

Emergency Care Improvement Programme and End of Life Care: Addenbrooke's Hospital, Cambridge University Hospital

Background

The ambition of the ECIP End of Life project was **to improve the quality of care for patients who may be in their last three months of life who attend or are admitted to hospital in an emergency**, recognising the different needs of this group of patients in order to facilitate the right care, in the right place by the right person.

The project was commissioned by NHS Improvement as a developmental pilot to test proof of concept and as such set aside from the main ECIP programme. The project took a different approach working in partnership with the voluntary sector, the National Council for Palliative Care (NCPC), and relevant experts using QI (Quality Improvement) methodology. The intention was for the project to be very specific with a narrow scope enabling site teams to focus on acute admissions and the accident and emergency department (A&E) for people who may be in the last three months of life. Starting in May/June 2016 the project was initially due to run for 12 months but was given six months extension to finish at the end of September 2017.

Four site teams were selected from across the country that were part of the main ECIP cohort and offered an opportunity to receive targeted support to improve end of life care:

Cambridge University Hospitals is a university teaching hospital with over a 1,000 beds. Residents of the CCG, 42% of all deaths were in hospital (2011-13), compared to the national average of 49%. In 2015 there were 1,484 deaths throughout the Trust, with an average of five to six deaths in A&E each month, however the specialist palliative care team did not routinely go into A&E.

Particular challenges included finding the best end of life care language to use with general staff and patients; engaging interest in EoLC from a busy A&E. They were also aware that there were issues with staff not recognising they are providing EoLC when they do; there is little information comes in with patients and minimal 'co-ordination' of EoLC across organisational boundaries; slow Continuing Healthcare Care (CHC) fast track discharges compounded by different geographical

communities having different processes; and there is currently no local CCG EoLC clinical or non-clinical group.

The approach

The approach was taken to work alongside each of the four sites to identify areas for improvement using a three-tiered quality improvement approach underpinned by the use of quality improvement methodology: 1) *a site visit*. 2) *a Patient and Relative Experience Walkthrough*. 3) *Case file review*.

The programme delivery team at the **National Council of Palliative Care** (now **Hospice UK**) designed a **case file review** tool aimed at providing retrospective analysis of the last three months of life of a patient journey for patients admitted through AMU or A&E. The **case file review** was designed to identify **existing good and best practice** as well as **missed opportunities** by looking at pre-existing clinical issues for patients who had been admitted with existing life-limiting or frailty conditions.

Data analysis

A day one census was completed of patients in the hospital on the 21st October 2015 to measure on going mortality. The census included all patients who were inpatients on the day of the census, excluding those in paediatric and maternity services (division E). Available data items included demographics, date of death, division and specialty of those involved in care; admission type (planned and unplanned), and frailty scores for the over 75. For patients who died in the year the census identified; resource utilization data; bed days; admissions and A&E attendances.

Results of the census

858 patients identified in CUHFT on 21st 2015 (excluding those under the care of division E)

Mean age	66.5 years
Percent of female	50.47%
Unplanned admissions	82.28%
Over the following 365 days, of the 858:	
Number of patients that died	223 (25.99%)
Number that died in CUH	51 (5.94%)
Median number if A&E attendance	2
The median bed days in the census year	40
The median number of admissions in the census year	3

This census replicated a study from Scottish hospitals¹ and showed CUH has similar results where over a quarter of patients had died in the year. Predictions of survival were calculated and shared with clinicians.

Case file review

The case file review identified 1,157 adult patients who died in Cambridge University Hospitals in 2016 (excluding patients who were admitted directly to intensive care); 299 (26%) patients had a length of stay of less than three days, while 60% patients dying in CUH had either been an outpatient or inpatient in the previous three months.

In addition the case study provided evidence of patients receiving treatment that may be non-beneficial as well as evidence of excellent discussions relating to end of life care with relatives on first day of admission but not always relayed to ward team or actioned.

This project came a year in to a three-year strategy for end of life care in CUH with revised structure and governance including a 'workbook' that lists every action and is reviewed by EoLC operations and steering groups every other month.

Improvements

Mortality surveillance group including methodology development relating to national directives.

EoLC dashboard with questions based on National Care of the Dying Audit. Vast amount of patient level data pulled through from all available electronic medical records from complaints to specialist palliative care.

Increased SPC activity over the previous year in all areas, not just cancer; thought to be due to increased awareness of SPC services.

Education and training (planned and ad-hoc) and mandatory training: first time end of life care has been incorporated into mandatory training.

Planned revision to communication skills training: communication skills separated out from other training as it was felt that they went beyond end of life care.

EoLC information revised for patients using consistent terminology highlighted by the Patient and Carer Experience Walkthrough.

¹ D Clarke et al 2014. Imminence of death among hospital inpatients: Prevalent cohort study *Palliative Medicine* 2014, Vol. 28(6) 474–479. <http://journals.sagepub.com/doi/pdf/10.1177/0269216314526443>

Improved environment through improvements in corridors and non-clinical areas following Patient and Carer Experience Walkthrough.

Fast track discharge delays have been reduced from 10 to 11 days to six days.

All monitored through the EOLC ops and steering groups.

How do they know if these improvements make a difference?

Expected outcomes:

- A standardised approach to reviewing mortality.
- A trust wide EoLC education plan with trust oversight.
- Raised awareness of EoLC standards within wards (with evidence of achievements to tell the story of implementation).
- A cultural shift (evidence that this has started: non-executive director on steering group, dying matters wide engagement move to ReSPECT, increased referrals to palliative care team, Trust approach to Morbidity and Mortality review).

What resources were needed?

- Time and commitment from clinical leads – work needs owners who have the time to lead and motivate others across a big agenda.
- Have a written prioritised plan to stay focused.
- Patient insight to see that things that professions don't.

Contact

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