Haven review 2013

Will McConnell
2013 - A year of headlines...

The surgeons whose patients were up to 30 times likelier to die: NHS to publish death rates of doctors for the first time.

The figures will be released today on the NHS Choices website its publication could be halted by legal challenges from some hospitals.
2013 – loads of reports

Seven Day Consultant

NHS Services,
Seven Days a Week
Forum
Summary of Initial Findings

First published: December 2013

Securing the future of excellent patient care
Final report of the independent review
Led by Professor David Greenaway

MORE CARE, LESS PATHWAY
A REVIEW OF THE LIVERPOOL CARE PATHWAY
A year of contradictions....
2013 – a year of contradictions...

• Going forwards and backwards – or circles
• Increasing workload on primary care but fewer resources,
• Increasing workload in secondary care while moving resources into the community,
• Innovation vs non-evidence-based policy making,
• Rationalising services whilst trying to maintain diversity of provision,
• Competing multiplicity of providers but a greater need of integration of care
• Reducing junior doctors but no viable workforce alternatives,
• 7-day working when we cannot even stretch effectively and safely over 5,
• More measuring stuff but less managerial support,
• Constant media and political pounding about quality but no prospect of resources to deliver it,
Transformational Leadership
Marion Jacobs
Mahatma Ghandhi

“Be the change you want to see in the world”

“Whenever you are confronted with an opponent. Conquer him with love”

“Nobody can hurt me without my permission.”
Movement of trainees

UK

Australasia
Leadership in the Clinical Setting

- Return to the bedside
- Phone consultations
- Telehealth
- Trust
Incorrect priorities do damage: ......In some organisations, in the place of the prime directive, “the needs of the patient come first”, goals of (a) hitting targets and (b) reducing costs have taken centre stage. Although other goals are also important, where the central focus on patients falters, signals to staff, both at the front line and in regulatory and supervisory bodies, can become contaminated. Listening to and responding to patients’ needs then become, at best, secondary aims. Bad news becomes unwelcome and, over time, it is too often silenced. Under such conditions organisations can hit the target, but miss the point.
• Your nation’s commitment to health care as a human right and to healing as a shared mission is second to none in the world. And all of that is possible through you; only through you.

• But, it gets rough sometime, doesn’t it? Because you work in a publicly led and publicly funded system of care, you operate under a spotlight more intense than most professional communities ever do. And truth to tell, it doesn’t always go so well.
• In such a (learning) culture, measurement is not a threat, it is a resource; ambition is not stressful, it is exciting; defects are seen as opportunities to learn; and curiosity abounds.

• We would hope to see the English NHS emerge as a vital “learning organization,” with you, who work in and for it, experiencing pride and joy in pursuing the great mission you have chosen: to heal.
NHS Values as practised

- Get VTEs done
- Clear ED within 4 hours
- Get them out by 1pm
- Get the TTOs done
- Do your diary monitoring
- Work outside 48 hours doesn’t count
Is this professionalism?

• Box-ticking
• Clock-watching
• Bean-counting
• Form-filling
**Some box-ticking is OK...**

### Adult Asthma Admission Proforma

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the patient been admitted with asthma in the last year?</td>
<td></td>
</tr>
<tr>
<td>Has the patient had previous admission to ICU? (If so specify month &amp; year)</td>
<td></td>
</tr>
<tr>
<td>PEF</td>
<td>Link</td>
</tr>
<tr>
<td>O2 usage needed to be maintained at 94-96%</td>
<td></td>
</tr>
<tr>
<td>Drive resuscitation with oxygen at a flow rate of at least 5 L/min</td>
<td></td>
</tr>
<tr>
<td>If FEF &lt; 50% ABG should be performed</td>
<td></td>
</tr>
</tbody>
</table>

**Classification of Asthma Severity:**

- **Mild:**
  - Nocturnal symptoms three times per week
  - Morn. symp. 1-2 days per week
  - FEV1/FVC > 70%
  - PEF > 80% predicted
  - Well-controlled with inhaled corticosteroids

- **Mild to moderate:**
  - Night symp. 3 days per week
  - Morn. symp. ≤ 2 days per week
  - FEV1/FVC > 70%
  - PEF < 80% predicted
  - Well controlled with inhaled corticosteroids, some exacerbations

- **Moderate:**
  - Night symp. 4 days per week
  - Morn. symp. ≥ 3 days per week
  - FEV1/FVC > 70%
  - PEF < 70% predicted
  - Irregular exacerbations, requires systemic steroids

- **Severe:**
  - Night symp. ≥ 5 days per week
  - Morn. symp. ≥ 5 days per week
  - FEV1/FVC < 70%
  - PEF < 50% predicted
  - Frequent exacerbations requiring oral steroids

### Adult Asthma Discharge Checklist

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer should be Yes for each question unless reason given</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEF within 75% of predicted/usual best?</td>
<td></td>
</tr>
<tr>
<td>Clinical variation &lt; 26%?</td>
<td></td>
</tr>
<tr>
<td>Has patient been on inhaled medication for at least 24 hours prior to discharge?</td>
<td></td>
</tr>
<tr>
<td>Review all asthma medication?</td>
<td></td>
</tr>
<tr>
<td>Patient discharged on oral steroids?</td>
<td></td>
</tr>
<tr>
<td>If discharged on oral steroids, has patient been informed about stopping &amp; starting treatment?</td>
<td></td>
</tr>
<tr>
<td>Patient discharged on inhaler steroid (due to severe exacerbation)</td>
<td></td>
</tr>
<tr>
<td>Thyrads discussed &amp; occupation?</td>
<td></td>
</tr>
</tbody>
</table>

**Any compliance issues addressed?**

- **Inhaler technique checked?**
  - Good
  - Poor
  - Corrected

- **Written set management plan given to patient?**
  - No
  - Yes

- **Has GP follow up been arranged within 7 days?**
  - No
  - Yes

- **Respiratory specialist follow up within 4-6 weeks?**
  - No
  - Yes

**Signature**

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Date</th>
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</table>

**Please file in clinical history**
Is there another way?

- Trust and appreciate the staff more
- Close eye but light touch
- Only introduce tick boxes if they help
- IT needs to work for us, not against us
- Handover vows
Quality improvement fellows

• Dementia awareness
  – Motivating staff to:
    • Realise there is a problem
    • Do something about it
    • Appreciate the positive outcomes
    • Then – any more problems to solve?

• Telephone consultations
• Teaching professionalism
• Selling Tomorrow’s Teachers
• Mentorship programme
**Foundation Programme**

- Undergraduate degree

**Broad-Based Specialty Training**

- Postgraduate medical training

**Professional Practice**

- Doctors are able to practice with no or limited clinical supervision within multidisciplinary teams and networks.

They are able to make safe and competent judgements in broad specialty areas.

**Training duration**

- 2 years

**4–6 years (depending on specialty requirements)**

**Evaluation**

- Widely varying opportunities provided across different specialty areas.

- Includes several different placements in both acute and community settings.

**Within broad-based specialty training, doctors can:**

- Train across the breadth of specialties;
- Choose their training within particular patient groups at any point in the training;
- Re-direct specialties by transferring competences within or between groups of specialties;
- Combine specialty training with academic research.

**Further opportunities to:**

- Maintain capabilities and develop practice through CPD;
- Enhance career and gain additional expertise through undertaking in special interest areas;
- Develop depth of knowledge by learning through experience and reflecting on their practice;
- Move into education, management and leadership roles.

**Rest of career**
Shape of Training – Vicky Osgood

• Last year.....
• Recommendations:
  – Respond to demographics
  – Involve patients
  – Career advice for medical students
  – Full registration
  – Generic skills training
  – Assessments
  – Longer placements
  – High quality training and supervision
  – Broad specialty training based on patient care themes
  – Review curricula
  – Be able to manage acutely ill patients with comorbidities
  – Local needs
  – Flexible clinical academic training
  – Structured CPD
  – Credentialed programmes
  – Review barriers to entering training programme
  – Broad based specialty training
  – UK -wide Delivery Group
GP consultations per patient per year
7Cs

• Organisational environment
  – 3 Cs
• Individual behaviour
  – 4 Cs
   • Communication
   • Compassion
   • Capability
   • Constraints (don’t let them rule)
Compassion – the solution?

How to encourage compassion

Central to the assessment of compassion

Compassions: Regular, to be completed by all on admission to hospital. Fletcher go wrong? Help them understand why they failed.

What could complicate external inspection?

Compassions, regular, to be completed.
Acculturation

Acculturation explains the process of cultural change and psychological change that results following meeting between cultures.[1] The effects of acculturation can be seen at multiple levels in both interacting cultures. At the group level, acculturation often results in changes to culture, customs, and social institutions. Noticeable group level effects of acculturation often include changes in food, clothing, and language. At the individual level, differences in the way individuals acculturate have been shown to be associated not just with changes in daily behavior, but with numerous measures of psychological and physical well-being. As acculturation is used to describe the process of first-culture learning, acculturation can be thought of as second-culture learning.

The concept of acculturation has been studied scientifically since 1918.[2] As it has been approached at different times from the fields of psychology, anthropology, and sociology, numerous theories and definitions have emerged to describe elements of the acculturative process. Despite definitions and evidence that acculturation entails a two-way process of change, research and theory have primarily focused on the adjustments and adaptations made by minorities such as immigrants, refugees, and indigenous peoples in response to their contact with the dominant majority. Contemporary research has primarily focused on different strategies of acculturation and how variations in acculturation affect how well individuals adapt to their society.

Contents

1 Historical approaches
2 Conceptual models
   2.1 Kramar
   2.2 Gudykunst and Kim
   2.3 Fourfold models
Cultural Competence

• Majid Jalil and Rosslynne Freeman
• How quickly can the culture change?
• Dilsher Singh
• Confusing phrases – spend a penny
  – Specialist Commissioning
  – Integrated Care
  – Community
Transferring care into the community

• Jayne Hazelgrove
• Mike Masding
• Katrina Percy
• Stuart Ward
• Partha Kar
Peter Drucker

“Ninety percent of what we call 'management' consists of making it difficult for people to get things done.”
Kevin “Scargill” McKinlay

• ?privatisation by the back door
Mike Masding

- Eye contact with Julia Harris
- “If we wait for evidence, we’ll never do anything”
- But we need evidence to know WHAT to do....
- Not cost neutral interventions
What about moving resources and care into the community?

Integrated Care

• I’m an enthusiast but .......... how to do it?
• The Guardian 4/1/2014:
• Dr Martin McShane wants some family doctors to do extra training and become "complex care GPs", to look after only people with long-term conditions, especially the 5% of the population who are the heaviest users of NHS services and take up most of doctors' and nurses' time. They would then lead small teams of health and social care professionals who would try to keep the patients as well as possible in their own homes. As many as 50 GP practices could come together to do that, as well as looking after elderly patients in care homes and using telehealth to monitor patients who are still living at home, he says.
• The government's planned £3.8bn-a-year Better Care Fund, which starts in April 2015, will fund the integration of health and social care services
Action plans for COPD – GsuST BMJ 2012

• 464 patients in Glasgow (only UK RCT) – severe COPD following an admission
• half with supported self management – education and regular nurse visits over 1 year
• Both groups – smoking cessation and PR
GsuST trial 2012

- No difference
- **BUT**
  - Over half declined to take part
  - Those who did correctly self manage did have fewer deaths and admission
RCT of case management for COPD in the USA – May 2012

• Education, self management plan, regular phone calls
• Study stopped half way through (200 in each group)
• No difference in hospitalisations
• Mortality greater in intervention group (28 vs 10 deaths, p=0.003) – most excess deaths due to COPD
Evercare model of case management of high risk elderly cases (not just COPD)

- Gravelle et al BMJ 2007
- 9 PCTs, 64 practices
- Higher hospital admissions (NS increase of 16%) and mortality (NS increase of 34%) with Evercare
Case Management of high risk patients

- 16 integrated care pilot sites
- 117 practices, 3600 patients – case management of high risk patients (many COPD)
- Compare with half of England (17000 patients)
What about virtual wards/ case management?

- Geraint Lewis - Won the Guardian Public Servant of the Year Award 2007
- Croyden then Devon and Wandsworth

People identified as being at risk of an emergency hospital admission are being admitted instead to a “virtual ward” and looked after by a team of health professionals in the community in an attempt to care for them in their own home. The idea, developed by Croydon primary care trust, in south London, has been so successful that the model is now being adopted by other PCTs around the UK.
• Compared with matched controls, we found no evidence of a reduction in emergency hospital admissions for patients who received this type of care in the six months after starting the intervention. Nor did we find evidence of a reduction in ambulatory care sensitive hospital admissions or mortality in this period. We did, however, observe a reduction in elective hospital admissions and in outpatient attendances in the six months after starting the intervention.

• Over the six month follow-up period of analysis these direct costs were of the order of £510-£2,890 per patient.

• Our study was not designed to assess changes in the quality of life of Virtual Ward, but there are anecdotal reports that patients were highly satisfied with the intervention.
What about telehealth?
Telemonitoring in COPD
BMJ Oct 2013

• 256 COPD patients in Scotland with a previous admission randomised to telemonitoring vs usual care

• Primary outcome – time to first readmission
Telemonitoring in COPD
BMJ Oct 2013

- No admissions prevented
- 270 extra home visits
- 2500 extra phone calls
- And no difference in quality of life
Notable Practice Awards
Evidence for improved patient care

- D-dimer
Take Home Messages

- Relationships
- Trust
- Food