Turning Strategy into Reality – Q&A's

Mon 22 June, morning webinar

Question	Answer
Love Sally's provocation - thank you. My Q to Sally is - Recognising clinical audit programmes have been in place for many years and evolving pressures within health and care. How do you feel an acute or community provider can shift to more effectively utilise outcome data and clinical audit to enable patient centred approaches?	There are many ways but I will make 2 key suggestions here: firstly, to capture outcome data as an evolution of QoF so that we can be assured that we are managing eg. chronic disease really well. This can then be triangulated with outcome data that might traditionally be associated with secondary care , to ensure whole pathway value. Secondly, community providers (working with acute) can triangulate outcome data to model the 'cost of not doing' a community intervention to the wider system (as we saw with the ambulance/palliative care example). Both of these approaches are really key to achieving left shift, because they begin to outline in detail the resource allocation needed earlier in a patient pathway instead of investing in layered services of hand offs, admission avoidance and signposting, for example.
Thank you Sally, I am the Head of clinical Effectiveness , at Yorkshire ambulance service, and are looking to doing we we used to call interface audits in the past following the full pathway of patient journey, ie we one of our audits relatate to COPD patient. However, your comments about the transpansancy of Data is key, and often data sharing agreements can really hold up interface audits. the Data-protection act verbalised the value of this in Research, but clinical audit seem to be overlooked in the act. i believe there is value in a national data-sharing agreement for	Absolutely agree with this. At the very least a framework of IG guidance is needed for this type of use case, something I pushed hard for in my old role in Wales (with some success)

these types of clinical audits , for consistently and time audits, i would be interesting in your opinion	
Do you have a view on PREMs vs PROMs? Do you think PREMS are equally useful?	Yes, PREMs are useful. They just have a different purpose. We need to understand both outcomes and experiences.
Great presentation. costing is something clinicians hardly understand or get involved mostly. with communication gaps with finance, managers and clinicians, how to reduce this divide? any tips	Thank you 😊. Yes, I have done a great deal of work on this aspect. Moving towards value-based approaches takes a great deal of work on culture , education and engagement. In particular, building bridges and collaborations between clinicians, managers, accountants and informaticians. It takes a village!!
Thank you. We are currently reviewing all our PEOLC with a birds eye view. I am keen to change our focus on process metrics to patient outcome metrics (as ICB clinical lead). Do you have any advice on this? I am interested in factoring in social value too but not much evidence on this.	Have you seen the IPOS palliative care PROM? Other approaches might include symptom burden and preferred place of care (I am sure you have considered these). V helpful to triangulate as with the ambulance case in the presentation as this can provide justification for investment. Social value can be captured but in my experience tends to require some specialist health economist input. There is also a FROM (family reported outcome) tool and a carer burden tool (Zarit).
ref., private-public partnerships in the NHS and related contractual/ commercial agreements - how do you see data transparency and access ?	There is no doubt in my mind that this is necessary but it is still problematic isn't it?! Exactly how this is done depends on the specific details of the case: sometimes it is helpful to have an independent third party as the broker of the data. Companies like Digipharm do this. I think the new procurement guidance from NHSE also has a key role to play.
We have more data than ever? Do you see AI as an opportunity or a threat to triangulation of the data?	I worry about the effect of incomplete data on AI algorithms and, whilst there is huge potential in many ways, there is a lot of simple stuff we can do by making clinical audit data more visible.

	That should have the effect of improving data quality as well, which will help the AI.
What is your sense of the level of underreporting from trusts when it comes to audits, and how does this influence interpretation of the data?	I am amazed that we do not pay much greater attention to this as a system. Imagine is the finance depts submitted incomplete returns!! It just wouldn't happen....greater visibility should improve this situation.
Radically, would you see any prospect of change to GP status as being not simply 'contractors' but 100% NHS employees? And further, would you see this as being a way to change service delivery and practice?	Ooh, controversial. However, as someone who held a contract and was a firm believer in the independent contractor status, times change. If we want to achieve fully integrated care and transform the way we deliver care uniformly and avoid fragmentation, then I now believe it is inevitable we will need to move this model. Singapore's move to 'teams within teams' in their new polyclinics is a good example of how it can be done well and still maintain continuity of care.
Reflecting on Sally's talk about clinical audit as an enabler of value-based healthcare and clinical audit to influence to policy and strategy, it is clear that national audit including the FFFAP programme are key to improving outcomes and experience my Q is: Do you feel that a value based patient centred approach could further strengthen the RCPs programme? Is there an opportunity to re-frame the work in a value based approach whilst still realising the programme. Would be interesting to explore from a sustainability perspective as well as impact.	Value based approach like that being done in Wales is definitely possible.

Given that women are disproportionately affected by osteoporosis and fragility fractures, was menopausal status or history of HRT use collected as part of the audit data?	While we collect data on medications used to manage the condition there is no specific reference to HRT. This data is captured as 'other medications'. We do not collect data on menopausal/perimenopausal status.
What is your sense of the level of underreporting from trusts when it comes to audits, and how does this influence interpretation of the data?	Under-reporting and low case ascertainment are an issue more in the FLS and NAIF audits. Hip fractures seems to be consistently reported to its full. The gap in case ascertainment is a significant issue. It has improved over the years. As you can imagine, this is less than ideal. Interpretation of data is done taking this into consideration.
more of a comment than a question. we have utilised the NHFD data and (are consistently a high performer in many areas) - it's now being used to map services across our group. We do have difficulty getting clinician buy in both medical and nursing to ensure we collect all the data due to clinical pressures - especially with the FLSDB - I think this is really helpful to share with the clinicians to demonstrate the importance of collecting accurate and full data as much as possible	Clinician engagement varies due to multiple factors- including a perception that audit work is above and beyond routine clinical work! Everyone working in this field should take ownership of reporting to the audit.
picking up on a question from my colleague Garry Tan below - bringing national audit datasets together could be the next big step in this world. for example linking diabetes data to Fractures data that has just been discussed would be powerful. would ACAR be interested in supporting this kind of linkage (and making it easier in terms of practically linking the data, creating analytical resourceand gleaning insights)?	If there's demand from the community, we could look at running a roundtable to scope the opportunity

Brilliant news about ACAR. Will there be a minimum competencies or entry requirements for clinical audit professional membership?	We'd be happy to explore this with the community where they see benefit in demonstrating professional competencies.
How will ACARQI and NCA-ACE be supporting one another and how will they differ?	The purpose of NCA-ACE is to strengthen and support the delivery of local clinical audit and clinical effectiveness activity within NHS trusts including participation in national audits and quality accounts. NCA-ACE is aimed primarily at clinical audit and clinical effectiveness staff working within NHS trusts and health boards, audit leads within provider organisations, and staff responsible for the governance, delivery or local implementation of national audits. ACAR-QI's purpose is to strengthen the clinical audit and registry community by supporting collaboration, shared standards, professional development and the use of audit and registry intelligence for quality improvement, assurance and patient benefit. Whilst we are still developing ACAR-QI's terms-of-reference, it will have a broader membership.
great initiative. not a question but suggestion - don't focus on sharing positive outcomes in ACAR-QI platform. failed projects are also v important to learn from.	We'd be interested in developing cases studies to support sharing and learning across the community.
Can HQIP confirm ACAR-QI will be a not for profit initiative, i.e. all member fees will be re-invested into the community the association is set up to support?	ACAR-QI is hosted by HQIP, a not-for-profit and registered charity.