Portsmouth Hospitals NHS
NHS Trust

**TRUST BOARD PUBLIC – OCTOBER 2013**

**Agenda Item Number: 204/13**
**Enclosure Number: (10)**

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| **Subject:** | Portsmouth Hospitals NHS Trust - Response to Neuberger Report on the Liverpool Care Pathway (LCP) |
| **Prepared by:**<br>**Sponsored by:**<br>**Presented by:** | Dr Ian Cairns, Consultant - Specialist Palliative Care<br>Julie Dawes, Director of Nursing<br>Julie Dawes, Director of Nursing |
| **Purpose of paper** | To brief the Board on the key points and actions taken in response to the Neuberger Report. |
| **Key points for Trust Board members**<br>*Briefly summarise in bullet point format the main points and key issues that the Trust Board members should focus on including conclusions and proposals* | Trust Board are asked to:<br>o Note the actions taken<br>o Note the outcome of the end of life care complaints review |
| **Options and decisions required**<br>*Clearly identify options that are to be considered and any decisions required* | For noting. |
| **Next steps / future actions**:<br>*Clearly identify what will follow the Trust Board's discussion* | The report and its recoemmendations will continue to be monitored via the End of Life Care Steering Group and will be incoporated in to a new End of Life Care Strategy. This strategy will be submitted to the Trust Board for approval in the next quarter. |
| **Consideration of legal issues (including Equality Impact Assessment)?** | None. |
| **Consideration of Public and Patient Involvement and Communications Implications?** | None. |

| **Links to Portsmouth Hospitals NHS Trust Board Strategic Aims, Assurance Framework/Corporate Risk Register** | |
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| **Strategic Aim** | Strategic Aim 1 |
| **BAF/Corporate Risk Register Reference (if applicable)** | NA |

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| **Risk Description** | NA |
| **CQC Reference** | NA |

| **Committees/Meetings at which paper has been approved:** | **Date** |
|---|---|
| NA | |

**Portsmouth Hospitals NHS Trust - Response to Neuberger Report on the Liverpool Care Pathway (LCP)**

## 1.0 Introduction

Although it has been employed over the past 10 years to offer a framework for care for a person who may die within days, a "storm" of adverse media reporting in 2011-12 led to the Health Minister appointing Baroness Julia Neuberger to conduct an independent review of the LCP and its use across the country. The Report entitled "More Care, less Pathway"- A Review of the Liverpool Care Pathway was published in July 2013.

## 2.0 Key findings

These are the key findings of the Report:

- The Report finds that there is plenty of evidence that, when used properly, patients die a peaceful, and dignified death when the LCP is employed. BUT the Review Panel were also convinced, that implementation of the LCP is not infrequently associated with poor care. The Panel were however, anxious to recognise the valuable contribution the LCP had made to the "timeliness and quality of clinical decision making of dying patients".

- They could find no strong evidence comparing the benefits of "Pathway" directed care over other forms of care, and acknowledged that the diagnosis of dying is a complex and imprecise area.

- They found that " Perfectly preventable problems of communication between clinicians, relatives & carers appear to account for a substantial part of the recent controversy & unhappiness surrounding the LCP."

- They found that the LCP appeared to be used, in some cases as a "protocol to be followed, rather than as a set of alerts and guidelines for good practice… with the inherent risk that insufficient attention is paid to signs of reversibility in the patient's condition." They saw a perceived lack of medical review for patients using the LCP, and that the "tick-box" exercise in some cases appeared to include the prescription of strong opioids and sedatives without justification.

- They emphasised the importance of good mouth care in a patient who might be dying, and found no justification for denying a fluids or food for a patient able to swallow them.

## 3.0 Recommendations of the Report

For full Report see Web Address :
https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients (Table of Recommendations pages 52-59.)

In essence, the Report recommends the "phasing out" of the LCP over the next six to twelve months, and replacement by "an end of life care plan for each patient, backed up by condition-specific good practice guidance."

It recommends that end of life care be urgently included into the new hospital inspection plan, and further that the Care Quality Commission (CQC) should carry out a thematic review of the care of dying patients in all care settings.

It recommends increased access in hospitals to Palliative Care Teams for advice and support for individual patients, as well as training for all staff.

It recommends that senior medical staff need to be involved more in communication, and decision making with patients and families around possible end of life decisions, and the review of these.

It reminds Hospitals that approximately half of all deaths in a community occur in hospitals, and that despite a culture emphasising "cure", that care of the dying a "Core Duty" of Hospital Trusts; this irrespective of other business driven aspirations.

**4.0 Portsmouth Hospitals NHS Trust – actions take in response to the report**

- An early statement for staff suggesting that they should not use the LCP UNLESS they were prepared to do this with full regard to the LCP documentation, and the recommendations of the Neuberger Report.
- For Ward teams to seek advice at an early stage from the Hospital Palliative Care Team, and End of Life Nursing Support team, regarding the care of individual patients.
- As per the instructions of the Secretary of State, a review of all complaints which might be about end of life care and the use of the LCP in the past three years has been conducted, with the intention of deciding whether any of these cases should be reviewed in the light of the Neuberger Report.
- To enable us to demonstrate an ongoing commitment to the provision of best quality end of life care - Development of an Audit of some key areas of communication and practice of care for a patient who may be dying. This audit to replace the current monthly data collection on the use of the LCP, and to be broader in terms of looking at a representative sample of all expected deaths in the hospital.
- A working party has met to discuss the provision of appropriate nursing documentation in the absence of the document provided by the LCP.
- Keep in contact with national developments regarding new "individualised Care Plans" to replace the LCP.
- The Director of Nursing nominated to take a lead exec role in End of Life Care.

**5.0 Summary of the review of LCP and end of life care complaints**

Present:

- Lucy Docherty Governor
- Julie Dawes Director of Nursing
- Lorna Wilkinson Deputy Director of Nursing
- Ian Cairns Palliative care Consultant

**Background**

The group came together following a letter received from the office of Norman Lamb regarding the LCP review. There was a recommendation within this letter that due to new information coming to light NHS Trusts should decide whether any complaints received over the recent 2 years should be re opened. The complaints team carried out a word search in Datix on LCP/Liverpool care Pathway and End of life. This produced 23 complaints (8 picked up under LCP search and 15 related to end of life where this was mentioned in the summary. The group were confident that the search had been wide enough as some of these complaints although mentioning a search term did not have LCP necessarily central to the content of the complaint.

In addition, to put this into context, 800 patients have died on the LCP per year at PHT.

**Objectives**

To gain assurance around end of life care in the Trust

- to identify whether there had been a specific problem
- to consider how such complaints were managed and investigated
- to consider whether any required re opening and investigating where this was found not to be the case
- to identify lessons/ themes to inform future practice.

**Non LCP Themes**

From the 23 complaints, the main themes arising were:

- Mismatch with what people thought was happening and what actually was – communication
- Not understanding the processes/what is happening
- Ward moves, when end of life
- Transfer/discharge near end of life
- Pain relief
- Elderly and ill/co morbidities – many of the patients were very complex with multiple system problems
- Nursing care – mouth care/hygiene needs

**LCP Complaints were reviewed in detail**

336/11 – Not specifically about LCP. Gap between transfer from ICU and C6 and then subsequent lack of attention regarding end of life care. Potential learning - should hospital palliative care team have been involved prior to transfer? Patient was showing signs of distress when relatives arrived. Complaint has been to the Ombudsman so nil to do now as completed, does not require re investigation.

437/11 – Communication: differing account of events. Seemed to be a large family ? no spokesperson, did communication get lost amongst the family individuals? Lack of consistency on communication messages e.g. metastatic cancer. Nil else to do on the complaint response, does not require re investigation.

491/11 – 2 differing clinical opinions re LCP on critical care. Poor communication around this differing opinion. Nil else to do for complaint, does not require re investigation.

431/11 – pain relief and lack of anticipatory prescribing. Complaint not about patient being on the LCP but poor application of pain relief principles. CD needed so that the detail can be heard

439/12 – nil required re complaint, fully resolved. Relative now involved in EoL Steering Group. Communication and understanding patient pathway, LCP, myths around drinking on the LCP.

475/12 – need the CD.

2010/13 – speed with which the patient was put onto the LCP. Family were not at the hospital – conversations were had over the phone. Poor preparation and patient in a 4 bedder when family arrived. Does not require re investigation

151/13 – no consultation with family re LCP. Communication. Does not require re investigation

**Further Action**

- 2 CDs to be acquired and listened to with learning added to the above log
- No complaints found thus far which require re opening
- Dr Ian Cairns to incorporate findings into wider paper

## 6.0 Conclusion

The report and findings will continue to be monitored through the End of Life Steering Group and will be incorporated in to the End of Life Strategy.