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The newsletter of the Joint ASA/JRCALC Clinical Effectiveness Committee and the ASA National Clinical Effectiveness Programme

JRCALC
JOINT ROYAL COLLEGES AMBULANCE LIAISON COMMITTEE

ASA

In this Issue:

Clinical Risk Management - Developing standards and guidance for NHS Ambulance Trusts

As reported in the last edition of *Ambulance UK,* the ASA met in July with the NHS Litigation Authority to expand upon the existing ambulance standard, with the potential to amalgamate clinical and non-clinical assessments, and to design a risk management guidance manual specifically for ambulance trusts.

This initial meeting was attended by:
Richard Diment - Chief Executive - ASA
Steve Edwards - Clinical Governance Manager - West Midlands
Stuart Nicholls - National Clinical Effectiveness Programme Manager - ASA
Robert Cocks - Medical Director - NHSLA
Alison Bartholomew - Risk Manager - NHSLA
Aileen Orr - Assessor Risk Management Team -

The membership will be expanded to cover urban and rural ambulance services, geographical spread of services and organisational position of the members within the services. The ASA has invited nominations from its member services.

Terms of Reference

These were set with the following timescales in mind within which the group has to develop new standards and the accompanying guidance manual:

- The date set for introduction of the new standards is April 2002.
- The seminars held this October, will inform ambulance trusts of the areas the new standards will address and how these standards were determined.
- It is anticipated that the ambulance standards will be piloted from 31 December 2001.

Aims and Objectives

The group discussed and agreed upon the following:

1. To produce and implement additional risk management standards for ambulance trusts that combine their clinical and non-clinical risks.
2. Determine a simplified assessment process.
3. Production of a risk management manual of guidance for ambulance trusts.
4. Adopt a common format and style that mirrors that currently used by CNST and the Controls Assurance standards.
5. Information will be shared with every ambulance trusts Chief Executive and Risk Manager. It is anticipated the minutes of the Ambulance standard development group will be distributed to all members, the ASA and JRCALC either in hard copy, via email or use of relevant web sites.

Developing the Ambulance Standards

The group came up with several areas of perceived risk .In addition other areas of risk identified in response to the NHSLA's letter to ambulance services.

Response times
Thrombolysis
Consent
Obstetric Care
Guidance on paediatric emergencies
Patient Report forms and documentation
Air ambulance
Pre-hospital guidelines
NHS Direct
"Treat or transfer"
Handover of Care
First Responders

Starting Point

Claims data would be helpful in determining the risks ambulance trusts are subject to. The data will be anonymised and circulated to all group members. The ambulance clinical governance group network would be questioned on what areas they consider to be the most risk exposed.

Risk Management Guidance Manual
The NHSLA/CNST intend to produce a guidance manual to accompany the new standards. This needs to be complete by April 2002.

It was proposed the ASA, JRCALC and perhaps the NHSLA websites be used to inform members of the standards as we develop and introduce them.

The next meeting of the group, including the expanded membership, will be held in early November and will consider all the feedback from the ambulance service seminar held on 15 October 2001.

Guidance from the NICE

The following article provides summaries of guidance from the National Institute for Clinical Excellence (NICE)

Implementing NICE Guidance: A practical handbook for professionals

"Good clinical guidance, if properly developed, disseminated and implemented, improves the healthcare of the population as a whole and supports health professionals in doing their best for individual patients.
NICE guidance will cover both individual health technologies and the clinical management of specific conditions. We will ensure that the technology appraisals and guidelines we develop are based on robust research findings, address cost as well as clinical effectiveness and are distributed to clinicians and patients in a form that will be useful on a day to day basis.
NICE guidance will be published at a significant rate over the next few years; up to 20 clinical guidelines and 50 technology appraisals per year, and each piece is important. As a consequence, careful planning for effective implementation is now a crucial task for all NHS organisations.
Whilst NICE does not have a remit for implementation of its guidance, it wants to help those that do. Therefore, the Institute has supported the National Prescribing Centre in the production of this handbook, to assist you with the local implementation of our guidance.
This handbook is a practical guide for NHS clinicians and managers on how to adopt and monitor national guidance.
Developed with NHS staff working at the coal-face, it looks at the roles and responsibilities of key individuals in health service organisations, and provides useful examples, checklists and frameworks for ensuring NICE guidance is translated into local action.
Whether you are actively involved in managing the implementation of guidance, or you just need to know what is going on, this handbook is essential reading and I commend it to you."

This guidance may assist with the implementation of the JRCALC Clinical Guidelines locally within ambulance services and can be downloaded from the following website:

http://www.npc.co.uk/publications/nice/nice.htm

National Audit Projects - establishing the successes and the lessons learnt

1. Background

1.1.The Institute inherited a programme of national audits projects commissioned by the Department of Health. Ten of these projects termed National Sentinel Audits (NSA) were commissioned at the same time towards the end of 1997. Most of these projects have now been completed (Table 1).

1.2. National audit projects must add value to the NHS and facilitate improvements in patient care. It is important that the lessons learnt from these projects influence the design and management of future projects. Knowledge of the successful aspects of the these projects as well as the lessons learnt will inform the Institute's role in commissioning and managing future national audit projects.

1.3. Feedback from a wide range of sources has contributed to this paper:

Clinical audit staff at a number of conference sessions including *Clinical Audit '98,* and *Clinical Excellence 2000,*
NSA project leads and regional audit staff at a meeting hosted by the National Centre for Clinical Audit in February 1999,
delegates at a national audit workshop hosted by the Institute in March 2000, · an Institute review of all the completed national audit projects, project leads of national audit projects, centres that work with the Institute on clinical audit, including the Collaborating Centres, and local NHS staff that have taken part in national audit projects

2. Successes

2.1. The sentinel audit programme has demonstrated how audit can constructively assist NHS clinical and non-clinical staff to work together towards delivering improved patient care. Some national audit projects have been associated with significant improvements in the quality of care provided in a number of NHS services (e.g. stroke care).

2.2. Positive attributes of sentinel audit projects included: developing flagship methodologies, clarifying national standards, raising the profile of clinical audit, encouraging a shared enthusiasm for the constructive use of clinical audit, raising the profile of specific clinical topics, facilitating national and local comparison of quality of care, facilitating the opportunity for clinical benchmarking.

3. Lessons learnt

3.1. The lessons learnt from the national sentinel audit programme can be divided into two broad categories:

a) project management, including topic selection, planning and resources and communication, and b) project methodology including design, data issues, implementability, stakeholder involvement and the provision of support for local improvement.

4. Summary of lessons learnt

4.1. Project management

4.1.1. Topic selection

Lesson one: The method for gathering and prioritising topics for national comparative audit should be as transparent as possible and involve service providers, users and NHS staff.

National Sentinel Audit topics chosen were of varying relevance and interest to the service. They did not always match local priorities or national policy objectives.

4.1.2. Planning and resources

Lesson two: Detailed information should be provided as early as possible and again at the recruitment stage to facilitate planning for participation in the project.

The expectation for improvements in patient care should be explicitly articulated in the recruitment documents to engage the enthusiasm of local staff. Advance notices and recruitment documents should make available the project objectives, an outline of the proposed audit protocol, proposed networking opportunities and plans for supporting local improvement initiatives.

Lesson three: Adequate time is required for the project leads to engage relevant staff within NHS organisations, and for the organisation to plan their involvement in the project.

Early distribution of the audit protocol including details of the cost of participation, estimated number of cases to be audited and the time required to audit an average set of case notes would facilitate local planning for the resources required to participate (e.g. budgeting for recruitment of data collection/entry staff, cost of notes retrieval etc.).

Lesson four: National audit projects are resource intensive at both national and local level. Projects will require a significant commitment from local NHS organisations. Start dates within a programme of national audits should take account of local business planning cycles and be staggered to assist capacity management within the NHS.

Scheduling and planning issues were identified within the NSA programme. Many of the projects were started at the same time, leading to capacity problems in the NHS at key stages (e.g. during data collection). From the perspective of the project leads, these problems arose from the tight time frame of the bidding and funding mechanism.

4.1.3. Communication

Lesson five: Communication should take place via agreed communication channels such as professional networks and via clinical governance leads in NHS organisations.

From the perspective of NHS staff, recruitment of NHS organisations was carried out through many uncoordinated channels. Project leads spread the recruitment net wide via professional networks as endorsement by the relevant professional bodies is very important.

However there was little direct communication with clinical audit departments. Although local "sign up", leadership and internal communication are primarily local issues, there is a need to understand the role of staff responsible for project and change management locally and the important part they can play in these projects.

Lesson six: Stakeholders should be kept well informed. Clear, effective, two-way communication channels should be established with the NHS organisations including those that are not yet able to participate in order to maximise the impact of the audit on improving patient care.

Newsletters, conference and journal communications, email lists and the NICE or project websites are ways of keeping all stakeholders up to date with progress and forthcoming events.

Lesson seven: Networking opportunities are valued by practitioners and should be made available at national, regional and local level.

Workshops are reported to have enabled the development of supportive relationships between participants. Regional opportunities were particularly appreciated, as this minimised time spent away from the workplace and created a sense of local solidarity. Such multidisciplinary meetings allowed discussion of the implications of local results within the national audit.

There are particular logistical challenges of communicating with up to 9000 primary health care teams in England and Wales and encouraging them to take part in national audit projects. The need to support primary care teams, and the variety of data recording systems are in operation should be appreciated.

4.2. Project methodology

4.2.1. Design

Lesson eight: The design of a national audit project should conform to the current best practice principles for a clinical audit project and it is essential the audit loop is completed. National audit projects that do not audit practice against nationally agreed criteria should be referred to as a baseline audit or survey.

Without adherence to principles of best practice in clinical audit at a national level, local initiatives to enthuse clinicians about the benefits of participating in clinical audit (i.e. change & improvement) are seriously undermined. Some of the national sentinel audits were surveys or baseline audits in clinical areas where no commonly agreed standards of care existed.

Lesson nine: Adequate time should be spent ensuring that the design of the national audit project is right. Poor design can result in an audit that doesn't benefit patients or staff and can

be wasteful of time and resources. It should be possible to judge from the audit protocol whether the proposed audit will enable care to be reliably assessed against the criteria.

Considerable effort is required to develop a data collection tool that is unambiguous and reliable. Stakeholders and audit specialists working in the NHS should be involved from the outset to refine the design.

Lesson ten: The design of the audit tool should be kept as straightforward as possible and the amount of data to be collected kept to a minimum.

Collecting more data than is absolutely necessary creates more work for staff and increases the chance that data will be collected hastily or inaccurately. In the presence of good quality baseline data the number of variables for which data is collected should be reduced to the minimum. Piloting should be used to establish the minimum dataset required to permit statistically robust conclusions to be drawn.

Lesson eleven: The methodology for data validation and analysis should be transparent. Transparency raises the credibility of data compared at national level and highlights local data quality issues.

Centres leading national audit projects should share knowledge of methodological approaches to data entry and analysis. Common processes should allow errors in data entry or analysis to be identified and rectified quickly to ensure ongoing confidence in the results returned to the NHS.

Lesson twelve: The commissioning of a national audit tool should be accompanied by a package of resources including supportive information on setting up the audit, sample size, how to involve service users, and how to interpret and take action on the results. The data collection tool should be supported by, and cross-referenced to, suitable educational material.

The purpose of audit is to bring about improvements in care. Local NHS staff appreciated support in addressing changes required as a result of audit.

4.2.2. Implementability

Lesson thirteen: The audit tool should be subjected to robust formal piloting using a randomly selected group of clinicians and audit staff working in the NHS, avoiding the bias associated with self selected groups of enthusiasts.

In one national audit tool questions were considered unclear and practitioners were left feeling that their views on how to improve the data collection tool had not been heard. Practitioners felt that the tool had been developed by experts with no feel for the 'real world'.

Lesson fourteen: All national audits should have a clear data collection strategy. The data entry and analysis framework should be appropriately designed for the clinical setting in which the audit is being conducted.

Areas not supported by adequate IT may require central analysis of the data or the provision of a simple analysis tool for use locally. One national audit provided clear guidance on how and when to collect the data, how to fill in the forms, and couriers were sent to collect data from hospitals at set times. Analysis of results was provided within weeks. The level of IT support needed from local IT departments and via a project helpdesk facility has been considerable during current national comparative audit projects.

4.2.3. Stakeholder involvement

Lesson fifteen: All groups with an interest in the aspects of care covered by the proposed national audit project should be involved.

Stakeholders should be consulted on the scope, design and presentation of the results and where appropriate should be actively involved in developing the review criteria and establishing action plans for change.

4.2.4. Support for improvement

Lesson sixteen: Mechanisms to maximise organisational support and commitment should be invoked at the recruitment stage. Projects should be embedded into clinical governance strategies. Successful methods for supporting change should be shared.

In sites where there was visible management support and commitment, both in terms of time and resources, respondents were clear that the national audit project had been successful. However, where such support and commitment was seen to be absent, a number of difficulties were experienced.

Lesson seventeen: Statistically robust results presented to the NHS in an easily understandable format and within a reasonable time frame can provide a powerful driver for change locally.

Timely reporting of the results is crucial otherwise the relevance of data collected lessens and there may be reduced interest in the report.

Lesson eighteen: Results should be presented to allow organisations to see clearly whether they are achieving the expected best practice, and to compare their performance against similar health economies.

Within some of the national audit projects the comparisons to 'what is possible' in other units through benchmarking added value to the results and facilitated change.

Nicki Bromwich, Audit Programme Manager, NICE. June 2001

Table 1. National Audit Projects

Completed projects (lead organisation)	Ongoing projects

Leg Ulcers (RCN) Management of violence in clinical settings (RCPsych) Audit tool for acute back pain (IMRCI) Evidence based prescribing for older people (RCP) Stroke (RCP) Falls in older people (CSP) Helicobacter Pylori (RCPath) Cataract (RCOpth)	Caesarean Section (RCOG) Clinical Practice Evaluation Programme (RCGP) Sudden Death in Epilepsy (SUDEP) (Epilepsy Bereaved) Myocardial Infarction National Audit Project (MINAP) (RCP) Quality Indicators for Diabetes Services (Diabetes UK) (QUIDS - formerly NW Regional Diabetes Audit)

Best Practice in Clinical Audit – a practical handbook based on a review of the evidence NICE are shortly due to publish the above handbook on clinical audit. The ASANCEP participated in the evaluation and review of various drafts and believes the advice and literature can readily be transferred to clinical audit within the ambulance service. Keep your eye on the NICE and ASANCEP websites for news…

Guidelines Stakeholder Interest

We have registered the interest of the ASA and JRCALC in the following guidelines:

New Programme

- The management of patients who intentionally harm themselves
- The assessment and prevention of falls in older people, including recurrent falls.
- Epilepsy
- Chronic Obstructive Pulmonary Disease

Earlier Programme

- Depression
- Head Injury in Children and Adults
- Heart Failure
- Hypertension
- Induction of Labour
- Electronic Fetal Monitoring
- Pressure Ulcers
- Type 1 Diabetes
- Type 2 Diabetes – Foot Care
- Type 2 Diabetes – Glycaemic Control
- Type 2 Diabetes – Hypertension
- Type 2 Diabetes – Lipids

If you have any prehospital evidence you feel should be considered as a part of the guideline development process please forward any information to Stuart Nicholls at the ASA offices.

NICE Annual Conference : 5th - 6th December 2001 Excel London

Details can be found on the event organisers website http://www.sterlingevents.co.uk

JOINT ROYAL COLLEGES AMBULANCE SERVICE LIAISON COMMITTEE (JRCALC) CONFERENCE

at the Royal College of Physicians of London.

Friday 2nd November 2001

Provisional Programme

09.30	**Registration and Coffee**
10.00	Welcome and Introduction - *Chair JRCALC Professor Douglas Chamberlain*
10.10	The Emergency Care Review - Dr David Carson
10.40	Implications for ambulance services (Gron Roberts)
11.00	Implications for education & training - (Judy Hardagon)
11.20	Decision support software - (Paul Jenkins)
11.40	Coffee
12.00	Ethics and pre-hospital research
12.30	Discussion
13.00	**Lunch**
13.45	The new Health Professions Council: progress with the Paramedic Board
14.00	Soonest Thrombolysis - the emerging national picture
14.15	Guidelines update - Ian McNeil
14.30	Clinical audit systems - Stuart Nicholls
14.45	Discussion
15.00	**Tea**
15.15	Prehospital treatment of LVF (for frusemide?)
15.30	Prehospital treatment of LVF (against frusemide?)
15.45	Discussion
16.15	Closing comments and summary

More details and booking forms will appear soon on the JRCALC website - http://www.jrcalc.org.uk

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