COMMON THEMES 2024

A summary of themes arising from NCEPOD reports relevant to all healthcare specialties

NCEPOD

Improving the quality of healthcare

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INTRODUCTION AND METHOD

The Confidential Enquiry into Perioperative Deaths (CEPOD) was published in 1987 in response to professional concern about perioperative deaths.[1] After the publication of the report the Department of Health announced that it would fund a National Confidential Enquiry to repeat the work, and so NCEPOD as an organisation was established, publishing its first report in 1989.[2] NCEPOD reviewed in-hospital perioperative deaths annually until 2003 when its remit was extended to review the quality of medical care too. At that time the method was also changed so that anyone could suggest an idea for a topic for review and the topics and reviews became more focused. Each report explores a specific topic in detail and over the years, several common themes have emerged that are relevant to the care of all patients admitted to hospital.

In 2018 we drafted a review of these common themes – the report can be read here.

In 2024 we reviewed this document in light of more recent reports and produced this second version. We have added in the following themes:

1. Communication with the family, parents and carers
2. Developing a personalised transition plan
3. Post-discharge follow-up

And we have removed themes no longer considered pertinent:

1. Critical care review
2. Supervision of trainee doctors
3. Morbidity and mortality reviews
4. Common clinical condition

METHOD

This report is an extension to the previous report. To extract the common themes for this report, all NCEPOD recommendations were listed and marked as a theme according to content by one reviewer Hafsa Rubab.

Each theme was then counted and ranked into numerical order. The top nine themes were included in this review. Certain themes from the previous report have been incorporated into this report as they are still relevant.

This report is intended to be an evolving document and a 'living report.' As NCEPOD undertakes more studies further evidence will be added to the chapters and possibly chapters will no longer be relevant or new ones will emerge, either from changes in practice in healthcare or perhaps a light being shone on the smaller common themes that have evolved over the lifetime of NCEPOD reports.

COMMON THEME 1: MULTIDISCIPLINARY REVIEW

A young patient with diabetes was admitted with critical foot ischaemia, sepsis and low blood pressure. They had an acute kidney injury on admission and blood sugar was poorly controlled. Amputation was deferred until the medical complications had stabilised. The first review by a physician was by the medical registrar seven days after admission following a medical emergency call when the patient developed signs of severe sepsis.

The reviewers commented that the pre-operative care was poorly organised. Earlier review by a medical team could have optimised management of diabetes, sepsis and renal function and both prevented deterioration and allowed earlier surgery.

Since the remit of NCEPOD was changed in 2003 to look at medical as well as surgical care, the emphasis on the patient pathway has become the focus of many reports. As the demographics of the patient population have shown a natural tendency towards older age, reflecting the general population, the prevalence of co-morbid conditions has also increased. This has impacted on the skills of the team who treat the patient, as the need for multidisciplinary input is ever increasing. Multidisciplinary reviews will be required at various stages of the pathway. At admission the need for both medical and surgical involvement may be seen. Prior to planned admissions for surgical and other invasive procedures, there will be involvement by pre-operative assessment teams. Throughout the patient's stay until discharge there may be the requirement of acute pain teams, dietitians, alcohol-liaison services or physiotherapists for example. *This area of MDT input overlaps with the common theme of follow-up after discharge (Chapter 9).*

This theme is based on 10,455 cases from 23 past reports since 2000.
NCEPOD reports on which the above recommendation was formed.

2023	Crohn's Disease – Making the Cut	Page 8 Rec. 3
2023	Transition from Child into Adult Healthcare – The Inbetweeners	Page 9 Rec. 4 & 8
2021	Dysphagia in Parkinson's Disease – Hard to Swallow	Page 10 Rec. 8
2020	Long Term Ventilation – Balancing the Pressures	Page 13 Rec. 3
2019	Mental Healthcare in Young People and Young Adults	Page 10 Rec. 4
2018	Perioperative Diabetes – High and Lows	Page 14 Rec. 7
2018	Cancer in Children, Teens and Young Adults – On the Right Course	Page 61 Rec. 1
2018	Acute heart failure – Failure to Function	Page 81 Recs. 2 & 3
2017	Mental healthcare in General Hospitals – Treat as One	Page 87 Rec. 17
2016	Acute Pancreatitis – Treat the Cause	Page 71 Rec. 6
2014	Lower Limb Amputation – Working Together	Page 123 Rec. 4
2014	Tracheostomies – On the Right Trach	Page 101 Rec. 15
2013	Alcohol-Related Liver Disease – Measuring the Units	Page 37 Rec. 2
2012	Bariatric Surgery – Too Lean a Service	Page 51 Recs. 3 & 4
2011	Surgery in Children – Are we There Yet	Page 70 Rec. 4
2010	Surgery in the Elderly – An Age Old Problem	Page 39 Recs. 1 & 3
2010	Parenteral Nutrition – A Mixed Bag	Page 78 Rec. 1

2008	Coronary Artery Bypass Grafts – The Heart of the Matter	Page 71 Recs. 1,2 & 5
2008	Systemic Anticancer Therapy – For Better, For Worse	Page 65 Rec. 1
2008	Sickle Cell Disease – A Sickle Crisis	Page 46 Rec. 2
2007	Trauma – Trauma: Who Cares?	Page 48 Rec. 1
2004	Endoscopy – Scoping Our Practice	Recs. Rec. 2
2001	Perioperative Deaths – Changing the Way We Operate	Page 75 Rec. 1

Links to relevant external documents

Royal College of Physicians of London Future Hospital Commission

NHS England » Making it happen: Multi-disciplinary team (MDT) working

COMMON THEME 2: COMMUNICATION WITH FAMILY, PARENTS AND CARERS

An older teenager with relapsed Hodgkin's Lymphoma underwent allogenic stem cell transplant to consolidate the chance of cure. The patient was discharged home with no obvious information on how to get back in touch if any issues occurred. A month later they presented with fever and infection. The patient was admitted to critical care with multi-organ failure and died there a week later.

When the patient had been seen in clinic a few days before admission there was a 3-day history of infection which had not been investigated further. English was not the family's first language.

The reviewers considered that this case exemplified the need for patients and relatives to be made aware of the possible complications, how to recognise them and what to do in the event of a complication occurring.

Hospital admissions present an excellent opportunity to assess and enhance a patient's general physical health and involving family/carers can offer valuable support. Following a patient's admission to the hospital, decisions on patients' care should be taken in collaboration with the patient, their family and carers. Their Involvement in the planning and treatment options is a fundamental element of good medical practice (GMP). This includes ensuring access to clear information regarding a patient's treatment upon admission to the ward, updating ward staff about the patient's general well-being, and informing family and friends about how they can support the patient's recovery. Additionally, they should receive clear instructions regarding any post-discharge follow-up plans and be informed about the benefits and potential side effects of any treatment.

This theme is based on 1,067cases from 7 past reports since 2018.
NCEPOD reports on which the above recommendation was formed.

2023	Transition from Child into Adult Healthcare – The Inbetweeners	Page 9 Rec. 2
2022	Physical Healthcare in Mental Health Inpatient Settings – A Picture of Health	Page 11 Rec. 7
2021	Dysphagia in Parkinson's Disease – Hard to swallow	Page 9 Rec. 2 Page 11 Rec. 10
2020	Long Term Ventilation: Balancing the Pressures	Page13 Rec. 4
2020	Acute Bowel Obstruction – Delay in Transit	Page 13 Rec. 10
2018	Cancer in Children, Teens and Young Adults – On the Right Course	Page 62 Rec. 6 Page 63 Rec. 13
2018	Acute Heart Failure – Failure to Function	Page 82 Rec. 8

Links to relevant external documents

Patient and Family Involvement: A Discussion of Co-Led Redesign of Healthcare Services
Communication between family carers and health professionals about end-of-life care for older people in the acute hospital setting: a qualitative study - PMC (nih.gov)

COMMON THEME 3: CONSENT

An elderly patient with multiple comorbidities was admitted from a nursing home with faeculent vomiting and abdominal distension. An abdominal X-ray showed large bowel obstruction. The patient was resuscitated with intravenous fluids and underwent a CT scan within 24 hours which showed a sigmoid colon cancer with liver metastases. The patient underwent a laparotomy with bowel resection and end colostomy, at which peritoneal disease was noted. The patient was treated in critical care postoperatively but deteriorated with pneumonia once on the ward and died three weeks after admission when a decision was made not to escalate treatment further.

Case reviewers believed other options for treatment were not considered or discussed with the patient. They stated that the patient underwent a major surgical intervention without considering less invasive procedures such as stenting or stoma formation which may have been more appropriate in this situation. Palliative care aimed at symptom control was also not considered or discussed with the patient.

Consent is an issue that has been investigated in several NCEPOD surgical reports. The GMC provides guidance on who should obtain consent: "*If you are the doctor providing treatment or undertaking an investigation, it is your responsibility to discuss it with the patient and obtain consent, as you will have a comprehensive understanding of the procedure or treatment, how it is carried out and the risks attached to it. Where this is not practicable, you may delegate these tasks provided you ensure the person to whom you delegate: is suitably trained and qualified; has sufficient knowledge of the proposed investigation or treatment, and understands the risks involved; acts in accordance with GMC guidance*".[1]

All too frequently NCEPOD has commented on, and viewed examples of poor consent processes. These have included examples such as no evidence of consent, those taking consent being too junior, absence of any risk recorded on the consent, inappropriate consent such as lack of consideration to the mental capacity of the patient, or their age, rushed consent, illegible consent and poor evidence of communication with the patient.

This theme is based on 9,521 cases from 14 past reports since 2000.
NCEPOD reports on which the above recommendation was formed.

2023	Crohn's Disease – Making the Cut	Page 9 Rec. 10
2022	Physical Healthcare in Mental Health Inpatient Settings – A Picture of Health	Page 9 Rec. 2
2019	Mental Healthcare in Young People and Young Adults	Page 14 Rec. 10
2018	Cancer in Children, Teens and Young Adults – On the Right Course	Page 62 Rec. 4 &5
2014	Lower Limb Amputation – Working Together	Page 124 Rec. 11
2012	Bariatric Surgery – Too Lean a Service	Page 63 Rec. 1
2011	Perioperative Care – Knowing the Risk	Page 46 Rec. 3
2011	Surgery in Children – Are we There Yet	Page 71 Rec. 1
2010	Surgery in the Elderly – An Age Old Problem	Page 39 Rec. 2

2010	Cosmetic Surgery – On the Face of it	Page 8 Rec. 5
2008	Coronary Artery Bypass Grafts – The Heart of the Matter	Page 128 Recs. 2-4
2008	Systemic Anticancer Therapy – For Better, For Worse	Page 65 Recs. 3-5
2004	Endoscopy – Scoping Our Practice	Recs. Rec. 4
2001	Perioperative Deaths – Changing the Way We Operate	Page 61 Rec. 5

References

1. General Medical Council: Consent, patients and doctors making decisions together

Links to relevant external documents

NHS - Consent to treatment

COMMON THEME 4: MONITORING AND EARLY WARNING SCORES

An elderly patient presented to hospital with a five-day history of severe diarrhoea. Initial physiological observations were blood pressure 95/55mmHg, pulse 135 bpm, temperature 37.9˚ C. There was no record of respiratory rate or urine output. There was no record of an assessment of volaemic status. Over the next 48 hours observations were repeated eight times and revealed persistent hypotension, tachycardia and, on the four occasions where it was measured, tachypnoea. No urinary catheter was inserted. Biochemistry performed 48 hours after admission showed urea 33mmol/l, creatinine 455micromol/l and a severe metabolic acidosis. Despite eventual escalation of care to include critical care admission and renal replacement therapy the patient did not recover.

Case reviewers believed that there were long delays in recognition of signs of acute illness that prevented the provision of timely and appropriate care. The use of the National Early Warning Score (NEWS2) may have prevented these delays.

Deficiencies in the recognition of ill patients have been identified for many years and the care of the acutely ill hospitalised patient presents ongoing problems for healthcare services. Deficiencies are often related to poor management of simple aspects of acute care – those involving the patient's airway, breathing and circulation, oxygen therapy, fluid balance and monitoring. Other contributory factors highlighted in many NCEPOD reports include organisational failures, such as a lack of knowledge, failure to appreciate the clinical urgency of a situation, a lack of supervision, failure to seek advice, delayed response and poor communication.

NICE published a clinical guideline for the recognition and assessment of the acutely unwell inpatient.[1] This comprehensive document takes note of previous NCEPOD work and makes recommendations to provide a structure for recognising and responding to acute illness. One of the major elements of these recommendations is a 'track and trigger' system or early warning score (EWS). Various scoring systems have been developed.

A standardised approach has been developed with the introduction of a National Early Warning Score – NEWS2.[2] This consists of a monitoring tool which can track changes in patient condition to ensure rapid identification of high-risk patients and a structure to ensure an appropriate response.

This theme is based on 26,652 cases from 21 past reports since 2000.
NCEPOD reports on which the above recommendation was formed.

2022	Epilepsy Care – Disordered Activity	Page 9 Rec. 11 & 12
2022	Physical Healthcare in Mental Health Inpatient Settings – A Picture of Health	Page 9 Rec. 1
2020	Long Term Ventilation – Balancing the Pressures	Page 15 Rec. 10
2018	Acute Heart Failure – Failure to Function	Page 82 Rec. 7
2016	Acute Pancreatitis – Treat the Cause	Page 71 Rec. 5

2015	Sepsis – Just Say Sepsis!	Page 107 Rec. 5
2014	Tracheostomies – On the Right Trach	Page 91 Rec. 13
2013	Alcohol-Related Liver Disease – Measuring the Units	Page 63 Rec. 19
2012	Cardiac Arrests – Time to Intervene	Page 60 Rec. 2
2011	Perioperative Care – Knowing the Risk	Page 46 Rec. 5
2010	Surgery in the Elderly – An Age Old Problem	Page 79 Recs. 1 & 2
2010	Parenteral Nutrition – A Mixed Bag	Page 30 Recs. 4-6
2009	Deaths in Acute Hospitals – Caring to the End	Page 54 Rec. 1
2009	Acute Kidney Injury – Adding Insult to Injury	Page 43 Rec. 2
2008	Coronary Artery Bypass Grafts – The Heart of the Matter	Page 92 Rec. 4
2008	Sickle Cell Disease – A Sickle Crisis	Page 58 Recs. 1&2
2007	Emergency Admissions – A Journey in the Right Direction	Page 67 Recs. 2&3
2005	Critically Ill Patients – An Acute Problem	Sect 4 Rec. 5
2004	Endoscopy – Scoping Our Practice	Recs. Rec. 10
2002	Perioperative Deaths – Functioning as a team	Page 63 Rec. 3
2001	Perioperative Deaths – Changing the Way We Operate	Page 84 Rec. 3

References

1. NICE Clinical Guideline 50 – acutely ill adults in hospital: recognizing and responding to deterioration

2. Royal College of Physicians – national early warning score (NEWS2)

Links to other relevant external documents

Acute care toolkit 2: High-quality acute care

Acute care toolkit 6: The medical patient at risk

COMMON THEME 5: DOCUMENTATION

A 45-year-old patient with schizophrenia, diabetes and COPD was admitted with a relapse of psychosis. The admitting on-call doctor carried out an initial physical health assessment. The doctor undertook a medication reconciliation and documented that the day team needed to complete this process and take medical history. Case reviewers noted that for the next four weeks ward round documentation included a cut and paste summary of this initial incomplete and inaccurate medication list and history. Admission physical health observations were also repeatedly re-entered although they were no longer contemporaneous nor accurate. There was an extensive physical health proforma in the patient's notes which was incomplete apart from vital signs.

Reviewers noted the safety risks presented by cutting and pasting inaccurate information into the clinical record and from the use of cumbersome assessment tools that were inconsistently used.

Good Medical Practice states that in providing care clinicians must 'keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to the patients, and any drugs prescribed or other investigation or treatment'.[1] The Patient records should record the frequency and outcomes of take and post take ward rounds. Well written and timely treatment escalation plans help avoid unnecessary procedures and ensure prompt escalation of care, especially if clinical deterioration occurs out of working hours when the admitting team may not be available in the hospital.

The Royal College of Surgeons' 'Good Surgical Practice' makes a number of recommendations regarding record keeping.[2] These include:

- Ensuring all medical records are legible, complete and contemporaneous, and have the patient's identification details on them
- Ensuring that each time an entry is made in the notes they are signed and dated with the name of the most senior surgeon at the visit being noted
- Ensuring that a record is made of important events and communications with the patient or supporter
- Any changes in the treatment plan are recorded
- Ensuring there are legible operative and follow up notes.

The Royal College of Physicians 'Acute Care Toolkit 2' states the quality of record keeping is compromised (on AMU) by a lack of standardised documentation.[3]

The case study above reflects the exception rather than the norm. NCEPOD case reviewers have assessed over 48,000 set of case notes in the history of NCEPOD and the one issue that has been a constant throughout is the poor quality of documentation, ranging from illegible handwriting to the absence of name, grade, times, specialty, observations or incorrect medication charts to the fact that something was done such as a procedure or the detailing of a management plan – it can often be deduced but is not explicitly stated. An example of this was the reason for the title 'Just Say Sepsis' as it was clear from pieces of information in the case notes that the patient was septic, but

no one was documenting ‘sepsis’, therefore it doesn’t get coded and the true incidence of sepsis in hospitals is not known.
Beyond coding, poor documentation may lead to poor care as any important omission means that the patient notes are misleading. Furthermore, the patient care record is a legal document that should accurately reflect what has been done. In the view of lawyers, if it is not written down it was not done.

This theme is based on 27,032 cases from 15 past reports since 2000.
NCEPOD reports on which the above recommendation was formed.

2023	Crohn’s Disease – Making the Cut	Page 8 Rec. 4
2022	Epilepsy Care – Disordered Activity?	Page 7 Rec. 2
2022	Physical Healthcare in Mental Health Inpatient Settings – A Picture of Health	Page 9 Rec. 2
2021	Dysphagia in Parkinson’s Disease – Hard to Swallow	Page 9 Rec. 1
2018	Acute Heart Failure – Failure to Function	Page 82 Rec 9
2018	Cancer in Children, Teens and Young Adults: On the Right Course	Page 63 Rec 13
2012	Bariatric Surgery – Too Lean a Service	Page 51 Rec. 4
2012	Cardiac Arrests – Time to Intervene	Page 45 Rec. 4
2011	Surgery in Children – Are we There Yet	Page 71 Rec. 1
2010	Parenteral Nutrition – A Mixed Bag	Page 30 Recs. 3-5
2009	Deaths in Acute Hospitals – Caring to the End	Page 54 Recs. 1-3
2007	Emergency Admissions – A Journey in the Right Direction	Page 37 Rec. 4
2005	Critically Ill Patients – An Acute Problem	Sect 10 Recs. 1-3
2002	Perioperative Deaths – Functioning as a Team	Page 19 Rec. 2
2001	Perioperative Deaths – Changing the Way We Operate	Page 43 Rec. 4

References

1. General Medical Council: Good Medical Practice
2. Royal College of Surgeons: Good Surgical Practice

Links to relevant external documents

How to keep good clinical records

Acute care toolkit 1: Handover

Healthcare record standards – Royal College of Physicians and Academy of Medical Royal Colleges

COMMON THEME 6: TRANSITION PLANNING

A 17-year-old patient with a diagnosis of sickle cell disease came to the UK at the age of 15 and was seen in the children and young person's sickle cell clinic. There was no mention of, or discussion about, the patient's future healthcare. The patient was not seen by adult haematology services in any clinic appointment. Clinic letters were not addressed to the patient; there was no transition plan nor documentation such as Ready Steady Go in the patient's case notes. There was mention in the notes that the patient was morbidly obese and had mental health problems. Aged 17, the patient had an acute sickle cell crisis necessitating hospital admission and was initially seen in the adult emergency department before being admitted to the adult ward. On discharge, the patient was followed up in the adult sickle cell clinic. The clinic letter stated that the patient had '… been transitioned to adult services.'

The reviewers highlighted the lack of understanding between transition - a process which is inclusive of providing developmentally appropriate healthcare, and transfer - the physical move from child into adult services.

Transition describes the process of moving from child to adult healthcare, encompassing both physical and mental health aspects. It includes initial planning, the actual transfer between services, and ongoing support. However, if the transition process is not well managed, it can pose challenges for children and young people, potentially leading to a decline in their overall physical or mental well-being. This can be prevented by effective planning and bridging the gap between child and adult care. Ideally, services should be flexible to meet young people's needs up to the age of 25 years, especially those with complex health issues, acknowledging that they may require an extended transition period.

Recent reports from NCEPOD have highlighted delays or the absence of formal transition by the age of 18 for individuals with complex needs. Consequently, transition to adult services was recognised as an area of improvement by parents, carers and healthcare professionals. Some parent carers have expressed frustration over a lack of information or support. One possible explanation for this discrepancy may be that the concept of transition is poorly understood with a lack of education for young people, parents, and healthcare professionals around the distinction between transition and transfer. This was clearly reflected in the response from young people and carers when asked about their understanding of the transition process.

This theme is based on 853 cases from 4 past reports since 2018.
NCEPOD reports on which the above recommendation was formed.

2023	Transition from Child into Adult Healthcare – The Inbetweeners	Page 9 Rec. 5 Page 10 Rec. 7
2023	Healthcare Inequalities	Page 8
2020	Long Term Ventilation: Balancing the Pressures	Page 14 Rec. 5
2017	Mental healthcare in General Hospitals – Treat as One	Page 12 Rec. 4-5

Links to relevant external documents

Facilitating transition of young people with long-term health conditions from children's to adults' healthcare services-implications of a 5 year research programme

Priorities and Outcomes for Youth-Adult Transitions in Hospital Care: Perspectives of Inpatient Clinical Leaders at US Children's Hospitals

Towards safe and effective transition from adolescence to adulthood

The transition to adulthood for youth living with rate diseases

Gaps in transitional care to adulthood for patients with cerebral palsy: A systematic review

COMMON THEME 7: CLINICAL NETWORKS

A 78-year-old patient with mild vascular dementia and metastatic lung cancer had been admitted with increasingly challenging behaviour. Shortly after admission the patient became withdrawn and confused. An urgent in-reach review was provided by the respiratory and palliative care team who visited the ward and confirmed the patient was in the terminal stages of their illness. The ward team agreed that any transfer to an alternative care setting would be disruptive and distressing. End of life care planning was put in place with the family, mental health team and medical teams. A comprehensive plan was drawn up to provide symptom control. A few weeks later the patient died comfortably in the ward with their family present.

Case reviewers believed excellent care had been provided. They stated the close working relationships between all clinical teams, efforts to ensure the family were involved and supported throughout, the flexibility of the medical teams visiting the ward and exceptionally clear documentation in the patient's care plan which ensured all out of hours staff knew the care plan had contributed to exemplary end of life care.

Establishing well organised clinical networks of care is important if we want to be able to do complex things better. Networks of care may be formal or informal. The definition of a formal network that NCEPOD has used is: "*A linked group of health professionals and organisations from primary, secondary and tertiary care and social care and other services working together in a coordinated manner with clear governance and accountability arrangements*".[1] An informal network has been defined as: "*A collaboration between health professionals and/or organisations from primary, secondary and/or tertiary care, and other services, aimed to improve services and patient care, but without specified accountability to the commissioning organisation*".[1]

Many NCEPOD reports have commented on the use of networks and noting that informal networks and ad hoc/good-will cover are not robust and lead to delays in treatment or the use of alternative, more invasive treatments.

This theme is based on 5,652 cases from 15 past reports since 2000.
NCEPOD reports on which the above recommendation was formed.

2023	Transition from Child into Adult Healthcare – The Inbetweeners	Page 9 Rec. 6
2022	Physical Healthcare in Mental Health Inpatient Settings	Page 10 Rec. 5
2021	Dysphagia in Parkinson's Disease: Hard to swallow?	Page 10 Rec. 9
2020	Long Term Ventilation: Balancing the Pressures	Page 13 Rec. 4
2020	Acute Bowel Obstruction: Delay in Transit	Page 13 Rec. 9
2018	Acute Heart Failure: Failure to Function	Page 82 Rec 11
2017	Mental healthcare in General Hospitals – Treat as One	Page 13 Rec. 6
2016	Acute Pancreatitis – Treat the Cause	Page 72 Rec. 14
2015	Gastrointestinal Haemorrhage – Time to Get Control	Page 97 Rec. 1
2013	Subarachnoid Haemorrhage – Managing the Flow	Page 39 Rec. 1
2011	Surgery in Children – Are we There Yet	Page 42 Rec. 2

2008	Systemic Anticancer Therapy – For Better, For Worse	Page 38 Rec. 2
2007	Trauma – Trauma: Who Cares?	Page 116 Rec. 5 Page 124 Rec. 4

References

1. Department of Health. A Guide to Promote a Shared Understanding of the Benefits of Managed Local Networks

Links to relevant external documents

The management and effectiveness of professional and clinical networks

Royal College of Paediatrics and Child Health. Bringing Networks to Life. A guide to understanding pathways and implementing networks

COMMON THEME 8: LOCAL POLICIES, PROTOCOL, PROFORMA AND GUIDELINES

A frail elderly patient with symptoms of large bowel obstruction was admitted to a surgical ward via the emergency department at 2.30pm. Whilst the ward care provided was good, there was no evidence in the case notes that the patient had seen a senior clinician or consultant until the ward round the next day. At this point a CT was requested and subsequently a decision to undergo surgery was made. The patient was operated on the same day but experienced an extended stay in critical care postoperatively, with eventual discharge home 14 days later.

Reviewers believed this patient should have been seen sooner by a consultant as the delay to diagnosis and subsequent surgery had an impact on the outcome of the patient.

It is worth noting the difference in terminology, which is often used interchangeably:
Policy: The course or principle of action adopted or proposed by an organisation or individual – this might be defined nationally or locally.
Protocol: The accepted or established code of procedure or behaviour in any individual or group, organisation, or situation.
Guideline: A general rule, principle, or piece of advice
Proforma: A document that satisfies minimum or set requirements

Trusts/Health Boards should have policy documents stating how to deal with most general healthcare situations. This might mean adhering to national or local guidelines. Separate protocols provide a step-by-step approach on how to comply with the policy or guideline, which may be hospital or even specialty specific. However, these policies, guidelines and protocols are only effective if they are actioned. Review of case notes frequently highlights that although hospitals believe they have these, in fact they are not being followed, often because the staff managing the patients do not know of their existence. Many NCEPOD reports have highlighted the need for policies and protocols in both the organisation of care and in clinical care, such as use of antimicrobials, escalation of care, use of networks, resuscitation, transfer, insertion of central venous catheters, parenteral nutrition, neutopaenic sepsis, sepsis, subarachnoid haemorrhage and trauma to example just a few.

This theme is based on 15,430 cases from 21 past reports since 2000.
NCEPOD reports on which the above recommendation was formed.

2023	Crohn's Disease – Making the cut?	Page 7 Rec. 1 Page 8 Recs. 3 & 6 Page 9 Rec. 10 Page 10 Rec. 12
2022	Epilepsy Care – Disordered Activity	Page 8 Rec. 4 & 6
2022	Physical Healthcare in Mental Health Inpatient Settings – A Picture of Health	Page 10 Rec. 3,6 & 7

2021	In Hospital Care of Out-of-Hospital Cardiac Arrests – Time Matters	Page 10 Rec. 5
2020	Long Term Ventilation – Balancing the Pressures	Page 14 Rec. 8
2018	Cancer in Children, Teens and Young Adults – On the Right Course	Page 64 Rec 16
2018	Acute Heart Failure – Failure to Function	Page 81 Rec 5 & 6
2017	Mental Healthcare in General Hospitals – Treat as One	Page 87 Rec. 18
2016	Pancreatitis – Treat the Cause	Page 71 Rec. 5
2015	Sepsis – Just Say Sepsis!	Page 107 Rec. 1
2014	Tracheostomies – On the Right Trach	Page 91 Rec. 13
2013	Subarachnoid Haemorrhage – Managing the Flow	Page 62 Rec. 6
2011	Surgery in Children – Are we There Yet	Page 42 Rec. 4
2010	Surgery in the Elderly – An Age Old Problem	Page 126 Rec. 3
2010	Parenteral Nutrition – A Mixed Bag	Page 30 Rec. 8
2009	Acute Kidney Injury – Adding Insult to Injury	Page 50 Rec. 2
2008	Sickle Cell Disease – A Sickle Crisis	Page 65 Rec. 4
2008	Systemic Anticancer Therapy – For Better, For Worse	Page 113 Rec. 2
2004	Endoscopy – Scoping Our Practice	Recs. Rec. 6
2002	Perioperative Deaths – Functioning as a team	Page 41 Recs. 2 & 4
2001	Perioperative Deaths – Changing the Way We Operate	Page 75 Rec. 2

Links to relevant external documents

Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. Lancet. 1993;342:1317–1322.

Effective Health Care, 1994. Implementing clinical practice guidelines. No 8

COMMON THEME 9: FOLLOW-UP POST DISCHARGE

Middle-aged patient with known epilepsy and alcohol abuse was admitted with an increased number of seizures in the preceding week after a period of abstinence. Adherence to medication had been adequate but the patient had been struggling at times with control of their drinking. Having been admitted to the medical admissions unit, the patient was discharged within 48 hours, during which time they were not referred to or seen by the neurology team or alcohol cessation service. On discharge no follow-up was arranged and the patient's neurology team was not contacted.

Reviewers considered that this case highlighted the need for greater specialist neurology input into the care of people presenting with deterioration in their seizure status. They were also of the opinion that the post-discharge care of the patient could have been co-ordinated better if members of the neurology and alcohol team had been contacted.

Commencement of discharge planning at the earliest stage of hospital admission is essential. This should entail all relevant members of the integrated care network to enable a prompt and safe discharge home or to other community services. However, recent studies by NCEPOD have underscored discharge planning and arrangements as areas in need of significant improvement. Inadequate discharge planning has been reported to have led to insufficient community staffing and training resulting in gaps in overall care packages, nursing support, and care continuity.

Upon discharge from the hospital, patients should receive a comprehensive summary comprising:

- A named healthcare co-ordinator, their contact details
- Their diagnosis
- Current medications and description of any monitoring required
- Individualised guidance on self-management
- Functional abilities and social care needs
- Follow-up plans
- Information on how to access urgent care

Integral to discharge planning is the involvement of general practitioners (GPs) in clinical management post-discharge. Their exclusion represents a missed opportunity, emphasising the importance of integrating them at an earlier stage of treatment. Electronic communication may serve as the most efficient means of engaging GPs. Inadequate discharge management has been associated with heightened readmissions to Accident & Emergency departments. Sufficient discharge planning would result in decreased readmission rates, prevention of adverse events, and the assurance of a safe transition for patients from the hospital to their homes/ community.

This theme is based on 2,470 cases from 8 past reports since 2018.
NCEPOD reports on which the above recommendation was formed.

2023	Crohn's Disease – Making the Cut	Page 9 Rec. 9
2022	Epilepsy Care – Disordered Activity	Page 10 Rec. 13 & 14
2022	Physical Healthcare in Mental Health Inpatient Settings – A Picture of Health	Page 12 Rec. 12
2021	Dysphagia in Parkinson's Disease –Hard to Swallow	Page 10 Rec.11
2020	Long Term Ventilation – Balancing the Pressures	Page 15 Rec. 11
2020	Acute Bowel Obstruction – Delay in Transit	Page 13 Rec. 11
2018	Acute Heart Failure – Failure to Function	Page 82 Rec 10

Links to relevant external documents

Transitional Care Strategies from Hospital to Home

Discharge Planning

A Systemic review of interventions to follow-up test results pending at discharge

CONCLUSION

Over time, this document will undergo changes, with chapters being added or removed to reflect shifts in the healthcare services under review. Our report has particularly emphasised the critical role of communicating with patients' family and friends as a fundamental aspect of best practice. Additionally, it is imperative to develop personalised transition plans and conduct post-discharge follow-ups to address current patient challenges effectively.

While there has been an increased adoption of early warning scores and care networks, certain longstanding issues persist. These include inadequate documentation, multidisciplinary review, early warning score monitoring, consent, and the utilisation of clinical networks, all of which require continued attention and enhancement.

What this report does highlight is that there is much good learning taking place across all aspects of our healthcare systems, and this should be celebrated, but there is still more to do and so hopefully this report will give food for thought across a multidisciplinary readership.

VERSION CONTROL

Date last updated	By whom	Change made
July 2017	Marisa Mason	Released to HQIP
August 2018	Marisa Mason	Updated regarding NEWS2
March 2024	Hafsa Rubab	Themes added and others removed (see introduction)
March 2025	Marisa Mason	Case studies updated