we learn

Sandwell and West Birmingham NHS Trust

@SWBQuality

Organisation Wide Learning

Learning from National Reports — Edition: May 2023

Welcome to May 2023 edition of welearn. #welearnWednesday

Each Month we will present key learning themes from local serious incidents, investigations, complaints, litigation, or coroner cases.

The learning may not have a direct link to your area of work. However, the learning provides an opportunity to reflect on some of the wider issues that could be for you to consider.

This Month we are looking and identifying where we take learning from National reports

National Reports

There are a number of important aspects that we ought to reflect on when learning from National Reports:

- They aid us to “spotlight” areas for improvement, to consider ways of evaluating and implementing their findings
- They give us a picture of the standard of care across Trusts to determine where our services compare with others
- National Safety investigations or Reports may be via independent organisations that aid to inform national policy change or national Health and Social Care reviews
- They showcase what we do well

HQIP Healthcare Quality Improvement Partnership

2023 summaries

GO TO
https://www.hqip.org.uk/programme-summaries/

*National Hip Fracture Database: updated 23 February 2023

*National Lung Cancer Audit (NLCA) – State of the nation report 2023

*National Audit of Breast Cancer in Older Patients:15 February 2023

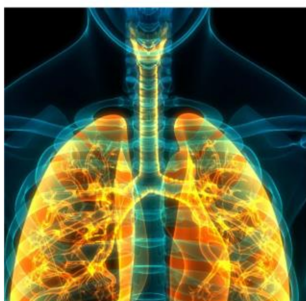
*Oesophageal Caner Report: 12 January 2023

*National Intensive Care Audit: 10 Feb 2023

Focus On: NLCA

National Lung Cancer Audit

The report found that the number of patients diagnosed in England in 2021 has recovered to pre- pandemic levels, with 34,478 patients diagnosed with lung cancer (31,371 in 2020 and 33,091 in 2019).



Focus on: National Audit of Care at the End of Life (NACEL)

This Audit helps us see how we measure up against best practice standards to find opportunities to improve the quality of care of people and those important to them at the end of life in our hospitals, highlighting what works well and what can be improved.

By auditing the notes of people who had died, surveying of our clinicians and bereaved family members they found that our areas needing improvement are:

1. recognising the possibility of imminent death.
2. the use of an individualised plan of care (SCP) to guide good care, completed by the multi-disciplinary team.
3. Meeting the needs of families.

Consistently excellent care at the end of life

Summary Domain Compliance Over Time, including Category Scores

	National 2022	SWB 2022	SWB 2021	SWB 2019	SWB 2018
Recognising the possibility of imminent death	↓70%	↓60%	↑66%	↓64%	75%
Domain score		- no longer scored -			8.7
Communication with the dying person	↑85%	↑79%	↑74%	↑56%	38%
Domain score	8.0	7.5	6.6	6.0	6.5
Communication with families and others	↑71%	↑67%	↓60%	↑64%	45%
Domain score	7.1	7.0	5.9	6.0	5.8
Involved in decision making	↓92%	↑92%	↑89%	-	63%
Domain score	9.2	9.2	8.9	-	8.0
Individualised plan of care	↑71%	↑63%	↓61%	↑64%	50%
Domain score	7.6	6.6	5.8	5.7	6.5
Needs of families and others	↑58%	↓32%	↓39%	↑56%	39%
Domain score	5.5	3.4	4.2	4.5	5.7
Families' and others' experience of care	↓70%	↓50%	↓51%	↓56%	58%
Domain score	6.3	4.4	4.7	6.1	3.3
Governance	-	-	↑100%	-	75%
Domain score	-	-	10	-	7.5
Workforce/specialist palliative care	↓67%	↑94%	↑72%	↑64%	48%
Domain score	8.1	10	8.8	8.8	8.3
Staff confidence	↑77%	↑85%	74%	-	-
Domain score	7.5	7.4	7.4	-	-
Staff support	↑69%	↑71%	48%	-	-
Domain score	7.1	6.9	5.8	-	-
Care and culture	↑78%	↑73%	64%	-	-
Domain score	7.6	6.8	6.8	-	-

Please take time to read and understand where we benchmark nationally and where we have worsened or improved year on year.

Consider your own practice and how this resonates with you: where you may require more knowledge or skills in caring for our patients and families as they approach the end of their lives?

KEY LEARNING

1. We need to support families more.
2. Staff who completed the survey felt confident to care but this wasn't matched by family experience.
3. Communication with families about choices, prognosis and medications can be improved.
4. Late recognition of dying reduces choices and means many people die in hospital who would have preferred to die elsewhere.

It's time to:

✓Think early about whether someone might be dying and communicate this possibility clearly.

✓Start a Supportive Care plan earlier to support choice & care.

✓Involve patient and their families in conversations to focus on what matters most.

✓Consider whether invasive and burdensome treatments are likely to benefit.

✓Involve all of the multidisciplinary team to support our patients and the people who care for them.

What can I do?

1. Upskill yourself using EOL training modules and face to face training.
2. Reflect and review what happens now in your clinical area, what goes well what could be better?
3. Find ways to hear patient and family feedback to focus on what will make a difference.
4. Check you local quality end of life dashboard data.
5. Access supporting information and guidance at Connected Palliative Care (swbh.nhs.uk) intranet page

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At SWB every person who is approaching the end of their life should be seen, heard and cared for by people who understand their needs.

National Audit of Care at the End of Life

Healthcare Safety Investigation Branch (HSIB)

Harm caused by Clinical investigation booking systems'

https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/hsib-interim-bulletin-clinical-investigation-booking-systems-failures.pdf

Healthcare services use paper-based or fully electronic systems, or a combination of the two (hybrid systems), to communicate to patients the time, date and location of their appointment.

These systems also produce information for patients about actions they need to take to prepare for their appointment.

Written patient communication is a key output of clinical investigation booking systems.

The investigation has **identified issues with written communication to non-English speaking patients and their families**.

The investigation has found **that trusts have relied on patients having access to friends or family** who can translate written Communications for them. The expectation to use friends or family for this purpose means that patients may have no choice other than to share private and personal information which they ordinarily would not. This reliance can create opportunities for misunderstandings, or **issues of control where relationships or cultural influences may influence the information passed on.**

Harm caused by delays in transferring patients to the right place of care

(Interim 3rd Bulletin Feb 27, 2023).

In February HSIB published their 3rd interim bulletin as part of this investigation, which recommends a national response to tackle this urgent issue: the impact including patient experiences that pertain to related safety issues.

Reviews identify that we need to ***improve patient and caregiver experiences with delayed hospital discharge***, including ***enhanced communication*** with patients and families. Taking *a* ***person-centred approach to care delivery*** is particularly important during care transitions when patients and caregivers are often at their most vulnerable.

Case Study: January 2023 a Norfolk coroner warned that ambulance transfer delays risk future deaths. She sent a Regulation 28 Report to Prevent Future Deaths to: Steve Barclay MP and The Norfolk and Waveney Integrated Care Board and Chief Coroner with a response awaited and due 3rd March 2023.

Question: Do we fully understand our patients and caregivers perspectives towards delayed hospital discharge and the context surrounding delayed discharges? Are we focussing mostly on safety and less so on experience in this context?

Recommendation: Have a better understanding of the experiences of patients and caregivers that could contribute to patient- and family-centred approaches and strategies to address delayed hospital discharges.

Care Quality Commission

2023 Reports

A review to identify improvements in how CQC learn from, respond to and act on concerns.

Monitoring Mental Health Act

***Monitoring the Mental Health Act is our annual report on the use of the Mental Health Act (MHA).**
It looks at how providers are caring for patients, and whether patients' rights are being protected.

https://www.cqc.org.uk/publications/monitoring-mental-health-act/2021-2022

An independent review which Zoë Leventhal KC was appointed to lead. This looks into the handling of protected disclosures shared by Mr Kumar, alongside a sample of other information of concern shared with us by health and care staff.

On 24 August 2022, the Employment Tribunal found that Mr Shyam Kumar, a consultant orthopaedic surgeon employed at University Hospitals of Morecambe Bay NHS Foundation Trust, had been disengaged from his role as a Specialist Advisor within the Care Quality Commission (CQC) on account of having made "protected disclosures" to the CQC. This means he had raised concerns with CQC about the health of patients and other important issues and had done so in the public interest.

https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.cqc.org.uk%2Fsites%2Fdefault%2Ffiles%2F2023-03%2F20230328%2520Executive%2520summary_0.odt&wdOrigin=BROWSELINK

NHS England

Experiences of being in hospital for people with a learning disability and autistic people November 2022

'Please allow me to tell you a true story that happened a few days ago.

I took my little dog to the vet because he had injured his front paw. Ted was in pain and was being very difficult for the vetto treat. He was scared, it was bright, it was noisy, he did not know the vet or the nurse, he was getting agitated and began to bark and whimper. I observed the vet talk softly, quietly, and soothingly to Ted. I observed her standing back, giving Ted time and space, she was building his trust. She turned to me as Ted's carer and asked what worked best for Ted. I told her that the environment was too noisy for him. She immediately moved Ted to a quieter room, dimming down the light. She continued to reassure Ted, using a soft tone that was relaxed. Ted relaxed and his paw was treated effectively, he had a positive outcome.'

Recommendations: The Oliver McGowan Mandatory Training on Learning Disability and Autism is delivered in one of two Tiers.

HEE recently developed The Oliver McGowan Mandatory Training Tier guidance for employers with examples.

Five principles for implementing the NHS Impact approach to improvement in England

This Report describes 5 guiding principles that should inform implementing the NHS Impact approach to improvement to maximise the chances of success in the current climate. They present recommendations for provider organisation, system and national leaders on the steps needed to translate these principles into sustained improvements across ICSs.

https://www.health.org.uk/publications/long-reads/five-principles-for-implementing-the-nhs-impact-approach