HQIP
Healthcare Quality Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Workshop summary – Developing creative approaches to quality improvement

This workshop began with a presentation Professor Martin Elliott and Professor Allan Goldman, Great Ormond Street Hospital.

The presenters gave an overview of quality improvement work that has been done at GOSH involving external input from Formula One, a mathematician from Harvard, and Jim Reinartsen from the USA. This has helped them to be creative in redesigning their services, particularly booking and admissions.

Key points:

- A focus of their work was around reviewing efficiency which they see as another dimension of quality. The work presented was an example of where conducting a clinical audit can improve efficiency and save time.
- The work with Formula One highlighted the fact that, unlike F1, the clinical team do not rehearse their actions or procedures. They introduced a new procedure and rehearsed it with several scenarios, and care improved dramatically. This in turn has been reflected in reduced staff stress and sickness rates.
- The links with industry led the team to develop business aims and use process mapping, something which is not traditionally used in the NHS and which we generally lack skills to do.
- A key question they ask is “would this quality of care be acceptable to me or my family?” If the answer is no then we should do something about it.
- They also changed the focus from risk and incidents to asking “How many children did we harm this month?”. The names of the children were listed and this turned incident data into something real, and just highlighting this data led to an improvement by itself without any further action.
- The opportunity costs were considered, which involved thinking about what they were not doing, or what opportunities they were missing, whilst they were dealing with incidents, complications, medical errors and bed blockers.
- Benchmarking data is useful but GOSH had decided that aiming for the national average was not sufficient, and they want to aim to be the best.

Summary:
A key message was the value of discussing and considering quality at all times, discussing it as a team and discussing it at every opportunity, even in the pub! Having an external viewpoint has been invaluable in being creative about quality improvement. All trusts can be creative and involve external consultants - industry is willing to help, we just need to ask.

HQIP

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Workshop summary – Encouraging patient involvement

Joan Saddler, National Director Patient and Public Affairs Commissioning and Systems Management at the Department of Health, opened up the session with a presentation covering:

- Design and delivery of service
- Personalisation
- Experience, improving quality
- Empowerment to choose best option for themselves
- Meet higher expectations
- Able to engage properly
- Get to grips with technology
- Poor understanding at high level of NHS about clinical engagement with users
- PPI is enshrined within legislation though there is still an issue of listening to patients after 25 years of the Bristol case.

Key points of discussion included:

- Easier to support PPE at a local level and there are more and more good examples from local clinical audits
- Harder at national level to access patients and understand the need, however the RCP's f*alls and bone health audit* gave examples of using focus groups, sending out questionnaires and working with Help the Aged/Age Concern to understand how best to facilitate focus groups; an example was to hold the group in a centre that had wheelchair access and ensuring that chairs had arms.
- Patient engagement is now a performance indicator and links into Quality Accounts.
- Few examples of what "good" looks like when involving patients in clinical audit and no size fits all.
- However, there is a lot of negativity around PPE and people often look for reasons to not involve patients. The same models and examples are being reproduced but it is up to clinical audit leads to adapt them for their own projects.
- How do we avoid being tokenistic?

Actions for HQIP and Clinical audit leads:

- More guidance specifically for clinical audit with examples of best practice.
- Tailor the process for the patient, for example, online questionnaires for the 9-5 workers, focus groups for older patients.

HQIP

- Utilise organisations that represent patients, especially for transient groups such as new mothers or children.

Summary:

- PPE is more achievable at the local level.
- We must persevere and adapt models for the relevant audience.
- PPE is invaluable.
- Act on what patients say.
- More guidance and examples of best practice needed.
- Clinical audit leads to take more risks and approach PPE positively.

HQIP

Healthcare Quality Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Workshop summary – Contributing to revalidation

Elaine Tait, CEO at the Royal College of Physicians in Edinburgh, began this workshop with a presentation covering the following points:

- purpose of revalidation
- the two components of revalidation – relicensing and recertification
- five year renewal
- the four GMC domains: Knowledge, skills & performance; Safety & quality; Communication, partnership & teamwork; Maintaining trust
- checklist of supporting information for revalidation
- the importance of revalidation
- the challenges being faced
- participation, reflection and taking action from the results of high clinical audit.

Following the presentation, attendees discussed the following questions:

- *Can audits distinguish individual from team performance?*
  - depends on the clinical activity
  - useful to audit within defined unit
  - do not want to duplicate the effort of individuals by asking for similar figures and thereby creating a negative approach
  - the current system focuses on individuals, and not individuals in context as part of a team who are responsible
  - should be focussing on team performance rather than individual activity
  - should look at conducting international audits
  - there could be a good individual supporting a poor team, or a poor individual being masked by a good team.

- *Will revalidation distort audit priorities and resources?*
  - definition of clinical audit should be expanded
  - it should be each trust's responsibility to have their own process for revalidation
  - revalidation could be helpful in encouraging more people to participate in audit
  - people will probably use the resources they already have in place for their revalidation
  - concern that the audit individuals use to revalidate may not be acceptable
  - would not distort, but would rebalance priorities.

- *Will NCAAG advice clash with HQIP guidance?*
  - guidance is important
  - could use feedback to set benchmarks
  - would not clash but give different perspective.

Healthcare Quality Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

The key points raised from the workshop were:

- when individuals are assessed, their team should also be taken into consideration
- audits were originally set up for quality improvement and we do not want to create negativity by individuals now seeing audits as the way to prove that they are validated doctors. We do not want the process to be completed purely as a tick box exercise.

HQIP

HQIP
Healthcare Quality
Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Workshop summary – Communicating results effectively

This workshop was introduced and presented by Dr Ian Arnott, UK Inflammatory Bowel Disease Audit and Linda Cuthbertson, PR Manager, Royal College of Physicians.

Their presentations covered the following issues:

- Communicating and audit
- Communication strategies

The following were then discussed:

Why communicate an audit?
Communicating an audit was seen as good. Publication of results inspires local action and thereby further encourages trusts to find out how they performed against their peers.

What are the strategies for communicating audit?
The workshop identified the following methods:

- Media coverage. Things to bear in mind when using the media route were
    - Timing: Choose a day and time for maximum impact – eg Sunday night for national coverage or Thursday/Friday for the medical journals. Avoid major events as this will mean a slide in interest levels
    - Ensure significant staff are available and primed for any statements and/or interviews
    - Bad results or headlines tends to achieve a wider audience
    - Competition for publicity is fierce, find a headline that will grab attention
    - Medical news receives better coverage during a general election year
    - Partner with other organisations for more impetus
    - Piggyback on to conferences or other events.
- NHS Trust communication sent to Chief Executives and Clinical Directors

Where it was identified that timing and target audience were important, the following was put forward as a way of deciding what the best course of action could be:

- Aim for national coverage if the results are national
- Aim for both local and national coverage is the audit is local.

Other methods explored for communicating audit were via:

- local MP, ministers and special advisors to ministers
- parliamentary groups
- patient groups.

The workshop closed with the following take home message:
"Think of far reaching channels for communicating audit and try to look beyond the traditional peer review journals".

HQIP

HQIP
Healthcare Quality Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Workshop summary – Identifying and managing outliers

The workshop was introduced and chaired by Dr Jo Modder, Clinical Director of the Obstetrics Centre for Maternal and Child Enquires (CMACE). CMACE carries out perinatal and maternal mortality surveillance as part of the CEMACH programme.

The following key areas were covered in the presentation:

Data quality:

- Data cleansing
- Data validation
- Trends and rates
- Trust specific reports.

How are Outliers identified:

- Funnel plot – using crude measurement of still birth rates
- Using 95% confidence interval
- Average still birth
- Perform case adjustments.

Rates are not adjusted for (shows current weaknesses of the outlier identification process):

- Local population
- Risks of the pregnancy
- Neonatal death - Severity of clinical conditions at birth
- Problems with denominator data.

Terminology for potential Outliers:

- 1 year identification   Isolated
- 2 years identification-   Recurrent
- 3 years identification-   Persistent

Confidence intervals :

- Using two confidence interval rates to compare and contrast number of potential outliers indentified, one was set at 99% and the other was set at 95%.

Review points and feedback cycles:

- For denominator data annual request goes out in February with a deadline to return data by June.   The cut off point for data is September in the previous year.
- Trust specific reports are available in November.

HQIP

HQIP
Healthcare Quality
Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Key Issues discussed:

Identifying outliers

- Individual surgeons versus units and teams
- Using funnel plot as a representation of who is in or out of the acceptable range
- Need agreed standards of measurement (difficult task)
- Bench-marking within profession (very important)
- Consensus: the group agreed that outlying data should be measuring unit based performance
- Need agreed indicators for "good performers" which can be refined over time
- Need different methods to identify high volume and low volume surgeons.

Managing outliers

- Writing/contacting to >95% confidence interval units
- Inform clinical directors in writing
- Has to be professionally led
- Only satisfied when the evidence has been presented that "potential outliers" are being managed/investigated
- Review and report frequency needs to be manageable, practical and achievable: Biannual or annual as oppose to real time
- The outlier monitoring process should be managed as an integral part of the quality improvement programme of units and strategic health authorities.

Three key points:

- Data needs to be validated first before any conclusions can be drawn
- Analysed and validated data should be made available in public domains, for examples the Cancer and Transplant audits
- Risk adjustment is crucial to ensure the data quality and integrity.

Lessons learnt/good practice:

- Ensure data quality, integrity and robustness -need to work out a policy of risk adjustment/ case mix/ no double counting.
- Good practice to use the term 'potential outlier' until the case is proven
- Establish an acceptable and workable confidence interval level which is profession led
- Establish a workable and practical data review points, report production points and types of reports required for different purposes ie SHA/Trust/ hospital/ team level report
- May need to consider a charging policy for different types of report for different audiences
- Key roles are to indentify and notify the relevant bodies. The responsibility to investigate lies with CEOs of different trusts. The end point comes when the EOs subsequently demonstrate that the "potential outlier" had been investigated and managed accordingly.

HQIP

HQIP
Healthcare Quality
Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Workshop summary – Engaging local staff

This workshop began with a presentation from David Cromwell, Clinical Effectiveness Unit, Royal College of Surgeons of England and Steve Dean, Senior Project Manager for the National Cancer Audits, NHS Information Centre.

Their presentation covered the steps taken to increase local engagement in the National Mastectomy & Breast Reconstruction Audit. They explained how the composition of the audit team, the objectives and design of the audit, and the comprehensive communication strategy, boosted local engagement.

Following the presentation, workshop attendees discussed the following areas regarding local engagement:

- The importance of focussed communication with the local clinical leads and data collection leads for each trust, with the Chief Executive and local Trust Board only being called on if there was a lack of response from the clinical leads
- Engaging professional groups in the planning of the audit helped overcome initial resistance
- Time spent on validation of the audit method is never wasted
- The method required continuous input of data, so that communication links were developed over time by regular contact between the national team and the local participants
- The audit had a clear and limited focus, avoiding conflict with other breast cancer audits
- It is much more challenging to try and audit a service which involves a variety of providers, eg. bone health where both primary and secondary care must co-operate
- There was a bandwagon effect, so that publication of interim results created a sense of competition between trusts and a feeling that no-one wanted to be left out.

HQIP

HQIP
Healthcare Quality
Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Workshop summary – Primary care commissioning

This workshop was introduced by Liz Allan, NHS Diabetes Project Manager and Mark Hannigan with their presentations covering:

- Implementing clinical audit into primary care
- Commissioners – who are they?

The following was then discussed:

Implementing clinical audit into primary care

The National Standards Framework has enabled Diabetes to become a part of Primary Care, however, difficulties on obtaining sufficient and adequate data from primary care units has been a key difficulty in primary care representation. It was imperative therefore to identify a strategy as to how this can be overcome.

Questions were put to the workshop for discussion:

Commissioners – who are they and how can they help?

- Commissioners are responsible for the services that are provided to Primary care sectors
- Commissioners checked value for money
- Commissioners bought in services from providers, they hold the funds
- Commissioners monitor contracts and their delivery, so it is imperative that clinical audit is provided for in a contract for services. Once this is achieved, the Commissioner shall ensure that the providers deliver the audit.

How do we achieve sign-up from primary care?

- Use stakeholders in primary care trusts
- Local clinical champions
- Other organisations
- Quality improvement patient groups
- Engage GPs in conversations
- Find easier methods for the return of data such as the IT structure for collecting data as differing systems and methods slows this down and in worse cases, stops it all together.

In conclusion, the workshop identified the following key issues:

- Existing clinical networks should be utilised
- Data systems need to be looked into to facilitate participation
- Build audit into service contracts.

HQIP

HQIP
Healthcare Quality Improvement Partnership

Embedding clinical audit at the heart of the quality agenda: national clinical audit summit

3rd November 2009, Royal College of Physicians, London

Workshop summary – Supporting local change

This workshop began with presentations from Carol Paton from the Prescribing Observatory for Mental Health (POMH) and Dr Gary Inglis from the Assertive Outreach Team in Greenwich for Oxleas NHS Foundation Trust.

Carol Paton gave an overview of the National Audit of Screening for Metabolic Side Effects of Antipsychotic Drugs in Patients Treated by Assertive Outreach Teams. Dr Inglis then provided a local perspective of participating in the audit.

Key points:

- There was a big improvement nationally after the first re-audit, but the Greenwich team did not initially see the same level of improvement as neighbouring teams
- Therefore, the team adopted a positive and pro-active approach to changing practice at the local level and improving the results
- By finding the local solutions to local problems and acknowledging that the structures and issues particular to the area required tailored solutions, the team were able to dramatically improve their performance on this issue
- The example highlighted the need for a positive outlook and a proactive attitude, and the advantage of playing to a team's strengths when reviewing their data for a national audit
- The team were able to tackle issues through a holistic approach, looking beyond the prescription of medication to wider issues such as fitness and social issues, working with colleagues in other teams and disciplines to achieve results.

Summary:
Whilst trusts are audited in the same way, and presented as part of national results in a uniform fashion, the local realities behind the results are specific to each hospital and surgery in each trust. Therefore, in order to tackle issues, teams need to find their own solutions and their own way to achieve the right results. Overall, a positive, proactive attitude and a team response are fundamental to supporting local change.

HQIP