



A description and comparison of palliative care services in a developed country and a developing country: England and Sri Lanka and lessons to learn

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Abstract

Introduction: Palliative care is an essential element of any comprehensive and integrated healthcare system, and access to palliative care is a fundamental human right. The proportion of people in need of palliative care is rising globally. **Objective:** To describe and compare the palliative care service delivery system to support patients who need palliative care in England and Sri Lanka. **Methods:** Description and comparison based on expert consultation, reviewing governmental policy, web sites, other documents, and relevant scientific literature. **Results:** England has a long history of evolution in palliative care, and the country has a well-established palliative care delivery system. Sri Lanka is a developing country with a short history of palliative care initiatives compared to England. However, Sri Lanka has a robust healthcare system in which the integration of palliative care services has already been implemented. Numerous effective initiatives used in England in delivering palliative care services successfully could be adapted and utilized to strengthen the palliative care delivery system in Sri Lanka. **Conclusion:** Although England has a well-developed and comprehensive palliative care delivery system, compared to Sri Lanka, both countries still showcase the need for further improvement in services. Specific palliative care initiatives applied in England could be incorporated to strengthen and improve the services in Sri Lanka.

Keywords: Palliative care. England. Sri Lanka.

Introduction

The World Health Organization (WHO) defines palliative care as "an approach that improves patients' quality of life (adults and children) and their families facing problems associated with life-limiting illnesses, usually progressive. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual" (WHO).

In 2014, World Health Assembly (WHA) unanimously passed the first-ever global resolution on palliative care, WHA67.19, "Strengthening of Palliative Care as a Component of Comprehensive Care throughout the Life Course." This called upon WHO all member states to improve access to palliative care as a core component of health systems, with an emphasis on ensuring that policies are in place, comprehensive education on palliative care is available, essential palliative care medicines are available and affordable, and that programs are funded and implemented [1].

Worldwide, over 56.8 million people are estimated to require palliative care yearly. However, these services are not accessible to most people in need, especially in low and middle-income countries (LMICs). Most adults in need of palliative care (76%) live in LMICs; among them, the highest proportion are in low-income countries [2]. Compared to developed countries, where a comprehensive palliative care service is available, in developing countries, palliative care is under development, and developments are continuing in palliative care services worldwide [3,4].

Therefore, while a developed country like England, with a long history of palliative care, is placed at the one



end of the spectrum of palliative care services, a developing country, like Sri Lanka, with a short history of palliative care, is at the other end of the spectrum.

This article aimed to describe the evolution of palliative care services in a developed country like England and a developing country like Sri Lanka and to compile recommendations on applying the systems used in England in improving the delivery of palliative care in Sri Lanka.

Methods

Relevant documents (policies/guidelines/articles and relevant websites) related to palliative care service delivery in England and Sri Lanka were referred and reviewed, aiming to study the evolution of palliative care services in both countries and how these services are currently organized, funded and provided. Those findings were strengthened by the facts gained from discussions with experts.

This report will elaborate on the historical development of palliative care, available policies and strategies, the services provided at present and the recommendations that could be compiled from the initiatives used in England in delivering palliative care services successfully to strengthen the palliative care delivery system in Sri Lanka.

This report includes a description and a comparison of the two systems under the following subtopics:

Section 1- History and evolution of palliative care delivery

Section 2- Comparison of available National strategies for improving palliative care services

Section 3- Current system of palliative care delivery

Results

Section 1- History and evolution of palliative care delivery

England

The historical development of palliative care in England traces back to the institutional origin of hospices in very early times. In 1891, the free home for the dying (Hostel of God) was established in Clapham, London, followed by St Joseph's Hospice in Hackney in 1905, east of London. All these pre and proto-hospices shared the concepts of religious, philanthropic, moral and medical.

Cicely Saunders is a pioneer in the path of palliative care development during the 1950s and 1960s in England. Her first published paper was central to establishing modern palliative care. It discussed the value of special homes for dying people, the terminal

stage of the disease, and pain while emphasizing the need for good physical care combined with psychological and spiritual assistance. This was followed by many other publications. Cicely Saunders laid down the principles of a new approach to caring for dying people. Finally, her ideas became real by opening the world's first modern hospice in 1967, the St Christopher's Hospice in South London. Though this was developed separately from National Health Service (NHS), it closely allied to NHS with a sustainable National and international fund-raising campaign. This nascent movement quickly spread worldwide. At the time of the opening of St Christopher's, neither the term "Hospice movement" nor the description "Palliative care" were in use [5,6].

Using St Christopher's as a model, by the early 1970s, hospices have begun to appear in different parts of the UK. At this stage, hospices were concerned as places which facilitated peaceful death for the patients at the terminal stage and were driven exclusively by the charitable sector [5]. With time, by 1969, Home care services developed at St Christopher's Hospice, taking the hospice skills and philosophy into the wider community. During the mid-1970s, specially selected and trained Macmillan nurses were appointed to provide specialist advice, guidance and education to the primary healthcare team members. Initially, this was funded by the Macmillan charity. Similarly, the Marie Curie Foundation has provided home nursing, especially at night, for patients at the end of life since the late 1950s [5].

In parallel to those, the development of a specialist support team in the hospital setting first appeared in Britain in 1976 at St Thomas's Hospital. These multidisciplinary teams comprised doctors, nurses, social workers, chaplains, and secretaries focusing on pain and symptom management and patient and caregiver's emotional support [5]. Later on, the development of Day care services took place as an additional element: the first started at St Luke's Hospice, Sheffield, in 1975. By the late 1990s, the day units had been expanded to over 200 programmes in the UK. During daycare services, there is an opportunity to pain and symptom management. However, the main emphasis was the patient's social and personal needs, including therapeutic activities such as painting, crafts, poets, etc. [5].

In the UK, this rapid expansion of hospice and palliative care services has proceeded over 30 years. One significant landmark in palliative care development worldwide has been the emergence of the Specialty of Palliative care. The recognition of palliative medicine as a speciality took place in Britain in 1987, and in 1991 the National Council for Hospice and Specialist Palliative Care Services (NCHSPC) was formed [5].



All palliative care services have proliferated since 1965, including Home support services. Since mid-1985, a sharp upturn could be seen in hospital-based palliative care after palliative medicine became a recognized speciality.

Sri Lanka

In the Sri Lankan health system context, palliative care appeared as a new concept without a long history compared to England. The written literature on health care policies has stated the palliative care services in the "National Policy & Strategic Framework for Prevention and Control of Chronic Non-communicable Diseases (2010)". In which the palliative services have been identified and stated as "Facilitate the provision of optimal NCD care by strengthening the health system to provide integrated and appropriate curative, preventive, rehabilitative and palliative services at each service level".

Then in the 'Sri Lanka National Health Policy 2016 – 2025', palliative care has been identified under the broad strategic direction of 'Promotion of equitable access to quality rehabilitation care'. It is mentioned that 'The mainstream health system should provide Palliative Care to all patients who need such care for them to live and die with dignity'. In addition, several other policies in the country have identified palliative care as a continuum of care, including the National Policy & Strategic Framework of Prevention & Control of Cancers (2015), National Elderly Health Policy (2017), National Health Policy 2016 – 2025 and further palliative care has been identified as a prioritized activity of National Multi-Sectoral Action Plan for the Prevention & Control of Non-Communicable Diseases 2016 – 2020. The National Cancer Control Program (NCCP), Ministry of Health, has been identified as the National focal point of cancer control, prevention and palliative care, while the Palliative care and Survivorship unit of the NCCP plays a crucial role in establishing palliative care services within the country [7]. In 2019, the National Strategic Framework for Palliative Care (NSFPC) Development in Sri Lanka 2019 – 2023 was launched by the NCCP. This strategic framework is expected to facilitate streamlining the ongoing activities in palliative care in Sri Lanka.

Meanwhile, a volunteer task force for palliative and end-of-life care (PCTF) was established by Sri Lanka Medical Association in 2016, comprising a multidisciplinary team including health care professionals, legal fraternity, and civil society. In collaboration with the Ministry of Health, this task force is engaged in addressing the needs of developing palliative care services in the country, such as sensitizing the general public on the importance of palliative care and training health care professionals on palliative care [8].

Though the word "palliative care" began to appear in healthcare policies of Sri Lanka only during the last decade, certain palliative care services have a long history than that, and these services have been limited to hospice care till early 2010 [9]. Examples of them are 'Shantha Sevana', which was established in 1996 in Maharagama [10], The "Sri Sathya Sai Suva Sevana Cancer Hospice" in Hanwella, inaugurated in the year 2002 [11], CANE hospice Jaffna in 2006 [9], and Cancer care hospice Anuradhapura in 2011 [12]. These facilities provide palliative care for advanced cancer patients. Sensitizing health staff in palliative care, especially medical officers, was led by the Sri Lanka College of General Practitioners in early 2010, followed by NCCP Sri Lanka [9].

Later on, identifying the importance of initiating postgraduate-level teaching programmes on palliative care and highlighting the need at the National Advisory Committee Meeting on Cancer Control, and the advocacy conducted by multiple agencies on this, resulted in the initiation of a postgraduate Diploma in palliative care. It was initiated in 2015 through a board of study in a Multidisciplinary study course providing comprehensive training [13].

Section 2 - Comparison of available National strategies for improving palliative care services

The first national strategy for end-of-life care in England was developed in 2008 [14], and building on this strategy, in 2015, a national framework for local action for 2015-2020, the Ambitions for Palliative and End of Life Care was published by the National Palliative and End of Life Care Partnership. Subsequently, a refresh of the Ambitions Framework- Palliative and End of Life Care: A national framework for local action 2021-2026 was published in May 2021 with six Ambitions for Palliative and End of Life Care.

NHS is a member of the National Palliative and End-of-Life Care Ambitions Partnership and has jointly developed the system-wide Ambitions for Palliative and end-of-life care: a national framework for local action 2021-26 [15]. Ambitions for Palliative and End-of-Life Care: A National framework for local action 2021-2026. This framework was developed by a partnership of national organizations across the statutory and voluntary sectors and set out their vision to improve end-of-life care through partnership and collaborative action between organizations at the local level throughout England [15].

Through this framework, NHS England and NHS Improvement intend an ambitious and transformative approach to palliative and end-of-life care (PEoLC) during 2021-2026 to ensure sustainable, responsive, personalized care for all, irrespective of age, area, condition or setting. The following are the national



workstreams for PEOLC that will consider an all-age approach to PEOLC, working with people of lived experience and working to improve access, improve sustainability, and reduce health inequalities:

Clinical Excellence

To support outstanding clinical care based on the best available evidence, to ensure personalized palliative and end-of-life care for people of all ages in all settings.

Commissioning

Supporting regional ICS/STPs in the commissioning and contracting of good PEOLC, ensuring optimal use of funding and sustainability for the future.

Data and Intelligence

Establishing a clear pathway for defining, developing and implementing information standards for PEOLC. This framework has presented their overarching vision and the six ambitions they want to achieve as mentioned in the Table 1.

Table 1. Six Ambitions for palliative and end of life care as in Ambitions Framework.

Number	Ambitions
1	Each person is seen as an individual
2	Each person gets fair access to care
3	Maximizing comfort and well-being
4	Care is coordinated
5	All staff are prepared to care
6	Each community is prepared to help

As they have clearly described, the foundations for the ambitions are Personalized care planning, Education and training, Evidence and information, Co-design, shared records, 24/7 access, Those important to the dying person, and leadership. If these pillars are briefly described:

1. Personalized Care Planning

All patients approaching the end of life should be offered the chance to create a personalized care plan, which should be updated to reflect their changing needs. These discussions should be between the patient, those important to them (as they wish) and their healthcare providers. It should allow people to express: their preferences for care and set personal goals for the time they have left. It should include the possibility of recording preferences that might guide others if the person were to lose the mental capacity to make their own decisions (advance care planning). Furthermore,

this should also encompass the chance to appoint a person with lasting powers of attorney or allow the person to trust their professional carers to act in their best interests.

2. Education and Training

Every professional must be competent and up-to-date in the knowledge and practice that enable them to play their part in good end-of-life care. Every locality and every profession must have a framework for their education, training and continuing professional development to achieve and maintain this competence.

3. Evidence and Information

Service providers across all sectors, as well as the professionals who work within them, should participate in national initiatives to collect comprehensive, robust and anonymous data. These data should inform judgements about the quality and accessibility of services and support quality improvements.

4. Co-design

Systems of end-of-life care are best designed in collaboration with people with personal and professional experience in palliative and end-of-life care.

5. Shared Records

To ensure the plan can guide a person-centred approach, it has to be available to that person so that they can review, change and update it themselves. Subject to that person's consent, or if they lack mental capacity, in their best interests, the plan should also be shared with all those who may be involved in their care. All electronic systems for sharing health-related preferences must encompass the recording and sharing preferences at the end of life. The widespread use of electronic systems should be encouraged across health and social care providers in the statutory, voluntary and private sectors. This will require support for and investment in the use of information technology (IT).

6. 24/7 Access

Every person at the end of life should have access to 24/7 services as needed as a matter of course. The distress of uncontrolled pain and symptoms cannot wait for 'opening hours'. This is a necessary system-wide expectation, and good end-of-life care cannot be achieved without it.

7. Those Important to the Dying Person

Good palliative and end-of-life care includes giving care and support to families, friends, carers and all those who are important to the dying person. This must



encompass good bereavement and pre-bereavement care for children and young people.

8. Leadership

In whatever country context, high or low income, the responsibility for dying well should not fall solely to health and social services, nor solely to communities; a partnership approach involving shared power, shared decision making, and co-design of services is essential to enable people to die well. Similar to this, the National Strategic Framework for Palliative Care Development in Sri Lanka 2019 – 2023 consists of 11 Strategies in the strategic framework [16], which comprehensively cover all the areas that need to be addressed as mentioned in Table 2. Currently, Sri Lanka is in the process of achieving those strategies.

Table 2: Strategic directions in the National Strategic Framework for Palliative Care Development in Sri Lanka 2019-2023.

Strategies in the strategic framework	
1	Ensure that palliative care is recognized and resourced as an integral component of the health system by making palliative care an essential component of comprehensive health care.
2	Facilitate the effective integration of specialist palliative care and palliative care services across all service settings, namely at tertiary, secondary, primary and community levels.
3	Develop and make skilled multidisciplinary human resources and infrastructure available to deliver palliative care services at institutional and community levels.
4	Ensure that patients and their families receive the palliative care services they need when and where required and adhere to protocols and guidelines in palliative care.
5	Ensure the availability of essential drugs & technologies for providing palliative care at all levels: tertiary, secondary, primary and community.
6	Build partnerships with government and non-governmental organizations for the delivery of palliative care.
7	Empower family members, caregivers and the general public for the provision of palliative care.
8	Encourage research on palliative care in assessing needs and suitable models for implementing palliative care services.
9	Ensure adequate financing and resource allocation for cost-effective delivery of palliative care.
10	Strengthen legislative framework for delivery of palliative care.
11	Ensure monitoring & evaluation framework for palliative care services

Studying the systems used in developed countries to achieve their targets may be helpful, where we can adapt some of their strategies to ours.

The Current System of Palliative Care Delivery England

NHS England and NHS Improvement lead the National Health Service in England [17]. NHS England and NHS Improvement are responsible for; providing national direction on service improvement and transformation, governance and accountability, standards of best practice, and quality of data and information. NHS England is working with the government, partners from across the health and care system, voluntary, community and social enterprise partners and people with lived experience to improve palliative and end-of-life care across the country.

Hospital-Based Palliative Care

Hospital-based palliative care teams (HPCTs) began in the UK at St Thomas's Hospital in 1976, and since then, this concept has expanded. By 1996, most hospitals had either a multidisciplinary palliative care team or a palliative care nurse specialist. Some HPCTs have developed from existing pain/symptom control teams, and others have been initiated by pre-existed hospice services, e.g. Macmillan Cancer Relief [5].

Some HPCTs have designated beds for palliative patients, and it was associated with consultants in palliative medicine. More commonly HPCTs play an advisory role, providing specialist resources for the ward teams. Often, HPCTs have close professional and organizational links to a local hospice or community-based specialist services. Further, they coordinate complex and integrated services across institutional boundaries; inpatient care within the hospital is complemented by home care visiting services; and outpatient clinics and daycare facilities by linking the patients with relevant facilities [5].

Palliative Care at Home

Providing support and services for patients dying at home has been recognized as a goal of health care policy. A wide variety of specialists delivers home-based palliative care depending on the local service availability/condition of the patient/ extent of his/her informal support, etc. The following teams mainly provide palliative care at home:

Primary Health Care Team

This team usually consist of a general practitioner, a practice nurse and a district nurse. This team is the first point of contact with health care for most people at home.

Other Support Services

There is a wide range of other health (physiotherapy, home visits of specialist staff such as



stoma care/ breast care) and social services that may include home care workers, social workers etc., and volunteers from local support groups for respite sitting/bereavement follow up / social care needs etc. This support service improves the quality of life of people with palliative care needs, helps the patients maintain independence, and reduces the burden on the family.

Specialist Palliative Care at Home

These community Palliative care specialist teams are usually attached to the community unit/hospital/hospices. They deliver services to people living at home. Mostly the patients are referred to this service by their general practitioner (GP)/ by the hospital team / Hospice team.

Hospices

In-patient hospices are the original model of palliative care delivery in the UK. Hospices are managed mainly by charity organizations and are partly funded by NHS. Some hospices exclusively provide inpatient care, some only daycare, and some provide both. Most hospices provide Medical and Nursing care for people with cancer and a small number with other conditions. Patients are referred to the hospices for one of three reasons: Respite care, Symptom control, e.g. pain, breathlessness, vomiting etc and end-of-life care. The length of a patient's stay depends on the condition and why they are admitted. Usually, respite will be as planned and usually one week; for symptom control, the average length of stay is 10 - 14 days. In addition to the above services, hospices usually provide numerous other Patient and Carer Well-being Services, including Lymphoedema services, Living Well Programs, Fatigue and Breathlessness Management Programmes, Home care services, and many more [18].

Almost all patients admitted to the hospices have a form called ReSPECT with them, which facilitates the management of the patient according to the wishes of the patient and his/her carer and family. Usually, it is filled by the GP / hospital team on prior occasions, and the form is carried with the patient, and the health care providers edit it. ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. ReSPECT is a process that creates personalized recommendations for a person's clinical care in an emergency where they cannot make or express choices. The plan is created through conversations between a person and their health professionals [19,20].

Sri Lanka

Similar to England, Hospital-based palliative care services are delivered through specialized units with a

specialized multidisciplinary team (palliative care consult services). The first Palliative Care Consultative Service & Palliative Care Clinic was established in 2015 at the Apeksha Hospital, Maharagama [21]. In addition to that, currently, palliative care consult services are provided at Teaching Hospital Ratnapura, Lady Ridgeway Hospital for Children, Teaching Hospital Karapitya, and Colombo South Teaching Hospital Kalubowila. In addition to these specialized care units, primary palliative care needs are addressed through oncology clinics of cancer treatment centers nationwide.

Home-Based Palliative

Home-based palliative care was not a well-addressed area in the recent past except for the few teams either attached to a hospital or NGO were the leading providers. However, the Ministry of Health has identified the need and appointed Public Health Nursing Officers (PHNO) to primary medical care institutions to initiate Home-based palliative care, linking with the closest primary medical care institution [9].

Hospice

Hospice care is mainly provided through the NGOs in Sri Lanka, compared to England, which receives some financial support from NHS. In Sri Lanka, hospices are solely powered by NGOs. While most of them provide inpatient hospice services, some NGOs provide home-based palliative care services, facility of Cancer day care centres, Community centres for the rehabilitation of cancer patients and other supportive care services [22].

Discussion with Recommendations

Though England has a robust, well-established palliative care service delivery system, they are trying to extend and improve their services more through the initiatives in the Ambitions framework. As a developing country, Sri Lanka has achieved a lot and is yet to achieve more to build a sustainable palliative care delivery system.

In parallel to the Ambitions for Palliative and End of Life Care, the national framework for local action in England, the following foundations needed to be considered and incorporated in to the Sri Lankan system of Palliative care delivery as well; Personalized care planning; It is recommended to offer the chance to create a personalized care plan for patients approaching the end of life, and this should be updated to reflect their changing needs, Education and training related to palliative care; Steps should be taken to make every health care professional competent and up to date in the knowledge and practice that enable them to play their part in good end-of-life care, Evidence and information-



All service providers should participate in national initiatives to collect comprehensive, robust, anonymous data and these data should be utilized to assess the quality and accessibility of services and for quality improvements. Shared records- Healthcare providers should be encouraged to share patients' care plans among all involved in care provision.

To facilitate this, the widespread use of electronic systems should be encouraged across health and social care providers in the government, voluntary and private sectors. This will be a challenging target to achieve. First, however, steps should be taken to pilot the project utilizing limited resources, 24/7 access- It should be encouraged to provide 24hrs access to end-of-life care services as needed. This could be achieved by establishing a 24/7 teleconsultation service for palliative care provision at the PCCS. If the patient's needs cannot be met by teleconsultation, the patient could be advised to visit the nearest relevant service centre, and it is recommended to ensure the provision of care and support to the patient and loved ones throughout the disease trajectory. This must encompass good bereavement and pre-bereavement care for them.

Palliative care is not the sole responsibility of health or the community. It is recommended to have a partnership approach involving shared power, shared decision-making, and co-design of services is essential to enable people to die well. Furthermore, all health and social care professionals in all systems must be competent in caring for dying patients and their families. These are core skills, and dying patients should be referred to specialist palliative care services (where available) only when specialist support is necessary.

Patients and families should be provided with clear information about the uncertainties and the potential benefits, risks, and harms of interventions in potentially life-limiting illnesses to enable more informed decisions. When the second strategic direction, "Facilitate the effective integration of specialist palliative and palliative care services across all service settings, namely at tertiary, secondary, primary and community levels" of SFWPC, is considered, strengthening of hospital-based palliative care services are needed to be carried out through.

Encouraging the establishment of Hospital-based palliative care teams (HBPCTs) at least above the Base hospital level –HBPCTs can be developed based on existing pain management teams if there is such a team or not it could be developed from the available resources such as consultant physician of the hospital. Strengthening Palliative Care Consult Service (PCCS)-SFWPC have already identified the need for palliative care consult services, human resource, and their duties and services (Consultant - Team leader, Medical

Officers, Nursing Officers, Social Service Officer, Counsellor, Pharmacist, Health Care Assistants) have been already defined. In addition to the officers mentioned above, physiotherapists, speech therapists, occupational therapists, psychologists, nutritionists etc. are ideally needed for optimal service delivery. Therefore, establishing an extended 'Palliative care team' is recommended to provide comprehensive care for those in need.

PCCSs have already been established in some cancer treatment centres and General Hospitals(GH). However, other similar hospitals should be encouraged to establish the service, and steps should be taken to strengthen the already established services by regular monitoring and evaluation. In England, besides the staff mentioned above, a Chaplain is a PCCS team member who provides a remarkable service in promoting a patient's spiritual well-being. This could be achieved in Sri Lanka by identifying a chaplain from each religion, from the nearby chaplaincy and calling them for their support when there is a need for this service.

In the hospital with PCCS, having designated beds for palliative patients will facilitate the service provision. In addition to this, Specialist Palliative Care Hospital Team in England play an advisory role, providing specialist resources for the ward teams. These teams maintain close professional and organizational links to a local hospice or community-based specialist services to support needy patients continuously.

It is recommended to establish close professional and organizational links between PCCS and local hospices in each district of Sri Lanka so that they can provide an integrated service across institutional boundaries. For example, inpatient care within the hospital could be complemented by home care visiting services, outpatient clinics, and daycare facilities by linking the patients with relevant facilities.

Further to hospital-based care, Community level palliative care services, and most importantly, Palliative care at home is the other component that should be strengthened in the Sri Lankan system. In England, they deliver home care through a Primary health care team, which usually consists of a general practitioner, a practice nurse and a district nurse- and this team is the first point of contact with health care for the people at home.

Other support services are there to complement the service of the primary care team. There is a wide range of other health (physiotherapy, home visits of specialist staff such as stoma care/ breast care) and social services that may include home care workers, social workers etc., and volunteers from local support groups for respite sitting/bereavement follow up/social care needs etc. This support service improves the quality



of life of people with palliative care needs, helps the patients maintain independence, and reduces the burden on the family.

To provide Specialist palliative care at home, they have specialist palliative care teams attached to the community unit/hospital/hospices. They deliver services to people living at home. Mostly the patients are referred to this service by their GP / by the hospital team / Hospice team.

The Sri Lankan system has appointed Public Health Nursing Officers to District hospitals. One hundred public health nursing officers were appointed to 100 Healthy Lifestyle Centers (HLCs) in 25 districts of Sri Lanka [23]. They work within the assigned area and with individuals, families and communities to prevent and control non-communicable diseases (NCDs) and provide comprehensive nursing care. This service provided by the PHNO could be more organized by identifying other support workers who can help in PHNOs' work. At least PHNO can refer the patients to them, like physiotherapists, social workers from relevant GA offices, and Counselors, so they can make a local community team to support palliative care patients at home.

Encouraging the establishment of Specialist palliative care teams who provide home care, at least in the private sector, for the people who can afford it would be helpful until such a free service is developed. In developing community care, the hospices play the third most important role, and the strategies to develop the hospice sector in the Sri Lankan setting are crucial in providing palliative care services.

While studying the hospice care system in England, several good points that could be adapted to the Sri Lankan health system were noted. First, they provide highly amendable services through their well-experienced and qualified team. Their referral system is much better when compared to the Sri Lankan system. If the Myton Hospice is considered, the method of referring the patients to the hospice is transparent for everyone as It is well explained on their website. Healthcare professionals can refer patients over the phone or by submitting an online form with patient details.

It seems an efficient way of referring patients to the required care pathways. Their website showcases the required information on referring to each hospice care service so that it is evident for the health care professionals seeing the patients in the hospitals. This system of referring patients to hospices is needed to develop in Sri Lanka and should be encouraged to facilitate referrals from hospitals to hospices. In addition, the link between hospitals and the hospice system should be strengthened.

Referrals to any of the facilities in the hospice could be made via the patient's GP, Public Health nursing officers or the hospital. Hospices should be encouraged to link with nearby leading hospitals and disseminate information about their services and how to refer to them.

The inpatient unit of the hospices also supports people in their final days in England. All of their inpatient services are provided free of charge; This includes relatives' accommodation available in each hospice for family members who may not be local and wish to be with a loved one at the end of their life.

It is recommended to have relative accommodation in Sri Lankan hospices and at least one room to comfort a peaceful death for a patient with their family around. Reasons for referring a patient to a hospice and the duration of the stay are well defined in the system of England. In Sri Lanka also, hospices should be encouraged to have an admission policy to avoid unnecessary admissions and focus on the patients who need it and, if possible, limit their stay depending on the need.

In the hospices in England, before discharging a patient, they will ensure that the care and support the patient need is in place to ensure a safe discharge. In addition, they have multidisciplinary team meetings weekly, discussing the admitted and discharged patients during that week and ensuring all the necessary supportive care is provided even after their discharge.

Having Multidisciplinary team meetings in hospices, with the participation of the consultant of the nearby hospital, should be encouraged to maximize the care provided by the hospice. In hospices in England, almost all of the admitted patients have a form called ReSPECT with them, which facilitates the management of the patient according to the wishes of the patient and his/her carer and family. In Sri Lanka, it was initiated to provide a palliative care record. However, it still needs to be widely used with these patients. Healthcare professionals should be encouraged to discuss with patients about his/her wishes and record them in their records, or should consider having a separate form like ReSPECT for each patient, including their priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that they would want, that would not help, or that they would not want.

The hospice-at-home concept will be new in Sri Lanka. Many people choose to be at their own homes with their loved ones in the last weeks and days of life. Certain hospices like Myton in Warwick and Coventry in England have a team of experienced nurses and care staff caring for people in their homes. The care and



services provided to the patients and their families through home visits are called Myton at Home.

They offer a high-quality support service delivered by experienced staff who are specialists in end-of-life care. This service operates seven days a week, and they provide the following services at the patient's residence: Personal care, support for the whole family, providing emotional and psychological support as well as practical advice or training from the Myton at Home team, night sit support for patients at the end of life, Interim care while a continuing healthcare (CHC) package is being put together by the NHS, respite care to allow carers a break, following an assessment of individual needs a plan of care will be discussed and agreed with the patient and whomever they wish to be included. This model of care could be piloted in Sri Lanka and should test the feasibility, at least initially in the private sector/ with a small fee.

Education on palliative care is vital to sustaining the system, education on death, dying, and end-of-life care for a person and their family must be integral, substantial, and mandatory in the curriculum of every health and social care student and continuing education for practising professionals. Therefore our undergraduate curriculums should include new, more practical ways of teaching palliative care, such as case-based learning and academic days on palliative care, including discussions with multidisciplinary team members followed by lectures and discussion of case management in the clinical settings. Further, steps should be taken to accelerate the establishment and implementation of palliative care MD in the postgraduate institute of medicine to appoint palliative care consultants in the near future to the Sri Lankan General Hospitals.

Conclusion

Though England and Sri Lanka are two countries which are non-comparable in many aspects, their targets in palliative care strategic frameworks are mostly towards achieving a standard of care for people in need. Further, several strategies used in England to optimize palliative care services could be easily adapted to Sri Lankan settings as we already have a robust health system.

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Conflict of interest

The authors declare no conflict of interest.

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