



# A quality **and** outcomes framework for community paediatrics

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Cliona Ni Bhrolchain *and many*  
*thanks to Professor Martin Roland*

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17 September 2008



## Aims of the workshop

1. To present a **simple** but comprehensive and validated **framework** for quality and outcomes
2. To discuss **a few possible quality indicators** to prepare for monitoring of the **core offer** for disabled children

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# Plan of the workshop

- **First : presentation**  
background & simple definitions  
share briefly some of Derby' s work so far
- **Second : let's work at it together**  
discuss whether we could agree a QOF for disabled children's services (four groups)
- **Third : Feedback**  
from groups and way forward

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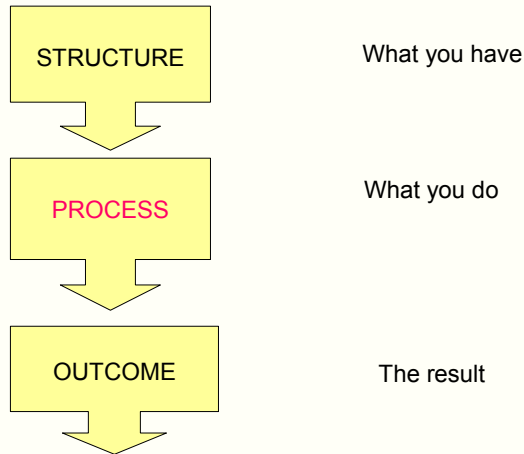


## What *indicates* **quality** in health services?

It is NOT just outcomes  
(though that's what we get asked about most)

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# Audit framework



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## What is a desired outcome?



- **A measurable improvement in health status**
  - A relatively easy one (for the doctor):
- **Improved haemoglobin** after treatment for iron deficiency anaemia
  - A slightly more complex one
- **Resolution of continence problems**
  - After intervention

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# Problems with outcomes



- Very difficult to define
- **Academics** spend years doing that
- **Managers** and commissioners want simple answers which don't exist as yet
- **Clinicians** want something meaningful to them and pragmatic
- **Patients/carers** don't usually get asked!

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# Proxy outcomes



- Where the **true** outcome is too difficult to measure
  - eg immunisation
- We don't know how many cases were really prevented
- So we use **coverage** as a **proxy** outcome and don't rely usually on notifications

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## Allan Colver and the BPA 1989



- Seminal work, 20 years ahead of its time
- Very few true / proxy outcomes measures
- Start treatment for **hypothyroidism** by 21 days in 90% of cases
- Identify severe **hearing loss** and fit hearing aids by 18 months in 90% of cases
- Identify **significant special educational needs** by age 4 years in 90% of cases

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## Is that all there is to it then?



- (Clinical) Outcomes may be the Holy Grail
- **BUT** they do **not** tell the quality story well
  - e.g/
    - What is the desired outcome for a child with Downs syndrome? or with terminal illness?  
???????
    - Can we / should we define the desired **quality** of health services for such a child and her family?

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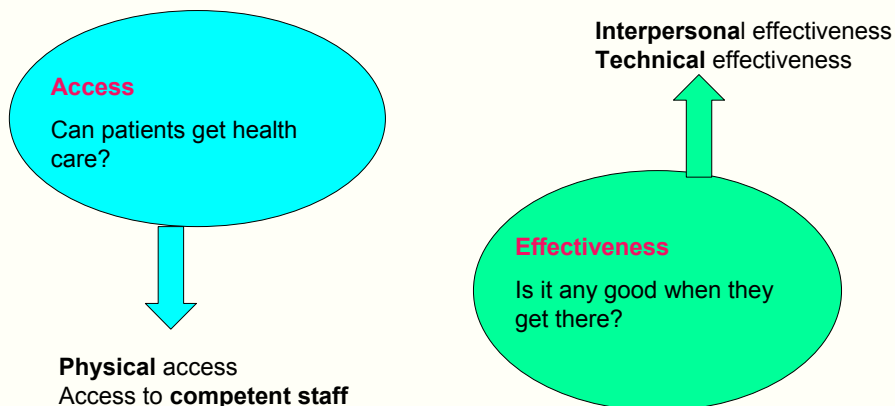
# The **four** dimensions of **quality**



- There are four essential dimensions of quality
- Two for **individual** patients (which please patients, carers, and clinicians most)
- Two for **populations** (which please public health, financiers, managers and commissioners most)

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## Quality for **individual** patients

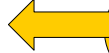


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# Quality for populations



Horizontal  
Vertical



## Equity

Access for all

Access based on need

## Efficiency (cost)

Also matters to individual patients if paying for care

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# Quality domains

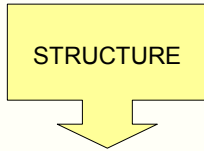


1. Access
2. Effectiveness
3. Equity
4. Efficiency

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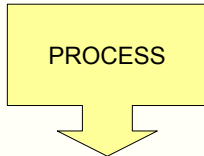


# Audit components



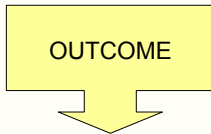
Visible aspects (*what you have*)

e.g. buildings, equipment, staff, **strategies**, appointment **systems**



What goes on within structure (*what are you doing with what you have*)

e.g. consulting, **decision-making**, appointment making, prescribing, referring, training, letter writing

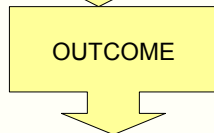
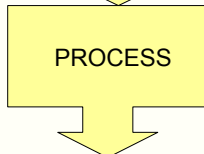
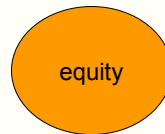
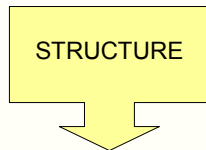
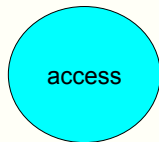


Consequences of providing care (*what you get*)

e.g. morbidity, mortality, quality of life, user **satisfaction/experience**, costs

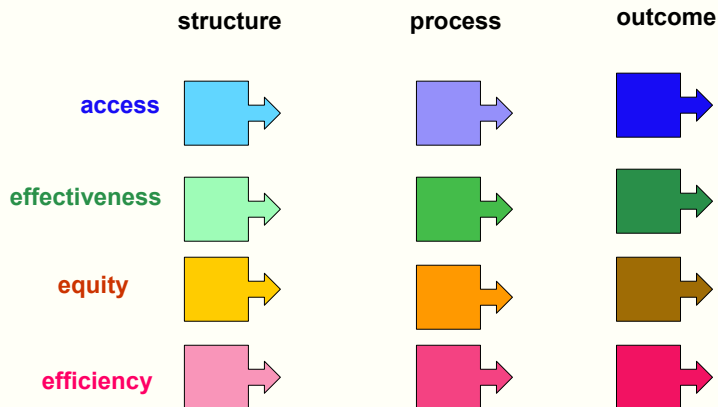
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# Framework for *each* domain of quality



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# A quality and outcomes framework



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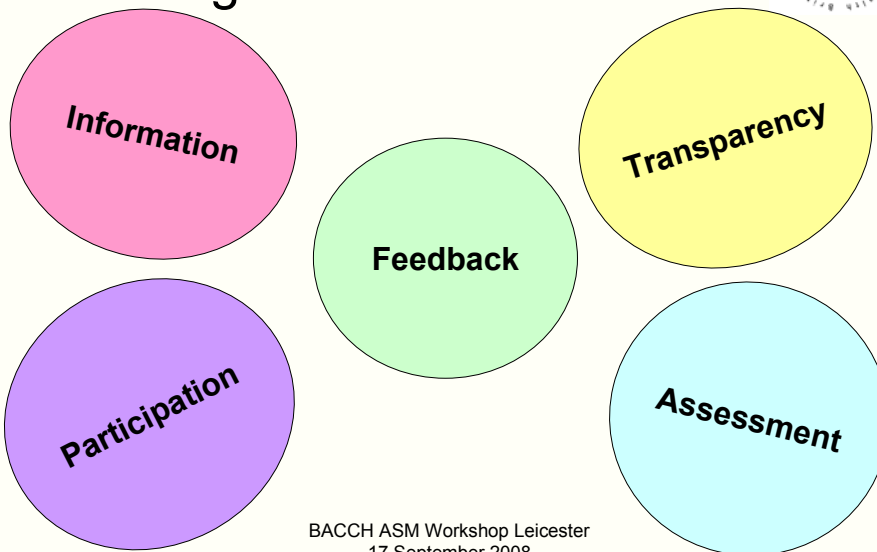
## Indicators



- Indicators are **measurable** aspects of **performance** for which there is **evidence** or **consensus** that what is measured can be used to assess quality
- Indicators must be distinguished from
  - guidelines
  - standards
  - targets

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# Core offer for disabled children PSA target 12



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## Assessment standards



- **Be holistic and co-ordinated**, undertaken as far as possible in the same place at the same time, and be provided as early as possible with minimum waiting times
- **Be based on the family's consent** to share information and an understanding of the purpose and possible outcomes of the assessment
- **Be based on shared information**, for example the Common Assessment Framework or relevant extract from a statement of special educational needs, as a platform for more specialist assessments, ensuring that families do not have to provide the same information time and time again
- **Be prompt and multi agency**
- **Be undertaken by staff with the right skills** for diagnosis, assessment, treatment and ongoing care and support

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## Access to **information**: possible indicators



- **Structure:** website, leaflets, telephone line
- **processes:** for providing the above eg producing leaflets and staffing phone line
- **outcome:** parents report easy access to good information in high % of cases

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## Access to **skilled staff**: possible indicators



- **structure:** training strategy
- **processes:**
  - CPD
  - Appraisals
  - Supervision
- **Outcomes:**  
High staff satisfaction/low level of adverse incidents due to staff mistakes

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## Interpersonal effectiveness: possible indicators



- **Structure:** audit strategy, complaint procedure
- **Process:**  
staff communications skills  
Copying letters to parents/cyp
- **Outcomes:**  
good user satisfaction surveys  
demonstrated learning from suggestions,  
compliments and **complaints**

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## Technical effectiveness: possible indicators



- **Structure:** audit strategy
- **Process:**  
*Audit of hypothyroidism screening in  
Downs syndrome*
- **Outcome:**
- Age at identification of sentinel conditions  
eg **sensorineural hearing loss**, significant  
special needs.

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# Equity: possible indicators



- **Transparency in how available levels of support are determined**
- **Structure**
- Referral and acceptance criteria
- eg dyspraxic children
- **Process:** monitoring of RTC for non gp referrals, RTT for therapy referrals
- **Outcome**  
%of wheelchairs provided within X weeks of referrals vz % of nebulisers?

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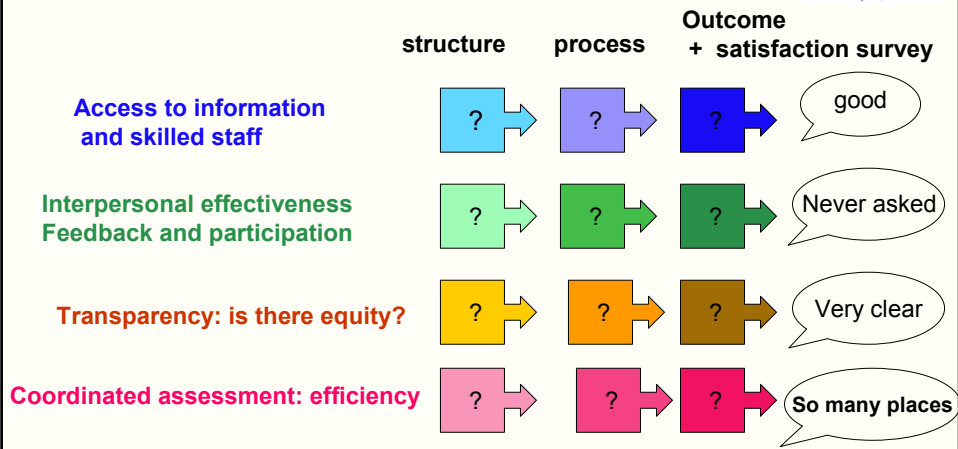
# Efficiency: possible indicators



- **Integrated assessment provided by different services in a coherent coordinated way**
- **Structure:** CDC/local clinic/staffing
- **Processes:** appointments/use of CAF
- **Outcomes:** number of appointments needed for assessment, number of sites visited per child, **parent/CYP survey**

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# A quality and outcomes framework



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## Time to get to work 20 mins



- Discuss, agree 1-2 indicators max!
- **Information & skilled staff**  
(access) **Group 1**
- **Feedback and participation**  
(effectiveness) **Group 2**
- **Transparency**  
(equity) **Group 3**
- Holistic and **coordinated** assessment  
(efficiency) **Group 4**

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# Feedback & way forward



- Each group
  - Conclusions
  - What next?
- 
- **THANK YOU FOR YOUR CONTRIBUTION!**

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# Childhood disability

PSA target No 12  
'Core offer'

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To be useful indicators should...



Measure aspects of quality

Be based on science  
or expert opinion

Be used to highlight areas  
for further investigation,  
not judge performance

Represent aspects of care  
within the control  
of the practitioner

Be appropriate to the situation

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# Assessments to cover



- Consideration of inclusive options as well as specialist services including the offer of direct payments and support to manage direct payments
- Family support plan in Early Support for 0 – 4, and person-centred transition planning for young people from 14
- Consideration of the need for a key worker

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# Existing tools we might use



- Structure
  - CS Mapping; RCPCH census; HCC survey/review
- Process
  - Appointment process; Map of Medicine; equipment waiting times; patient satisfaction
- Outcome
  - Age at identification ;waiting times; patient satisfaction survey; education records; DLA
- PCT/SHA self audit/assessment

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# Measures for thought!

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## Structure: do we have?

- Diagnostic/disability register
- CDC
- Using Early Support Programme
- Assessment 'in same place in same time'
- Access to specialist services e.g. botulinum, communication aids
- Audit
- Workforce

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## Process: do these happen?



- 18 weeks from referral to treatment (agreed pathways in place; compliance with pathway audited)
- Agreed Family Service Plan
- Transition plans

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## Process



- SEN medical reports returned within timescale (proxy outcome)
- Information given on DLA (how to measure?)

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# Outcome



- Age at identification
- Services in place before school (define)
- Educational attainment
- Disabled children excluded /out of school
- Age at 1<sup>st</sup> orthopaedic surgery for CP?
- Sleep & behaviour difficulties?
- Patient / carer satisfaction surveys

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# Derby's experience with QOF



Some indicators **common** to all community paediatric services (generic)

- Some **specific** to network planning groups
- i.e. safeguarding, *disability*, mental health, CICA, vulnerable adolescents
- Favourable response from commissioners
- **Work in progress!**

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## Derby's generic qof for physical access



- **Structure:** bus routes, opening hours, interpreter availability, CYP friendly premises
- **Process:** referrals & appointment processes
- **Outcomes:** activity statistics, DNA rate, 13 week RTC%, 18week RTT %, appropriate referral base, appropriate venues
- *Evidence for each indicator and actions needed*

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## Derby's generic qof for access to competent staff



- **Structure:** HR and training strategies
- **Processes** for assuring competency: CPD, appraisals, supervision, team development
- **Outcomes:** low staff turnover, good staff career progression, high staff competence
- *Evidence for above and actions needed*

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## Derby's generic qof for interpersonal effectiveness



- **Structure:** audit strategy and programme
- (annual children's services audit showcase)
- **Process:** staff communication skills, copying letters to parents / CYP, clinical reports
- **Outcomes:** good user satisfaction demonstrated by surveys, demonstrated learning from compliments, complaints and adverse incidents/exception audits
- *Evidence and actions needed*

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## Derby's generic qof for technical effectiveness processes



- **Structure:** audit strategy and programme (annual children's services audit showcase )
- **Process** (proxy outcome) audits
- Immunisation,
- LAC assessments,
- Peer review for csa and nai medicals
- Downs syndrome hypothyroidism and coeliac screening

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## Derby's generic qof for technical effectiveness outcomes



- **Outcomes** audits
- anaemia: Haemoglobin after treatment
- Soiling: resolution after treatment
- Child death reviews: preventable deaths
- Physical disability: early detection of hearing impairment
- Learning disability: early detection of children with statements at year 2
- Improved scores for ADHD on medication
- *evidence and actions needed*

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## Derby's generic qof for Equity



- **Structure:** strategy: access for all dependent upon clinical need (service priority list)
- **Process:**
  - Referral process depends upon clinical need and not referral source;
  - Referrals prioritised on basis of clinical need
- **Outcomes:**

Dependent upon clinical need; service accessed by vulnerable population

*Evidence for above and actions needed*

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## Derby's generic qof for efficiency



- **Structure:** strategy: the service aims to deliver a holistic assessment and work with other agencies to secure a team around the child
- **Process:** sufficient time allocated to ensure a full assessment (physical learning emotional and psychosocial) and link with wider MDT across agencies; caseload control
- **Outcome:** follow up is appropriate for case mix  
cost per case is comparable with other providers for same quality of service

*evidence for above and actions needed*

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# Derby outcomes 1



## Being healthy

### 1 **Immunisation -**

coverage more than 95%;BCG audit in high risk children with TB

### 2 **Iron deficiency Anaemia -**

Hb > 11g after intervention in 90%

### 3 **Constipation, leading to soiling -**

Early treatment with appropriate medication until complete resolution.

*Needs better definition eg less than x soiling episodes per week/ month*

### 4 **Minority & Ethnic Groups**

Numbers of children diagnosed with autosomal recessive congenital disorders.

### 5 **Child death reviews**

Numbers of children dying with known risk factors.

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# Derby outcomes 2



## Being safe

### 6 **LAC. Adoption Medicals**

All LAC children to have an initial Health Medical Assessment, dental and eye checks, and substance abuse questioning

.% with improved immunisation status after one year

### 7 **CHILD PROTECTION Child sexual abuse -**

Peer review audit 90% agreement

### 8 **CHILD PROTECTION NAI -**

Peer review audit 90% agreement

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# Derby outcomes 3



## Enjoying and achieving

### **9 Physical disability: Hearing Impairment -**

All/90% children with significant, permanent sensorineural hearing loss, should be diagnosed, and habilitation started, by six months of age.

### **10 Learning Disabilities – Special Needs**

90% of children with statements at year 2 identified by age 3 years

### **11 Downs syndrome**

Blood screening for hypothyroidism and celiac disease 90% coverage

### **12 Mental health: ADHD on medication**

*Better Connors/SDQ scores*

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