National Quality Improvement & Clinical Audit Networks (NQICAN) response to the Academy of Medical Royal Colleges "Quality Improvement - training for better outcomes" (link to full document)

Following publication of the above document and presentation by medical lead Dr Emma Vaux at our NQICAN meeting in June 2016 – we (NQICAN) were asked to review the document to see how the clinical audit professionals can help with taking forward the recommendations. We were given 4 questions in particular to focus our feedback. The document and the 4 questions were circulated around the networks and feedback sent to NQICAN chair Carl Walker. The responses were summarised by Carl adding in relevant NQICAN discussion & feedback received from Clinical Audit Support Centre, and reviewed with a sub-group of 4 regional chairs. The follow response was sent to Dr Vaux on 6th January 2017. Dr Vaux responded on the 17th January and gave us permission to publish her response - which for ease of reference has been added to the end to the document.

General Clinical Audit Network / chair feedback on the document

General feedback was that this was a rather damning document regarding clinical audit. There is confusion mentioned with regards to 'clinical audit' and 'quality improvement', but this document seems to forget that clinical audit is very much part of quality improvement and provides clear standards to compare practice. There is a suggestion that "audit does not go past the first step of data collection" - closing the loop of the audit and seeing any changes made through to the end is more about how the project is managed, there may be financial implications to making a change, but this would be the same for any project. Every idea for a project should be reviewed and the appropriate methodology chosen to best suit what is required, whether this be clinical audit, PDSA or whatever.

The document has an openly negative stance towards CA that appears to be un-evidenced. For example, the use of the word 'OR' in the title immediately puts CA and QI into conflict with one another which is unhelpful and unnecessary given CA is a QI methodology.

References to audit are usually negative e.g. 'static' whereas QI is talked up e.g. 'dynamic'. The single twitter quote is anti-audit. The bizarre analogy to painting a wall is anti-audit and utterly meaningless in my opinion. How can the author credibly equate healthcare improvement with decorating?

Then there are positive CA statements that members wholly agreed with in the document:

- p18 'Audit cycle is effectively completed by using improvement methodologies'
- p20 Use QI methods at the change part of the clinical audit cycle - yes we should be doing this now
- p39 'Audit departments should be ready and willing to support QI training and activity" - I feel we should be moving to this
- p50 'baseline audit becomes the starting point for continuous innovation and improvement

There are plenty of published studies that assess the impact of CA and QI but none are referenced. This feels more like a 'comment piece' rather than a national report. The entire document lacks references to credible evidence. It is unclear who authored it and whether the long list of names at the bottom have actually read it or agreed with it

Diagrams on page 18 used to promote the value of QI are not referenced and meaningless.

Various bullets on the second-half of page 17 describe CA as a data collection process that only reaches one cycle which is therefore easy to do and why trainees opt for this approach. However, it needs to be pointed out that Trusts monitor CA closely and usually have registration processes in place - which is not always the case currently for QI. CA projects are likely to be scrutinized by committee much more than QI projects and this is in fact why many trainees are now opting to undertake weak QI projects.

The document makes no mention of NCAs which is strange given the negativity towards local CA. NCAs which are well funded and within the remit of the Colleges take far too much clinical time to undertake. Usually longer to report than local audits on average and there are many and continued issues with NCAs which are fed back from local departments would not pass the quality checks that we insist upon for local audit.

Local audit, by comparison is chronically underfunded, there is no national training scheme and many departments have too few staff and are overrun by national audits.

A couple of points raised appeared to highlight a lack of awareness for example “A repository of quality improvement activity should be established to empower learning and sharing” – what about the NICE upload database, BMJ QI Journal, HQIP case studies, CASC junior doctor awards? Couldn’t these just be adapted?

“A stakeholder group should be established under the auspices of a national body such as the Academy of Medical Royal Colleges to align planning in quality improvement activity by key stakeholders and topic experts for the long-term, that is applicable to everybody, and to contribute to improving patient outcomes through education, training, research and collaboration” - Isn’t this the role NAGCAE / HQIP? plus NICE already does a great deal of this work with regards to setting the standards and highlights the topics when they issue new guidance – I think perhaps here it is only the tools that are needed, not another body?. I’d be interested to know the scope of the body if NICE does the ground work already? Are they thinking more strategically, i.e. based upon suggestions by Public Health England or CQC?

I agree that audits undertaken by junior doctors sometimes (rather than often as stated on p12) fail to change practice. This depends on so many other factors, not just the fact that the methodology being used is 'clinical audit'. It depends on culture, Consultant input, handover to next lot of junior doctors, how good the audit facilitation by the Audit team is, etc. I have seen no research evidence to show that using QI methodology in the form of PDSA for example will 'always' change practice. I think this too will depend on these other factors.

I have some issue with the language in the document in terms of clinical audit. In a number of places it talked about moving from audit to QI. For example on p14 talking about "moving from audit (data collection) to using data to drive improvement" and again on p58. I think years ago when audit was first started it concentrated on data collection without resulting in improvement and it still may be in some places and at some times, but I don't think this is generally true now. I think we often see changes made - it’s the sustainability of them that is our main challenge and I think this is true for QI methodologies too from my experience.

Continuing with the language, I feel it would have been useful in this document to describe clinical audit as a QI methodology in that this is implicit in the audit cycle. I don't think it is helpful to talk about quality improvement (for instance as used on p20) as though this is the process itself and can only mean using for instance the PDSA cycle and not clinical audit. It should talk about QI methodologies leading to quality improvement. In the same way, Figure 3 on p21 talks about 'moving from audit to QI' - this is always something I have had trouble with from the RCP's Learning to make a difference programme.

I think there was a useful quote in the document from an FY2 trainee that many on-going clinical audits are 'quality improvement' but that the trainees see only one cycle because they are there for a short period of time. I have lots of examples of these in my trust, e.g. DNAR, NEWS, WHO etc.

A few other points to make:

- If QI methodologies such as Model for Improvement are to work well for improving care for patients, which is what it’s all about, then we need to see evidence that it does this better than clinical audit and doesn't fall foul of the same problems, e.g. lack of sustainability because junior doctors move on so quickly, lack of consultant engagement (See paper by Mary Dixon Woods et al – Does Quality Improvement improve quality?)

- The system of junior doctors moving on/finding their next jobs and the pressure they feel under to take part in numerous pieces of improvement work to put on their CVs needs to be addressed. Quantity rather than quality seems to be sought. The participation in QI/audit work sometimes seems to me to be much more about the CV than improving patient care - and I can understand this to some extent because it’s competitive. This does not help sustainable improvement and could fall into the trap of making involvement in QI activity also a tick box exercise.

- HQIP needs to consider how the National Clinical Audit & Patient Outcomes Programme (NCAPOP) can be badged within a QI framework

Responses to Dr Vaux's questions proposed at NQICAN meeting:

1) **What do you think Quality Improvement (QI) support should look like at organisational Level?**

In order to support QI at the organisational level you need to have the following:

- Strong Leadership in the QI (board level). The message re QI has to be unequivocal
- Enough expertise in house to support QI. Clinical Audit (CA) is a QI process so it could be managed by the CA team in collaboration with others.
- Stop QI vs CA culture - promote systematic approach to improvement - educating staff so that they can choose best method for project
- Strong organisational culture supporting QI activities (starting at Board - also senior consultants, other departments, QI\CA workshops, QI\CA awards for the best project etc.)
- Joined up thinking / Good Governance

There is anecdotal evidence within our network that in a number of Trusts QI is being developed separately from Clinical Audit – which leads to a risk of lack of joined up thinking on how to improve care. Clinical Audit staff already have many if not all of the skills needed to develop QI – Boards should consider developing the staff already in place to deliver these projects (i.e. the QI team, where appropriate). This could be ideal. If not then a QI programme (including Clinical Audit programmes) should be developed to ensure they complement each other.

It is also important for trusts to be in a position to evidence that activity in QI is effective and in particular that improvements are being implemented to 'close the loop'. The best way to do this is to ensure good governance takes place (ideally through already established processes via a trust's governance departments).

If it isn't monitored centrally then there is an increased risk that QI projects and activity becomes fragmented, particularly where there is little effective cross-communication between directorates/departments. There could be the risk of duplication of effort, thus wasting NHS staff time which could be effectively used elsewhere, especially in the current financial climate. This would then make it difficult for a trust board to gain assurance but also to evidence compliance to external regulators, such as CQC.

2 How to interlink with Health Education England (HEE) Approach

QI is an integral part of the HEE approach. HEE can help to identify the skills needed by the NHS employers to provide effective and safe care to patients.

HEE can commission training programmes for students with an extra emphasis put on QI, they can also put training together via the NHS Leadership Academy to hone staff understanding of the QI process and consequently to create better leaders.

HEE can also encourage NHS employers to invest in their staff by equipping them with the skills needed for effective evaluation of their own work, e.g. the various QI approaches including Clinical Audit set out in the HQIP guide to Quality Improvement Methods.

NB HEE is involved in some of our clinical audit / QI networks and has provided QI training sessions at recent meetings. We also promote HEE regional QI events across our networks and encourage members to attend.

3 What evidence do you have of trainee QI activity?

There is a lot of evidence of Clinical Audit (CA) activity and how this can lead to a desired change. If we treat CA as part of the QI process then the answer is there is a lot of evidence around. If we specifically look at the PDSA cycles, use of run charts etc. then the evidence is much more fragmented.

QI is developing at some sites but is not established in the same way as clinical audit and there is often no "QI programme", or if so these are developing only at certain sites region. We have examples where a Community Health Care trust are developing a Quality Improvement Champion programme in which begins in November – being a community Trust this is open to a much wider group of staff than trainee doctors and we believe this will be the first formal programme that has been produced of this kind.

Another Foundation Trust (FT) have developed QI information for inclusion in the new doctors induction pack. They have education department representation in QI board which links in with the regional deanery. QI training/learning resources are available on their iLearn system (on-line training booking site). At another acute foundation trust, a QI programme is being 'managed' by the clinical audit team who have widened their remit to under both PDSA and clinical audit. This programme is added to by projects undertaken by the Core Medical Trainee doctors who all have to do a QI project as part of their training.

Another trust is trying to stop giving juniors data collection to do and ask them to focus on making changes to act on previous clinical audit results and measure impact prospectively.

Currently many trainees are not given any protected time to undertake their QI projects and this needs to change as it gives out the wrong message if QI is a fundamental part of their role as doctors.

4. Evidence of Sustainability

As the evidence is patchy and with junior doctors on the rotation all the time, we feel that some time has to pass before the QI (understood as The Model of Improvement (PDSA) etc.) is fully anchored in Trust approaches to continuously monitoring the level of care. It is when 'today' junior doctors become consultants that a change in the approach will be visible and evidence will start mounting

We would also argue that QI has the same issues of sustainability and perhaps more unless a similar level of governance / project registration is applied to QI as Clinical Audit – this is an inherent problem unless departments or directorates take on QI or Clinical Audit as strategic department improvement projects rather than something the Junior doctor has to do to satisfy a learning requirement. Again here good governance is a must.

If QI is done well and process followed in full (and, very importantly, governed well) we believe that improvements will be more tangible, and can be better showcased to other departments to foster more activity & to engage others.

There is a danger that QI could become too clinician-centric with nursing and other grades being less involved. There needs to be an inclusive, trust approach to ensure sustainability"

Electronic patient records must be promoted as an essential resource to aid QI sustainability (as well as it being effective and efficient) – too much time is spent collecting data from notes in the absence of an EPR leaving little time / resource to interpret data, make interventions for improvement and monitor their effectiveness in impacting on patient outcomes. Trusts should invest in software and analysts to abstract improvement data from systems and present it correctly.

In Summary

From our experience, a Trust needs a variety of tools available to them (as set out in the HQIP QI methods guide) to assess, monitor and improve the Quality of care given to patients.

However perhaps even more important is the value of a good governance system, which will allow learning from QI activity, be it Clinical Audit, Plan Do Study Act, cycles, or other methods, to be shared across the Trust and allow Trusts and the NHS as a whole to learn as individual staff and clinicians move on in their careers. As stated in the report a true Multi-Disciplinary Approach is essential.

Carl Walker

National Quality Improvement & Clinical Audit Network (NQICAN) chair

Response to NQICAN.

January 17th 2017

Dear Carl

Thank you for sharing the recent response from NQICAN to the AoMRC Report Quality improvement: Training for Better Outcomes, published in March 2016.

The aim from the AoMRC Task and Finish Group has been on how to make quality improvement an integral part of the core business of healthcare, with a focus on those in medical training as a starting point. The report was very well received and the recommendations recognised to be an opportunity to create a better understanding across colleges of quality improvement methodology, and instil a greater confidence in our abilities to implement it at all levels of training, and beyond. As an example, the NHS Improvement report, December 2016, 'Developing People – Improving Care' has, as one of its recommendations, implementing the recommendations of the AoMRC report.

The AoMRC report recommendations are now the foundation for the new Academy Quality Improvement Working Group which launches today. You may have seen the statement related to this released today by the Academy?

One of the many challenges of improvement is the language used. Clinical audit is one of the quality improvement methodologies. As the HQIP Guide to Quality improvement, 2015, states 'There has been a focus in recent years upon clinical audit as a key healthcare quality improvement method, however other data-driven methods are in many instances more fitting and complementary to clinical audit, reviewing wider systems for assurance and improvement and offering solutions. A vast range of quality improvement methods exist and their applications are endless, with many branches of improvement science still in early stages of development in healthcare.'

Clinical audit in the hands of most trainees has had a very narrow focus which has been primarily on the start of the audit cycle 'are we doing the right thing?' and 'how are we doing?' rather than using the data collected to drive improvement and recognising the need to make change in a real time and dynamic way. This is well evidenced not least from trainees' eportfolios and ARCPs. In addition, it was this finding that fuelled the launch of the Royal College of Physician's Learning to Make a Difference (LTMD) programme in 2010 (1). When trainees are asked 'is clinical audit quality improvement?' over 80% sadly say no (LTMD data).

In current work we are doing with HQIP, using national clinical audit (NCA) as the catalyst for improvement in our LTMD beyond CMT programme, less than 5% trainees have heard of NCA. None have heard of HQIP. This is, I would say, not necessarily a reflection of clinical audit as a methodology, which when used correctly is an important tool for improving quality (acknowledged in today's Academy statement), but in how it has been understood, implemented and supported for the majority of trainees. That is the particular frustration. Not of well executed clinical audit but of poorly implemented and poorly supported audit. In addition, the use of the term audit as a tool for improvement and as a tool for assurance perpetuates this confusion. I got a real sense of that shared frustration from NQICAN when you kindly invited me to a meeting. There are some pockets across the UK where clinical audit in the hands of

trainees is happening in the way intended, is a very positive learning experience and is making a difference. But that is not usual practice. I suspect this is not through want of trying by hospital clinical audit departments but more the silo ways we work and train at present. I think renaming audit teams as improvement teams, as you suggest, would be an enabling step for all.

Recent reports and developments highlight how important using a common language is and why it remains so very bewildering for trainees, and others, as a result. In December, 2016, NHSI published 'Developing people- improving care' and the National Quality Board published 'Shared Commitment to Quality' (7 steps to quality). The Health Education England Quality Framework 2016/17 has as one of its aims, 'To embed a shared definition, measurement and benchmarks of quality across England to support quality improvement.' These all talk about the steps to take to build capability to improve. These reports do not mention clinical audit. The upcoming General Medical Council Generic Professional Capabilities, that will underpin all medical curricula, launches April 2017, has as one of its 10 domains, 'capabilities in patient safety and improvement'. This includes 'contribute to improvements in a practice setting or wider clinical environment through examining information from audit, inquiries, critical incidents or complaints, and implementing appropriate changes.' The wording seemingly defines audit much more in the context of an inspection type process rather than a tool for improvement.

What is so important now is to get it right for all quality improvement methodologies, which includes clinical audit. But we do want healthcare professionals to think more broadly than just clinical audit. We want trainees, and teams, to have the right training and support in quality improvement, use the right methodology for the right context and learn how to do this in the very complex healthcare environment we work in. Clinical audit is one of those tools.

I think this demonstrates there is still a gap in what quality improvement means and the strength of alignment in everyone's endeavours. I think we could do something very positive together, perhaps with NQICAN being part of the wider reference group working with the AoMRC in getting this right. I hope your members would see this is as a real opportunity to making a difference together.

Best wishes

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Dr Emma Vaux

Clinical Associate AoMRC

1. http://www.clinmed.rcpjournal.org/content/12/6/520.full.pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjui6qUhcnRAhXLCcAKHdZMCVQQFgggMAI&usg=AFQjCNEVfUjWFN1u5EJCJ8xzrXaOfEFWCg