Outcomes quality measures used by UK anaesthetic departments

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The HSRC has established a working group to develop a 'quality framework' for measuring and reporting clinical outcomes relevant to anaesthesia and perioperative medicine. The group encompasses clinicians and academics, and is tasked with this work in order to address the need to report our clinical outcomes as part of our portfolio of supporting information for revalidation, as well as (more importantly) to enable quality improvement and, finally, in order to facilitate health services research.

Quality of care may be measured using Donabedian's model of 'structure' (the environment in which healthcare is delivered), 'process' (the method of healthcare delivery), and 'outcome' (either patient reported or objective, such as mortality). Structural elements might include measures of theatre efficiency, departmental characteristics (e.g. number of consultants, trainees and speciality doctors) and availability of particular technologies (e.g. ultrasound machines). Process measures are more familiar to those of us who engage in departmental audits, and often focus on adherence to 'best practice' guidelines – for example, compliance with the WHO checklist, adherence to protocols for venous thromboembolism or perioperative antibiotic prophylaxis, or rates of use of the oesophageal Doppler in major open abdominal surgery. Outcome measures may be divided into patient reported (e.g. satisfaction, quality of recovery or pain scores) and objective (e.g. mortality or complications).

In order to develop a framework for assessing quality of care in anaesthesia, we are initially looking to define what is already being measured 'at the coal face', in order to determine feasibility of recording and reporting some of these metrics in a systematic manner across healthcare institutions. The Quality, Audit and Research Coordinators (QuARCs) in each anaesthetic department (or the Clinical Directors in departments who have not yet nominated a QuARC) will have recently received an email from the College asking them to complete a short online survey asking for information on which measures are currently collected in their department, the frequency of data collection, and the methods (if any) of the feedback of these data to practising anaesthetists.

What will this information-gathering exercise help us to achieve? Ultimately, we should be aiming for nationally co-ordinated data collection, thereby facilitating comparative audit and quality improvement. The data should comprise both patient risk measures (in order to enable meaningful comparison between institutions), and structure, process and outcome measures. Alongside the rest of the NHS, we should be seeking patient reported outcome to inform our practice. In a resource-constrained environment, we need to define the strategy for achieving these aims without incurring significant extra expense. It is likely that the best system would involve participation in a series of 'sprint audits' looking at specific patients or procedures, on a cyclical basis. Infrastructure for a centralised data-entry system, analysis and timely reporting back to trusts will need to be developed. National reports will need to be generated, with areas for improvement highlighted, and centrally co-ordinated re-auditing.

We are a long way from realising this ideal. In order to make a start, your participation in our survey is essential. This will ensure that the development of our quality framework is approached from the 'bottom up' rather than the 'top down'. Implementation of the aspirational system detailed above will take years, and we will need to edge towards it gradually, and in a way which will neither disenfranchise individuals, nor place unreasonable extra financial burden on trusts. However, the key point is that we must get started. Once we have demonstrated 'proof of concept' – i.e. that systematic nationally co-ordinated data collection in perioperative medicine is feasible, and can benefit patients, clinicians and trusts – then we can only hope that, in the same way that the ICNARC Case Mix Programme has developed, most of us would rather be 'in the club' than out.