The summary and recommendations presented here are for clinicians, and are taken from Improving end-of-life care: professional development for physicians, a working party report from the Royal College of Physicians (RCP). A second leaflet is available, aimed at commissioners, trusts and managers. You can download both leaflets and the full report from the RCP’s website at www.rcplondon.ac.uk/resources/improving-end-of-life-care-professional-development-for-physicians

The report sets out a range of practical proposals and tools to enable all physicians to improve their care of patients towards the end of their lives.

The report’s recommendations are endorsed by Professor Sir Mike Richards, national clinical director for cancer and end of life care, Dame Sally C Davies, chief medical officer and chief scientific advisor and Sir Richard Thompson, president, Royal College of Physicians.

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*The report was prepared by a working party of the Royal College of Physicians, the National End of Life Care Programme and the Association for Palliative Medicine of Great Britain and Ireland. Improving end-of-life care: professional development for physicians. London: RCP, 2012. www.rcplondon.ac.uk/resources/improving-end-of-life-care-professional-development-for-physicians
The need for improved end-of-life care

End-of-life care may span many months or even years. Late recognition of deteriorating health and a prevailing culture where this is not openly discussed with patients until the last days of life, leads to most people dying in the acute hospital environment. When asked, most people would prefer both to spend more time, and to die, at home.

The first National End of Life Care Strategy for England published in 2008 and its counterparts in Scotland and Wales encouraged early recognition of people entering the last phase of their lives with open, sensitive discussion of their preferences for type and place of care. It emphasised that this must be underpinned by training and professional development for a range of staff who deliver care at the end of life.

Many people will continue to die in the acute hospital environment, either by choice or because of the circumstances of their illness. Delivering high-quality care to the dying remains a key part of hospital practice.

Over recent years a wealth of resources has been developed to support the delivery of high-quality care within and across care settings. Although some, such as the Liverpool Care Pathway for the Dying Patient, have been widely adopted, most have not yet become part of routine practice at a personal or organisational level.

The role for physicians in improving end-of-life care

The delivery of good care at the end of life cannot be left to specialists in palliative care but is an important part of the role of most physicians, particularly if the NHS is to cope with an aging population.

In developing the report, an online survey of nearly 2,000 physicians was conducted, which was followed by focus groups and telephone interviews. Most physicians recognised the importance of delivering good end-of-life care in their practice. The majority reported that they were confident and competent in most aspects of such care, although less so when dealing with advance care planning and people with dementia. Surprisingly, only a third had attended any learning event on end-of-life care in the last five years and many of those were on communication skills.

Data from complaints and audits would suggest that either the self-reported confidence of physicians is sometimes misplaced, or that physicians are not putting their skills into practice. The earlier identification of patients entering their last phase of life and planning with them for their preferences for care is an area that is particularly lacking. Patients and their carers have an important role in helping staff to consider their practice more carefully. Patient stories provide a powerful resource, though in this context they may be told by bereaved carers. Physicians should seek ways to incorporate patients’ feedback into their day-to-day care.

Hospital palliative care teams have a key role in setting the culture for end-of-life care as well as delivering high-quality care to those with the highest level of need. Physicians reported having learnt most from spending time with good palliative care teams and services, in joint clinics, ward rounds or placements.

The use of an integrated care pathway for the dying has helped physicians to deliver high-quality care in the last hours and days of life, when it has been underpinned by an extensive programme of education and support. The introduction of tools without such support may lead to a ‘tick box’ approach which is counterproductive and should be discouraged.

Tools to help physicians to recognise the last phase of life earlier in patients’ illnesses and to begin to talk with them about their preferences, such as the AMBER care bundle, should be developed and evaluated. They should be introduced with due regard for the training and support needed to use them appropriately and sensitively.
Recommendations

These recommendations are for clinicians. To see the full set of recommendations, for trust boards, commissioners, medical schools and the RCP, please refer to the full report.

Recommendations for all physicians

> Physicians whose practice includes patients in the last phase of their lives should consider using the ‘Top ten tips’ and ‘Prompts for ward rounds and mortality and morbidity meetings’ provided in this report during their routine practice (see next page and last page).

> Medical consultants should provide leadership in establishing opportunities for professional development in end-of-life care in their own settings, including agreeing how best to implement this as a department/directorate and across the trust.

> Teams involved in end-of-life care should actively plan for cultural change in the delivery of care at the end of life by identifying medical leaders, engaging colleagues and supporting the development of expertise among colleagues.

> In order to influence their practice and ensure that patients have time to adjust, physicians must recognise that end-of-life care is not just care in the last few hours and days but that it marks the last phase of life, which may be many months or sometimes years.

> Professional development for end-of-life care should:
  – strengthen multiprofessional teams and promote collaboration between team members
  – support the development of effective communication skills through interactive approaches such as simulation, observation and practice with feedback
  – use opportunities in routine practice to draw on clinical experiences with a direct relevance to patient care, developing problem-solving and reflective skills
  – actively seek engagement with, and feedback from, patients and caregivers to improve understanding of the patient experience
  – be embedded into a wide range of educational events such as conferences, workshops and study days, not just those that focus specifically on end-of-life care.

> Reflection and learning on end-of-life care should be integrated with daily clinical practice. This may be done through directorate meetings; structured multidisciplinary meetings; mortality and morbidity meetings; joint ward rounds and outpatient clinics with palliative care colleagues; grand rounds; mentoring; and placements.

> Consultants who provide care at the end of life should incorporate this into their continuing professional development (CPD) and undertake at least one learning event in end-of-life care within a five-year CPD cycle. This should be reviewed at their annual consultant appraisal.

> Hospital and primary care teams should acquaint themselves with the range of general and disease-specific tools to identify patients with advanced illness, or who may be approaching the end of life, and consider their applicability and use within their routine practice.

> Joint learning with GPs should be encouraged to further the understanding of each other’s roles and services and to improve coordination of care across traditional boundaries.

> The use of e-learning, such as End of Life Care for All (e-ELCA), to support work-based learning should be included where relevant.
Recommendations for palliative care teams

> Specialist palliative care clinicians should develop wide-ranging educational skills in supporting colleagues through formal and non-formal learning by:
  – using structured interactive events
  – facilitating effective bedside teaching
  – conducting joint ward rounds and mentoring colleagues
  – facilitating mortality and morbidity meetings.

> Hospital palliative care teams should include leading professional development in end-of-life care as an integral part of their role. This should include providing support as well as working with staff from other disciplines and professions to learn with, and from, them.

> Local palliative care providers should work with the palliative and end-of-life care networks to deliver more extensive and targeted CPD for physicians.

Top ten tips for physicians

1. **Integrate palliative care into your daily practice** — ask a member of your palliative care team to attend clinics, ward rounds and multidisciplinary team meetings, especially in areas with a high proportion of patients who require palliative care.

2. **Adopt the ‘prompt tool’ during the post-take ward round** to help identify patients who require supportive care (see last page).

3. **Adopt the ‘prompt tool’ during mortality and morbidity meetings** to see whether patients’ choices for type and place of care were ascertained in a timely way and acted on (see last page).

4. **Actively incorporate feedback from patients and carers** to guide your professional development.

5. **Refer to your local palliative care guidelines** for quick reference and a stepwise management guide to common palliative care problems.

6. **Include at least one learning event on ‘end-of-life care’** within a 5-year continuing professional development (CPD) cycle.

7. **Find an up-to-date list of useful courses on palliative and end-of-life care** locally and nationally at [www.apmonline.org](http://www.apmonline.org).

8. **Approach your hospital palliative care team** to find out about professional development opportunities in your trust or unit.

9. **Find advice and guidance on prescribing in palliative care** by registering at [www.palliativedrugs.com](http://www.palliativedrugs.com).

Prompt tool for post-take ward rounds / general ward rounds

> Does the patient have an advance care plan?
> Does the patient have a valid and applicable advance decision to refuse treatment (ADRT)?
> Does the patient fall into one of these categories:
  - advanced, progressive, incurable condition(s)
  - general frailty and coexisting conditions that mean they may be expected to die within 12 months
  - existing condition(s) where they are at risk of dying from a sudden acute crisis
  - life-threatening acute condition caused by sudden catastrophic event(s)?

If so, discuss preferences of treatment and place of care with the patient and their family.

Prompt tool for mortality and morbidity meetings

> Was this death expected?
> Were the patient’s priorities for end-of-life care (eg place of care/death) known?
  - If yes, were they adhered to?
  - If no, were there opportunities for advance care planning?
> Was the patient’s terminal care supported by an integrated care pathway for the dying patient?
  - If not, should it have been?

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2 Marie Curie Palliative Care Institute. Liverpool Care Pathway for the Dying Patient. www.lcp.mcpcil.org.uk/liverpool-care-pathway

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