

# Quality Improvement News

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## Category: 14 (1 December 2023)

[What do the early emergency care sitreps tell us about this winter?](#)

[DECEMBER 21, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"WHAT DO THE EARLY EMERGENCY CARE SITREPS TELL US ABOUT THIS WINTER?"](#)

NHS Confederation – 19th December 2023

Analysis of winter 2023's emergency care sitreps and the implications for the rest of the winter.

Further information – [What do the early emergency care sitreps tell us about this winter?](#)

[Patient choice guidance](#)

[DECEMBER 21, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"PATIENT CHOICE GUIDANCE"](#)

NHS England – 19th December 2023

This guidance outlines how commissioners, providers and primary care referrers can meet the statutory, contractual and policy obligations which enable patients' rights to choice as set out in the [NHS Constitution for England](#).

[Patient choice guidance](#)

[What's driving increasing length of stay in hospitals since 2019?](#)

[DECEMBER 19, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"WHAT'S DRIVING INCREASING LENGTH OF STAY IN HOSPITALS SINCE 2019?"](#)

Health Foundation – 19th December 2023

Our analysis contributes to the debate around NHS productivity and raises questions about the contribution COVID-19 might have made to changes in length of stay in 2022. Further work is needed to better understand the contribution COVID-19 is making, the mechanisms behind this and

whether these patterns have persisted into 2023. Efforts to address this, and other challenges, are needed if the NHS is to achieve its ambition to improve productivity levels.

Further information – [What's driving increasing length of stay in hospitals since 2019?](#)

[Building the economic case for social prescribing](#)

[DECEMBER 15, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"BUILDING THE ECONOMIC CASE FOR SOCIAL PRESCRIBING"](#)

National Academy for Social Prescribing (NASP)

NASP has published 13 evidence publications to date which suggest that social prescribing can reduce costs and pressure in the health care system. Recognising the urgent need to demonstrate the health economic benefits of social prescribing, NASP commissioned a rapid scoping review of 19 studies on the economic impact of social prescribing and 7 studies on the impact of social prescribing on health service usage.

Social prescribing can save money and findings from studies using 5 different methods show that social prescribing can have a positive economic impact

Studies suggest that social prescribing schemes can deliver between £2.14 and £8.56 for every £1 invested

Social prescribing can reduce pressure on the NHS, this includes reduced GP appointments, reduced hospital admissions and reduced A&E visits for people who have been referred to social prescribing

More research is needed to access better data and demonstrate benefits more clearly

Briefing: [Building the economic case for social prescribing](#)

Full report: [Building the economic case for social prescribing](#)

[Palliative and end of life care in Integrated Care Systems – Exploring how Integrated Care Systems are responding to the Health and Care Act 2022](#)

[DECEMBER 15, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"PALLIATIVE AND END OF LIFE CARE IN INTEGRATED CARE SYSTEMS – EXPLORING HOW INTEGRATED CARE SYSTEMS ARE RESPONDING TO THE HEALTH AND CARE ACT 2022"](#)

Marie Curie – Nov 2023

At Marie Curie, we were very encouraged by the inclusion in the Health and Care Act 2022 of a statutory duty for Integrated Care Boards (ICBs) to commission palliative and end of life care services that meet the needs of their populations. We understand the immense pressures on the health and care system at the present time and want to work closely with ICBs across the country to understand the support they need to act on this new duty – one which we believe has the potential to reduce pressures on the wider system, in addition to improving end of life experience for all. This is why we wrote to ICBs recently and asked them about their work on palliative and end of life care for adults. The survey findings provide a timely insight into how systems are responding to the new legal duty and the opportunities and barriers they are experiencing when seeking to meet this duty.

Read the Report – [Palliative and end of life care in Integrated Care Systems – Exploring how Integrated Care Systems are responding to the Health and Care Act 2022](#)

[I just want to be me'. Trans and Gender Diverse Communities Access to and Experiences of Palliative and End of Life Care.](#)

[DECEMBER 15, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"I JUST WANT TO BE ME'. TRANS AND GENDER DIVERSE COMMUNITIES ACCESS TO AND EXPERIENCES OF PALLIATIVE AND END OF LIFE CARE."](#)

Hospice UK; 2023.

Trans and gender-diverse people frequently experience inequitable access to health and care services, and the same is true for care at the end of life.

This report uses real-world experience to highlight the needs of these communities, and sets out recommendations for what hospices and palliative care professionals can do to make end of life care more equitable and accessible for everyone.

Read the Report – [I Just Want To Be Me](#)

[Diabetes Prevention Programme \(DPP\) Non-Diabetic Hyperglycaemia \(NDH\) State of the Nation report \(England only\)](#)

[DECEMBER 14, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"DIABETES PREVENTION PROGRAMME \(DPP\) NON-DIABETIC HYPERGLYCAEMIA \(NDH\) STATE OF THE NATION REPORT \(ENGLAND ONLY\)"](#)

HQIP – 14th December 2023

The National Diabetes Audit (NDA) Diabetes Prevention Programme (DPP) has published a report on Non-Diabetic Hyperglycaemia (NDH) State of the Nation report (England only), based on data from 1 January 2021 to 31 March 2022.

Covering diagnosis of NDH, routine care of people with NDH and referrals to the NHS Diabetes Prevention Programme (NHS DPP), this report uses data from English General Practice (GP) systems for 2021-22 and data from the NHS DPP programme providers for referrals from January 2021 up to the end of March 2022.

Read the Report – You can view an infographic relating to this report by using the button below. To see the report and detailed analysis, use the following links:[NDA Non-Diabetic Hyperglycaemia \(NDH\) Overview](#) and [NDA Non-Diabetic Hyperglycaemia \(NDH\) Detailed Analysis](#).

[Community Acquired Pneumonia – Consolidation Required](#)

[DECEMBER 14, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"COMMUNITY ACQUIRED PNEUMONIA – CONSOLIDATION REQUIRED"](#)

HQIP – 14th December 2023

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has published Consolidation Required, a review of the care provided to adults presenting to hospital with a diagnosis of Community Acquired Pneumonia (CAP). This report uses data from clinician questionnaires, organisational questionnaires, and case note peer reviews to examine the quality of care provided to sampled patients.

Read the Report – [Community Acquired Pneumonia – Consolidation Required](#)

[MBRRACE-UK Comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death](#)

[DECEMBER 14, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"MBRRACE-UK COMPARISON OF THE CARE OF ASIAN AND WHITE WOMEN WHO HAVE EXPERIENCED A STILLBIRTH OR NEONATAL DEATH"](#)

HQIP – 14th December 2023

The Maternal, Newborn and Infant Clinical Outcome Review Programme has published an MBRRACE-UK Perinatal confidential enquiry report on a comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death. It is based on deaths reviewed in England, Wales, Scotland and Northern Ireland, for the period between 1 July 2019 and December 2019.

The overall findings of this enquiry were based on the consensus opinion of panel members concerning the quality of care provided for 34 Asian and 35 White mothers and their babies. This enquiry was developed to try and identify any differences in the quality of care provided to women of Asian ethnicity compared with their White counterparts, and forms the main focus of this report. As such, the recommendations are targeted at trying to ensure equity for the quality of care provision for both Asian and White mothers and their babies.

Read the Report – [MBRRACE-UK Comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death](#)

[Young people with type 2 diabetes state of the nation report](#)

[DECEMBER 14, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"YOUNG PEOPLE WITH TYPE 2 DIABETES STATE OF THE NATION REPORT"](#)

HQIP – 14th December 2023

The National Diabetes Audit (NDA) has published a State of the Nation report on Young people with type 2 diabetes. This is the second of these reports, aiming to document the number of people with type 2 diabetes up to the age of 40 years, their patient characteristics and the diabetes care they receive. This is important because adverse diabetes and cardiovascular outcomes are more common in people who develop type 2 diabetes at an earlier age and it is thought the numbers of affected individuals are increasing.

This overview details the findings and recommendations relating to diabetes care for young people with type 2 diabetes for the 2021-22 audit which covers the period 1 January 2021 to 31 March 2022. More specifically, it covers:

Trends in cross-sectional prevalence and characteristics of young people with type 2 diabetes over the last 5 audit years (2017-18 to 2021-22)

Receipt of care processes and treatment target achievement in people with type 2 diabetes at young age

Treatment received, including statins and antihypertensive treatment, along with the location of care.

Read the Report – To see the report and detailed analysis, use the following links: [NDA Young People Type 2 Overview](#) and [NDA Young People Type 2 Detailed Analysis](#).

[Infection related deaths of children and young people in England](#)

[DECEMBER 14, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"INFECTION RELATED DEATHS OF CHILDREN AND YOUNG PEOPLE IN ENGLAND"](#)

HQIP – 14th December 2023

The National Child Mortality Database (NCMD) has published its latest Thematic Report. Based on data from April 2019 to March 2022, this report includes child deaths where infection may have contributed to the death and those where infection provided a complete and sufficient explanation of death, and covers:

Variations in incidence of child deaths with infection

Infection related deaths

Characteristics of children who died where infection may have contributed or caused the death and where infection provided a complete and sufficient explanation of death

Details of the infections and their clinical presentations.

It also includes learning from Child Death Overview Panel (CDOP) completed child death reviews where death was categorised as infection, as well as next steps.

Read the Report – [Infection related deaths of children and young people in England](#)

[MBRRACE-UK Comparison of the care of Black and White women who have experienced a stillbirth or neonatal death](#)

[DECEMBER 14, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"MBRRACE-UK COMPARISON OF THE CARE OF BLACK AND WHITE WOMEN WHO HAVE EXPERIENCED A STILLBIRTH OR NEONATAL DEATH"](#)

HQIP – 14th December 2023

The Maternal, Newborn and Infant Clinical Outcome Review Programme has published an MBRRACE-UK Perinatal confidential enquiry report on a comparison of the care of Black and White women who have experienced a stillbirth or neonatal death. It is based on deaths reviewed in England, Wales, Scotland and Northern Ireland, for the period between 1 July 2019 and 31 December 2019.

The overall findings of this enquiry were based on the consensus opinion of panel members concerning the quality of care provided for the 36 Black and 35 White mothers and their babies. This enquiry was developed to try and identify any differences in the quality of care provided to women of Black ethnicity compared with their White counterparts, and forms the main focus of this report. As such, the recommendations are targeted at trying to ensure equity for the quality of care provision for both Black and White mothers and their babies

Read the Report – [MBRRACE-UK Comparison of the care of Black and White women who have experienced a stillbirth or neonatal death](#)

[PICANet Paediatric critical care state of the nation report](#)

[DECEMBER 14, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"PICANET PAEDIATRIC CRITICAL CARE STATE OF THE NATION REPORT"](#)

HQIP – 14th December 2023

The Paediatric Intensive Care Audit Network (PICANet) has published the National Paediatric Critical Care Audit State Nation Report for 2023. Based on a data collection period from January 2020 to December 2022, it describes paediatric critical care activity which occurred within Level 3 paediatric intensive care units and Specialist Paediatric Critical Care Transport Services in the United Kingdom (UK) and Republic of Ireland (ROI).

This report contains key information on referral, transport and admission events collected by the National Paediatric Critical Care Audit to monitor the delivery and quality of care in relation to agreed standards and evaluate clinical outcomes to inform national policy in paediatric critical care. It reports on the following five key metrics relevant to Paediatric Intensive Care services:

case ascertainment including timeliness of data submission

retrieval mobilisation times

emergency readmissions within 48 hours of discharge

unplanned extubation in PICU

mortality in PICU.

Read the full report: – [PICANet Paediatric critical care state of the nation report](#)

[HQIP's Annual Report: April 2022–March 2023](#)

[DECEMBER 12, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"HQIP'S ANNUAL REPORT: APRIL 2022–MARCH 2023"](#)

HQIP – November 2023

This was a year in which we, along with everyone else in healthcare, were able – albeit tentatively – to turn our attention back to the future. While COVID-19 continued in its various guises (one in 13 people in the UK were reported to have the virus at the end of March 2022), it was clear that the sector needed to plan for recovery. But what did this mean in practice, and what was feasible, in an already overstretched service? Identifying where resources were needed most, and where they would make the greatest difference to achieve maximum impact, was – and still is – part of the solution. In other words, it was clear that we needed to 'follow the data'. So, the value of audit and clinical outcome data was never greater than in 2022-23.

In addition to HQIP's accounts, this annual report shares our strategic objectives and key achievements for 1 April 2022 – 31 March 2023 as well as future plans.

HQIP's latest annual report is now available to view and [download](#).

[Meeting the needs of autistic adults in mental health services](#)

[DECEMBER 12, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"MEETING THE NEEDS OF AUTISTIC ADULTS IN MENTAL HEALTH SERVICES"](#)

NHS England – 12th December 2023

This guidance is for for integrated care boards, health organisations and wider system partners and provides advice on how to improve the quality, accessibility and acceptability of care and support for autistic adults through the implementation of 10 principles.

[Meeting the needs of autistic adults in mental health services](#)

[Consultation to reduce unwarranted or avoidable dementia-related hospital occupancy in England](#)

[DECEMBER 12, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"CONSULTATION TO REDUCE UNWARRANTED OR AVOIDABLE DEMENTIA-RELATED HOSPITAL OCCUPANCY IN ENGLAND"](#)

The Geller Commission – 2023

The Geller Commission is an independent review into clinical pathways for people living with dementia in the UK. It will produce a series of practical steps that can be taken to reduce the number of people with dementia in hospital without a specific acute medical reason. The Commission is now seeking views on how to reduce unwarranted or avoidable dementia-related hospital occupancy in England. The consultation closes at 11.59pm on 31 January 2024.

Read the Report – [Consultation to reduce unwarranted or avoidable dementia-related hospital occupancy in England](#)

[Healthcare Inspectorate Wales Annual Report 2022-2023](#)

[DECEMBER 12, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"HEALTHCARE INSPECTORATE WALES ANNUAL REPORT 2022-2023"](#)

Healthcare Inspectorate Wales – December 2023

This report sets out our key findings from the regulation, inspection, and review of healthcare services in Wales. It outlines how we carried out our functions across Wales, seeking assurance on the quality and safety of healthcare services through a range of activities including inspections and review work in the NHS, and regulatory assurance work in the independent healthcare sector. It provides a summary of what our work has found, the main challenges within healthcare across Wales and provides our view on areas of national concern.

Read the Report – [Healthcare Inspectorate Wales Annual Report 2022-2023](#)

[RCOG publishes Good Practice Paper on Maternity Triage](#)

[DECEMBER 12, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"RCOG PUBLISHES GOOD PRACTICE PAPER ON MATERNITY TRIAGE"](#)

RCOG – 11th December 2023

The Royal College of Obstetricians and Gynaecologists (RCOG) has published a new Good Practice Paper providing recommendations for maternity triage operational structure and pathways, to support safe care of pregnant and newly postnatal woman and people outside of scheduled appointments.

The paper recommends that maternity triage departments implement the Birmingham Symptom-specific Obstetric Triage System (BSOTS), which is the recommended triage system in England and has been widely adopted in the UK. Using this system offers standardised initial assessment and symptom-specific algorithms to identify those women who require more urgent attention in a busy clinical setting.

To support this process, the paper also recommends that women should be provided with information regarding how and when to call or to attend the maternity triage unit, and that a dedicated telephone advice line answered by a midwife is made available 24/7 outside the clinical area. Women attending the unit should be initially assessed by a midwife within 15 minutes of

attendance and prioritised using algorithms which determine urgency of further investigations and seniority of review.

Read – [Good Practice Paper No. 17 Maternity Triage](#)

[Learning from Lives and Deaths – people with a learning disability and autistic people 2022](#)

[DECEMBER 5, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"LEARNING FROM LIVES AND DEATHS – PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE 2022"](#)

King's College London – Published November 2023

The 2022 learning from lives and deaths reviews for people with learning disability and autistic people (LeDeR) [report](#) summarises the lives and deaths of people with a learning disability and autistic people. It explores themes including causes and circumstances of death, avoidable mortality and quality of care.

[LeDeR Report 2022 – Main Report](#)

[Integrated care partnerships: driving the future vision for health and care](#)

[DECEMBER 5, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"INTEGRATED CARE PARTNERSHIPS: DRIVING THE FUTURE VISION FOR HEALTH AND CARE"](#)

NHS Confederation – 5th December 2023

An in-depth look at the role of integrated care partnerships and what lies ahead.

Read the Report – [Integrated care partnerships: driving the future vision for health and care](#)

[Implementation, readiness and resourcing: a practical guide to the adoption and spread of health innovation programmes](#)

[DECEMBER 5, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"IMPLEMENTATION, READINESS AND RESOURCING: A PRACTICAL GUIDE TO THE ADOPTION AND SPREAD OF HEALTH INNOVATION PROGRAMMES"](#)

Health Innovation Network

This guide aims to provide an easy-to-adapt framework for people working within health and care systems seeking to adopt and embed a service innovation or transformation. Applicable to large- and small-scale projects across multiple locations, it synthesises learning from Focus ADHD (attention deficit hyperactivity disorder), a national programme implemented at pace across England between April 2020 and March 2023 via the 15 local health innovation networks that make up the Health Innovation Network.

Access the Guide – [Implementation, readiness and resourcing: a practical guide to the adoption and spread of health innovation programmes](#)

[How can we improve partnerships between healthcare providers?](#)

[DECEMBER 5, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"HOW CAN WE IMPROVE PARTNERSHIPS BETWEEN HEALTHCARE PROVIDERS?"](#)

NIHR – 1st December 2023



Effective collaborations between healthcare providers can improve quality of care and resolve staffing issues. New research highlighted the key components of successful collaborations.

Researchers reviewed evidence and interviewed NHS staff and the public about how, why and when collaborations between healthcare providers were effective. They found that successful partnerships are built on trust and shared beliefs. Clear priorities for improvement, roles and responsibilities that are clearly set out in contracts, and similar working cultures in partner organisations, all supported collaboration. Staff appreciated leaders' enthusiasm for partnerships, especially when they acknowledged the challenge of staff shortages.

The practical advice in this research could help NHS providers, managers, policymakers, and leaders of collaborations to improve partnerships.

Further information – [How can we improve partnerships between healthcare providers?](#)

This summary is based on: Millar R, and others. [Towards achieving interorganisational collaboration between health-care providers: a realist evidence synthesis](#). Health and Social Care Delivery Research 2023; 11: 1 – 158.

[Progress and challenge in delivering safe and effective care 2023 – RCN](#)

[DECEMBER 4, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"PROGRESS AND CHALLENGE IN DELIVERING SAFE AND EFFECTIVE CARE 2023 – RCN"](#)

RCN – November 2023

This report outlines the national themes and actions required from the Welsh government to support the implementation of the Nurse Staffing Levels (Wales) Act 2016. It then looks in detail at the picture in each of the seven health boards in Wales. This report is also available in Welsh under publication code 011 091. It is the third in a series of reports, and focuses primarily on 2022-2023.

Read the Report – [Progress and challenge in delivering safe and effective care 2023](#)

[New report sets out how hospital admissions can be avoided and how patient flow can be improved ahead of busy winter period](#)

[DECEMBER 1, 2023](#) ~ [LEAVE A COMMENT](#) ~ [EDIT"NEW REPORT SETS OUT HOW HOSPITAL ADMISSIONS CAN BE AVOIDED AND HOW PATIENT FLOW CAN BE IMPROVED AHEAD OF BUSY WINTER PERIOD"](#)

CCN – November 2023

A major new report released today sets out how the health and social care system can work better this winter – by avoiding unnecessary hospital admissions and improving patient flow.

Published ahead of what is expected to be another challenging winter period for the NHS and social care, the new study from the County Councils Network (CCN) and Newton explores how the system to admit and discharge older people from hospital and support their care needs could work better, potentially improving the lives of tens of thousands of over 65s and reducing costs to the NHS and local government over £2.5bn.

Read the Report – [Finding a way home](#)

[Transforming health and wellbeing services through population health management](#)

[DECEMBER 1, 2023 ~ LEAVE A COMMENT ~ EDIT"TRANSFORMING HEALTH AND WELLBEING SERVICES THROUGH POPULATION HEALTH MANAGEMENT"](#)

NHS Confederation – Nov 2023

A rising number of NHS organisations are combining traditional approaches – responding to illness where it occurs – with population health approaches that seek to better understand, target and prevent illness. This report explores four case studies where population health and population health management approaches have been developed in recent years and show demonstrable benefits.

[Transforming health and wellbeing services through population health management](#)

[Investing to save: the capital requirement for a more sustainable NHS in England](#)

[DECEMBER 1, 2023 ~ LEAVE A COMMENT ~ EDIT"INVESTING TO SAVE: THE CAPITAL REQUIREMENT FOR A MORE SUSTAINABLE NHS IN ENGLAND"](#)

NHS Confederation – Nov 2023

This report finds that NHS capital budgets need to nearly double from £7.7 billion to £14.1 billion – an extra £6.4 billion – if the NHS is to clear the building repairs backlog and overhaul the estate to enable greater productivity and faster patient care. Capital funding drives productivity but the NHS has lagged behind other countries in terms of capital investment for more than five decades. The NHS now has the sixth lowest number of CT and MRI scanners per million people of the Organisation for Economic Co-operation and Development (OECD) countries. NHS leaders have said that increasing capital funding is their top financial priority ahead of the next election, alongside reform of how the capital regime operates.

[Investing to save: the capital requirement for a more sustainable NHS in England](#)