Across Cheshire, health professionals and patients have come together to create local end-of-life care plans, aligned with the recently five priorities for care.

**Working together on a new end-of-life care plan**

In this article...

- Developing a local replacement for the Liverpool Care Pathway
- The importance of partnership with professionals and patients

**5 key points**

1. Individualised care planning aligned with five key priorities has now replaced the Liverpool Care Pathway.

2. The five priorities cover decision-making, communication and care planning and apply to all settings.

3. Local approaches to care planning are now recommended.

4. Clinical leaders and the public should be involved in creating local guidance.

5. Education and training for staff are essential for success.

**End of life care requires a concerted approach to ensure that patients and their families and carers receive high-quality, seamless care. In Cheshire, organisational leaders have come together to create a replacement for the Liverpool Care Pathway in partnership with patients.**

**Replacing the LCP**

An independent review of end-of-life care recommended that the use of the Liverpool Care Pathway should cease by July 2014, and that dying patients should instead have individualised care plans (Neuberger, 2013). Department of Health guidance also recommended a more localised approach rather than a national template (DH, 2013).

In August 2013, the Cheshire End of Life Partnership (EoLP) began to design a system-wide approach to care during the last days of life, working across three local clinical commissioning groups.

The EoLP led on the development of a locality-wide action plan, with support from GPs, district nurses, Macmillan nurses, hospital consultants, care home managers and hospice staff. There were also representatives from specialties such as learning disabilities, dementia and safeguarding. A member of the public also participated to represent the views of carers.

Fifteen priority areas for local action were identified, including the development of a care plan to replace the LCP, and comprehensive guidance on end-of-life care.

The draft care plan was informed by the recommendations of the Neuberger review, alongside interim guidance provided by the Leadership Alliance for the Care of Dying People (LACDP), outlining what are known as the “five priorities” for care of the dying (NHS England, 2014). Each section seeks to address the key areas of concern raised within the LCP review, including hydration and nutrition, communication with the patient and significant others, timely recognition of dying, eliciting patient preferences and choices, and regular review by a senior clinician. Each section of the care plan has a tab to identify which professional disciplines are responsible for completing the questions, and there is a doctors-only...
Consulting on the draft plan

We made the draft available for three weeks in April 2014, to local professionals, carers, members of the public, faith and other community groups, with feedback facilitated via an online questionnaire. Media such as Twitter, local press and patient user forums were used to raise awareness of the consultation period and to gain widespread feedback. Public and patient participation was essential in order to gain the support and confidence of local people, particularly as the national media coverage around the LCP demonstrated increased public anxiety in relation to end-of-life care.

Open comments were welcomed and were thematically analysed. The questionnaire resulted in 52 online responses, with an additional 10 email responses.

Of the 62 responses received, nine were from members of the public, one from a patient user group, and one from a hospital chaplaincy team. In total, we received 51 responses from local health and social care professionals, half of whom were working within an acute hospital setting. The main themes identified were:

» A need for more explicit patient and family involvement at the point the care plan is commenced, with the names of professionals involved in making the decision that the person is dying;
» Language used needed to be understood by patients, families and carers;
» The term ‘potential’ to die was deemed inappropriate;
» Details of lasting power of attorney for health and welfare, where relevant, needed to be clearer so that staff know who to consult;
» Members of staff, patients, families and carers needed more information to guide and support the delivery of the care principles set out within the plan.
» Elements of the care plan were duplicating information that is already recorded elsewhere within medical/nursing notes;
» Concern about the length of the care plan, and suggestions to reduce the amount of writing and adopt a more structured format;
» Reservations about the daily assessment format, which gave no indication of how to evaluate the effectiveness of interventions such as pain relief;
» The symptom control algorithms used within previous end-of-life care documentation provided a useful reference point and should therefore remain within the new care plan;
» Training was considered essential to ensure the plan is used appropriately.

The results of the consultation were used to inform the final version of the local care plan and it was launched in July 2014.

Education, facilitation, evaluation

Facilitators within the EoLP’s service development team have led presentations and updates within hospitals, hospices, care homes, community and primary care. This work has involved presenting at board meetings, attending departmental meetings, running drop-in sessions in the workplace, and working with individuals to facilitate the use of the care plan within clinical practice. A statement to support the launch of the care plan was published by the Health and Wellbeing Board for local people and professionals.

Events were hosted to listen to public views using the networks built by the public health arm of the EoLP. These include dedicated groups within The Cheshire Living Well, Dying Well Partnership which reflect a wide range of community representation. The research and evaluation work stream played a role in devising the consultation questionnaire and in future will provide advice for audit and evaluation of the care plan.

One of the key strengths of the EoLP approach has been the ability to support the launch of the care plan with blended learning devised by the education and practice development team. Training on the five priorities for care of the dying is covered within academic programmes, study days, and statutory and mandatory training events, as well as being available as part of bespoke education packages. Supportive learning resources are also under development to include e-learning, podcasts, DVDs and paper resources that can be downloaded via the Cheshire Electronic Prognostic Assessment and Information Guide for End of life care (ePAIGE) website (tinyurl.com/EPAIGE).

Care planning now and in future

During the consultation period, a member of the public suggested that a care plan was not needed because good-quality end-of-life care should not be centred on one piece of paper. While the project steering group agreed with this in principle, evidence from repeated clinical audits across partner organisations presents a convincing argument that without a framework to guide delivery and documentation of end-of-life care, which reflect a wide range of

### TABLE 1. TIMELINE FOR CARE PLAN DEVELOPMENT

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
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</thead>
<tbody>
<tr>
<td>August 2013</td>
<td>Project steering group established to develop action plan</td>
</tr>
<tr>
<td>February 2014</td>
<td>Sub groups formed to develop new documentation, an education and training plan and supportive resources</td>
</tr>
<tr>
<td>April 2014</td>
<td>Care plan out for professional and public consultation</td>
</tr>
<tr>
<td>May 2014</td>
<td>Review of consultation feedback, amendments made</td>
</tr>
<tr>
<td>June 2014</td>
<td>Consultation statement published to acknowledge the feedback received and to detail the responses made</td>
</tr>
<tr>
<td>July 2014</td>
<td>Care plan launched across two acute hospitals, two hospices, care homes, and within primary care</td>
</tr>
<tr>
<td>Autumn 2014</td>
<td>Review of care plan and creation of supporting documents</td>
</tr>
<tr>
<td>January 2015</td>
<td>Evaluation of the care plan</td>
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</tbody>
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Innovation
End-of-life care

care, many important elements can be unintentionally missed. This is important when patients move between care settings, as staff knowledge, confidence and experience in end-of-life care may vary. However, education and training around use of the new care plan will centre around achieving the five priorities for care, as opposed to the completion of a document.

One of the major criticisms of the LCP was the reliance on tick boxes and therefore the inability to hold professionals accountable for precise elements of their decision-making and care provision. While some practitioners used free text to expand on the decisions made and the care provided, this practice was largely inconsistent and variable across care settings. The new care plan will place an onus on the individual who is providing the care and/or making the decisions to provide explicit documentation that will reduce the risk of misinterpretation. Care must be taken to ensure the documentation is individualised to the patients and their families or carers.

All EoLP partners understand the value of using a common framework for last days of life across the locality, and recognise the positive impact this will have on continuity of care as patients traverse different professional and organisational boundaries. For example, a patient discharged from a hospital ward will now go home with the new care plan, explicitly detailing the agreed care and associated communication with the patient and family/carers. This documentation will then be continued by community-based professionals.

Further activity and evaluation
In autumn 2014, the two original subgroups reconvened to plan further work, aligning all local education and training to recommendations made by the LACDP (2014), and to develop supporting resources alongside the care plan. These include professional guidance notes, patient and carer information, and specialist inserts for staff in intensive care and those caring for people with dementia or learning disabilities.

The executive boards of all relevant partners have signed up to the new care planning approach and await feedback following evaluation in January 2015. The EoLP has been asked to provide specific feedback on progress with educating local care homes around use of the care plan. Continuous feedback will inform the future direction of education and training.

Commitment and engagement
Replacing the LCP is not easy. It is important to adopt a new approach that sees the care plan not as a document to be filled in but as an integral part of a process of needs assessment, information and communication, and person-centred care. The importance of sensitivity to local needs and contexts cannot be underestimated. Patient and public involvement plays a central role in all aspects of this work.

Long-term committed leadership from clinicians, managers and organisations providing care is essential, and can be further enhanced by leaders from patient groups and voluntary organisations. Genuine partnership, such as through the EoLP, facilitates implementation and agreement for cross-organisational working. We also feel it was important that our small team could move the work forward both strategically and operationally, maintaining momentum throughout.

To have a system like e-PAIGE, which supports ongoing learning, is invaluable. To have a system like e-PAIGE, which provides access to topical information and guidance notes, patient and carer information and encouragement at an organisational level will help ensure the acquisition of key knowledge and skills among the workforce. It is through active engagement with learning that individuals gain the understanding and confidence to apply their skills and knowledge. NT

References
Department of Health (2013) Overhaul of End-of-Life Care System. tinyurl.com/DHOverhaulEOL
Leadership Alliance for the Care of Dying People (2014) One Chance to Get it Right. tinyurl.com/LACDOneChance

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