

# Clinical Audit and healthcare

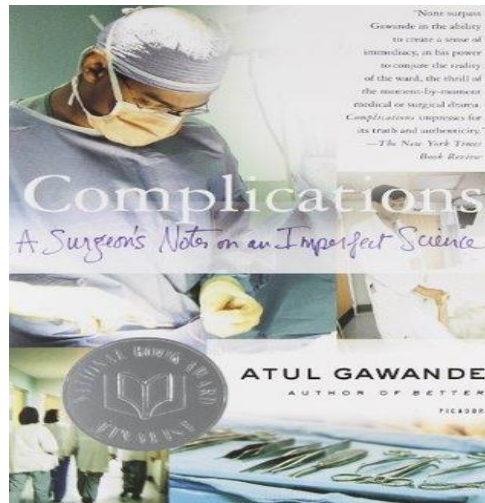
Dr Colm Henry  
Chief Clinical Officer  
HSE  
@CcoHse

4<sup>th</sup> November 2019



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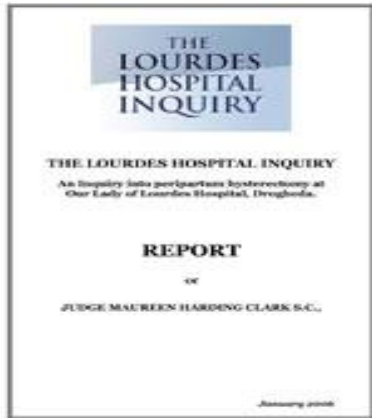
## An imperfect science



*"We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line."*

Atul Gawande (2002), *Complications: A Surgeon's Notes on an Imperfect Science*

## Imperfection and fallability



## A promise to learn; a commitment to act Don Berwick on Mid-Staffordshire

- *'The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care'.*
- *'All healthcare professionals have an ethical duty to improve system in which they work'*



A PROMISE TO LEARN – A  
COMMITMENT TO ACT:  
IMPROVING THE SAFETY OF  
PATIENTS IN ENGLAND

August 6<sup>th</sup>, 2013  
Don Berwick, MD

## Building a Culture of Patient Safety

Report on the Commission for Patient Safety and Quality Assurance



### Clinical Effectiveness and Audit:

*'It (clinical audit) arguably constitutes the single most important method that any healthcare organisation can use to understand and assure the quality of the service that it provides..... It also provides a powerful mechanism for ongoing quality improvement, highlighting incidences where standards are not met and identifying opportunities for improvement.'*

# Building a Culture of Patient Safety

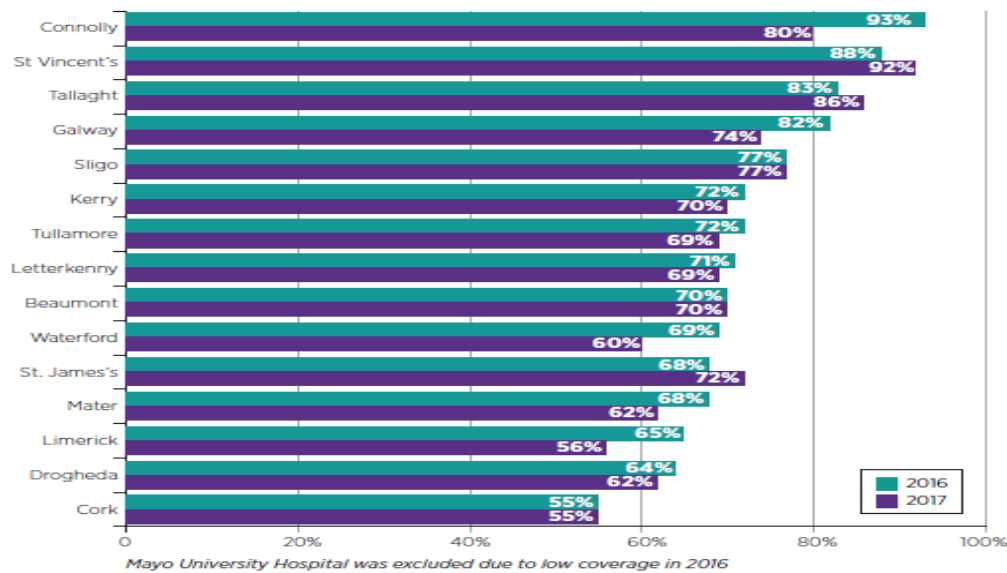
## Report on the Commission for Patient Safety and Quality Assurance: key recommendations **pertaining to audit**

- **All clinicians, both as individuals and as members of teams or networks, must actively participate in clinical audit in compliance with national standards and priorities.**
- All licensed healthcare facilities must demonstrate active participation in local and national clinical audit as appropriate to their services.
- **Clinical audit should be considered within an integrated safety and quality governance framework and should be linked to service plans and to local, national and professional priorities.**
- As part of the implementation of this Report, a group should be established to develop national programmes of and standards for clinical and other forms of audit which support the safety and quality of health services and are linked to national health priorities.
- **Legislation should be enacted to give exemption from Freedom of Information legislation and to grant legal protection from disclosure to data related to patient safety and quality improvement that are collected and analysed by healthcare organisations for internal use or shared with others solely for purposes of improving safety and quality.**



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## Audit driving improvement: Hip fracture surgery within 48 hours

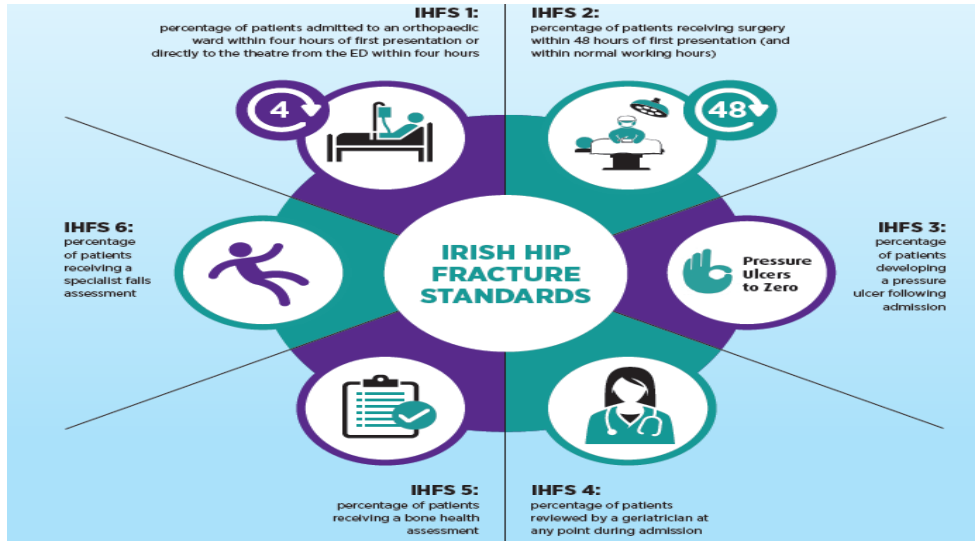


**FIGURE 3A IHFS 2: PERCENTAGE RECEIVING SURGERY WITHIN 48 HOURS (AND WITHIN NORMAL WORKING HOURS), BY INDIVIDUAL HOSPITAL PERFORMANCE, 2016 AND 2017\***



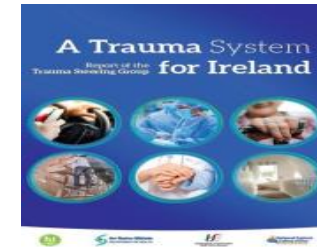
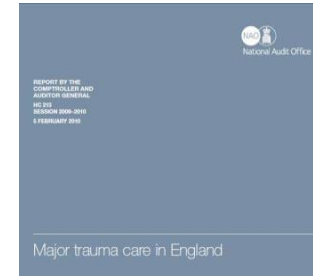
## Irish Hip Fracture Database: best practice tariff

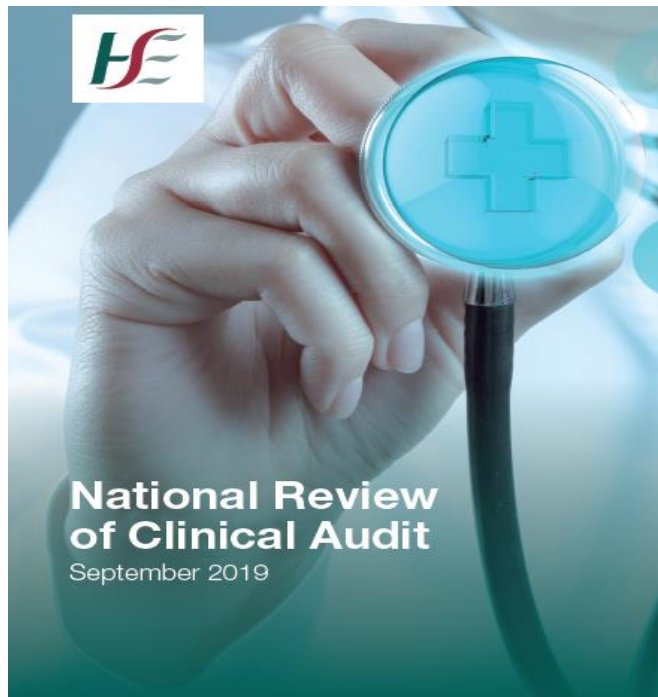
- Best practice tariff was introduced in 2018
- Meet all six clinical standards and two data quality standards and hospitals receive extra
- €1000 per case.



## Major trauma: audit as a driver for change

- ‘Despite repeated reports identifying poor practice... there has been little action to improve major trauma care.....It is not feasible, nor efficient to expect all hospitals to have the facilities and skills to provide effective specialist treatment, 24 hours a day, 7 days a week, when the number of cases of major trauma is relatively small. To deliver improved value for money, major trauma services need to be better coordinated and organised across the patient pathway’*





## Terms of Reference

The purpose of this review was to identify the structures and supports required to ensure the continuation and flourishing of clinical audit across the Irish healthcare system.

This review considered clinical audit, including governance, at all levels:

- national
- local
- individual clinician
- healthcare audits carried out by the HSE Quality Assurance and Verification (QAV) Division.

## National Review of Clinical Audit

### Threats to Clinical Audit

- ❑ CervicalCheck controversy and aftermath
- ❑ Concerns around Open Disclosure and protection for audit
- ❑ GDPR and audit

### Commissioned national review:

- ❑ Completed June 2019
- ❑ Presented to HSE Executive & Quality & Safety Board, DOH Sep 2019

## Key Findings - Local Challenges

- Time to collect/ validate audit data
- Tools & supports to analyse data
- Time & Funding to implement changes
  - Training
  - New equipment
  - Staffing
- Governance



## Key Findings - National Challenges

- Funding for data collection at existing sites
- Funding for development new audits
- Electronic Health Record
- Unique Health Identifier



## National Review of Clinical Audit



- ❑ Action Plan: 24 recommendations
- ❑ Address local & national issues
- ❑ Responsibility of CCO
- ❑ Oversight
  - National Committee for Clinical Audit
  - Updates to HSE Governance Safety & Quality Committee
- ❑ Launched November 2019

## Key recommendations

- ☐ Governance, nationally and locally
- ☐ Single audit portal on HSE website with complete lists of currently recognised NCAs
- ☐ Publish and retain list of recommended local clinical audits
- ☐ Support for education and training in audit
- ☐ Clear accountability for recommendations of audit
- ☐ Reconciliation of clinical audit with GDPR requirements



## Progress to Date / Next Steps

- ❑ Established national oversight committee
- ❑ Process for prioritisation of national clinical audit completed – rolled out in 2020
- ❑ Completed gap analysis of recommendations
- ❑ Developed high level model for national support centre for local clinical audit
- ❑ **Next Steps**
  - Establish national support centre
  - Embed audit in care delivery organisations

## Audit and quality assurance in Ireland – at a crossroads

- ❑ *“An unaudited system is one in which standards can drop and that will go undetected....I do know that every woman’s health in this country is adversely affected by having an unaudited system.”*  
Dr Ciara Kelly, Sunday Independent, November 3<sup>rd</sup> 2019
- ❑ Audit and all quality assurance activities are essential components for a healthcare system which is continuously learning and improving. If they stop or are stunted in any way, patients and patient safety will pay the price.

## Audit and Patient Safety Bill – current state of play

- Outcome from the Madden Commission.
- Currently “ a general scheme”
  - requires legal drafting
  - Formal consultation process
  - Oireachtas
- Definition: ‘process to improve patient care and outcomes involving documented, structured and systematic review and evaluation, against clinical standards, or clinical guidelines of clinical care and, where necessary, actions to improve clinical care...’
- Proposed protection for audit conditional on compliance with guidance which will be issued by Minister (determined following public consultation)
  - The definition of clinical audit as outlined in the Bill
  - Mandatory open disclosure

## What is our Ambition

- To build a positive culture of improvement that will continue to benefit patients in the health service.
- Clinical audit is a key driver of this culture:
  - » It will assure us
  - » It will challenge us
  - » It will make us better

