

Palliative care in a changing treatment landscape



<https://uk.pinterest.com/pin/arran-from-ayr-beach--73676143879263825/>

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Session intended learning outcomes

By the end, participants should be able to:

- | | | | |
|----|-------|---------------------------|---|
| 01 | _____ | Understand scope | Explain palliative care as early, holistic support for people with cancer and other life-limiting conditions. |
| 02 | _____ | Outline change | Describe how modern treatments create varied, uncertain regimes and trajectories. |
| 03 | _____ | Reflect on support | Identify practical approaches for staff living with life-limiting conditions and for their managers. |

What does the word “palliative” make you think of?

When does palliative care begin?

- A. During the last 48 hours of life
 - B. When curative treatment has stopped
 - C. When a patient is diagnosed with a serious or life-limiting illness
 - D. Six months before death is expected
 - E. Only after referral to a hospice service
-

According to NHS England, when does end of life care generally apply?

- A. The last 48 hours of life
 - B. The last 30 days of life
 - C. The last 6 months of life
 - D. The last 12 months of life
 - E. After all active treatment has stopped
-

What is Palliative care?

Palliative care aims to improve quality of life by preventing and relieving suffering across physical, psychological, social and spiritual domains.

Physical
symptoms,
function,
treatment toxicity

Psychological
anxiety, mood,
uncertainty

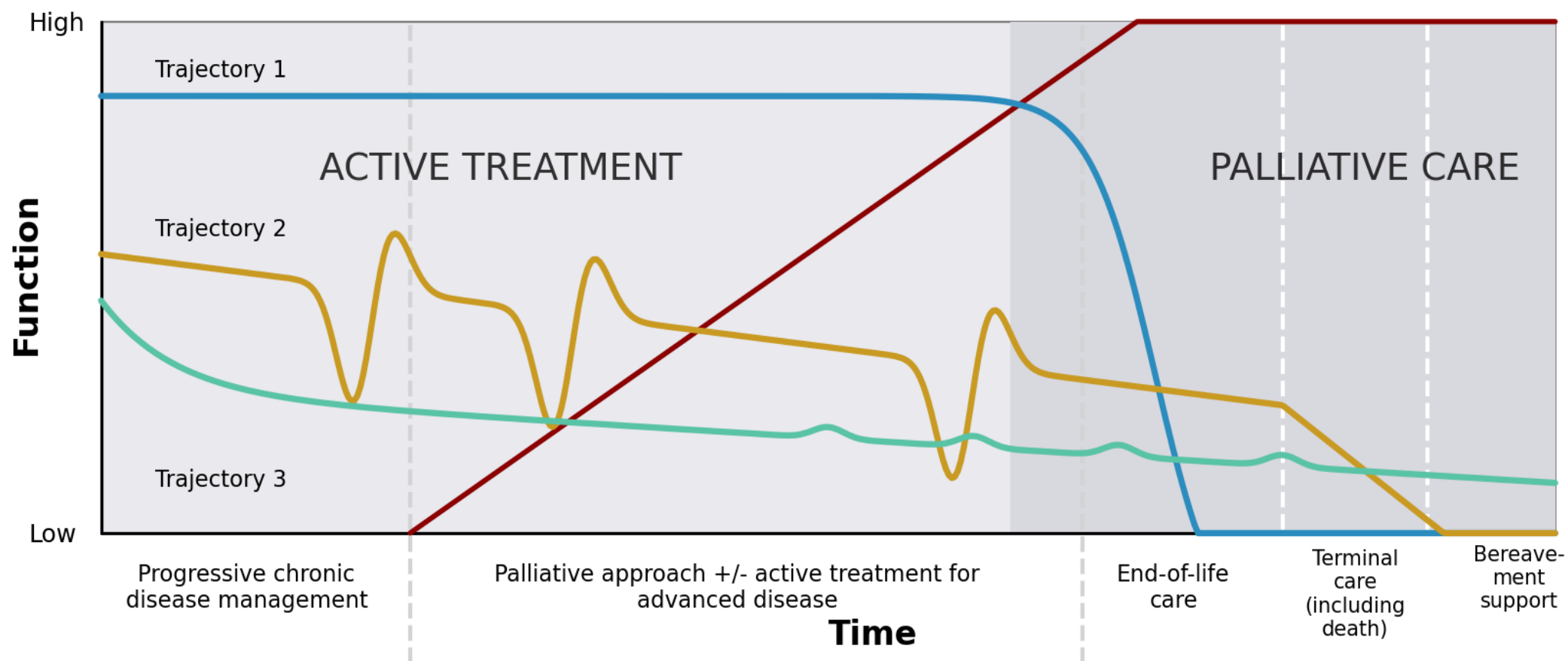
Social
family, finance,
roles, work

Spiritual
meaning, values,
what matters



Common misconception: “palliative” means stopping active treatment. In practice, it can be concurrent, incremental and revisited.

The landscape has shifted: from linear decline to variable trajectories



Case study

42 year old

Colorectal cancer - on palliative systemic anticancer treatment (SACT)

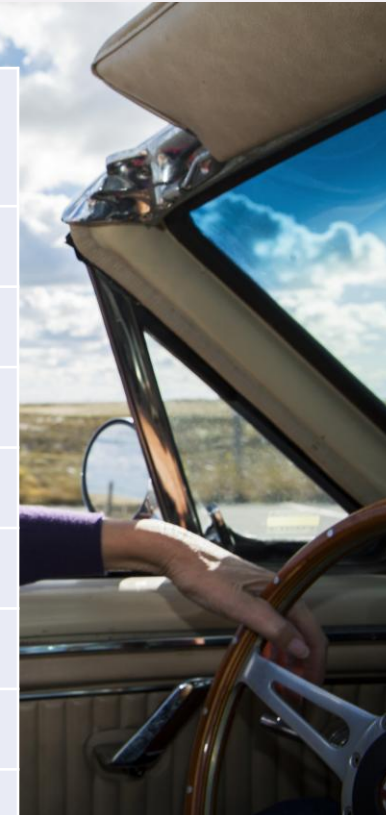
Prognosis 18 months

Working

Drugs and driving

Can sally drive?

'Medicinal' drugs (risk based approach)	Threshold limit in blood
clonazepam	50µg/L
diazepam	550µg/L
flunitrazepam	300µg/L
lorazepam	100µg/L
methadone	500µg/L
morphine	80µg/L
oxazepam	300µg/L
temazepam	1,000µg/L



Why treatment regimes vary

Treatment is shaped by disease biology, patient context, available services and changing goals.

Disease factors

tumour type
stage and
trajectory
biomarkers
comorbidities

Treatment intent intent

curative
disease control
symptom relief
trial participation

Regime burden

oral / IV /
radiotherapy
frequency and travel
toxicity profile
monitoring needs

Person context

values and priorities
family and carers
work and finance
capacity and consent

PALLIATIVE CARE CONTRIBUTION

clarify goals

make choices
visible and
flexible

manage
symptoms
anticipate
toxicity and
escalation

coordinate care
joint oncology,
primary care,
community and
and palliative
care

support family

address carer
strain and
bereavement risk

Generalist and specialist palliative care work as one system

Specialist palliative care

complex symptoms • complex decisions
• family / spiritual distress

Shared care

oncology / disease team • primary
care • community teams • hospice

All clinicians

routine symptom enquiry • honest
communication • values-based

REFERRAL TRIGGERS

- 01** symptoms remain uncontrolled despite usual management
- 02** unresolved distress, conflict or uncertainty about goals
- 03** recurrent admissions or escalating care needs
- 04** carer strain, safeguarding or complex family needs
- 05** rapid change, dying phase, or need for anticipatory planning

Parallel planning: active treatment and future care planning together

Disease-directed treatment

●
tests • treatment cycles • toxicity review • response assessment ●

Symptom and wellbeing support

●
pain, breathlessness, fatigue • psychological support • rehabilitation

Future care planning

●
what matters • escalation decisions • place of care • key contacts

Conversation prompts

“What are you hoping this treatment will do?”
changed quickly, who should we call?”

“What worries you most?”

“If things changed quickly,

When the person living with serious illness is illness is also a colleague

Core stance

The colleague remains the expert in what they want shared, what support helps, and how work fits with treatment and life priorities.

Privacy

agree who knows what, and when

Flexibility

hours, location, duties, duties, appointments appointments

Continuity

planned contact and review points

Agency

ask before assuming capability or wishes

Safety

risk assessment

Team impact

support workload and emotions without disclosure

Managers: a practical support rhythm

Good support is not a single conversation; it is an agreed pattern that can change.

1

Listen

Start with open questions. Agree what the colleague wants kept confidential.

2

Plan

Document contact preferences, work priorities, adjustments and escalation routes.

3

Adjust

Use HR / occupational health, health, risk assessment and flexible working options.

4

Review

Set a cadence; treatment effects and personal goals can change quickly.

Manager questions: “ What would a good week at work look like for you now?”

Reflection: support the supporter

Assumptions

What might I be assuming about prognosis, capacity or what “support” means?

Boundaries

What is mine to hold — and what needs HR, occupational health, clinical health, clinical or peer support?

Equity

How would we make comparable support available for non-cancer non-cancer life-limiting illness?

Communication

How will we protect confidentiality while keeping the wider team safe team safe and informed?

Action

What is one change we can make this month to reduce crisis-only support?

Key messages

Early and parallel

Palliative care can start alongside active treatment and evolves with need.

Integrated and coordinated coordinated

Generalist skills plus specialist input reduce gaps and crisis referrals.

Holistic and practical

Physical, psychological, social and spiritual issues are part of care.

Compassionate workplaces workplaces

Staff with serious illness need privacy, privacy, agency, flexible support and review.

Selected sources

WHO palliative care fact sheets (global and Europe); NICE NG142 End of life care for adults: service delivery; NICE NG31 Care of dying adults in the last days of life; ASCO 2024 Palliative Care for Patients With Cancer guideline update; EAPC 2022 standards and norms; NHS England personalised cancer care and heart failure palliative framework; Macmillan work and cancer resources; ACAS / GOV.UK / HSE reasonable adjustments guidance.

Thank you