

# Palliative medicine

## A Impact 1: large number of patients dying from influenza need acute end-of-life care in hospital and community

### Implications

- ▶ Community end-of-life care will be led by primary care teams.
- ▶ Involvement of specialist palliative care teams will be mainly through provision of advice rather than face-to-face input.
- ▶ Palliative care teams will support end-of-life care for those admitted to hospitals.
- ▶ Access to syringe-drivers and supplies of oxygen for symptom support in communities will rapidly be exhausted.

### Proposed response

- ▶ Community teams should be provided with palliative care resource packs, not yet developed nationally.
- ▶ The use of non-injectable parenteral routes for medication, including buccal/rectal, should be maximised.
- ▶ A programme of rapid training for carers should be instigated.
- ▶ Pharmacy services should be extended.

### Planning

#### *Now*

- ▶ Develop criteria for an end-of-life integrated care pathway to be used in those dying from influenza.
- ▶ Develop resource pack with medication for symptom management.
- ▶ Develop brief training package for carers to administer the medications.

#### *Pandemic imminent*

- ▶ Ensure that care teams have local 24-hour access to drug supplies/resource packs.

## B Impact 2: increased demand upon palliative care services by non-influenza cases

In the event of an influenza pandemic it is anticipated that palliative care teams, in addition to caring for patients with influenza, will face an increased workload from non-influenza cases.

Factors will include:

- ▶ existing patients with palliative care needs who cannot access secondary care in crisis

- ▶ palliative care services are referred additional patients who cannot access hospital care as they do not meet the criteria for admission
- ▶ palliative treatments (eg chemotherapy, transfusion drainage of effusions) may be limited or curtailed with additional need for community support.

### Implications

- ▶ Hospital palliative care teams will be required to facilitate patients' early discharge from hospital if they were already in hospital at the start of the pandemic.
- ▶ Uncontrolled/complex problems have to be managed at home/hospice.
- ▶ There will be increased numbers with distress beyond the 'usual' palliative care population.
- ▶ There may be limited access to syringe-drivers for symptom support in community, and limited or unsustainable number of staff available to supervise use.
- ▶ There will be increasing demand on hospice beds.

### Proposed response

- ▶ Enhance availability of 24-hour palliative care advice by telephone for professionals and patients/relatives.
- ▶ Increase domiciliary services to support those with complex needs at home.
- ▶ Reconfigure specialist palliative care services, for example:
  - maintain hospice beds
  - close hospice beds and staff support community care including nursing home beds
  - possibly redeploy hospital teams into the community.
- ▶ Maximise the use of non-injectable parenteral routes for medication (buccal/rectal) where possible, but the training of carers should include giving injections.
- ▶ Provide additional home palliative care packs link to extended pharmacy services.

### Planning

#### *Now*

- ▶ Local palliative care lead should develop plan with flu pandemic coordinator at primary care trust.
- ▶ Agree nominated hospice beds to provide palliative care resource for locality.
- ▶ Agree local system to prioritise access to inpatient beds.
- ▶ Agree system to prioritise workload in the community.
- ▶ Develop palliative care resource pack and brief training for carers.

#### *Pandemic imminent*

- ▶ Ensure the list of staff with community experience, nurse prescribers etc is up to date.
- ▶ Ensure local 24-hour access to palliative care drugs/resource packs.

## **C Impact 3: depletion of existing specialist palliative care teams (up to 50% become ill)**

### **Implications**

- ▶ Try to conserve enough fit staff at any time to support essential activities.
- ▶ Maximise use of experienced/trained staff contacts who may be drafted into action.
- ▶ Ensure staff take appropriate steps to reduce risk of acquiring or transmitting infection.
- ▶ Reconfigure services temporarily to provide support where most needed.

### **Proposed response**

- ▶ Staff should be trained in infection control measures.
- ▶ Increase available supplies of antiviral/immunisation drugs and face masks.
- ▶ Cancel non-essential activities: teaching, lymphoedema, day hospice respite care services.
- ▶ Consider switch from inpatient hospice care to community support model (see also Impact 2).

### **Planning**

#### *Now*

- ▶ Identify palliative care leads for each locality to work with flu pandemic coordinators.
- ▶ Provide flu pandemic training programme for palliative care teams.
- ▶ Prepare staff lists to include retired/bank/volunteer contacts with specialist palliative care experience.
- ▶ Agree plans for use of services within each locality.

#### *Pandemic imminent*

- ▶ Distribute supplies, antivirals, face masks, disposable respirators.
- ▶ Review/update contact lists.
- ▶ Modify services.

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