Advances in Palliative Care: the UK perspective

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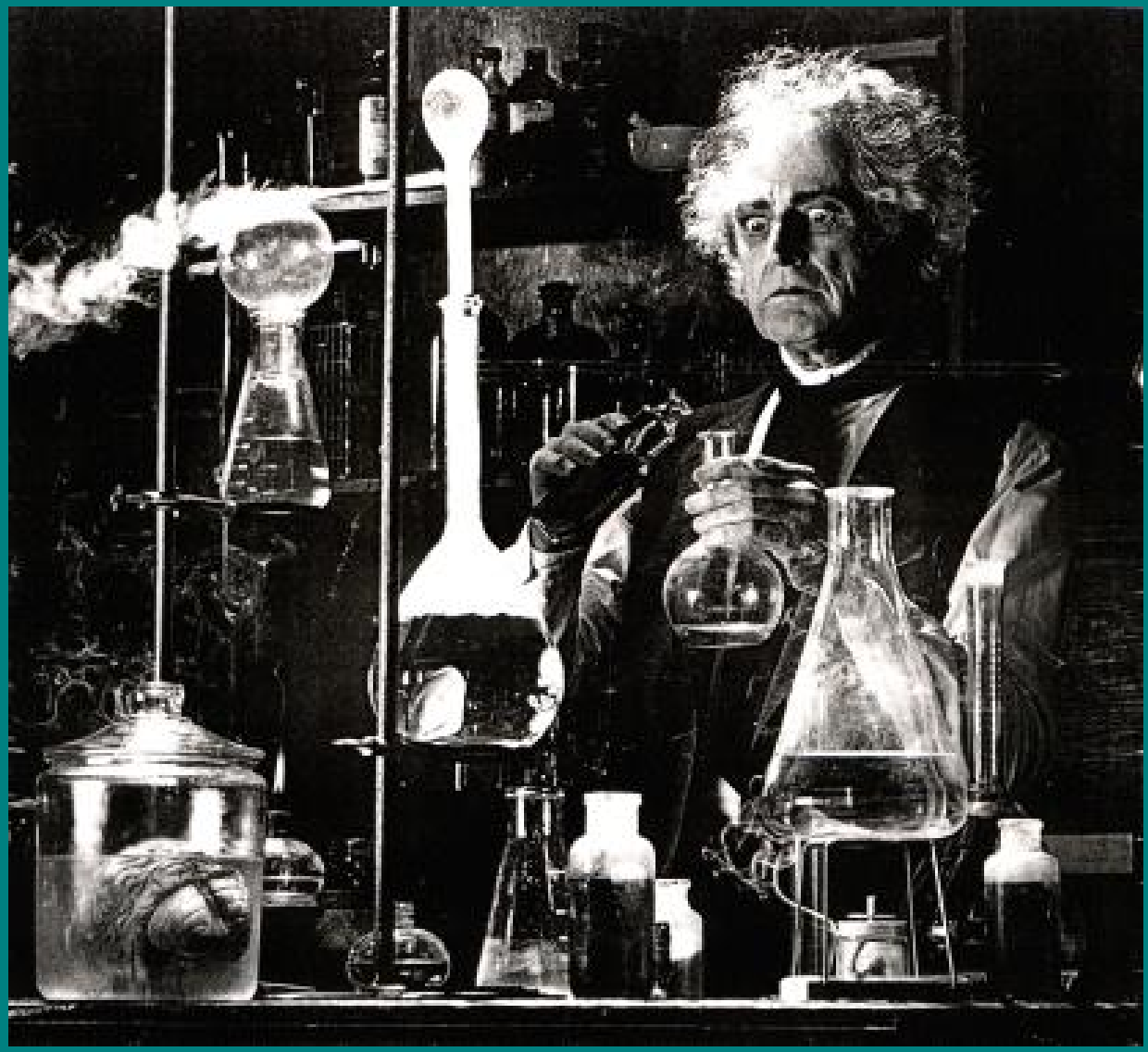
No new wonder drugs!



Developments

- Strategic
- Research
- Education

Strategic

- NHS Cancer Plan
- NICE Guidelines
- Palliative care Gold Standards Framework
- End of Life Pathway
- NHS End of Life Care Programme

Key developments are strategic

- NHS Cancer Plan
- NICE Guidelines
- Palliative care Gold Standards Framework
- End of Life Pathway
- NHS End of Life Care Programme

"The care of the dying must be raised to the level of the best"

The NHS Cancer Plan 2000

National Institute Clinical Excellence (NICE)

- Sets standards for best clinical practice
- Guidelines for cancer and non cancer
- All cancer guidelines recognise need for specialist palliative care
- All multidisciplinary teams must have specialist palliative care input

Change in palliative care working

- Less hospice based
- Integrated with acute medical care
- Hospital based teams
- All hospitals will have an attending palliative care consultant
- Parallel palliative care clinics

Integrated lung cancer clinic

- Respiratory physician
- Lung oncologist
- Palliative care physician
- Community specialist nurse
- Lung cancer specialist nurse

Integrated Lung Cancer Clinic

- Decrease acute hospital admissions
- Improved working between hospital and primary care
- Advanced decision making
- Increased home deaths

Community palliative care

- The majority of people wish to have their care delivered at home
- Majority of people die within hospital following acute admission
- Enhanced primary care skills
- Enhanced hospice at home services

The Gold Standards Framework (GSF) is a framework to enable a gold standard of care for all people nearing the end of their lives.

There are now three separate strands to the GSF programme:

- GSF in Primary Care
- GSF in Care Homes
- Developments in end of life care

Developments in end of life care

- Prognostic Indicator Guidance
- Advance Care Planning
- After Death Analysis audit tools

- **Identify** patients in need of palliative/supportive care towards the end of life
- **Assess** their needs, symptoms, preferences and any issues important to them
- **Plan** care around patient's needs and preferences and enable these to be fulfilled, in particular support patients to live and die where they choose

5 Goals of GSF

- Patients are as symptom controlled as possible
- Place of care – patients are enabled to live well and die well in their preferred place of care
- Security and support – better advance care planning, information, less fear, fewer crises/admissions to hospital
- Carers are supported, informed, enabled and empowered
- Staff confidence, communication and co-working are improved

Standards

C1 - Communication
C2 - Co-ordination
C3 - Control of symptoms
C4 - Continuity including out of hours
C5 - Continued learning
C6 - Carer support
C7 - Care in the dying phase

How do we deliver best practice

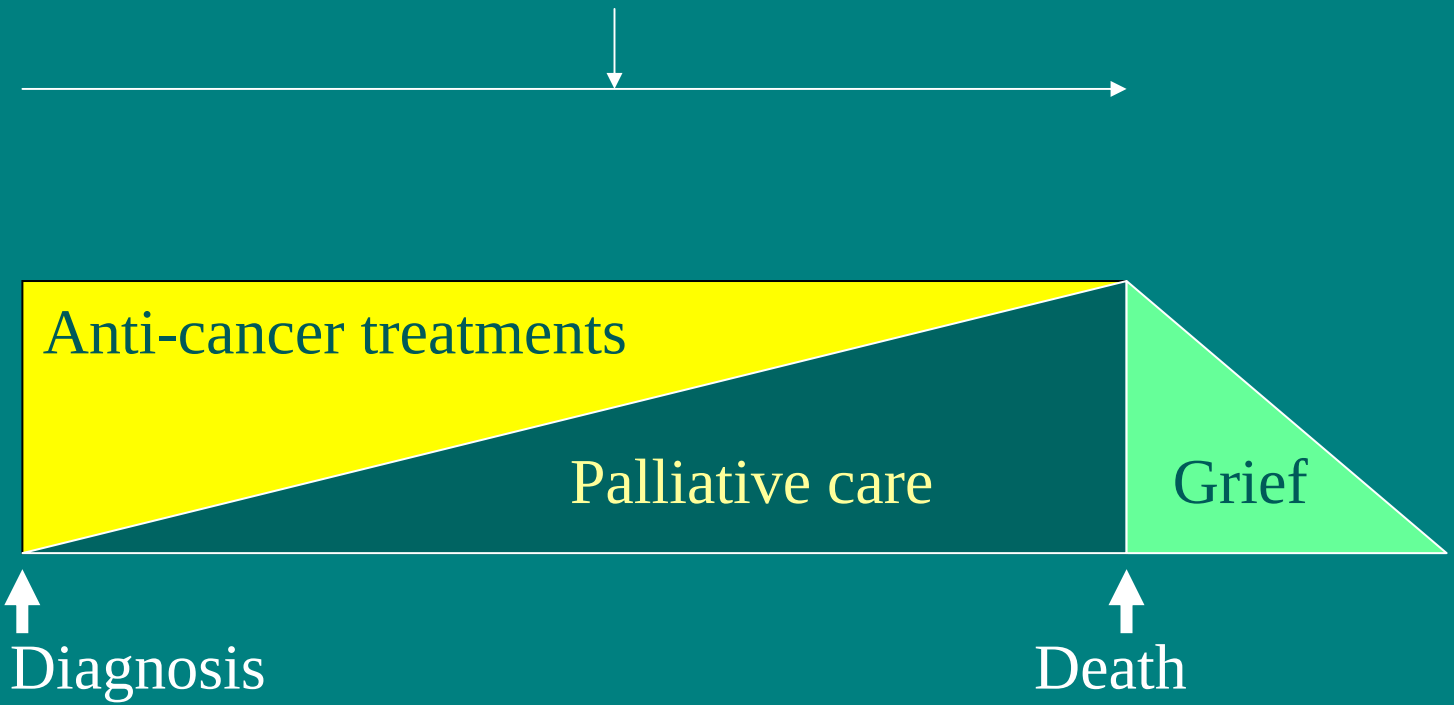
- Need to know what best practice is
- Research
- Training
- Resources
- Engage with commissioners
- Governmental level

Care of the dying pathway

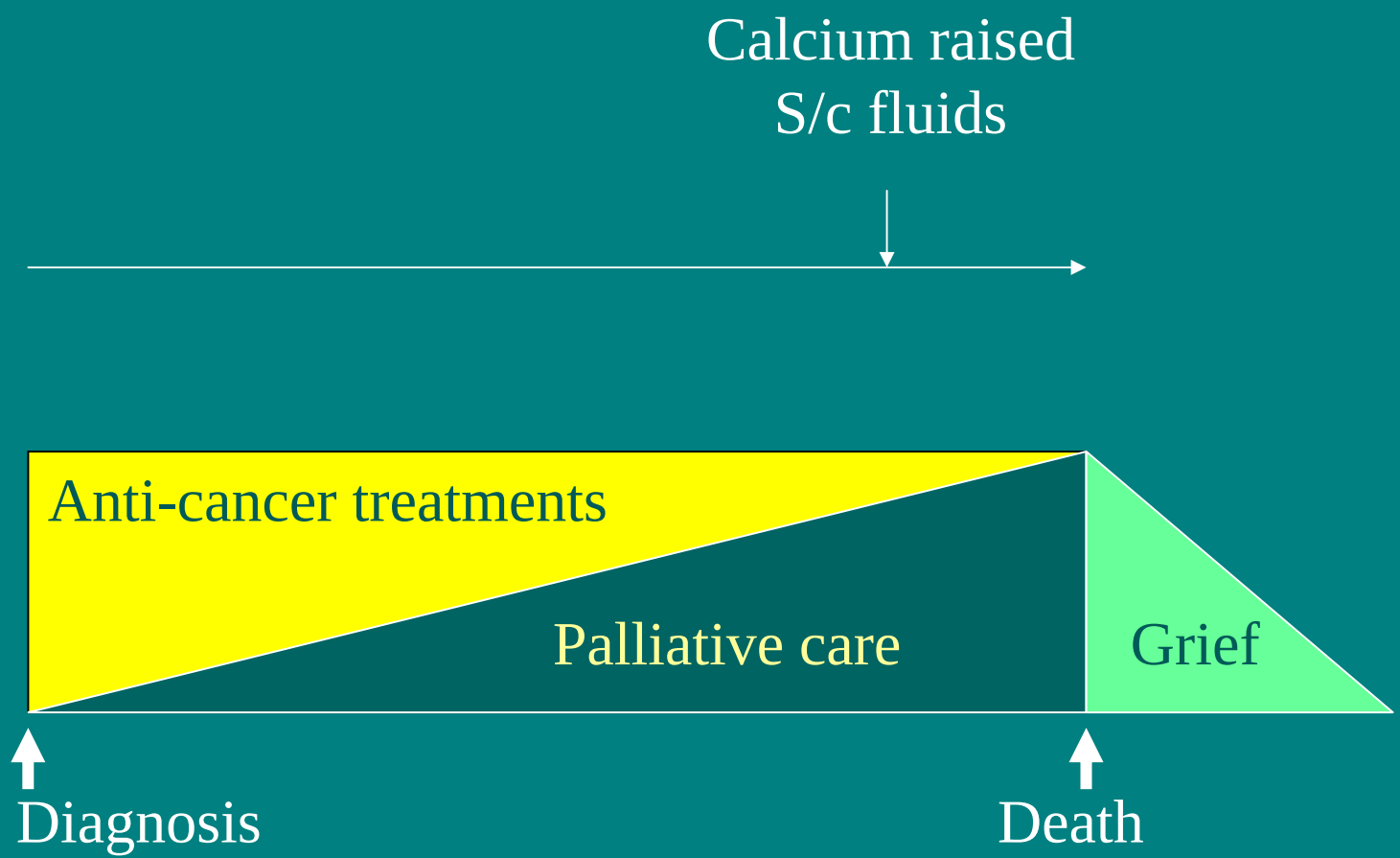
- Ensures that dying patients receive same standard of care wherever they are being looked after
- Auditable outcomes
- Guidance for all healthcare workers
- Patient focussed

When is someone dying?

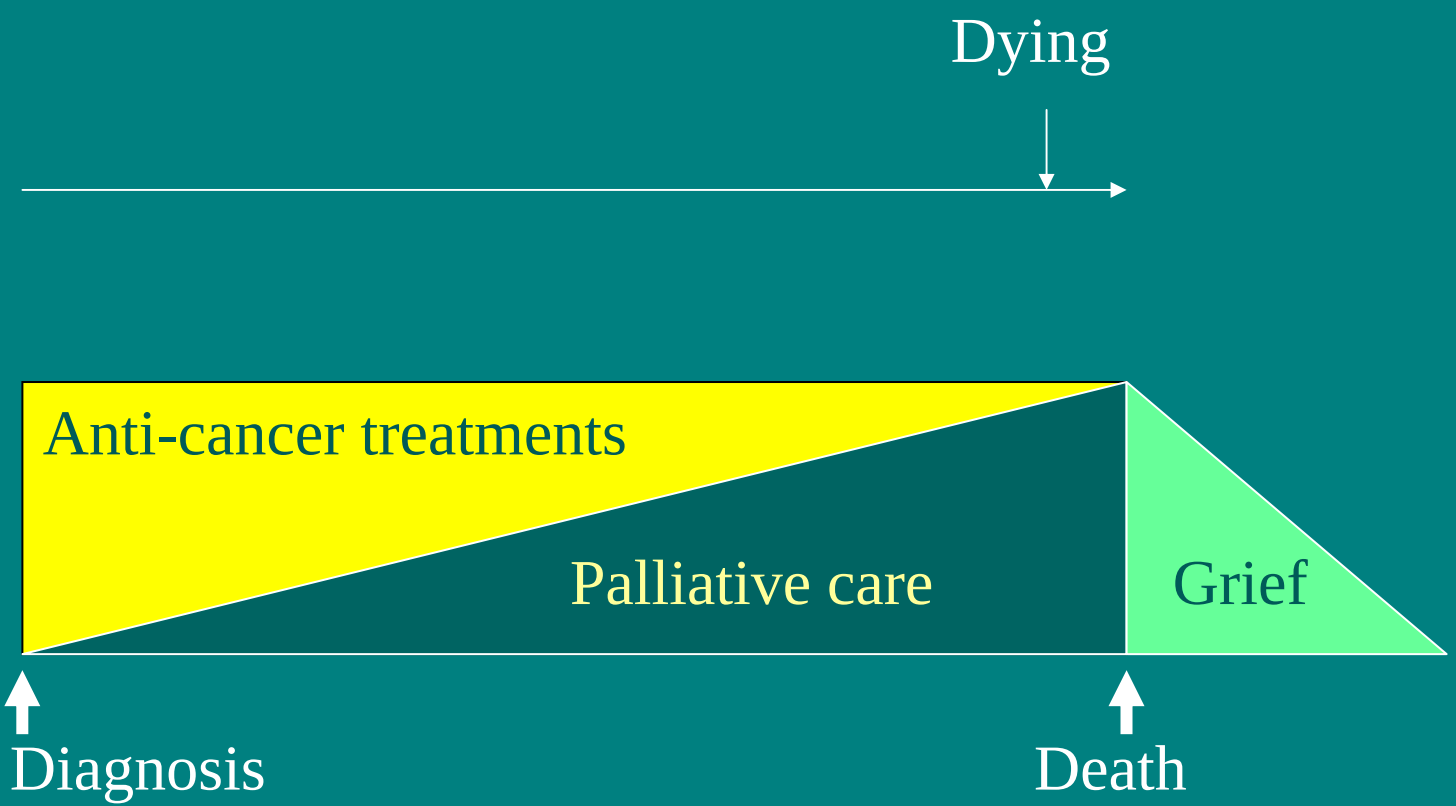
Stop statins etc
Allow sugar up



Dying now?


Calcium raised
S/c fluids
Anti-cancer treatments
Palliative care
Grief
Diagnosis
Death

Or now?


Dying
Anti-cancer treatments
Palliative care
Grief
Diagnosis
Death

Care of the dying pathway

- Care in last 48 hours of life
- Checks ‘dying’ is diagnosed
- Relatives informed
- Unnecessary drugs stopped
- If not swallowing, then alternatives available in syringe driver
- Variance sheet records if anything outside planned drugs is used

Outreach of palliative care

Integrated care pathway

- A document that outlines best practice for a patient in last days of life
- Based on achieving goals
- Incorporates care of family
- Multi-disciplinary document
- Replaces medical and nursing notes

The document

- Putting a patient on the pathway
- Initial assessment
- Ongoing assessment
- Care after death
- Variance
- Drug sheet

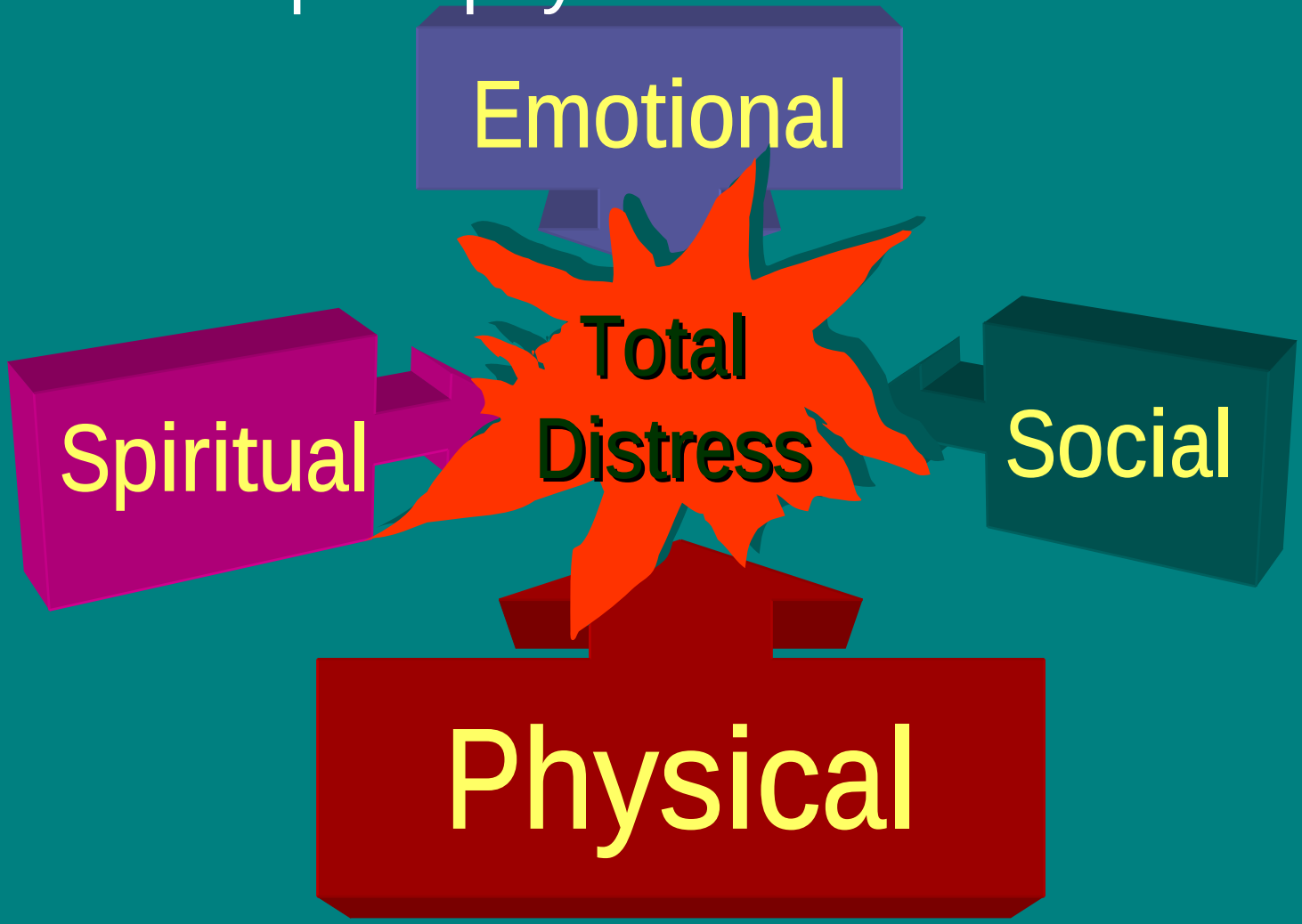
Benefits

- Multi-professional
- Best practice
- Consistent quality
- Efficient
- Powerful tool
- Learning tool
- Improves communication

Disadvantages

- Time consuming
- Not individualised care
- Insults current practice
- Complex cases

To help recognise when a patient is dying and to promptly assess all needs



Aims

- Diagnose dying
- Relieve symptoms and fears
- Provide support for carers
- Enable to die in place of choice
- Minimise problems with bereavement

Factors facilitating successful implementation

- Gaining commitment on all levels
- Generating enthusiasm amongst staff
- Comprehensive training
- Engendering local "ownership"
- Feedback and support
- Regular review and refresher sessions

Problems

- Fear of failure
- Local politics
- Peer pressure to resist change

“Doctor to dead horse as if it were still alive never gives it up for lost”

The core formulary

Recommended drugs	Reason
Diamorphine	**Analgesic**
Hyoscine Hydrobromide	**Anticholinergic**
Midazolam	**Anxiolytic**
Cyclizine	**Anti-emetic**

Does not mean that all care stops

‘allow natural death’

Last 48 hours of life

97% of patients appear adequately symptom controlled when dying with the use of a core formulary of just four main drugs

‘Dying’ must be diagnosed - not assumed!

Care requirements for drugs in last 48 hours can be predicted

Non malignant disease

Ageing Population in Hong Kong

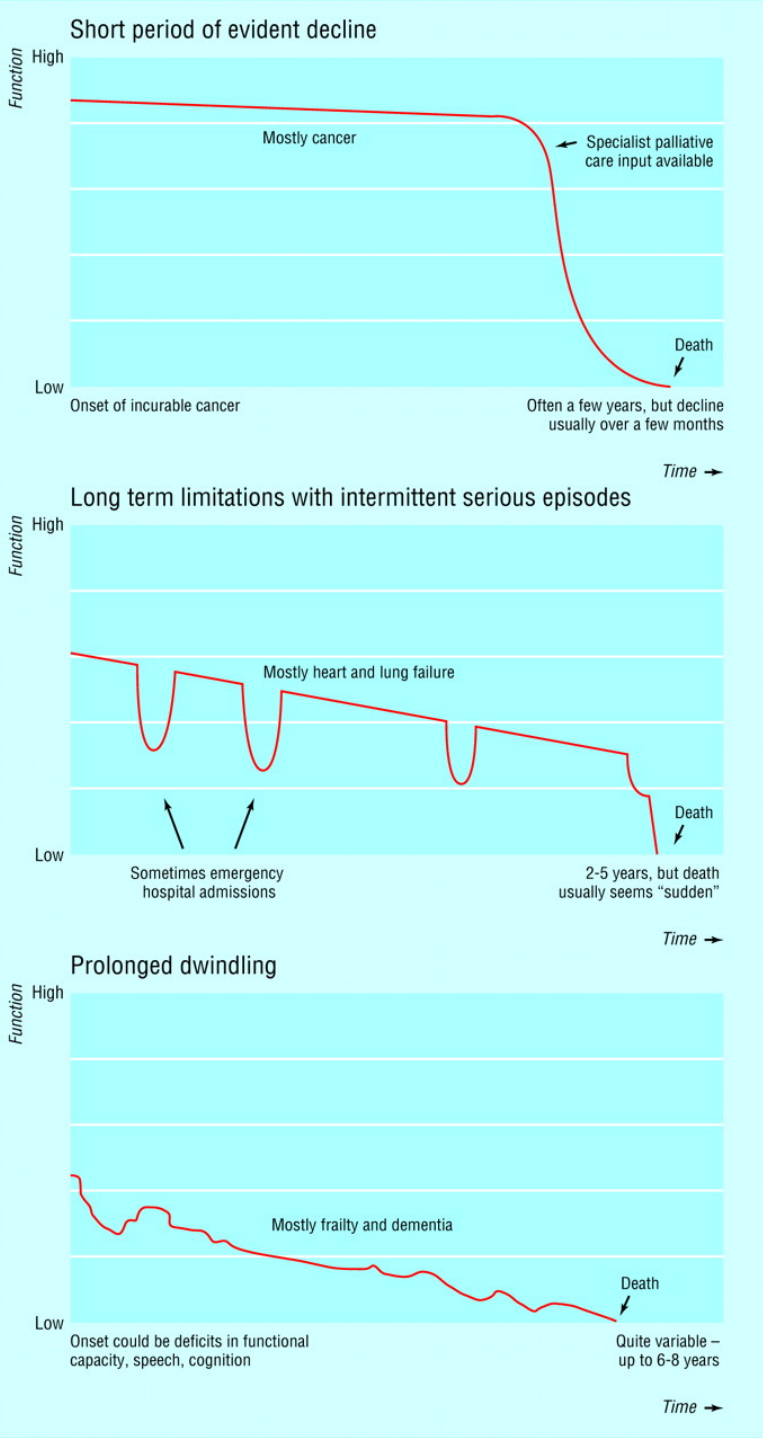
	2005	2033
Age greater than 65	12.1%	26.8%

Number of Hong Kong Deaths 2006

Cause	Number	Rate per 100,000
Cancer	12,160	177.3
Heart disease	5,684	82.9
Pneumonia	4,116	60.0
Cerebrovascular disease	3,334	48.6
Lower resp disease	1,957	29.5

Symptom prevalence in advanced disease

Cancer		Heart/ Lung disease	
Pain	(35 – 96%)	Dyspnoea	(60 – 88%)
Confusion	(6 – 93%)	Fatigue	(69 – 82%)
Anorexia	(30 -92%)	Pain	(41 – 77%)
Fatigue	(32 – 90%)	Anxiety / depression	(9 – 49%)
Anxiety / depression	(3 – 79%)	Insomnia	(36 - 48%)
Dyspnoea	(10 – 70%)	Nausea	(17 – 48%)
Insomnia	(9 – 69%)	Constipation	(38 – 42%)
Nausea	(6 – 68%)	Anorexia	(21 – 41%)


Short period of evident decline
Function
High
Low
Mostly cancer
Specialist palliative care input available
Death
Onset of incurable cancer
Often a few years, but decline usually over a few months
Time
Long term limitations with intermittent serious episodes
Function
High
Low
Mostly heart and lung failure
Death
Sometimes emergency hospital admissions
2-5 years, but death usually seems "sudden"
Time
Prolonged dwindling
Function
High
Low
Mostly frailty and dementia
Death
Onset could be deficits in functional capacity, speech, cognition
Quite variable – up to 6-8 years
Time

Challenges

- Equity of care
- Delivered at place of patient preference
- Adequately resourced
- Adequate training and leadership

Thank you