

# Lessons from the UK experience

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- *Masters in Public Health, Harvard School of Public Health, 2009/11*
- *Medical Director, Winchester & Eastleigh NHS Trust, 2004/09*
- *NHS Consultant Physician and Geriatrician, since 1990*
- *MB BCh BAO, Queen's University Belfast 1982*

*\*Health Foundation QI Fellowship*



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# Clinical Effectiveness & Evaluation Unit at RCP

- National clinical audits, databases, confidential enquiries
  - Stroke, Falls, Hip fracture, COPD, IBD, Lung cancer, Asthma
  - Dementia, blood transfusion, end of life care etc
- Specific quality improvement activity
  - Fallsafe care bundle, stroke and lung cancer peer review, elder friendly ward quality mark etc



# Overview

- The wider national and international context
- Improving quality of care
- Where does clinical audit fit?
- How should we build and develop audit programs for maximum impact?



# *The good news.....*



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*We are not alone....*



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# *Every healthcare system struggles with...*

- Increasing costs
- Poor quality
- Variability



*..in addition, we all have some specific local issues, related to culture, politics, funding, context etc*



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***The bad news....***



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# No-one has cracked it...

Exhibit ES-1. Overall Ranking

Country Rankings	
	1.00-2.33
	2.34-4.66
	4.67-7.00



	AUS	CAN	GER	NETH	NZ	UK	US
<b>OVERALL RANKING (2010)</b>	3	6	4	1	5	2	7
<b>Quality Care</b>	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
<b>Access</b>	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
<b>Efficiency</b>	2	6	5	3	4	1	7
<b>Equity</b>	4	5	3	1	6	2	7
<b>Long, Healthy, Productive Lives</b>	1	2	3	4	5	6	7
<b>Health Expenditures/Capita, 2007</b>	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: \* Estimate. Expenditures shown in \$US PPP (purchasing power parity).

Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, OECD Health Data, 2009 (Paris: OECD, Nov. 2009).

# In the English NHS we face...

## Generic issues

- Rising costs, poor quality, variability

## Specific UK issues

- Lower baseline spending (9.6% GDP\*)
- Higher efficiency expectation than most
- ...but higher recent growth than most

*\*Ireland 2009 = 9.5% GDP  
2011 estimate = 8.9% GDP*

*Source; OECD health data 2011*



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# ..and the fallout from.....



*... and subsequent similar findings elsewhere*



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# Common themes

- Poor care for older patients, especially those with complex problems and cognitive impairment
- General hospital wards
- Poor end of life care
- Inadequate communication with families
- Inadequate response to warning signals
- Inadequate attention to falls, nutrition, hydration, continence issues
- Apparent lack of compassion by some staff



# Common themes

- Leadership deficiencies
  - At all levels, including national
  - Boards out of touch with what was happening on Wards
  - Misalignment between policies and practice
  - Focus on targets and finance, at the cost of quality
  - Inattention to feedback from families and to other warning signals



# UK dementia audits themes

- Lack of infrastructure around training, basic processes, policies & procedures
- Deficiencies in processes of basic clinical care
- Misalignment between policies and practice
- Insufficient Board awareness of issues related to dementia, falls, readmissions, nutrition etc





## Prime Minister's challenge on dementia

Delivering major improvements in dementia care and research by 2015



**The Dementia Challenge**  
Fighting back against dementia



# RCP Future Hospital Commission report 2013

- If we can get it right for;
  - The complex elderly
  - ..emergency admissions, on general wards
  - ..especially those with cognitive impairment
- Then we can probably get it right for the whole system
- We should recognize that patients' experience of care is as important as clinical outcomes





# How does clinical audit improve quality of care?



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# *Improving quality*

## Top down

- Targets and directives (MRSA etc in the UK)
- National campaigns & strategies (the Dementia Challenge?)
- Using the payment system
  - “P4P” in the US
  - QOF in the UK
  - Non payment for “Never events”
  - CQUINs in NHS England
- Regulatory
  - Inspection, CQC etc
  - Accreditation
- Setting the agenda and modelling culture



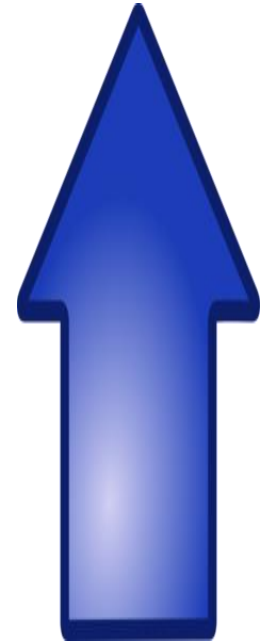
# *Improving quality*

## Bottom up

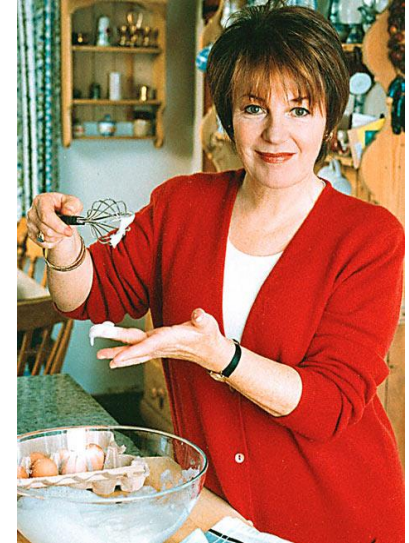
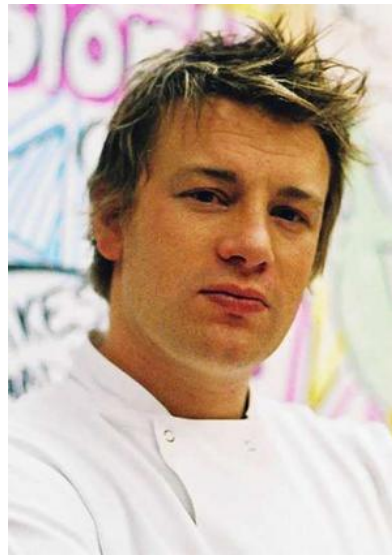
- “Industrial” Quality Improvement approaches (PDSA, Lean etc)
- Professional initiatives
  - Clinical audit, guidelines and protocols
  - Accreditation & peer review
  - Clinically led local QI work

## Patient-directed

- Public reporting of outcomes
- Patient groups
- (?the market??)



# The best approach to improving quality?



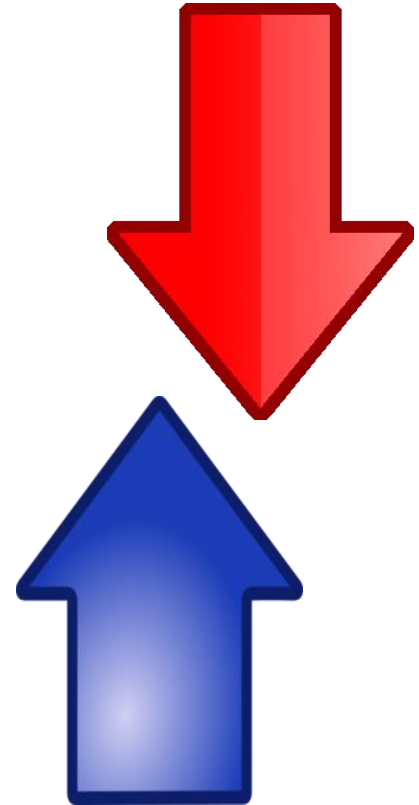
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# *Improving quality*

## The “best” approach?

- Probably a mixture of all
- alignment of external rewards, incentives and penalties
- with intrinsic (professional) motivation
- Making the right thing easier
- Removing barriers to high quality
- All approaches have strengths and weaknesses



# Clinical audits....

- Seem to work best when they seek to influence at several different levels
- Front line clinical involvement is essential, but not sufficient
- Adapt depending on their degree of maturity
- ...and are supported by approaches to help clinicians make local improvements



# Early stage clinical audits...

- Get the topic on the political and policy agenda
- Provide data
  - *The big picture is more important than local performance*
- Energize clinicians
- Interest clinical leaders and academics
- Engage patient and voluntary groups



# As audit matures expect...

- A focus on methodology and data quality
- Local data of interest to regulators, press, the public
- The focus to move from organizational to process and outcome measures
- A need to accompany data collection with support for quality improvement
- Concerns about the burden of data collection and alignment with other work
- More emphasis on patient and family experience





# Support for local quality improvement



## FRAILsafe (v6)

Date: / /

Phase 1 – Patient Identification	
<p>CONFUSED? REDUCED MOBILITY? CARE HOME RESIDENT?</p>	<p>➔ If the answer is YES to any of these proceed to phase 2</p>

Phase 2: Clinical Response	Circle	Action if YES
Confusion		
Is there delirium?	Y / N	Follow local guideline
Is there a diagnosis of dementia?	Y / N	Follow local guideline
Equipment		
Cannula	Y / N	➔ Is it still required?
Urinary Catheter	Y / N	
Bed rail	Y / N	
Reduced mobility	Y / N	Document a mobility plan for the next 24 hours
Falls risk	Y / N	Follow local guideline
Pressure sore risk	Y / N	Follow local guideline
Advance care plan		
Resuscitation status considered	Y / N	Consider if DNAR form needs completing.
<p>➔ Has a medication review been completed? <input type="checkbox"/></p>		

Phase 3 – daily monitoring	Day 1	Day 2	Day 3	Day 4	Day 5
New or worsening confusion?	Y / N	Y / N	Y / N	Y / N	Y / N
Equipment reviewed?	Y / N	Y / N	Y / N	Y / N	Y / N
Mobility plan documented?	Y / N	Y / N	Y / N	Y / N	Y / N
Signature/initials					

*With thanks to Tom Downes, BGS*

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# Support for local quality improvement



Downloaded from [qualitysafety.bmj.com](http://qualitysafety.bmj.com) on August 9, 2012 - Published by group.bmj.com  
 BMJ Quality & Safety Online First, published on 9 August 2012 as 10.1136/bmjqs-2012-000944  
 Original research

## Reciprocal peer review for quality improvement: an ethnographic case study of the Improving Lung Cancer Outcomes Project

Emma-Louise Aveling,<sup>1</sup> Graham Martin,<sup>1</sup> Senai Jiménez García,<sup>2</sup> Lisa Martin,<sup>3</sup> Georgia Herbert,<sup>1</sup> Natalie Armstrong,<sup>1</sup> Mary Dixon-Woods,<sup>1</sup> Ian Woolhouse<sup>4,5</sup>

<sup>1</sup>Department of Health Sciences, Social Science Applied to Healthcare Improvement, Research

### ABSTRACT

**Background:** Peer review offers a promising way of promoting improvement in health systems, but the national model is not yet clear. We aimed to describe

because of well publicised failures.<sup>1</sup> The current trend is towards external regulation. However, it has proved difficult to design regu-



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### The Improving Lung Cancer Outcomes Project (ILCOP):

A study of the feasibility of a national reciprocal peer review and facilitated quality improvement programme  
 S Jimenez,<sup>1</sup> L Martin,<sup>1</sup> E Aveling,<sup>2</sup> G Martin,<sup>1</sup> I Woolhouse<sup>1</sup> Royal College of Physicians,<sup>1</sup> University of Leicester.

#### Background

Validation needs in lung cancer outcomes in the UK, which is not fully explained by difference in case mix. The Improving Lung Cancer Outcomes Project (ILCOP) aims to address this via a two-year reciprocal programme of quality improvement (QI) activities. Here, we describe the feasibility and acceptability of delivering this programme nationwide.

#### Results

Seventy-one out of 134 (53%) trusts agreed to participate. The site visits for the 70 trusts in the intervention arm (Fig 1) were attended by 235 multidisciplinary team (MDT) members (Fig 2) and took a median of 10 days.

#### Table 1. Quality improvement measures

Area for improvement	No. of plans
MDT activities	43
Patient experience	9
MDT effectiveness	14
Genetic collection	7

The external evaluation team confirmed that visits were seen in a supportive and open environment, the possibility of highlighting challenges and current ways of working.

A number of patients from participating trusts are shown below:

"It seems like this project has maybe created that opportunity for people who've maybe been sitting in their MDTs thinking 'This isn't right' but not quite getting that bit of how they could improve it. Suddenly sort of opening up ideas for them to be able to do that."

"I think people are more likely to respect and take on board the views of people who are doing similar roles to themselves. It's difficult to perhaps gain further or some you know, member of management coming in and saying 'You should do this, you should do that'."

"Any forum that brings like-minded, forward-thinking clinicians together to exchange ideas and improve the services for our patients has to be a good thing."

#### Conclusions

Reciprocal peer review and facilitated QI planning are both feasible and acceptable. ILCOP was perceived as supportive and not open to the possibility of negatively challenging current ways of working. ILCOP allowed local flexibility to address specific issues rather than centrally dictated changes.

Considerable resources are required to organise study site visits, provide on-site patient feedback and to maintain the focus on QI plans.

Consideration should be given to incorporating ILCOP methodology into national cancer peer review programmes.



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*What next??*



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# I'd suggest....

- Think about alignment of initiatives
  - National strategy and other policy work
  - Guidelines?
  - Colleges and specialist society support
  - Regulation?
  - Inspection?
- Support for local clinicians and services
  - QI approaches?



# I'd suggest....

- Refine and develop the audit approach
  - A patient and family perspective
  - More robust methodology
    - *(sampling, data collection etc)*
  - Individual hospital level data
  - QI programs and approaches



# Acknowledgements

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