Lessons from the UK experience

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*Health Foundation QI Fellowship
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.....
We are not alone....
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
The bad news....
No-one has cracked it...

### Exhibit ES-1. Overall Ranking

<table>
<thead>
<tr>
<th>Country Rankings</th>
<th>1.00-2.33</th>
<th>2.34-4.66</th>
<th>4.67-7.00</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OVERALL RANKING (2010)</strong></td>
<td>AUS</td>
<td>CAN</td>
<td>GER</td>
</tr>
<tr>
<td>Quality Care</td>
<td>3</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Effective Care</td>
<td>4</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Safe Care</td>
<td>6</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Coordinated Care</td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Patient-Centered Care</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Access</td>
<td>6.5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Cost-Related Problem</td>
<td>6</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>Timeliness of Care</td>
<td>6</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Efficiency</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Equity</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Long, Healthy, Productive Lives</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Health Expenditures/Capita, 2007</td>
<td>$3,357</td>
<td>$3,895</td>
<td>$3,588</td>
</tr>
</tbody>
</table>

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
..and the fallout from.....

... and subsequent similar findings elsewhere
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
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?
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?
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

The Quality Mark for Elder-Friendly Hospital Wards

FRAILsafe (v6)

Data: /

Phase 1 - Patient Identification
CONFUSED? REDUCED MOBILITY? CARE HOME RESIDENT?
If the answer is YES to any of these proceed to phase 2

Phase 2 - Clinical Response

<table>
<thead>
<tr>
<th>Circle</th>
<th>Action if YES</th>
</tr>
</thead>
</table>
| Confusion
  - Is there delirium?
  - Is there a diagnosis of dementia? | Y / N Follow local guideline |
| Equipment
  - Cannula
  - Urinary Catheter
  - Bed rail | Y / N Is it still required? |
| 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 |

Has a medication review been completed? □

Phase 3 - Daily Monitoring

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever or worsening confusion?</td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
</tr>
<tr>
<td>Equipment reviewed?</td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
</tr>
<tr>
<td>Mobility plan documented?</td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
<td>Y / N</td>
</tr>
<tr>
<td>Stature/weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With thanks to Tom Downes, BGS

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

Emma-Louise Aveling,1 Graham Martin,1SENia Jiménez Garcia,2Lisa Martin,3Georgia Herbert,1Natalie Armstrong,1Mary Dixon-Woods,1Ian Woolhouse1,5

ABSTRACT

Background: Peer review offers a promising way of promoting improvement in health systems, but the method is not without its limitations. This article describes how reciprocal peer review was implemented because of well publicised failures. The current trend is towards external regulation. However, it has proved difficult to design regu-

Support for local quality improvement
What next??
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
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