



What happened to the Liverpool Care Pathway?

This factsheet explains what the Liverpool Care Pathway was and sets out the approach to caring for dying people that has been identified following its withdrawal. If you have any questions about your end-of-life rights and choices you can call our free Information Line on **0800 999 2434**.

What was the Liverpool Care Pathway?

The Liverpool Care Pathway (LCP) was developed during the late 1990s at the Royal Liverpool University Hospital, in conjunction with Marie Curie Palliative Care Institute. It was intended to provide the best possible quality of care for dying patients, and was seen as a way of transferring best practice from hospices into other care settings such as hospitals. Its aim was to ensure that everyone expected to die within hours or days received the same high standard of care, regardless of where they were being cared for.

The LCP was not a form of treatment but instead set out a number of steps that doctors and nurses should take to make a dying patient as comfortable as possible.

Criticism and review of the LCP

In 2013, the LCP came under substantial criticism in the media and elsewhere after concerns were reported that the use of the LCP hastened people's deaths through over-prescription of painkillers and/or the withdrawal of hydration or nutrition. There were also reports that people had been placed on the LCP without their consent or their family's knowledge.

This criticism prompted the government to commission an independent review of the LCP in England. The review looked at evidence from many sources, including written submissions and oral accounts from members of the public about their experiences of the LCP.

Findings of the review

The review found that, when used properly, the LCP helped patients to have a comfortable, dignified and pain-free death. However, the panel also heard of failings in its use.

Whilst research showed that communication between care professionals and families was generally good, there were some instances where it was reported as being very poor. There were concerns around treatment decisions being made without relatives being informed, family members not being told that their loved-one was dying and doctors communicating information hurriedly and inappropriately.

The review acknowledged the difficulty of diagnosing when someone is actually going to die and recognised that, in some instances, placing patients on the LCP caused distress to relatives and carers when the patient then recovered. It also concluded that using the term 'pathway' in relation to people who were dying was inappropriate, and recommended the term be dropped.

The review recommended that the use of the LCP should be phased out and replaced with personalised end-of-life care plans for individuals.

It also called for a coalition of regulatory and professional bodies to lead the way in creating and delivering the knowledge base, education, training and skills needed to make high quality care for dying patients a reality. In response to this, the 'Leadership Alliance for the Care of Dying People' (LACDP) formed to set out what should happen in place of the LCP.

Since July 2014 the LCP has been completely phased out.

What now happens in the place of the LCP?

In June 2014, the LACDP wrote the report *One Chance to Get it Right* which sets out the approach to caring for dying people that health and care organisations and staff caring for dying people in England should adopt. It identified five priorities for care necessary to achieve good quality care in the last days and hours of life.

This approach doesn't set out a protocol or process that has directly replaced the LCP, but instead details the ways in which care for people who are dying

should be responsive to the overall needs and wishes of individuals and their families.

The five priorities for care are:

- 1. 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.**

A shortcoming identified with the LCP was that sometimes people were identified as dying without them or their families being told. This care priority emphasises the importance of a doctor sensitively explaining the dying person's condition and prognosis and ensuring that the person's wishes are respected. If the person lacks capacity, the views of loved ones should be taken into account when their doctor is deciding what is in their best interests.

The LCP review also found that labelling people as 'dying' caused problems because some patients recovered. As a result, this priority ensures that care in the last days and hours of life should be viewed as a 'continuum', with the needs of the patient being regularly reviewed.

- 2. Sensitive communication takes place between staff and the person who is dying and those identified as important to them.**

Sensitive, honest and clear communication between staff and the person who is dying is vital to deliver good care and to enable the person to express their wishes. The same sensitivity should be used in discussion with those close to the dying person and conversations should be adapted to meet their needs.

Regular communication should be maintained and staff should proactively offer information. What is said should be documented to prevent conversations being unnecessarily repeated. Staff should check that what they have said has been understood and should listen and respond to concerns. If they need it, the dying person must also be given support to understand information and communicate their wishes.

- 3. 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.**

Sensitive communication is needed to determine who the dying person would like to be involved in discussions and decisions about their care. The extent to which they themselves would like to be involved in these conversations should also be established.

The dying person and those important to them should always know who is in charge of their treatment and care. Healthcare professionals also need to make it clear whether a dying person or someone close to them is being informed or consulted about their treatment.

If the dying person lacks capacity to make a particular decision, the decision made or action taken on their behalf must be in their best interests, and they should still be involved as far as possible in that decision. Professionals must respect a valid and applicable Advance Decision. If the dying person has made a Lasting Power of Attorney for Health and Welfare, then the attorney should make a best interests decision for the person.

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

The fourth priority highlights the importance of establishing the needs of those close to the dying person who are faced with the loss of a loved one. It is important that the healthcare team acknowledge that the death of a loved one is hard, and also that loved ones feel involved and have a role in ensuring the dying person receives a good standard of care.

Any specific needs for support or information voiced by the family should be met as far as possible by the healthcare team.

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

Each individual must have a plan of care. This plan should include any wishes for care and any treatment preferences that the dying person may have. It should also include information on symptom control, such as pain relief, and detail the individual's emotional, social, spiritual, cultural and religious needs. The plan needs to be documented so that any information shared with those involved in their care is consistent. The care plans should be regularly reviewed and any change in the person's preferences should be noted.

The care plans should be easily available across care providers, including ambulance services, social services and out-of-hours GPs, to ensure continuity in treatment.

Planning for dying is part of good care. The individual should be involved in the planning process if they wish to be, and if so, they should be supported to do this.

Food and drink can be important to the dying person's psychological wellbeing. Patients should be offered food and drink orally, as long as it would not harm them (for example, if there was risk of choking).

Implementing the priorities

These priorities for care now take the place of the LCP in providing an approach to caring for people in the last days and hours of life. It is the responsibility of each organisation locally to decide how to implement the priorities into daily practice.

The LACDP states that all staff who have contact with dying people must have the skills to care for people effectively and with compassion. The organisations that deliver care are responsible for ensuring that staff receive adequate training and ongoing development to enable them to do this.

How can we help?

- Compassion in Dying can support you to understand and exercise your rights to make decisions about treatment and care at the end of life
- We can send you a free Advance Decision form and support you to make a Lasting Power of Attorney for Health and Welfare
- We provide a free and comprehensive guide *Planning Ahead: Making choices for the End of Life*

If you would like further information, or would like to find out more about end-of-life rights more generally, please call our free **Information Line** on **0800 999 2434**.

Factsheet code and version number	IN05 v4
Publication/last review date	Jan 2015
Review due	Jan 2018

A list of evidence sources is available on request from info@compassionindying.org.uk.

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