

HISTORY OF THE LCP

Developing an ICP to guide the delivery of palliative care in its entirety is fraught with challenge because of the inherent complexity and wide-ranging nature of this specialty. Increasingly, the principles of good palliative care are seen as being important from the point of initial diagnosis of advancing disease to death. It would have been unrealistic to attempt to establish a pathway of care that could meet the needs of all patients throughout such a complex and protracted care trajectory. It was, therefore, vital to identify an important, yet discrete and time-bound element of palliative care that could be successfully mapped. To this end, in the late 1990's the Hospital Specialist Palliative Care Team (HSPCT) at the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) together with staff from the Marie Curie Hospice in Liverpool identified Integrated Care Pathways as a way to improve care for dying patients and their families

Although the hospice and hospital environments were clearly very different, it was felt that the development of an ICP to translate the hospice model of best practice in care for the dying into a template of care for use by ward staff in the acute setting would empower generalist workers and improve care for patients and families. By enabling ward staff to manage the majority of expected deaths appropriately, it would also allow the HSPCT to concentrate its efforts into supporting patients and families with more complex specialist needs.

With the support of Sue Overill who was the Integrated Care Pathways Co-ordinator at the RLBUHT, the HSPCT devised a care pathway for the last hours and days of life.

We believed that if we collaborated with our generic colleagues on essential elements of care in a progressive timeline within a pathway format, the HSPCT could successfully educate staff to take charge of their patients in a way, which will meet the needs of the patient and carer and staff.

We believed that the care of the dying had been regarded as specialist practice but that if we introduced a care pathway for the last days of life we could support the ward teams to manage this episode of care in the generic area and we could impact on the care of patients whom we would never meet.

A major cultural shift is required if the needs of dying people are to be met and the workforce is to be empowered to take a leading role in this process. Dying patients are an integral part of the population of general hospitals. 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. Often the complexity of the measurement of palliative care intervention has thwarted effective outcome measures being developed. We believe the Liverpool Care Pathway for the Dying Patient (LCP) has the ability to change practice promote multiprofessional collaboration and articulates evidence based practice.

The imperative for the project was to translate the excellent model of hospice care at the end of life into the acute arena and develop outcome measures for end of life care using an integrated care pathway.

We developed a cycle for learning and service improvement based on the some of the change management models from industry as successfully demonstrated by the modernisation agency with the NHS in the UK. The leadership guides related to generic service improvement are recommended for reference in support of this level of change within a clinical area.

The PDSA model for change was an extremely helpful tool for driving this improvement and helping us determine appropriate levers for change and develop a sustainable change.

www.institute.nhs.uk/products/improvementleadersguidesboxset.htm

Deming. W.Edwards (1994). The New Economics for Industry. Government, Education. Second Edition. Massachusetts Institute of Technology Centre for Advanced Engineering Study. Cambridge. Massachusetts.

At that time the programme was led by John Ellershaw - Medical Director / Marie Curie Centre Liverpool (MCCL) / Consultant - The Royal Liverpool and Broadgreen University Hospitals Trust (RLBUHT) Specialist Palliative Care Team (HSPCT) and Deborah Murphy - Directorate Manager HSPCT, RLBUHT and was supported by a steering group comprising input from other members of the HSPCT at the University Hospital. A multidisciplinary working party made up of those professionals representing elements of care felt to be important in the dying phase was set up. Included were representatives from nursing, palliative medicine, social work, pastoral care, pharmacy, members of the pilot ward team and an integrated care pathways co-ordinator. It was important that the group also included representation from Senior Management within the Trust to ensure executive endorsement of the programme.

The LCP has attracted the imagination of clinicians who want to mke a difference at the bedside.

The LCP Cental Team UK was developed to support the external requests for information and support.

The Award of Beacon Status in 2000 and the support of the Cancer Action Team and End of Life Care Programme has provided financial support and invaluable strategic guidance to the development of the programme.

The Marie curie Palliative Care Institute Liverpool (MCPCIL) was launched in 2004. The LCP Central Team UK now sits within the Institute with a national and international programme directed to making a real and sustained improvement in care in the last hours and days of life. Much more needs to be undertaken but the LCP is clearly a step in the right direction.

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.