Outcome measurement, service delivery & consultant behaviour: how to maintain team working in the NHS

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Outcome measurement, service delivery & consultant behaviour: *how to maintain team working*

- **What is Quality (as opposed to outcome)?**
- **What is Quality where I work?**
- What are the pressures for us?
  - Clinical
  - Financial
- How are we reconciling these to maintain teams and team ethos?
- What’s the way forward?
What is quality?

- There are five questions we ask of all care services.
- They're at the heart of the way we regulate and they help us to make sure we focus on the things that matter to people.
- We ask the same five questions of all the services we inspect:
  - Are they safe?
  - Are they effective?
  - Are they caring?
  - Are they responsive to people's needs?
  - Are they well-led?
  - [Are they efficient?]
Evans TW, Future Hospital Journal June 2014.
Guiding principles ‘Quality where I work’:
Hospitals serve the needs of patients and must deliver:

- High quality care 24 hours per day, **seven days a week**
- Continuity of care for patients delivered with compassion
- Stable medical teams for patient care and education
- Effective relationships between medical teams & community
- Appropriate balance between specialist and general care
- Transfer realistically allocating responsibility for further action

*Leads to the concept of the ‘citizenship charter’*
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Outcome Measurement: Summer 2012

**Preceding period:**
- Results satisfactory: Quarterly report to Trust Governance & Quality Committee
- Significant changes in personnel 2008-10 (> 6 consultants departed)
- Summer 2012:
  - SCTS changed algorithms; not supplied to Trust
  - Results no longer satisfactory
  - No individual surgeon outlying; site overall red outlier

**Reaction of trust:**
- Quality & Productivity Meetings: *‘Whole pathway’ approach adopted*
- Mandatory attendance
- Chaired by MD; Terms of reference and reporting structures agreed
- Directors of Operations, Commissioning, Directorate Manager, Governance Leads all present
- All C/T surgeons not operating, Divisional Director, Director of Catheter Laboratories, Lead Cardiologist for Referral Hospitals, Directors of ICU and Theatres, anaesthetists.
- Reported to Trust Governance & Quality Committee and Board Audit Committee
- **FRCS review of systems requested for early 2013**
Workstreams

• Current case load composition: historical change and comparison with other centres [niches vs volume, Tariff]

• Horizon scanning
• Innovation, research & development

Cardiac Surgical Pathway

Current surgical activity

Optimal service lines

New case mix, volumes

Referral sources:
• Hospital based [targets]
• Marketing [inc to patients]
• Communications
• Management of referrals

Physical:
• Site
• New facilities & diagnostics

Teams:
• Surgeons, anaesthetists nurses, diagnostics

Pt encounters:
• OPD
• PA Unit
• Post op & FU

Research, Education & Learning

IT: call centre, telemedicine, EPR/notes
Outcomes at Harefield, (SCTS) April 2010 – March 2013

2009-12: 2500 operations, RAM 4.19%
2008-11: 2493 operations, RAM 5.33%
2010-13: 2527 operations, RAM 3.67%

National average: 2.52% (2010-13)

National average RAM:
2008-11 2.69%
2009-12 2.63%
2010-13 2.52%

<table>
<thead>
<tr>
<th>Location</th>
<th>2008-11</th>
<th>2009-12</th>
<th>2010-13</th>
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<tbody>
<tr>
<td>Harefield</td>
<td>0.65%</td>
<td>0.34%</td>
<td>0.30%</td>
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<tr>
<td>Brompton</td>
<td>0.16%</td>
<td>0.29%</td>
<td>0.31%</td>
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<tr>
<td>Trust</td>
<td>0.41%</td>
<td>0.32%</td>
<td>0.29%</td>
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</tbody>
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HH 3 Year Survival funnel plot
Data Provided by SCTS

National average RAS:
2009-12: **97.37%**
2010-13: **97.48%**
2011-14: **97.70%**

2010-13: 2527 operations with a risk adjusted survival rate of 96.33%
2009-12: 2500 operations with a risk adjusted survival rate of 95.81%
2011-14: 2640 operations with a risk adjusted survival rate of 97.08%

The orange 99.8% control limit is the alert line used by SCTS to indicate outcomes are outside the expected range. The funnel plot control limits have changed over time and this chart shows the funnel plot limits for the most recent period 2011-14. Further information can be found on the SCTS website (http://scts.org/patients/hospitals/centre.aspx?id=58&name=hadfield_hospital)
RBH 3 Year In-hospital survival funnel plot
Data provided by SCTS

2010-13: 2145 operations with a risk adjusted survival rate of 97.22%
2009-12: 2293 operations with a risk adjusted survival rate of 97.18%
2011-14: 2018 operations with a risk adjusted survival rate of 97.17%
2011-14: Predicted mortality 97.59%

National average RAS:
2009-12: 97.37%
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2011-14: 97.70%

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Governance & Quality Committee

Trust Management Committee

Trust Audit & Risk Committee

Trust Board

Safe & Effective
Outcomes data
Quality dash
Infection prevention & control
Morbidity & Mortality Review
NICE, NCEPOD
Clinical Audit

Caring & Responsive
Patient & carer survey
Complaints & claims
Consent & information
Waiting lists, cancellations
Discharges, readmissions
Confidentiality
Outpatient Services

Well led
Appraisal & revalidation
Education & Training
Risk Register
Safety climate survey

Divisions & Directorates Quality & Safety Groups
Heart (RBH)
Heart (HH)
Anaesthesia & CC
Respiratory Medicine
Children's Services
Laboratory Services
In-Trust Monitoring of Outcomes

Severity of outlier status alert

Internal Reporting

+ Chief Executive Officer
Supported by Director of Performance
Discussed at Trust R & S Committee and Board

External Reporting/involvement (as appropriate)

CQC, Monitor, professional societies, Royal Colleges, GMC

+ Medical Director & Responsible Officer
Supported by Head of Quality & Safety
Reported to Trust Risk & Safety Committee

Professional societies, Royal Colleges

+ Divisional Director
Supported by Quality & Safety Lead for Division
Reported to Divisional Quality Committee, and Trust Governance & Quality Committee to timetable

Professional societies, other C/T centres

Clinical Lead
Supported by Clinical Information Analyst for specialty
Dedicated forum for review and ‘real-time’ analysis

Professional engagement with societies, other centres, networks etc

Data from local databases and/or national groups e.g. NICOR

Local Management

Trust Management
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SLR 2013/14 NHS Contribution by Care Group

Contribution (£) | Contribution % | Average Contribution %

Graph showing contributions by care group.
EXTENSION, with Out-Patient Dept., X-Ray, Throat, Cardiographic, Dental Dept., &c., Operating Theatres and Research Laboratories.
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New research priority areas for discussion:

*Fuelling the clinical mission*

**New themes**

- Evaluation & application of Devices
- Infection
- Environmental determinants of disease
- Tissue injury & repair
- Early warnings & predictors of disease: the prodrome
- Improving quality of care & life

**Applied in**

- Structural heart disease
- Arrhythmias
- Heart failure
- Revasc
- Transpl/VAD
- Ht Assess
- Critical Care

- Pleural Dis
- Lung I & I Cancer
- Asthma & Allergy

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- PAH

**With partners**

- IC Funders Industry
- Industry Funders ICMS
- IC Manchester Funders Industry
- Funders HSE DEFRA FSA
- NW London / AHSN Commissioners NIHR Industry
- RMH CLAHRC Industry
- NW London / AHSN Commissioners Non-cardiothoracic collaborators

**Personalised medicine**
Appendix 1

HEART DIVISION
- Congenital heart disease
- Structural heart disease
- Heart failure
  - Coronary artery disease
    - acute / chronic
- Arrhythmias

LUNG DIVISION
- Cancer
- Lung failure
- Asthma & allergy

Assessment:
- Heart: Imaging (Nuclear, CMR, CT), Function (Echo), Metabolic (MVO₂), Electrophysiology
- Lung: Sleep, Imaging (CT, PET), Lung function, Pre op assessment, Respiratory muscles

Critical illness & non cardiothoracic clinical support

Clinical & Research Governance
Service lines

New structure:

Access:
- Patients: Call centre, email, apps
- Clinicians: + telemed, remote monitor
- Researchers: Call centre, email.

Non admitted pt [information exchange]:
- [Other] hospital based [network]
- Hospital based [restructured OPD]
- Community based [GP, independent]

Inpatients:
- [Other] hospitals [network]
- Acute access, assessment, intervention
- Organ support & transplant

Diagnostics:
- Imaging, physiology, labs

Clinical support:
- Anaesthesia
- Genetics

Resources:
- IT [data set],
- Biobank
- Programmed investigation unit (PIU) trials

Research & Clinical Governance
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• Regional alignment (AHSC)
• International responsibilities
• Shifting services
• ...growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21.

• ...to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two...

• The NHS’ long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years.... 3% by the end of the period – provided... (we) see a bigger share of the efficiency coming from wider system improvements...... [October 2014]
• **Continuous quality improvement.** The payment system needs to promote the long-term, sustainable well-being of the whole person by reimbursing providers for delivering specified quality outcomes for patients rather than particular treatments or inputs.

• **Sustainable service delivery.** The payment system needs to incentivise best practice efficient and accessible delivery of care, to make sure that NHS funding goes as far as it can for patients.

• **Appropriate allocation and management of risk.** The payment system can help to make sure that financial risks in the NHS, caused by demand pressures or operational performance, sit with those organisations, whether commissioners or providers, that are best able to influence or absorb them in the context in which they arise.
Hospitals and hospital chains all over the world have adopted a common set of metrics to monitor and improve the productivity of their operations. These include cost per adjusted admission to provide a consistent and accepted currency with which they can compare the relative performance of their hospitals.

By adopting such an approach productivity improves – no suitable metric exists for the NHS, so we have no way of comparing NHS hospital efficiency.

By adopting the Adjusted Treatment Index (ATI), the NHS will be able to measure hospital efficiency and will align with global best practice.
Data:
• Stop changing the goal posts; make algorithms (now) available.
• Index cases (1st time AVR, revasc etc) questionable (exclusions)
• Mortality increasingly useless, morbidity [? markers] at least as helpful

Structures:
• ‘Whole system’ reporting needed; CT surgeons tiny part of pathway
• Consider publishing pathway/team results

Professional support:
• ‘Advice’ not ‘inspection’ (SCTS/RCS vs CQC, Monitor, GMC)
• ‘Buddying’ between trusts performing similar work
• International comparators helpful
Medical Director:

- Must have ‘operational authority’: the ‘magic 200’, the walk round
- Needs to admire colleagues and must be visible ‘Chief of Medicine’
- Cannot shirk responsibilities: ‘I don’t believe the data’
- Should have a clear strategy/3 year plan (Board approved):
  - Recruit to it (robust induction of all medical staff)
  - Integrated structures that work and support team working
  - Devolve responsibility
  - Report to plan
  - Aggressive on appraisal and job planning (7 day program)
  - Use external agencies to benchmark and assist

- Move on when done