CLINICAL AUDIT & QUALITY IMPROVEMENT
DANCING PARTNERS OR STRICTLY RIVALS?

HQIP Healthcare Quality Improvement Partnership

CLINICAL AUDIT AWARENESS WEEK 2023

19-23 June 2023

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Inspired by a masterclass by
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A recording of the session will be available at www.hqip.org.uk

Why even pose this question?

Like any call to action, this session arose from my personal views / observations that:

We have different 'tribes' within NHS improvement circles

- Both Clinical Audit and QI approaches have their strengths and limitations
- By working in silos, teams miss the chance to combine and integrate the best aspects of different methodologies, leveraging their complementary strengths
- Locally this might mean:
  - Uncoordinated projects
  - Barriers to effective communication and collaboration among different teams or departments, limiting the potential for collective learning and improvement
  - Inefficient working, confusing messages & increased cognitive load from 'multiple priorities'
  - Unnecessary confusion, misunderstandings, and difficulties in measuring and comparing improvement outcomes.

We determine too early which improvement approach to take

- Are MDTs for improvement being used? to understand a problem before deciding on an approach?

A lack of fidelity to quality improvement methods

- In our attempts to engage widely, we've moved away from respect for complexity and rigour of methods
- Research shows the use of insufficiently systematic approaches to understanding problems and their causes, and incorrectly attributing cause and effect

A frequent conflation of the term "Quality Improvement" with a broad range of activities that seek to improve quality, possibly due to:

- The continual 'repackaging' of improvement methods
- Undue 'adaptation' at local level, undermining the rigorous and faithful application of improvement methods. (Not just framing or presenting methods in a way that better suits the culture and organisation).
- A lack of understanding / improvement capability

"Improvement work draws on the epistemology of a variety of fields, and depending on one's field of study, the same words can carry different connotations, a particularly undesirable state of affairs".
SQUIRE Guidelines 2022

Are we talking the same language?

Systems of work in the NHS are massively complex and standardisation is low

- Standardisation of processes is seen as a political potato around autonomy rather than a spectrum or choice
- Standardisation has the power to drastically improve quality through:
  - reducing clinical and operational variation
  - increasing efficiency through interoperability
  - reducing the reinvention of 'solutions' in multiple ways e.g. discharge planning.

ORIGINS

Quality Planning

Ongoing process of:

- Understanding the needs of, and what matters to, those we serve;
  - across all dimensions of quality
  - jointly with ICS partners (population focus)
- Evidence, and learning-informed decision-making
- Triangulating of data and evidence across pathways and services to identify gaps
- Setting of focused priorities to maximise impact
- Establishing systems & processes

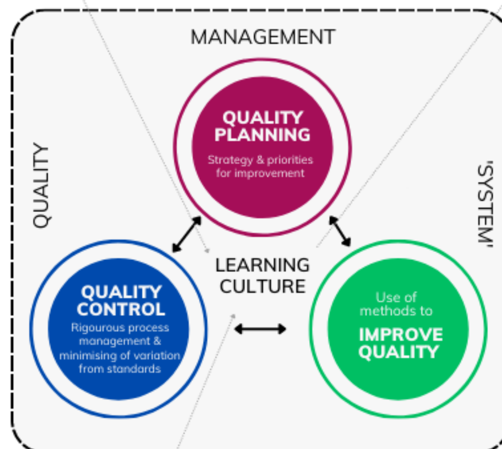
Quality Control

Methods to reduce risk, stabilise & secure the foundations for further improvement through:

- Clear standards & expected outcomes
- Use of high reliability principles for daily process management
- Process standardisation & documentation e.g. ISO9001 supported by policies
- Monitoring & detection of variation / non-compliance against regulation, guidance, accreditations

Particularly suited to:
- High risk processes, to prevent harm
- Evidenced 'best-practice' for improved outcomes
- Daily processes done by many hands

Appetite for learning & sharing knowledge e.g. National Clinical Audits, Evidence-based practice, Research, Good practices from elsewhere



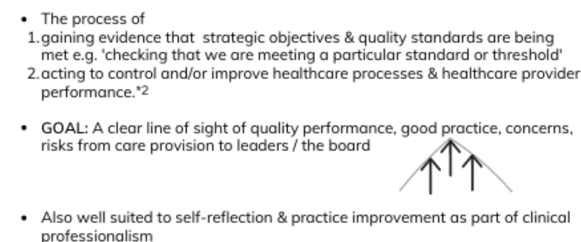
A FOCUS ON QUALITY IN THE 'DNA' OF THE ORGANISATION

How would we 'know' we have it at provider level?

- Superior outcomes for our patients & communities
- An organisation-wide approach to improvement-designed to local needs
  - The act of improving quality is embedded in daily habits & routines for all, building commitment
  - Data is routinely triangulated & fed back for learning
  - Improvement activity occurs at all levels and areas
- Collective & Compassionate Leadership Culture:
  - Constancy of purpose to shared vision & values and a shared single view of 'Quality'
  - High relational connectedness for learning & sharing
  - Distributed Clinical leadership & inter-professional collaboration
  - Priorities focus efforts on 'what matters most', these are aligned at all levels
  - Leaders model, frame, empower & coach - not order, solve or instruct
- "Strategic ambidexterity": "the ability to balance short-, medium and long-term strategic and operational priorities" *1

Quality Assurance (NHS Governance)

- The process of
  1. gaining evidence that strategic objectives & quality standards are being met e.g. 'checking that we are meeting a particular standard or threshold'
  2. acting to control and/or improve healthcare processes & healthcare provider performance.*2
- GOAL: A clear line of sight of quality performance, good practice, concerns, risks from care provision to leaders / the board



- Also well suited to self-reflection & practice improvement as part of clinical professionalism

Common Assurance tools: Clinical Audit, accreditation & inspection *2

Quality Improvement Approaches

Particularly suited to:
- Complex challenges
- Creative solutions

Continuous QI methodologies vary, however typically agreed principles include:

- The systematic use of:
  - "methods and tools to continuously improve quality of care and outcomes for patients" *3
  - 'data guided activities' e.g. clear aims, a basket of measures, trends over time, quantitative and qualitative measures, pragmatism *4
- Consideration of the whole 'system', interconnected processes, social dynamics & readiness to change. Solution design to fit the special characteristics of the targeted local environment(s).
- Methodology to solution design / refinement by iterative methodology *4
- Ownership / leadership by those who do the work.

Other approaches / terms we use in the NHS include:

- **'Service Transformation':** More radical approaches to change usually at service / organisational level, but done at system/ national level as needed to improve the health of the local population. The focus is often operational performance issues such as flow, efficiency, which done robustly incorporates a range of process methods such as Lean, Six Sigma.
- **Service review / evaluation:** Review of the effectiveness and/or efficiency of a service
- **Service introduction or redesign**: The creation or renovation, of new services, innovations, technologies and/ or practices with service 'design' process starting afresh
- **Reactive problem-solving**: Taking action to 'fix' a process, without the use of an improvement 'method'

NB: The above may/ may not include the QI principles below, a sufficiently systematic approach and/or fidelity to a method such as Lean Six Sigma which 'builds-in' reliability.

Please note: This diagram is not intended to be a faithful representation of the Juran Trilogy (see www.juran.com). In the NHS "Quality Improvement" is a term that is often misused, referring to efforts to improve are not in line with the principles of a systematic QI approach. By using the term QI to refer ONLY to work in line with the suggested principles, fidelity to systematic methods may be encouraged.

METHODS

The Quality Improvement 'dance' involves:

- A balance between structure, adaptability and improvisation

For example, each QI method has key steps (e.g. Define, Measure, Analyse, Improve, Control) however:

- New information may emerge which requires going back to earlier steps
- A project may use / combine multiple methodologies in one project
- There are choices about which tools are used during a project, the pace, depth of analysis etc

- A journey of discovery toward sustainable solutions
  - Scoping and investigation of the problem, no assumptions
  - No 'solutions' are predetermined, but emerge from insight and learning
  - A continuous process of learning what works best
  - Data used for learning, not judgment / criticism
- Patient Centredness
  - A commitment to focusing on outcomes for, listening to and involving patients
- Equal Partnership
  - Working collectively not hierarchically, showing respect for people, not 'doing to'
- A coordinated effort, and leadership for change
  - Each team must be aware of the movements and actions of other teams in order to be effective (nothing is viewed in isolation)
  - Recognition of the 'human factors' to change to maximise the likelihood of sustaining and scaling change. e.g. minimally disruptive interventions

One of many QI methodologies: Not suitable for every project

Model for Improvement

One of many QI methods:

Developed by Associates in Process Improvement *5

Key principles of this method:

- Pragmatic variant of the scientific method : Understand the problem, Make a hypothesis (also called a theory of change), then test the hypothesis by putting a solution temporarily in place.
- Rapid cycles: Smaller more frequent samples to enable cycles faster than traditional audit

PLAN

- Problem definition & review - Go see, map the process(es), consider the causes
- Set SMART AIMS for the project (How good, by when)
- Identify a change idea a& make a hypothesis
- Plan the test itself

DO

- Run the test, collecting data continuously
- Start small (can be one patient, one day)

STUDY

- Review data / learning from the 'test'

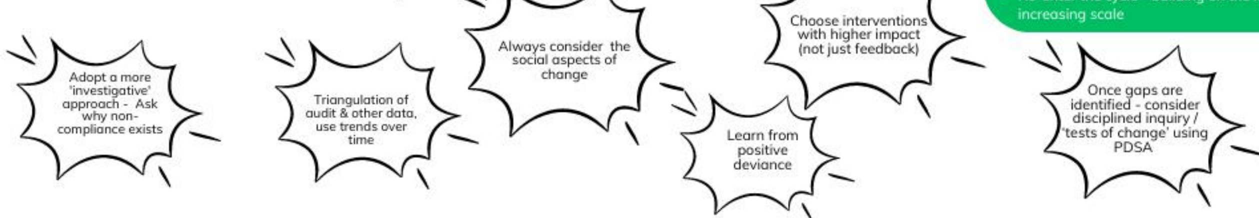
ACT

- Decide whether to adapt, adopt, abandon the idea

ADAPT, ADOPT OR ABANDON

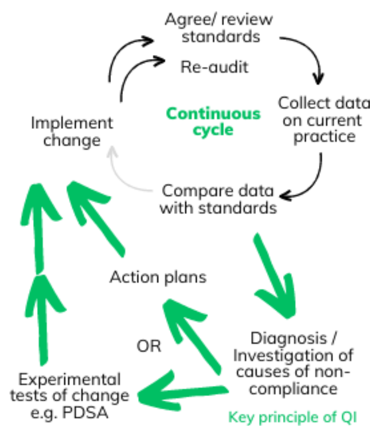
- Re-enter the cycle - building on the learning, increasing scale

What Clinical Audit teams can learn from QI



Historically produced for 'assurance'

Clinical Audit



Key principles of this method:

- A systematic review of care against explicit criteria against an accepted standard
- Standards are evidence-based and/or agreed best-practice
- Audit results as a prompt to implement change
  - Impact locally on clinicians therefore all data to be fully quality assured
-
  - Engagement of clinical teams in 'owning the results'
- Re-audits measure improvement / sustainability once the interventions have been implemented

Evidence-based view of 'ideal care' | G A P | Actual care

Clinical Audit as a QI Tool

- Already used as a QI tool in many areas of healthcare.
- CA can provide:
  - a robust measurement tool for assessing compliance and identifying gaps
  - red flags alerting poor performance
  - rigour that gains the credibility of clinicians

What is different from traditional clinical audit?

- An investigation of the nature and causes of the problem
- A relentless pursuit of perfection: Not accepting a high % of standard met, but continuous improvement
- Action planning is already part of Clinical Audit
  - Action plans utilise 'stronger' interventions i.e. considering the 'system' that drives behaviour / performance, not jus relying on feedback
  - Action plans can be more robust when combined with QI tools

NB: This does not necessarily mean PDSA, but an approach to improvement that takes into account the QI principles on page 1.

What QI practitioners can learn from the 'rigour' of Clinical Audit

The Clinical Audit 'dance'

- A series of steps that are repeated in a coordinated and deliberate way, in a specific order.
- The structure and rhythm of the method is always followed
- Focuses on maintaining stability / compliance - Setting clear standards /
- Makes good use of evidence-based practice
- Clinical Audit plans are typically integrated and aligned with the overarching strategic priorities of the organisation or system

Maintain fidelity in the application of Improvement Methods.

Make good use of existing knowledge / evidence of 'what works'

Use Clinical Audit for robust baseline data collection tool and as part of Quality Control post-improvement

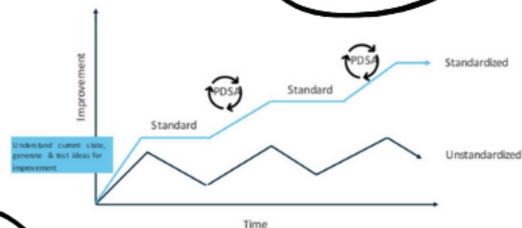


Image adapted from Lean Enterprise Institute: www.lean.org

Embrace standardisation as a shared understanding of the best known way to get to the best possible outcome, then PDSA

A strategic plan of improvement priorities should guide project choice
As opposed to 1000s of small unaligned projects

Recognise that learning and accountability are not mutually exclusive in a QMS

MOVING FORWARD

Why 'dance together'?

- 'Dance'? Both Clinical Audit & QI are evidence-based and share some similar principles, they are not interchangeable but they can be complementary partners.

- Each approach has strengths and weaknesses, suited to solving different types of problems, practitioners bring complementary skills and assets.

- No single approach is a silver bullet, often a combination is needed. There are additional benefits in undertaking QI with other change approaches, either
  - concurrently (using audit to inform iterative tests of change) or
  - consecutively (using QI to adapt published research to local context) *6

- Silos do not help ease the challenge of a 'pressured system' - QI and CA involve the same clinical teams, and the same patients.

What can Clinical Audit and QI professionals do?

- Recognise the value of the different methodologies:
  - Build relationships between CA & QI teams, convene around shared priorities
  - Build upon this by developing a unifying / connecting structure, strategy & overarching approach
  - Be adaptable - Harness the 'systems' mindset AND the structured, disciplined approach of measuring clinical practice against standards

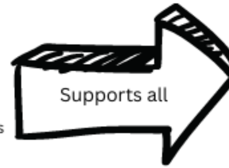
- When leading improvement:
  - Consider the right methodology / combination
  - Tailor the approach:" the scope and scale of change, the amount of preparation prior to use, rigour of the evaluation, time, expertise, management support and funding must be carefully aligned" *7
  - Plan for sustainability & scale / replicability at the start, identifying common principles: Standardise key principles, then customise at implementation to local context *8

The Future of Clinical Audit as part of a Quality Management System

As the healthcare landscape continues to evolve, ensuring high-quality care delivery remains a top priority.

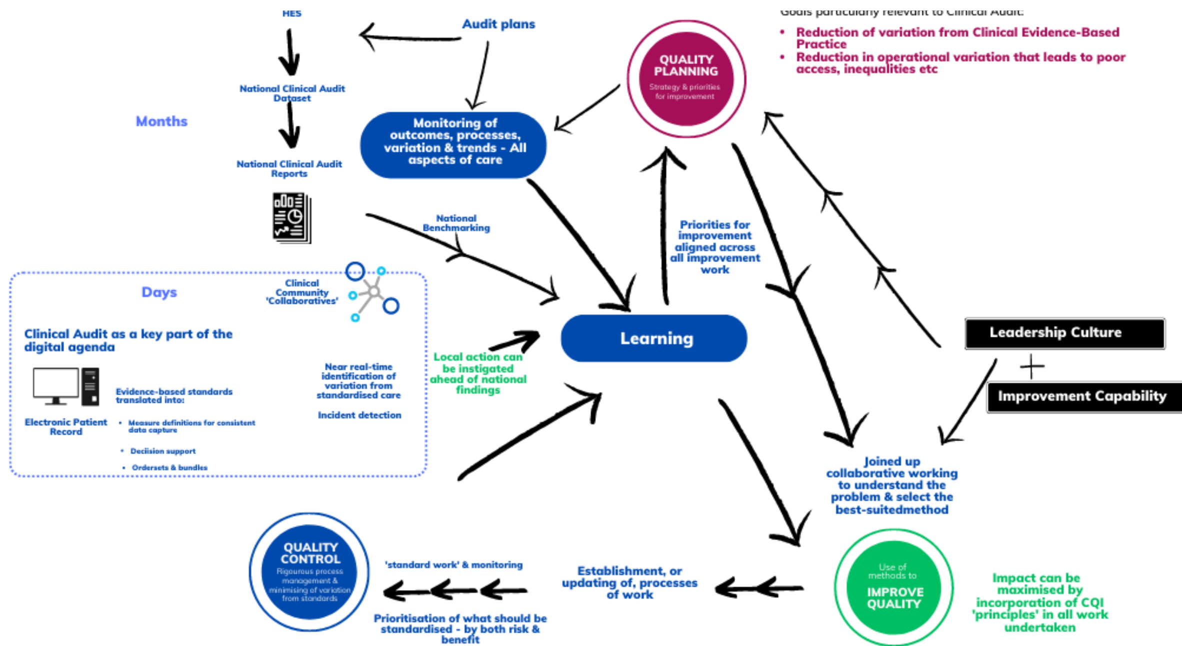
Clinical audit, a systematic review of care against specific criteria, has long played a vital role in quality management systems, but likely to become even more central to improving quality because of:

- Growing integration with Continuous Quality Improvement methods
  - Clinical audit is no longer a standalone activity but an integral part of a broader continuous quality improvement framework.
  - The future of clinical audit lies in its seamless integration with quality improvement initiatives such as Plan-Do-Study-Act (PDSA) cycles and Lean methodologies.
- Progress towards more timely (even real-time) data, and greater potentials for triangulation with other data (incl. GIRFT)
- Increasing focus on Outcome measure, including PREMs, PROMs and quality of life measures as patient-centered measurement of 'Quality'
- Increased opportunity to use clinical audit data at ICS level in addition that at national level
  - Collaboration and learning from variation
  - Shared learning and best practice dissemination across healthcare systems



Key success facors in the NHSE IMPACT framework

1. A shared commitment to quality
2. Population-focused
3. Co-production with people using services, the public and staff
4. Clear and transparent decision-making
5. Timely and transparent information sharing
6. Subsidiarity



Recommended reads: Clinical Audit

- Clinical audit: a simple guide for NHS boards and partners. Healthcare Quality Improvement Partnership. 2010
- Healthcare Quality Improvement Partnership. Guide to Involving Junior Doctors in Clinical Audit and Quality Improvement. London: HQIP; 2016.
- Solberg LI, Mosser G, McDonald S. The three faces of performance measurement: improvement, accountability, and research. Jt Comm J Qual Improv 1997

Recommended reads: Quality Improvement

- HQIP Quality Improvement Magasine www.hqip.org.uk
- FREE E-Learning: An introduction to QI www.hqip.org.uk
- Fereday S. A Guide to Quality Improvement Methods. London: Healthcare Quality Improvement Partnership; 2015 www.hqip.org.uk
- Quality Improvement in Healthcare - YouTube
- Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., Provost, L. P., 2009. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance
- BMJ April 2022 A special supplement in partnership with The Health Foundation

References

- *1 Five principles for implementing the NHS Impact approach to improvement in England | The Health Foundation
- *2 Reed, Julie E. et al. "The foundations of quality improvement science." Future Hospital Journal 3 (2016): 199 - 202.
- *3 Making the case for Quality Improvement, King's Fund. www.kingsfund.org.uk/publications/making-case-quality-improvement
- *4 Rubenstein L, Khodyakov D, Hempel S, et al. How can we recognize continuous quality improvement? Int J Qual Health Care. 2014;26(1):6–15
- *5 Model for Improvement. Associates in Process Improvement. www.apiweb.org
- *6 Backhouse A, Ogunlayi F. Quality improvement into practice BMJ 2020; 368
- *7 Reed JE, Card AJ. The problem with Plan-Do-Study-Act cycles. BMJ Qual Saf 2016;25:147-52. 10.1136/bmjqs-2015-005076 26700542
- *8 Dixon-Woods M, Martin GP. Does quality improvement improve quality? Future Hosp J 2016;3:191-4. doi:10.7861/futurehosp.3-3-191

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