC guidance and logo guidance in support of the recognition of collaborative working.(copies of these are available on request)

There is a phased approach in line with the UK implementation / dissemination process available to our international colleagues to guide them through a valid and reliable process

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WINNING HEARTS AND MINDS

A major cultural shift is required if the needs of dying people are to be met and the workforce are to be empowered to take a leading role in this process. Dying patients are an integral part of the population. Their death must not be considered a failure; the only failure is, if a person's death is not as restful and dignified as possible.

Since improvement depends on the actions of people, ultimately it comes down to winning hearts and minds. No matter how good you believe the LCP Framework is you cannot just expect others to do as they are told, nor can you be everywhere at once to ensure compliance. Command and control will not be successful in this process.

Individuals may modify their behaviour and participate in change during the course of a focused improvement effort, but if they do not emerge from the effort with fundamentally new capabilities or beliefs the performance benefits erode away and sustainable change is lost.

The LCP is only as good as the people using it. It represents a step in the right direction towards best practice for all whose death is expected.

The LCP document itself will only make a real difference if it is used alongside an implementation and dissemination model firmly embedded in the organisation and supported by a continuous learning programme.

The LCP acts as a catalyst for organisational change, it can generate discussions on a local, national and international level that can only serve to improve care of the dying from bedside to policy.

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CONTACT DETAILS

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