



The PQIP API Collaborative

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Welcome



- Sessions will be recorded
- Housekeeping: Respect and professional conduct
- Why set up an API Collaborative?
- A Collaborative approach to QI
- How the Collaborative will run

PQIP

PQIP Perioperative Quality Improvement Programme

Report 4
July 2021 to March 2023

NIAA HSRC | **NIHR** | **Central London Patient Safety Research Collaborative** | **RCOA** | **The Health Foundation** | **UCL source**

PQIP Perioperative Quality Improvement Programme

On the Road to Recovery **NIAA HSRC** Health Services Research Centre

- 1 Early Screening**
Identify patients in need of optimisation early, and at the latest when they are added to a surgical waiting list. In England this is now NHS policy for inpatient surgery, embedded in the elective recovery plan (2022) and standard NHS contract (2023/24).
Filter optimised patients who have less comorbidity, a reduced length of stay and who have fast on-the-day cancellations.
- 2 High Risk Patients**
Use a consistent validated risk score such as SORT across your teams to assess patients' risk of postoperative complications and morbidity. A 2023 systematic review found SORT to have the best combination of accuracy and clinical usability of any published preoperative risk assessment tool worldwide (sortsurgery.com).
Actively identify postoperative destination for patients with >5% 30-day mortality risk consider enhanced care >5% requires critical care.
Frailty increases a patient's vulnerability to adverse outcomes following surgery. Consistently use a **Frailty** scale as part of your risk assessment.
Improve risk factors that make a difference to patient outcomes such as anaemia and diabetes.
New research from PQIP can help you identify patients at risk of severe pain, who can be referred to pain services for additional support. Severe pain is more common to patients with cancer, insulin-dependent diabetes, who smoke or are on opioids preoperatively.
- 3 Day of Surgery**
All sites are consistently performing highly on day of surgery admission, intra-operative antibiotic prophylaxis, and ensuring patients have a temperature over 36 degrees on arrival to recovery. These process metrics have generally become embedded into practice and in most sites, will no longer need QI interventions to improve compliance.
The ERAS Society makes a strong recommendation for perioperative carbohydrate loading for abdominal, colorectal, gynaecological, urological and thoracic surgery.
Where surgery has an expected blood loss of >500ml, transfusion should be anticipated.
- 4 First 24 hours after Surgery**
It is time to rethink enhanced recovery and focus on the core processes that can improve patient outcomes.
Drinking, Eating and Mobilising (DrEaMing) in the first 24 hours after surgery is associated with reduced length of stay and lower inpatient costs. The NHS England quality standard has been extended and broadened for 23/24. This is a great QI opportunity for all services.
Focus on improving process metrics that limit patient ability to DrEaM, for example reducing use of nasogastric tubes and abdominal drains, and addressing postoperative pain.
Severe postoperative pain continues to be common, especially on day 1. Identify local structural or process issues underpinning inadequate analgesia for patients.
- 5 In-Patient Stay**
The **Blue Survey** is an important tool to inform your local anaesthetists how satisfied patients are with their provided anaesthetic care and can guide improvement initiatives. In the PQIP cohort, which is partly day high-risk, the inpatient postoperative complication rate is 25%. [Complications increase LOS and result in increased days from treatment, increased readmission, and increased cost.](#)
postVAD is a new PQIP initiative, providing near-real-time risk-adjusted morbidity monitoring. **PostVAD** can support local teams identify early trends positive and concerning trends in day morbidity to enable more timely investigation of care processes and support local QI. Go to the PQIP website for further information.
- 6 Longer Term Outcomes**
Patient Reported Outcome Measures are essential to understanding patient's experience and recovery following surgery. These measures can be used to measure benefits and harms of treatments, inform the consent process and aid shared decision-making.
The EQ-5D-5L and the WHO Disability Assessment Schedule are two quality of life questionnaires recommended by PQIP at 6 and 12 months postoperatively, but follow-up rates could be better in most hospitals. Consider how your PQIP team can increase capture of this quality-of-life data to help improve care for future patients.

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Top 5 improvement priorities 2023–2024

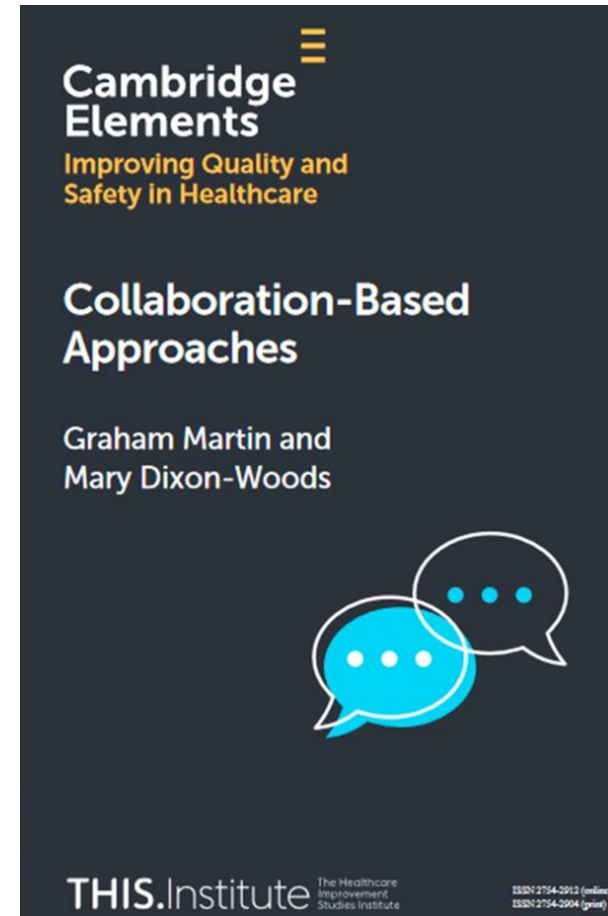
- 1 DrEaMing**
• Drinking, Eating and Mobilising within 24 hours of surgery is associated with reduced length of stay and fewer inpatient complications.
• The **NHS England DrEaMing Quality Standard** has been updated for 2023/24. It includes more procedures and a higher minimum threshold of 70%, to promote DrEaMing, alongside the principles of enhanced recovery, to as many patients as possible.
• Focus on improving modifiable processes that limit a patient's ability to DrEaM: reducing use of nasogastric tubes and abdominal drains, optimising preoperative anaemia, and targeting postoperative pain.
- 2 Patient Blood Management**
• Even mild perioperative anaemia is an independent risk factor for adverse postoperative outcomes and an increased risk of morbidity and mortality.
• **NHS Blood and Transplant** recommends that all patients receive prophylactic tranexamic acid for surgery where expected blood loss is over 500ml.
• Adopt a **Patient Blood Management** approach, developing a patient-centric multidisciplinary local pathway. This should support early diagnosis and treatment of anaemia, minimise intraoperative blood loss and reduces postoperative blood transfusion.
- 3 Individualised Risk and Frailty Assessment**
• Frailty increases a patient's vulnerability to adverse outcomes following surgery.
• Incorporate and consistently use a **Frailty assessment tool** in your teams' preassessment pathway.
• Consistently use a **locally agreed risk assessment tool**, such as **SORT**, for all patients.
• Plan patient's postoperative destination based on their risk score to ensure appropriate patients are admitted to critical care (>5% mortality risk) and where available, enhanced care (>1% mortality risk).
- 4 Individualised Pain Management**
• Severe postoperative pain is common, unpleasant and avoidable. Pain is associated with increased morbidity and mortality, prolonged LOS, delayed recovery and reduced quality of life.
• Identify patients at higher risk of pain and consider additional interventions including preoperative expectation management and acute pain team review postoperatively.
• Address modifiable factors associated with increased risk, these include smoking, diabetes treated with insulin and anxiety.
- 5 Embedding into Clinical Practice**
• PQIP is much more than a research study! Its main aim is to support you to support local QI.
• Focus local recruitment on a single speciality or a small number of surgical specialities to maximise opportunities for local QI.
• Collaboration is at the core of sustainable QI. Collaborate locally by co-designing QI interventions with your local team. Collaborate nationally by joining the PQIP webinars.
• Enrol motivated trainees in the **NIHR Associate Principal Investigator** scheme, to help lead locally with data collection, recruitment and results dissemination. Embed trainee involvement into your PQIP team.

www.pqip.org.uk

Why explore using a collaborative

“Improving quality requires systems for sharing knowledge, coordinating and organising activity and encouraging cultures that support change”

“Data collection on its own is not enough: the effort invested in data collection must be matched by similarly robust efforts directed toward improvement” (Ko, et al JAMA 2022)



A collaborative QI approach

“A group of professionals coming together, either from within an organisation or across multiple organisations, to learn from and motivate each other to improve the quality of health services.”

Healthcare systems are social organisations and although systems and processes are important, so is human behaviour.

Reference: De Silva D 2014, improvement collaboratives in healthcare [ImprovementCollaborativesInHealthcare.pdf](#)



References:

- De Silva D 2014, improvement collaboratives in healthcare [ImprovementCollaborativesInHealthcare.pdf](#)
- The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003.
- www.pqip.org

A PQIP Associate PI collaborative

For the API:

- Support APIs to get the most out of PQIP
- Contribute to a National QI collaborative
- Efficient, meaningful and data driven QI
- Educational sessions in QI
- CPD
- Foster interest in QI as well as research

For PQIP

- Stimulate focused recruitment
- Increased involvement of the MDT in PQIP
- API to help with dissemination of data results
- Someone on “the ground” helping with use of data and dashboards
- Delivery of sustained, meaningful QI in PQIP priorities at local sites
- Improved outcomes for patients

Ultimate aims for QI as a trainee

- Avoid working on QI in an individual silo
- Use data out there
- Collaborate across speciality and with patients
- Continuity and robust handover
- Advocate for meaningful projects and enthuse those involved
- Change the perception of what is seen as achievement in QI
- Ask for help and support

How the Scheme will run

- Webinar 2-3 monthly
- Key speakers on PQIP, QI methodology, barriers and facilitators to QI, patients and their role in QI
- Main focus on discussion and sharing of ideas
- Action periods
- DrEaMing and local QI