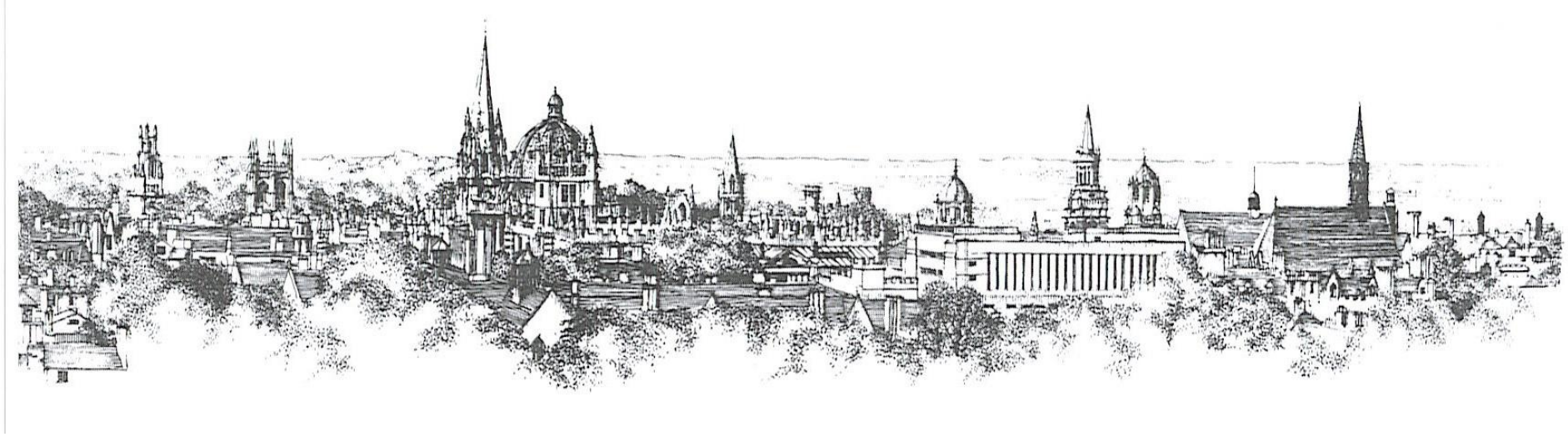


Palliative Medicine:
From Childhood Dreams to Mature Adulthood

Bee Wee and Richard Hillier: Oxford, UK

22nd January 2015

Danish Association for Palliative Medicine Annual Meeting 2015

Plan for this morning

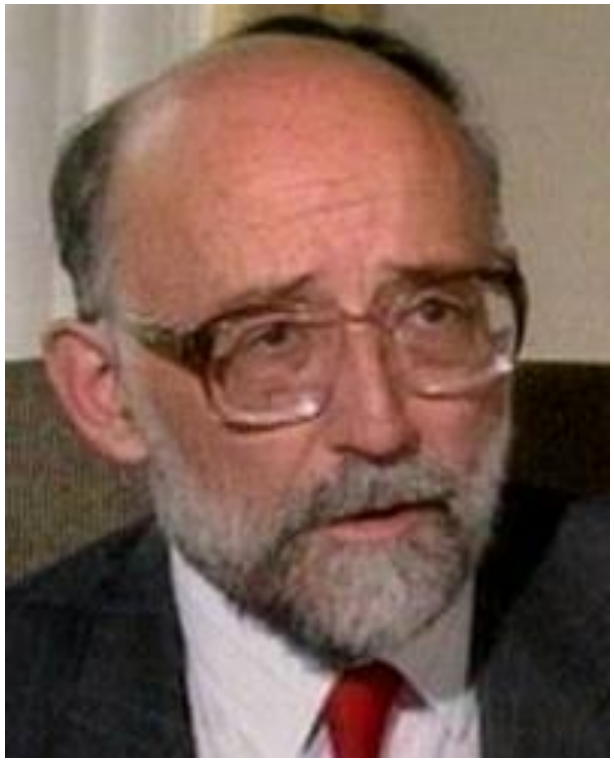
- Our proposal
- Your objectives
- Learning from our experience
- Break
- The palliative medicine doctor:
  - Multiple ‘hats’
  - Postgraduate education

Hospice: the pioneers





Hospice: the facilitators





Development since 1968

Time	Hospice/palliative care units
1968	1
5 years later	2
10 years later	10
1982	1st children's hospice
2012	223

Important developments

- 1985 – Association for Palliative Medicine
- 1987 – Became medical specialty – RCP
- 1990 – 4 year training programme developed
- 1996 – Curriculum for students, GP trainees
- 1999 – National Cancer Director
- 2000 – National Cancer Plan

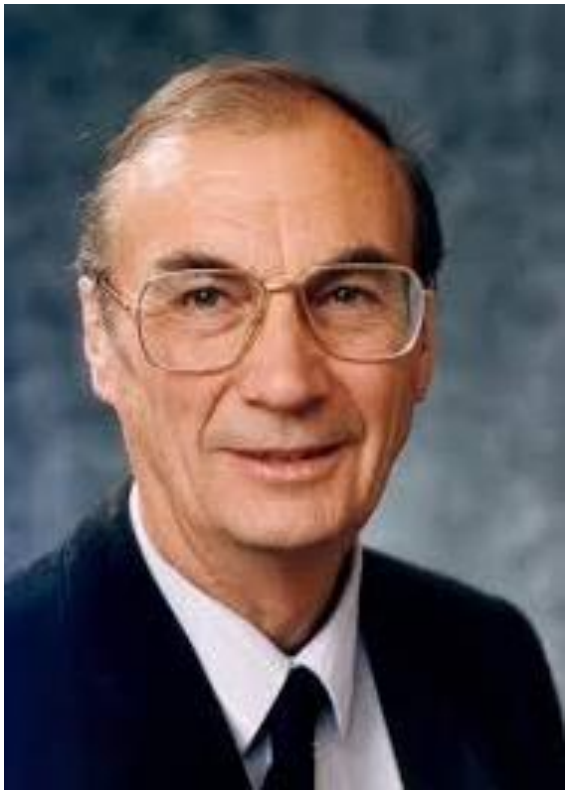


National Cancer Plan (2000)

- £50m / year invested in hospices
- NHS contribution to charitable hospices
- Macmillan nurses to be extended
- Research and education in cancer and palliative care
- Formation of a Cancer Task Force (pall care involvement)

Hospice: the pioneers

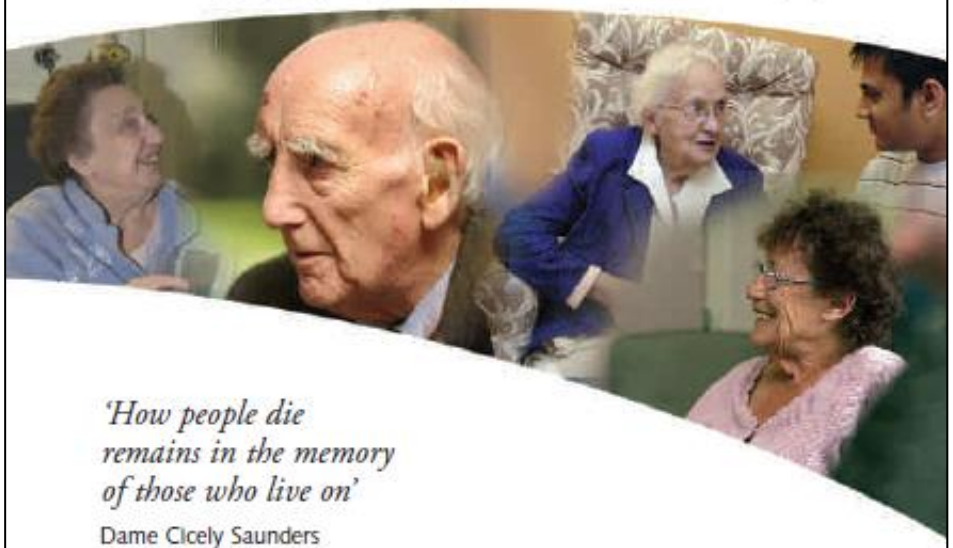




DH Department of Health

End of Life Care Strategy

Promoting high quality care for all adults at the end of life



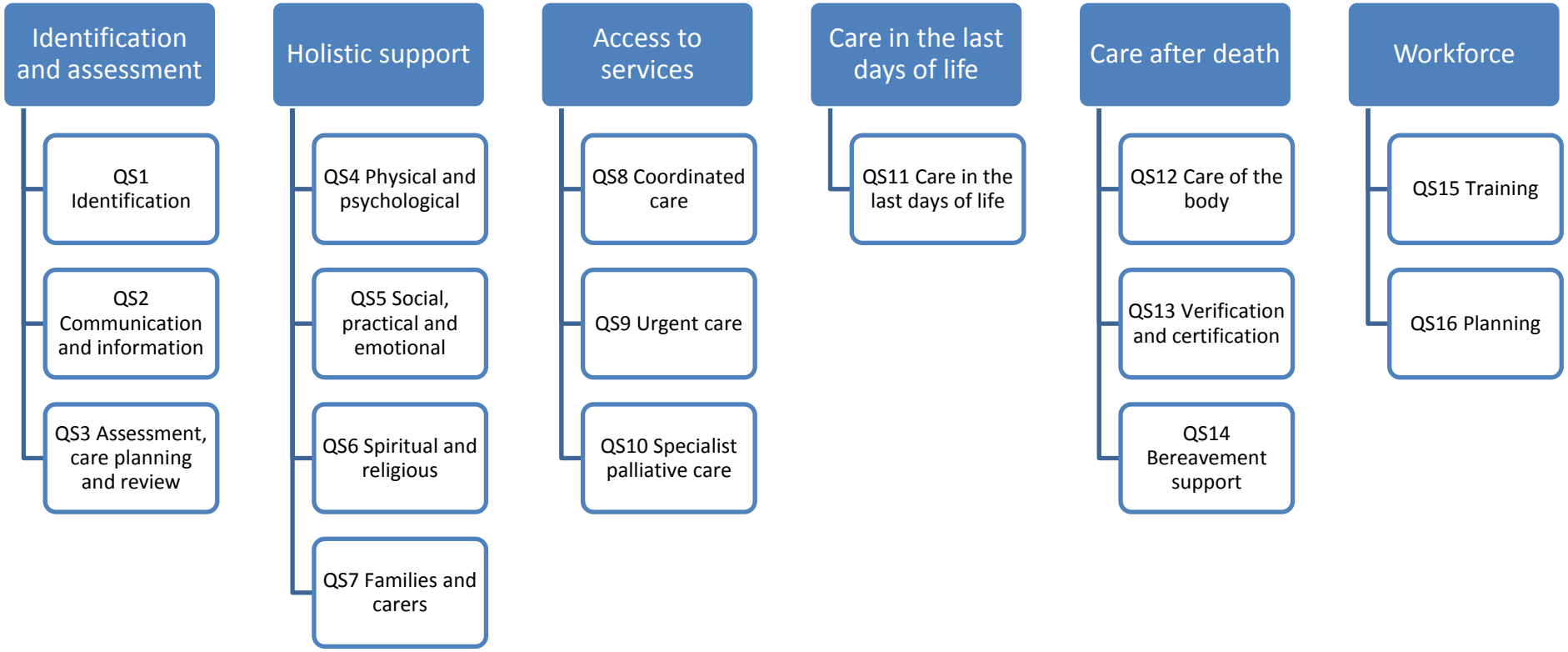
'How people die remains in the memory of those who live on'

Dame Cicely Saunders
Founder of the Modern Hospice Movement

July 2008

NHS

NICE Quality Standard: End of Life Care for Adults





- 8 modules: assessment, advance care planning, communication skills, symptom management, integrating learning, bereavement, spirituality, social care

- 156 e-learning sessions

- Aspirations and intentions
  - all health and social work professionals
  - free of charge
  - key part of workforce development

http://www.e-lfh.org.uk/programmes/end-of-life-care/

2013 was a momentous year

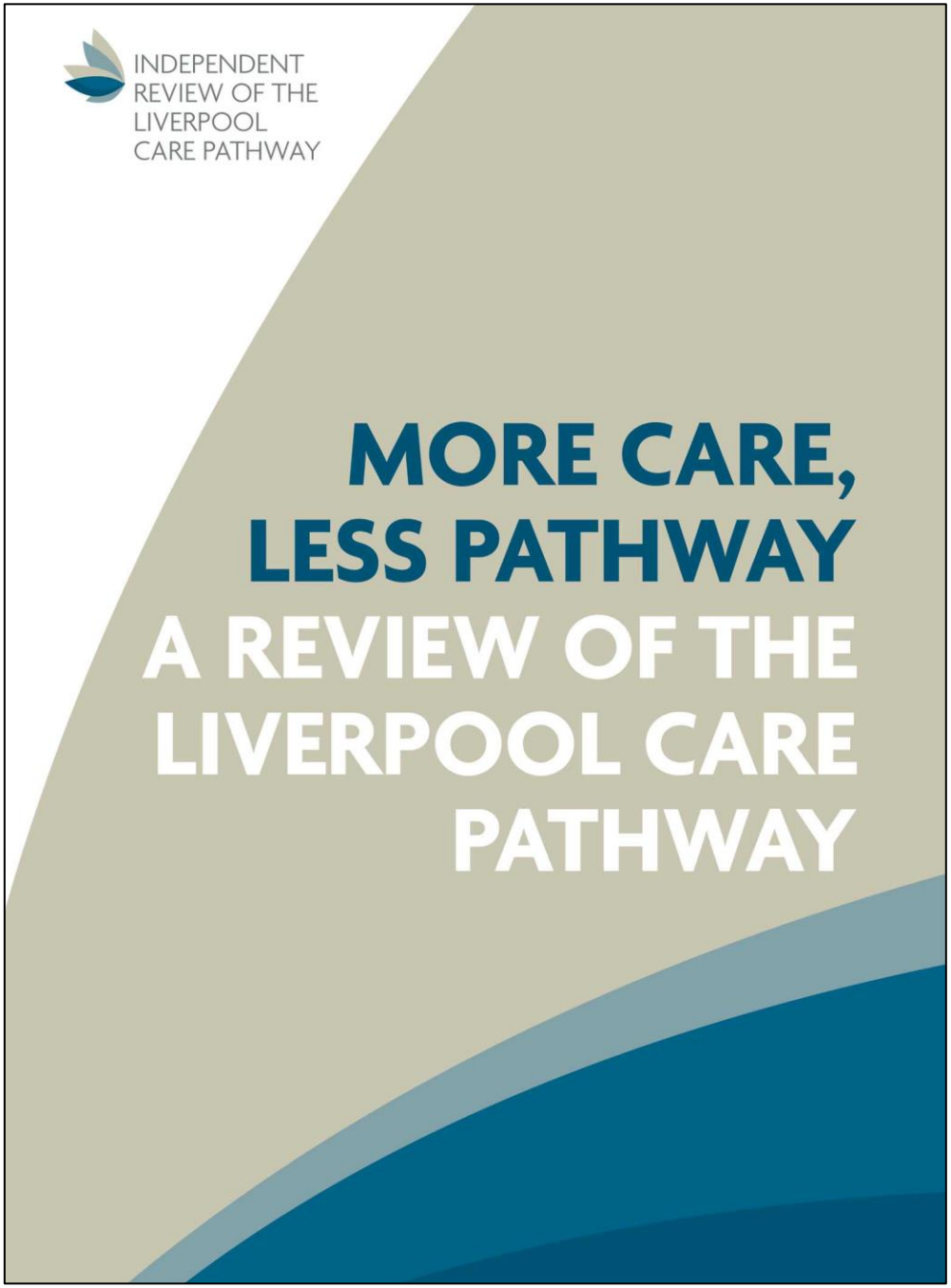
- Radical change to the National Health Service in England
  - new structures
  - new organisations
  - new people
  - new ways of doing things
  - focus shift to outcomes
- Growing financial challenge
- Fundamentally challenging reports: Francis, Berwick
- More Care Less Pathway (Neuberger)
- Blows to public confidence and professional morale

Liverpool Care Pathway

- Good idea
- Based on sound palliative care principles
- Transported hospice practice in hospital setting
- Worked well where all elements fully implemented and resources to support
- Accepted by government (2004)

But……

- Not always used properly
- ‘Pathway’ became euphemism for ‘dying’
- Misunderstood – led to inappropriate withdrawal of food and fluids
- Often poor communication with patients and families
- Some professionals and families lost confidence
- The media…….



Good when used properly

No research evidence of effectiveness or harm

LCP was being used as a protocol or tick box exercise by some
(not as a guide to good practice)

Poor communication and decisions taken without discussion/informing family

LCP to be phased out within 6-12 mths and replaced with individualised end of life care plan

Coalition of regulatory and professional bodies to lead the way for ensuring high quality care for dying patients

Leadership Alliance for the Care of Dying People

Care Quality Commission
College of Health Care Chaplains
Department of Health
General Medical Council
General Pharmaceutical Council
Health and Care Professions Council
Health Education England
Macmillan Cancer Support
Marie Curie Cancer Care
Monitor
National Institute for Health Research
NHS England
NHS Improving Quality
NHS Trust Development Authority
NICE (National Institute for Health and Care Excellence)
Nursing and Midwifery Council
Public Health England
Royal College of GPs
Royal College of Nursing
Royal College of Physicians
Sue Ryder

Marie Curie Cancer Care also represented Help the Hospices and the National Council for Palliative Care; Sue Ryder also represented the National Care Forum; Macmillan Cancer Support also represented the Richmond Group of Charities.



https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323189/Commitment_statements.pdf

Priorities for Care of the Dying Person

Recognise

The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

Always consider reversible causes, e.g. infection, dehydration, hypercalcaemia, etc.

Communicate

Sensitive communication takes place between staff and the dying person, and those identified as important to them.

Involve

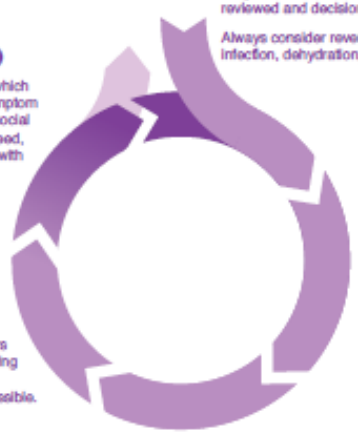
The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

Support

The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

Plan & Do

An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

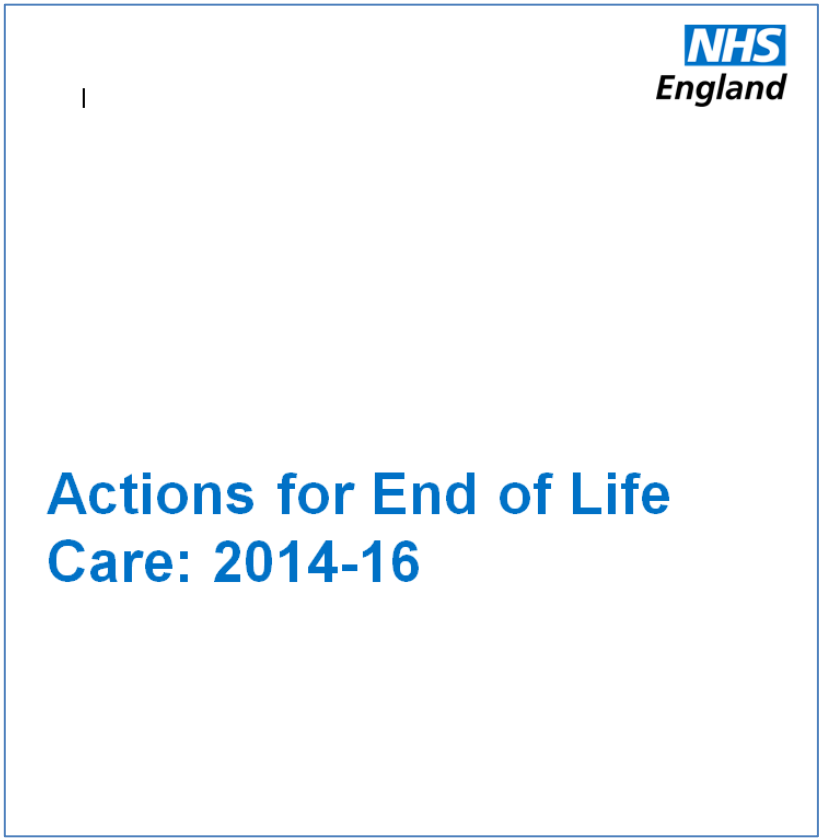


If unsure, or the dying person or those important to them raise concerns, a senior clinician must review the person and the goals and plan of care.

Local palliative care contact:

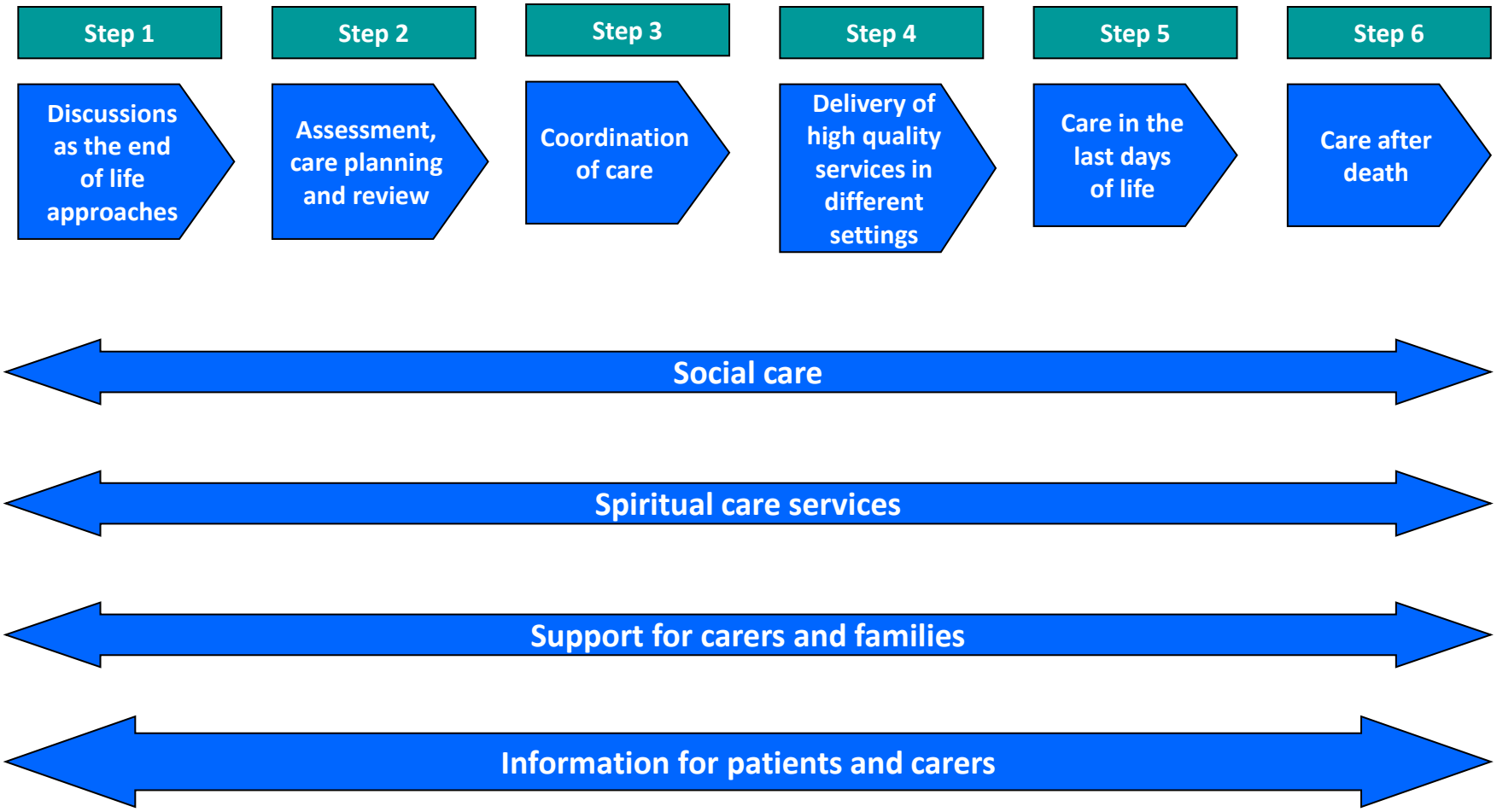
For further guidance www.nhsiq.nhs.uk/endoflifecare

scan on a smartphone to access to website guidance

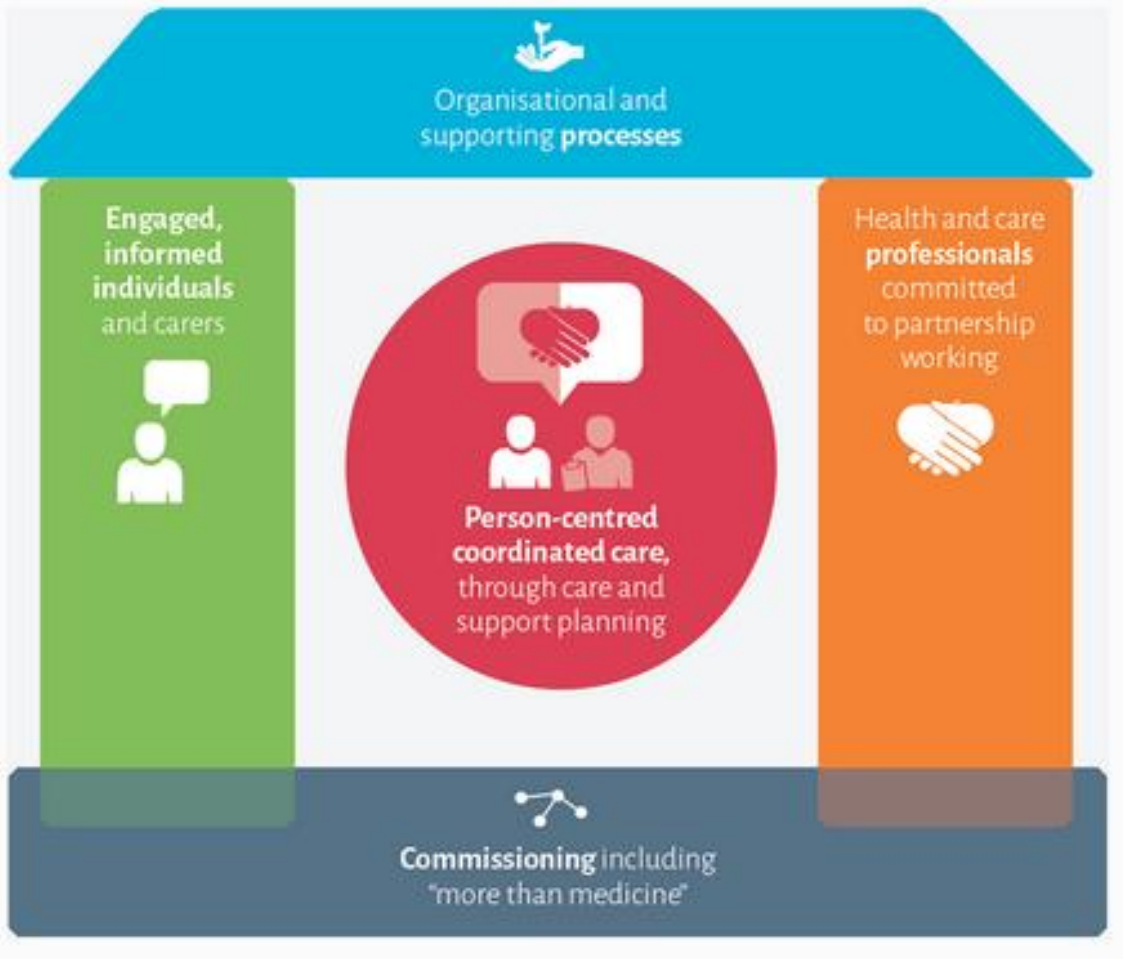


http://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf

The End of Life Care Pathway



House of Care framework: for EoLC

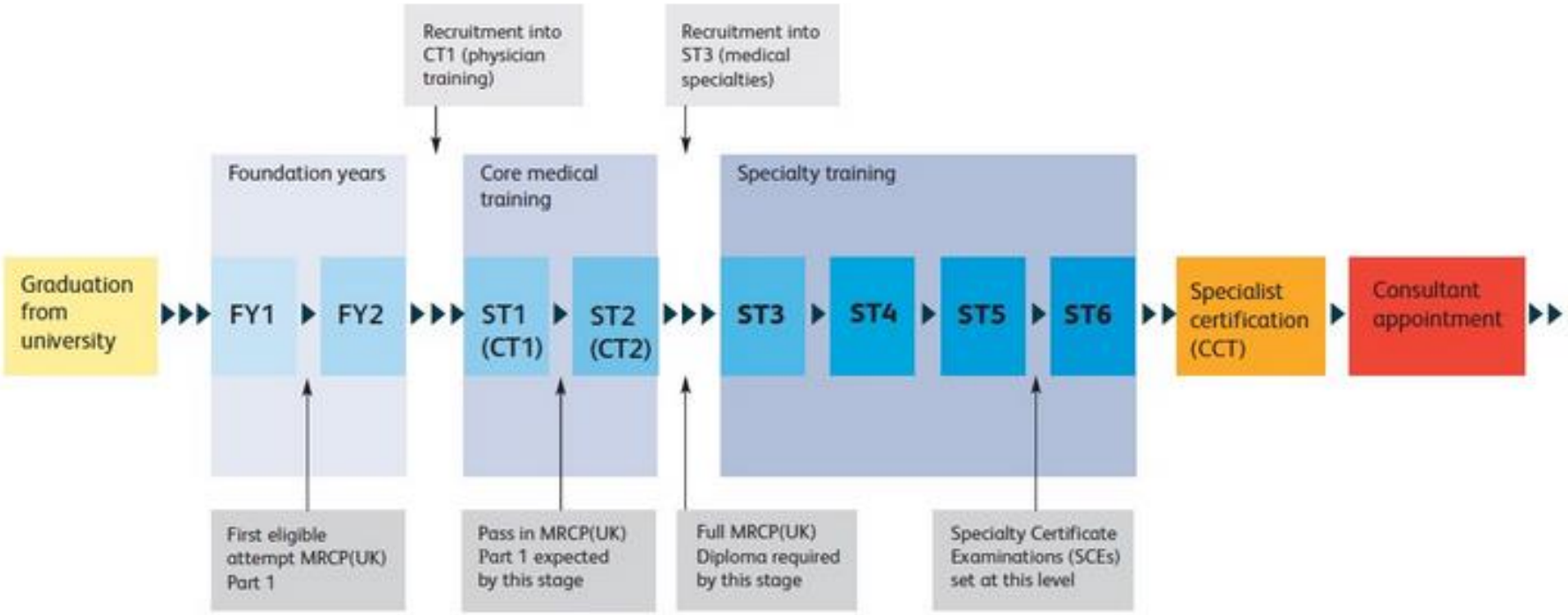


Engaged, involved and compassionate communities

Undergraduate palliative medicine

Compared to 2000/2001:

- Teaching on care of dying, death and bereavement now mandatory
- Teaching methods similar: lectures, small group discussion, video, case discussion, patients and role-play
- New features: MDT meetings and e-learning
- Teachers: PM specialists, GPs, specialist nurses
- Assessment: 83% now (25% in 2000)

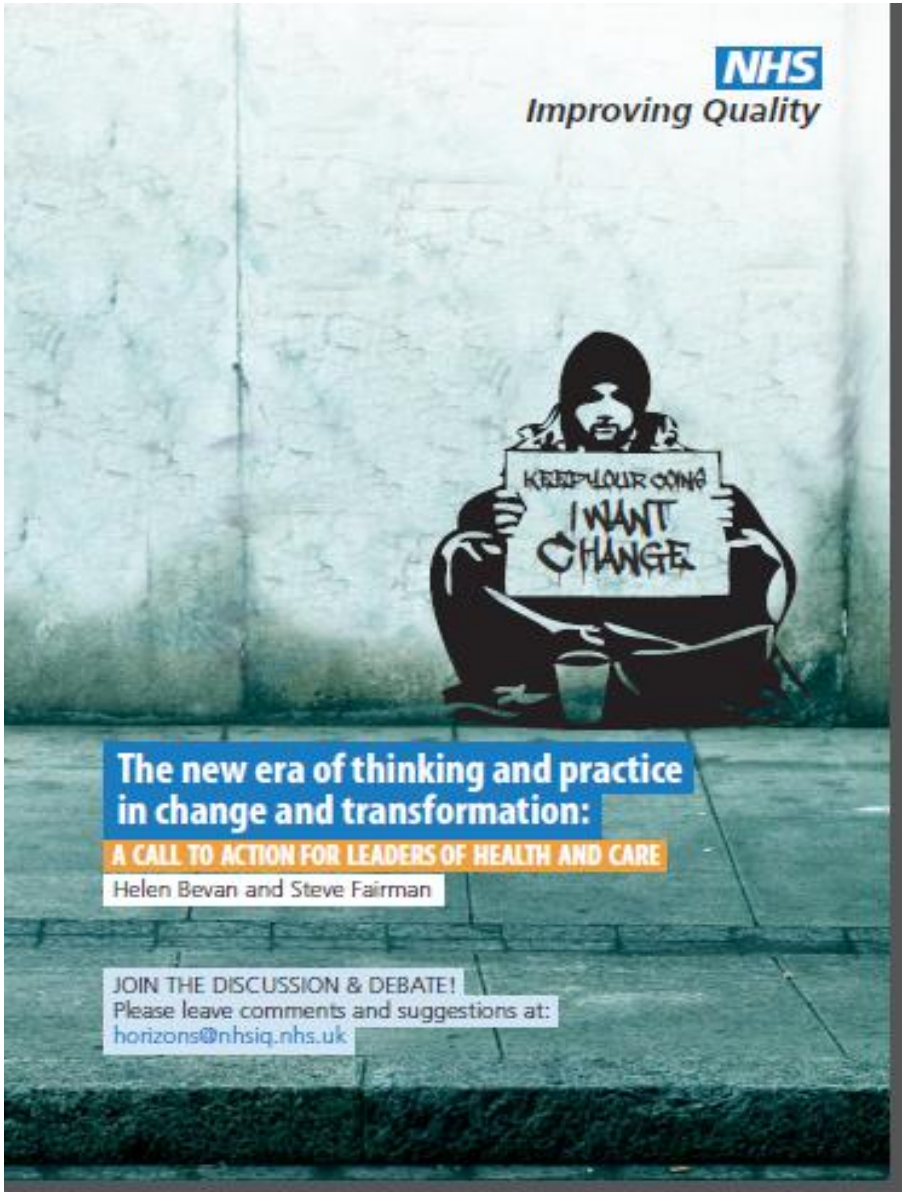

Recruitment into CT1 (physician training)
Recruitment into ST3 (medical specialties)
Foundation years
Core medical training
Specialty training
Graduation from university
FY1
FY2
ST1 (CT1)
ST2 (CT2)
ST3
ST4
ST5
ST6
Specialist certification (CCT)
Consultant appointment
First eligible attempt MRCP(UK) Part 1
Pass in MRCP(UK) Part 1 expected by this stage
Full MRCP(UK) Diploma required by this stage
Specialty Certificate Examinations (SCEs) set at this level


Clinical expertise
Leadership
Research
Education
Clinical governance
Palliative Medicine Physician

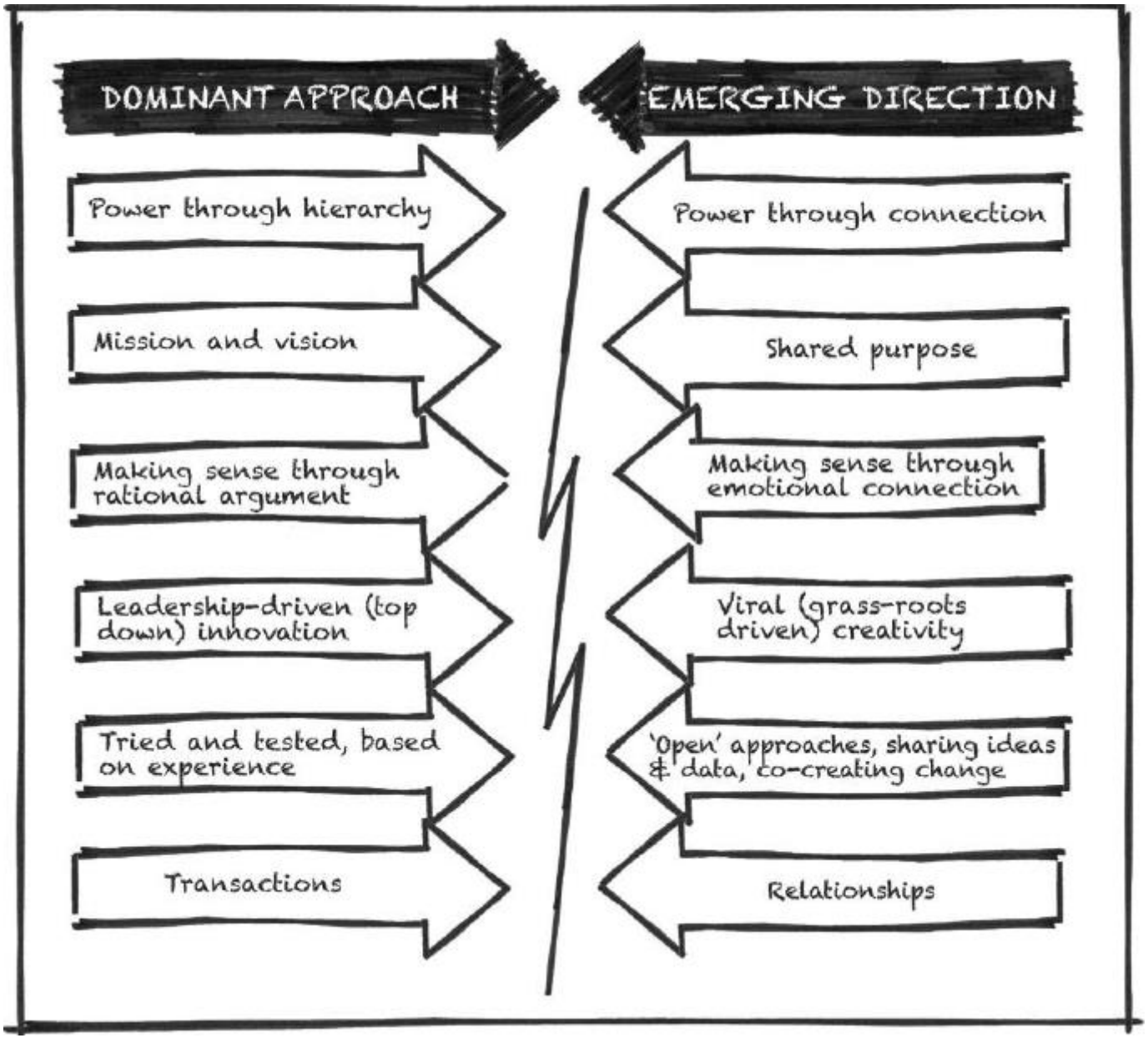

Interdisciplinary working
Multiprofessional team
Clinical expertise
Clinical governance
Leadership
Palliative Medicine Physician
Education
Research
Undergraduate
Postgraduate
Specialist
CPD
Generating
Curating
Disseminating

Palliative medicine physicians

- Brainstorm and capture your thoughts and ideas about how to increase effectiveness and impact: within your team, locally and as a national body
- ‘Paint a picture’ that captures the most important aspects of your vision
  - What needs to be done to make this happen?
  - How can this be done?
  - Who will do any of this?
  - What resources will you draw on?



http://www.nhsiq.nhs.uk/resource-search/publications/white-paper.aspx



horizons@nhsiq.nhs.uk

Enabling transformational change

1. People – question the norm: ‘rocking boat’ but staying on board
2. Leading from the edge – moving change processes to, and from, ‘the edge’
3. From ‘diagnostic’ to ‘dialogic’ – changing conversation and mindset
4. Curators of knowledge – greater focus on ‘tacit knowledge’ (know-how)
5. Bridge building to connect the disconnected

horizons@nhsiq.nhs.uk