Liverpool care pathway is scrapped after review finds it was not well used

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The Liverpool care pathway for patients needing care at the end of life, though well intentioned and often admirably carried out, should be scrapped in favour of individualised care plans, says an independent review immediately accepted by the UK government.

Too often, the review found, the pathway was applied with a lack of expert knowledge and care, its advice turned into a set of rigid instructions by staff who had not been properly trained. Its very name suggested that it was a pathway with only one possible destination, “a conveyer belt to death,” it said. Hospitals were rewarded financially for using the pathway, creating the impression that they were hastening death for financial gain. All this must change, the review concludes.

The review, chaired by the rabbi and peer Julia Neuberger, makes few direct criticisms of the pathway itself apart from its name. In the right environment, and with the right staff, it had enabled many people to have a better death than might otherwise have been the case. But the team heard evidence that “disturbed and upset them,” Neuberger said, that while it might be good guidance it was not well used. The review concludes: “The Liverpool Care Pathway is being perceived by some of its users—doctors and nurses—not as a document, nor as a guideline, but most frequently as a set of instructions and prescriptions, that is to say a protocol.”

Families were often shocked to discover that their dying relatives had been put on the pathway without much consultation, over a weekend, and on the instructions of a junior doctor. Sometimes this involved the administration of powerful painkillers, even if the patient was not in pain, and the withdrawal of nutrition and hydration. Staff responsible for such poor care “thought they were doing the right thing,” Neuberger said at a press conference to launch the report on 15 July. “They thought they were obeying the guidelines.”

Yet the actual pathway, she said, had been based on good hospice care, and hospitals had been given extra money to introduce it as a way of providing better care for the dying. Dennis Cox, a GP who chaired the review’s clinical subgroup, said it had been a shame that the pathway had become a brand, but it had—and now the brand is damaged beyond fixing.”

In future, the review says, patients should be provided with an individual end of life care plan, supervised by a consultant and clearly communicated to patients where possible and to families where not, after open discussion. Different conditions would call for different plans, rather than a single “one size fits all” protocol.

Neuberger was asked how she could be sure that such plans would prove any more caring than the pathway they replaced. She replied, “We want a strategic approach involving regulators, the royal colleges, the General Medical Council, the Nursing and Midwifery Council, NHS England, and the National Institute for Health and Care Excellence.” Everybody should be involved, and hospital regulators should be tasked with ensuring that plans were properly organised and managed.

The review criticised the Nursing and Midwifery Council, which it said had never issued any guidance to those it regulates over use of the pathway.

The government responded by accepting the recommendations, promising that the pathway would be phased out over the next 6-12 months and calling on NHS England, along with clinical commissioning groups, to remove financial incentives immediately. Families with concerns would be given access to independent assessors, while hospital trusts should appoint one member of their board to review end of life care and any complaints arising from how it is delivered.

Norman Lamb, the care and support minister who commissioned the review, said, “I have personally heard families describe staff slavishly following a process without care or compassion and leaving people suffering at the end of their lives. This is something we cannot allow to go on.

“People’s final days should be as comfortable and dignified as possible. That is why there is a place for thoughtful and careful end of life care that involves patients and their families, but it is clear what we have now needs to be replaced so we can create a better way of doing this.”

NHS England and the Royal Colleges of Physicians and General Practitioners welcomed the review’s conclusions. Clare Gerada, chairwoman of the Royal College of General Practitioners, warned, however, of the danger of “throwing the baby out with the bathwater.” She said, “We need to take what has been shown to work from the existing pathway and make sure that it is implemented consistently across the country to ensure that all patients receive high quality and compassionate end of life care.”

Eve Richardson, chief executive of the National Council for Palliative Care and the Dying Matters Coalition, an umbrella organisation for those involved in palliative, end of life, and hospice care, said the recommendations had the potential to

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make “a real and much needed difference to the quality of care that people receive in the last days of their life.”

She added, “If further evidence were needed—after a series of critical reports ranging from the Francis inquiry [into failings at Mid Staffordshire NHS Foundation Trust] to last week’s National Bereavement Survey—that the current state of care for the dying needs to be dramatically overhauled and staggeringly different standards of end of life care urgently addressed, then this report undoubtedly provides it.

“There can be no excuse for not treating people with dignity, compassion, and respect when they are dying, at the very time that they most need this. It is essential that whatever follows the Liverpool care pathway must be developed in partnership with patients, carers, and staff to ensure better outcomes for people who are dying and their families.”


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