

Palliative Care bulletin

Autumn 2013

Inside this issue:

Liverpool Care Pathway review	1
Randomised trial of LCP	1
Future hospital commission	2
Commissioning children's palliative care	3
Cochrane Reviews	4
Journal abstracts	6

Liverpool Care Pathway review

The Department of Health has published the results of the review of the Liverpool Care Pathway (LCP) for dying patients. The report 'More care, less pathway: a review of the Liverpool Care Pathway' sets out recommendations including: phasing out the LCP and replacing it with an individual end of life care plan; a general principle that a patient should only be placed on the LCP or a similar approach by a senior responsible clinician in consultation with the health care team; unless there is a very good reason, a decision to withdraw or not to start a life-prolonging treatment should not be taken during any 'out of hours' period; an urgent call for the Nursing and Midwifery Council to issue guidance on end of life care; an end to incentive payments for use of the LCP and similar approaches; and a new system-wide approach to improving the quality of care for the dying. Read the full report [here](#)



[INDEPENDENT REVIEW OF THE LIVERPOOL CARE PATHWAY](#)



[Liverpool Care Pathway for patients with cancer in hospital: a cluster randomised trial](#)

First randomised trial of Liverpool Care Pathway finds little clinical benefit

The first randomised trial to test the effectiveness of the Liverpool Care Pathway (LCP) programme, developed and implemented widely to support patients as they near death, has found little clinical benefit compared with standard care for cancer patients dying in hospital. Based on these findings published in [The Lancet](#), the authors suggest that any initiative to replace the LCP in England should be 'grounded in scientific evidence' and tested in controlled trials before it is implemented. The LCP was jointly developed by the Marie Curie Hospice Liverpool and the Royal Liverpool University Hospital in the late 1990s with the aim of rolling out the best practice of hospices to hospitals, to provide uniform, high-quality, dignified care for dying patients in the last days or hours of life. But its effectiveness for improving care for the dying has not been assessed in a randomised trial until now.

TRFT Library &
Knowledge Service
Oak House
Moorhead Way
Bramley
Rotherham
S66 1YY

01709 302096

Future Hospital Commission: Care comes to the patient in the future hospital

Royal College of Physicians, September 2013

Patients could in future be treated at home by hospital doctors under plans for a revolution in the way healthcare is delivered reports The Guardian. Hospitals will lose much of their central role in the National Health Service (NHS), with more care and treatment being provided in homes and care homes, under radical proposals drawn up by a landmark inquiry instigated by hospital doctors themselves, which has been broadly welcomed by the government.

If implemented, the report would lead to a major shift towards caring for the sickest patients at home for longer and out of hospital, unless absolutely necessary, by having health professionals come to them instead of them having to attend regular appointments. The commission, a panel of medical experts, warned that hospitals will not survive unless they dramatically overhaul how they handle the growing number of medical patients, whose more serious illnesses draw heavily on NHS services.

Extract from Royal College of Physicians report:

Patients who are dying need access to palliative care. For those with life-limiting illnesses, decisions about care escalation must be made before an acute deterioration occurs. The use of advanced care plans, developed in conjunction with the patient or, if incapacitated, with their carers, is essential. Clinical decisions about ceilings of care, based on patients' and carers' wishes alongside projected clinical outcomes, need to be made, as well as decisions about resuscitation. Clinical skills are needed to recognise when a patient is dying, as well as skills in communicating with patients and relatives when that is the case.

Access the full report:



NICE Guidance on your mobile

You can now get new
guidance on your
mobile phone.

Download the new NICE
Guidance app to your phone
for instant and
mobile access to all NICE
Guidance

[Download the app for
iPhone](#)

[Download the app for
android](#)

Rotherham Hospice staff can make use of a range of library and knowledge services, including:

- Enquiry service
- Group and 1-to-1 training
- Literature searching
- Current awareness information service
- Inter-library loans
- Journal Clubs

Knowledge.service@rothgen.nhs.uk

Other news

Commissioning children's palliative care in the new NHS: a guide for CCGs



This [guide](#) for all CCGs describes the population of children who need palliative care; the services and professionals who provide it; and how children's palliative should be commissioned within the context of the five stages of commissioning set out by the NHS Institute for Innovation and Improvement.

Together for Short Lives wants to see children's palliative care commissioned effectively so that children and families get the support they need. This means clarity about what is commissioned nationally and locally, and fair and transparent commissioning from all providers in the statutory and voluntary sectors, including children's hospices.

Children with life-threatening and life-limiting conditions are small in number, but very often need highly complex care. This can make it challenging for commissioners to plan and commission effectively. We want to see CCGs collaborating to commission children's palliative care across a larger population.

Keeping you up-to-date

We offer a Journal Table of Contents alert service, which is a quick and easy way to keep up to date and informed in your area of interest. Each time a new issue of a journal is published, we will send you the table of contents in an email. If you would like to register to this service, let us know at knowledge.service@rothgen.nhs.uk along with the title of the journal(s) you are interested in.



Midhurst Macmillan Community Specialist Palliative Care Service: Delivering end-of-life care in the community

This [case study](#) looks at the Midhurst Macmillan Service – a community-based, consultant-led, specialist palliative care service in a rural community in the south of England. The service covers approximately 150,000 people across three counties – Surrey, Hampshire and West Sussex. It is jointly funded by the NHS and Macmillan Cancer Support up to a total value of £1.2 million per year.

Cochrane reviews

Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers

When faced with the prospect of dying with an advanced illness, the majority of people prefer to die at home, yet in many countries around the world they are most likely to die in hospital. We reviewed all known studies that evaluated home palliative care services, i.e. experienced home care teams of health professionals specialised in the control of a wide range of problems associated with advanced illness - physical, psychological, social, spiritual. We wanted to see how much of a difference these services make to people's chances of dying at home, but also to other important aspects for patients towards the end of life, such as symptoms (e.g. pain) and family distress. We also compared the impact on the costs with care. On the basis of 23 studies including 37,561 patients and 4042 family caregivers, we found that when someone with an advanced illness gets home palliative care, their chances of dying at home more than double.

Home palliative care services also help reduce the symptom burden people may experience as a result of advanced illness, without increasing grief for family caregivers after the patient dies. In these circumstances, patients who wish to die at home should be offered home palliative care. There is still scope to improve home palliative care services and increase the benefits for patients and families without raising costs.

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007760.pub2/pdf>

Pharmacological interventions for pruritus in adult palliative care patients

Pruritus is the medical name for itching, which can be a problem in palliative care settings where treatments for cancer or severe kidney disease are being given. In this review we looked for high quality clinical trials of drug therapies to prevent or treat itching in palliative care. We found that 30 different drugs had been tested in 40 studies, involving 1286 people with itch. There was very little information about any particular drug treatment on which to base a trustworthy assessment of whether, or how well, the different drugs worked. There was enough information to point out some possibly useful treatments for particular causes of the itch. These included indomethacin for HIV-associated itch, gabapentin and nalfurafine for itch associated with chronic kidney disease, and rifampicin and flumecinol for itch associated with liver problems. Paroxetine may be a drug of general relevance whatever the cause of the itching. The amount of information identified is too limited to say anything definite about harm. Research in palliative care is difficult and short term, but we need more good quality studies on preventing and treating itch (pruritis).

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008320.pub2/pdf>



Cochrane review

Oral morphine for cancer pain

Morphine taken by mouth produced good pain relief for most people with moderate or severe cancer pain. One person in two or three who gets cancer will suffer from pain that becomes moderate or severe in intensity. The pain tends to get worse as the cancer progresses. Morphine taken by mouth has been used since the 1950s for controlling cancer pain. In 1986 the World Health Organization recommended taking an oral solution of morphine every four hours. Morphine is now available in a number of different formats that release the morphine over various periods of time. Morphine immediate release is rapidly absorbed, and would usually be taken every four hours. Modified release tablets are available that release morphine more slowly, so that they can be taken only twice a day or even only once a day.

In this review we set out to estimate how well morphine worked, how many people had side effects, and how severe those side effects were – for example, whether they were so severe that participants stopped taking their oral morphine. We found 62 studies with 4241 participants. The studies were often small, compared many different preparations, and used different study designs. This made it difficult to work out whether any one tablet or preparation of oral morphine was better than any other. There did not seem to be much difference between them. More than 9 in 10 participants had pain that went from moderate or severe before taking morphine to pain that was no worse than mild pain when taking morphine. More than 6 in 10 participants were very satisfied with the morphine treatment, or considered the result to be very good or excellent. Only about 1 person in 20 stopped taking morphine because of side effects. Morphine is associated with some unwanted effects, mainly constipation, and nausea and vomiting.

At one level these are good results. On another level, we could wish for more consistency in study design, and especially in study reporting, which should include the outcome of pain reduced to tolerable levels – no worse than mild pain – so that people with cancer are not bothered by pain.

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003868.pub3/pdf>

TRFT Enquiry service

A literature search and enquiry service is available to all Hospice staff in Rotherham. We aim to find the best available evidence to support patient care, service development, research and continuing professional development.

If you need information simply contact us with details of your enquiry by email to

Knowledge.service@rothgen.nhs.uk

Or fax it to: 01709 302002

Find out how we can help: <http://www.rotherhamhospital.nhs.uk/lks>

Search our catalogue: <http://rotherham.nhslibraries.com>

Follow us on Twitter: @RotherhamNHSLib 

Journal abstracts

A qualitative study examining the sustainability of shared care in the delivery of palliative care services in the community

BMC Palliative Care 2013, 12: 32

This paper focuses on the sustainability of existing palliative care teams that provide home-based care in a shared care model. For the purposes of this study, following Evashwick and Ory (2003), sustainability is understood and approached as the ability to continue the program over time. Understanding factors that influence the sustainability of teams and ways to mitigate these factors is paramount to improving the longevity and quality of service delivery models of this kind.

Using qualitative data collected in interviews, the aim of this study is twofold: (1) to explore the factors that affect the sustainability of the teams at three different scales, and; (2) based on the results of this study, to propose a set of recommendations that will contribute to the sustainability of PC teams.

Sustainability was conceptualized from two angles: internal and external. An overview of external sustainability was provided and the merging of data from all participant groups showed that the sustainability of teams was largely dependent on actors and organizations at the local (community), regional (Local Health Integration Network or LHIN) and provincial scales. The three scales are not self-contained or singular entities but rather are connected. Integration and collaboration within and between scales is necessary, as community capacity will inevitably reach its threshold without support of the province, which provides funding to the LHIN. While the community continues to advocate for the teams, in the long-term, they will need additional supports from the LHIN and province. The province has the authority and capacity to engrain its support for teams through a formal strategy. The recommendations are presented based on scale to better illustrate how actors and organizations could move forward.

This study may inform program and policy specific to strategic ways to improve the provision of team-based palliative home care using a shared care model, while simultaneously providing direction for team-based program delivery and sustainability for other jurisdictions.

Time of death and presence of family at death in a UK hospice

European Journal of Palliative Care, Sep 2013, vol. 20, no. 5, p. 223-225

There are often concerns that people die at certain times of the day or night. An enduring theme is that death is more likely in the early hours; sometimes nursing staff are convinced that the majority of deaths occur on their shift, whether this is day or night. There is little evidence about time of death.

Looking at a large cohort of patients who had died at Wisdom Hospice, the authors found that deaths were spread evenly across day and night, and that a majority of patients had a family member present when they died.

Copies of the articles listed in this bulletin are available on request:

please contact knowledge.service@rothgen.nhs.uk

Journal abstracts

Exploring public awareness and perceptions of palliative care: A qualitative study

Palliative Medicine, September 2013, 1-8.

Research suggests that the public appear to be confused about the meaning of palliative care. Given the aging population and associated increase in the number of patients requiring palliative care it is vital to explore the public's understanding of this concept. Health promoting palliative care seeks to translate hospice and palliative care ideals into broader public health practice. The aim of this paper is to explore public perceptions of palliative care and identify strategies to raise awareness.

Semi structured telephone interviews were undertaken (n=50) with members of the public who volunteered to participate in the study. The interviews focused on knowledge and perceptions of palliative care; expectations of palliative care services and the identification of strategies to raise public awareness of palliative care. The interviews were audio recorded and content analysed.

The results showed that most participants had a general knowledge of palliative care, largely influenced by their own personal experience. They identified that palliative care was about caring for people who were dying and maintaining comfort in the last days of life. Participant's expectations of services included: holistic support, symptom management; good communication; and practical support to enable choice and carer support. A key aspect identified for promoting palliative care was the development of understanding and use of the term itself and targeted educational strategies.

Palliative Care in Long-term Care Settings for Older People: findings from an EAPC Taskforce

European Journal of Palliative Care September/October 2013, 20(5), 251-253.

The work of the European Association for Palliative Care (EAPC) Taskforce on Palliative Care in Long-term Care Settings for Older People is now completed. How can such care be improved? Elisabeth Reitingger et al briefly describe the Taskforce's methods and key findings.

View full text [here](#)

Maintaining hope in emotionally distressed terminally ill patients

European Journal of Palliative Care September/October 2013, 20(5), 232-236.

Folkman writes: 'Few would question the critical importance of hope when facing serious and prolonged threats to psychological and physical well-being, whether our own or that of a loved one'. A systematic review has concluded that many different definitions of hope have been put forward and that there is a lack of uniformity between researchers. Rather than offer yet another definition of hope, patients in the current study were simply asked what they hoped for.

Copies of the articles listed in this bulletin are available on request:

please contact knowledge.service@rothgen.nhs.uk

Journal abstracts

Reduction in symptoms for homebound patients receiving home-based primary and palliative care.

Journal of Palliative Medicine, September 2013, 16(9), 1048-54.

Increasing numbers of patients are living with multiple, chronic medical conditions and functional impairments that leave them homebound. Home-based primary and palliative care (HBPC) programs provide access to health care services for this vulnerable population. Homebound patients have high symptom burden upon program enrolment. Yet little is known as to how individual symptoms are managed at home, especially over longer time periods. The purpose of this study was to determine whether high symptom burden decreases following HBPC enrolment. All patients newly enrolled in an HBPC program who reported at least one symptom on the Edmonton Symptom Assessment Scale (ESAS) were eligible for telephone ESAS follow-up. Patients received a comprehensive initial home visit and assessment by a physician with subsequent follow-up care, interdisciplinary care management including social work, and urgent in-home care as necessary. Multivariate linear mixed models with repeated measures were used to assess the impact of HBPC on pain, depression, anxiety, tiredness, and loss of appetite among patients with moderate to severe symptom levels at baseline. Results: One hundred forty patients were followed. Patient pain, anxiety, depression, and tiredness significantly decreased following intervention with symptom reductions seen at 3 weeks and maintained at 12 weeks. Loss of appetite trended toward an overall significant decrease and showed significant reductions at 12 week follow-up.

Dignity: A unifying concept for palliative care and human rights.

Progress in Palliative Care, September 2013

The concept of human dignity is complex. Its meaning and emphasis have shifted over time. It is a concept that occupies a central place in two disciplines – palliative care and human rights law. This article examines the evolution of the meaning of dignity, the nature of intrinsic and extrinsic dignity and its place in palliative care and human rights law (especially as it pertains to the international right to health care). The thesis of this article is that the recognition of and response to the inherent dignity of the human person is a unifying concept for the two disciplines and forms part of the theoretical foundation of the assertion that palliative care is a fundamental human right.

Rotating to oral methadone in advanced cancer patients: a case series.

Journal of Palliative Medicine, September 2013, 16(9), 1154-7

Methadone is increasingly being used to treat patients whose pain does not respond well to other opioids. Advantages over morphine sulphate and its alternatives include low cost, lack of active metabolites and efficacy against neuropathic pain. We describe two cases with cancer pain successfully switched to methadone. In both cases the dose of the previous opioid was limited by development of opioid toxicity. We used the Morley-Makin conversion method and modified it by reducing the 'as required' dose by a third. The initial methadone doses for these cases were lower than predicted doses. In cases where cancer patients fail to respond or develop tolerance to opioids, conversion to methadone is a reasonable approach.