

The Impact of NCEPOD Reports

This paper summarises the impact that NCEPOD has had over recent years. A history of NCEPOD can be found in Appendix 1.

Since NCEPOD was awarded the tender for the Clinical Outcome Review Programme into Medical and Surgical Care, five studies have been published:
Children's Surgery (*Are We There Yet?* 2011)
Peri-operative Care (*Knowing the Risk*, 2011)
Cardiac Arrest Procedures (*Time to Intervene?* 2012)
Bariatric Surgery (*Too Lean a Service?* 2012)
All of these studies started before the tender process. Under the new contract the topics chosen were:
Alcohol-Related Liver Disease (*Measuring the Units*, 2013) and
Subarachnoid Haemorrhage (*Managing the Flow?* 2013).

This paper will review the impact of these reports, and will also draw on some of the wider impact that NCEPOD has had, as often it takes time to demonstrate the full effect of a report.

1. How we assess impact

Typically NCEPOD reports attract widespread publicity when they are launched; sometimes feeding stories hostile to the NHS. We regard these as a necessary evil: on the one hand the profession and the organisations have to be galvanised to take action and no-one will act on advice they do not notice, so it is vital that we do make a public impact. On the other hand we are aware that the NHS does not need any more hostile criticism and our reports do deliberately highlight the positives that our Advisors identify.

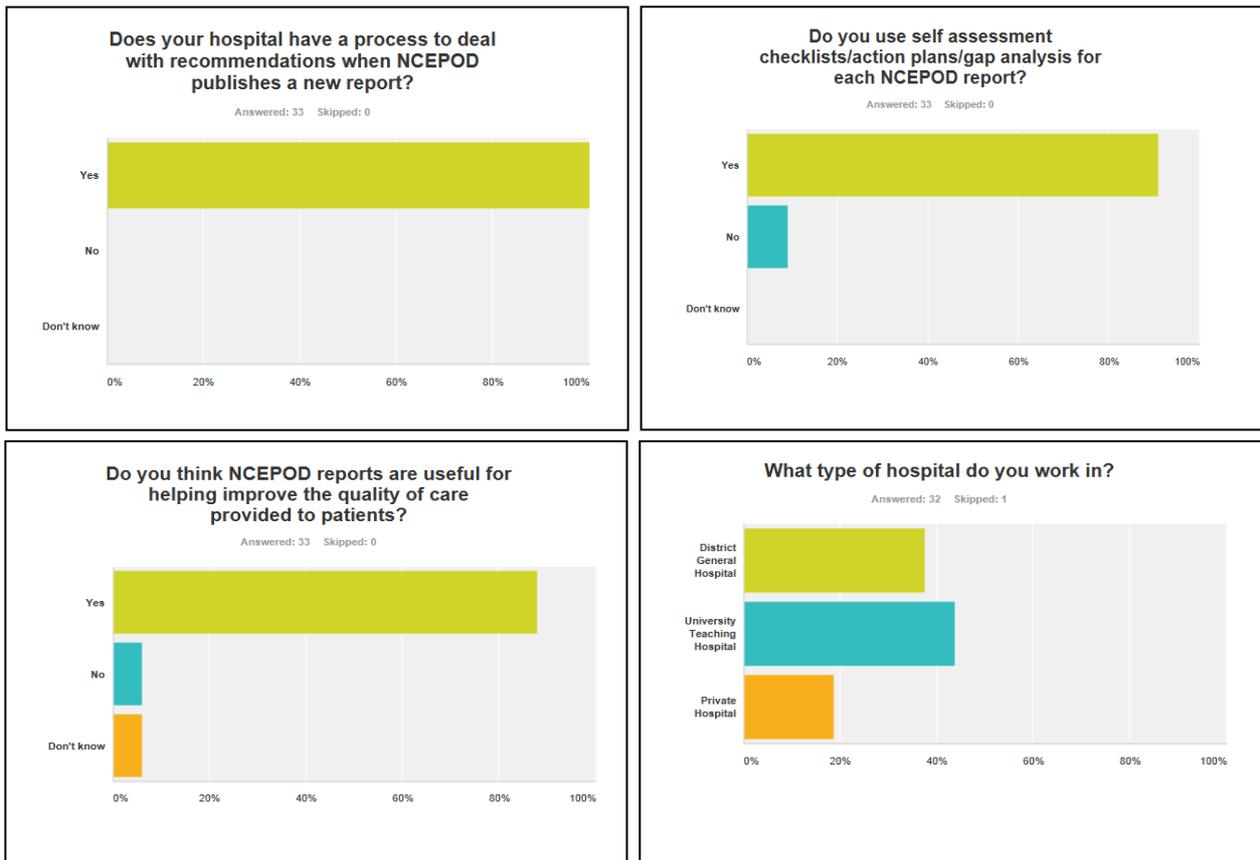
Historically it was much easier for NCEPOD to demonstrate the change linked to our recommendations; undertaking a review of in-hospital surgical mortality provided the means to review actual changes year on year by asking the same questions in an 'audit' manner. We saw the arrival of 'CEPOD' emergency theatres and a reduction in out of hours operating, both attributed to our reports. We also know from these reports that it often took 5-10 years for recommendations to fully take effect; e.g. we tracked a recommendation made in 1990 stating that hospitals should have more ICU beds to seeing a difference in 2000 but nothing happened before 1995. Therefore, as our remit has been extended and varied, and our method altered to account for this, we now need surrogate markers to help us identify the impact our reports have had.

2. Local Hospital Impact - Drivers for Improvement

To undertake the work we do NCEPOD harnesses enormous volunteer resources, from a network of unpaid Local Reporters (one in every hospital) who collect data for us, supplemented by a growing number of Ambassadors – senior clinicians who support the Local Reporters as well as disseminating our message.

We know from many informal discussions with NCEPOD Local Reporters/NCEPOD Ambassadors and clinicians that a lot of excellent work is undertaken locally to implement our recommendations. To capture some of this we have recently started a piece of work, asking Local Reporters if they would share their successes with us. We have done this in two ways; the first is an open survey allowing people to comment confidentially. There are a few set questions but also some free text comments. The second is for people to return evidence/comments directly to us so that we can see what is being done.

Summarised below are the findings of this piece of work so far:



We also asked, for each report below whether it had influenced change in their hospital:

	Yes	No	Don't know	Not applicable	Too soon to say
Measuring the Units (alcohol related liver disease)	6.25% 2	9.38% 3	9.38% 3	9.38% 3	65.63% 21
Too Lean a Service? (bariatric surgery)	21.88% 7	18.75% 6	3.13% 1	43.75% 14	12.50% 4
Time to Intervene? (cardiac arrests)	65.63% 21	3.13% 1	9.38% 3	3.13% 1	18.75% 6
Knowing the Risk (peri-operative care)	78.13% 25	0% 0	15.63% 5	0% 0	6.25% 2
Are We There Yet? (children's surgery)	61.29% 19	0% 0	12.90% 4	16.13% 5	9.68% 3
A Mixed Bag (parenteral nutrition)	64.52% 20	6.45% 2	22.58% 7	6.45% 2	0% 0

An Age old Problem (surgery in the elderly)	70.97% 22	0% 0	22.58% 7	0% 0	6.45% 2
Caring to the End? (deaths within 4 days of admission)	45.16% 14	3.23% 1	45.16% 14	3.23% 1	3.23% 1
Adding Insult to Injury (acute kidney injury)	48.39% 15	6.45% 2	32.26% 10	9.68% 3	3.23% 1
For Better, For Worse? (systemic anti-cancer therapy)	22.58% 7	9.68% 3	41.94% 13	25.81% 8	0% 0
The Heart of the Matter (coronary artery bypass grafts)	9.68% 3	6.45% 2	29.03% 9	54.84% 17	0% 0
A Sickle Crisis? (sickle cell disease)	19.35% 6	9.68% 3	35.48% 11	35.48% 11	0% 0
A journey in the right direction? (emergency admissions)	35.48% 11	6.45% 2	45.16% 14	12.90% 4	0% 0
Trauma: Who cares? (severely injured patients)	38.71% 12	9.68% 3	35.48% 11	16.13% 5	0% 0
The Coroners' Autopsy	9.68% 3	9.68% 3	58.06% 18	22.58% 7	0% 0
An Acute Problem? (admission to critical care)	29.03% 9	6.45% 2	54.84% 17	9.68% 3	0% 0
A Service in Need of Surgery? (aortic aneurysms)	12.90% 4	9.68% 3	48.39% 15	29.03% 9	0% 0
Scoping our Practice (endoscopy)	29.03% 9	3.23% 1	61.29% 19	6.45% 2	0% 0
NCEPOD 30-day surgical reports - pre 2004	32.26% 10	6.45% 2	58.06% 18	3.23% 1	0% 0

From the free-text comments and direct emails to NCEPOD the following quotes have been taken - the full list can be found in Appendix 2:

Are We There Yet?

"We had a complete review of all children's services, updated training schedules and developed a change of paediatric cover available (medical) at the hospital."

Too Lean a Service?

"We had to demonstrate to our Trust Board that we were compliant with ALL of the NCEPOD recommendations. This was taken as a clinical governance issue and a patient safety one."

Measuring the Units

"Because of this report I was able to recruit an alcohol liaison nurse, the funding for which I lost some years ago and have been trying to get back."

Time to Intervene

"This NCEPOD report has had a clear impact on the provision of resuscitation at our hospital. Specifically, the recommendation on page 68 that "The use of 'ceilings of care' documentation would facilitate decision-making and clarity of intent." Partly in response to this recommendation, the Hospital introduced a combined DNACPR/Ceiling of Treatment (CoT) form in July 2012. We have seen a significant improvement in the completion of these forms. Our cardiac arrest rate has decreased from 1.57 per 1000 admissions in 2011-2012 to 1.29 per 1000 admissions in 2012-13 (P=0.20) - although not statistically significant as yet I am expecting this cardiac arrest rate to continue to fall as a result of the CoT form."

General comment on our working

"From the point of view of a clinical effectiveness manager, I find the consistency with which NCEPOD deals with all of its studies and publication of recommendations together with the outstanding support for NCEPOD reporters, an invaluable bonus that enables us to work smartly with assessing compliance with their recommendations. The NHS knows what NCEPOD means, it's almost a trademark and everyone takes their recommendations very seriously and knows it's important to work hard to achieve full compliance. There is no doubt in my mind that the main benefit is to improve patient care and improve practice faster."

Our recommendations will not improve the quality of care for patients unless local clinicians and those responsible for managing local services act on them. We prepare audit toolkits for each study which enable doctors, nurses, risk managers and service managers to replicate parts of our studies in their own hospitals, comparing their organisational issues and performance with the national experience described in the report. These toolkits are freely available from our website and are regularly downloaded.

Downloaded toolkits:

Measuring the Units (alcohol-related liver disease)	37
Too Lean a Service? (bariatric surgery)	197
Time to Intervene? (cardiac arrests)	731
Knowing the Risk (peri-operative care)	694
Are We There Yet? (children's surgery)	424
A Mixed Bag (parenteral nutrition)	1336
An Age old Problem (surgery in the elderly)	1323
Caring to the End? (deaths within 4 days of admission)	62
Adding Insult to Injury (acute kidney injury)	864

3. National impact

On a national level, the measurement of impact comes in the form of national organisations e.g. specialty associations Medical Royal Colleges/NICE/DH/NHSE welcoming the reports, stating their importance and demonstrating a commitment to use them.

For each report we have published we have compiled a record of actions following publication, from media coverage on the day, to where our reports are cited after publication. These files are extensive and are therefore available from NCEPOD should you wish to read them.

Summarised below is some of the national level responses and influence that our reports have had, a fuller list can be seen in Appendix 3:

A Mixed Bag (parenteral nutrition)

“The NCEPOD Report ‘A Mixed Bag’ provides solid evidence that many hospitals are currently delivering unsafe artificial nutrition to the most vulnerable adults and babies.”

Dr Mike Stroud, Chair of BAPEN

Are We There Yet? (children's surgery)

“We welcome your valuable analysis of this vital aspect of health provision for children. The report has recommended the development of general paediatric surgical networks. We strongly support this approach to organising and providing care.”

Rt Hon Andrew Lansley, Secretary of State for Health

Trauma: Who cares? (severely injured patients)

The recommendations from this report formed the basis of the job description for a new NCD for Trauma and Professor Keith Willet was appointed.

“This important study by NCEPOD restates the need for regional trauma systems that provide high-level trauma care. The Government must now act on these recommendations and urgently implement a national trauma system. People must be confident that if they suffer injury, wherever they are and whatever the cause, they will receive trauma care equal to the best in the world.” **Royal College of Surgeons of England**

Adding Insult to Injury (acute kidney injury)

NICE have developed guidelines for AKI, recently published through the national press, citing our work as underpinning their production.

“Thank you for your letter of 14 May to Liam Donaldson and Bruce Keogh, enclosing copy of ‘Adding Insult to Injury’. This report has raised important issues about patient safety and we are seriously concerned that guidelines in this area have not yet been taken on board. The National Clinical Director for Kidney Care will consider the recommendations with SHA Medical Directors and other stakeholders and develop an action plan, which should be available later this year, to support the NHS in improving practice in this area.” **Ann Keen, Health Minister 2009**

“.....I believe that ‘Adding Insult to Injury’ will have played a major part in spurring the NHS to raise its performance in this area.” **Dr Donal O’Donoghue, NCD for Kidney Disease 2009**

“As you know, the 2009 NCEPOD report ‘Adding Insult to injury’ identified serious shortcomings in the management of Acute Kidney Injury (AKI) in hospitals. In response to this report, the AKI Delivery Group and the AoMRC have produced a Competency Framework to promote better care of patients with AKI by clinical teams. The document defines a framework of competencies for prevention, recognition, and management of Acute Kidney Injury. Its aim is to provide consistent standards for all staff involved in the care of acutely ill patients, outlining what is expected of both teams and individuals, and improving accountability at all levels. The framework was produced by a multi-disciplinary working group...copies of the framework have been sent to medical school deans, Post-graduate Deans, and Chief Executives of all acute hospitals in the UK, as well as to the multi-disciplinary agencies listed above and key patient groups.” **Dr Donal O’Donoghue, NCD for Kidney Disease 2010**

END OF SUMMARY

Appendix 1

1. Background to NCEPOD

The National Confidential Enquiry into *Perioperative* Deaths (NCEPOD) was formed in 1988 as an independent body of medical professionals to examine the quality of care received by surgical and anaesthetic patients who died within 30 days of a surgical procedure. The principle aim was to improve patient safety by identifying remediable factors in the care provided. An annual report was published; each with a different surgical focus e.g. surgery in the elderly and the young, or a specific procedure such as aortic aneurysms. At that time NCEPOD received the majority of its funding from the Department of Health (DH).

Just over a decade later (1999) following publication of '*A First Class Service: Quality in the New NHS*', government liaison and funding for NCEPOD (in England and Wales) was transferred from the DH to the National Institute of (Health and) Clinical Excellence (NICE). A review of NCEPOD, along with the other confidential enquiries, was instituted in 2000 and was chaired by Professor Sir John Grimley Evans. In April 2002, as a result of a public consultation, NCEPOD was asked to extend its remit to review the care received by medical patients. Outcome measures were extended to include near misses as well as death.

To reflect this extension to its remit NCEPOD changed its name to become the 'National Confidential Enquiry into *Patient Outcome* and Death' in 2003. By this time the organisation had taken on its current form, an independent charity directed by a Steering Group of nominees from each of the Royal Colleges and other professional organisations, supported by Local Reporters in every hospital. Subsequently we have appointed Ambassadors, senior doctors in most Trusts.

In 2005 following a review of Arms Length Bodies NCEPOD was 'moved' to the National Patient Safety Agency, which took over the Government liaison and funding for England and Wales.

In 2011, after successfully winning the bid to carry on this work programme, now named the Clinical Outcome Review Programme into Medical and Surgical Care, the work 'transferred' to the Healthcare Quality Improvement Partnership (HQIP), which took over the commissioning and funding on behalf of England, Wales, Northern Ireland and the Offshore Islands.

2. Reviews of NCEPOD, assessing impact and reputation

During its history NCEPOD has undergone a number of formal reviews, both externally and internally, as a means to ensure that the organisation is fulfilling its requirements to the professions and the public. These have provided both a stimulus to debate within the Enquiry and helped to ensure that the Enquiry has retained its value in changing times. The quality of our work, the respect in which we are held and the impact we have had on improvements within the NHS has been repeatedly acknowledged by the government, the professions and the public, not least by five independent assessments over the last 10 years from

- CASPE (Clinical accountability, Service Planning and Evaluation) Research for the King's Fund,
- NICE,
- a professional reputation audit, the NPSA and
- a survey of all our stakeholders.

In 1998, NCEPOD commissioned an external evaluation of its work by CASPE research. This was funded by the King's Fund and the Nuffield Trust. Twenty recommendations were made covering such issues as, the introduction of a structured review of cases, improving communication with NCEPOD Local Reporters and a policy on the retention of data.

In 2004 NICE undertook a review of the methods used by NCEPOD (and the other confidential enquires). The outcome focussed on the process of topic selection, in which NCEPOD's method was transferred to the other two enquiries and in addition it was suggested that NCEPOD should adopt a case-control aspect to supplement the peer review process. This was undertaken on our review of coronary artery bypass grafts and found to be an unacceptable scientific method to apply to a confidential enquiry. The unique feature of a confidential enquiry is that the peer review of the cases allows practising clinicians to identify remediable deficiencies in the care of the patient which cannot be achieved by statistical method including case-control.

In 2006 NCEPOD commissioned a reputation audit, conducted by Opinion Leader Research. The aim of this was to gauge how NCEPOD is recognised by the professions and other regulatory/peer bodies. The results were very encouraging and it was generally reported that NCEPOD is respected most particularly because of its independence and strict confidentiality.

In 2007 a review by the NPSA was conducted and reported that NCEPOD was considered to be excellent value for money. It was recommended that primary care should be removed from NCEPOD's remit.

In 2012 NCEPOD undertook a stakeholder survey to understand what our stakeholders think we do well, and to find out where and what improvements can be made. The aim of this review was to gauge the perceptions of NCEPOD at a local level; and to explore how reports are received, and the impact of recommendations, at both a local and national level.

The main findings were:

- The majority of respondents (65%, 231/358) rated the overall impact of NCEPOD as a national organisation reviewing the quality of patient care as high to extremely high.
- 92% of respondents were of the opinion that the organisation is well respected by clinicians.
- 57% (200/353) of respondents rated the overall reputation of NCEPOD as high to extremely high.
- Independence from the Government was rated as important-extremely important by 80% (310/386) respondents.
- The standard of NCEPOD recommendations was rated to be above adequate by 69% (253/368) of respondents.
- The ease of implementation of recommendations was rated as neither easy nor difficult to implement by 64% (235/366) of respondents and difficult-extremely difficult by 25% (93/366) of respondents.
- 63% (222/355) of respondents indicated the topics chosen to be NCEPOD studies were relevant or extremely relevant.

It has been repeatedly acknowledged that our strength is that we are clinically led and independent of the DH/NHSE, of NHS management and of the professional institutions. Yet all of these groups are essential to make our work effective. We are a co-operative effort in which the profession and the NHS come together in a continuing quest to narrow the gap between what should happen and what does happen to patients in the NHS and private sectors.

To undertake the work we do NCEPOD harnesses enormous volunteer resources, from a network of unpaid Local Reporters (one in every hospital) who collect data for us, supplemented by a growing number of Ambassadors – senior clinicians who support the Local Reporters as well as disseminating our message. We also have in place an army of volunteers – the Trustees, the Steering Group and the Advisors we recruit for each study – totalling in excess of 10,000 hours, which if paid for would cost an average, £200,000 per year.

Our reputation for protecting the confidences of patients, relatives, staff and hospitals means that we are able to command trust from all these groups. This is essential because the data we need to collect includes candid reports from staff as well as the clinical notes. NCEPOD abides by its detailed information security policies which have been audited to ISO 27001 standards; we are registered for the Data Protection Act and have HRA-CAG approval under Section 251 of the NHS Act 2006 to collect these datasets without obtaining consent.

Appendix 2

Measuring the Units

- *Discussions with pre assessment around referring patients for alcohol advice prior to admission*
- *Guidelines are being updated*
- *There is a planned overhaul of alcohol services within the Trust and certainly this report will provide very useful levers*
- *From a local perspective I have already been asked to respond on behalf of the Trust to the report and to complete an analysis of where we perform as an organisation in the areas highlighted by the report. Hence it's clear the organisation is taking it seriously but too early to know what the outcomes will be*
- *Because of this report I was able to recruit an alcohol liaison nurse, the funding for which I lost some years ago and have been trying to get back*

Too Lean a Service?

- *Dietetics and psychology increased for bariatric patients*
- *Currently some patients sign the first part of the consent form at pre-assessment and the second part on the day of surgery. The majority of patients are consented on the day of surgery. With the implementation of our new pathway patients will sign the first part of the consent at their surgical appointment and the second part on the day of surgery*
- *Additional backing for a supporting role for the bariatric service*
- *We had to demonstrate to our Trust Board that we were compliant with ALL of the NCEPOD recommendations. This was taken as a clinical governance issue and a patient safety one*
- *The biggest impact I think is on the recognition that psychological support has been lacking in many services - this report is always cited as the example of this, and it is having a knock-on effect on how services are developing. Certainly this issue is now in the fore-front of many people's thinking and it will probably be prominent in some NICE-approved guidance on medical weight assessment and management clinics which are currently being worked on.*

'Time to Intervene'

- *We have implemented the NEWS charts (in exchange for MEWS) and underlined the importance of using a track and trigger process in response to our patient's condition score. We use this process as part of our unplanned cardiac arrest scenarios.*
- *We audit the use of DNAR forms - and ensure all end of life patients are involved in the decision with regard to resuscitation. NCEPOD and this paper was a trigger to both these actions in my hospital*
- *This NCEPOD report has had a clear impact on the provision of resuscitation at our hospital. Specifically, the recommendation on page 68 that "The use of 'ceilings of care' documentation would facilitate decision-making and clarity of intent. Partly in response to this recommendation, the Hospital introduced a combined DNACPR/Ceiling of Treatment (COT) form in July 2012. We have seen a significant improvement in the completion of these forms. Our cardiac arrest rate has decreased from 1.57 per 1000 admissions in 2011-2012 to 1.29 per 1000 admissions in 2012-13 (P=0.20) - although not statistically significant as yet I am expecting this cardiac arrest rate to continue to fall as a result of the COT form.*
- *Led to changes to airway equipment on resuscitation trolleys*
- *Setting of target for reduction in cardiac arrest calls*
- *Documentation of DNR status on admission and audit of cardiac arrests*

- *A timely review of admitted patients (within 12 hours) by a consultant*
- *Admission documentation to ensure that CPR status of all patients is considered upon admission*
- *Educate teams/ junior doctors to request type and frequency of observations for each individual patient*
- *Further emphasised the need for prevention of cardiac arrest as other reports also have and led to local projects that have seen reduction in cardiac arrests in high risk areas*
- *We have been trying to get funding for an outreach team here for some time. We have certainly used the Time to Intervene study as part of the evidence we have used to forward this initiative. The recruitment process is currently taking place and we will have an outreach team led by a Nurse Consultant shortly. I would thank you for the opportunity in taking part of this study and endorse that it has had an effect here.*
- *The NCEPOD cardiac arrest study had an immediate and (hopefully) sustained impact here, in that we promptly instigated one of the key recommendations. In addition to our annual audit of DNAR/DNACPR orders, we now review every cardiac arrest (using the same methodology) with regards to whether a DNAR/DNACPR decision could / should have been made*
- *It has provided an invaluable insight as to how we compared to the national picture (at the time of the report) and a sound evidence base from which to move forward in ensuring that an appropriately collaborative and increasingly patient-centred view is taken*
- *I report that data in my annual report to the Trust Quality & Safety Committee, the Trust's 'Failure to rescue' task & finish group. Furthermore, all cardiac arrest events are closely scrutinised through the associated work of the 'failure to rescue, clinical governance & risk management forums*
- *My view of the NCEPOD report was that it was very timely. I agreed with the executive summary that this was probably the most important NCEPOD report for 10 years. We have done a huge amount of work disseminating the report throughout all the clinicians in the Trust. We have tried hard to implement all the recommendations of the report. The most valuable aspect of this report to my mind is the concept of futility - applying cardiopulmonary resuscitation to patients of advance age with severe co-morbidities is inappropriate and futile. It is fundamentally unethical, in lieu of proper decision making, to simply leave a patient for active cardiopulmonary resuscitation and to expose them to a 'poor natural death' and then subject them to an intervention with no realistic chance of a good outcome. The really hard bit of this implementation is that it challenged long established beliefs held by the medical profession that death is a failure. There is now the concept of allowing a natural death, recognising end of life and making appropriate plans for patients. This requires work and good communication*
- *My conclusion is that I fully endorse the work you do, especially this report, which was both excellent and timely and gave us a platform on which to try to bring about whole scale change in our profession*
- *Medical director along with all senior consultants review all medical notes of patients who suffer cardiac arrest and document these findings and report to clinical governance steering group*

Knowing the Risk

- *Introduction of better pre-op assessment of risk including cardiopulmonary exercise testing and anaesthetic assessment clinics*
- *Introduction of protocol driven pre-assessment clinics*
- *Increased number of ICU beds*

- *All patients having elective surgery are reviewed in a preoperative assessment clinic, where a consultant anaesthetist is able to see patients who have been screened and found to be high risk*
- *All high risk patients undergoing emergency surgery are discussed with the responsible consultant anaesthetist and surgeon*

Are We There Yet?

- *Clear operational policies for team working in children surgery teams now in place*
- *Clinical networks for children's surgery developed*
- *We have introduced a section for example, in our consent form, for the surgeon/doctor to include the risk of mortality*
- *An operational policy for paediatric surgery*
- *Major review of children's surgery in this adult hospital-rationalised in partnership with local children's hospital*
- *We had a complete review of all children's services, updated training schedules and developed a change of paediatric cover available (medical) at the hospital*
- *Engagement in paediatric surgical review and development of paediatric surgical network*
- *Tightening up of policies*
- *Paediatric surgery and ITU for teenagers*
- *Quarterly paediatric surgical board reporting to Q+S / CESG? Chaired by anaesthetic and surgical paediatric champion*
- *Clinical audits using standards based on NCEPOD recommendations*
- *More paediatric consultants now coding their notes*

An Age Old Problem

- *Data being collected to review if a frailty score would add to clinical assessment of risk Pain scores on obs charts & audited*
- *Investment in more Healthcare of the Elderly consultants*
- *Elderly patient go to ICU after laparotomy*
- *Review of pre op assessments of elderly patients requiring surgery*

A Mixed Bag

- *New Trust guidelines were developed*
- *Nutrition services have been overhauled*
- *Nutrition support team has been established*
- *Annual audits of compliance with the requirement for nutrition screening has shown this to be poor: Replacement of existing MUST with new nutrition screening tool*
- *Training of ward staff regarding accurate use of screening tool*
- *Considering the recruitment of dietetic assistants on the wards to improve compliance of nutrition screening, first line nutrition support for patients and daily monitoring of nutritional care plans*

Caring to the end?

- *Training of junior nurses and doctors in vital sign monitoring - CPF now in place, rolling out of NEWS from August with new criteria for calling PERT*
- *The anaesthetic department have only just started using new anaesthetic charts. However all high risk cases are discussed with the coordinating consultant / on-call consultant and whose name is recorded in the anaesthetic rota, if not on the chart*

Adding Insult to Injury

- *We have had additional training on AKI and introduced specific questions on our admission proforma*
- *Renal consultant does AKI ward round daily*

A Sickle Crisis

- *New Trust guidelines were developed*

Trauma: Who cares?

- *Development of major trauma centre*
- *We now have a proper trauma team*

Emergency Admissions in the Right Direction

- *Acute medical team have trialled a proforma for Consultant PTWR review and have demonstrated significant improvements in PTWR documentation with its use. The results were presented at the society of Acute Medicine conference*

An Acute Problem

- *Introduction of early warning scoring*
- *Development of critical care outreach*
- *Improved early warning scoring systems*

NCEPOD surgical reports pre-2004

- *Emergency on call theatre (and trauma theatre)*
- *From the outset of NCEPOD we established a 6 weekly meeting of all surgeons and anaesthetists to meet and present audits and feedback on 'NCEPOD' cases. Attendance is compulsory. Despite many efforts by management to reclaim this half day meeting we have been able, by demonstrating its effectiveness, to keep it going (since 1998). We also have had a 'Surgical Mortality Review Committee since 2002, which reviews deaths in all patients receiving surgical input (although we do occasionally miss some cases admitted under the physicians), regardless of whether or not they have surgery. Ideally the cases are reviewed by a surgeon and an anaesthetist as they have materially different perspectives. Any cases where care is less than good are presented at the audit/ NCEPOD meeting. We tried to establish a similar forum for medicine but because of the much greater number of deaths this has proved more challenging.*
- *The biggest change was with the early reports recommending Emergency theatres. We have also reduced night time operations.*
- *Introduction of separate CEPOD list for paediatric emergencies, separation of adult and paediatric recovery areas.*

Lectures and Toolkits

We are well aware that if we are going to punch our weight in changing practice, we have to achieve an impact at a local level. Our authors, co-ordinators trustees and staff present the lessons of our reports in lectures to various local audiences in individual hospitals. They provide an opportunity for individual hospitals to reflect on the problems that we have identified at a national level.

General comments received

- *I think the Local Reporter role is a strength of your organisation as it means trusts are able to establish a positive culture towards recommendations from national confidential enquiries. This is really important to keep things running smoothly. For me it would be great if NCEPOD could take all CORPs under their wing to achieve consistency throughout the NHS. I can't understate the benefits your approach, and your excellent communication with organisations. I never feel we are swamped with information; we only get what we absolutely need to participate and implement recommendations. This approach is invaluable when it comes to things such as policy monitoring and preparing for Quality Accounts. My one wish was for all national confidential enquiries to be hosted by one organisation so we can get CE reporters established, to develop a relationship with the national team. I feel it would be a great shame if the excellent work you do was ever disrupted. It would be 'a step in the wrong direction' to lose the service and lesson-learning you provide to the country.*
- *Thank you for what you do. I think NCEPOD perform an extremely important role in reducing risk and improving patient focused safety in healthcare.*
- *Some of the studies can be difficult to do. We have struggled with the scale of the tracheostomy study for example. The usual case note review retrospectively is far more achievable in a busy acute setting. However NCEPOD is firmly recognised for the benefit it can bring to us as an organisation.*
- *We are aware of the need to ensure that we monitor these more robustly in future to answer this type of enquiry. I can say that in the past debates have been had at Quality Groups in trust on the recommendations made.*
- *From the point of view of a clinical effectiveness manager, I find the consistency with which NCEPOD deals with all of its studies and publication of recommendations together with the outstanding support for NCEPOD reporters, an invaluable bonus that enables us to work smartly with assessing compliance with their recommendations. The NHS knows what NCEPOD means, it's almost a trademark and everyone takes their recommendations very seriously and knows it's important to work hard to achieve full compliance. There is no doubt in my mind that the main benefit is to improve patient care and improve practice faster.*
- *Surgeons, anaesthetists and pathologists are well engaged with this process from when it was periop deaths as opposed to 'patient outcome and death'. Far less engagement evident from physicians.*
- *NCEPOD dovetails with the work we are doing locally on mortality and I try to marry the two efforts. I am pleased to note that NCEPOD seems to investigate the very areas that are of concern to me locally. SAH would be a typical example, as would be alcohol.*
- *Very variable opinions and knowledge of NCEPOD among consultants. Still sometimes seen as low priority or not mandatory so takes strong leadership from the Medical Directors to ensure participation and response.*
- *We have also used information from the NHS Litigation Authority to see how well Trusts are complying with their standards for the Clinical Negligence Scheme for Trusts (CNST); one of which is participation in the National Confidential Enquiries.*
- *From this we know that for 2012/13, 51 Acute Trusts were compliant with best practice for complying with National Confidential Enquiries (31 had reached Level 1, 7 had then reached Level 2 and 13 had reached Level 3). This includes all Confidential Enquiries, not just NCEPOD.*

Appendix 3

<p>Too Lean a Service? (bariatric surgery)</p>
<p>President of BOMSS, said: “BOMSS welcomes the main recommendations made in this report, which lend powerful and much needed support to our longstanding endeavours to raise quality and to define practice, a process supported by the Royal College of Surgeons.”</p>
<p>Time to Intervene? (cardiac arrests)</p>
<p>The Resuscitation Council (UK) has based many of its updated Quality Standards for Cardiopulmonary Resuscitation Practice and Training on the NCEPOD recommendations. NCEPOD are working with the RCP London to review the use of Ceilings of Treatment documentation.</p> <p>‘<i>Together for Health –A Delivery Plan for the Critically Ill</i>’ The Welsh Government cited this report as one of the drivers for this programme.</p>
<p>Knowing the Risk (peri-operative care)</p>
<p>NCEPOD is working with the AoMRC aiming to take forward a piece of work on identifying high risk patients.</p>
<p>Are We There Yet? (children's surgery)</p>
<p>“We welcome your valuable analysis of this vital aspect of health provision for children. The report has recommended the development of general paediatric surgical networks. We strongly support this approach to organising and providing care.” Andrew Lansley, Secretary of State for Health</p>
<p>A Mixed Bag (parenteral nutrition)</p>
<p>Dr Mike Stroud, Chair of BAPEN stated: “The NCEPOD Report ‘A Mixed Bag’ provides solid evidence that many hospitals are currently delivering unsafe artificial nutrition to the most vulnerable adults and babies.”</p>
<p>On the face of it (Cosmetic surgery) – a review of organisational data only</p>
<p>This study was unusual, being the fruits of a survey of organisations rather than cases. It revealed an extraordinary picture of occasional surgeons doing very small numbers of operations in a cottage industry, bereft of formal training, supervision or audit, of operations being sold on the basis of no indication other than patient choice. It led directly to a working group at the RCSEng and the Keogh Committee’s review of cosmetic practice.</p>
<p>An Age old Problem (surgery in the elderly)</p>
<p>“This study paints a disturbing and unacceptable picture of the quality of care experienced by older people.” Paul Burstow, Health Minister</p> <p>President of the British Geriatrics Society stated “To many of us geriatrician working with older surgical patients, the findings of the report confirm our day to day experiences.”</p> <p>This report has particularly drawn attention to the difficulties of ensuring that elderly surgical patients must have a more holistic approach to their comorbidities and a multi-disciplinary course needs to be set from the outset.</p>
<p>Caring to the End? (deaths within 4 days of admission)</p>
<p>Mr John Black, President of the Royal College of Surgeons said “This hard hitting report highlights the loss of proper team working in UK hospitals, resulting in dangerous failures of communication which make it harder and harder for clinicians to provide safe care for patients. The Royal college of Surgeons has been warning for some time about the dangers of multiple handovers.”</p>

Adding Insult to Injury (acute kidney injury)

NICE have developed guidelines for AKI, recently published through the national press, citing our work as the underpinning of their production.

“Thank you for your letter of 14 May to Liam Donaldson and Bruce Keogh, enclosing copy of 'Adding Insult to Injury'. This report has raised important issues about patient safety and we are seriously concerned that guidelines in this area have not yet been taken on board. The National Clinical Director for Kidney Care will consider the recommendations with SHA Medical Directors and other stakeholders and develop an action plan, which should be available later this year, to support the NHS in improving practice in this area.” **Ann Keen, Health Minister 2009**

“.....I believe that 'Adding Insult to Injury' will have played a major part in spurring the NHS to raise its performance in this area.” **Dr Donal O'Donoghue, NCD for Kidney Disease 2009**

“As you know, the 2009 NCEPOD report 'Adding Insult to injury' identified serious shortcomings in the management of Acute Kidney Injury (AKI) in hospitals. In response to this report, the AKI Delivery Group and the AoMRC have produced a Competency Framework to promote better care of patients with AKI by clinical teams. The document defines a framework of competencies for prevention, recognition, and management of Acute Kidney Injury. Its aim is to provide consistent standards for all staff involved in the care of acutely ill patients, outlining what is expected of both teams and individuals, and improving accountability at all levels. The framework was produced by a multi-disciplinary working group...copies of the framework have been sent to medical school deans, Post-graduate Deans, and Chief Executives of all acute hospitals in the UK, as well as to the multi-disciplinary agencies listed above and key patient groups.” **Dr Donal O'Donoghue 2010**

'Together for Health –A Delivery Plan for the Critically Ill' The Welsh Government cited this report as one of the drivers for this programme, and states “Acute Kidney Injury champions have been identified in each Local Health Board and improved diagnostic tools are currently being developed by biochemists in Wales and England. Their introduction will have the potential to greatly improve the assessment of risk of developing acute kidney injury.

For Better, For Worse? (systemic anti-cancer therapy)

The recommendations from this report were embedded into guidelines produced by the National Chemotherapy Advisory Group at the DH. **Prof Sir Mike Richards (NCD for Cancer)** stated – “The Department of Health and the National Chemotherapy Advisory Group (NCAG) takes the findings of the NCEPOD study very seriously. The conclusion that treatment probably caused or hastened death in 27% of the cases examined and only 35% of the cases reviewed in its study were judged as having received good care demonstrates the urgent need for improvements in the safety and quality of services. The recommendations of the NCEPOD report have all been addressed in the NCAG draft guidance.”

A Sickle Crisis? (sickle cell disease)

This report led to the development of NICE Guidelines for Pain in Sickle Cell Disease, and more recently a NICE Quality Standard, where the only source of reference was this report.

A journey in the right direction? (emergency admissions)

'Together for Health –A Delivery Plan for the Critically Ill' The Welsh Government cited this report as one of the drivers for this programme.

This report was the first to identify the need for consultant review within 12 hours of admission which was subsequently adopted by the Royal College of Physicians of London. It is still not being achieved consistently, as our more recent reports have shown, but the profession is united on the need for this and progress towards this end is still being made.

Trauma: Who cares? (severely injured patients)

The recommendations from this report were added to the job description for a new NCD for Trauma and Professor Keith Willet was appointed.

“This important study by NCEPOD restates the need for regional trauma systems that provide high-level trauma care. The Government must now act on these recommendations and urgently implement a national trauma system. People must be confident that if they suffer injury, wherever they are and whatever the cause, they will receive trauma care equal to the best in the world.”

Royal College of Surgeons of England

The Coroner’s Autopsy

This coincided with the reform of the Coroner’s bill and as a result the report was used as reference during the editing of it.

An Acute Problem? (admission to critical care)

This report led to the development of NICE Clinical Guideline 50 – Recognition of the acutely ill patient.

All of these reports have made a significant and acknowledged contribution to the way in which the NHS and the professions have confronted the problems that they described. Sometimes we have provided the evidence to establish the need for action in areas where the problem was recognised by others, on other occasions we have revealed problems that had not been recognised before. Whilst it is important that we know we have the support of national bodies it is equally important that our reports – which are more targeted to the local clinician – are welcomed as a means to make change.

END