



Research

NEWS

September 2015

For more information about any of the articles contained within this newsletter please contact: idalizanukis@loros.co.uk

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Issue N^o 8

In August, LOROS was fortunate to welcome Dr Ros Taylor MBE, National Director for Hospice Care. Dr Taylor met with Professor Christina Faull, Research Lead at LOROS, and in this article shares her thoughts on the development of research at LOROS....

Dame Cicely Saunders identified research as one of the three vital pillars of hospice care – care, education and research! Research has been the last pillar to be taken up more widely by hospices but we are at a really exciting crossroads. LOROS has demonstrated exactly how a hospice can take the research agenda forward and I was really excited to read the latest Research Impact Report: [CLICK HERE](#)

It feels as though the whole of LOROS is now behind the research agenda with resources, training and commitment to building the evidence base for hospice care. This is in line with the NHS research focus which has stepped up with the inclusion of a 'duty' to research in the Health and Social Care Act 2012.

Thank you all for what you are doing – it will make a difference to many patients and families

It has been said that hospices can no longer rely on a 'drawer full of thank you letters' to demonstrate the impact that we make to patients and families. Thank you letters are very important but they are only one corner of the impact triangle. The other two corners, beyond patient experience, are outcomes where we specifically measure the difference we make to individuals, and evidence – proper research in groups of patients and families conducted in a systematic and rigorous way.

Hospices are ideally placed to lead and collaborate on research projects – we have access to thousands of patients and families and we now know that taking part in research is often a very meaningful task for patients and families as they face the end of their lives. Professor Irene Higginson is

ensuring that palliative care becomes a specialty recognised by the National Institute of Health Research and this will make a difference as there will be more resources to support palliative research nationally.

There is currently a shocking lack of investment nationally in palliative research – just 10p in every £100 spent on medical research is spent on end of life research. Dr Katherine Sleeman spoke about this very powerfully at the Hospice UK Conference last year: [CLICK HERE](#)

So its good to see that hospices are investing their hard-earned funds into work that will drive palliative care forward.

Hospice UK has a vision, building on the Commission into the Future of Hospice Care, that hospices cluster together around an academic centre and share research posts, share recruitment to projects and share the understanding and knowledge that contributes to good practice. LOROS is leading the way with its collaboration with De Montfort University and we hope to widely share their resources with other hospices to inspire them to take the next steps.



Professor Christina Faull, welcomes Dr Ros Taylor MBE to LOROS (Right)

LOROS

Hospice Care for Leicester, Leicestershire & Rutland

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Being there for you
and your family



In March, LOROS welcomed a new Chief Executive: John Knight joined us from the Isle of Man, where he had worked for fourteen years as CEO of the charitable organisation The Children's Centre. In this article, John shares some of his initial thoughts on the value of the growing research activity at LOROS...

It is a great privilege to have been offered the position of Chief Executive of LOROS and I am now beginning to feel 'settled in' after my first 6 months.

The fact that LOROS champions research resonated with me from the moment I became aware of the organisation. I firmly believe that the most successful bodies are those that are inquisitive, forward facing and proactive in developing practice and provoking thought. Some time ago my own MBA dissertation was researching and reviewing the 'Preparation for Political Leadership' in the Isle of Man. Although this was a comparatively brief study it did expose me to the fascinating world of research.

I find myself to be naturally intrigued by the area of 'impact'. It is a challenging concept - being able to capture and measure the benefits and improvements created by a new way of working. It is vital to recognise that standing still in this fast moving world may often actually mean we're going backwards!

The research work undertaken at LOROS is clearly growing in its significance year upon year. The '2011-2014 Impact Report' shows the increasing participation in research activities by staff team members and patients. It also gives some clear examples of impact generated both within and outside of LOROS, the growth in beneficial

collaborations and the considerable amount of funding that has been successfully drawn in to support research activity.

All of this only helps to ensure that LOROS is forward facing, endeavouring to be at the forefront of new ideas and ultimately supporting the on-going commitment to excellence in palliative care that lies at the heart of the charity.

If you would like to read the LOROS Research 'Impact Report, 2011-2014: [CLICK HERE](#)

Time for ACTION

A phase III multicentre cluster randomised clinical trial to assess whether the Respecting Choices Program improves quality of life and symptoms of patients with advanced cancer

...By Glenys Caswell

Advance care planning (ACP) is a formalised process of communication for future care planning between patients, relatives and professional caregivers. ACP enables patients to express their views, values and treatment choices for their future care.

The European wide ACTION project is studying the effect of ACP in patients with cancer.

In total, 1334 patients will be recruited, with either advanced lung or colorectal cancer. Patients will receive either ACP or 'care as usual' and the self-reported quality of life and other relevant outcomes of these two groups will be compared.

ACTION involves 20 hospitals in 6 countries, including the UK. Leicester is a 'care as usual' site, and LOROS is acting as a centre for identifying

patients who are eligible to take part. Christina Faull is the local principal investigator.

Aidan Dunphy and Karen Lord are the research nurses who are recruiting patients by liaising with clinical teams. Support is provided from the University of Nottingham by Jane Seymour, Kristian Pollock and Glenys Caswell.

ACTION began in December 2013 and will continue until the end of 2018.

If you have any questions or would like to learn more about the study, please contact the research nurses, Aidan or Karen on: 0116 258 6499 or 07940 001 674

For information about the Respecting Choices Programme: [CLICK HERE](#)



Members of the European Research Team for ACTION

Second from right: Professor Sheila Payne, from Lancaster University, who is leading the project
Centre: Professor Jane Seymour, from Nottingham University who is Principle Investigator

Dr Julie Fish, Professor of Social Work & Health Inequalities at De Montfort University, shares findings from her recent study looking at the

cancer journey for LGBT people



The Mary Seacole Research Centre at De Montfort University have released the

report of their recent research into aspects of the care and treatment experienced by lesbian, gay and bisexual (LGB) people diagnosed with cancer.

The study found that there were specific issues and concerns experienced by LGB patients as they negotiated the journey through their cancer diagnosis and treatment. Many of these concerns related to disclosing their sexual orientation to medical professionals, and to dealing with the possibility of discrimination in the hospital environment. It also found that there is a lack of formal support groups and targeted health information for LGB people with cancer.

More than two million people in the UK currently live with cancer. It is estimated that 40,000 of these are LGBT people. International research shows that LGBT people are at a higher risk of being diagnosed with certain types of cancer than the remaining population, and the Department of Health Cancer Patient Experience Survey (CPES) revealed some differences in the quality of care, and in the interactions of LGB patients with cancer professionals in the NHS.

In comparison to heterosexual survey respondents, LGB people reported less positive patient experiences in relation to four over-arching domains: accessible information, psychosocial support, the human rights concerns of dignity and respect, and management of pain.

Researchers identified three over-arching themes that had concerned LGB cancer patients during their treatment journey. The first concern was whether or not it was

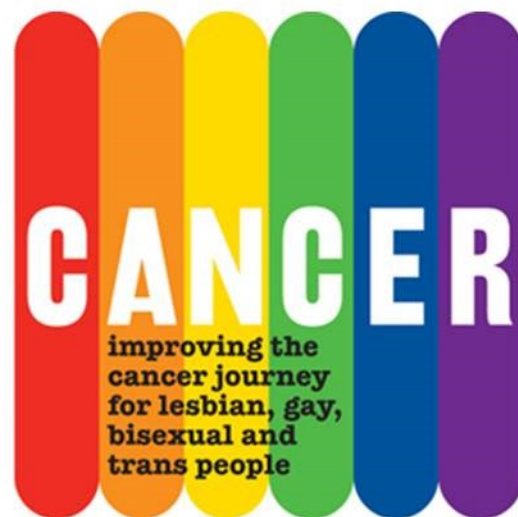
relevant to disclose their sexual orientation to medical professionals.

Previous research suggests that there are benefits and risks associated with both disclosure and non-disclosure in the case of treatment for cancer. The main drawbacks of non-disclosure are known to be that LGB people's health may be negatively affected; they may be subject to inappropriate questioning; irrelevant health information may be provided; and they may experience anxiety about inadvertently revealing their sexual orientation in the healthcare setting. Disclosure on the other hand is seen to lead to LGB patients being more satisfied and comfortable with the care they receive; they experience greater ease in communicating with their doctor; and they allow for the possibility of including their same-sex partner in treatment decisions.

Nine of the 17 study participants disclosed their sexuality, explicitly, to medical or nursing staff during the consultative or investigative period of their treatment. For many of them, their thoughts focussed on how the professional might react to them. They tried to anticipate how they might respond if the professional was embarrassed or uncomfortable. One participant experienced explicit animosity from a doctor but a significant number expressed the feeling that disclosing their sexual orientation led to a more positive experience

Secondly, subtle discrimination within the hospital environment was something that some participants experienced during their cancer journey. One participant discussed how he became aware of hospital staff expressing non-verbal disapproval of his sexuality:

You pick up very quickly that you are deemed not to be approved of, for want of a better term, and we picked that up straight away.



Another participant felt uncomfortable in asking certain questions relating to sexual behaviour because of concerns about the responses he may receive:

I didn't feel comfortable asking all the ins and outs about the sexual side of things. I think if I'd known that the consultant sitting opposite me was gay I would've been completely open but I suppose really I didn't want any negative reaction.

The third recurring theme was the ability to find benefit from the experience of dealing with cancer, despite it being a negative and often frightening and challenging life event. The research found that this was particularly so for patients who had the support of a partner during their care, with the cancer diagnosis acting to strengthen their relationship and bring them closer together.

Several recommendations for healthcare practice have been made, including encouraging equality for LGBT people right the way through the cancer journey and ensuring that medical curricula on qualifying programmes includes content relevant to LGBT care. It is recognised that the most helpful care and support for LGBT cancer patients is accessed mainly through LGBT specific cancer support groups and some mainstream cancer charities, and that these need to be supported to provide more access for patients UK wide.

It is envisaged that the findings will be used to inform further research and as evidence to underpin work to ensure that sufficient support, advice and consideration is provided for cancer patients who are LGB, or transgender (T).

To read the full report:

[CLICK HERE](#)



If you would like to hear more about Dr Fish's study, she will be delivering a Cup O' Learning session at LOROS on 1st October...For more details, see our Dates for the Dairy page



Issue N°3 of our newsletter featured an article on a new project, looking at communication: VERDIS aims to analyse the conversations of real patient and doctor consultations and evaluate their use as teaching resources for professionals.

Two years on, and the study is progressing very well...we would like to thank Becky, Laura and Joe (members of the VERDIS research team), for their following updates...

Piloting the new 'Real Talk' training resource

...Becky Whittaker, Assistant Professor of Palliative & End of Life Care, University of Nottingham

Stage two of the VERDIS project is nearly complete. A total of 37 consultations were recorded in the outpatient, inpatient, and day therapy services. Recordings involved 37 patients, 17 accompanying relatives/friends, and 5 experienced palliative care doctors. These recordings are now being analysed by the research team who will report on a range of topics including: communication practices between experienced doctors, patients and relatives; talking about and making plans for future scenarios; negotiating decisions where the doctor's and the patient's preferences differ; what empathy looks like and does in practice; and how patients and doctors communicate about the nature of pain.

An exciting development in the project is launch of the 'Real Talk' training resource which is designed for use in face to face training events. The aim of Real Talk is to provide guidance for good practice in



video-based research on healthcare communication. The DVD resource captures clips from the recordings which are presented as scenarios, based around cases where doctors and patients move towards talking about the patient's illness progression and end of life, and in cases where patients ask 'how long have I got' questions.

Becky Whittaker, Assistant Professor at the University of Nottingham and an

experienced educator, has joined the VERDIS team to pilot Real Talk. We aim to involve approximately 40 experienced communication skills trainers across the UK in healthcare communication training events up to December 2015. The pilot provides an opportunity to evaluate the usability and acceptability of Real Talk via a mixture of semi-structured interviews, observations and questionnaire survey.

We are looking for additional trainers to pilot the materials.



Please email Becky at verdis@nottingham.ac.uk if you are interested in finding out more.



VERDIS welcomes Laura Jenkins...

Conversation Analysis to describe in detail how children express pain during family mealtimes, and the ways in which parents' responses deal with how severe the pain is and how to manage it.

Research has been balanced with her own family life; Laura had her first daughter in the final months of her PhD, and her second daughter a few years later when she was undertaking a project in communication and medical settings at the University of Sheffield. This research involved using Conversation Analysis to teach doctors

to design their questions so that patients have more chance to talk about their seizures in ways that give clues as to what is causing them.

Laura joins the VERDIS study which is looking at video-based communication research in supportive and Palliative Care. She will work part-time for 22 months, particularly focusing on episodes in which doctors and patients talk about pain and pain relief.

Laura Jenkins has a background in psychology, with a particular interest in issues to do with health and communication. During her PhD at Loughborough university, she used

Continued...
Page 4

Joe Ford: Analysis work on 'Empathy'

VERDIS *continued...*



I am a PhD student

in the Department of Social Sciences at Loughborough University. This department has a strong tradition of analysing real-life interactions to see how they unfold. It was through this that I became involved in the VERDIS research project, which is using recordings of actual palliative care consultations to look at how doctors and patients communicate. Based on this, training will be given to other

My role within the VERDIS project is to analyse empathy, which can be defined very broadly as the doctor understanding what the patient is experiencing

palliative care doctors on how they might improve their communication skills.

In practice, this has entailed going through the recorded consultations, making notes on empathic moments, and analysing how and why empathy is done by doctors. So far, I have observed two types of empathy. The first involves empathy being used to respond directly to patients who are talking about their emotional distress or their physical difficulties. The second involves empathy being used proactively in the process of, for example, recommending a treatment (i.e. the doctor suggests that a particular treatment would be good for the patient because they



know how tough things are for the patient). I am currently in the process of expanding upon these findings and hope to begin publishing them in the near future.

To link to the latest VERDIS newsletters, and keep up to date with recent publications and findings from the project [CLICK HERE](#)

Withdrawal of assisted ventilation at the request of a patient with MND: Informing practice, transforming care

Over the past 4 years I have been immensely privileged to lead work to understand the experiences of family and professionals who have supported patients with MND, who are dependent on assisted ventilation and decide that the treatment is no longer benefitting them. I shall never forget the first patient who asked me to stop their ventilation and manage their breathlessness in a different way. This happens quite rarely but is a complex and very challenging area of care. I am profoundly indebted to several patients and their families that have encouraged me to take forward research in this area.

Funded by LOROS and the Motor Neurone Disease Association, I have worked with Kay Phelps and Emma Regen at the University of Leicester to analyse the experiences of 17 family



Kay Phelps and Emma Regen (Right)

members and 50 medical, nursing and allied health professionals from across the UK. Our findings, which are the first in the world of literature, revealed considerable need for improvements in care. As a result of this I have chaired a multi-professional group to develop National Guidance which will be published later this year by the Association for Palliative Medicine of Great Britain and Ireland.

To read the latest publications from the study, click on the links below:

Faull C, Rowe-Haynes C, Oliver D. 2013. The issues for palliative medicine doctors surrounding the withdrawal of NIV at the request of a patient with MND: a scoping study. *BMJ Supportive and Palliative Care* doi:10.1136/bmjspcare-2013-000470 [CLICK HERE](#)

Faull C, Rowe-Haynes C, Phelps K, Regen E, Oliver D, McDermott C. 2012. Withdrawal of Ventilation at the Request of a Patient with Motor Neurone Disease. A Retrospective Exploration of the Experience of Doctors, Non-Medical Health Professionals and Close Family [CLICK HERE](#)

Clinical Genetics in a Palliative Care Setting

Lisa Ingleby, a first year trainee on the Clinical Psychology Doctorate course at Leicester University, approached the research team in September 2013, hoping to recruit staff participants through LOROS, for her qualitative study: *Clinical Genetics in a Palliative Care Setting*:

A Qualitative Exploration of the Barriers and Levers Staff Report when Discussing Family Risk. Lisa is now in the process of completing her thesis, and here shares a brief overview of key findings from her study:



Palliative care settings represent a final opportunity for those in end of life care to provide genetic material needed to offer prediction of genetic risk for successor generations; referrals from hospice care

clinicians appear low relative to community prevalence rates of genetic susceptibility and final opportunities may be being missed.

My study aimed to gain an understanding of the awareness of hospice staff regarding genetic testing and pathways to clinical genetics, and to explore potential barriers and levers to discussing genetic risk with families in a hospice context.

The research sought to develop an understanding of what promotes or prevents staff discussions regarding familial risk with patients during end of life care.

Participants' comprised 13 hospice staff members of whom 12 were female. A broad range of professional disciplines were represented. Experience of working in the hospice ranged from six months to 23 years. The study was qualitative and used semi-structured interviews and vignettes to explore the main issues. Thematic Analysis was utilised to draw out main themes and concepts (*see diagram).

Four main themes and eight sub-themes emerged from the project:

1. Values and Ethos of Hospice Care

- 1a. Priority of Dying
- 1b. Providing Comfort and Alleviating Distress

2. Concord and Discord

- 2a. Causing Distress
- 2b. Impact of Staff's own Experiences
- 2c. Potential for Negative Affect in Staff

3. External Levers and Barriers Beyond the Self

- 3a. Prompts to Discuss
- 3b. Knowledge and Education
- 3c. Existing Systems

4. Integrating Clinical Genetics into Practice

While exercising appropriate caution regarding the methodological limits of the present study, some useful areas for development have been revealed:

Addressing Intervention at Multiple Levels

The wider evidence regarding implementation of novel areas suggests that the complex and at times ethically challenging area of clinical genetics should be addressed at multiple levels to become successfully integrated into palliative care.

Increasing the Knowledge Base

Concerns about lack of knowledge and education in relation to the area of clinical genetics was apparent across all professional groups and this appears to be one area where clinical genetics services could provide training to increase confidence in knowing who, when and where to refer potentially affected patients. This could assuage concerns about making errors in discussions with patients. It may be helpful for this additional factual knowledge to be linked to other areas of practice where difficult topics are broached such as discussing preferred place of death.

Building Relationships between Services

The relational context of delivering palliative care appears to be as significant to the multi-disciplinary team as it is to patient care. The results of the present study indicate a need to promote and nurture the more relational aspects of collaborative working to encourage more informal exchanges between clinical genetics and palliative care staff.

Keeping Clinical Genetics Prominent in Palliative Care Agenda

To ensure continued awareness of genetic issues, regular training as well as promoting opportunities for colleagues from different teams to 'shadow' each other are potentially useful. Services may find it helpful to include clinical genetics as an agenda item during multi-disciplinary team meetings to ensure this

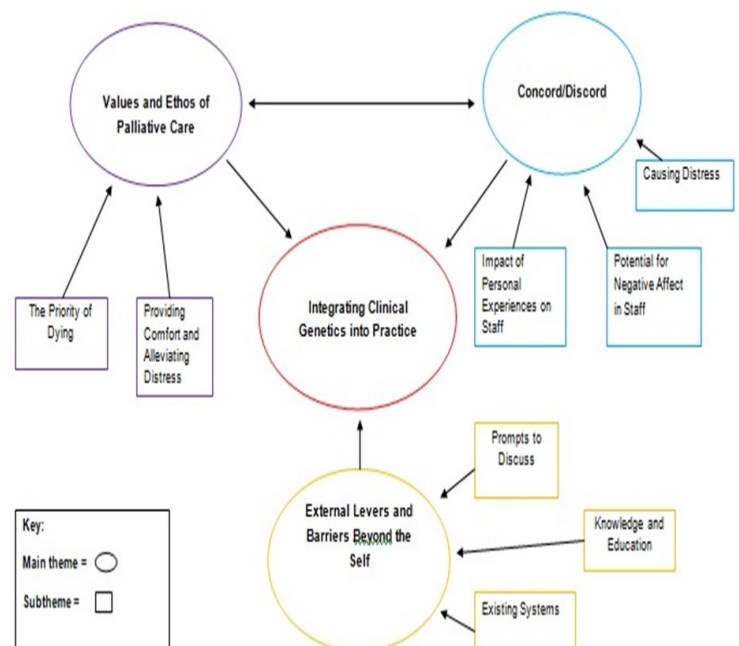
is considered and discussed alongside other routine care objectives. It appears that interventions which are seen as consistent with the aims of palliative care are adopted successfully so therefore framing clinical genetics within the wider aim of delivering holistic care to the patient and their family may be helpful.

Involving all Professions in Training Opportunities

It has been noted that nurses and healthcare assistants spend a great deal of time interacting with their patients and the intimacy of care tasks often develops close and trusting relationships within which patients discuss their hopes and fears. A familiarity with the area would allow more opportunities for concerns to be identified and taken further as part of a whole team approach.

Further research

While research regarding clinical genetics in the area of palliative care is relatively in its infancy, this appears particularly pertinent for those from diverse cultural backgrounds. While this is touched upon in the present study, it would be helpful for future research to more fully investigate the acceptability and interest of people from minority ethnic backgrounds in discussing potential genetic risk, in order to promote equity of accessibility for patients from all backgrounds.



*Thematic Analysis was utilised to draw out main themes and concepts

Fancy a spot of reading?



The following Palliative Care Evidence Update has been produced by the UHL Clinical Librarian Service. For abstracts of the reviews, please click on the titles. There may be a link to the full text in the top right hand corner of the webpage. You may have to log in using your NHS Athens username and password, if you don't have one go to [Register for Athens](#) and register for free.

If full text is not available then please [email the UHL library](#) to request a copy, directly quoting the number(s) of the articles you would like.



New and Updated Cochrane Systematic Reviews:

1) [Laxatives for the management of constipation in people receiving palliative care](#)

Authors' conclusions: This second update found that laxatives were of similar effectiveness but the evidence remains limited due to insufficient data from a few small RCTs. None of the studies evaluated polyethylene glycol or any intervention given rectally. There is a need for more trials to evaluate the effectiveness of laxatives in palliative care populations. Extrapolating findings on the effectiveness of laxatives evaluated in other populations should proceed with caution. This is because of the differences inherent in people receiving palliative care that may impact, in a likely negative way, on the effect of a laxative.

2) [Milnacipran for neuropathic pain in adults](#)

Authors' conclusions: There was no evidence to support the use of milnacipran to treat neuropathic pain conditions.

3) [Amitriptyline for neuropathic pain in adults](#)

Authors' conclusions: Amitriptyline has been a first-line treatment for neuropathic pain for many years. The fact that there is no supportive unbiased evidence for a beneficial effect is disappointing, but has to be balanced against decades of successful treatment in many people with neuropathic pain. There is no good evidence of a lack of effect; rather our concern should be of overestimation of treatment effect. Amitriptyline should continue to be used as part of the treatment of neuropathic pain, but only a minority of people will achieve satisfactory pain relief. Limited information suggests that failure with one antidepressant does not mean failure with all.

4) [Spinal cord stimulation for cancer-related pain in adults](#)

Authors' conclusions: Since the first publication of this review, no new studies were identified. Current evidence is insufficient to establish the role of SCS in treating refractory cancer-related pain. Future randomised studies should focus on the implantation of SCS in participants with cancer-related pain.

5) [Topical NSAIDs for acute musculoskeletal pain in adults](#)

Authors' conclusions: Topical NSAIDs provided good levels of pain relief in acute conditions such as sprains, strains and overuse injuries, probably similar to that provided by oral NSAIDs. Gel formulations of diclofenac (as Emugel®), ibuprofen, and ketoprofen, and some diclofenac patches, provided the best effects. Adverse events were usually minimal.

Since the last version of this review, the new included studies have provided additional information. In particular, information on topical diclofenac is greatly expanded. The present review supports the previous review in concluding that topical NSAIDs are effective in providing pain relief, and goes further to demonstrate that certain formulations, mainly gel formulations of diclofenac, ibuprofen, and ketoprofen, provide the best results. Large amounts of unpublished data have been identified, and this could influence results in updates of this review.

6) [Transcutaneous electrical nerve stimulation for acute pain](#)

Authors' conclusions: This Cochrane Review update includes seven new trials, in addition to the 12 trials reviewed in the first update in 2011. The analysis provides tentative evidence that TENS reduces pain intensity over and above that seen with placebo (no current) TENS when administered as a stand-alone treatment for acute pain in adults. The high risk of bias associated with inadequate sample sizes in treatment arms and unsuccessful blinding of treatment interventions makes definitive conclusions impossible. There was incomplete reporting of treatment in many reports making replication of trials impossible.

7) [Tapentadol for chronic musculoskeletal pain in adults](#)

Authors' conclusions: Tapentadol extended release is associated with a reduction in pain intensity in comparison to placebo and oxycodone. However, the clinical significance of the results is uncertain due to the following reasons: modest difference between interventions in efficacy outcomes, high heterogeneity in some comparisons and outcomes, high withdrawals rates, lack of data for the primary outcome in some studies and impossibility to use BOCF as imputation method. Tapentadol is associated with a more favourable safety profile and tolerability than oxycodone.

8) [Pharmacological treatments for fatigue associated with palliative care](#)

Authors' conclusions: Based on limited evidence, we cannot recommend a specific drug for the treatment of fatigue in palliative care patients. Fatigue research in palliative care seems to focus on modafinil and methylphenidate, which may be beneficial for the treatment of fatigue associated with palliative care although further research about their efficacy is needed. Dexamethasone, methylprednisolone, acetylsalicylic acid, armodafinil, amantadine and L-carnitine should be further examined. Consensus is needed regarding fatigue outcome parameters for clinical trials.

continued...

Good Quality Systematic Reviews:

- 9) [Improving the quality of life at the end of life](#)
- 10) [Grief & depression at the end of life](#)
- 11) [Protocolised approach to end-of-life care in the ICU--the ICU PALCare Pilot Project](#)
- 12) [Estimating the effect of palliative care interventions and advance care planning on ICU utilization: a systematic review](#)
- 13) [Quantifying the value of palliative care and advance care planning](#)
- 14) [A call for equity in the delivery of UK palliative care](#)
- 15) [Most palliative physicians want no role in assisted death](#)
- 16) [One decade of improving palliative care of metastatic renal cell carcinoma by antiangiogenic therapies: time to move toward RCC cure](#)
- 17) [Truth telling and treatment strategies in end-of-life care in physician-led accountable care organizations: discrepancies between patients' preferences and physicians' perceptions](#)
- 18) [Pediatric palliative care and inpatient hospital costs: a longitudinal cohort study](#)
- 19) [The role of the OncPal deprescribing guideline in end-of-life care](#)
- 20) [Palliative performance scale and survival among outpatients with advanced cancer](#)
- 21) [Spiritual well-being among outpatients with cancer receiving concurrent oncologic and palliative care](#)
- 22) [Association between the duration of palliative care service and survival in terminal cancer patients](#)
- 23) [The oncology palliative care clinic at the Princess Margaret Cancer Centre: an early intervention model for patients with advanced cancer](#)
- 24) [Palliative care and neurology: time for a paradigm shift](#)
- 25) [Bedside clinical signs associated with impending death in patients with advanced cancer: preliminary findings of a prospective, longitudinal cohort study](#)
- 26) [Safety and palliative efficacy of single-dose 8-Gy reirradiation for painful local failure in patients with stage IV non-small cell lung cancer previously treated with radical chemoradiation therapy](#)



Remember you can
click on the titles to take you to the link

Reports:

27) End of Life Care

Public Health England National End of Life Care Intelligence Network has published [What We Know Now 2014](#). It finds that home continues to be the preferred place of death for people in England, followed by hospices and care homes. The factors most important to people at the end of their life are; having pain and other symptoms managed effectively, being surrounded by loved ones and being treated with dignity. The report highlights a growing understanding within the health sector of what is important to people at the end of life.

Additional link: [PHE press release](#)



If full text is not available then please
email the [UHL library](#)

Latest Journal Table of Contents:

- 28) [American Journal of Hospice and Palliative Medicine](#)
- 29) [BMC Palliative Care](#)
- 30) [Current Opinion in Supportive and Palliative Care](#)
- 31) [European Journal of Palliative Care](#)
- 32) [International Journal of Palliative Nursing](#)
- 33) [Internet Journal of Pain, Symptom Control and Palliative Care](#)
- 34) [Journal of Hospice & Palliative Nursing](#)
- 35) [Journal of Pain and Symptom Management](#)
- 36) [Journal of Palliative Medicine](#)
- 37) [Palliative & Supportive Care](#)
- 38) [Palliative Medicine](#)
- 39) [Progress in Palliative Care](#)



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This bulletin has been created by the University Hospitals of Leicester Clinical Librarian Team.

You can view all copies of previous bulletins online [here](#).

All LOROS staff are reminded that the LOROS research bursaries are back for a second year!

Become involved this year in research to improve LOROS services for the benefit of patients and families that we care for

It may be that you want to attend, or present at, a conference; go on a research training course; secure funding to backfill your time so that you can develop an idea or a project; or are looking for support with fees to support a research qualification.

For further information, please speak with a member of the research team, or email: research@loros.co.uk

The closing date is **October 1st 2015**

Good Clinical Practice & Research Consent Training

Dates below, facilitated by the University Hospitals of Leicester, to be held in the Professorial Seminar room, LGH. For information, or to book, email:

RITraining@uhl-tr.nhs.uk

7 th October	GCP1*	09:30-11:30
7 th October	GCP2	09:00-12:00
7 th October	Consent	12:30-14:45
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4 th November	GCP 1	09:30-11:30
4 th November	GCP 2	09:00-12:00
4 th November	Consent	12:30-14:45
<hr/>		
16 th December	GCP1	09:30-11:30
16 th December	GCP 2	09:00-12:00
16 th December	Consent	12:30-14:45
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13 th January 2016	GCP 1	09:30-11:30
13 th January 2016	GCP 2	09:00-12:00
13 th January 2016	Consent	12:30-14:45

*GCP 1 is for Non-CTIMP studies

GCP 2 covers both Non-CTIMP and CTIMP studies

The 11th Palliative Care Congress

Glasgow
9 -11 March 2016

CALL FOR PAPERS CLOSES:
5pm, FRIDAY 25 SEPTEMBER
2015

For more information

[CLICK HERE](#)

RCN Annual International Nursing Research Conference

Edinburgh
6-8 April 2016

CALL FOR PAPERS OPENS LATE
SUMMER
[CLICK HERE](#)



A Cup O' Learning & A Slice O' Cake:

Lesbian, Gay & Bisexual People's Experiences of Cancer Care - study findings (Dr Julie Fish)

1st October 2015,
2:30 - 3:30pm, PC1 LOROS

Cost: FREE

To book, email:

research@loros.co.uk

(cake is provided!)



CENTRE FOR THE PROMOTION OF EXCELLENCE IN PALLIATIVE CARE

INFORMING PRACTICE TRANSFORMING CARE

LOROS
Hospice Care for Leicester, Leicestershire & Rutland

The LOROS/DMU Centre for the Promotion of Excellence in Palliative Care (CPEP) Annual Lecture 2015

What will survive of us?

What archaeology and anthropology can teach us about how people prepare for what happens after their death

Sarah Tarlow, Professor of Archaeology,

University of Leicester

6:30pm, Thursday 12th November, EM0.28 Lecture Theatre, DMU

Cost: FREE

To reserve a place, contact the LOROS Education Team on:

0116 231 8455 /Email: education@loros.co.uk

