Improving communication between healthcare professionals and patients in the NHS in England

Summary report

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Foreword

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In 2016, when I wrote *The Long and Winding Road*, the reception to its publication was muted. The case it put forward was simple: improvements in communication between healthcare professionals and patients were likely to improve the quality of patient care and to reduce its cost. The patient *and* the taxpayer would benefit. The first part of the case was not difficult to make. Indeed, it had been made many times before. But the second part was more innovative and apparently less easily received. It was almost as though there was some embarrassment about accepting a spend-to-save case in this aspect of public policy. The most that critics could say was that there was debate to be had about which element of healthcare should be the focus for the preferred investment. Nobody took issue with the core argument, just with its emphasis.

A year passed and it seemed the report had lost its traction. To revive interest in the topic, I pressed the case with Sir Simon Stevens, CEO of NHS England, urging him to provide a substantive response to the report. Here, after all, was an opportunity to improve healthcare and to save money, all at a time when the NHS was under exceptional budgetary pressure. But I was conscious that Sir Simon receives countless proposals for new expenditure plans. In that context, I congratulate him on his response. He commissioned a detailed study into how this invest-to-save project could be taken forward.

Two years on we have in this report the results of the study commissioned by Sir Simon. The report has weighed the evidence and has been subject to rigorous review at each stage of its development. Its main recommendation is investment in a single, strategic intervention: training clinicians to have conversations with patients nearing the end of their lives about what these patients want from their care. The patient benefits by themselves make a powerful case for introducing these conversations as routine practice across NHS Acute Hospital Trusts. The associated health system benefits quantified in the report make that case compelling. There will be discussion about the precise level of financial savings to be realised. But the return on investment estimated in this report is on such a scale, there cannot be any serious doubt that a positive return will be secured.

We all know that studies by themselves do not make a jot of difference to patients' experience of healthcare, nor do they save a pound of public expenditure. So I commend the recommendations of this systematic study to Sir Simon and his colleagues for immediate implementation. The time for debate on the focus of investment is over, the time for action is now. Patients taxpayers will benefit.

Summary

Introduction

Over the past 20 years a wealth of studies has shown the positive effects of interventions to improve communication between clinicians and patients. Studies from around the world demonstrate that effective patient/clinician communication can improve patients' experiences and health outcomes.

Building on this evidence base and the 2016 report *A Long and Winding Road,* NHS England[1] convened a Clinical Communications Steering Group (the Steering Group[2]) in 2018 to find out:

- Whether this evidence now supports systematic investment in improving clinician/patient communication across NHS Acute Trusts in England
- If so, what particular intervention or interventions to target.

To answer these questions, the Steering Group commissioned a systematic review of the international literature on interventions to improve clinician-patient communication. Its aim was to identify interventions that have previously demonstrated a positive difference to patient experience and clinical outcomes, while also reducing financial demands on the health system. The options identified needed to be interventions that policy makers, commissioners and service managers across the NHS could replicate accurately, with a reasonable return on their investment and at a manageable level of implementation risk.

The systematic review has been undertaken by SQW, an independent research and consultancy organisation. This report has been prepared by SQW and presents key findings from the systematic review and the evidence base which supports the case for investing in improving communication between clinicians and patients in the NHS.

Of the options identified by the literature review, this report recommends that NHS England & NHS Improvement initially invest in a single intervention: introducing patient-centred goals of care conversations with patients presenting in Acute Medical Units (AMUs) and Surgical Assessment Units (SAUs) who are at risk of dying in the next 12 months and/or are at risk of serious clinical deterioration and death during their presentation.

These voluntary conversations between patients and a clinical member of staff take place within 48 hours of the patient's admission. In the course of the conversation: the clinician gives the patient information about their condition and treatment options; the patient has the opportunity to express their particular values, goals, priorities and treatment preferences; the clinician hears and respects these values, priorities and preferences; and the clinician records them in a single care planning document. This document would be created during the first conversation and updated as needed during subsequent conversations. Patients and their families keep a paper copy of the original plan and any updates. Staff also record the decisions and any other key outcomes of the conversations in their organisation's electronic system.

The evidence indicates that **introducing these conversations as routine clinical practice will significantly improve the experience of patients nearing the end of their lives, enhancing**

[1] Since merged with NHS Improvement to form NHS England & NHS Improvement.
[2] See Acknowledgements for members.

their quality of life while reducing their requirements for critical care. This reduction in demand for hospital care means the costs of introducing goals of care conversations are more than outweighed by the likely savings.

The modelling of the potential **cost savings presented in this report shows them to represent an estimated potential saving to the national healthcare system of £502million per year (2019/20 values)** when all NHS Acute Trusts have embedded goals of care conversations as normal practice.

The combination of significant patient benefits and lower hospital costs makes a compelling case for introducing goals of care conversations with patients nearing the end of their lives across the NHS. This study recommends extending the practice nationally and includes an action plan for a national rollout. An NHS Trust is currently undertaking a proof of concept programme to consider the viability of further rollout.

The study's advisory group also recommends a subsequent rollout of the intervention to respiratory, cardiology and elderly care wards within acute providers. This is estimated to yield a further £59million per annum of potential savings (2019/20 values).

Research and collaboration supporting goals of care conversations

The recommended intervention draws on research studies that examined the impact of three personalised end of life care planning interventions. It blends elements from each of these into a single, cohesive care planning conversation and educational package.

The recommended structure and implementation plan for the conversations have been refined in collaboration with an advisory group comprising academic and clinical experts in end of life care and patient-clinician communication.

The core elements of this recommended approach are consistent with the Liverpool Care Pathway review of 2013[3] and subsequent end of life care audits undertaken by the Royal College of Physicians (RCP)[4] [5]. This recommended approach should be considered in conjunction with the ongoing revisions to the General Medical Council's consent guidance.

Patient benefits from goals of care conversations

Personalised care planning can bring substantial benefits to patients and their families. Evidence suggests that as a result of having care planning conversations:

- **Patients' wishes are better recorded and adhered to by staff providing their care.** In line with their expressed wishes, patients who undertake personalised care planning are more likely to receive palliative care instead of curative care, are less likely to receive unwanted invasive treatments, and are more likely to die at home rather than in hospital (evidence suggests show more patients would prefer to die at home than currently do).

[3] Findings of that review published here.
[4] The latest of which - *End of Life Care Audit: Dying in Hospital* – is published here.
[5] The Liverpool Care Pathway review and RCP audits did not feature in the international literature reviewed during this study, but the approach's consistency with each has been advised by this study's advisory group.

- **Patients' satisfaction with their care improves.** Patients can experience improvements in their quality of life and wellbeing, and less depression and anxiety. Family satisfaction is also demonstrated to improve, whilst stress, anxiety and depression are reduced in surviving relatives.
- **Patients may also live longer.** Evidence shows an association between personalised care planning and lower patient mortality rates.

Healthcare system benefits

There is strong evidence that holding goals of care conversations with patients who have life-limiting/terminal illnesses reduces **the time these patients spend in hospital in the 12 months before they die.** This kind of care planning can also reduce emergency admissions and calls for emergency teams to attend to patients already in hospital. In addition, end of life discussions have been associated with reduced invasive medical care near death, such as ventilation and resuscitation.

The costs of introducing goals of care conversations into hospitals are more than outweighed by savings from the associated reduction in time spent in hospital. The net estimated cost saving for an average NHS Acute Trust from introducing goals of care conversations with these patients would be £3million per year, representing a total annual cost saving to NHS hospitals of £502million.

Once goals of care conversations in AMUs and SAUs have become routine and their benefits demonstrated, they can be introduced into other areas of care in a second phase of the national rollout. This study's advisory group recommends the approach could be **extended to respiratory, cardiology and elderly care wards within acute providers**.

We estimate that this wider rollout of goals of care planning could generate a further total cost saving to NHS hospitals of £59 million per year (2019-20 values).

None of the studies reviewed looked at whether patients' lower use of secondary care led to increased use of social, hospice, community or primary care services. Potential costs to these services could therefore not be accounted for in our cost/savings analysis of the intervention. However, the scale of the net savings to the NHS noted above is likely to offset a modest rise in utilisation of other services. Reducing patient bed days during end of life may also give acute services more capacity to deal with other pressures, potentially allowing them to increase throughput on elective operations and/or improve waiting time performance.

Any knock-on effects on demand, costs and capacity elsewhere in the health and social care system need to be captured and monitored in the continuing review of the impact of introducing goals of care conversations.

Implementing the introduction of goals of care conversations

Introducing goals of care conversations in AMUs and SAUs with all admitted patients identified as being at increased risk of serious clinical deterioration and death during their presentation and/or at risk of dying within the next 12 months requires a number of actions at national and local levels.

Actions for NHS Acute Trusts

For NHS Acute Trusts, the headline actions are setting up regular training for the appropriate staff, planning for the impact that delivering the intervention will have on resources[6], and making sure systems for storing plans and monitoring and evaluating this intervention are adequate:

- **Setting up regular training for the AMU/SAU staff who conduct goals of care conversations.** These will be core medical trainees (CT2), specialist registrars (ST2), charge nurses, advanced nurse practitioners and band 6-7 physiotherapists or occupational therapists. Based on advisory group steer, we recommend that these staff members would all need to attend a 2-day modular training course, plus a follow up half-day session 3-6 months later. Training would be repeated annually, to make sure new staff are familiar with the principles and processes.

- Alongside training for the clinicians who hold the goals of care conversations with patients, **consultants and matrons on AMU/SAU rotas would require an introductory session** to understand the need for goals of care conversations and how to listen to and act on the information they yield. This single training session is planned to take two hours.

- **Planning for the impact on resources.** Trusts will need to estimate the number of patients eligible for goals of care conversations, to allocate the right amount of clinicians' time to conducting conversations. On average, about 24% of all patients admitted to AMUs/SAUs will be eligible. Holding a goals of care conversation takes about 30 minutes of additional clinical time per patient. Discharged patients would need a second 30-minute conversation to revise their plan before they leave the hospital.

- **Maintaining systems for managing care plans and for monitoring delivery.** Trusts' existing planning documents and record keeping systems should be capable of capturing the level and detail of information needed for storing and amending care plans, for local and national care planning, and for monitoring/evaluation purposes. A member of administrative staff at each Trust would need to collate, standardise and submit the relevant data to national project management and evaluation teams.

Actions at the national level

At a national level, the main actions required are as follows:

- **Establishing 'proof of concept' in one Trust** to generate implementation learning and evidence of impact to inform wider roll-out.

- **Establishing a 'development group'** with appropriate skills and expertise to design a standard training programme. This group will play a key role during the first 3-6 months of developing the intervention and have less input thereafter. The expertise and skills needed by the development group are expected to include:

[6] Some actions, such as procuring training sessions, are assumed to necessitate a cash spend Other actions, such as clinicians' time to hold goals of care conversations and attend training, will require dedicated resourcing but are not assumed to be an 'additional' cost requiring cash outlay by Trusts. Our cost/savings analysis in the main body of this report only includes the cost of actions requiring a cash spend/incurring an additional cost. All estimated costs are detailed in full in Annex C of the main report.

  - Clinical expertise in and knowledge of end of life care and AMUs/SAUs during phase one, and in elderly care, cardiology and respiratory care for phase two
  - Communication skills training expertise, including personalised care planning
  - Educational skills, with a focus on workforce development in secondary care
  - Evaluation expertise, including capturing data and insights from patients and secondary care settings.

- **Developing a 'train the trainers programme'.** The development group would establish a train the trainers team, create a faculty of trainers and simulated patients, and liaise with wider stakeholders at local and national levels.
- **Appointing a national project team** to manage national rollout and implementation of this intervention. The roles of this team would include: supporting and coordinating development group activities and the work of the train the trainers team; developing training materials; procuring and sharing promotional materials; engaging with Trusts to promote participation in the training programme and subsequent delivery of conversations; organising training sessions and liaising with trainers/simulated patients; monitoring training and implementation; liaison with national stakeholders and the governance board; risk and budget management; and oversight of work undertaken to evaluate the intervention.
- **Identifying an appropriate governance body** to oversee the national rollout. We recommend a dedicated project board reporting to NHS England's End of Life Care Programme Board.

Actions to support monitoring and evaluation

Information recorded by clinical staff undertaking care planning conversations at each Trust would need to meet national monitoring and evaluation requirements. As noted above, Trusts would need to submit the relevant data to the national project management and evaluation teams. To facilitate monitoring and evaluation, we recommend exploring options for national standardised planning documents and data as the rollout progresses.

Critical success factors

Successful introduction of goals of care conversations for patients approaching end of life is likely to depend on the following critical factors.

- NHS managers and clinicians embed **a culture of shared decision-making**. Open conversations with patients about their care and wishes at the end of their lives become 'business as usual' as Trust staff recognise these conversations are critical to patients' wellbeing.
- Clinical staff within all AMUs and SAUs (plus cardiology, respiratory and elderly care units during phase two) undertake goals of care conversations to the **same quality standard** and capture common information fields. This would ensure patients have equal access to high quality goals of care conversations whichever Trust they are admitted to, and enable monitoring and evaluation of the conversations.

- Trust leaders and AMU/SAU managers **release clinical staff** to participate in the training and **free up capacity** for clinicians to undertake the conversations on an ongoing basis. This is one of the biggest challenges to implementing the intervention, given the multiple competing demands on staff in acute settings. Communication between the national project team and the Trusts involved will be critical.
- **NHS England & NHS Improvement prioritise** the intervention, management of its development and implementation, and oversight of its evaluation.

To realise success, **staff need to understand *why*** they are being asked to hold the goals of care conversations and *what* it will mean for them and their patients in practical terms. The **benefits must be clearly articulated** – both to and by senior leaders and frontline clinicians – including the anticipated outcomes for patients and the expected implications for service use. Trusts need to disseminate a nationally-designed communication programme to raise awareness, inform staff about training, identify the expected benefits and supporting evidence, share the actual results, and show how the intervention aligns with priorities in the Long Term Plan. Communication about this intervention is likely to need to be continuous, not just during its initial introduction in each Trust.