The Queen Elizabeth Hospital NHS
King's Lynn
NHS Foundation Trust

REPORT TO THE BOARD OF DIRECTORS (IN PUBLIC)

SUBMITTED BY:	REPORT FOR:		IMPACT:		
Dr D Blackburn	Decision		High	Med	Low
CONSULTATION:	Information	✓		✓	
	REPORT TYPE:		RELATED WORK:		
	Strategic				
	Operational	✓			
	Governance				

BAF ref:	1a(i), 1a vi),
Monitor Compliance Framework:	NA
CQC Essential Standard Reference:	Outcomes 2, 4, 14 & 16
NHSLA Standard Reference:	NA
Media / Communications:	Media coverage during October / November 2012

Meeting Date: **26th November 2012**
Report Title: **The Liverpool Care Pathway**

Purpose: To provide the context for the presentation to the Board of Directors on the Liverpool Care Pathway

Summary: Recent serious criticism has been raised about the use of the End of Life Liverpool Care Pathway (LCP) and yet the very reason for its roll-out across the country in the first place was because of concerns about poor care at the end of life.

This paper discusses:

- the history of the development of the LCP
- how and when the LCP is used
- consulting and communicating with the patient and his or her family
- how the use of the LCP use is rigorously monitored

Financial Implications / Efficiency Savings / Quality Improvement:

None as a direct result of this report

Risk Assessment:

Strategic / External	Operational/ Organisational	Financial	Clinical	Legal/ Regulatory	Reputational / Patient Experience
	✓		✓	✓	✓

Recommendations:
The Board is invited to consider the contextual information contained in this report, in preparation for its presentation and debate on the Liverpool Care Pathway.

The Liverpool Care Pathway

1. Recent serious criticism has been raised about the use of the End of Life Liverpool Care Pathway (LCP) and yet the very reason for its roll-out across the country in the first place was because of concerns about poor care at the end of life. The LCP is so named because it originated from the Marie Curie Hospice in Liverpool and the aim was to share the recognised high standard of care and skills from the hospice environment to improve the care of dying people elsewhere. The LCP itself is a document for recording decision-making and the care of patients expected to die within hours or a small number of days. It ensures very regular checks are being made for all patients' needs; including communication and support for the family and that the continued appropriateness of the care-plan is regularly reviewed.

2. The most important principle of the pathway is that very careful thought is required to ensure that it is correctly initiated. It requires medical and nursing staff to reflect and consider that all available treatment options have been exhausted and that the person is sadly in the last few hours or days of life. Far from preventing patients receiving treatment, it first acts as a 'double check' to ensure that all options are exhausted. It advises a further opinion if there is any doubt and so a 'triple check' may occur. It always requires discussion with the family about the plan of care. Ultimately the very steps necessary in order to commence the Liverpool Care Pathway may well mean that the pathway is not started and treatment options not previously considered are commenced instead. Equally the necessary constant review of patients on the pathway means it can be discontinued at any time.

3. Once it is recognised that the person is within the last few hours or days of life, consideration should then be given to the question of where the best place is for the person to die. This should be discussed sensitively with the patient (if possible) and the family and a decision made according to choice and the persons overall medical and nursing needs. Many choose to remain in the same location of care but others choose to move e.g. discharge home from hospital or to a nursing home/hospice bed if available.

4. The Liverpool Care Pathway prioritizes the correct and speedy management of pain and distress for which rapid access to medication should always be made available. Importantly there is no medical evidence that *appropriate* doses of pain relief or other medication speed up a person's death. Medical and nursing staff have a very clear responsibility to prevent treatable suffering and must be able to provide appropriate medication without fear of recrimination.

5. Any care which will benefit the patient should be given and importantly this can include supportive fluid but this may do more harm than good in the imminently dying (often causes increased respiratory secretions or 'death rattle'). Equally, any care which will not benefit the patient should be stopped or reduced (e.g. repeat blood tests, blood pressure measurement and some medications). All these decisions need to be individualised on a case by case and day by day basis as the patient's condition changes. This is not evidence of neglect or about preventing people receiving treatment or care but about providing the right interventions that will help and equally avoiding those that will not. Communication with the family coupled with support is essential through all these issues.

6. When the expected death of the person occurs, Cardio Pulmonary Resuscitation (CPR) would not be commenced because this is futile in the presence of overwhelming irreversible disease and of course because it would prevent a peaceful demise – again the LCP requires that this is discussed with the family in advance. Care continues after death and includes respect for the deceased and support for the family and loved ones.

7. Finally, if the Liverpool Care Pathway did not exist, we would still need to provide a plan of care for our dying patients, which clearly should revolve around the principles above: therefore our plan of care should be the same with or without the LCP document. In effect the LCP is little more than a record of care and a reminder of what needs to be covered. This brings us back to why the LCP was introduced in the first place, which was because good practice and care was not always happening and some dying patients and their relatives were not receiving the care they should at the end of life.

Dr Blackburn 9/11/12