Q I – The RCP Perspective

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What Physicians do.

- Observe
- Communicate
- Assess and understand
- Philosophical and inductive reasoning
- Put established theories into practice (wisdom)
- Use data to support planned experimentation
- Show compassion, build relationships

All physicians aim to continuously improve their services for patients

500 years of medicine
Clinical Practice.

UNDERSTAND THE PATIENT:
- Need
- Condition
- Environment
- Aspirations

CONSIDER:
- Potential interventions/actions
- Risks and benefits
- Share options with patient
- Agree actions

MONITOR:
- Effectiveness of interventions
- Adverse effects
- Patients overall condition

500 years of medicine
Defining the RCP’s approach to quality

The Royal College of Physicians’ approach to quality takes a population, system and individual perspective.

When approaching quality, we need to create, maintain and improve the best possible balance between population health and wellbeing, individual care, and sustainability.

This balance requires a system-level approach to quality involving multiple partners and other agencies. The concept of value is the best balance we can achieve between these three domains.
Defining the RCP’s approach to quality

The best possible care for the individual and the population should be:*

- **safe** – minimising harm to staff and patients from the care that is intended to help them
- **effective** – based on scientific knowledge reliably delivered to all who choose to benefit from it and refraining from actions to those not likely to benefit
- **person-centred** – care that is respectful of and responsive to the needs and values of the individual patient, family and carers. Care should be coordinated, and care decisions made in partnership between professionals and patients/carers
- **timely** – reducing waits and harmful delays for both those who receive and those who give care
- **efficient** – minimising waste and maximising benefits of resources, including skills, equipment, finance, ideas and energy
- **equitable** – care that does not vary in quality of delivery or outcome because of personal characteristics, geographical location, time of the day/week and socio-economical status

* After Institute of Medicine, 2001
Improving quality vs quality improvement

**Improving quality**: Making healthcare safe, effective, patient-centred, timely, efficient and equitable

**Quality improvement**: Aims to bring about a measurable improvement by applying scientific methods within a healthcare setting. Uses common approaches to improve quality
Quality and Safety at the RCP

Education
• Developing Physicians and teams at all stages of their careers

Improving quality and safety:
• Evidence based guideline development
• Clinical audit
• Health informatics

Assuring quality and safety:
• Accreditation of services
• Invited service reviews
• Patient safety

Innovating quality and safety:
• Future hospital
• Quality Improvement Programme

Royal College of Physicians
500 years of medicine
# RCP QI Programme

<table>
<thead>
<tr>
<th>Building capacity</th>
<th>Collaboratives</th>
<th>Virtual hub</th>
<th>Leadership for improvement</th>
<th>Research and development</th>
<th>Bespoke support</th>
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<tbody>
<tr>
<td>Equip the healthcare workforce with skills and expertise to continuously improve services</td>
<td>9 month, topic specific, quality improvement course for clinicians and their teams</td>
<td>Connecting people, best practice, tools and evidence</td>
<td>Develop medical leaders who can influence and embed a culture of quality and continuous improvement</td>
<td>Develop, adapt, design new improvement methods and knowledge</td>
<td>Provide expert assessment and support in tackling particular organisational and service challenges</td>
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## RCP QI Faculty

**Aims** to make quality improvement easily accessible to all doctors and support physicians in developing and providing safe, timely, evidence-based, efficient and patient-centred care to achieve the RCP’s strategic aim of improving quality

Delivered through 6 work streams, supported by a faculty of quality improvement experts
What makes RCP QI unique?

• **Evidence-based**: even if emerging or being created
• An **open space approach**: everyone’s input is valued
• Based on system learning about **local need**: influence of the Future Hospital programme about doing QI across teams and systems with patients at the centre
• **Clinically driven** and **relevant** to current workplaces
• **Environmentally aware**
• **Development** spanning career and different leadership levels
All physicians aim to continuously improve their services for patients

They need the skills to work at 4 levels,

- Large Scale Change - for population level strategic changes
- Service design and improvement within and across pathways
- Process improvements within current services
- Day to day problem solving.

RCPQI will develop support to physicians and their teams at all stages of their career to deliver improvements in care and services

*Professionalising Quality Improvement*
Art and Science of Leadership and Improvement
Mindset

- Capability 1: Understanding the system
  analysis, method, complexity
- Capability 2: Human elements of change
  human factors, stakeholder, psychology of change
- Capability 3: Measurement of change
  quantitative and qualitative time series analysis,
  variation, assurance vs improvement
- Capability 4: Implementing change
  Interplay technical and behavioural and systems,
  coaching, project management
- Capability 5: Sustainability and spread
  Scale up and spread mechanisms, marketing,
  dissemination
- Capability 6: Leadership and team working
  Team leadership, team culture, resilience

Skills.

Process

- Project Set-up
- Diagnostics
- Intervention & Impact
- Sustain & Spread

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Royal College of Physicians Excellence in Patient Care Awards

The Acute Frailty Network winners of the Quality Improvement Award

![Graph showing data for Portsmouth Avoided Admissions and OPM Wards - Length of Stay](image-url)
### Northumbria Rheumatology Group Visits.

**Mixed Follow-up Group Clinic Outcomes**

<table>
<thead>
<tr>
<th>To Dec 2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Attendances</td>
<td>1653</td>
<td>2055</td>
<td>2498</td>
</tr>
<tr>
<td>Total Number of clinics</td>
<td>101</td>
<td>123</td>
<td>145</td>
</tr>
<tr>
<td>Mean attendance in period</td>
<td>16</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Low DAS/Remission, %</td>
<td>38</td>
<td>41</td>
<td>40</td>
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**Injections**

| 57% | 53% | 55% | 55% |

**Administrațion**
- pre-clinic information: previous diagnoses & medications listed
- in-clinic arrangements: update to above, plus current state
- post-clinic reporting: letter to patient & GP
- follow-up: monthly if active, annual review if stable

**Clinical**
- micro-consult: joint scoring, disease activity score
- individual concerns/information: encouraged to raise in group
- im steroid from clinic nurse
- given leaflets on proposed new drugs
- prescriptions at end of session

**Input**
- ground rules: shared confidentiality & fair contribution
- consultant-led review of treat to target & tight control
- outcomes

**Discussion**
- patient-led discussion: fatigue, sleep disturbance, types of pain
- Q & A
- advice on topics raised by patients during the micro-consults

### Patient perspective [https://vimeo.com/242809838](https://vimeo.com/242809838)

500 years of medicine
Respiratory Change Room - Sheffield.
In March 2012 the Royal College of Physicians established the Future Hospital Commission, chaired by Professor Sir Michael Rawlins, to address growing concerns about the standards of care currently seen in hospitals.

The commission published its final report, Future hospital: caring for medical patients, in September 2013. The report set out the commission’s vision for hospital services structured around the needs of patients, now and in the future. Recommendations are drawn from the very best of our hospital services, taking examples of existing innovative, patient-centred services to develop a comprehensive model of hospital care that meets the needs of patients, now and in the future.

Future hospital: caring for medical patients focuses on the care of acutely ill medical patients; the organisation of hospital services; and the role of physicians and doctors in training across the medical specialties in England and Wales. Hospitals people’s needs are often complex, and hospital services must be organised to respond to all aspects of physical health (including multiple acute and chronic conditions), mental health and wellbeing, and social and support needs. The model of care proposed by the Future Hospital Commission is underpinned by the principle that hospitals must be designed around the needs of patients.
RCP Future Hospital Development sites

Betsi Cadwaladr University Health Board - using telemedicine to improve access to care for frail and elderly patients in rural Wales

Mid Yorkshire Hospitals NHS Trust - develop an older people assessment service / unit as part of an acute care hub supporting frail older patients with fragility syndrome

East Lancashire Hospitals NHS Trust - delivering better quality and more effective services for frail and elderly patients using integrated teams working

Worthing Hospital : Emergency Floor.

Central and South Manchester - single respiratory integrated care service

North West Paediatric Allergy Network - empowering patients, parents and primary care professionals in the management of common food allergies

Sandwell and West Birmingham Hospitals NHS Trust - increasing early diagnosis and detection of respiratory conditions in the community

North West Surrey CCG and Ashford and St Peter’s Hospital - locality hubs for older people with frailty

500 years of medicine
Emergency Care Pathway

- Community Support
  - Falls
  - Respiratory
  - Children

- Redesigned ‘Emergency Village’

- Model Ward

- Discharge Interface with Intermediate Care

Clinical Flow / Operating Management System

Joined up Care / In hospital Care and Support
Designing Acute Medicine “front door”
Redesigning Acute Medical Care

Complaints from 8 per month to 8 per year
Multiple improvement projects
100% mandatory training
“A Tale of 2 eras”
JB 81 yr Man- Limited mobility, type 2 diabetes, CABG

June 2015
• Fell in garden
• Fractured NOF, admitted RBH
• Operated, to be transferred to Clitheroe CH
• Post op infection delayed transfer by 3 weeks
• Transferred at 10pm to Pendle CH family phoned from ward.
After 4 days back to RBH
• On discharge care package – did not arrive for 4 days. Change of provider
• Family took over care

August 2016
• Admitted with high blood sugar and reduced consciousness
• After stabilisation initial plan for Clitheroe CH, but changed to home with INT, and community Diabetes Nurse, District Nurse, physio
• Community pharmacist did medicines review in home
• Praise for INT coordinator
• District nurse liaises with GP
• Managed exacerbation without hospital
• “treat us as people not numbers”

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• Physicians effectively lead teams to improve care in complex situations
• At different stages of careers
• Patients and families must be a central part of the improvement teams
• Use an evidence based approach to improvement, and embrace that
• Measurement is key
• Creating communities of support makes delivery more likely and creates resilience and professional satisfaction
• RCPE sponsorship and coordination helps

➢ Reduced length of stay
➢ Earlier multiprofessional review
➢ More integrated care for patients and practitioners
➢ Improved patient satisfaction
➢ Staff satisfaction – more valued, work more rewarding
Chief registrar programme

- The FHP pilot began in April 2016
- Programme lasts for 12 months
- Second cohort of 42 young doctors

TOMORROWS LEADERS

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QI Posters at Innovation in Medicine 2018

34 posters from Chief Registrars

25 selected posters from Core Medical Trainees
RCP Guidance CMTs and QI

• The skills, behaviours and knowledge of improving service delivery and quality is a core part of professionalism for physicians.

• Within the core medical training curriculum this is supported by the requirement to undertake a quality improvement (QI) project each year.

QI projects should:
• Not consist solely of data collection
• Involve working as part of a multiprofessional team
• Utilise QI methodology such as plan, do, study, act cycles and real-time measurement based on timeseries data
• Consider long-term sustainability from the start.

QI projects may:
• Not be completed within a year
• Be implemented over two years of core medical training
• Not reach their ultimate goal
• Continue, spread or sustain work that is already underway
• Use national audit data as the stimulus for a quality improvement project, but should incorporate elements of discovery and measurement beyond pure data collection.
Improving the rate of timely EDAN completions on Ward J08
Amy Hicks, Andrew Batt, Khudaim Mobeen

Amy’s results

- Trigger: Patient #NOF following delayed discharge
- Team: Junior doctors, ward manager, ward clerk, AHPs
- Interventions tested and adapted
- Spread to other wards

- There were no further delayed discharges due to clinical authorisation
- We were unable to keep an accurate record of the process measure
Ashford and St Peters Hospitals NHS Foundation Trust

“Be the change”
RCP QI Programme

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Characteristics of successfully implementing change

- Establish and adapt the change team
- Align with system/organizational priorities – setting clear measurable aim.
- Breaking the problem down into manageable parts
- Culture of possibility and learning (from “failure”)
- Leaders and followers
- Use qualitative and quantitative data to assess and adapt change (adaptive experimentation)
- Use change methodology
- National/regional/organisational programme – Local adaptation
- Patients champions and partners
- Perseverance
Cultural, organisational and system level challenges

- Multiple changes in senior leadership
- Silos within organisation
e.g. Nursing, medical, therapies, governance, QI, service development
- Regulation, operational and financial performance
- We know what to do.
- Organisational sign up and methodology
- Demoralised by failure
- Commissioning vs provision
- Time and space for QI and development
- Working as a single system
- Competing priorities
What can you do?

➢ Clinical Service leader: – analyse and identify priorities for improvement, build the team. Connect with experts, connect across the system

➢ Consultant – identify opportunities, lead or be part of an improvement team, support trainees in projects

➢ Trainees – get together, network, keep it small and achievable, be part of an improvement team, share your work

➢ QI practitioner – support SAM QI programme and RCP QI

➢ QI expert – consider joining RCP QI Faculty

➢ ALL – Learn through doing, supported by peers, develop your skills, create and sustain a culture of learning and continuous improvement, be the change
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