Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

TRUST BOARD

26th September 2013

TITLE	**Responding to the More Care less Pathway - Liverpool Care Pathway Review 2013**
EXECUTIVE SUMMARY	The paper provides assurance to the Board on ASPH's progress and planning in relation to the acute hospital specific actions identified within the 44 actions outlined by the National Review.
ASSURANCE (Risk) / IMPLICATIONS	Board assurance is provided within the paper with regards to the key recommendation and the current recommendations for ASPH regarding the End of Life Care.
LINK TO STRATEGIC OBJECTIVE	**SO1:** To achieve the highest possible quality of care and treatment for our patients in terms of outcome, safety and experience.
STAKEHOLDER / PATIENT IMPACT AND VIEWS / STAFF VIEWS	Internal stakeholders only involved at this stage of the response to the LCP review paper 2013.
EQUALITY AND DIVERSITY ISSUES	None known.
LEGAL ISSUES	None known.
The Trust Board is asked to:	Discuss the paper, note any recommendations that may arise and obtain assurance of ASPH's approach since the review.
Submitted by:	Dr David Fluck, Medical Director and Ms Suzanne Rankin, Chief Nurse
Date:	19th September 2013
Decision:	For Assurance

Ashford and St. Peter's Hospitals NHS
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Responding to the More Care less Pathway –

Liverpool Care Pathway Review 2013

In July 2013 the Trust Board received a paper outlining the National Review into the Liverpool care Pathway.

The detail and 44 recommendations are at https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients.

There are 16 identifiable recommendations which require action by ASPH and the plan outlining the Trust response is set out below. Assurance is given that these action plans are in place and will be monitored by the End of Life Steering Group chaired by Dr Peter Wilkinson.

	LCP Review recommendations	Actions	Time scale	Lead
3.	The name 'Liverpool Care Pathway' should be abandoned, and within the area of end of life care, the term 'pathway' should be avoided. An 'end of life care plan' should be sufficient for both professionals and lay people.	LCP at ASPH has been withdrawn.	Completed	Specialist Palliative Care Team (Clinical leads Dr Zivai Nangati & Sue Dargan)
		All Care of the Dying documents are being reviewed to assess terminology, consistency and to remove any reference to a pathway.	3 months	
14.	Every patient diagnosed as dying should have a clearly identified senior responsible clinician accountable for their care during any 'out of hours' period. Unless it is unavoidable, urgent, and is clearly in the patient's best interests, the decision to withdraw or not to start a life-prolonging treatment should be taken in the cool light of day by the senior responsible clinician in	ASPH are supporting consistency in care, ensuring dying patients have a clearly identified senior responsible clinician accountable for their care. Decisions regarding withdrawing or not to starting a life-prolonging treatment are made by the MDT and senior	3 months	Dr David Fluck and Dr Peter Wilkinson (End of Life Care Clinical Lead)

	consultation with the healthcare team. The practice of making such decisions in the middle of the night, at weekends or on Bank Holidays, by staff that do not have the requisite training and competence, should cease forthwith.	responsible clinician during the working week where ever possible. This should be incorporated in the relevant Trust policies.		
16.	The Review panel is deeply concerned that the GMC guidance is clearly not always being followed in the care of the dying, and recommends that the Royal Colleges review the effectiveness of any training in shared decision-making that they provide, examining the extent to which it closely reflects the professional standards in GMC and NMC guidance and required competencies in this area, with a view to ensuring continued competence is maintained across the education and training spectrum from undergraduate teaching and learning through to continued professional development.	The Trust has a responsibility to ensure Continuing Professional Development for all Health Care Professionals caring for the dying. End of Life Care (EOLC) training should be provided to all Trust employers involved in the care of the dying. This should be incorporated in staff mandatory training.	1 year	Trust Board and Specialist Palliative Care Team (Clinical Leads Dr Zivai Nangati & Sue Dargan)
19.	All staff in contact with patients should be trained in the appropriate use of hydration and nutrition at the end of life and how to discuss this with patients, their relatives and carers.	This would be incorporated in the above EOLC training.	Training to start within 3 months and delivered to all staff within 1 year	Suzanne Rankin and David Fluck
20.	There should be duty on all staff to ensure that patients who are able to eat and drink should be supported to do so.	The EOLC leads (Ward Managers) will be made aware of their responsibility to ensure that all patients who are able to eat and drink are being supported to do so.	Immediate	Suzanne Rankin

		This should be documented on the appropriate chart.		
21.	Failure to support oral hydration and nutrition when still possible and desired should be regarded as professional misconduct.	Failure to support oral hydration and nutrition when still possible and desired will be regarded as professional misconduct and dealt with as per Trust policy.	Immediate	Suzanne Rankin and David Fluck
23.	Before a syringe driver is commenced, this must be discussed as far as possible with the patient, their relatives or carers, and the reasoning documented.	This will be incorporated in EOLC and syringe driver training. It will also form part of the EOL core care plan (in development).	3 months	Specialist Palliative Care Team (Clinical leads Dr Zivai Nangati & Sue Dargan)
26.	A named consultant or GP, respectively, should take overall responsibility for the care of patients who are dying in hospital or the community.	ASPH are supporting consistency in care, ensuring dying patients have a clearly identified senior responsible clinician accountable for their care.	Immediate	Trust Board and Dr David Fluck
27.	The name of a registered nurse responsible for leading the nursing care of the dying patient should be allocated at the beginning of each shift. This nurse will be responsible also for communicating effectively with the family, checking their understanding, and ensuring that any emerging concerns are addressed.	The EOLC leads (Ward Managers) will be made aware of their responsibility to ensure that all patients are allocated a registered nurse responsible for leading the nursing care at the beginning of each shift	Immediate	Suzanne Rankin
28.	The boards of healthcare providers providing care for the dying should give responsibility for this to one of its members –	The End of Life Steering group now includes a lay member	Achieved	End of Life Steering group

	preferably a lay member whose focus will be on the dying patient, their relatives and carers – as a matter of urgency. This is particularly important for acute hospitals.			
29.	Guidance should specify that the senior clinician writes in the patient's notes a record of the face to face conversation in which the end of life care plan was first discussed with the patient's relatives or carers. The record of that conversation must include the following: That the clinician explained that the patient is now dying and when and how death might be expected to occur. If the family or carers do not accept that the patient is dying, the clinician has explained the basis for that judgement. That the relatives or carers had the opportunity to ask questions.	The 'Principles of Care for the Dying Patient' (in development) will specify that the senior clinician writes in the patient's notes a record of the face to face conversation in which the end of life care plan was first discussed with the patient's relatives or carers. This is already incorporated in the 'Breaking Bad News' Trust Policy. EOLC communication will be incorporated in EOLC training.	3 months	End of Life Steering Group
30.	A shared care folder, kept at the hospital bedside and designed for communication between patients, relatives and the staff, should be introduced, supported by training for staff on how to use it.	There are a number of communication folders in use nationally. The End of Life Care Steering Group will allocate this task to a sub-group.	6 months	End of Life Steering Group
31.	There should be better integration in the community between LCP or other similar documentation and the existing system of shared care folders, so that the care provided by relatives and carers (professional or otherwise) is noted, and their contribution is incorporated into documentation.	To be highlighted at the next North West Surrey End of Life Steering Group meeting.	1 month	Specialist Palliative Care Team (Clinical leads Dr Zivai Nangati & Sue Dargan)
32.	For each patient on an end of life care plan that has no means of	Elements of this are	2 months	End of Life

	expressing preferences and no representation by a relative or carer, views on their care should be represented by an independent advocate, whether appointed under the Mental Capacity Act 2005, a chaplain, or an appropriate person provided through a voluntary organisation. This applies to people of whatever age who lack capacity.	already embedded in ASPH Trust practice and policy (Mental Capacity Act 2005). The additional role of Chaplaincy as the patient advocate in these circumstances will be discussed at the next End of Life Steering Group meeting.		Steering Group
33.	Funding should be made available to enable palliative care teams to be accessible at any time of the day or night, both in hospitals and in community settings, seven days a week.	The Trust Board to review allocation of funds to provide 24hr palliative care support, which could be provided via the hospices if funded.	3 months	Trust Board
38.	Use of the Liverpool Care Pathway should be replaced within the next six to 12 months by an end of life care plan for each patient, backed up by condition-specific good practice guidance.	LCP at ASPH has been withdrawn. We are awaiting national guidance regarding a replacement which is being coordinated by Dr Bee Wee, Clinical Director for End of Life Care, NHS England.	12 months	NHS England