HQIP

Healthcare Quality Improvement Partnership

Clinical leadership challenges: The role of national clinical audits and registries in improving patient outcomes

Views from the HQIP Clinical Leadership Seminar, London 27 May 2016

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Executive summary

Healthcare Quality Improvement Partnership (HQIP) works extensively with national clinical leaders through the National Clinical Audit and Patient Outcomes Programme (NCAPOP) and the Clinical Outcomes Publication (COP) programme.

The importance of clinical leadership in supporting quality improvement is well documented.[1]Importantly the Health Foundation found *"As QI work becomes more complex, NHS leaders increasingly rely on their interpersonal and relational skills to bring about the changes involved. These skills characterise the leader as playing a key role in enabling others in the system to contribute their views, expertise and ideas."*

Our experience of working with clinical leaders across our programmes this year identified challenges in relation to tackling the identification of statistical outliers, particularly within the high profile setting of the publication of audit data in NHS Choices and MyNHS as part of the COP programme. We organised a seminar to give clinical leaders an opportunity to share their experiences and challenges. Appendix 1 details the contents of wide ranging discussions held by participants across a number of key questions posed by HQIP to stimulate debate. The main challenges described by participants at the event were:

- Providing leadership that encourages interest in national clinical audit data when there are limitations to the data that reduce its face value for some clinicians
- Finding ways to shift the perception of national clinical audit away from just being a tool to identify poor performance to a way to celebrate excellence as well
- Programme management challenges in relation to securing access to NHS Digital[2]data
- Managing the tension between the strong preference among clinicians for publishing audit data at unit/team level instead of consultant level

Participants identified the following key goals to support future positive development of national audits:

- Increase the impact of the audits and their reports
- Increased timeliness of data reporting, making data more valuable for local improvements needs
- Evolve the measures reported on to those considered most meaningful by the clinical community
- Collectively move to a position of effective working with NHS Digital to secure more timely access to the national data sets and using that data to improve the data quality of national clinical audits
- Find more ways to celebrate excellence
- Encourage individuals and units to monitor their data closely to enable identification of results drifting toward negative outlier status. So providing an opportunity to review whether there is scope to improve their clinical practice and avoid reaching negative outlier status
- Provide (and facilitate access to) greater support for individuals and units that find themselves identified as negative outliers
- Consider how individuals such as medical directors can be assisted during challenging episodes where services and individuals they are responsible for are the subject of high profile scrutiny

[1] What's leadership got to do with it? (Health Foundation, 2001, http://www.health.org.uk/sites/default/files/WhatsLeadershipGotToDoWithIt.pdf), The Future of leadership and management in the NHS, (Kings Fund, 2011 http://www.kingsfund.org.uk/sites/files/kf/future-of-leadership-and-management-nhs-may-2011-kings-fund.pdf 0, Guide for Clinical Audit Leads (HQIP, 2011, http://www.hqip.org.uk/public/cms/253/625/19/189/HQIP-Guide-for-clinical-audit-leads-2011.pdf?realName=tS36Jn.pdf)

[2] Formerly the Health and Social Care Information Centre

HQIP actions

Whilst tackling the challenges and achieving the goals above will require a number of key stakeholders working in partnership with clinical leaders and the audits, HQIP has identified the following key actions it will undertake to support progress:

- Form a methodological working group to provide support to audit providers in improving data quality and analysis to allow for wider and more timely publication of data
- Continue to seek feedback on future editions of the COP Technical Manual to ensure it is helpful to clinical leaders and audits
- Where possible continue to commission audit measures that are considered more meaningful by the clinical community
- Require HQIP-commissioned audits to report with minimum delay, where possible with real time data access for participants
- Ensure HQIP is always available to provide support and advice to audits and clinical leaders tackling outlier performance challenges
- Write to NHS Digital and NHS England on behalf of the audit community to continue dialogue aimed at improving the flow of data through the system
- Support audits to be able to publish credible positive outliers and encourage positive recognition of this by NHS England and other stakeholders

Introduction

HQIP holds the contract to commission, manage and develop the NCAPOP on behalf of NHS England. The programme comprises more than 30 clinical audits (and 11 other national improvement projects) that cover care provided to people with a wide range of medical, surgical and mental health conditions. The audits measure healthcare practice on specific conditions against accepted standards, providing patients, the public and clinicians with a clear picture of the standards of healthcare being achieved. They give healthcare providers benchmarked reports on their performance, with the aim of sharing best practice in support of improvement in the care provided.

The COP programme supports national clinical audits to publish key metrics on NHS Choices and MyNHS, in addition to their standard reporting mechanisms. This high profile publication of audit data has the potential to generate a high level of scrutiny for clinicians and hospitals participating in the relevant audits. The programme has now supported 14 different specialities to publish their data at consultant and team/unit level covering more than 50 different indicators and more than 500,000 episodes of care.

Effective clinical leadership is key to ensuring these national clinical audits are able to drive quality improvement and work successfully in partnership with their respective specialist societies. Audit clinical leads also need to have a good understanding of the challenges for local clinical leadership in ensuring effective engagement with national clinical audit.

Over the course of the year there have been examples of excellent clinical leadership demonstrated by those leading national clinical audit. The HQIP COP and NCAPOP teams consider it a priority to continue to support and encourage positive clinical leadership for the national clinical audits and support the spreading of best practice. As such, HQIP organised a seminar aimed at supporting this spread.

Clinical leadership challenges

Audits commissioned by HQIP are required to include integrated clinical leadership. Importantly, this leadership should be independent to professional society leadership, but securing representation from such organisations in the audit governance is crucial.

In its two year study of clinical leadership the Health Foundation found "Engagement and relationship skills are fundamentally important in leading improvement," and "As QI work becomes more complex, NHS leaders increasingly rely on their interpersonal and relational skills to bring about the changes involved. These skills characterise the leader as playing a key role in enabling others in the system to contribute their views, expertise and ideas."[3]

This echoed HQIPs own guidance for leaders of local clinical audit which identifies a wide range of responsibilities and skill sets. These include the need to facilitate any communication or subsequent processes on the findings of clinical audits to achieve identified improvements in the quality or safety of patient care. Colleagues need support to carry out individual local improvement.[4]

HQIPs own experience of working with audit clinical leads have identified the following as key challenges:

- Tackling data quality and analysis challenges
- Increased scrutiny of national clinical audit findings (including media interest) as a result of publication on NHS Choices and MyNHS as a result as part of the COP programme
- Ensuring appropriate and effective responses to findings of negative outlying performance
- Finding ways to use national clinical audit to celebrate excellence
- Balancing expectations of commissioners of national clinical audit programmes with those of the clinical community in relation to the concerns around granularity of data publication and measures selection
- Communicating the importance of national clinical audit findings (and the value to be gained from participating in them) to the clinical community

[3] What's leadership got to do with it? (Health Foundation, 2001, http://www.health.org.uk/sites/default/files/WhatsLeadershipGotToDoWithIt.pdf),
[4] Guide for Clinical Audit Leads (HQIP, 2011, http://www.hqip.org.uk/public/cms/253/625/19/189/HQIP-Guide-for-clinical-audit-leads-2011.pdf?realName=tS36Jn.pdf)

Aims of the meeting

The aim of the seminar was to support national clinical audit leaders in their role by the mutual identification of key challenges and sharing of approaches taken in addressing them.

We chose a focus on outlier management as this is the area that has created challenge for clinical leaders participating in COP. It was felt that this was the area most likely to stimulate meaningful debate and to be of interest to target attendees.

We also invited the CQC to participate to provide an opportunity for them to explain their future plans for using national clinical audit data.

Meeting format

Below the key elements of the meeting are detailed. Alongside hearing from guest speakers with both prepared remarks and Q&A sessions, participants were asked to contribute to round table discussions considering key issues and challenges for clinical leaders of national clinical audits. In the following pages we provide more detail on the key messages for each of these sessions.

Clinical leadership challenges: from data to quality improvement- Professor Sir Mike Richards, chief inspector of hospitals, CQC

Clinical leadership in assuring and improving clinical services-Professor Sir Bruce Keogh, medical director, NHS England

Q&A

- Professor Sir Bruce Keogh, medical director, NHS England
- Professor Sir Mike Richards, chief inspector of hospitals, CQC
- Professor Danny Keenan, medical director, HQIP

Handling outliers: lessons learned from a national and local level

- Professor Danny Keenan, medical director, HQIP
- Mr Graham Cooper, president, SCTS
- Dr Stephen Holmberg, medical director, Brighton & Sussex University Hospitals NHS Trust

Round table discussions

- Question 1: Is NCA and registry data used to drive genuine local QI for patients?
- Question 2: How do you view outlier analysis? With confidence or scepticism?
- Question 3: What support is missing in NCAPOP outlier management?
- Question 4: How can we get better at celebrating excellence?

Chair's closing remarks: Professor Danny Keenan, medical director, HQIP

Summaries of guest speaker presentations

Professor Sir Mike Richards

Professor Sir Mike Richards explained the current CQC approaches in using data to support inspections, giving an overview of how CQC carried out inspections and how findings were combined with other information and translated into ratings for hospitals for each core service and for the Hospital overall.

He then moved on to describe the partnership project between CQC and HQIP that is supporting the improved use of national clinical audits to supply data to be used as part of the monitoring framework. He explained how this process was being developed in partnership with the clinical leadership of audits specifically in relation to measures selection and the provision of supporting information. This will enable inspection and monitoring teams to understand and make best use of the data. Sir Mike emphasised that the CQC was primarily interested in ensuring organisations responded appropriately to national clinical audit findings, rather than seeing national clinical audit data itself as a tool to prompt regulatory action.

Professor Sir Bruce Keogh

Professor Sir Bruce Keogh congratulated the audit clinical leadership community for delivering a world beating programme of clinical audit across a wide array of clinical specialities. Sir Bruce described the inception of NHS Choices and its remarkable growth to include the clinical outcomes publication data, but highlighted his desire for significant improvement in how the data was displayed on MyNHS to better reflect that consultants were working in units/teams. Sir Bruce recognised the potential drawbacks of consultant level data publication but confirmed his view that this approach was here to stay. Sir Bruce reflected on the challenges audits were facing in terms of resources and highlighted how this made it even more critical for audits to demonstrate value for money both nationally and to local Trust managers.

Professor Danny Keenan

Professor Keenan opened the event by highlighting that being a clinical leader in an audit can be very challenging and identified that in the preceding year HQIP had had direct experience of working with clinical leaders on very real challenges. He invited attendees to use the day as an opportunity to identify to HQIP and stakeholders how they can be better supported to be successful clinical leaders.

Mr Graham Cooper

Mr Graham Cooper is President of the Cardiothoracic Society and in that role works with the Adult Cardiac Surgery national clinical audit to manage unit and individual level mortality outliers. Mr Cooper explained the data quality limitations related to data timeliness that created challenges for the audit and participating clinicians. Mr Cooper emphasised his desire to support clinicians with outlying performance

Dr Stephen Holmberg

Dr Stephen Holmberg is Medical Director of a Trust identified by a national clinical audit as having an outlying unit and individual. Dr Holmberg described the approach taken by the Trust to be open and transparent about problems and supportive of individuals and teams whilst requiring them to engage positively with improvement processes. Dr Holmberg spoke powerfully about the very real personal trauma that can arise from being identified as an outlier, identifying another challenge for clinical leaders to manage.

Key findings and next steps

Findings drawn from views expressed during guest speaker Q&A sessions and as part of discussions from questions posed by HQIP. Appendix 1 captures detailed notes, but the main challenges described were:

- Providing leadership that encourages interest in national clinical audit data when there are limitations to the data that reduce its face value for some clinicians
- Finding ways to shift the perception of national clinical audit away from just being a tool to identify poor performance to a way to celebrate excellence as well
- Programme management challenges in relation to securing access to NHS Digital[5] data
- Managing the tension between the strong preference among clinicians for publishing audit data at unit/team level instead of consultant level

Participants identified the following key goals to support future positive development of national audits:

- Increase the impact of the audits and their reports
- Increased timeliness of data reporting, making data more valuable for local improvements needs
- Evolve the measures reported on to those considered most meaningful by the clinical community
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- Find more ways to celebrate excellence
- Encourage individuals and units to monitor their data closely to enable identification of results drifting toward negative outlier status. So providing an opportunity to review whether there is scope to improve their clinical practice and avoid reaching negative outlier status
- Provide (and facilitate access to) greater support for individuals and units that find themselves identified as negative outliers
- Consider how individuals such as medical directors can be assisted during challenging episodes where services and individuals they are responsible for are the subject of high profile scrutiny

HQIP actions: HQIP recognises its key role in supporting national clinical audits and their clinical leaders in achieving these goals, either directly, via commissioning, formally/informally in a supportive role, and in engaging with partner organisations. Tackling the challenges and achieving goals will require numerous stakeholders working in partnership with clinical leaders and audits. HQIP will action the following:

- Form a methodological working group to provide support to audit providers in improving data quality and analysis to allow for wider and more timely publication of data
- Continue to seek feedback on future editions of the COP Technical Manual to ensure it is helpful to clinical leaders and audits
- Where possible continue to commission audit measures that are considered more meaningful by the clinical community
- Require HQIP-commissioned audits to report with minimum delay, where possible with real time data access for participants
- Ensure HQIP is always available to provide support and advice to audits and clinical leaders tackling outlier performance challenges
- Write to NHS Digital and NHS England on behalf of the audit community to continue dialogue aimed at improving the flow of data through the system
- Support audits to be able to publish credible positive outliers and encourage positive recognition of this by NHS England and other stakeholders

[5] Health and Social Care Information Centre

Appendix 1: Seminar round table discussion themes

Meeting participants divided into groups, discussed and fed back on key questions in relation to NCA. The discussion content has been used to draw out key themes, but these notes capture more detailed points.

Question 1 Is NCA and registry data used to drive genuine local QI for patients?	1.aWork with patients to set a quality agenda 1.b Audits to engage with local teams – requires a local audit champion 1.c Design audit to deliver QA and QI – QA and QI mean different things to different people 1.d Customer segmentation 1.e Data is all important as is its quality / credibility 1.f Share data in a non judgmental way to drive quality 1.g Data ownership – professional 1.h Collective responsibility of teams to improve 1.i Format reporting – local needs timely and patient level 1.j PDSA – need data to support this rapid cycle change 1.k National level data – board level 1.l Evidence of responsiveness to QI 1.m Customer segmentation is key – different requirements and more targeted reporting 1.n VLAD charts 1.o Augment data with other sources 1.p Improvement in commissioning the audits to support QI from the outset 1.q Limited impact in local commissioning - alignment with best practice tariff 1.r Data representation - drives improvement and sharing outcomes – professionally objective 1.s Rapidity of audit cycle **Summary:** Participants reported a very mixed picture audit data use depending on the audit and setting. In some settings data was reviewed real time, discussed in a meaningful way and used as basis for QI programmes. But, more often than not, the national clinical audit data was not timely enough and not available real time to enable its use for QI locally.
Question 2 How do you view outlier analysis? With confidence or scepticism?	2.a Sceptical – necessary evil 2.b Focus on teams 2.c Clinicians to decide the outcomes to be reported 2.d Take control of the communications around outliers 2.e Sensitivity of analysis and data quality 2.f Early warning system – pre alert system 2.g Focus on the middle ground of the improvement still required 2.h Issues around confidence in results 2.i Who owns the issues, who is responsible, what is the governance structure? 2.j How does the audit support improvement – “and not just a whack on the head”? 2.k Not all indicators are put on the outlier framework 2.l We can risk adjust but data quality is still an issue 2.m If data in is rubbish – output will be rubbish 2.n Communication to the public 2.o Event rates determine how likely you are to be an outlier. Should be a threshold 2.p Confidential inquiry style review can lead to more learning for rare outcomes 2.q Clinical interpretation is critical – not just statistical 2.r Normalising the audit system 2.s People inside the funnel – false reassurance and positive outliers – aspiring to good practice 2.t Accept reporting of positive and negative outliers **Summary:** There were two key outlier challenges: first, data was not timely enough (because of either publication lag or aggregating data for volume reasons over three+ years). This undermined its utility. Secondly, concerns individual outliers were unfair as they did not reflect the often present collective responsibility for outcomes. However, participants recognised its necessity and a desire for more effective data collection to allow for earlier detection of problems.

Question 3 What support is missing in NCAPOP outlier management?	3.a HQIP support on methodological issues on local feedback or quick / rapid monitoring 3.b Outlier management needs stronger clinical engagement between audit and provider 3.c Move away from bureaucratic to interactive processes – high importance on stakeholder relationships 3.d The process has changed, the focus is not only to inform but to also help manage 3.e Peer review essential 3.f Need to change culture of specialist societies 3.g Need peer review earlier than alarm level 3.h More real-time local validation 3.i Local 1st reaction to negative outliers "data is wrong" is very rare 3.j Some units have no support from audit and locally individuals can be left floundering - is this an indication of Trust not being well led? 3.k Do Trust boards use outlier data routinely? 3.l Audits need to do more to engage with Trust boards 3.m International benchmarks are often lacking – but they are valuable where they exist 3.n Focus should be on results first, before looking at whether or not you are an outlier **Summary:** Requests for support centred on tackling the challenges described elsewhere particularly in relation making data collection to publication more timely. Participants also wanted to be clear about their roles and responsibilities and to find ways to ensure Trusts reacted in a positive supportive manner to outlier status.
Question 4 How can we get better at celebrating excellence?	4.a PROMS 4.b Celebrating excellence 4.c Concerns raised about interpretation of media 4.d Speed it up 4.e Its about pulling the average up - whole system improvement Example: 30 day mortality went from 10% to 1% , improvement in the mean 4.f Picking the correct measures 4.g Evidence for process measures is limited 4.h It was always be a system, not just the clinicians 4.i How to we distil success 4.j How does management learn about what makes a successful team / programme? – i.e. sharing with the board / MD 4.k NHS is working their socks off just to deliver, so finding time to learn from each other is difficult 4.l Linking metrics to patient safety **Summary:** The emphasis in this area was on developing measures that provided a better reflection of the nature of clinical care to provide a richer source of data in which positive approaches to care could be identified. There was also acceptance that media and others will always have a greater focus on negative performance. There were also concerns that data quality undermined the ability to be completely confident in identifying positive performance so this needed to be addressed.

Appendix 2: Delegate list

Dr	Paul	Beckett	Consultant chest physician	Royal Derby Hospital
Miss	Rachel	Bell	Consultant vascular surgeon	Vascular Society Audit Committee
Dr	Mohsin	Choudry	National medical director's clinical fellow	Royal College of Physicians
Prof	Noel	Clarke	Consultant urological surgeon	The Christie & Salford Royal Hospitals
	Louise	Cleaver	COP project manager	Healthcare Quality Improvement Partnership
	Nichola	Coates	NBSR administrator	National Bariatric Surgery Register
Prof	Tim	Coats	Professor of emergency medicine	University of Leicester
Mr	Graham	Cooper	President	Society for Cardiothoracic Surgery
	Simone	Cort	Administrator clinical services	British Society of Gastroenterology
Prof	Mike	Crawford	Director, College Centre for Quality Improvement	Royal College of Psychiatrists
Dr	David	Cromwell	Director, CEU	Royal College of Surgeons of England
	Rosie	Dickinson	Project manager, NLCA	Royal College of Physicians
	Emma	Doyle	Head of data policy	NHS England
	Richard	Driscoll	Chair of trustees	Healthcare Quality Improvement Partnership
Prof	Jonathan	Duckett	Consultant urogynaecologist	British Society of Urogynaecology
Dr	Colin	Dunkley	Consultant paediatrician, Epilepsy12	Sherwood Forest Hospitals
Dr	Rodney	Franklin	Clinical lead NCHD audit	National Institute for Cardiovascular Outcomes Research
	Tom	Furber	Data policy manager	NHS England
Prof	Mike	Grocot	Project team chair, NELA	NIAA Health Services Research Centre, Royal College of Anaesthetists
Dr	Tina	Harris	Senior clinical lead, NMPA	Royal College of Obstetricians & Gynaecologists
Dr	Jane	Hawdon	CAG director women's & children's health	Barts Health NHS Trust
	Louisa	Hermans	Programme manager	British Association of Urological Surgeons
Dr	Sasha	Hewitt	Associate director	Healthcare Quality Improvement Partnership
Dr	Stephen	Holmberg	Medical director	Brighton & Sussex University Hospitals NHS Trust
	Keira	Huber	Communications officer	Healthcare Quality Improvement Partnership
Prof	Iain	Hutchison	Professor OMFS	University College London Hospitals
	Jane	Ingham	CEO	Healthcare Quality Improvement Partnership
Dr	Martin	James	Associate director, SSNAP	Royal College of Physicians
Prof	Danny	Keenan	Medical director	Healthcare Quality Improvement Partnership
Prof	Bruce	Keogh	National medical director	NHS England
Mr	Richard	Kerr	Consultant neurosurgeon	Oxford University hospital foundation trust
	Mike	Kimmons	Chief executive	British Orthopaedic Association
	Hannah	Knight	NMPA audit lead	Royal College of Obstetricians & Gynaecologists
Mr	Mark	Lansdown	Consultant surgeon & President BAETS	Leeds Teaching Hospitals
Dr	Jo	Ledingham	National audit clinical director	British Society for Rheumatology

Dr	Nick	Lewis-Barned	Consultant physician, Clinical lead NPID audit	Northumbria Healthcare
	James	Ludley	Senior communications officer	National Joint Registry
Dr	Sheila	Marriott	Regional director	Royal College of Nursing
Prof	Finbarr	Martin	Clinical lead, FFAP	Kings College London
Mr	Nick	Maynard	Consultant surgeon	Oxford University Hospitals Trust
Prof	Theresa	McDonagh	Professor of heart failure & Consultant cardiologist	Kings College London
	David	McKinlay	Programme manager	Healthcare Quality Improvement Partnership
	Viktoria	McMillan	Programme manager, COPD audit	Royal College of Physicians
Dr	Ramani	Moonesinghe	Director, NIAA Health Services Research Centre	Royal College of Anaesthetists
Prof	Christopher	Moran	National clinical director for trauma	NHS England
Dr	Kieran	Mullan	Clinical lead, COP	Healthcare Quality Improvement Partnership
Dr	Francis	Murgatroyd	Consultant cardiologist	King's College Hospital, London
Mr	Richard	Page	Consultant thoracic surgeon	Liverpool Heart & Chest Hospital
Dr	Roger	Parslow	Senior lecturer in epidemiology, PICANet	University of Leeds
Dr	Dharmintra	Pasupathy	Senior lecturer & Consultant in obstetrics	Guy's & St Thomas' NHS Trust & King's College London
Mr	Martyn	Porter	Medical director	National Joint Registry
Prof	Tom	Quinn	Professor	MINAP Steering Group
Prof	Anne Marie	Rafferty	Professor of nursing policy	King's College London
Prof	Mike	Richards	Chief inspector of hospitals	Care Quality Commission
Prof	Tony	Rudd	SSNAP clinical lead	Royal College of Physicians & NHS England
	Jon	Shelton	Analytics manager (acute)	Care Quality Commission
Dr	Yvonne	Silove	Associate director, NCAPOP	Healthcare Quality Improvement Partnership
	Mirek	Skrypak	Associate director, NCAPOP	Healthcare Quality Improvement Partnership
Mr	Peter	Small	Consultant surgeon	City Hospitals Sunderland NHS FT
Mr	Shaw	Somers	Consultant Surgeon	British Obesity & Metabolic Surgery Society
Prof	John	Sparrow	Clinical lead for NOD audit	University Hospitals Bristol NHS Foundation Trust
	Jill	Stoddart	Director	Healthcare Quality Improvement Partnership
	Tina	Strack	Associate director, NCAPOP	Healthcare Quality Improvement Partnership
	James	Thornton	Communications lead	Healthcare Quality Improvement Partnership
Dr	Sundeep	Thusu	Clinical fellow	Care Quality Commission
Miss	Abigail	Vallance	Clinical research fellow	National Bowel Cancer Audit
Mr	Rob	Wakeman	Orthopaedic clinical lead	National hip fracture database
Dr	Peter	Walton	Managing director	Dendrite Clinical Systems Ltd
Mr	Doug	West	SCTS thoracic surgery audit lead	University Hospitals Bristol
Dr	Kirsten	Windfuhr	Associate director	Healthcare Quality Improvement Partnership
Mrs	Maralyn	Woodford	Executive director	The Trauma Audit & Research Network
Dr	Andrew	Wragg	Cardiologist	Barts Health NHS Trust
	Sarvjit	Wunsch	NBSR administrator	National Bariatric Surgery Register