



Clinical Leadership, Audit and Learning

hello my name is...

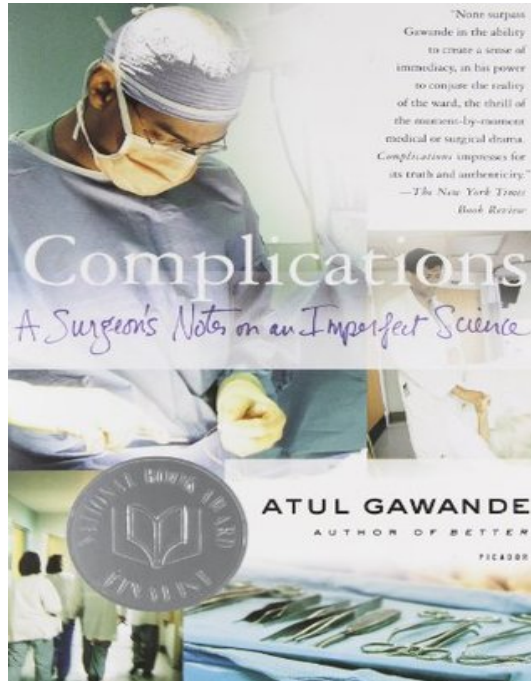
Dr. Colm Henry

Chief Clinical Officer, HSE



@ccohse

An imperfect science



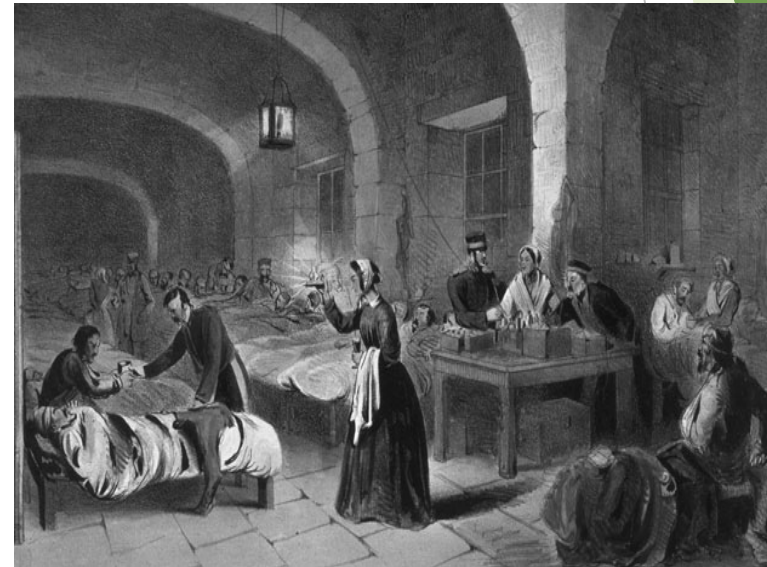
"We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line."

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

The long journey of improvement

'I am fain to sum up with an urgent appeal for adopting...some uniform system of publishing the statistical records of hospitals. There is a growing conviction that in all hospitals, even in those which are best conducted, there is a great and unnecessary waste of life...In attempting to arrive at the truth, I have applied everywhere for information, but in scarcely an instance have I been able to obtain any hospital records fit for any purposes of comparison....if wisely used, these improved statistics would tell us more of the relative value of particular operations and models of treatment than we have means of ascertaining at present...'

Florence Nightingale, Notes On Hospitals, 1863



Learning the hard way

Lourdes Hospital Report (2006) :

- Audit was not seen as an immediate imperative by management.
- The tools for audit were not available.
- Recording systems were inadequate, thereby compromising communication of clinical activity and stifling the opportunity for quality improvement.
- The process of audit was not understood by many of the witnesses to the Inquiry; audit and data collection were often confused.
- No protected time was set aside for hospital wide monthly audit.
- It was not recognised within the hospital that audit requires time and space and an audit coordinator to help to identify reasons for less favourable outcomes set against the comparators.

▶ Bristol Report (2001):

- ▶ Clinical audit should be at the core of a system of local monitoring of performance.
- ▶ It must be fully supported so that healthcare professionals have access to the necessary time, facilities, advice and expertise in order to conduct audit effectively.
- ▶ There should be a central clinical audit office in every trust that coordinates audit activity, provides advice and support for the audit process, and brings together the results of audit for the Trust as a whole.
- ▶ It should be a requirement for all healthcare professionals providing clinical care to participate in clinical audit as part of their contract of employment.

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 6th, 2013
Don Berwick, MD

Building a Culture of Patient Safety

Report on the Commission for Patient Safety and Quality Assurance



Vision for Commission:

'Knowledgeable patients receiving safe and effective care from skilled professionals in appropriate environments with assessed outcomes'.

Clinical Effectiveness and Audit:

'It is essential in any healthcare system that healthcare professionals, multi-disciplinary teams, organisations and the wider healthcare service are able to use information to monitor the safety and quality of the services that are being provided so as to enable the sharing of good practice, make improvements as required and inform the planning of services'.

'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.'

NOCA National Office of Clinical Audit

▶ 2012 - established

- ▶ Madden report and RCSI work

▶ Independent board

- ▶ funded by HSE,
- ▶ operationally supported by RCSI

▶ 2013: hip fracture and major trauma

▶ 2014: maternity audits came under governance (National Perinatal Epidemiology Centre)

▶ 2015:

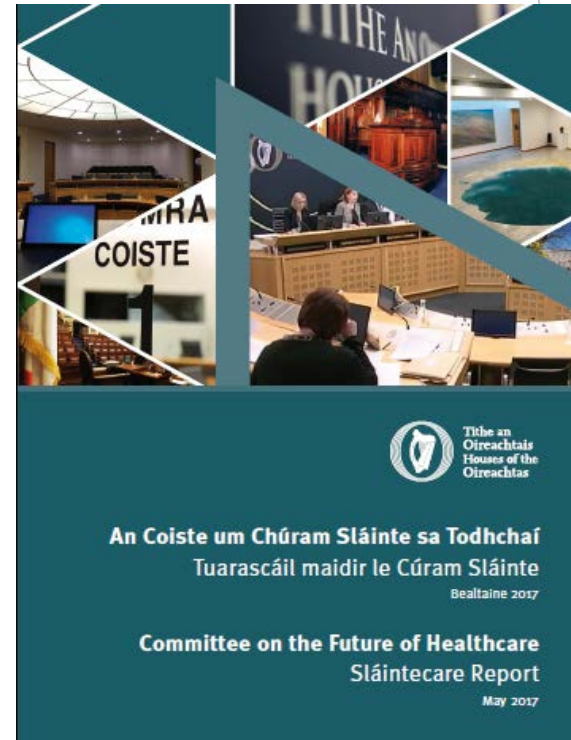
- ▶ rollout of National Audit Hospital Mortality
- ▶ ITU audit went live in first hospital

▶ 2016: Arthroplasty went live in first hospital

▶ 2019: Stroke and PPCI



- ▶ National and hospital reports: NAHM, hip fractures, major trauma
- ▶ Outcomes- critical step in linking audit of process and care
- ▶ Evidence of driving change - hip fracture and major trauma
- ▶ NOCA as driver for change for healthcare transformation
- ▶ Chronic disease and frailty
- ▶ Biannual meetings with new CCO office to set direction and strategy



Audit driving improvement: Hip fracture surgery within 48 hours

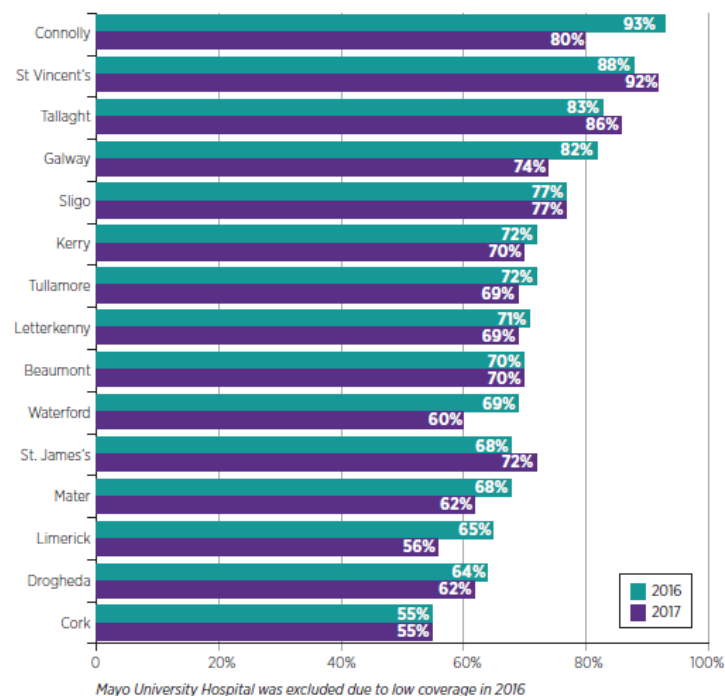


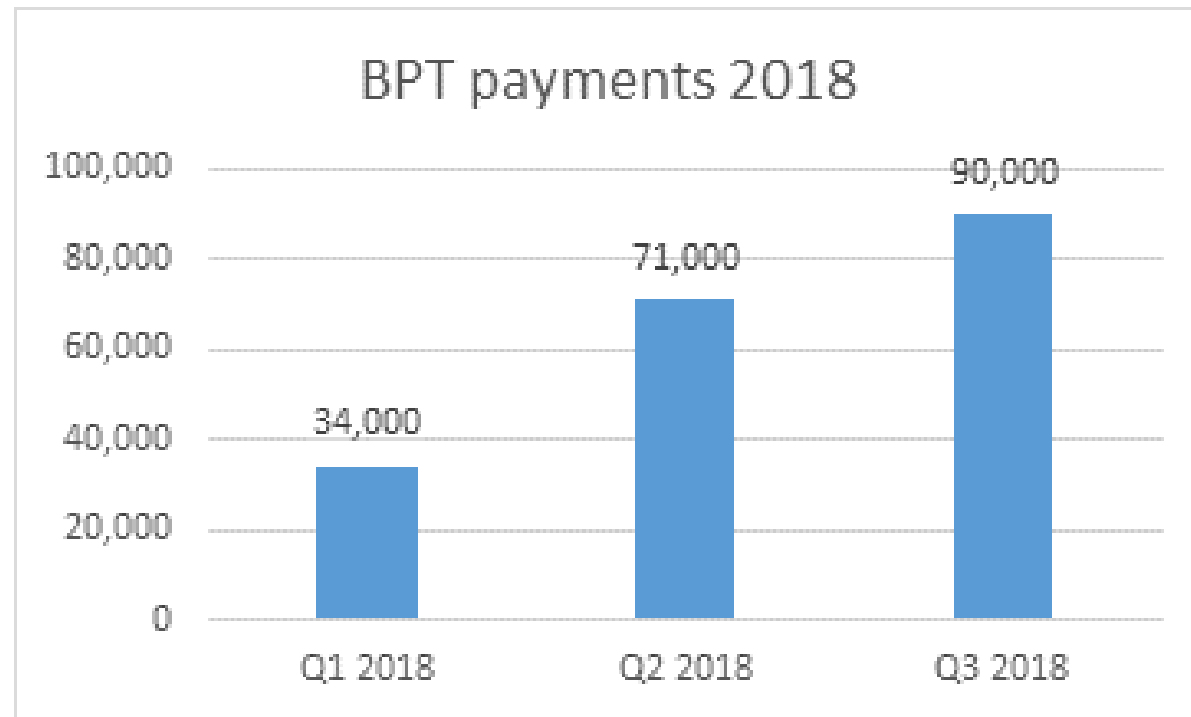
FIGURE 3A IHFS 2: PERCENTAGE RECEIVING SURGERY WITHIN 48 HOURS (AND WITHIN NORMAL WORKING HOURS), BY INDIVIDUAL HOSPITAL PERFORMANCE, 2016 AND 2017*

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.

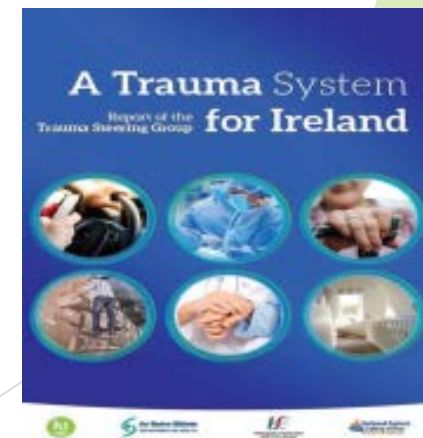
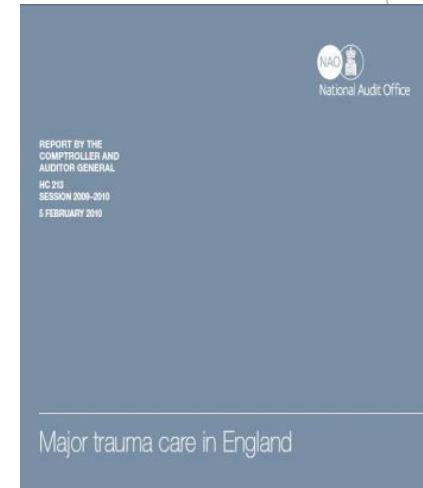


Best Practice Tariff payments 2018



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'*





National Sepsis Reports

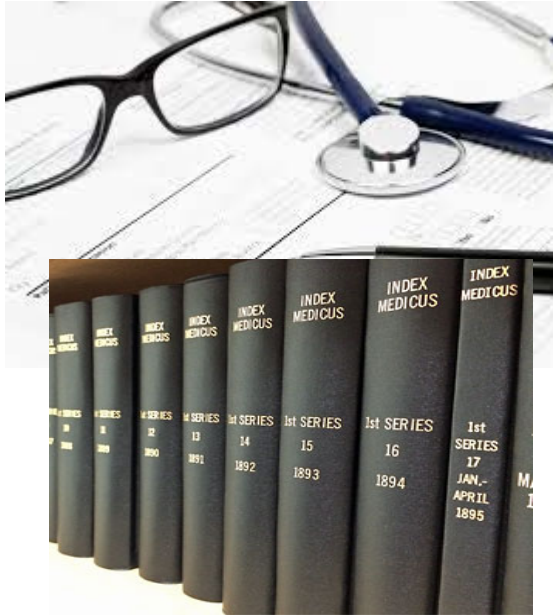


Process audit

Compliance	2016	2017	IEHG 2017	WGH 2017	% ↑/↓ from 2016
Sepsis documented correctly	60%	52.4%	45%	50%	28%↑
Antimicrobials within the 1 st hour	72%	77%	76%	67%	123%↑
Antimicrobials as per guideline	64%	85%	77%	75%	
Blood cultures before antimicrobials	80%	71%	58%	67%	
Lactate taken	90%	75%	78%	42%	
Repeat lactate (when indicated)	65%	71%	30%	67%	
Fluid bolus	72%	42%	27%	33%	

Audit and the EHCR

Before



Auditing is critical to improving standards of care but often is very time consuming.

After

Robson's 10-group classification	No. of CS over total no. of women in each group	Relative size of group (%)	CS rate in each group (%)	Contribution made by each group to overall CS rate of 20.3%
1. Nulliparous, single cephalic, >37 wks in spontaneous labor	96/737	28.9(737/2545)	13(96/737)	
2. Nulliparous, single cephalic, >37 wks, induced or CS before labor	47/58	2.2(58/2545)	8.1(47/58)	
3. Multiparous (excluding previous CS), single cephalic, >37 wks in spontaneous labor	33/1236	48.5(1236/2545)	2.6(33/1236)	
4. Multiparous (excluding prev CS), single cephalic >37 wks, induced or CS before labour	33/54	2.1(54/2545)	61.(33/54)	
5. Previous CS, single cephalic, >37 wks	173/297	11.6(297/2545)	58.2(173/297)	
6. All nulliparous breeches	30/33	1.2(30/33)	90.9(30/33)	
7. All multiparous breeches (including previous CS)	37/41	1.6(37/2545)	90.2(37/41)	
8. All multiple pregnancies (including previous CS)	26/37	1.4(37/2545)	70.2(26/37)	
9. All abnormal lies (including previous CS)	5/5	1.1(5/2545)	100(5/5)	
10. All single cephalic, <36 wks (including previous CS)	38/47	1.8(47/2545)	80.8(38/47)	



No more time wasted on manual collection of statistics: all at your finger tips.

National Review of Clinical Audit in the Irish Healthcare System - Office of CCO

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

This will include :

- ▶ National, Local and Individual Clinical Audits
- ▶ Identification of the opportunities, risks and issues impacting clinical audit
- ▶ Establish the “As Is” status of clinical audit in our system
- ▶ Review current guidance, training and supports for audit
- ▶ Review of governance arrangements at local and national level.

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





Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Thank you

Building a Better Health Service

CARE COMPASSION TRUST LEARNING

 **@ccohse**