PROCESSES AND SYSTEMS

Palliative care in acute hospitals – a new vision

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ABSTRACT

This article explores new and innovative ways of delivering palliative and end-of-life care (EoLC) within the acute hospital setting. Severe financial pressures in the NHS and social care, combined with the increasing clinical complexity of patients, have raised concerns about the quality of EoLC in hospitals. The creation of hospital palliative care units (PCUs) and other improvement initiatives will be described across two large acute hospital trusts which resulted in a rating of 'Outstanding' by the Care Quality Commission (CQC) for their delivery of end-of-life services.

Introduction

There has been a drive in the last decade to shift the delivery of palliative care from the hospital setting to community-based and hospice settings; this change is a response to both patient preference and to the variable quality of care experienced by patients dying in hospital.[1–3] Although more people are living and dying at home, around half still die in hospitals. When people are dying, their focus is less on the place of care and more on the quality of care.[4]

The national 'End of Life Care Strategy' for England identified some problems in the acute hospital setting which may lead to variations in the quality of EoLC care delivered to patients:[1]

- a failure to recognise that one of the core roles of an acute hospital is to provide care for the dying
- a failure to recognise when continuation of treatment is not in the best interest of the person, resulting in a failure to address their holistic needs
- a failure to take responsibility for enabling people to return home to die if that is their wish
- a lack of leadership on EoLC from senior managers and senior clinicians
- staff at all levels not having the necessary knowledge, skills and attitudes required to deliver high quality EoLC.

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The last decade has seen many developments in hospital-delivered EoLC, but significant concerns remain about variability in the quality of care.[3] Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) and Northumbria Healthcare Foundation Trust (NHFT) are notably contrasting organisations, the RLBUHT being a large teaching trust based in a city centre while the NHFT is an integrated community and hospital trust covering one of the largest geographical areas in the country. Despite these differences, they are united in a desire and commitment to deliver the best quality EoLC in all settings. Both trusts have applied similar principles to embed best practice and have shown that outstanding care can be achieved in the acute hospital setting.[5,6] Some of these initiatives are set out in this article. The objectives for both organisations were to increase the quality of palliative care within hospitals, to reduce the number of deaths in acute hospital beds and to ultimately increase the number of deaths in a palliative care setting or at home.

Service models

Traditionally, palliative care services have delivered a unitary model of care in hospitals. Patients are referred to a hospital palliative care team for advice and input, but remain under the care and responsibility of the referring clinician. Hospital palliative care teams typically provide one-off interventions for most patients or ongoing advice for more complex individuals. If the intensity of palliative care input increases or a palliative care bed is required, patients are referred to a hospice, usually in another location and often in another organisation. The aims and priorities of a hospice and acute trust are different which can sometimes lead to tensions in delivering an integrated model. Two key elements of the hospital palliative care model are discussed here: the specialist palliative care team and the creation of hospital palliative care units (PCUs). Both elements are intertwined to ensure patients are managed in the most appropriate setting, receiving palliative care input wherever they are physically based.

Remodelling hospital specialist palliative care teams

Both organisations have visible and approachable hospital specialist palliative care teams. They provide daily specialised trust-wide expertise to support all specialties, in addition to supporting patients on an individualised basis. They are particularly visible in areas of high intensity such as critical care, the emergency department and other admission areas where the team focus on addressing patient needs and helping with hospital

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flow. This work is underpinned by a full education programme and multiprofessional meetings which link up with other key services.

Accurately triaging patients is crucial and enables the team to identify patients who would benefit most from a palliative care bed, compared to those who need to stay in the acute environment or those who can get home. In hospital settings, patients often deteriorate quickly because of delayed recognition, treatment failure and withdrawal, or unexpected acute complications. Quick decisions need to be taken about their care in the last days of life, especially surrounding their place of care. Both services have developed rapid discharge processes to address this (see Box 1).

The RLBUHT Academic Hospital Specialist Palliative Care Team (AHSPCT) is a multiprofessional team providing care to all specialties 7 days a week. It consists of nurses, consultants and allied health professionals. It also incorporates chaplaincy, bereavement services, specialist pharmacy service, volunteer service, and complementary therapies. The team has a 'rapid discharge pathway' which supports coordinated care to enable patients, where possible, to be discharged home in the last hours/days of life, if this is what the patient wants.

In NHFT, a similar multiprofessional team of nurses, consultants, social workers, pharmacists and chaplains form the hospital specialist palliative care team. Patients known anywhere in the palliative care system set off a 'recurring admission patient alert' (RAPA) on attending the Accident and Emergency Department. This triggers a response by the palliative care team within an hour. Coupled with integrated electronic clinical records, this allows for continuation of complex management plans. Other patients are picked up through referrals. The team has been remodelled to deliver different levels of nursing input for different situations; specialist nurses focus on the more complex specialty-specific problems while palliative care nurses support ward staff with hands-on EoLC and help coordinate rapid or complex discharges home. The integrated service allows them to work across settings to accompany people home and hand over to community services. A rapid discharge process has been developed, accessing key components including a regional palliative care ambulance. The service will shortly be operating over 7 days.

Hospital specialist palliative care units

In some parts of the world hospital palliative care units (PCUs) are common, where inpatient palliative care services have evolved as part of their national health systems, compared to the UK where the NHS and voluntary sector palliative care services are separate. There are a number of potential drivers to creating a hospital PCU. Patients in hospital develop complex palliative and EoLC needs, requiring an intensity of palliative care involvement that would challenge the usual capabilities and resources of a hospital specialist palliative care team. Patients may have acute needs alongside their palliative care needs which are better led by palliative care with input from other teams. Patients with palliative care needs in a hospital setting are most likely to have their needs more quickly and effectively addressed being directly under the care of a specialist team rather than through providing advice to other teams. Finally, patient expectations are changing and the transition from acute to palliative care may be more easily managed in a hospital setting than by trying to move to a hospice.

The creation of the Academic Palliative Care Unit (APCU) at the RLBUHT was driven by the desire to provide the highest quality care for those people with the most complex needs in hospital.[7] The ACPU is a 12-bed inpatient unit that opened in 2016 as a research-led specialist unit. Patients who would benefit the most from this level of specialist care are identified by the AHSPCT, via liaison with other clinical colleagues and communication with the patient and the people important to them.

Northumbria Healthcare Foundation Trust opened their first PCU in North Tyneside Hospital (NTPCU) in 2009 with 19 beds, followed in 2012 with a 20-bed PCU at Wansbeck Hospital (WPCU).[8] The motivation was to address all of the above drivers, coupled with a local shortage of hospice beds. Patients are either admitted directly from the community (~40% of admissions) or from any hospital location. Initially, referral criteria were very strict and all patients required a specialist assessment. As mutual confidence and understanding of the role of the PCUs has grown, a telephone conversation is sufficient for urgent admissions. From hospital, these can happen any time of day or night. Direct community admissions currently take place during working hours; staffing will soon be in place to allow this at all times.

In both trusts, due to pressures on space, the PCUs are located separately to the hospital palliative care teams but work very closely together. The PCU teams are led by specialist-palliative care consultants, supported by a team of specially trained nurses, healthcare assistants, doctors, allied health professionals, counsellors/psychologists, complementary therapists, pharmacists and chaplains. Staffing levels are similar to those on other hospital wards. Nursing staff have been specially recruited, from a variety of backgrounds, to work in the PCU environment, all of whom demonstrate the right skill set, experience, compassion and emotional maturity to work in this area. Out-of-hours medical cover is provided first line by on-call doctors covering other wards with palliative medicine consultants on call at all times. Consultant trouble shooting ward rounds take place on Saturdays and Sundays which enables multidisciplinary decision making and input from an experienced senior consultant when required.

In all three PCUs, patients' needs are quickly and expertly addressed so they experience high-quality, holistic individualised care that is safe and reduces their length of stay wherever possible (see Box 2). The aim is for each patient to return home or to another appropriate place of care when stable, or to experience a dignified death while being cared for on the units. All PCUs have open visiting hours so family members can spend as much time as they wish on the units whenever suits them.

Box 1. Case example: hospital specialist palliative care team

A middle-aged woman was rapidly deteriorating in hospital and actively dying. She and her husband wished for her to die at home. The rapid discharge process was followed and everything was in place to get her home that day. The ambulance got called to another emergency which led to a concern that the patient may die before she got home. Her husband decided to drive her. The palliative care hospital nurse went in the car with the patient, settled her into bed, administered appropriate medication at home and handed over care to the district nurses when they arrived. The community nursing team and GP then managed her end-of-life care at home. Having the flexibility to work across settings improves care across transition points, thus reducing delay, which can be a barrier to achieving people's aspirations.

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Box 2. Case example: palliative care unit

An elderly man with advanced lung cancer had been admitted as an emergency to hospital with severe pain and breathlessness. The breathlessness was due to a complicated pleural effusion but his pain was also overwhelming. He was transferred to the palliative care unit where the team escalated his analgesia (methadone, gabapentin and amitryptilline) while also addressing his fear and anxiety. He required a chest drain which was managed by the respiratory team who continued shared care with the palliative care team throughout the admission. His family benefited from the support of the team and the ability to spend time with him at their convenience. After 10 days he was able to go home for ongoing care by the community team.

The physical environment

The importance of a well-designed physical health environment is well established.[9] Special attention and thought has been put into the design of the clinical and non-clinical areas within the PCUs so that patients, families and friends can all benefit from a supportive environment. The NTPCU was created in leased accommodation on the first-floor wing of a newly built nursing home, set within the hospital grounds and alongside an elderly care ward. It has 19 single rooms with en suite toilets and has been modified to meet hospital ward specifications. The WPCU is based on the main hospital corridor and has 20 beds; two bays of six beds, one bay of three beds and five single rooms. The ward has been modified to create more private spaces, and the colour scheme together with artwork has been designed to create a calming environment. For families there is a dedicated 'oasis' based in the hospital where they can rest and recharge in purpose-built facilities (Fig 1). This is available for relatives of all palliative care patients, based anywhere in the hospital.

The RLBUHT APCU incorporated the views of clinical staff, patients and families in to the design of the unit. A standard ward footprint was used within the main hospital building, but through using dedicated interior designers, particular features were created to enhance the environment: a hotel-style reception instead of a nurses' station, a family and friends' suite, complementary therapies suite and a separate clinical hub, in a setting of carefully chosen colour schemes and artwork to retain an air of calm (Fig 2).

Fig 1. Wansbeck oasis: relatives' accommodation to rest and recharge away from hospital wards.

Fig 2. Academic Palliative Care Unit, Liverpool: hotel style reception to provide a calmer and more welcoming experience.

There are four single rooms and two four bed bays, alongside dedicated family space.

Outcomes

Patient experience data from all three PCUs has been very high. Data from NHFT shows the creation of the PCUs has coincided with a progressive increase in the proportion of deaths at home and in the PCUs, with a significant reduction in deaths in acute hospital beds for the whole population. This, coupled with excellent patient experience data, has led to both trusts gaining national awards. Length of stay is 12–13 days with a discharge rate of about 50%.[8] The implementation of the RLBUHT APCU has been formally evaluated and, to date, shows an improvement in the timely discharge of complex specialist palliative care patients, with no increase in hospital deaths and an overwhelmingly positive response from stakeholders, patients and families,[7] as demonstrated by 100% positive results from the 'friends and family test'. Royal Liverpool and Broadgreen University Hospitals NHS Trust APCU data demonstrates an interesting cancer to non-cancer ratio, with 55% of patients having cancer and 45% non-cancer. This compares with a hospice mean of about 80% cancer and 20% non-cancer.[10]

Discussion

Delivering these innovative service models has required a number of key enablers:

Prioritising palliative and end-of-life care within the trust

Many acute hospital trusts are struggling with the provision of EoLC, and have been criticised for not giving EoLC a high enough priority or considering it core business.[1] In contrast, both NHFT and RLBUHT have clear strategies for its delivery with chief executive and board level leadership and scrutiny. This is further backed up by significant investment in palliative and end-of-life services and initiatives by reallocating resources from other acute services.

The clinicians and leaders of both palliative care services are outward looking with significant leadership roles, both within the trust and outside (clinical, management and academic). This is crucial in building trust within the organisation and allowing the confidence to take calculated risks such as creating the first PCUs in the country. Doing this without much evidence risked

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organisational reputation and local relationships in challenging a UK assumption that only hospices could deliver inpatient palliative care. Other concerns were a potential rise in hospital mortality rates (if more patients chose to die in hospital as a result of creating PCUs) and a potential reduction in the quality of palliative care in the rest of the hospital. In fact, creating the PCUs has given an additional visible presence to palliative care services helping to drive improvement throughout the hospital. This raises the profile of EoLC at all levels, helping to shape conversations and the strategic decisions that follow.

Organisation and funding

The PCUs are part of the medical beds in the hospital, created through reallocating medical beds to become palliative care beds. Clinically, this enables shared care and patients with more complex, higher dependency palliative and end-of-life care needs to have their care led by a palliative care consultant and specialist team, which would not be possible in other care settings. There is no extra cost attached to the palliative care beds, which attract a medicine tariff. Both organisations have seen an overall reduction in total beds so the PCUs have not placed additional strain on hospital services, eg junior doctors out of hours. This costs much less than a traditional hospice model, while offering a higher level of medical support than is possible in a hospice setting. This is because staffing levels are based on hospital ward levels, rather than a hospice, where economies of scale are achieved through being part of a larger hospital and not a stand-alone unit. Additionally, because PCUs are not specifically commissioned, the number of beds can be flexed according to clinical and organisational need; money can flow within an organisation more readily and creatively, whereas attempts to shift resource from hospital to community-based palliative care services have met with limited success. There is little evidence to support that investment in community palliative care services leads to a reduction in acute bed need.

Both organisations are committed to partnerships which enhance services, including academically with universities to enhance training and research alongside national organisations. This enables funding and expertise to come from multiple sources.

Following the CQC rating of 'Outstanding' for EoLC at the RLBUHT in July 2016, the trust took the step of consolidating its clinical and academic expertise through the establishment of an Academic Palliative and End of Life Care Centre with the aim of driving forward outstanding, evidence-based care for patients and their families. This academic centre brings together the AHSPCT and APCU clinical services in one Academic Palliative and End of Life Care Department within the trust and aligns this more closely with three other key pillars: the Palliative Care Institute at the University of Liverpool, and an EoLC strategic programme and supportive care services at the trust (Fig 3). This enables

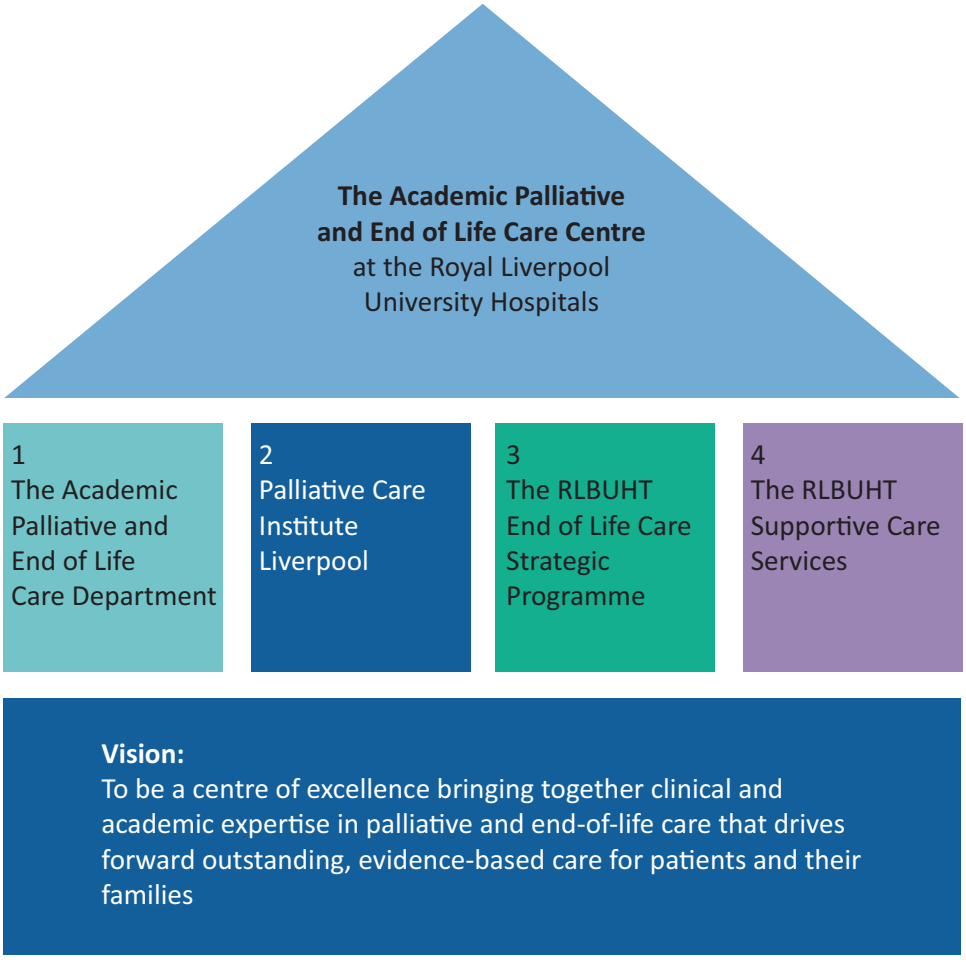

Fig 3. Liverpool Academic Palliative and End of Life Care Centre organisational structure.

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Fig 4. Northumbria Healthcare NHS Trust Palliative Care organisational structure.

greater coordination and alignment of research and development, education and service improvement programmes within palliative and end-of-life care. Crucially, it also facilitates the transfer of learning from this outstanding service across healthcare within the trust, for example through the Academic Centre's 'Communicating hospitals' programme.

Northumbria Healthcare Foundation Trust refreshed its approach to palliative and end-of-life services about 10 years ago. A steering group (consisting of the service leadership together with trust directors from the full spectrum of trust services) scrutinises data, models and strategy to make sure the end of life model is working effectively. This group is accountable to the board (Fig 4). The clinical service has four key elements: a joint venture with the national charity Marie Curie to deliver hospital and community specialist teams including a rapid response service 7 days a week, the inpatient palliative care units, support services (befriending, bereavement and day hospice) in partnership with Macmillan Cancer Support, and the education and research programme. The single service leadership and steering group ensures the cohesiveness of the service and was praised by CQC in awarding the trust 'outstanding' for EoLC.

Research

The development and implementation of the RLBUHT palliative care service is underpinned by research. The Academic Palliative and End of life Care Department is headed by a service manager with a nursing background and a professor of palliative medicine as clinical director, who are also associate director and director, respectively, of the Marie Curie Palliative Care Institute Liverpool (MCPCIL). The MCPCIL provides a robust academic underpinning for the unit and is a three-way partnership between the RLBUHT, the University of Liverpool and Marie Curie. The APCU was designed to both deliver research-based care and to enable patients to take part in research that improves care for the future, as innovations and learning are shared across the UK as well as globally.

Northumbria Healthcare Foundation Trust palliative care service has created a number of joint posts with Newcastle University as a means of recruiting high-calibre consultants and creating a clinical environment that continuously strives to improve the quality of its care. The palliative care service runs a successful doctorate programme and is currently in discussions with local partners to set up a full university academic department recognising the key relationship between service delivery, research and quality improvement.

Anticipatory decision making

Both organisations place a strong emphasis on advance care planning processes, crucially the discussion that takes place between staff and patients, and any plans that result. All trusts have a key focus on recognising the deteriorating patient through the use of a National Early Warning System (NEWS).[11] The important next step is deciding what action should follow. For patients with complex needs, especially palliative care needs, a reflex escalation in care can often lead to the wrong outcomes. These decisions often have to be made in the out-of-hours period by doctors in training with no prior knowledge of the patients. Northumbria Healthcare Foundation Trust has addressed this by a system-wide approach (led by critical care and palliative care) to communicating ahead of time how any deterioration in condition should be managed. A treatment escalation planning document is used throughout the trust to anticipate possible deteriorations in a patient's condition and set appropriate escalations of care with patients and their family.[8] This becomes a much more encompassing, holistic conversation than a 'Do not attempt cardiopulmonary resuscitation' (DNACPR) conversation, leading both to escalation and de-escalation of care, as appropriate.

Conclusions

In addressing the aspirations set out in the national framework *Ambitions for end-of-life care*,[12] both RLBUHT and NHFT have shown that hospital trusts can achieve more than simply making EoLC core business. End-of-life care can be a strength of an acute trust when the right service model is delivered.[5,6]

Palliative care units have been recommended as a model of good practice.[13] In particular, we believe the role of hospital PCUs will become increasingly important as the demographics of the population change and frailty, patients with multiple comorbidities and multiple organ failures come to the fore. The overlap with medical specialties will become increasingly important; RLBUHT is addressing this challenge by having a combined APCU with general medicine beds in the new hospital. With an increasing drive nationally to think about 'realistic medicine'[14] and the personalisation of care in those with complex problems, PCUs are well placed to improve care through dedicated specialist beds and reduce the number of people dying in acute beds without increasing cost. ■

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