HEALTHCARE QUALITY IMPROVEMENT PARTNERSHIP

In-focus impact reports
2021-22

Impact of NABCOP at system level 2022 Annual Report

Over the past six years, the NABCOP has reported on the care pathway from the point of diagnosis for older women (aged ≥70 years) in NHS hospitals within England and Wales, and contrasted the care received by older women to that received by women aged 50-69 years. Visit www.nabcop.org.uk for information about NABCOP including its Annual Reports.

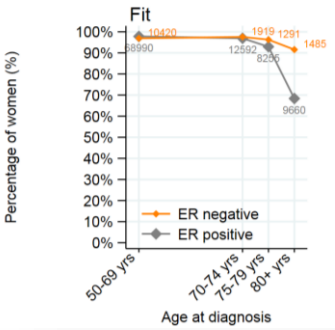
Two of the audit's Quality Improvement Goals have been to:

1. Increase the rate of surgery for fit older women with early invasive breast cancer (EIBC).
2. Increase the use of a reliable, consistent description of patient frailty & cognition.

Fitness and overall health can influence treatment choices for an older patient. When NABCOP started, the data available on patient fitness at the time of diagnosis were limited to the reported WHO performance status, and the Charlson Comorbidity Index (calculated from hospital diagnosis data). The NABCOP has taken two steps to augment these with a measure of patient frailty.

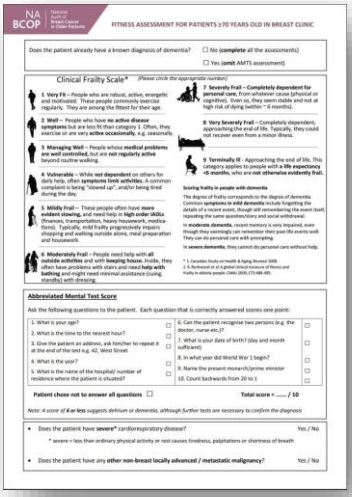
1. Development of the **Secondary Care Administrative Records Frailty (SCARF) Index**.

The first step was using hospital administrations data to develop a measure of frailty among women aged 50+ years with breast cancer. (Published online: https://pubmed.ncbi.nlm.nih.gov/32376755/)
The measure, called the SCARF Index, has enabled the NABCOP to more accurately highlight variation in the use of surgery among fit older women.



2. Development of the **NABCOP Fitness Assessment Form**, with stakeholders.

The NABCOP team worked with patient representatives and expert clinicians to develop the NABCOP Fitness Assessment Form, which was designed to assess patient fitness by staff in breast cancer clinics early in the care pathway. It can help identify patients who are frail, or who may require additional support throughout treatment, as well as informing treatment planning.



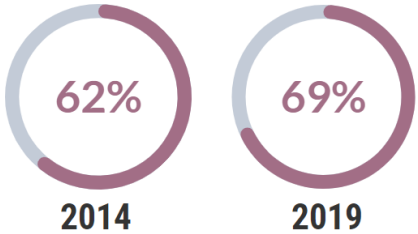
Completion of the form at the initial diagnostic clinic, for all women aged 70 and over presenting with suspicion of breast cancer, enables NHS organisations to formally document patient fitness prior to the discussion of treatment choices and provides a standardised way of measuring fitness. The form is downloadable from: https://www.nabcop.org.uk/resources/fitness-assessment-tool/

✓Use of the form is encouraged by clinical professional groups, including the Association of Breast Surgery.

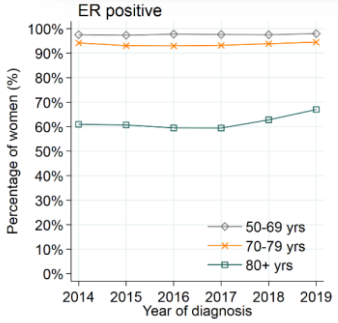
✓The data items are part of COSD V9.0 data returns for all English NHS trusts.

The NABCOP 2022 Annual Report highlighted increased rates of surgery:

Among women diagnosed with early invasive breast cancer in England and Wales from 2014 to 2019, use of surgery increased over time for women aged **80+ years** who were fit or with mild/moderate frailty.



Increased use of surgery was primarily among women with ER-positive EIBC →



National Impact of the National Emergency Laparotomy Audit (NELA)

NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy through the provision of high quality comparative data from all providers of emergency laparotomy in England and Wales. To do this, NELA continuously audits care against a set of key standards, including outcome measures, processes of care, and timeliness of care. Audit results are published in quarterly and annual reports. NELA have recently published their seventh annual report.

To improve quality, NELA have:

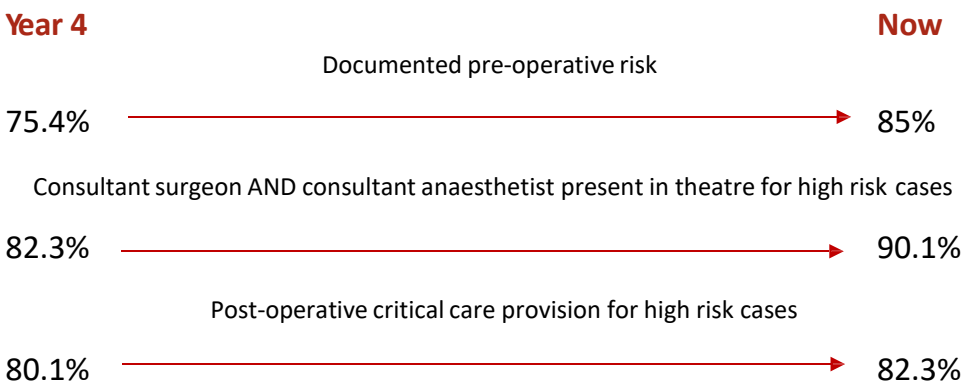
- Appointed a quality improvement (QI) clinical lead to lead on QI initiatives within the audit
- Refined the real-time data outputs and displays available on web-based QI dashboards to support local quality improvement and quality governance
- Refined the dataset based on stakeholder feedback to promote improvement in priority areas, including sepsis and care of the elderly
- Highlighted data-driven quality improvement opportunities in annual reports
- Implemented a programme of national QI webinars, each with at least 75 attendees
- Collaborated with other regulators and national improvement initiatives, including CQC, GIRFT, AHSNs, and others, to ensure that NELA data is available to a wide range of stakeholders and decision makers

Impact on Outcome Measures since Year 1 (2013/14) of NELA:

30-day mortality decreased from 11.8% to 8.7%

Decrease in average length of stay by **4 days** (19.2 to 15.1 days)

Impact on Processes of Care since Year 4* (2016/17) of NELA:



NELA has resulted in improved care for emergency laparotomy patients as highlighted above. Due in part to the QI initiatives NELA have implemented, noted above, fewer patients have died following surgery and patients spend less time in hospital. Looking forward, NELA aims to drive improvement in areas that have been more challenging to improve, such as reducing variation in processes of care and outcomes in different hospitals, management of infection, and the provision of multidisciplinary care for frail elderly patients who have undergone emergency laparotomy.

*Year 4 selected for comparison due to differences in question composition in earlier years limiting direct comparison

NMPA

National Maternity & Perinatal Audit

Celebrating public impact

March 2021- February 2022

The Women and Families Involvement Group is the NMPA's overarching patient and public involvement group and has been in place since the start of the audit. The NMPA also works with other lay advisors for specific topic work such as sprint audits and the Family Gateway

38
quotes from lay advisors across 3 NMPA outputs

23
lay advisors involved in the NMPA this year

3
lay summary documents coproduced with specific lay advisors

1
accessible animation created to introduce the NMPA

NMPA WEBSITE ANALYTICS

- 63,387 page views; 9,134 users (8,987 new users)
- Overall: 12,760 sessions; 4.97 pages per session; 3min13sec average session duration
- 84.8% new visitor; 15.2% returning visitor
- Devices used: 70% desktop; 29% mobile; 1% tablet

SOCIAL MEDIA ANALYTICS

@nmpa_audit
- 116 tweets
- 102.2k impressions
- 2.9k engagements

- 813 views of short video to advertise webinar on inequalities in maternity care
- over 100 attendees to inequalities webinar

Dr Sarah E Seaton @SarahESeaton · 8 Dec 2021
Enjoying this discussion on #MaternityInequalities, thanks to the @nmpa_audit for organising!

Anne Kavanagh @AnnamKavanagh · 8 Dec 2021
In other news, important findings from @nmpa_audit on #MaternityInequalities and #Maternityoutcomes being discussed on webinar now.

FAMILY GATEWAY

Making maternity information accessible

The Family Gateway has been coproduced with a lay group. Its overall aim is to produce an online resource, with printable content, aimed at women and birthing people, with the purpose of improving access to NMPA information.

www.maternityaudit.org.uk/pages/familygateway

BOG

Midwifery Feature Articles | Midwifery News

The National Maternity and Perinatal Audit: inequalities through COVID-19

The effects of the COVID-19 pandemic on many walks of life are slowly coming into the public domain. In this article Kirstin Webster, ANNP and NMPA Neonatal Clinical Fellow, describes the role of the National Maternity and Perinatal Audit, presenting results from research using the audit's data on births during.....

Read more

https://www.maternityandmidwifery.co.uk/the-national-maternity-and-perinatal-audit-inequalities-through-covid-19/

"It is important to remember, with a big data project like this, that each data point is a woman, birthing person or baby, and while their experience is a tiny contribution to the NMPA it's likely a huge and life-changing event for them."

(Kirsty Sharrock, WFIG member)

NBOCA | National Bowel Cancer Audit

Impact of the National Bowel Cancer Audit on Quality Improvement

NBOCA measures the quality and outcomes of NHS colorectal cancer care in England and Wales, and so support providers to improve the quality of the care received by patients.

QI OBJECTIVES

- 1. Improve Cancer Outcomes
- 2. Improve Patient Experience

PATIENT PATHWAY

- Diagnosis
- Perioperative Care
- Oncological Management
- Advanced Disease

IMPACTS OF NBOCA ACROSS THE PATHWAY

Cancer Outcomes

90-day post-operative mortality

3.5% (2015/16) → 2.6% (2019/20)

90-day mortality after emergency surgery

12.9% (2015/16) → 8.7% (2019/20)

Between-provider variation in adjuvant chemotherapy use *reduced*

27 trusts outside expected range (2015/16) → 21 trusts outside expected range (2019/20)

Patient Experience

Between-provider variation in 30-day readmission *reduced*

14 trusts outside expected range (2015/16) → 10 trusts outside expected range (2019/20)

Laparoscopic surgery

54% (2015/16) → 63% (2019/20)

2-year mortality after major resection

16.4% (2015/16) → 15.3% (2019/20)

Perioperative Care

Oncological Management

THE NBOCA QI PROGRAMME launched October 2021

Supported by interactive trust results at nboca.org.uk/trust-results

National targets set across the whole patient pathway (Diagnosis, Perioperative Care, Oncological Management, Advanced Disease)

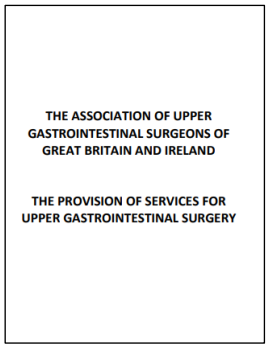
Providers to select key areas to target local QI initiatives

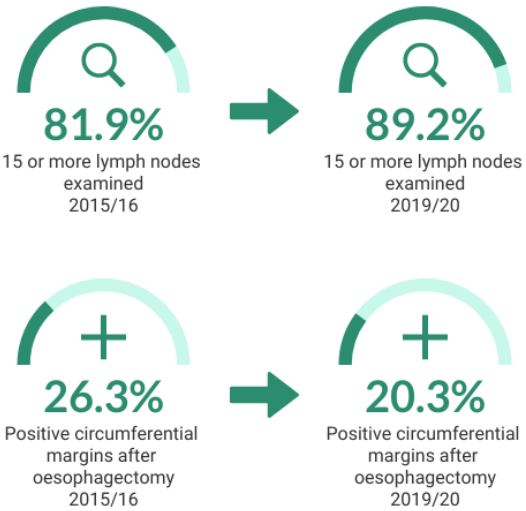
More details at nboca.org.uk/quality-improvement

NOGCA | National Oesophago-Gastric Cancer Audit

Impact of NOGCA at system level | 2021 Annual Report

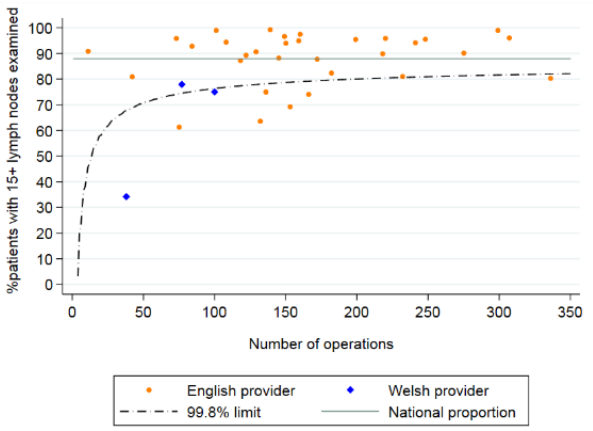
Since 2017, NOGCA has published information on four surgical pathology indicators, to support the implementation of recommendations in the 2016 Association of Upper Gastrointestinal Surgery of Great Britain and Ireland (AUGIS) Provision of Services for Upper Gastrointestinal Surgery document.





Over this time, pathology outcomes among patients who have curative surgery for oesophago-gastric (OG) cancer have improved:

- The proportion with 15 or more lymph nodes examined has increased from 81.9% among those diagnosed in 2015/16 to 89.2% in 2019/20.
- The proportion with positive circumferential margins after oesophagectomy has decreased from 26.3% to 20.3%.



Despite improvements nationally, NOGCA has found substantial variation in outcomes due to differences in the way surgical specimens are prepared for histological assessment.

This finding has prompted AUGIS and the Royal College of Pathologists to collaborate on developing recommendations for the standardisation of these methods.

AUGIS
ASSOCIATION OF UPPER GASTROINTESTINAL SURGERY OF GREAT BRITAIN AND IRELAND

The Royal College of Pathologists
Pathology: the science behind the cure

In our Quality Improvement plan, we have identified the following national objectives :

- Increase the proportion of patients who have the recommended minimum number of lymph nodes examined.
- Increase the proportion of patients who have negative surgical resection margins.

NEIAA
National Early Inflammatory Arthritis Audit

Impact of NEIAA at national level

Based on second Annual Report 2019 – 2020

NEIAA QI interventions

- NEIAA's improvement focus was on NICE Quality Standards (QS) 1-3, as these associate with improved patient outcomes
- The biggest improvements between year 1 and year 2 of the audit were for QS 1-3 (between 6 and 10%, compared with 0-5% for QS 4-7)

Early Referral and Review (QS1 and QS2)

13,578
Patients referred to early arthritis services in England and Wales between May 2019 and March 2020

47% referred within 3 working days (41% in year 1)

48% saw a rheumatologist within 3 weeks (38% in year 1)

6% improvement in speed of GP referrals

10% improvement in speed of hospital assessment

Treatment initiation (QS3)

64% started treatment promptly (an increase of **10%** from year 1)

Most common DMARD = methotrexate

QS4-7

94% had timely provision of education (QS4) (93% in year 1) (1% increase)
89% had an agreed treatment target (QS5) (84% in year 1) (5% increase)
92% had access to emergency care (QS6) (92% in year 1) (no increase)
48% had an annual review (QS7) (43% in year 1) (5% increase)

Other (non-audit) factors associated with improvement

- Introduction of the Best Practice Tariff has incentivised departments to meet ***all*** QS
- CQC utilising QS2 for reporting department performance
- GP e-learning on importance of prompt referral (QS1)

Summary

It is not possible to attribute the audit as the cause of stronger improvement for QS1-3, but it is nevertheless encouraging as it suggests audit improvement goals have a part to play in determining where improvement may be most focused.

How is SSNAP supporting the NHS Long Term Plan?

KING'S College LONDON SSNAP
Sentinel Stroke National Audit Programme

SSNAP data provides a baseline for the ambitions of the NHS Long Term Plan https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/stroke-care/ , as well as comparisons over time to measure progress. The SSNAP annual report 2020 identifies five key areas for progress based on the principal ambitions of the plan.

High quality specialist care

An increase in the number of patients receiving high quality specialist care. 90% of stroke patients should receive their care on a specialist unit.

83.8% *2013/14* → **84.1%** *2019/20* spend at least 90% of their stay on a stroke unit

given a swallow screen within 4 hours of arrival **63.5%** *2013/14* → **74.8%** *2019/20*

91.8% Proportion assessed by a stroke nurse within 24 hours is high

Higher intensity models of stroke rehabilitation

Out of hospital, more integrated and higher intensity rehabilitation for people recovering from stroke

	In hospital	Out of hospital
OT	67.0%	18.0%
PT	75.0%	22.4%
SLT	55.0%	14.7%

% patient days in care therapy received

Expanding reperfusion treatment

All patients who could benefit from thrombolysis (20%) receive it and expanding mechanical thrombectomy from 1% to 10% of all stroke patients

12% *received thrombolysis*

1.8% *received thrombectomy*

1607 *thrombectomies performed*

Meeting the 7-day Priority Clinical Standards for Stroke care

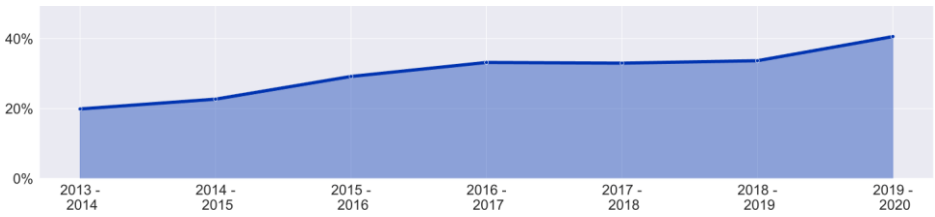
All patients with suspected acute stroke should be admitted directly to an acute stroke unit and be assessed by suitable stroke skilled consultant within 14 hours

58.3% *2018/19* → **55.0%** *2019/20* decline in the proportion directly admitted to a stroke unit within 4 hours

58.4% assessed by a stroke specialist within 14 hours of arrival

Improve outcomes to 6 months and beyond

To support improved outcomes to 6 months and beyond



Despite an increase in the proportion of patients receiving a follow-up, 60% of eligible patients still do not get a 6-month review

Looking forward Over the coming years, SSNAP data can be used to measure the progress of the long-term plan. SSNAP will be incorporating new measures into the dataset and future reports to support the long-term plan ambitions and integrated services, as well as new outputs to aid quality improvement.

**figures represent data for 2019/20 unless otherwise specified*

SSNAP during the COVID-19 pandemic: supporting the monitoring and recovery of stroke services

During the COVID-19 pandemic, SSNAP continued to provide data and produced new outputs to support national (NHS England Clinical Policy Unit, NHS Wales Delivery Unit and Northern Ireland Stroke Network), regional and local monitoring and responses.

Reporting during the pandemic

In April 2020, **93%** of acute sites continued with SSNAP data entry and by January 2021, **100%** had resumed full data entry

16% of these acute sites able to continue data entry due to minimum dataset introduced in April 2020

6000+ bespoke provider-level reports created since April 2020

High participation rates allows monitoring of services against standards to identify areas negatively impacted by the pandemic, and areas that continued to improve.

Improved

1.8% → 2.0% → 2.4%
2019/20 2020/21 2021/22
patients receiving thrombectomy

55.4% → 58.7% → 60.0%
2019/20 2020/21 2021/22
patients discharged to a stroke specialist ESD and/or CRT service

Maintained

55.1% → 55.2% → 54.7%
2019/20 2020/21 2021/22
patients scanned within 1 hour of arrival at hospital

Areas for improvement

3h15m → 3h25m → 3h47m
2019/20 2020/21 2021/22
median time from onset to arrival at first hospital

11.7% → 10.7% → 10.4%
2019/20 2020/21 2021/22
patients receiving thrombolysis

54.9% → 55.0% → 44.5%
2019/20 2020/21 2021/22
directly admitted to a stroke unit within 4 hours of arrival at hospital

SSNAP data allows identification of areas to focus post-pandemic quality improvement at a local, regional and national level.

Monthly reporting
Increased reporting frequency of key areas identified during the pandemic to monitor progress and change more regularly and plan for service improvement. Used internally by NHSE at the Stroke Delivery Board.

KING'S College LONDON

Local impact: National Clinical Audit of Psychosis QI Webinars – Outcome Measurement

What did we do?

In May and June 2020, the National Clinical Audit of Psychosis (NCAP) hosted 5 regional QI webinars for Early Intervention in Psychosis teams on outcome measurement. These covered:

- Presentations on the audit findings on outcome measurement, barriers and solutions in collecting outcome data, and QI models, tools and measures
- A Q&A and open discussion session, focusing on improvements made in collecting outcome measurement data (OMD) and how teams are doing this

Key impacts are summarised below:

Ideas for Repurposing Routine Outcome Measures were Shared

- A staff member in one service rebranded 'routine outcome measures' to 'therapeutic ROMs' and ran workshops to help staff use the worksheets as a tool to increase curiosity of patients
- Importance of making the data useful for patients and care coordinators, rather than seeing them as measures imposed by the government that has to be done as part of an audit

> *This can't be seen as being about performance management, this has to be seen as being driven by our clients and our clinicians and valuing it*

Participants Took Away Ideas for How to Share Practices

- Future Collaboration Platform is a good resource and platform
- Opportunities to share good practice through the Royal College of Psychiatrists and NCAP, such as newsletters and these webinars
- Talk to regional leads who can focus on the use of OMD and give platforms for teams to share their work with others
- Team away days and business meetings are great spaces to not only explore data, but share good practice

> *It wasn't about the process of collecting data, it was the value of what lay in that collection both for an individual and the service*

New Opportunities to Use and Collect Data were Developed

- Using Health of the Nation Outcome Scales (HoNOS – a measure of health and social functioning) to identify where patients with psychosis have come into the Trust but have not been referred to the correct team
- Collating all audit data on a spreadsheet and reviewing it at the start of the year to highlight differences and produce local action plans
- Hub manager sending out weekly emails to the whole team listing which records need their outcome measures completing to improve collection
- Using data to discuss areas of improvement within the region to 'buddy up' teams to run learning days together and take away practical tips on making improvements

> *Policy provides a scaffold for innovation to grow up – without that scaffold of policy directives and initiatives, it makes it hard to sustain local innovation; they work together*

NCAP
NATIONAL CLINICAL AUDIT OF PSYCHOSIS

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NPCA Patient Survey: Impact of Patient Reported Outcome Measures (PROMs)

NPCA
National Prostate Cancer Audit

Patients want PROMs

- High survey response rates demonstrate that patients strongly support PROMs
- Survey sent to >25,000 men diagnosed April 2015 – Sept. 2016>> 73% responded
- Survey sent to >10,500 men diagnosed April – Sept. 2018 >> 78% responded
- Patient information, lay summaries and slide sets

'Men who have been recently diagnosed are often keen to find out what other men, in similar circumstances, chose for their preferred treatment and what were the results of the treatment (how it affected their quality of life)' NPCA PPI Forum member

How PROMs outputs are used by the public*

·Information synthesis includes feedback from the NPCA PPI Forum

'Men use the results from the survey to look at how local NHS trusts compare with the national results and to see those which are above/below national standards' NPCA PPI Forum member

Reflections from a patient representative

Steve Allen, Tackle Prostate Cancer

What do patients expect of their treatment:

- No side effects
- Minimal impact on quality of life
- Equilibrium between quantity and quality of life

Much can be gained from the NPCA results reporting on patients' experience of care following diagnosis, and the side effects and quality of life following radical surgical or radiotherapy treatment. For instance, information on such problems as incontinence and sexual dysfunction are of paramount importance to patients and are reported by the NPCA. As the NPCA only started reporting for men diagnosed from 2014, information on the 'quantity of life' will be reported after further follow-up.

Performance indicators are used each year so that direct comparisons by hospital can be made and changes can be identified – all very much to the benefit of patients.

Read the full blog here

'PROMs are important for audits of services that aim to improve/protect functional outcomes. For men with localised prostate cancer undergoing radical treatments they provide a measure of the safety of care' NPCA Project Team member

Clinicians/providers accept PROMs as authoritative information

- PROMs provide additional information over and above what clinical/routinely collected data provide
- Changes in clinical measures may not always translate into benefits for patients
- Use of PROMs as performance indicators and outlier process to stimulate both national & local QI
- Individual provider-level results, reports, outlier improvement plans

The impact of using PROMs measures to stimulate QI and support for ongoing data collection were key themes during the NPCA QI workshop '*Reducing treatment-related toxicity after radical prostate cancer treatment*'. The priorities for improving the quality of care for prostate cancer patients are explored here.

'Given the similar survival results, PROMs results are especially important as a guide to help inform patient treatment decision-making for localised disease' NPCA QI workshop attendee

Improvements due to PROMs: examples from radiotherapy centres*

- Improved communication both within radiation oncology groups and across disciplines
- Regular inter-disciplinary meetings set up to discuss nuances of practice including case selection, contouring, dosimetry and follow-up processes
- Updates of local radiotherapy practice protocols
- Audit of treatment set-up to establish whether further reduction in margins are feasible
- Implementation of routine peer review processes for contours and plans
- Programme initiated for fiducial marker insertion
- Comparison of set up and dosimetry between treatment machines in the same department
- PROMs programme set up within individual centres to collate outcomes for radiotherapy patients
- Improved training for staff members involved in patient follow up

*Reported to the NPCA Project Team during the outlier process and NPCA QI workshop

'Understanding variation [in urinary and erectile function] between providers is important to drive quality improvement initiatives' NPCA QI workshop attendee

Using PROMs to compare the impact of ongoing changes in practice on functional outcomes:

- Robotic, laparoscopic or open radical prostatectomy British Journal of Cancer. 2018; 118:489-494
- Hypofractionated or conventionally fractionated external beam radiation (EBRT) J Clin Oncol. 2020; 38:744-752
- EBRT with or without brachytherapy boost Radiotherapy and Oncology 2021; 155;48-55

'Patients need to understand the likelihood, severity and duration of the side effects from potential treatment options in order to make an informed decision about initial treatment' NPCA QI workshop attendee