**EVIDENCE BRIEFING ON RECENT RESEARCH**

1. **Access to palliative care**
2. **Triggers to referral for cancer patients include ending of chemotherapy and radiotherapy; cancer patients that don't receive anti-cancer treatments are significantly less likely to access palliative care.**
3. **Triggers to referral for non-cancer patients include frequent unplanned hospital admissions though prognosis is not routinely discussed with these patients by acute care teams. Patients may be discharged with false hope and the expectation that GPs would address this.**
4. **Median contact time with palliative care teams before death for 4650 Leeds patients was 34 days to either community or hospital based services.**
5. **Contact time was significantly related to diagnosis (cancer = 37 days, non-cancer =16 days) and to age (< 50 years = 55 days, 50-74 years = 38 days, 75+ = 29 days).**
6. **There is a lack of patient materials available to support referral to palliative care; only 3 of the 31 oncology units in 20 hospitals across Yorkshire CRN region had information that highlighted benefits of palliative care.**

***KEY PRIORITIES:***

* *Enable earlier access to palliative care particularly for older patients and those with non-cancer diseases, or cancer patients that do not receive treatments*
* *Identify patients in primary care with chronic diseases that are increasingly frail and have frequent hospital admissions*
* *Support referral with better patient information that highlights benefits of palliative care*

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*Bennett MI, Ziegler LE, Allsop M, Daniel S, Hurlow A. What determines duration of palliative care before death for patients with advanced disease? A retrospective cohort study of community and hospital palliative care provision in a large UK city. BMJ Open 2016; 6(12):e012576* [*http://dx.doi.org/10.1136/bmjopen-2016-012576*](http://dx.doi.org/10.1136/bmjopen-2016-012576)

*Cheryl Craigs, Robert West, Adam Hurlow, Paul Carder, Michael I Bennett, Lucy Ziegler. Access to palliative care for patients with advanced cancer: A longitudinal population analysis. Eur J Cancer*

*Wyld L, Taylor SS, Ziegler L, Bennett MI. Patients understanding of palliative care, is the information good enough? A literature review and audit of information provision. Palliative Medicine*

1. **Access to pain management**
2. **National Survey of Bereaved People (VOICES) shows that in the last 3 months of life, pain control is poorest for patients cared for at home, and best for patients cared for in hospice.**
3. **Costs to CCGs of poor pain control are significant. Monthly costs of a cancer patient in pain at home: mild pain = £2437; moderate pain = £3146; severe pain = £3949.**
4. **Healthcare professionals remain fearful of initiating strong opioids for patients with advanced diseases, particularly in primary care, but are more confident when supported by expertise from palliative care teams.**
5. **In 6080 Leeds cancer patients, only 30% had received a strong opioid by 6 weeks before death; median treatment duration was 9 weeks.**
6. **Older patients were significantly less likely to receive an opioid. Patients who died in hospital were 60% less likely to have received a strong opioid in the community in the year before death than those who died in a hospice.**
7. **CQC now has standards for management of cancer pain which all NHS organisations are expected to meet that incorporate NICE recommendations on opioids.**

***KEY PRIORITIES:***

* *Improve pain control for patients cared for at home*
* *Support routine assessment of pain for patients with cancer and other advanced diseases and prompt access to appropriate analgesia*
* *Promote seeking of prescribing advice from specialist palliative care teams*

*National Survey of Bereaved People (VOICES): England. Office for National Statistics* [*https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/previousReleases*](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/previousReleases)

*Meads D, O’Dwyer J, Hulme CT, Chintakayala P, Vinall-Collier K, Bennett MI. Patient Preferences for Pain Management in Advanced Cancer: Results from a Discrete Choice Experiment. The Patient 2017*

*Gardiner C, Gott M, Ingleton C, Winslow M, Hughes P, Bennett MI. Attitudes of healthcare professionals to opioid prescribing in end of life care: a qualitative focus group study. J Pain and Symptom Management 2012; 44(2):206-14* [*http://dx.doi.org/10.1016/j.jpainsymman.2011.09.008*](http://dx.doi.org/10.1016/j.jpainsymman.2011.09.008)

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*CQC Key Core Standards for Pain Management.* [*www.cqc.org.uk*](http://www.cqc.org.uk)

*Bennett MI, Graham J, Schmidt-Hansen M, Prettyjohns M, Arnold S. Prescribing strong opioids for pain in adult palliative care: summary of NICE guidance. BMJ 2012;344:e2806.* [*https://doi.org/10.1136/bmj.e2806*](https://doi.org/10.1136/bmj.e2806)

1. **Support for self-management of pain**
2. **Patients want support for self-management and frequently trade-off pain against drug side effects in order to reduce interference in daily living.**
3. **Cancer patients with pain rank good communication and information more highly than access to healthcare professionals, and would rather see a specialist nurse than a GP.**
4. **Providing written information that addresses fears about pain and opioids, and gives practical advice on medicines management and explains how to access help, can reduce pain intensity more than paracetamol or gabapentin.**
5. **Pharmacist-delivered New Medicines Service for patients starting strong opioids is acceptable and feasible but needs further refinement.**
6. **Electronic pain and symptom monitoring appears effective in earlier stages of cancer but its place in palliative care is yet to be established.**
7. **Integrating simple interventions delivered by community palliative care nurses in routine care is feasible and currently being evaluated in multicentre RCTs co-ordinated from Leeds.**

***KEY PRIORITIES***

* *Determine effectiveness of implementing self-management interventions in routine palliative care that increase self-efficacy and reduce interference from pain*
* *Support NICE guidance on providing written information when initiating strong opioids*
* *Support greater access to specialist palliative care nurses or NMS trained pharmacists*

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*Savage I, Blenkinsopp A, Closs SJ, Bennett MI. Like doing a jigsaw with half the parts missing: community pharmacists and the management of cancer pain in the community. International Journal of Pharmacy Practice 2013;21(3):151-60* [*http://dx.doi.org/10.1111/j.2042-7174.2012.00245.x*](http://dx.doi.org/10.1111/j.2042-7174.2012.00245.x)

*Allsop M, Taylor S, Mulvey MR, Bennett MI, Bewick B. Information and communication technology for managing pain in palliative care: a review of the literature. BMJ Supportive and Palliative Care 2015;5:481-489* [*http://dx.doi.org/10.1136/bmjspcare-2013-000625*](http://dx.doi.org/10.1136/bmjspcare-2013-000625)

*Hughes N, Closs SJ, Bennett MI. Supporting self-management of pain by patients with advanced cancer: Views of palliative care professionals. Supportive Care in Cancer 2016;24(12):5049-5057* [*https://dx.doi.org/10.1007/s00520-016-3372-2*](https://dx.doi.org/10.1007/s00520-016-3372-2)

*Bennett MI, Mulvey MR et al. Self-Management of Analgesia and Related Treatments at the End of life (SMARTE) HTA report. National Institute for Health Research 2017*

1. **Advance care planning**
2. **Advance care plans reduce hospitalisations and increase satisfaction with care.**
3. **EPaCCS may simply reflect clinical activity rather than stimulate advance care planning but more detailed evaluation is needed.**
4. **Prescribing of anticipatory drugs for end of life care is recommended by NICE.**
5. **National activity of non-medical (nurse) prescribers in palliative care has doubled since 2012 and is increasingly focused on pain management, though contribution to all community palliative care prescribing remains very low.**

***KEY PRIORITIES***

* *Increase uptake of advance care plans for people with advanced diseases*
* *Understand role of EPaCCS further to determine effectiveness in routine care*
* *Facilitate non-medical prescribing activity by specialist nurses by enabling electronic prescribing linked to local pharmacies*

*Brinkman-Stoppelenburg A, Rietjens J, van der Heide A. The effects of advance care planning on end-of-life care: A systematic review . Palliative Medicine 2014; 28(8);1000–1025* [*https://doi.org/10.1177/0269216314526272*](https://doi.org/10.1177/0269216314526272)

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*Ziegler L, Bennett MI, Blenkinsopp A, Coppock S. Non-Medical Prescribing in palliative care: a regional survey to explore analgesic practice. Palliative Medicine 2015; 29(2):177–181* [*https://doi.org/10.1177/0269216314557346*](https://doi.org/10.1177/0269216314557346)

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*Ziegler L, Bennett MI, Mulvey M, Hamilton T, Blenkinsopp A. Palliative care prescribing in England; analysis of medical and non-medical activity 2011-2015.BMJ*

1. **Improving outcomes at end of life**
2. **In 2480 Leeds patients that died from cancer 2013-2014, 65% received at least one contact with palliative care services.**
3. **Patients that received palliative care were significantly more likely to avoid emergency admission to hospital in last 4 weeks of life and stop chemotherapy earlier compared to patients that did not receive palliative care.**
4. **Patients that received palliative care doubled the chance of accessing a strong opioid (53% versus 25%), and almost halved the risk of dying in hospital (23% versus 40%).**
5. **There was a clear dose-response relationship; for each cumulative contact or week with palliative care, a patient increased their odds of improved outcomes at the end of life.**
6. **The minimal effective dose of palliative care to avoid emergency admission, access a strong opioid and avoid hospital death was relatively minimal: two contacts initiated at least four weeks before death.**

***KEY PRIORITIES:***

* *Commission or support earlier contact with palliative care integrated alongside cancer management*
* *Determine applicability of this evidence for non-cancer diseases or undertake further research in key populations such as COPD or heart failure*
* *Use metrics derived from routinely collected data to monitor improvements in access to palliative care and outcomes*

*Ziegler L, Craigs C, West R, Hall G, Carder P, Hurlow A, Millares-Martin P, Bennett MI. What is the optimum duration and intensity of palliative care for patients with advanced cancer? A longitudinal population cohort study. Journal of Clinical Oncology 2017*

*Temel JS, Greer JA, Muzikansky A, Gallagher ER, Admane S, Jackson VA, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. The New England journal of medicine. 2010;363(8):733-42.* [*https://dx.doi.org/10.1056/NEJMoa1000678*](https://dx.doi.org/10.1056/NEJMoa1000678)

*Smith TJ, Temin S, Alesi ER, Abernethy AP, Balboni TA, Basch EM, et al. American Society of Clinical Oncology provisional clinical opinion: the integration of palliative care into standard oncology care. Journal of clinical oncology: official journal of the American Society of Clinical Oncology. 2012;30(8):880-7.* [*https://dx.doi.org/10.1200/JCO.2011.38.5161*](https://dx.doi.org/10.1200/JCO.2011.38.5161)