ASSESSING THE LANDSCAPE AND FUTURE ACTIONS FOR QUALITY IMPROVEMENT IN THE VETERINARY SECTOR / THE INSIGHTS, EXPECTATIONS AND ASPIRATIONS OF THE PROFESSION

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RCVS KNOWLEDGE

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PREFACE

In 2019, RAND Europe was commissioned by RCVS Knowledge to conduct an independent study into Quality Improvement in the veterinary sector. The aim of this was to explore the status of Quality Improvement today and what could be done, and by whom, in the near future to support the embedding of Quality Improvement in the sector.

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INTRODUCTION FROM RCVS KNOWLEDGE

Providing high-quality, safe and effective care for animals has always been the priority for the veterinary professions.

The delivery of that care is undergoing substantial change, with the continual corporatisation of the industry, increased expectations from clients, new technologies, recruitment challenges and an expanding evidence base.

We don't just want to adapt to our evolving environment; we want to maximise its potential.

To achieve that, we need a coherent and manageable framework in which lessons and developments are shared freely across the breadth of the veterinary professions, and evidence about what works, can be implemented. The framework we feel is best suited to that is Quality Improvement (QI).

This report outlines a roadmap for developing a culture of Quality Improvement in the veterinary professions. It collates insight from across the industry and takes cues from other domains that have cemented QI – notably human healthcare – to understand where we are now as a profession beginning to adopt Quality Improvement, what we need in order to evolve efficiently, and who can act as change leaders alongside RCVS Knowledge.

In 2018 we launched our continuously expanding suite of QI resources, designed to provide practice teams with time-efficient ways of implementing Quality Improvement, and to initiate those new to the concept. We will continue to build on this offering, as the key enabler to lead QI support for high-quality care. We know from human health experiences that silo working jeopardises the success of QI efforts. As such, we will encourage a harmonised approach; one which emphasises collaboration and shared learning. But, as many of the recommendations in this report indicate, we are reliant on active support and leadership from across the professions to make this happen.

The entire veterinary industry can realise the potential of QI – from the upper echelons of the key organisations to the dedicated vets and vet nurses treating and caring for patients, to those on the front desks of practice. This may require a change in the traditional style of leadership, and it will certainly require organisation-wide commitment. Above all, it will hinge on a culture that embraces a systematic and iterative approach to improvements for patients, based on continuous testing and measurement.

We believe that QI should be part of normal working, rather than an add-on to the day job. We support a one-team approach, focusing on how whole teams successfully work together and interact. Most fundamentally, although we know that there is room to improve, we acknowledge that everyone already strives to do their best – QI is simply the framework that can make that sustained endeavour a reality.

We are grateful to everyone who has worked on or engaged with this research to date, not just for their time and efforts, but also for the insights that they have helped to cultivate.

We know we don't know everything yet, and so our action plan – while committed to a stable approach to QI – will be flexible.

The time is now for the professions to embrace the opportunities presented by a culture of Quality Improvement and to translate them into safer, ever more efficient, and improved clinical outcomes for patients.

Together, we won't just achieve more: we can achieve our best.

Jacqui Molyneux FRCVS

Chair

RCVS Knowledge Board of Trustees

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RCVS Knowledge Quality Improvement Advisory Board

Chris Gush

Executive Director

RCVS Knowledge

INTRODUCTION FROM RAND EUROPE

There are new financial and operational challenges facing all parts of the veterinary world. Advocates of Quality Improvement (QI) suggest that QI is at the heart of responses to these challenges, allowing veterinary care to be both more efficient and of high quality. The many stakeholders who have engaged in this research overwhelmingly want to continue with this QI journey. However, they also want signposting and manageable steps to help them on their way.

What might the veterinary world look like further down this road? First, there would be fewer unwarranted variations in treatment. Overuse, misuse and underuse would steadily be identified and minimised. Teams would work more closely together, with a shared understanding of what quality looks like, how responsibilities for it are distributed, and how to measure progress. Clients would be reassured that their practice measures the quality of care for their animals, and they would be given opportunities to engage with improvement activities. This is not an entirely different world to today, but it would be a steadily improving version of it. QI offers sustained evolution, not revolution.

This is surely a prize worth fighting for. However, changing the way a sector routinely works is neither simple nor easy. Many stakeholders engaging with our research reported here noted that their enthusiasm for QI is balanced by their uncertainty about how to achieve it. We know from our research that people at the frontline of delivering quality need clear signposting and manageable activities that support their day-to-day activities (rather than add to them). We know from the human health sector that stability of commitment, consistency of approach, and organisational support will be far more successful than endlessly chasing the latest fashions or encouraging heroic acts of individuals. And we know that a particular style of leadership is required to support curiosity, team working, inter-disciplinary work and a culture based on learning rather than blame.

Four things will make this journey easier. First, data will be collected and used to track progress. Second, leaders will give a consistent message that this is important work and part of 'core business', and ensure resources are available to support it. Third, existing resources in HR, training, research, recruitment, promotion and so forth will be gently repurposed to support QI. Fourth, there will be a consistency of support and practice. We hope that this report contributes to the success of this journey.

Tom Ling

Head of Evaluation

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EXECUTIVE SUMMARY

Introduction

How healthcare is provided for animals is changing quickly in relation to technology and treatments, public expectations, organisational structures and resources. In the context of these changes, many who work in the sector view strengthening Quality Improvement practices as increasingly important. This has been evident throughout the research conducted for this study in interviews, focus groups, a profession-wide survey, a national summit and a review of Quality Improvement documentation. However, many also report that they are unclear how best to do this. These issues are outlined and analysed in this report along with recommendations.

Quality Improvement (most often with upper case QI) involves:

- understanding and articulating what is currently happening along with a data-led analysis of why this is or may be a problem
- establishing a baseline measuring the current performance of the team or pathway
- identifying a plausible improvement (based on an understanding of the current capacity of the service) and defining how improvement is to be measured
- making the changes and measuring the results
- depending upon the results, adapting the improvement approach and starting the cycle again.

One well-understood example of such an approach to improvement would be the clinical audit cycle. QI more generally also includes the use of specific tools and techniques designed to facilitate improvement such as Plan, Do, Study, Act cycles. The approach originated in manufacturing but has been substantially adapted to meet the needs of human healthcare, as well as veterinary practice, with one interviewee commenting:

> *'QI is just an essential part of that [clinical excellence] really. I think unless you're constantly questioning and auditing and justifying what you're doing, it's very easy to find you're failing to recognise something that's very obviously happening in front of you.'* (INT7 profession)[1]

[1] The interviews each have an assigned code based on the type of stakeholder and interview number. Further detail on the coding of the interviews (and other data collection methods) can be found in Section 2.

In human healthcare, there is now an extensive body of evidence. This literature not only highlights that QI has considerable potential to deliver better outcomes for patients but also demonstrates that there are no simple solutions that can be universally applied with any certainty of success. The research team reviewed a selection of systematic reviews relating to QI in human healthcare[2], in addition to drawing upon the evaluation team's wider immersion in this subject. In essence, there is a large volume of studies claiming positive results but a disappointingly low standard of evidence used in support of these findings. Furthermore, there is strong agreement that there is no single 'right' approach and approaches must be selected and then adapted according to the particular circumstances. In addition, even where there is a measurable improvement, more research is needed to understand the causal mechanisms which produce improved outcomes (for example, inspirational leadership, good use of tools or team engagement). From non-systematic reviews, the research team also know that improving the landscape for QI (i.e. the training, leadership, organisational support and financial incentives that shape QI activities) often depends upon picking a small number of approaches and applying them consistently to create a shared rhythm of learning, which may take years to fully take root.

In this context, the Royal College of Veterinary Surgeons Trust, trading as RCVS Knowledge, in 2017 invited a group of 'early adopters' to form a Quality Improvement Advisory Board (QIAB). RCVS Knowledge is seeking to support the profession in the enactment of QI techniques in veterinary practice. The aim is to produce practical tools, easily implemented in busy practices, to support both specific improvements in clinical decision making and support organisational changes that may help deliver such changes. To provide focus for this work, RCVS Knowledge has drawn from the 'menu' of improvement activities and established five key areas for action (RCVS Knowledge, 2017):

1. Clinical audit
2. Benchmarking
3. Significant event audit
4. Guidelines
5. Checklists.

> *'QI is trying to make sure that you are doing the right things that you should be doing and not just for the patient but for the client and staff as well.'* (INT11 profession)

The primary purpose of this research is to provide evidence to support decision makers in facilitating the implementation of QI techniques in veterinary practice. To this end, the research included:

- a review of QI documents from the sector
- semi-structured interviews with a range of stakeholders
- a profession-wide survey
- focus groups with Practice Standards Scheme (PSS) assessors
- a national summit for key policymakers.

The data collection and analysis from across the methodological approaches outlined above led to two groups of conclusions and a set of targeted recommendations.

[2] These are: Amaratunga & Dobranowski, 2016; Knudsen, Laursen, & Mainz, 2017; Powell, Rushmar, & Davies, 2009; Tina, Upham, Crossland, & Jackson, 2016; and Wells et al., 2018.

Conclusion 1: The evidence to support bringing QI into the veterinary sector is strong, but leadership is needed to make sense of QI and tailor it to the needs of practices

Studies from QI in human healthcare are positive but the quality of evidence is variable. In particular, there is very little data about the overall balance of the costs and benefits of QI. At the same time, the survey data, interviews, focus groups and summit all reinforced the view that while there is a broadly positive orientation towards QI, there is much less clarity about what this might involve in practice. Those new to QI reported that they are unclear about the best ways to get involved. The evidence is clear that the implementation of QI tools needs careful tailoring to particular circumstances and requires change management. At this early stage, the role of professional leadership is important in making sense of what QI means in practice, and the benefits it might bring, as well as in engaging the whole team to help embed improvements into the culture of practices.

> *'If you've got someone that has a passion for it then that helps. If you've got someone senior in your organisation that is keen on it and can see the benefit and are willing to use the resources to facilitate it then I think that is a big enabler.'* (INT11 profession)

Conclusion 2: Much of the institutional architecture is in place; QI requires evolution, not revolution. Change should be consistent, prioritised and involve the efficient use of time

The evaluation found neither a need, nor an appetite, for a whole new 'improvement architecture'. A firm nudge could be provided by:

- further strengthening the visibility of RCVS Knowledge products
- partially repurposing PSS to give greater prominence to QI
- strengthening mentoring and other community-building approaches
- ensuring that interviews, job descriptions, appraisals and recruitment reflect the growing importance of attitudes towards the adoption of continuous QI approaches
- building links with universities, educators and research funders to amplify the role of QI in teaching and research
- exploring the use of technology to facilitate data input and analysis.

Efforts to achieve change evolution rather than revolution (for example, the history in human healthcare of QI in Scotland or the Q Community)[3] show the importance of having a consistent approach allowing innovations to become embedded and to operate for long enough to demonstrate whether or not to abandon, adapt or spread (Dayan and Edwards, 2017; Haraden and Leitch, 2011; Mcdermott et al., 2015; Whitford, 2017). Strong leadership is required in order to avoid being driven by eternal attraction of the new. In prioritising action, it is also important to note that time constraints emerged as the most important barrier in the survey and finding ways that allow easy, visible and quick forms of QI should be prioritised (for example, techniques to find the root cause of persistent quality problems, run charts to measure progress or focused Plan, Do, Study, Act cycles).

[3] The Q Initiative is run by the Health Foundation and NHS England. It aims to create a network of improvers in the human healthcare sector across the UK. More information can be found at https://www.health.org.uk/what-we-do/supporting-health-care-improvement/partnerships-to-support-quality-improvement/the-q-community

Recommendations

The research gave rise to a set of recommendations summarised in the tables below. The evidence collected for these recommendations is sufficient to identify generic changes and the roles of different entities. However, applying these in specific organisational settings would require further work. For example, corporate practices have scale, finance and governance arrangements that provide opportunities and challenges that are different from those facing independent practices.

TABLE 1: LIST OF SHORT-, MEDIUM-, AND LONG-TERM RECOMMENDATIONS BY THEME

THEME 1: ACCUMULATE SOLID EVIDENCE AND PRIORITISE EFFORTS ACCORDINGLY

RECOMMENDATION	OWNER	SHORT/ MEDIUM/ LONG TERM
Provide guidance and support for QI approaches that collect information about costs, activities and benefits in consistent ways	RCVS Knowledge working with university researchers and research funders	LONG
Identify selected QI interventions for cost-benefit analyses to identify the business case for further expansion (or not)	RCVS Knowledge with health economists	LONG
Sequentially roll out clinical audits using apps or other types of technology and interfaces to minimise effort and costs	RCVS Knowledge with app developers and clinical audit leaders	MEDIUM
Systematically use complaints to prioritise issues and areas for improvement	Veterinary Client Mediation Service with RCVS Knowledge	MEDIUM
Set up a workshop involving RCVS and RCVS Knowledge along with other key stakeholders to engage with QI experts from human health (including Health Foundation, THIS Institute) to extract key lessons from human health	Collaboration with RCVS and RCVS Knowledge	MEDIUM

THEME 2: DELIVER LEADERSHIP AND ENGAGEMENT TO MAKE SENSE OF QI TO STAKEHOLDERS AND EXPLAIN WHAT IT MEANS IN PRACTICE

RECOMMENDATION	OWNER	SHORT/ MEDIUM/ LONG TERM
Develop a brand and communications strategy for QI with simple, direct language	RCVS Knowledge with stakeholders	MEDIUM
Consider establishing an improvement community, drawing on Q Initiative as an example, and develop a suite of activities such as site visits, webinars, etc. However, the funding model for this remains unclear	RCVS and RCVS Knowledge	SHORT
Identify business benefits (including well-being and morale of the workforce) of engaging with QI to encourage team retention and attraction to vacancies	Researchers and funders	MEDIUM
Emphasise learning through QI and clinical audit rather than blame	PSS assessors, professional bodies, practices	LONG
Develop a package of activities at practice level for easy routes to engaging with QI	Collaboration with RCVS Knowledge and individual practices	LONG
Encourage charities to mobilise resources behind QI and engage the public	Animal charities	LONG

THEME 3: RESHAPE EXISTING ACTIVITIES AND ORGANISATIONS TO MAKE QI AS EASY AS POSSIBLE; EVOLUTION NOT REVOLUTION

RECOMMENDATION	OWNER	SHORT/ MEDIUM/ LONG TERM
Increase the visibility of RCVS Knowledge QI products including toolkits and standardised documents; embedding QI in CPD	Collaboration of RCVS Knowledge with all stakeholders	LONG
Extend PSS to give greater prominence to QI and changes in practice, with a greater role for self-assessment in QI, with practices providing more self-assessment of improvement plans and their progress towards meeting their self-identified goals	The Practice Standards Group and RCVS Standards Committee and Council	MEDIUM
Introduce an award for QI	RCVS Knowledge	SHORT
Build on current experience to extend the role of clinical audit	RCVS Knowledge with clinical audit leaders	MEDIUM
Explore formal mentoring opportunities to entrench QI among those new to it	Employers/individual practices	MEDIUM
Write QI into job descriptions, appraisals and interviews (to assess attitudes towards adoption) and HR practices more generally	Individual practices	MEDIUM
Give QI a greater role in teaching and research	Universities, educators and research funders; journal editors	SHORT
Establish QI leads within each practice, with specific tasks subdivided and allocated amongst the team.	Individual practices	MEDIUM
Establish communication around QI across practices	Individual practices with RCVS Knowledge	MEDIUM
Better integrate the principles and practices of QI as a specialism within the Advanced Practitioner Certificate and Advanced Veterinary Nursing qualifications.	Universities and educators	MEDIUM
Integrate QI with CPD training and all education	CPD delivery organisations, universities, colleges and other educators	MEDIUM

THEME 4: PURSUE CONSISTENT, PRIORITISED AND SEQUENCED ACTIVITIES IN A STABLE IMPROVEMENT LANDSCAPE

RECOMMENDATION	OWNER	SHORT/ MEDIUM/ LONG TERM
Establish a strategic direction that prioritises a stable commitment and consistent approach to QI techniques	RCVS Knowledge	LONG
Focus on providing opportunities to engage, that use small amounts of time	RCVS Knowledge	LONG
Allocate protected time to all team members for QI	Practice strategy leaders and practice owners/managers	MEDIUM
Encourage improvement approaches that are delivered continuously rather than one-off 'heroic' interventions	RCVS Knowledge	SHORT
Establish a balance between e-enabled activities and face-to-face activities	RCVS Knowledge	SHORT
Consider establishing an Improvement Lab for one-off, focused improvement challenges	RCVS Knowledge plus potential funders	MEDIUM

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ABBREVIATIONS

BAVECC	The British Association of Veterinary Emergency & Critical Care
BCVA	British Cattle Veterinary Association
BEVA	British Equine Veterinary Association
BSAVA	British Small Animal Veterinary Association
BVNA	British Veterinary Nursing Association
BVA	British Veterinary Association
BVHA	British Veterinary Hospital Association
CEVM	Centre for Evidence-based Veterinary Medicine
CPD	Continuing Professional Development
DEFRA	Department for Environment, Food and Rural Affairs
FIVP	The Federation of Independent Veterinary Practices
HR	Human Resources
NHS	National Health Service
PDSA	People's Dispensary for Sick Animals
PMS	Practice Management System
PSS	Practice Standards Scheme
QI	Quality Improvement
QIAB	RCVS Knowledge Quality Improvement Advisory Board
RCVS	Royal College of Veterinary Surgeons
RCVS Knowledge	Royal College of Veterinary Surgeons Trust, trading as RCVS Knowledge
RSPCA	Royal Society for the Prevention of Cruelty to Animals
SAVSNET	Small Animal Veterinary Surveillance Network
SPVS	The Society of Practising Veterinary Surgeons
TB	Tuberculosis
VCMS	Veterinary Client Mediation Service
VDS	The Veterinary Defence Society
VMD	The Veterinary Medicines Directorate
WSAVA	World Small Animal Veterinary Association

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We are also grateful for the participants who took the time to engage with this project. This would not have been possible without their valuable insights and sharing of experiences.

1. THE CURRENT QUALITY IMPROVEMENT LANDSCAPE IN THE VETERINARY SECTOR

This chapter will provide an introduction as to what Quality Improvement (QI) means, the progress that has been made in the veterinary sector in the last 15 years, and the improvements that are needed to help further embed QI within the sector. The aims of the research and structure of the report will be outlined at the end of this chapter.

1.1. WHAT IS QUALITY IMPROVEMENT?

A distinguishing feature of Quality Improvement (QI) is that it involves taking a formal and explicit approach to something already being done and seeking to do it measurably better. This contrasts with innovation which is concerned with doing something novel that, by definition, has not been tried before; there is, in reality, a continuous spectrum between these. QI therefore involves:

- understanding and articulating what is currently happening along with a data-led analysis of why this is or may be a problem
- establishing a baseline measuring current performance
- identifying a plausible improvement (based on an understanding of the current capacity of the service) and defining how improvement is to be measured
- making the change and measuring the results
- depending upon the results, adapting the improvement approach and continuing the cycle again.

Within this very broad definition, there are a number of approaches and practices[4] that can be selected and then tailored to a particular situation.

RCVS Knowledge is aware of the contribution made by QI in other industries, including in human healthcare and in 2017 invited a group of 'early adopters' to form a Quality Improvement Advisory Board (QIAB). RCVS Knowledge is seeking to support the profession in the enactment of QI techniques in veterinary practice. The aim is to produce practical tools, easily implemented in busy practices, to support decision

[4] See, for example, http://reader.health.org.uk/QualityImprovementMadeSimple/what-are-quality-and-quality-improvement#how-can-we-improve-quality

making and secure improved and measurable outcomes. To provide a focus for this work, RCVS Knowledge has drawn from the 'menu' of improvement activities and established five key areas for action (RCVS Knowledge, 2017):

1. Clinical audit
2. Benchmarking
3. Significant event audit
4. Guidelines
5. Checklists.

The primary purpose of this research is to provide evidence for decision makers to deliver support to veterinary practices in delivering QI. Further work is being completed to develop tools and resources to progress each of these five areas. The following section will provide an overview of current progress across these five areas and elsewhere within the veterinary sector. Additional information on current QI activities can be found later in this chapter.

1.2. THE CURRENT STATUS OF QI IN THE VETERINARY SECTOR

As noted, QI involves taking a formal and explicit approach to improvement. Current interest in bringing QI into veterinary practice should not be taken to imply that previously there was no interest in improving the quality of care. Only that earlier (often more informal, tacit, and implicit) activities are no longer felt to be sufficient when compared to improvements which are possible through new technologies and devices, new evidence from clinical audit, and new models of care. In addition, veterinary professionals are often engaged in QI without necessarily realising that these actions come under the umbrella of QI and, therefore, may not close the loop on monitoring these activities to ensure they are having the desired impact. The case for QI is that there is a gap between current practice and what the evidence tells us is achievable practice that can be realised by adopting a systematic and formal approach to improvement. It is important to note that QI is not a process with an endpoint, it is a continual process that runs in cycles, as was summarised by one of the interviewees:

> *'It [QI] is a cyclical process rather than a journey from A to B.'* (INT11 profession)

Since the concept of an audit was first introduced into veterinary practice in 1998 by the British Veterinary Hospital Association (BVHA), and the later establishment of the Practice Standards Scheme (PSS) in 2005,[5] more attention has been focused on QI within the sector. The QI documents the research team reviewed highlight the resources and time that have been put into driving QI from a range of stakeholders, including RCVS Knowledge, in addition to others such as large practice groups.[6] These literature resources and other data collection methods highlighting the particular differences in the approaches to QI and the resources available to do so between smaller practices are discussed in detail throughout this report. Much of the QI work going on in the veterinary sector falls into one of five areas, as identified from the review

[5] For more details on the PSS, see: https://www.rcvs.org.uk/setting-standards/practice-standards-scheme/

[6] Larger practice groups are defined as those with 50 or more practice premises and smaller practices are those with 49 or fewer premises. In the UK, the number of practices with 50 or more registered premises includes: Vets Now Ltd, Linnaeus Group, Medivet, VetPartners, Vets4Pets and Companion Care Vets, CVS Group plc and Independent Vetcare Ltd (correct as at 2nd July 2019)

of QI-related veterinary documents. These are outlined in Annex A, along with some examples of activities identified from the literature.

This section will provide a brief overview of the current approaches to QI in the veterinary sector. Additional detail on this, which draws on the data the research team have collected throughout this research, is discussed in Chapter 4.

1.2.1. Adapting learning from the NHS to the veterinary context

QI within human healthcare is continuing to develop and evidence about what works (and what does not) is becoming richer and more systematic. Consequently, it may be helpful to summarise what is known, systematically reviewed and relevant to this study.

In 2009, Powell and colleagues showed that there was much evidence about different approaches to QI in human healthcare but little about financial costs. There was no straightforward taxonomy of approaches and, in general, it was considered impossible to identify a single 'right' model; QI approaches should be tailored to the particular circumstances. Amaratunga and Dobranowski (2016) reviewed the application of Lean and Six Sigma[7] QI methods in radiology and found that there were highly plausible accounts of how these methods could reduce error and costs, but there was an absence of rigorous research capable of attributing improved outcomes to the methods. Meanwhile, Wells and colleagues (2018) conducted a systematic review of improvement collaboratives in particular and found that Quality Improvement collaboratives have been widely adopted as support for QI. The research suggests that they are highly promising approaches to improvement, but the authors emphasise that results must be interpreted with caution because fewer than one-third met established quality and reporting criteria. Finally, in a systematic review of Plan, Do, Study, Act methods[8] in QI studies, Knudsen, Laursen, and Mainz (2017) concluded that despite the great increase in QI studies in recent years, reporting has been too inconsistent and insufficiently thorough to be certain about the causal relationships between the methods pursued and the reported effects.

From this we can conclude at least three things relevant to this study:

1. There are many studies in human healthcare which suggest promising results from QI, but the quality of the evidence produced in support of these claims should make us aware that we should be cautious about the quality of the evidence while recognising that there are widely reported benefits.
2. There is considerable agreement that there is no single 'right' model and that approaches must be adapted to circumstances; measuring what works and then improving – or abandoning – it.
3. There are few persuasive cost–benefit analyses and therefore building the business case in animal healthcare will be important.

[7] The Lean methodology originates from manufacturing and is aimed at reducing waste by cutting out steps and activities that do not add value. Six Sigma methodology also aims to reduce waste and in this case by streamlining and improving business processes.

[8] According to an NHS Improvement publication: 'The model for improvement provides a framework for developing, testing and implementing changes leading to improvement. It is based on scientific method and moderates the impulse to take immediate action with the wisdom of careful study. Using Plan, Do, Study, Act cycles enables you to test out changes on a small scale, building on the learning from these test cycles in a structured way before wholesale implementation. This gives stakeholders the opportunity to see if the proposed change will succeed and is a powerful tool for learning from ideas that do and don't work. This way, the process of change is safer and less disruptive for patients and staff.' (ACT Academy, 2018).

1.2.2. Bringing insights from human healthcare into animal healthcare

There is a small body of research on bringing insights from human to animal healthcare. Ballantyne (2016) and Oxtoby and Mossop (2016) discuss areas where the veterinary sector could learn from the NHS and discuss the factors that need to be considered when implementing activities designed for humans into animal healthcare. This focuses particularly on data collection and infrastructure and investment in QI-related areas. Data collection and infrastructure in the NHS are further ahead but the veterinary sector is starting to develop improved data collection systems and approaches, for example, the RCVS Code of Professional Conduct[9] emphasises the importance of collecting data via audits and to gain PSS hospital accreditation, practices must implement clinical audits and mortality and morbidity reviews (Oxtoby and Mossop, 2016). However, at the time of writing, these authors emphasise that further work is needed to bring the veterinary sector up to the same standard as there is currently no national, centrally located hub for data collection and treatment approaches are not standardised across the sector, which makes data collection and analysis difficult (Oxtoby and Mossop, 2016).

The same authors also discussed how the NHS values and provides resources for QI skill development, including teamwork and behaviour. Although communication is taught at undergraduate level during veterinary education, there is little seen of this QI skill development after graduation (Oxtoby and Mossop, 2016). The need for more QI skill development will be discussed in more detail in Section 7.5.

Although the veterinary sector could learn from the NHS in terms of development and implementation of QI activities, any lessons need to be adapted to ensure they are appropriate for the veterinary sector. Some key differences between human and animal healthcare include:

- The NHS being much larger than the veterinary sector.
- Veterinary practices are regulated by a single body, rather than the many regulators seen with the NHS.
- Veterinary practices being more exposed to market pressures (Oxtoby and Mossop, 2016).
- Less evidence is available in veterinary medicine when compared to what is available in human healthcare (Ballantyne 2016).
- The fee structures within veterinary healthcare are different compared to human healthcare in the UK (the NHS is funded by the government, etc.).

Quality Improvement in human healthcare has also been influenced by the experience of the aviation sector, with particular reference to checklists, training, crew resource management, incident reporting, culture and human factors (Kapur et al., 2015). Of particular interest to the veterinary sector would be the relevance of encouraging a learning rather than a blaming culture (and this was reaffirmed through the summit) and the importance of considering a role for Cognitive Bias Avoidance Training as part of post-qualification staff training to help reduce the risk of decision making errors (Hambley, 2018). It is worth noting that the NHS does not always avoid a blaming culture.

1.3. CONTEXT AND AIMS OF THIS RESEARCH

Although the veterinary profession has made a lot of progress in introducing QI to the sector since 1998 and developing it over time, it is not yet embedded in day-to-day work across the sector. QI activities appear to be informal and unrecorded, and if they are implemented, it is unclear if any changes are made

[9] This will be referred to as the RCVS Code of Conduct throughout the remainder of this report.

as a result of QI activities, or if changes are monitored to measure any impacts. There is no robust body of evidence that can guide decision makers with certainty, but there are highly promising insights that can provide the beginning of a more evidence-driven application of QI in animal healthcare.

To help address these uncertainties, RCVS Knowledge, with the support of the QIAB, commissioned RAND Europe to conduct a piece of independent research to explore the drivers, barriers and facilitators of QI in the veterinary sector as a stepping stone for the profession to make decisions about how best to take QI forward.

In consultation with RCVS Knowledge, the evaluation team developed three overarching research questions to be explored during this research project:

1. What the veterinary profession (which includes for the purpose of this research veterinary surgeons, veterinary nurses and veterinary managers) is currently undertaking in their workplace to improve quality?
2. What shapes, or could shape, the veterinary profession's motivations for being engaged and involved with QI?
3. What RCVS Knowledge and other stakeholders[10] can do to overcome the barriers, and support the enablers for the veterinary profession, to engage with Quality Improvement in practice?

The following chapter discusses the methodological approaches to answer these research questions.

1.4. STRUCTURE OF THIS REPORT

This report is structured as follows. Chapter 2 provides a summary of the methodological approach to the study and the limitations (with additional information available in Annex B). Chapters 3–7 discuss the research findings. Chapter 3 reports on findings of the veterinary professions' awareness, perceptions and understanding of QI. Chapter 4 reports on the current approaches to QI. Chapter 5 reports on the factors that support the profession to engage with QI and that act as barriers. Chapter 6 discusses the possibility of involving clients in QI. Chapter 7 discusses what various stakeholders in the veterinary sector could do to support QI. Chapter 8 discusses these findings and draws conclusions as to what they may mean for veterinary practice. Finally, Chapter 9 provides recommendations for each key stakeholder involved in QI within the sector.

[10] By other stakeholders, the research team mean any organisation involved in the veterinary sector, such as universities and other educational institutions, individual veterinary practices and team members, professional veterinary organisations, the veterinary client mediation service, CPD providers and PMS providers, among others.

2. METHODOLOGY

The methodological approach for this project was designed to allow the research team to engage with as many stakeholders as possible, including members of the veterinary profession, within the available resources. A mixed-methods approach was taken to gather various insights from these stakeholders and ensure the results are robust and reliable. The methods the research team used included:

- a review of QI documents from the sector
- 18 semi-structured interviews with key stakeholders
- a survey of 471 members of the profession
- two focus groups with 14 PSS assessors
- a national summit attended by 50 policymakers and influencers from the veterinary profession.

Additional details for the above approaches can be found in Annex B.

Each methodology was adapted to answer the research questions outlined at the end of the previous chapter. The approach was designed in consultation with RCVS Knowledge during the inception phase of the project.

While the research team aimed to be as robust as possible when designing and conducting the project and analysing the results, there are some limitations and caveats to the approach which will be discussed at the end of this chapter.

2.1. DOCUMENT REVIEW

A review of QI-related documents from RCVS, RCVS Knowledge, academic, large practice groups and professional bodies was carried out at the start of the project (January–February 2019), with additional documents of interest reviewed throughout the remainder of the project. The aim of this was to summarise what is happening in terms of QI in the sector at the moment, how it has changed over time and what plans are in place to support QI in the near future.

The documents the research team reviewed were provided by RCVS Knowledge and included both academic and grey literature. To identify relevant academic literature, RCVS Knowledge Library and Information Services conducted a search using keywords related to QI and of literature that had been published since 2008 (the full search strategy can be found in Section B.1), which led to 421 identified articles. To identify relevant articles from this 421, one member of the research team searched for keywords in the title/abstracts, including 'quality improvement', 'clinical governance', 'improvement' and 'clinical audit'. Articles not in English, books, podcasts and descriptions of events/workshops without information on results were excluded. This led to nine articles identified as relevant and information

extracted. In addition to this, RCVS Knowledge sent a list of 36 grey literature documents it identified as being relevant to the research. This included QI strategy documents and QI reports from RCVS Knowledge, large practice groups and RCVS webpages with QI information, such as the Code of Conduct for veterinary surgeons and nurses, among others. One member of the research team reviewed each document, and extracted the relevant information.

Information from these 45 articles relevant to the research was extracted into a short write-up and information from this has been incorporated throughout the report. It is important to note that we were aware of only CVS having published a QI report at the time the document review was conducted. Therefore, the research team were unable to reference QI reports from other practice groups.

In addition to the documents sent by RCVS Knowledge, five key systematic reviews covering QI in human healthcare were included. The purpose of this was to explore where progress made within the veterinary sector by RCVS, RCVS Knowledge and others sits within the evidence base of human healthcare.

2.2. KEY STAKEHOLDER SEMI-STRUCTURED INTERVIEWS

18 semi-structured interviews were conducted with key stakeholders across March–May 2019 by telephone. The stakeholders, numbers, aims of the interviews and the codes used throughout this report are shown in Table 2.

TABLE 2: THE NUMBER OF STAKEHOLDER INTERVIEWS, THE AIM OF INTERVIEWING EACH AND THE CODE USED TO REFERENCE INTERVIEW DATA THROUGHOUT THE REPORT

STAKEHOLDER	NUMBER	AIM OF THE INTERVIEW	CODE
Animal charity	1	To understand the current QI initiatives in place within the charity, the barriers and enablers faced by animal charities and how QI can be taken forward in the sector.	INTX charity
Animal owner	2	To provide perspectives on where animal owners think improvements can be made in the veterinary sector.	INTX owner
Members of the profession	10	To understand the current status of QI across the veterinary sector, the motivations for professionals to engage with QI and the enablers and barriers they face, and how professionals would like QI to be taken forward in the veterinary sector.	INTX profession
Large practice groups' Clinical Governance leads	2	To understand the motivations and constraints regarding QI for those in practice.	INTX LPG
RCVS Knowledge QIAB member	1	To gain an understanding of the context of QI in the veterinary sector, the hopes for this project and the role of the QIAB in QI now and in the future.	INTX QIAB
Representatives from organisations who deal with veterinary clients' complaints	2[11]	To cover the background of QI in the veterinary sector and explore where animal owners think improvements can be made in the sector.	INTX complaints

Members of the profession were identified using random sampling to ensure the research team spoke with individuals with a range of backgrounds and experiences, including: animal species treated, practice type (i.e. from larger or smaller practice groups), whether the practice is PSS accredited (representing the level of engagement with QI) and years since graduation. These individuals were randomly selected using the RCVS member database. The demographics for each of the profession interviews is in Annex B (Table 5).

The individuals identified through random sampling were searched online to explore their background and experience (as the RCVS database only includes individuals' names, email addresses and whether they are a nurse or surgeon) to ensure the research team spoke to at least one individual from each of the criteria outlined in Table 2. All interviewees completed and signed a consent form ahead of the interview.

The research team produced a semi-structured interview protocol tailored to each stakeholder group. A semi-structured approach to the interviews allowed the research team to ask a standard set of questions across and within stakeholder groups, while allowing the flexibility to tailor questions to the specific interviewee's knowledge and experience, as well as follow up on interesting areas mentioned by the

[11] One of these interviewees was involved in veterinary client mediation, which provides independent support to veterinary practices and clients to resolve a complaint.

interviewees that are not explicitly touched on in the protocol. Each stakeholder interview protocol is in Section B.2.

Each interview was recorded, partially transcribed and provided with a code, which is used throughout this report when referring to data collected from interviews (Table 2). The interviews were analysed using Nvivo; 'nodes' were created for each interview question and the transcripts were coded within this template. New nodes were added into the Nvivo file if other topics were discussed by interviewees. Using Nvivo allows for accurate and efficient cross-analysis of interview data across and within stakeholder groups.

2.3. FOCUS GROUPS WITH PSS ASSESSORS

Two focus groups were conducted with PSS assessors in March 2019. These were both face-to-face focus groups and took place before and after a day of PSS training. Pam Mosedale MRCVS, the lead PSS assessor at RCVS, invited all PSS assessors to these focus groups with 14 out of the 24 assessors agreeing to take part (seven participants for each group).

PSS assessors enter a large variety of practices across the country with a mandate to assess and assure the standards of clinical governance (among other standards). As such, they were identified as key stakeholders to understand the current landscape of QI in veterinary practices. The demographics of the focus group participants are in Annex B (Table 6).

The aim of these focus groups was to understand the motivations of the profession to become involved with QI (including getting PSS accredited) as well as explore what RCVS and others could do to support QI going forward. Each focus group participant completed a consent form ahead of the focus group.

As with the interviews, the focus group protocol followed a semi-structured format to allow exploration of additional areas during the session if they arose (this protocol is in Section B.4). Each focus group was recorded, transcribed and analysed in Nvivo along with the interview data. Data from the focus groups is referenced throughout the report using similar codes as the interviews, either FG1 or FG2.

2.4. SURVEY OF THE VETERINARY PROFESSION

In collaboration with RCVS Knowledge, the research team designed, conducted, promoted and analysed a national survey open to all members of the veterinary profession to explore how veterinary professionals (including surgeons, nurses and practice managers, as well as students and researchers/academics) perceive QI, their awareness and understanding of QI initiatives, which QI methods they implement on a day-to-day basis, what supports or acts as a barrier to this implementation, and who they think is responsible for supporting QI going forward.

The survey questions were designed in consultation with RCVS Knowledge. The survey was conducted using SmartSurvey and was disseminated by RCVS Knowledge through various channels to reach as many of the profession as possible, including social media and a press release. Details of those invited to participate can be found in Annex B.6. A prize of a £150 Amazon voucher was offered to one random individual who responded to the survey to act as an incentive. The survey was open for six weeks between February and April 2019. A total of 485 responses were received, which was higher than originally anticipated and offers us an accurate representation of the views of the profession within a ±4 per cent

margin of error.[12] The demographics of the respondents are also similar to those seen across the profession as a whole, based on RCVS data, including animal species treated, job role, age and type of practice.[13]

Raw responses were exported from SmartSurvey to Excel. Those respondents who did not agree to the consent questions were removed (14 participants) which left 471 responses to be analysed. Each survey question and the analysed response can be found in Section B.5.

2.5. NATIONAL SUMMIT FOR SUPPORTING QUALITY IMPROVEMENT IN VETERINARY CARE 2019

In May 2019, RCVS Knowledge and RAND Europe hosted the National Summit for Supporting Quality Improvement in Veterinary Care in London. This event was attended by over 50 key stakeholders in the veterinary sector including major veterinary organisations, animal charities, veterinary practices and universities and educators, among others. A list of organisations invited to participate in the summit can be found in Annex B.6. The aim of this summit was two-fold; to:

- validate the research findings and ensure all important factors had been covered
- explore the possible actions for supporting QI going forward and which stakeholder/organisations are responsible for each of these.

The agenda for the day can be found in Section B.5. Cross-analysis of all other data collection methods prior to the summit highlighted five key challenges faced by the profession and these were the focus of activities throughout the day:

1. How do organisations get to a position where **dedicated time** can be prioritised for teams to implement QI in practice? Which stakeholder/s can fill this role?
2. How and what **training/education/professional** development is needed/can be provided? Which stakeholder/s can fill this role?
3. What **resources** (physical/technical, e.g. better tools/Practice Management Systems (PMS)/national audits/universal nomenclature, etc.) will make embedding QI more likely to take place, easier to embed and more likely to have an impact? Which stakeholder/s can fill this role?
4. How can we better **communicate and demonstrate its importance and benefit** (to patient care and business)? Which stakeholder/s can fill this role?
5. How do we secure **buy-in** from employers and colleagues (organisationally/professionally/contractually, including locums)? Which stakeholder/s can fill this role?

The thoughts and ideas shared throughout the summit have been cross-analysed with the rest of the data collected during this research and have been reported in both the results and discussion chapters. These can be identified as '(summit)'.

[12] This was calculated using SmartSurvey's margin of error calculator and was based on the 2016 estimates that the veterinary profession consists of 30,000 people and the survey received 471 responses.

[13] For more information on the demographics of the veterinary profession, see RCVS Facts, available at: https://www.rcvs.org.uk/news-and-views/publications/rcvs-facts-2017/?destination=%2Fnews-and-views%2Fpublications%2F

2.6. LIMITATIONS AND CAVEATS

Although the research team and RCVS Knowledge have made every effort to ensure this research is as robust as possible, there are inevitably some limitations:

- Although the search for the academic literature used multiple keywords to identify relevant documents and RCVS Knowledge has a good understanding of the available grey literature on QI, this was not a systematic search of the literature and so the research team cannot be sure if this covered all available articles. However, the document review was intended to be a high-level summary of the general progress of QI in the sector today and what some of the plans are to support and improve this going forward, rather than a systematic review of all available literature.
- As the research team only conducted a small number of interviews, with only one or two interviews for most stakeholder groups, this may not be a representation of views across the veterinary sector. However, the research team engaged with a range of different members of the profession and with other stakeholders who have a well-rounded view of QI to give us as balanced insight as possible. In addition, the research team only conducted two interviews with animal owners, one of which was associated with RCVS. However, the research team felt this interviewee provided a balanced view of their experience with veterinary care and did not appear to be biased in their responses. The research team also explored the possible role of animal owners in QI in other interviews and the survey to ensure the research team obtained as balanced a view as possible.
- As with all interviews, focus groups and surveys, the questions can be interpreted differently and some individuals may have been reluctant to share sensitive information with us. To mitigate this issue, the research team designed all data collection questions in consultation with RCVS Knowledge to ensure they were adapted to be answered by a veterinary audience. The research team also made clear in the privacy information for all data collection methods that RAND Europe are an independent organisation and would not be sharing raw data with RCVS Knowledge or others.
- During the inception stage of the project, the research team and RCVS Knowledge were aware of the possibility of only collecting data from individuals more engaged with QI during the profession interviews and survey. To mitigate this as much as possible, members of the profession working in practices that were not PSS accredited were interviewed and RCVS Knowledge disseminated the survey through multiple channels to reach as much of the profession as possible. This included promotion through major veterinary organisations including to Veterinary Surgeons and Nurses through RCVS News, through a variety of practice groups, the veterinary press and through social media.
- The majority of survey respondents (82 per cent) and interviewees were based in England and so it may be difficult to generalise the survey results to the three other UK nations.
- The way the survey was designed meant that individuals who were not familiar with Clinical Governance sections of the Code of Conduct and/or the PSS had to select the option that they were not aware of these initiatives for multiple questions. Interestingly, the number of participants reporting that they were not familiar with these increased as the survey progressed. This can be seen in Figure 32 to Figure 34 in Section B.5 for the Code of Conduct, and Figure 35 and Figure 40 for the PSS. This increase is particularly evident for the PSS; those reporting they were not familiar with the Clinical Governance section of the PSS increased from 8.07 per cent to 24.84 per cent, whereas for the Code of Conduct it increased from 7.43 per cent to 16.56 per cent. This

may indicate a lowering of engagement as participants progressed through the survey, or that they had changed their minds on what familiar meant. It may also indicate that members of the profession feel familiar with the Code of Conduct and PSS in general, but not with the Clinical Governance sections in particular.

- While the research team and RCVS Knowledge made every effort to optimise the design of the survey, the survey relied on self-reported data which can suffer certain biases, e.g. social desirability bias or respondents may forget details.
- Although the term 'Quality Improvement' was used throughout this research, the veterinary sector often uses the term 'Clinical Governance' instead of this, for example, within the Code of Conduct and PSS guidance. This may have meant some members of the profession were unaware that the ways these terms are used sometimes overlap (with Clinical Governance identifying areas to address and QI providing tools to address these). However, most participants seemed to understand the overlap between these terms and the researchers used both terms throughout the interviews to mitigate any confusion. The terminology used during the survey was often Quality Improvement, which may have led to some confusion and uncertainty; however, the research team also included the term Clinical Governance when referring to many RCVS initiatives as this is the term used for these, which should have reduced uncertainty.
- Finally, although the number of survey responses was better than expected at 471, this was much fewer than the total number of veterinary professionals (close to 30,000 as of 2016) (Royal College of Veterinary Surgeons, 2017a). However, as discussed previously, this number is within a ±4 per cent margin of error and the demographics are similar to that seen across the profession as a whole.

3. PERCEPTIONS, AWARENESS AND UNDERSTANDING OF QI AMONG THE VETERINARY PROFESSION

This chapter provides an overview of how familiar the veterinary profession is with QI, including the Clinical Governance sections of the Code of Conduct and PSS, how they perceive QI (whether the profession views QI as a benefit to care), and how well they understand QI, including how appropriate they think the Clinical Governance sections of the Code of Conduct and PSS are in supporting QI. The results of this section are summarised in the box below.

- Although the profession report they are aware of QI, including the Code of Conduct and PSS, the depth of this understanding varies. Professionals whose job role incorporate some aspect of QI, or require an understanding of the Code of Conduct or PSS, are more likely to have an in-depth understanding of these and the requirements set within them. Unsurprisingly, professionals based in PSS-accredited practices are more likely to be familiar with the PSS which often includes large practice groups of which many require all their branches to be accredited.
- QI was generally viewed in a positive light and professionals felt it provides benefit to patient care and to practices by allowing practices to provide a high standard of care. The PSS was also seen as providing benefit to care and is thought to be a helpful introduction to QI for those practices that are not familiar with QI. However, there were mixed views on the extent to which the PSS supports implementation of sustainable change in practices as the recommendations of the assessments are not mandatory for practices to implement. The Code of Conduct is seen as providing a baseline set of standards that all practices should be meeting to provide a safe level of care.
- Around half of veterinary professionals reported understanding the requirements set out in the Code of Conduct and the PSS and this group generally felt as though the requirements in both of these are appropriate. The relatively low level of understanding of the Code of Conduct and PSS may, in part, be due to veterinary professions not being familiar with either of these in-depth.

3.1. ALTHOUGH THE VETERINARY PROFESSION IS AWARE OF QI, THE CODE OF CONDUCT AND PSS IN GENERAL, THERE WAS VARIATION IN THE DEPTH OF THIS KNOWLEDGE

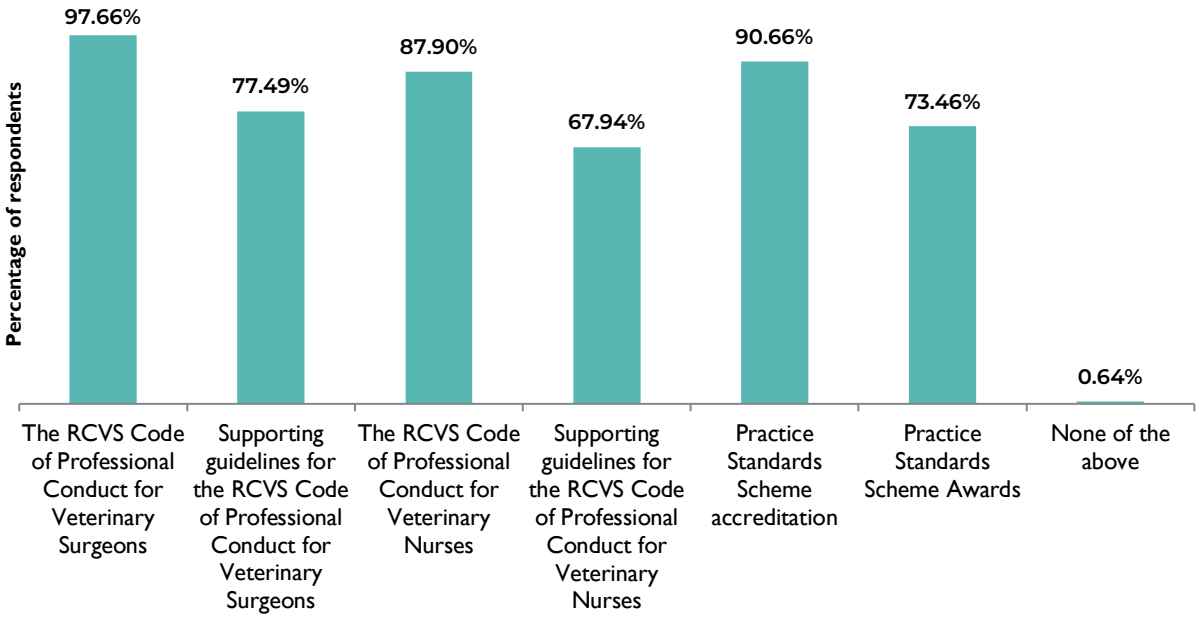
Across the members of the profession the research team consulted, it became apparent that the profession is generally aware of QI as a concept (or Clinical Governance, which is the term they may be more familiar with) and the activities that go on within their practice, as well as the Clinical Governance sections of the Code of Conduct and PSS. However, the awareness of QI activities going on within practices and more broadly did vary, and some participants knew of activities that are implemented in their practice but weren't necessarily aware that these activities come under the umbrella of QI, suggesting a lack of knowledge on what activities fall under QI and what this really means in practice.

Awareness of QI has likely increased over the last ten years as there has been a greater focus on it from RCVS Knowledge and other bodies including large practice groups (INT9 profession). However, it appears that the depth of awareness and knowledge is dependent on the individual's role and experience (INT9 profession, INT13 profession). This is particularly apparent when exploring the awareness of the PSS among the profession (discussed in more detail in the following section). Those who have some sort of QI aspect within their role were more likely to be aware of the types of activities that are used and of the resources available to support this (INT9 profession). In addition, one interviewee thought that veterinary surgeons, who work alone, away from a central practice team, were less likely to know about QI as they were less exposed to it on a day-to-day basis (INT13 profession).

It was thought that the length of experience in the veterinary sector could influence the extent of engagement and interest, and thus understanding, of QI. Those with a greater amount of experience might be more resistant to implementing QI and so might not be familiar with it (INT13 profession). Those who were newly graduated might have been more aware of QI as it is included in the university curriculum, e.g. communicating with clients effectively (INT12 profession). However, as will be discussed throughout this report, university education, and education in other establishments, may not be going as far as it could in including QI-related material and so new graduates may not be familiar with continuous Quality Improvement as they perhaps should be.

The following two sections will focus specifically on the profession's awareness of the PSS and the Code of Conduct for veterinary surgeons and nurses, primarily the sections within these that focus on Clinical Governance. As Figure 1 shows, general awareness of both these initiatives was fairly high among the members of the profession the research team surveyed, with less than 1 per cent not having heard of either the Code of Conduct or the PSS. However, when the research team explored the level of this awareness during the interviews, it became apparent that awareness was fairly widespread but not always deep. Similarly to the awareness of QI more generally across the profession, those whose roles involved some aspect of QI were likely to be more familiar with the PSS and Code of Conduct. This will be discussed in more detail in the following two sections.

FIGURE 1: SURVEY RESPONSES TO THE QUESTION: ARE YOU AWARE OF THE FOLLOWING ROYAL COLLEGE OF VETERINARY SURGEONS (RCVS) SCHEMES? SELECT ALL YOU ARE AWARE OF.



3.1.1. Familiarity with the PSS varies depending on the accreditation status of practices and the presence of QI leads

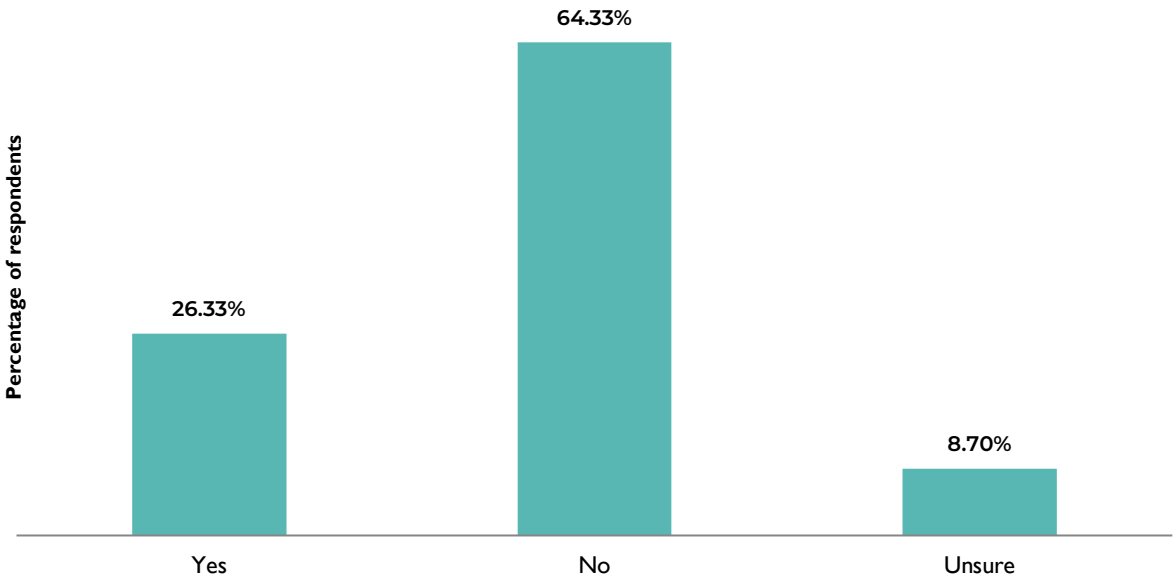
Although the survey responses in Figure 1 suggest that awareness of the PSS is fairly high among the profession (over 90 per cent for the scheme in general and 73 per cent for the awards), and when considering this is a voluntary scheme, accreditation within the sector is fairly high at roughly two-thirds of practices. However, when the research team explored this familiarity in more detail during the interviews, it became apparent that the level of familiarity differed depending on whether a practice was accredited and by different job roles.

In general, interviewees from practices that had undergone the PSS assessment were more familiar with it and the requirements set within the PSS, particularly if they had recently gone through an assessment (INT9 profession, INT10 profession, INT13 profession). It appears as though members of the profession based in large practice groups are more aware of the PSS requirements than those from smaller practices as many larger practices require all their branches to be PSS accredited (INT6 LPG, INT8 LPG).

It appears that many practices have informal or formal QI and/or PSS leads who will be very familiar with the scheme and the standards within this, whereas individuals within the same practice are not as familiar (INT6 LPG, INT8 LPG, INT7 profession, INT14 profession, INT17 profession). For example, one interviewee from a smaller practice group highlighted that the head receptionist within the practice leads on the PSS work and has a better understanding of the requirements than the interviewee who owned the practice, who reported never looking at the PSS requirements (INT14 profession). Similarly, two individuals from the same large practice group highlighted how team members within the group, particularly recently acquired non-PSS accredited practices, are not familiar with the PSS requirements, which is why they have set up a central, dedicated PSS team to visit each branch and go through the requirements with the team to help the practice get up to standard (INT8 LPG, INT17 profession).

In addition to awareness of the PSS as a whole, the research team also explored the professions' awareness of the PSS Team and Professional Responsibility award in the survey.[14] As Figure 2 shows, around two-thirds of respondents were not aware of this award; however, it is important to note that this award was only launched in 2015. This may reflect the level of uptake of this award; statistics from RCVS show that this has a much lower uptake compared to the Client Service Award, with only 33 practices across the UK having achieved it compared to 173 for the Client Service Award as of July 2019 (this uptake is also demonstrated in Figure 3).

FIGURE 2: SURVEY RESPONSES TO THE QUESTION: ARE YOU AWARE OF THE TEAM AND PROFESSIONAL RESPONSIBILITY AWARD OFFERED AS PART OF THE PRACTICE STANDARDS SCHEME?[15]



The research team also explored whether the survey respondents were aware of whether their practice held the Team and Professional Responsibility award. As Figure 3 indicated, almost two-thirds of survey respondents reported that their practice didn't have this award; however, interestingly, one-third didn't know if their practice held this award. This aligns with the responses shown in Figure 2 in that the majority of the respondents were not aware of this award and so may be unaware that their practice holds it. Similar results were seen when asking survey respondents whether they knew if their practice intended on getting the Team and Professional Responsibility award in the future (Figure 4), with over two-thirds indicating they didn't know.

[14] This award allows practices to demonstrate the value they place on supporting the welfare of the team and how they offer high-quality services to clients and patients, in part through implementing Clinical Governance activities. More information on this award and others can be found at https://www.rcvs.org.uk/setting-standards/practice-standards-scheme/apply-for-awards/awards-overview/

[15] These numbers do not add up to 100 per cent as three individuals (0.64 per cent) did not complete this question.

FIGURE 3: SURVEY RESPONSES TO THE QUESTION: DOES YOUR PRACTICE HOLD THE TEAM AND PROFESSIONAL RESPONSIBILITY AWARD OFFERED AS PART OF THE PRACTICE STANDARDS SCHEME?[16]

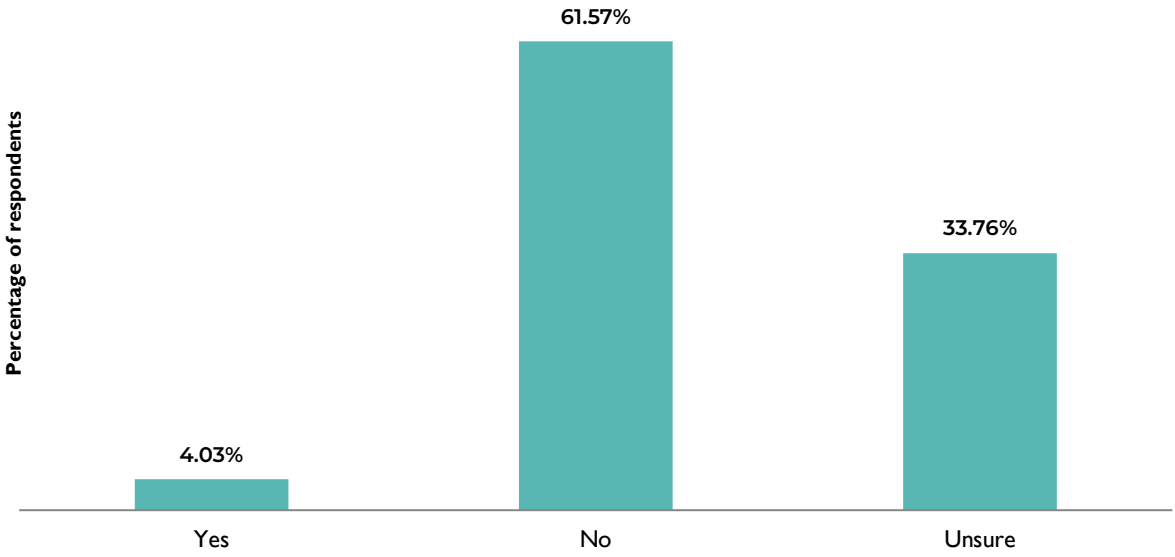
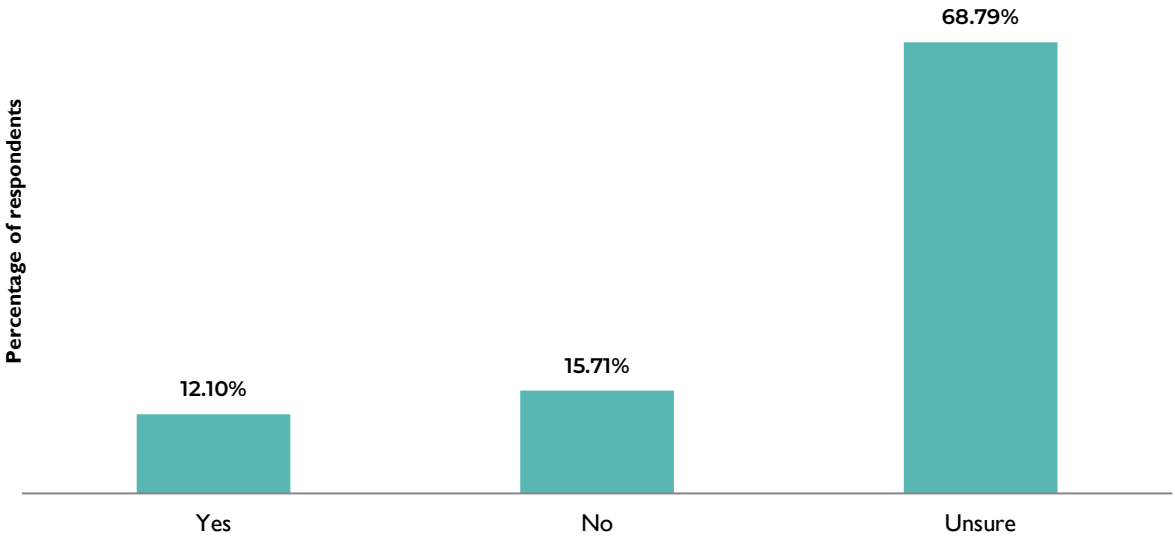


FIGURE 4: SURVEY RESPONSES TO THE QUESTION: DOES YOUR PRACTICE INTEND ON GAINING THE TEAM AND PROFESSIONAL RESPONSIBILITY AWARD IN THE NEAR FUTURE?[17]



3.1.2. Familiarity with the Code of Conduct varies with the length of experience and individual job role

Awareness of the RCVS Code of Conduct for veterinary surgeons and nurses appeared to follow a very similar trend to that of the PSS in that the profession is aware of what the Code of Conduct is but may not be familiar with the details, and those whose role involves some aspect of QI are more likely to be familiar with it.

[16] These numbers do not add up to 100 per cent as three individuals (0.64 per cent) did not complete this question.

[17] These numbers do not add up to 100 per cent as three individuals (0.64 per cent) did not complete this question.

As shown in Figure 1 earlier in this section, awareness of the Code of Conduct for veterinary surgeons is very high among the profession who responded to the survey at 98 per cent. This reduces slightly, although is still relatively high, when looking at the Code of Conduct for veterinary nurses (89 per cent) and the associated guidelines for both (77 per cent for Code of Conduct for veterinary surgeons and 68 per cent for Code of Conduct for veterinary nurses).

Despite the survey respondents indicating that awareness of the Code of Conduct is fairly high among the profession, on further exploration of this during the interviews it became clear that many individuals were not familiar with these in depth and did not keep up to date when new information is added (INT1 QIAB, INT6 LPG, INT7 profession, INT10 profession, INT14 profession). When discussing the Clinical Governance section of the Code of Conduct, in particular, a member of the QIAB felt as though most of the profession would not be aware that it is a part of the Code that is mandatory to follow (INT1 QIAB). This suggests that veterinary professions are most likely to be familiar with the Code of Conduct after graduating from university (as it is covered in the curriculum), and as professionals progress through their career they are not likely to keep refreshed and up to date on the Code.[18]

> *'I would hope [that they are familiar with the Code of Conduct] but it isn't really something at my fingertips these days.'* (INT10 profession)
>
> *'I don't think I would be alone in saying that when you're qualified for 25 years, you don't just sit down and read it [the Code of Conduct].'* (INT7 profession)

Similarly to the PSS, interviewees who were more familiar with the specifics of the Code of Conduct were most likely to come across it in their day-to-day role, particularly those with non-clinical roles as well as nurses whose responsibilities often extend to those beyond clinical tasks (INT9 profession, INT16 profession, INT18 profession). For example, one interviewee's role is part clinical and part administrative. The protocols and other QI activities they had introduced into their practice were based on the Code of Conduct (INT16 profession). Another interviewee was familiar with the Code of Conduct because of their enrolment in an MSc which included a module on Clinical Governance; this interviewee thought that the rest of the profession who had not been involved in this type of training would be less aware of the Code (INT9 profession).

One QI lead from a large practice group felt as though all team members in their practices were familiar with the Code of Conduct as it is the minimum standard the team is required to meet to provide safe care (INT8 LPG). This may suggest that those in management positions presume that frontline team members are familiar with the Code of Conduct, which may be the case, but may overestimate how familiar they are with the detail and how often it is incorporated into daily practice.

3.2. THE VETERINARY PROFESSION VIEWS QI AS A BENEFIT TO PRACTICE AND TO PATIENT CARE

Across the interviews and survey, the research team asked members of the profession what QI meant to them and whether they thought it would provide a benefit to the animals in their care. Overall, almost all individuals felt as though QI would improve the care they provided and shared a variety of reasons as to

[18] The Code of Conduct is refreshed every few years (the last update was in 2012) and all updates are uploaded to the RCVS website for veterinary surgeons: https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/ and veterinary nurses: (https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-nurses/.

what QI meant to them in their day-to-day work. When asked which term was best to describe improvement activities, QI or Clinical Governance, the responses to this were very mixed which may reflect the frequent use of the term 'Clinical Governance' in the veterinary sector in the past, and which might now be shifting to a preference for QI instead.

Figure 5 and Figure 6 show the survey responses when participants were asked whether they thought engaging with QI would improve care within their practice and across the UK. As this shows, almost all respondents felt as though QI could improve the quality of care they, and others across the UK, provide.

FIGURE 5: SURVEY RESPONSES TO THE QUESTION: WHICH OF THE FOLLOWING STATEMENTS DO YOU AGREE WITH REGARDING THE IMPACT OF QUALITY IMPROVEMENT ON YOUR PRACTICE?

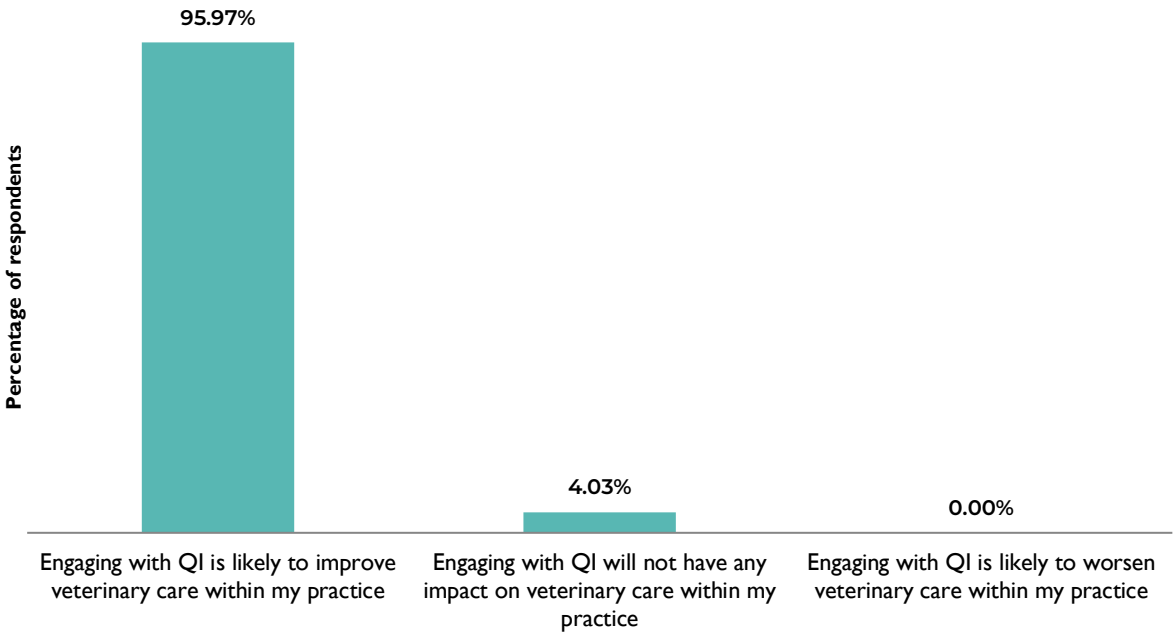
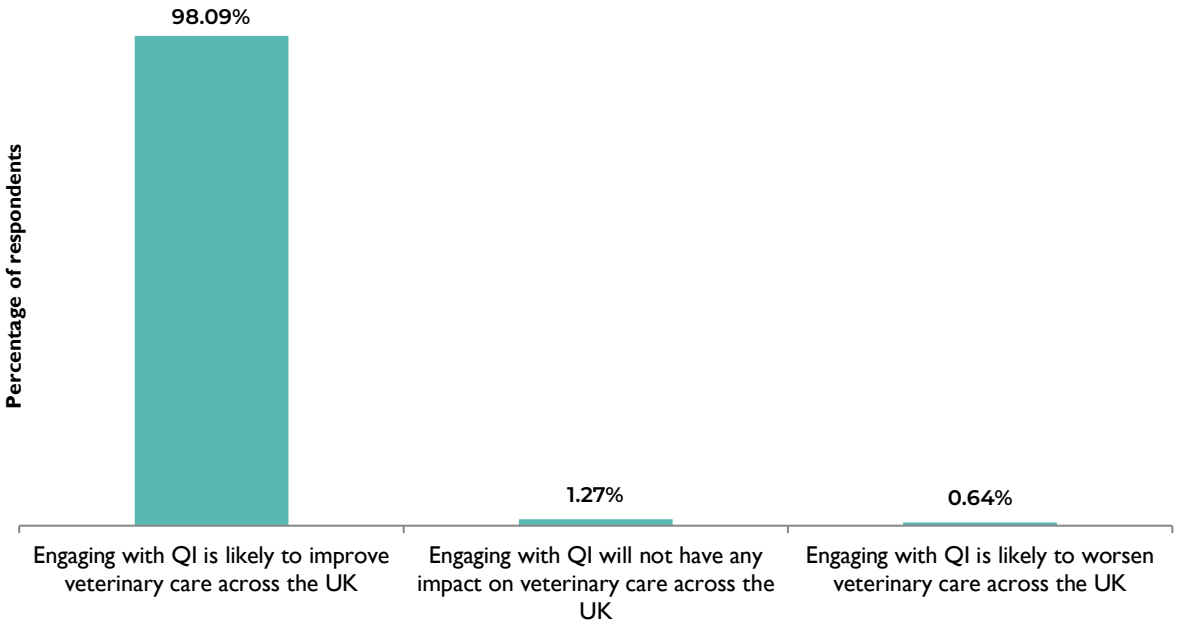


FIGURE 6: SURVEY RESPONSES TO THE QUESTION: WHICH OF THE FOLLOWING STATEMENTS DO YOU AGREE WITH REGARDING THE IMPACT OF QUALITY IMPROVEMENT ON VETERINARY CARE ACROSS THE UK?



Similar responses were seen when asking the interviewees what QI meant to them in their day-to-day role. Many individuals discussed how QI allows them to provide the best care possible to animals and reducing incidents of adverse events (INT4 profession, INT7 profession, INT9 profession, INT11 profession, INT16 profession, INT18 profession). It means trying to achieve clinical excellence and provide gold standard care within the practice, rather than 'cheap and cheerful' (INT7 profession, INT17 profession).

> *'To stop critical events from happening, or try and prevent them as much as possible, and provide the best service that we could.' (INT16 profession)*
>
> *'QI means striving to improve our clinical skills and improve a client's journey through a veterinary practice.' (INT14 profession)*

It was also highlighted by respondents that QI is also important in supporting veterinary teams, for example, to reduce staff turnover by increasing job satisfaction (INT4 profession, INT10 profession, INT11 profession).

> *'QI is trying to make sure that you are doing the right things that you should be doing and not just for the patient but for the client and staff as well.' (INT11 profession)*

The importance of QI providing a proactive measure for improving care was discussed as it allows for the identification of potential issues before they become an actual problem (INT7 profession, INT11 profession, INT16 profession).

> *'I think unless you're constantly questioning and auditing and justifying what you're doing, it's very easy to find you're failing to recognise something that's very obviously happening in front of you.' (INT7 profession)*

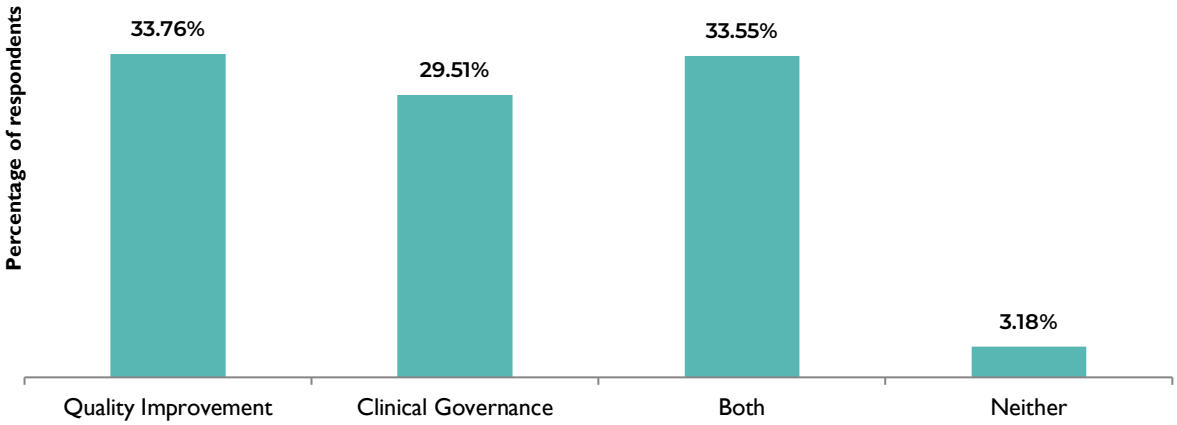
QI was also perceived to provide more effective evaluations of the care provided by a practice and to create more efficient improvement plans (INT17 profession). This interviewee discussed that QI allows the practice to set clear standards and plans for making improvements and to track progress against this. Thus the QI approaches implemented are more likely to be successful for both the practice as a business, and to the care of animals (INT17 profession), although it is important that these standards are evidence-based and have been shown to improve quality of care.

Many interviewees also discussed the importance of QI in providing a continual improvement process for the practice, rather than viewing QI as a one-off process with a finishing point (INT1 QIAB, INT9 profession, INT11 profession). This was thought to be important to keep up with changes in medicine and the identification of new evidence (INT9 profession). The importance of viewing QI as a continual process was discussed, as this will allow it to become embedded into the ethos and culture of the practice and to understand that improvements can always be made, even in areas that are performing well, and that review processes need to be cyclical rather than having a defined endpoint (INT1 QIAB, INT11 profession).

> *'It [QI] is a cyclical process rather than a journey from A to B.' (INT11 profession)*

When describing the preferred term for improvement activities, both survey respondents, interviewees and summit attendees were very mixed on whether they preferred the term QI or Clinical Governance. Figure 7 highlights this mixed response, with around one-third of participants each responding that they preferred QI, Clinical Governance or both terms. The research team would propose adopting the following long-standing approach in human health that sees Clinical Governance as: 'a framework through which NHS organisations are accountable for continually improving the quality of their services, safeguarding high standards by creating an environment in which excellence in clinical care will flourish' (Secretary of State for Health, 1997). In other words, Clinical Governance should be located as an approach that sits alongside and supports QI activities.

FIGURE 7: SURVEY RESPONSES TO THE QUESTION: WHICH OF THE FOLLOWING TERMS DO YOU THINK IS MORE RELEVANT AND USER-FRIENDLY FOR VETERINARY PROFESSIONS?



3.3. VETERINARY PROFESSIONALS VIEW THE PSS AS BENEFICIAL TO ANIMAL CARE AND TO PRACTICES, ALTHOUGH THERE WERE MIXED VIEWS ON THE EXTENT OF CHANGE IMPLEMENTED AFTER PSS INSPECTIONS

Across the interviews, the research team asked members of the profession what their perceptions of the PSS are and whether it provided a benefit to practices that are accredited. Overall, the interviewees held positive views of the PSS and felt as though it benefits business and patient care, although there were some concerns that the PSS assessment does not necessarily lead to changes in practice.

Interviewees felt as though the PSS was a simple process and had become easier since it was first introduced, with more information and guidance disseminated by RCVS (INT5 owner, INT10 profession, INT11 profession). Although there are still some paperwork requirements ahead of the assessment, this was thought to not be too time-consuming and the overall benefit of getting accreditation outweighed the time and resources that needed to be put in ahead of the assessment (INT10 profession, INT11 profession). However, one interviewee from an animal charity reported that they would be interested in getting some of the PSS awards, but thought that these would be too much work for the charity to take on across all sites (INT4 charity).

> *'People are pleased to be doing it [the PSS] and won't mind spending time on it.' (INT11 profession)*

The greater focus on how the practice worked and face-to-face interviews, rather than completing large amounts of paperwork, as was seen to be the case when the PSS was first set up, was deemed to be particularly important by one interviewee as a veterinary professional who treats farm animals (INT10 profession).

The PSS was seen as being a way of introducing practices to QI who are not familiar with it (INT6 LPG, INT11 profession). The PSS was reported by one interviewee to often be the first exposure to QI for a practice and provides them with a framework to start setting up QI activities (INT6 LPG). Advice from the PSS assessors during the assessment was particularly helpful for practices in guiding their QI activities, for example, setting up a process of tracking animals and procedures so this can be referred back to when needed rather than relying on memory, and helping to identify solutions to problems the practice may be facing (FG1, INT13 profession).

> *'The PSS scheme is a good start and is a good guide to get the main [QI] things in place.'* (INT11 profession)
>
> *'It [the PSS] is a good framework for starting QI.'* (INT6 LPG]

The PSS was also reported to provide a benefit to the practice from a business perspective (INT5 owner, INT10 profession). It provided a badge to advertise to clients that the practice is deemed to be of high quality by RCVS[19] and that this often makes the practice proud of their achievement (INT6 LPG, INT10 profession). However, one interviewee felt as though RCVS's marketing of the PSS to clients was lacking

[19] Although it is important to note that the PSS standards are set by the Practice Standards Group who represent the wider veterinary profession from a range of major veterinary organisations (including RCVS), the interviewees only referred to RCVS when speaking about this point.

when it was first set up and has meant clients are not aware of what being PSS accredited means and they do not seek practices that they know are accredited (INT14 profession).

> *'Practices are really proud when they get accredited, they are chuffed.' (INT6 LPG)*

Another benefit from a business perspective is that it allows comparison of similar practices to see how the services provided align with those from other practices (INT4 charity). This was deemed to be of particular importance by practices run by charities as it allows for a comparison to the wider veterinary community (INT4 charity), which is often difficult due to the complexities of sharing data on performance between private businesses.

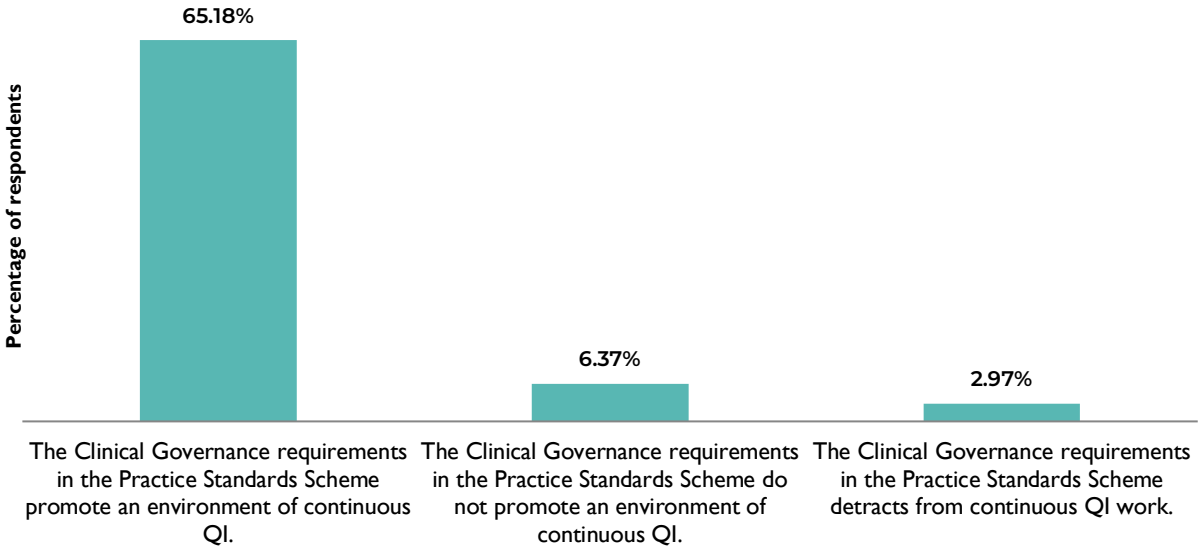
When asked about their views of the PSS, many respondents discussed the link between the PSS assessment and implementing change in practice with mixed views arising as to the extent of sustainable change seen as a result of a practice being accredited. It was suggested that whether a practice implements change after being assessed depends on its general QI culture and approach to improvement. Those practices (or a small number of individuals within practices) that are self-motivated to make improvements and see the assessment results as helpful guidance for improvement were thought to be more likely to implement sustained changes (INT7 profession, INT9 profession). One interviewee from a large practice group also highlighted this point, describing how the results of the PSS are taken seriously across all practices under its group structure and if any areas of improvement are found during the assessment, that these are addressed and then re-inspected by the practice (INT8 profession).

However, it was noted that the four-year gap between assessments can mean motivation and progress drops during this time and that this may be the case particularly for smaller practice groups that do not have the same processes in place as larger groups and may see it as more of a tick-box exercise (INT7 profession, INT8 profession, INT9 profession, INT13 profession), although random PSS assessments can occur in between the four-yearly assessments.

> *'Practices are really proud when they get accredited, they are chuffed.' (INT6 LPG)*

The research team also explored whether members of the profession felt as though the Clinical Governance section of the PSS supported QI (Figure 8). These results show that 65 per cent of those surveyed felt as though these requirements contributed to an environment of continuous QI in their practice. Only 6 per cent felt as though the PSS didn't have an impact on creating an environment to support QI and fewer than 3 per cent felt it detracted from QI work.

FIGURE 8: SURVEY RESPONSES TO THE QUESTION: PLEASE SELECT THE ANSWER BELOW THAT MOST CLOSELY APPLIES TO YOUR VIEWS OF THE PRACTICE STANDARDS SCHEME CLINICAL GOVERNANCE REQUIREMENTS.



3.3.1. The Code of Conduct provides baseline standards to provide safe care to all patients but it could do more to support QI

In general, the interviewees felt as though the Code of Conduct provides an effective set of baseline standards that all veterinary surgeons and nurses need to adhere to (INT8 LPG, INT10 profession, INT17 profession). One interviewee highlighted how the Code of Conduct had become embedded in practice, in part because it requires little time commitment to adhere to (INT16 profession).

When discussing the importance of the Code of Conduct, interviewees reported that it ensures all veterinary practices are providing standardised, safe care which provides benefit to both the veterinary team and clients (INT8 LPG, INT10 profession, INT17 profession).

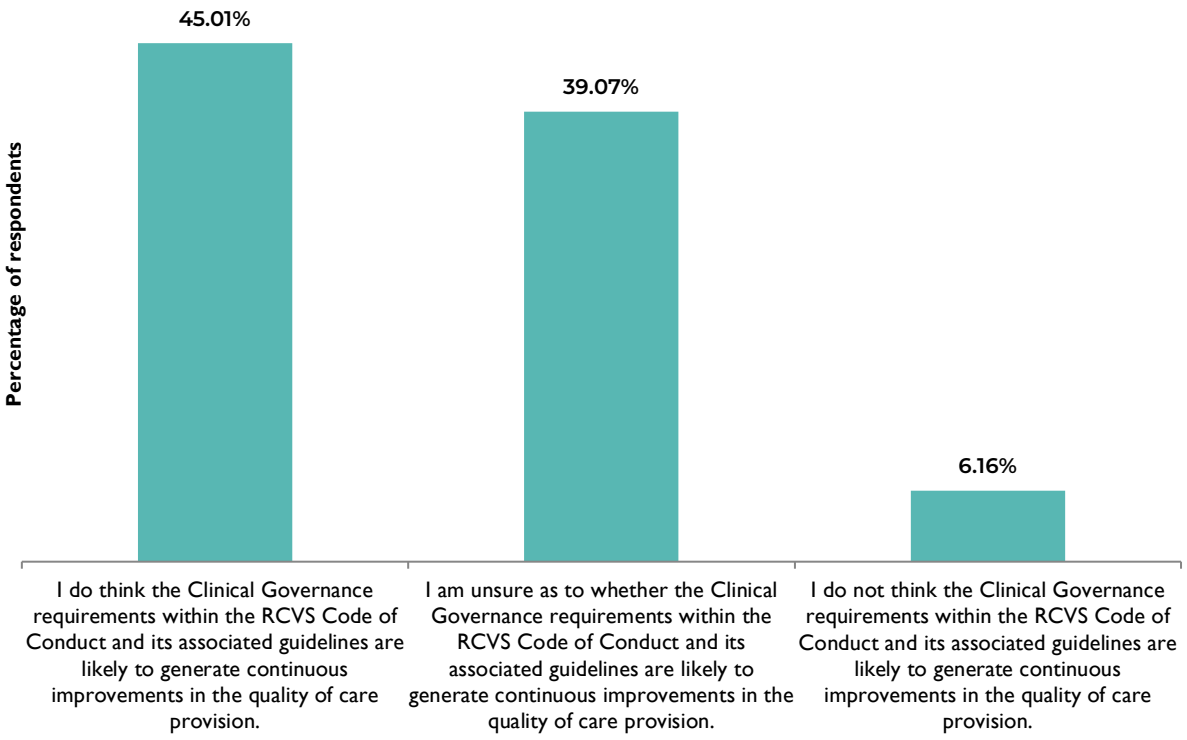
> *'The way I would see them [the Code of Conduct] is that they provide the baseline…if you are falling below the baseline then really there are questions about fitness to practice.'* (INT10 profession)

When discussing the Clinical Governance section of the Code of Conduct, in particular, interviewees felt as though the profession generally understood the importance of these standards and saw these as a benchmark to aim for (INT11 profession, INT5 owner).

As with the PSS, the research team also explored whether members of the profession felt as though the Code of Conduct supported QI and whether more could be done with the Code of Conduct to help support QI further. As Figure 9 shows, 45 per cent of the respondents felt as though the Code of Conduct supported practices in improving the care they provided and only 6 per cent felt they didn't. However, 39 per cent were unsure as to whether the Code of Conduct supported QI.

FIGURE 9: SURVEY RESPONSES TO THE QUESTION: WHICH OF THE FOLLOWING STATEMENTS IS MOST APPLICABLE TO YOU ABOUT THE CLINICAL GOVERNANCE STANDARDS OF THE RCVS CODE OF CONDUCT

AND THEIR ASSOCIATED GUIDELINES (FOR VETERINARY SURGEONS AND FOR VETERINARY NURSES) TO GENERATE CONTINUOUS IMPROVEMENT IN QUALITY OF CARE?[20]

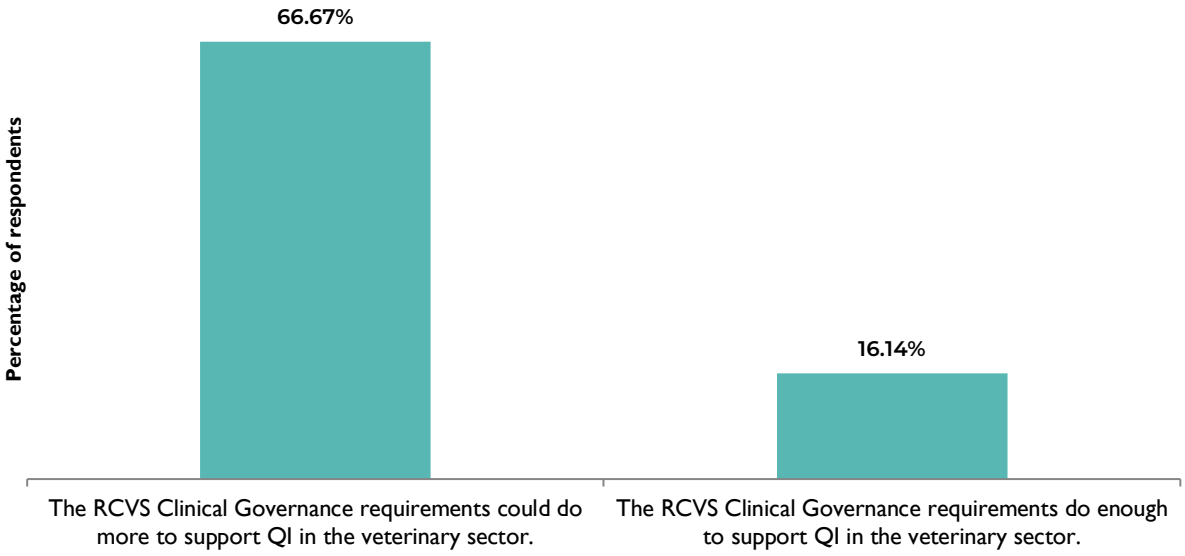


The research team explored this aspect in more detail through the interviews. In general, interviewees felt as though the Code of Conduct does support QI (INT6 LPG, INT8 LPG, INT9 profession). However, one interviewee highlighted the importance of having multiple processes in place to support QI and the Code of Conduct alone is not enough to increase QI across the profession (INT6 LPG).

The research team also investigated whether members of the profession thought the Code of Conduct could do more to support QI. As Figure 10 shows, two-thirds of respondents felt as though the Code of Conduct could be doing more to support QI across the veterinary sector, with only 16 per cent feeling as though it does enough. This was reflected by one interviewee who felt that the Clinical Governance standards need to be updated on a regular basis to reflect changes in practice, as well as to keep up with new QI progress (INT9 profession).

[20] These numbers don't add up to 100 per cent as three individuals (0.64 per cent) did not complete this question and 9.13 per cent reported that they were unaware of the Clinical Governance section of the Code of Conduct.

FIGURE 10: SURVEY RESPONSES TO THE QUESTION: PLEASE SELECT THE ANSWER BELOW THAT MOST CLOSELY APPLIES TO YOUR VIEWS OF THE CLINICAL GOVERNANCE REQUIREMENTS WITHIN THE RCVS CODE OF CONDUCT (FOR VETERINARY SURGEONS AND FOR VETERINARY NURSES).[21]



3.4. UNDERSTANDING OF THE CODE OF CONDUCT AND PSS VARIES AMONG THE VETERINARY PROFESSION

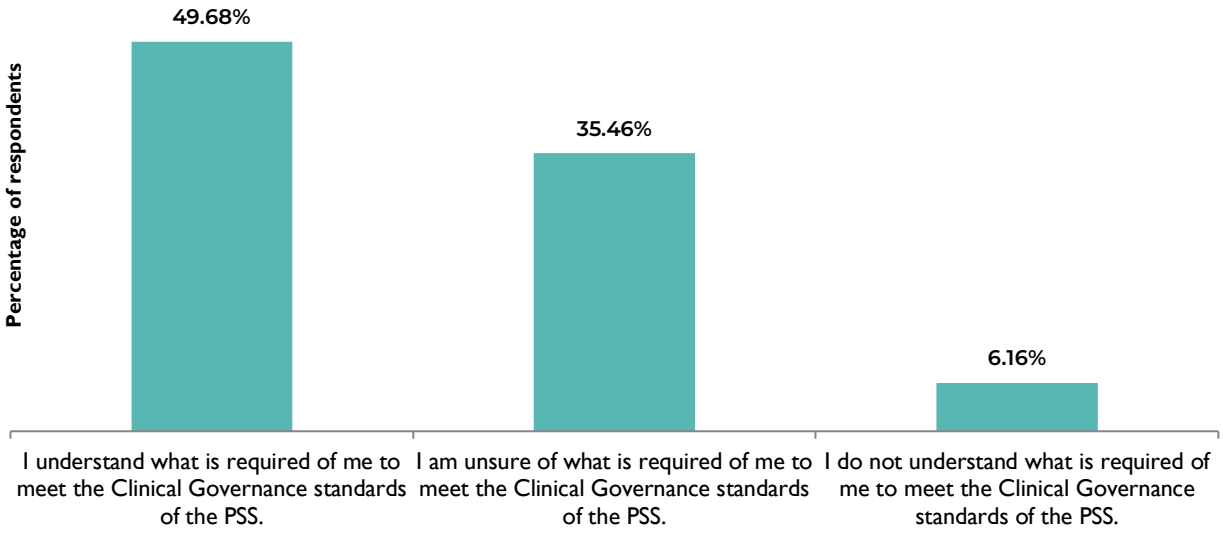
Throughout the survey and interviews, the research team explored how well the veterinary profession understood the requirements set out in the PSS and the Code of Conduct and whether they thought these standards were appropriate. The level of understanding of the requirements was mixed among the survey respondents; however, in general, interviewees who were familiar with the Code of Conduct and PSS felt as though the standards were appropriate for both. As with the previous section, this section will cover the PSS and Code of Conduct separately.

3.4.1. Understanding of the PSS is mixed among the profession, although the standards within the PSS are thought to be appropriate

Among the survey respondents, there were mixed responses as to how well the PSS was understood (Figure 11). Half of the respondents felt as though they understood the PSS requirements, whereas 35 per cent were unsure. Only 6 per cent reported they did not understand the requirements of the PSS.

[21] These numbers don't add up to 100 per cent as three individuals (0.64 per cent) did not complete this question and 16.56 per cent reported that they were unaware of the Clinical Governance section of the Code of Conduct.

FIGURE 11: SURVEY RESPONSES TO THE QUESTION: WHICH OF THE FOLLOWING STATEMENTS IS MOST APPLICABLE TO YOU AND YOUR PRACTICE ABOUT THE CLINICAL GOVERNANCE STANDARDS SET OUT IN THE PRACTICE STANDARDS SCHEME?[22]



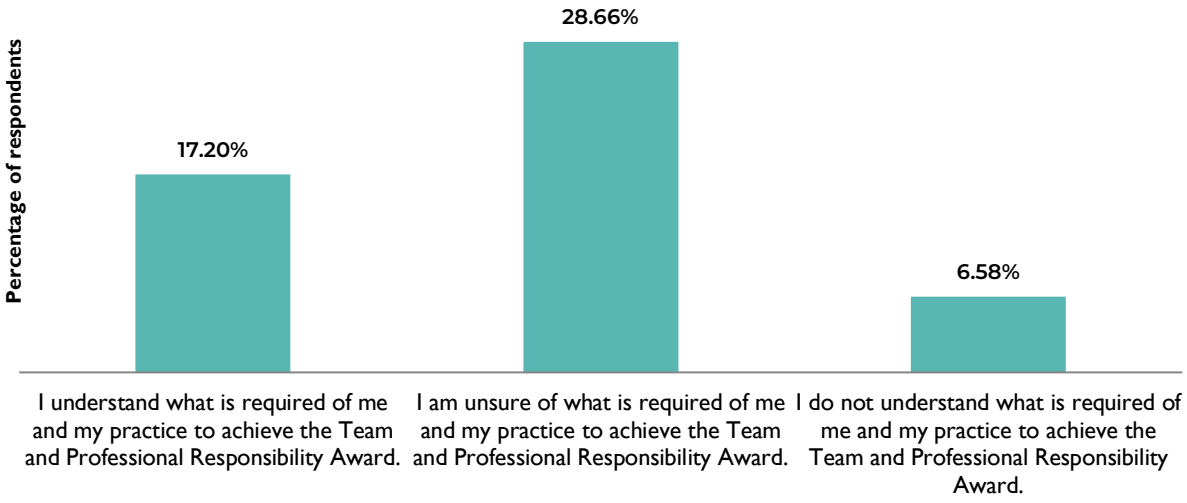
When exploring whether the standards of the PSS were appropriate during the interviews, individuals generally reported that these standards were appropriate. This included feedback that it aligns with the basic standards set in the Code of Conduct and the PSS assessment validates that the practice is working at or above these standards (INT9 profession). However, it was mentioned that those who are not accredited may not be aware of these requirements and so do not necessarily strive to meet them (INT6 LPG, INT7 profession). An example of this provided by an equine veterinary professional was that many equine vets still have practices with only one or two vets 'operating out of a car' and 'doing their own thing' so may not fulfil the PSS Clinical Governance standards (INT7 profession). However, it should be noted that the PSS introduced accreditation for equine ambulatory practices in 2015 to help overcome the particular challenges faced by these professionals. Although the Core standards of the PSS align with the Code of Conduct and veterinary legal requirements, one interviewee felt as though the PSS requirements were fairly low and that their practice was hoping to achieve a higher standard than these going forward (INT11 profession).

As in the section on awareness of QI, the research team also explored the profession's understanding of the Team and Professional Responsibility award offered under the PSS. As Figure 12 shows, out of those respondents who were aware of this award, the majority (29 per cent) were unsure of what is required of them to achieve the award and only 17 per cent did understand what was required.

This uncertainty in what the PSS is asking of practices is likely to link back to Section 3.1.1 in that although veterinary professionals have, in general, heard of the PSS, they may only have an in-depth understanding if their job role involves some aspect of QI or if they are based in a PSS-accredited practice.

[22] These numbers don't add up to 100 per cent as three individuals (0.64 per cent) did not complete this question and 8.07 per cent reported that they were not aware of the Clinical Governance standards of the PSS.

FIGURE 12: SURVEY RESPONSES TO THE QUESTION: WHICH OF THE FOLLOWING STATEMENTS IS MOST APPLICABLE TO YOU AND YOUR PRACTICE ABOUT THE TEAM AND PROFESSIONAL RESPONSIBILITY AWARD WITHIN THE PRACTICE STANDARDS SCHEME?[23]

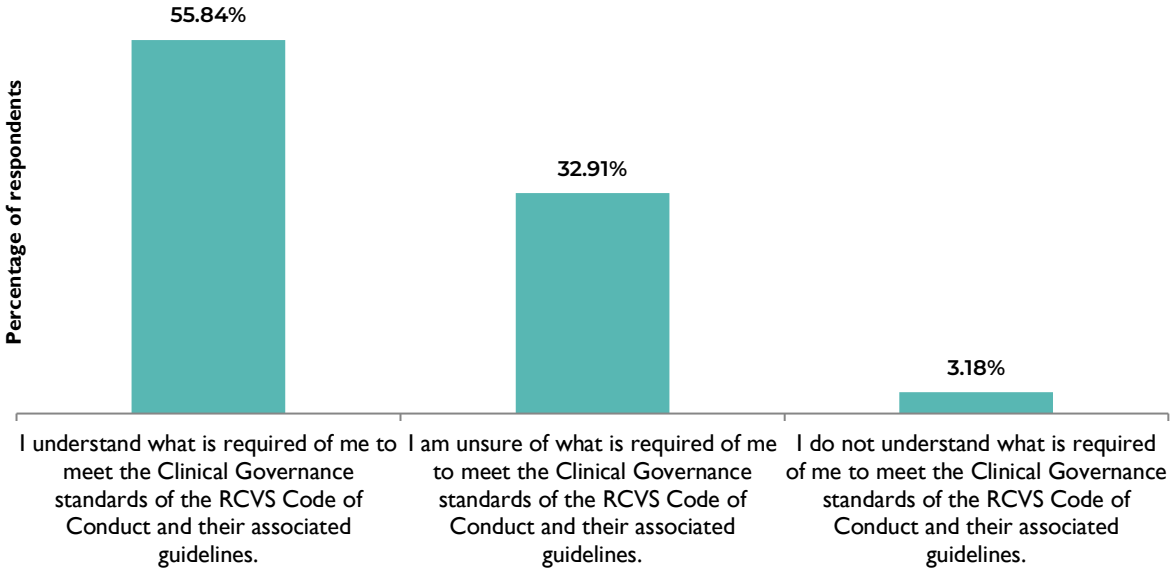


3.4.2. Understanding of the requirements set out in the Code of Conduct is mixed among the profession, although those familiar thought the requirements are appropriate

56 per cent of the survey respondents who were aware of the Code of Conduct felt as though they understood what is required of them to meet the Clinical Governance standards of the Code of Conduct and 33 per cent were unsure (Figure 13). Although only 3 per cent reported they didn't understand what was required of them, as the Code of Conduct outlines the basic standard that all veterinary surgeons and nurses must meet, this 36 per cent who were unsure or didn't understand the requirements suggests room for further improvement.

[23] These numbers don't add up to 100 per cent as three individuals (0.64 per cent) did not complete this question and the 46.92 per cent of responses who were not aware of this award were excluded from this chart.

FIGURE 13: SURVEY RESPONSES TO THE QUESTION: WHICH OF THE FOLLOWING STATEMENTS IS MOST APPLICABLE TO YOU ABOUT THE CLINICAL GOVERNANCE STANDARDS OF THE RCVS CODE OF CONDUCT AND THEIR ASSOCIATED GUIDELINES (FOR VETERINARY SURGEONS AND FOR VETERINARY NURSES)?



Many of the interviewees, although they were generally aware of the Code of Conduct, were not particularly familiar with these in depth and so were unable to comment on how well they understood the requirements and whether they are appropriate. Those that were aware of the Code of Conduct in more detail thought that the requirements were understandable, with one interviewee commenting that the Code of Conduct had become easier to follow in recent years and provided more examples, which were seen to be helpful (INT8 profession). One interviewee felt as though team members whose roles include only clinical activities were less likely to make the link between the Code of Conduct and QI activities that are implemented within practice (INT16).

4. CURRENT APPROACHES TO QI IN THE VETERINARY SECTOR

Although the research team identified many QI activities in place through the document review (some of which are outlined in Section 1.2), they were aware that many of these activities would not be publicly available or reported centrally to RCVS or RCVS Knowledge. Therefore, the research team explored in depth the average amount of time spent on QI, the kinds of QI activities veterinary practices have in place and the resources available to help the profession to engage and implement QI. A summary of the results covered in this chapter is presented in the box below.

- Veterinary professionals are already spending time on QI, and the amount of time spent appears to increase with greater veterinary experience and in corporate practices.
- A variety of QI approaches were reported to be used in practice, including regular meetings, clinical audits, significant event audits, protocols, checklists, guidelines, continuing professional development and surveys.
- RCVS Knowledge and corporate practices offer resources for practices wanting to get involved with QI. Establishing formal and informal QI leads can support these QI activities to become embedded and sustained in practice.

4.1. VETERINARY PROFESSIONALS ARE SPENDING TIME ON QI, WITH TIME SPENT INCREASING THE LENGTH OF EXPERIENCE AND IN LARGE PRACTICE GROUPS

The survey investigated how much time respondents had spent on QI activities in the last year. As Figure 14 shows, the majority of respondents spent one to three days on QI (30 per cent). Only 11 per cent reported that they had not spent any time on QI in the past 12 months. The research team also explored the differences in time spent on QI across different demographics, including job role, animal species treated, practice type and age. The results were fairly similar across these demographics, although those aged 65 and over were most likely to spend more than ten days on QI (67 per cent of this age group spent more than ten days). The next closest to this was those aged 55–64 in which 29 per cent spent more than ten days, which may reflect that those in more senior positions are able to dedicate more time to QI. For age in general, the trend appears to be that time spent on QI increases with age (Figure 15). Other demographics did not show particular differences in the survey.

FIGURE 14: SURVEY RESPONSES TO THE QUESTION: IN THE PAST 12 MONTHS, APPROXIMATELY HOW MUCH TIME IN TOTAL HAVE YOU SPENT ON QUALITY IMPROVEMENT ACTIVITIES?

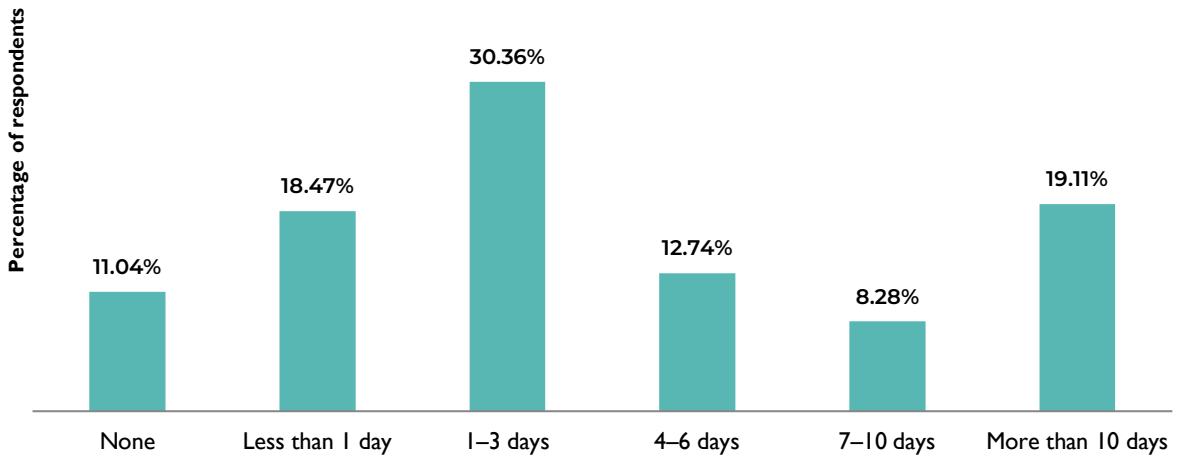
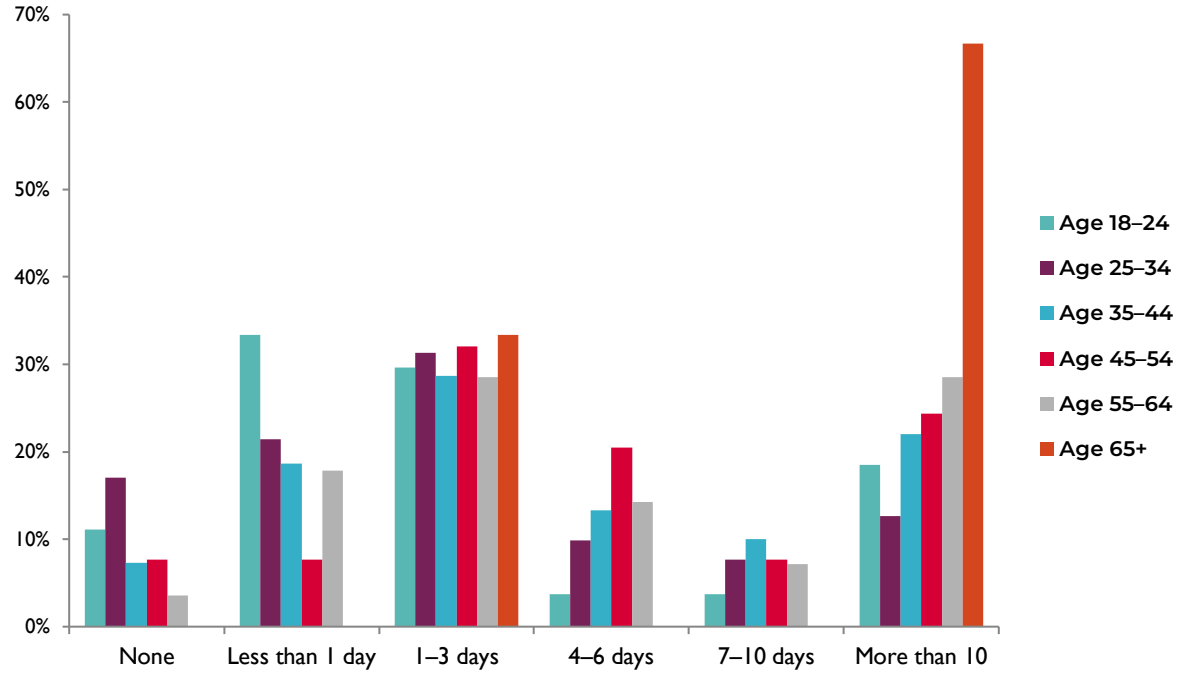


FIGURE 15: SURVEY RESPONSES BY AGE TO THE QUESTION: IN THE PAST 12 MONTHS, APPROXIMATELY HOW MUCH TIME IN TOTAL HAVE YOU SPENT ON QUALITY IMPROVEMENT ACTIVITIES?[24]



The research team explored the differences in time spent on QI between large and smaller group practices in the interviews and the QI documents reviewed. These suggest that QI activities are used to a greater extent after an independent practice has been bought by a large practice group, particularly when a practice is required to undergo PSS accreditation. It was reported that QI activities often become more formalised

[24] Two participants selected the option 'prefer not to say' when asked for their age and these results are not included in this graph. The large percentage of those aged 65+ spending more than 10 days on QI is due to the small sample size (only three participants were in this age group).

after an independent practice has been adopted by a large practice group. There will be more pressure from senior management to report on progress and to get PSS accreditation to ensure all practices within the large practice group are providing a standard level of care (INT10 profession, INT11 profession, INT17 profession, CVS Group plc, 2018). One interviewee discussed how this process was positive for the independent practice that is acquired, particularly if they didn't have many QI activities in place, as it provides them with a starting point to implement QI and to get the support it needs to achieve the standard required (INT11 profession).

These figures indicate that the veterinary profession is spending time on QI, and this was also evident from the interviews in which all interviewees could speak of at least one QI activity that was used in their practice. However, the use of QI tools and methods alone does not necessarily indicate effective QI, as following up on the results of these measurements and implementing change is equally important, as is sharing lessons profession-wide.

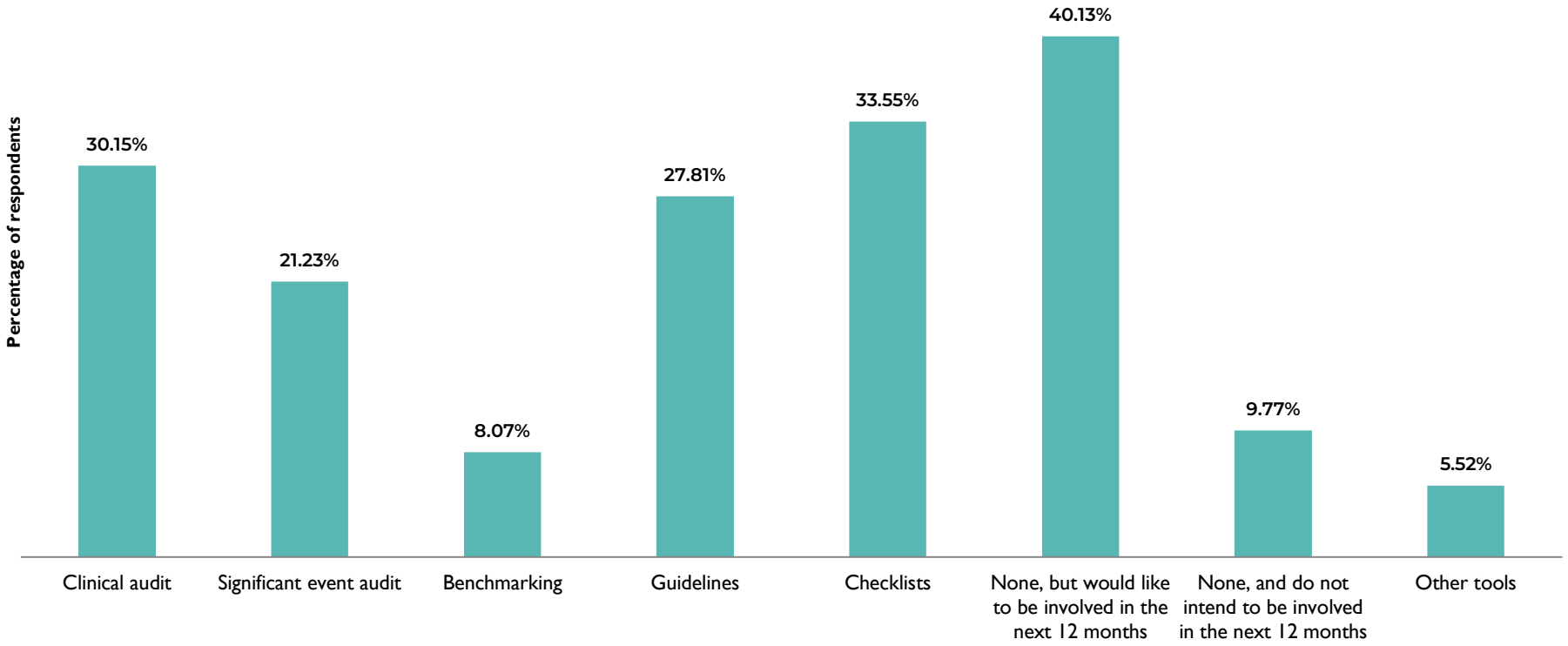
4.2. A RANGE OF QI ACTIVITIES ARE USED IN PRACTICE AND THESE ARE OFTEN DEVELOPED IN-HOUSE

The research team explored which RCVS Knowledge QI tools were used by the survey participants over the past 12 months. Although these tools have only been available since late 2018, around one-third of respondents reported having used at least one, with 40 per cent of respondents who hadn't used these resources indicating they would like to over the next 12 months (Figure 16). Only 10 per cent reported that they had not used any of the tools and did not intend to going forward. Of the responders who had used the RCVS Knowledge tools, around one-third had used checklists (34 per cent) and clinical audits (30 per cent). Very few respondents reported they had used benchmarking (8 per cent). 6 per cent of respondents had used other QI tools. When asked what 'other' tools were used, responses included:

- QI tools developed in-house, including by large practice groups
- Continuing Professional Development
- information from colleagues
- wider literature
- social media
- similar tools to those offered by RCVS Knowledge but from other sources.

The use of similar tools developed in-house, rather than RCVS Knowledge tools, was reported during the interviews (INT9 profession, INT17 profession, INT8 LPG). One of the QI lead interviewees explained that they did use tools from RCVS Knowledge alongside tools developed within their practice through evaluating the literature to see what evidence is available for a particular intervention to ensure any QI activities introduced are evidence-based (INT8 LPG). This interviewee and another commented that the practice mainly used in-house tools as, when the business began implementing QI, there were few resources available elsewhere (including from RCVS Knowledge, although these tools have been adopted by these interviewees' practices since they were produced) (INT8 LPG, INT9 profession). For example, there are some large group practices that have developed their tools based on the guidance offered by RCVS Knowledge, however, respondents may not have been involved in their translation into their setting, and therefore may not be aware that they originated from those offered by RCVS Knowledge (although practices are asked to acknowledge the work of RCVS Knowledge).

FIGURE 16: SURVEY RESPONSES TO THE QUESTION: HAVE YOU USED ANY OF THE FOLLOWING QUALITY IMPROVEMENT TOOLS FROM THE RCVS KNOWLEDGE QI SITE IN THE PAST 12 MONTHS?



A main focus of the interviews with various stakeholders was to explore whether the interviewee's practices had implemented QI activities and if so, what these were and the impact they were having. All of the interviewees within these groups reported at least one QI activity that was implemented in their practice, with many discussing multiple activities in place. This section will provide an overview of the types of QI activities the interviewees discussed, which includes:

- regular team meetings
- clinical audits and significant event audits (including significant event reporting through VetSafe, which is a part of conducting a significant event audit).
- protocols, checklists and guidelines
- Continuing Professional Development
- client and team member surveys.

Examples of specific QI activities were mentioned by some of the interviewees and these are included in boxes throughout this section to highlight the types of QI happening across the veterinary sector, and what the outcomes of these are.

The interviewees also discussed the resources and support they received in implementing these activities, particularly the structures put in place to have an individual group/team leading QI within the practice. This is also discussed in more detail later in this section.

4.2.1. Regular meetings

Almost all of the interviewees who worked in veterinary practice reported the use of regular meetings involving various team members to discuss any problems arising and to identify ways of solving these (INT7 profession, INT8 LPG, INT9 profession INT11 profession, INT12 profession, INT13 profession, INT14 profession, INT16 profession, INT17 profession, INT18 profession). The team members attending these meetings, their frequency, and their aims, slightly differed among the individuals the research team spoke to. How formal these meetings are also varied; some are very informal and not recorded in an official way, whereas others are much more formalised. For example, a QI lead outlined how the practices within the group have regular meetings which include forms for each branch to complete to record the meeting and to ensure any actions are followed up (INT8 LPG).

Some interviewees reported that all team members attend regular meetings, including veterinary surgeons, veterinary nurses and administrative staff (INT7 profession, INT13 profession, INT17 profession). For other practices, these meetings may only be for either veterinary nurses or surgeons (INT11 profession, INT18 profession). One interviewee highlighted how the nurses in their practice held regular meetings to discuss issues that are arising in practice and to identify solutions to these. The nurses identify the evidence base for their proposed solutions and take this to the veterinary surgeons for sign-off (INT11 profession). Other interviewees did not mention who attended these meetings. RCVS Knowledge supports the one-team approach as the ideal way to hold team meetings and to achieve Quality Improvement. This means that clinical meetings should include representation from all teams and minutes of these meetings should be shared, with actions and revised interventions (including protocols/guidelines/checklists), to encourage inter-professional working and joint decision making.

The frequency of these meetings also varied across the individuals the research team spoke to. Some happen once a week (INT16 profession), monthly or bi-monthly (INT7 profession, INT8 LPG, INT13 profession, INT17 profession, INT18 profession) or every six months (INT14 profession). Alternatively, some practices hold meetings only after a serious incident (INT11 profession).

The aim of the meetings appears to determine the frequency at which they occur; weekly meetings seem to involve weekly reminders for team members on general day-to-day activities, such as to complete consent forms and to communicate with the team on a regular basis (INT16 profession). Those on a monthly basis are used to discuss cases and any incidents that have occurred during that month. They provide an opportunity to get members of the team together to discuss both management and clinical matters and allow the sharing of experiences among the team (INT8 LPG, INT13 profession, INT18 profession). This is particularly helpful for practices with more than one location, as they can ensure the care provided, and improvement measures in place, are standardised across all branches (INT13 profession). One interviewee outlined how monthly meetings were held for all team members and more regular meetings with other key members of the team, including the head vet, head nurse and head receptionist (INT17 profession). Box 1 provides an example of how monthly morbidity and mortality meetings are used in an equine hospital, and how these have been linked to clinical audits. Meetings taking place on a less regular basis, such as every six months, can be used to discuss major events over the last half a year and to discuss possible new methods of measuring and tracking outcomes related to these incidents (INT14 profession).

Box 1: Example of how regular morbidity and mortality meetings are linked with clinical audits to track unexpected deaths in an equine hospital

For the last six or seven years, monthly morbidity and mortality rounds involving the hospital clinicians, head of clinic nurse, yard nurse team, house vets and business managers have been implemented and are used to discuss all cases from the past month in which a horse has died or was euthanised. Unexpected morbidities are discussed in detail, for example, those related to catheter problems or post-operative infections, and the reasons for these deaths are provided. An audit of these cases is kept with specific case-related details, such as complications, bandage rubs and use of restricted antimicrobials, so that these can be tracked and monitored across the practice (INT7 profession).

4.2.2. Clinical audits and significant event audits

As with the use of regular meetings, the interviewees frequently reported the use of clinical and significant event audits (including VetSafe,[25] which provides a system for significant event reporting as a part of completing audits within practices).

Clinical audits

Many interviewees discussed the use of the internal, in-house developed audits within their practice. Whether an internal audit is implemented and the scope and focus of it appears to depend on the size of the practice. For example, one interviewee from a large practice group outlined how, when the practice was smaller, there would be informal discussions of incidents and where improvements could be made, but as the practice grew in size this became more formal and was made mandatory across the practice (INT7 profession). An interviewee working for an animal charity also discussed the importance of implementing

[25] VetSafe is a Veterinary Defence Society (VDS) app that allows veterinary professionals to anonymously report significant events with the aim of understanding why mistakes occur and to stop them happening in the future. More information can be found here: http://www.vds-vetsafe.co.uk/

clinical audits due to the size of the organisation, which meant it was important to show that they were legally compliant, for example, by following data protection laws (INT4 charity).

> *'At some point we all just sat round a table, discussed any adverse effects, looked at where we could change, improve and modify what we did, and to critically evaluate it and audit it rather than just discuss it.'* (INT7 profession)

The focus of the audit also varies depending on the needs of the practice. One interviewee discussed how the senior management team of the large practice group decides what the focus of an audit should be depending on its size (INT8 LPG). The interviewees highlighted how an audit can have a more general focus, looking at aspects across the practice, or be focused on one specific area (INT8 LPG, INT11 profession). For example, one interviewee from a practice recently acquired by a large practice group highlighted an audit that was conducted into the presence of toxic chemicals as the practice uses a lot of chemotherapy drugs (INT11 profession). Another interviewee discussed how audits are used to explore the evidence base of a drug that is offered by a pharmaceutical company representative to ensure that it would provide a benefit to the practice and that its efficacy is based on robust evidence (INT9 profession). A similar example of using audits to provide an evidence base for introducing a new drug prescription process in a practice treating farm animals is outlined in Box 2. In addition, clinical auditing can also be used to provide a benchmark for practices to ensure that they are maintaining consistent standards (INT11 profession).

Box 2: Example of how an internal audit has been used to explore the evidence base for the prescription of antibiotics

> The practice was facing some difficulties in choosing which drugs to prescribe as the practice owner often only prescribed the drugs requested by the client (in this case, farmers), including when they asked for fluoroquinolone antibiotics for their animals when it may not have been needed. This made it difficult for the veterinary surgeons in the practice to take responsibility and ownership over their own antibiotic prescriptions to reduce the usage in light of increasing antibiotic resistance. In response, the practice vets conducted an in-house clinical audit of the outcomes of animals that were prescribed fluoroquinolones compared to the outcomes of animals that weren't prescribed it. This provided an evidence base to take to the practice owner, to show that animal outcomes weren't different whether they were prescribed fluoroquinolones or not, and so the audit was a helpful tool in leading to behavioural change (INT10 profession).

A member of the profession working for a charity outlined in detail how their two internal audits are run (Box 3). This interviewee discussed how both of these audits faced some resistance at first as they were seen as an added task on top of regular roles, but they have now become embedded across the organisation and team members understand the importance of auditing (INT16 profession).

Box 3: Example of how a formal internal audit is run across each hospital within a single animal charity

Within the animal charity, an internal audit is run every quarter by the head office and senior management team. Employees and head office staff from the charity are designated auditors who travel to each hospital. The focus of each audit changes every time, and spans a range of different areas, including clinical governance, such as drug handling, health and safety, budget management, client services and data protection, among others (INT16 profession).

In addition to these quarterly audits, other internal audits are run within individual practices by the head nurse three times a year. These have been in place for five years and involve randomly sampling a handful of consent forms and auditing the extent of their completion (i.e. 100 per cent completed, 90 per cent or not completed). The results of this are fed back to the team and they are reminded of the importance of fully completing the consent forms. If completion rates are low, this will be investigated to understand why and to put measures in place to mitigate this (INT16 profession).

In addition to in-house run audits, RCVS Knowledge also offers a clinical audit for the profession called vetAUDIT. The aim of this is to encourage the wider use of clinical audits by helping practices to overcome the challenges that can be faced when using audits and to provide a more structured and national approach to auditing. At the moment, vetAUDIT collects data on post-operative complication rates for routine neutering procedures to provide a benchmark for complication rates. As of March 2019, 36,218 routine surgical cases had been submitted to vetAUDIT. It is planned for this to expand to focus on a wider range of care pathways (RCVS Knowledge, n.d.).

The interviewees often referred to specific internal audits that had taken place in their practice and how the outcome of these had resulted in changes in practice. These, alongside those identified during the document review, are outlined in detail in Box 4. However, it was noted by one of the interviewees that internal audits are also helpful in identifying areas that do not need improvement and are functioning well. For example, this interviewee's practice audited rabbit intubation equipment and found that it was performing well and therefore that no changes were needed (INT9 profession).

Box 4: Examples of clinical audits identified through the interviews and review of QI documents, and the changes in practice implemented as a result of these

- An audit of intravenous catheter complications led to a practice identifying an increasing incidence of these complications over time. The practice contacted the manufacturer of the catheters to advise them on how the equipment was causing these problems, which resulted in changes to the design and manufacture of the catheters. The same practice conducted an audit into disinfection processes, which identified that there had been an increase in post-operative diarrhoea and infections. This led to a deep clean of the practice and a change to the 'deep clean' protocol. Since these changes, there has been a reduction in these post-operative complications (INT7 profession).
- An audit of pre- and post-operative patient temperature identified that temperature dropped the most after administration of pre-medication, rather than anaesthesia. As a result, the practice provides the animals with heat pads when they are administered pre-medication (INT9 profession).
- Infection control audits have identified novel infections within a practice and allowed these to be traced back to the cleaning techniques used on a particular patient, improving infection control (INT11 profession).
- CVS conducts an annual audit of controlled drugs. The first of these audits, conducted three years ago, identified that the recording of certain drug use compared to the actual use was outside of the variance advised by the VMD. As a result of this, CVS appointed a Head of Dispensary, introduced new controlled drug registers and provided general education on the topic which has reduced this variance to a more appropriate level (CVS Group plc, 2018).

Significant event audits

In addition to internal clinical audits, the interviewees and the documents the research team reviewed frequently discussed the use of significant event audits within their practices, including using the VetSafe app for significant event reporting (INT4 charity, INT6 LPG, INT8 LPG, INT9 profession, INT11 profession, INT14 profession, CVS Group plc, 2018). Interestingly, it was primarily interviewees from large group practices and charities that reported using significant event audits; only one of the interviewees discussing significant event audits was from a smaller practice group (INT14 profession).

It appears that from those significant event audits discussed by the interviewees, a more formal approach is most often taken in conducting these compared to the mix of formal and informal approaches seen with the internal clinical audits on wider topic areas. This may be because the data collected on significant event audits was only reported by those based in large group practices, which often require a more formal, structured system in place to ensure initiatives such as these are implemented equally across all practices.

As these audits are often conducted after an adverse incident, the literature and the interviewees highlighted the importance of avoiding placing blame on individuals and focusing instead on reflecting on the incident, so as to allow learning to happen and to be shared with the team (INT4 charity, INT8 LPG, CVS Group plc, 2018).

Some of the interviewees and the QI documents reviewed outlined that their practice uses VetSafe for reporting adverse incidents (INT6 LPG, INT8 LPG, INT11 profession, CVS Group plc, 2018). VetSafe is run by The Veterinary Defence Society (VDS) and is an online platform (including an app) in which

veterinary professionals report incidents or near misses that happen in their practice. The onus is then on the user to understand why these occurred, to learn from these incidents and to share this learning to reduce the incidence of these incidents going forward (The Veterinary Defence Society, n.d.). Since VetSafe was launched in April 2018, 1,003 incidents have been reported through the platform (as of July 2019). One QI lead for a large practice group discussed how their significant event reporting process has developed from the use of manual form completion and recording, to using VetSafe about one year ago, which is easier and quicker to use as it is all based online (INT6 LPG). Another interviewee discussed the impacts of using VetSafe in that they have been able to identify areas for improvement that they wouldn't have done without it, and as a result, positive changes have been introduced within the practice (INT11 profession).

Auditing after a serious incident can help to guide improvement and changes in practice to stop similar events happening in the future (INT11 profession, INT14 profession). Specific examples identified from the interviews and the review of QI documentation of how significant event audits can lead to change are outlined in Box 5.

Box 5: Example of how conducting a significant event audit can lead to changes in practice

- A few years ago, the practice identified that the infusion pumps they were using were leading to occasional, non-fatal drug overdoses from over-infusion as the pumps don't allow limitations on drugs to be set. As a result, the practice changed the infusion pumps they used which allowed a limit on the drug dose, which has led to a reduction in the number of overdoses (INT11 profession).
- In CVS practices, standard reports are used after every serious incident and practices are encouraged to reflect on these events and introduce changes to prevent them from happening again. 85 reports were submitted over 2017–2018 and these helped to identify three specific areas that were in need of improvement: thermal burn injuries, retained swabs and passport errors. Methods of improving these areas are currently being developed (CVS Group plc, 2018).

4.2.3. Protocols, checklists and guidelines

Many of the interviewees discussed their practices' use of protocols, checklists and guidelines. These were also included as examples of QI activities in the documents reviewed.

Protocols

Protocols were mentioned as being in use by a small number of interviewees and in the reviewed documents (INT4 charity, INT8 LPG, INT16 profession, INT17 profession). The protocols in place cover a variety of day-to-day activities within veterinary care, including reducing antibiotic use, swab counts and drug prescriptions (INT16 profession, INT17 profession). Protocols can also focus on team well-being as well as patient care. For example, one interviewee discussed the whistleblowing policy in place in which any team members in the practice can anonymously feedback to management if they think something is wrong (INT8 LPG).

The reasons for introducing protocols varied across practices and included:

- having a record of all procedures to refer back to if needed, for example, if a complaint occurs
- providing the same quality of care across all practices (relevant for large practice groups rather than smaller practice groups)

- providing a 'gold standard' level of care that is evidence-based (INT16 profession, INT17 profession). For example, one interviewee discussed the evidence-based protocols they have in place, one of which is a preferred drugs list that covers almost all the drugs required in practice. For a drug to be included on this list, it first has to pass through a clinical committee to ensure its use is based on rigorous evidence (INT17 profession).

As with the significant event audits, one interviewee discussed how the implementation of protocols within the charity they work for has gone from an informal process to a more official one over the last five years (INT16 profession). Although processes such as swab counts were in place previously, the results of these were not recorded and so there was no proof that these had taken place. As this led to some problems for the practice in not being able to back up claims made by clinical team members, the practice moved to have formal protocols in place which require forms to be completed to record all procedures (INT16 profession).

Checklists

Four interviewees discussed that their practice used checklists or would be introducing them in the near future (INT4 charity, INT8 LPG, INT16 profession, INT17 profession). One interviewee discussed how these were linked to the PSS assessment across the practices in the large practice group that they work for to ensure that all practices are reaching at least the minimum standard of care outlined by the PSS (INT17 profession).

Two interviewees from the same practice outlined how the regional management team conduct quarterly inspections of all practices using checklists and explore a range of Clinical Governance processes using this, such as euthanasia, referrals and post-operative complications. The use of these checklists has led to a reduction in the number of incidents seen in these large practice groups and the longer a practice has been a part of a large practice group, the greater this reduction becomes (INT8 LPG, INT17 profession). One interviewee provided detail on the checklists they have in place for keeping track of animals and equipment (Box 6). The QI lead from an animal charity reported that checklists were in the process of being introduced across the charity's clinics, for example, a nurse-led checklist is being implemented for anaesthesia (INT4 charity).

Box 6: Example of how a veterinary hospital introduced a three-part checklist process to track animals and equipment within the practice

A veterinary hospital has a three-part protocol for tracking animals across their journey through the practice for both surgical and in-patient cases. The first part involves providing all animals admitted to the hospital with an ID collar, similar to the ID wristband used in human healthcare. These collars match an animal to its paperwork, which is checked each time it comes out of the kennel for a procedure. Alongside this, all surgical procedures have a checklist to ensure the staff have the right animal and that the correct procedure is planned (if surgery is to take place). The second part of the process, if a surgical procedure is planned, is a surgical checklist in which all instruments used for a procedure are checked before starting, such as swabs and needles. The third and final part of the process is a checkout list to ensure all the instruments are removed from an animal at the end of a procedure. The paperwork associated with these checklists is kept with the animal wherever it is in the practice, and staff regularly check this paperwork to ensure it has been completed and to monitor any aftercare requirements (INT16 profession).

Guidelines

Only one interviewee mentioned the use of guidelines in their practice (INT18 profession). This included the use of the World Small Animal Veterinary Association (WSAVA) guidelines on vaccinations. The RCVS Code of Conduct was viewed to be a guideline by this interviewee (INT18 profession).

CVS identified that the number of medicine errors was fairly high among their practices and as a result, they set up the Medicines Error Working Party to create guidelines to help teams reduce the number of errors (CVS Group plc, 2018).

In addition, the Blue Cross, an animal charity, has developed guidelines for more than 60 common syndromes and conditions. These are evidence-based guidelines that have taken into account the ethical and quality of life considerations for animal care and have contributed to cost benefits for the charity (RCVS Knowledge, 2019a).

4.2.4. Continuing Professional Development (CPD) opportunities

Interviewees discussed CPD initiatives in place in their practices, which support the team in their day-to-day roles and can lead to improved care and client satisfaction (INT4 charity, INT10 profession, INT12 profession, INT14 profession).

One interviewee from a smaller practice group discussed in detail the in-house developed nursing progress log that was available to all care assistants and trainee/newly graduated nurses (INT12 profession). This involves logging activities throughout the day, which are then assessed by a clinical coach to sign off the team member in different areas of practice, such as restraining patients, client communication and emergency procedures. This ensures all junior nursing staff are aware of what they should know, and they have the knowledge to perform tasks to the appropriate standard. The national Nursing Progress Log is offered by RCVS. This practice decided to create a similar log in response to a questionnaire on nurses' clinical knowledge (INT12 profession).

Another example of CPD, provided by another interviewee, is the postgraduate tuberculosis (TB) testing education for farm vets offered by Improve International. This involves asking farm vets the structures and processes they have in place for TB (of which there is a lot of variance across the UK) and to provide support and guidance on how to improve these. This training was first implemented five years ago and is now seeing a 'trickle-down' effect, as those who have been through the programme are taking the learning back to their practice and sharing it with their colleagues (INT10 profession).

4.2.5. Client and veterinary team member surveys

Two interviewees discussed the implementation of client and veterinary team member surveys within their practice to help guide improvement activities. These interviewees were from an animal charity and large practice group; it was not mentioned by any members of the profession from smaller practice groups that surveys such as these were implemented. In addition to these examples, practices undertaking the PSS Client Service Award are required to conduct a client survey to understand aspects of service that could be improved.

One interviewee discussed the weekly patient safety survey which has been implemented for the last two and a half years across the clinics within the practice.[26] Each centre completes a weekly survey which is anonymous (the responses can only be linked back to the specific rehoming centre by one individual). The aim of this survey is to identify incidents that are not serious enough to be formally discussed within the senior leadership team but are still areas that could be improved. The main areas of improvement identified through this survey are related to medicine, particularly forgotten, lost or misdispensed medication, and

[26] Interviewee code has not been provided here as it could make the interviewee identifiable.

surgical incidents, for example, accidental cutting of the spleen or general anaesthetic incidents. The survey is also used to look at all deaths within the centres, which provides a formal method of death recording across the organisation that was not in place before this survey. The wider learning from these surveys is used to input into the updating and creation of new protocols and guidelines for the organisation. This survey has been successfully implemented across all practices, which the interviewee thought was in part because it has been introduced in a flat structure, so that anyone with a link to the veterinary suite in the clinic can complete the survey, including surgeons, nurses, managers or technicians. How this survey has become embedded in practice is discussed in more detail in Section 5.2.

One of the QI leads discussed the team and client satisfaction surveys that they use across all practices (INT8 LPG). Surveys are sent to clients after each visit to explore their satisfaction with the care their animal received, and team member engagement surveys are sent to different cohorts of staff to explore their engagement and satisfaction. The team member survey is used to identify areas for improvement and to introduce new initiatives for the team, such as training for graduates and new team members (INT8 LPG).

4.3. THERE ARE MANY RESOURCES AVAILABLE TO SUPPORT PRACTICES IN GETTING STARTED WITH QI, AND CREATING DEDICATED QI LEADS CAN HELP EMBED IMPROVEMENT ACTIVITIES IN PRACTICE

Throughout the interviews and review of QI-related documents, the research team identified multiple resources offered to practices to support them with the practical implementation of QI activities. These largely fell into one of two categories which will be discussed here:

- resources to get started with QI
- creating QI leads within practices.

Interestingly, these were all offered by either RCVS Knowledge or developed in-house by large practice groups. The research team did not identify any information on this type of support offered by smaller practice groups.[27]

4.3.1. RCVS Knowledge and large practice groups offer a range of resources to support practices to engage with and implement QI

Across the interviews and the documents reviewed, the research team identified various different freely-available resources in place to support QI that have been developed by RCVS Knowledge and developed in-house by large practice groups. Although many of these QI resources have only been available since 2018, the number of users of the resources is almost 26,000 (as of 9 July 2019).

RCVS Knowledge has a set of web pages dedicated to QI, which provide an introduction for veterinary professionals new to QI and provide links to RCVS Knowledge resources for implementing QI, particularly providing access to high quality evidence to select the QI approaches with the best evidence base (RCVS Knowledge, n.d.). Examples of some of these resources include:

- Quality Improvement resources: This hub includes free templates, courses, guides and case examples for QI techniques, including clinical audits, guidelines, checklists, benchmarking and significant event audits (RCVS Knowledge, n.d.). It also provides access to key sources of

[27] It is important to note that the research team did not explicitly ask this question in the interviews or survey, so participants may not have thought to share information on this.

information for practices seeking to further their knowledge in the area (RCVS Knowledge, 2019b, n.d.).

- vetAUDIT: A national audit for small animal neutering which assesses post-operative complication rates for routine neutering. Practices submit their data via the website, which is anonymised and analysed free of charge. Consolidated results are sent back so that practices can compare their post-operative complication rates to the national average. The aim is that practices will then use the data as part of a benchmarking exercise that could generate a move towards improvement. The site will soon also house a Canine Cruciate Registry, which aims to provide accurate rates of success and complications for the treatment of canine cruciate ligament ruptures (RCVS Knowledge, n.d.). The information gathered can be used to form evidence-based treatment plans, with the aim of improving patient care.
- *Veterinary Evidence*: Set up in 2016, this is an online, open-access, peer-reviewed journal publishing content related to evidence-based veterinary medicine and how this is applied in practice. The journal was updated in 2017 to start introducing audio summaries of papers, which highlight a paper's findings and how the recommendations can be implemented in practice. It now offers the opportunity for veterinary professionals to submit research questions directly to the journal (RCVS Knowledge, n.d.). Many of the research questions are based on questions asked of veterinary surgeons or veterinary nurses by clients, or from veterinary surgeons or veterinary nurses looking at online forums and discussion groups to see what animal owners are querying.
- inFOCUS: Expert reviewers are used to identify high-quality papers from 100 veterinary journals to allow veterinary professionals quick access to high-quality papers without having to spend time manually checking (RCVS Knowledge, n.d.).
- The Library and Information Service: Online portal providing access to more than 70 veterinary journals, the VetMed Resource (bibliographic database for veterinary medicine), targeted literature searching, workshops, expert advice, updates on key topics and postal loans/article requests (RCVS Knowledge, n.d.).

Some large practice groups also provide their own support to practices in implementing QI, particularly those that have been recently acquired, which is fairly similar to that offered by RCVS Knowledge in that it provides veterinary professionals with an understanding of what QI is and provides practical resources.

One of the QI leads outlined initiatives in place in their practices (INT6 LPG). This includes creating terms of reference and agenda templates to guide QI-related meetings; QI training to educate professionals on what QI is and how to get started with it; and writing guidance on conducting QI activities, such as significant event audits. This interviewee reported that these resources help veterinary professionals to feel more at ease in getting involved with QI and allow them to feel more comfortable in introducing them (INT6 LPG).

5. FACTORS THAT EITHER SUPPORT OR ACT AS BARRIERS TO IMPLEMENTING QI

Understanding the factors that supported the veterinary profession to engage with QI and those that acted as barriers was one of the main focuses of this research. The research team received a range of different factors that can affect engagement with QI positively and negatively, with the factors supporting QI often being the opposite of the barriers. Therefore, the research team have not separated the enablers and barriers in this chapter but will cover each of the most frequently reported factors, including:

- time
- support from colleagues and management
- resource availability
- QI leads
- training and CPD.

This chapter will also cover how the supporting factors and obstacles to QI can differ depending on practice types. The box below provides a summary of the results covered in this chapter.

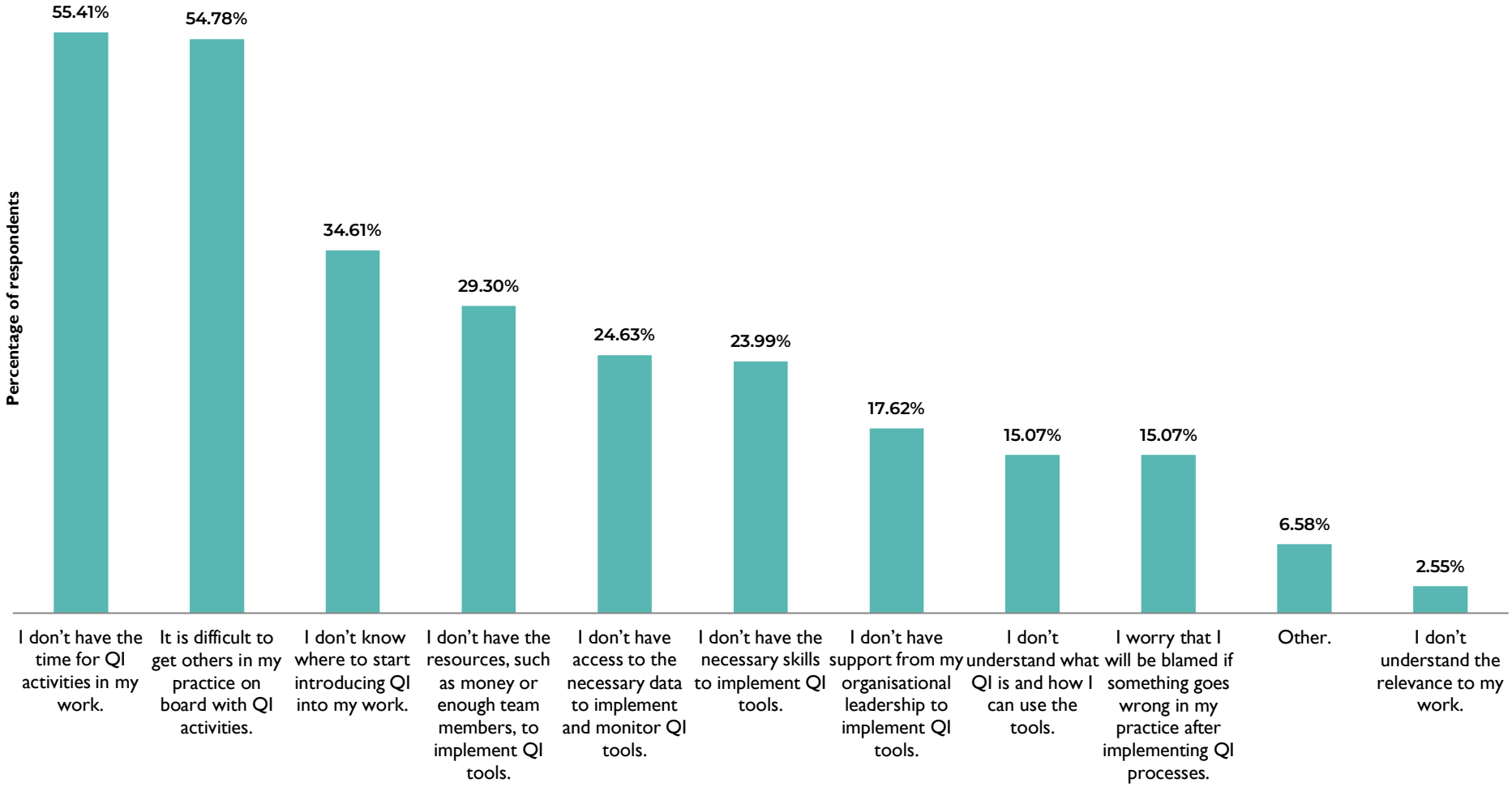
- A lack of time, challenges with getting colleagues on board with QI and not knowing where to start in introducing QI were seen as the main barriers to engaging with QI. Creating dedicated time for QI, more training/CPD on QI and greater availability of QI resources and guidance were thought to have the biggest impact on supporting and encouraging engagement across the veterinary sector.
- There are key differences between practice types that can influence their exposure to the supporting factors and barriers in implementing QI. More specialised practices and those dealing with small animals, rather than farm and equine animals, may find it easier to introduce QI activities. In addition, the extra resources within larger group practices, as well as the reputational stake, may make it easier to introduce QI compared to independent practices.

5.1. THE KEY FACTORS IN SUPPORTING AND CHALLENGING QI IMPLEMENTATION

The survey respondents were asked to identify the factors that they thought could best support them to engage with QI, and those that they felt acted as obstacles.

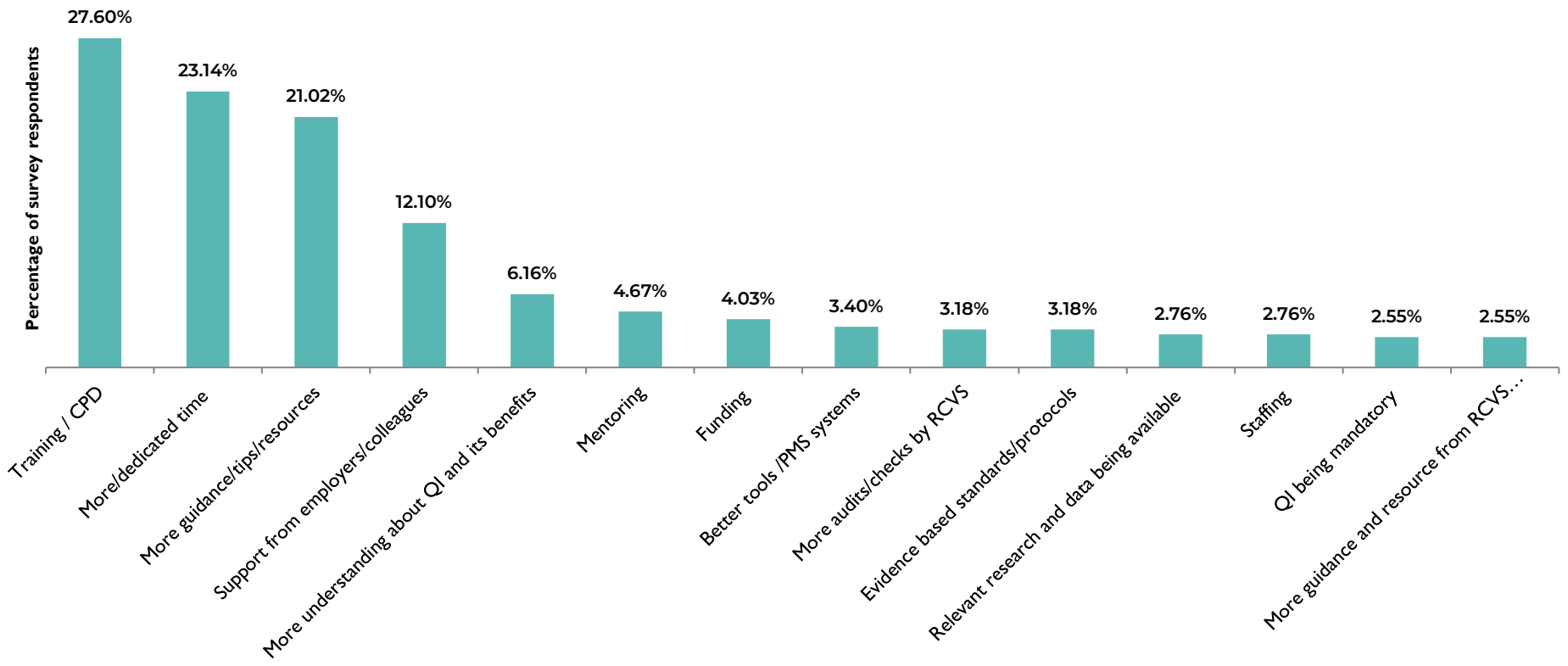
A range of barriers to engaging with QI were reported by survey respondents and are shown in Figure 17. The two main barriers identified, with over 50 per cent of respondents, are a lack of time (55 per cent) and difficulty getting others in the practice on board (54 per cent). The next most frequent challenges identified were knowing where to start with QI (35 per cent), having the right resources (29 per cent), having access to data (25 per cent) and having the relevant skills (24 per cent).

FIGURE 17: SURVEY RESPONSES TO THE QUESTION: WHAT ARE THE MAIN BARRIERS AND CHALLENGES YOU FACE WHEN ENGAGING IN QUALITY IMPROVEMENT ACTIVITIES?



Survey respondents were also asked to consider what would support and enable their future involvement in Quality Improvement, with the option of giving three free-text responses. The graph below (Figure 18) shows responses that received over 2 per cent of responses, analysed and grouped by common themes. It is interesting to note that the number of respondents reporting the barriers they face was much higher than those suggesting the factors that supported their engagement (the most frequently reported supporting factor was selected by 28 per cent of survey respondents, compared to 55 per cent of respondents selecting the largest barrier). This may be due to the design of the survey question; the barriers question asked respondents to select from a list of options, with the opportunity to add in other barriers using free-text boxes, whereas the supporting factors question provided three free-text boxes for respondents to complete. This is also likely to have led to the many more suggestions of supporting factors compared to the number of barriers.

FIGURE 18: SURVEY RESPONSES TO THE QUESTION: WHAT WOULD SUPPORT AND ENABLE YOUR FUTURE INVOLVEMENT IN QUALITY IMPROVEMENT?[28]



[28] Due to the large number of different types of responses, those submitted by fewer than 2 per cent of survey respondents have been removed from this graph. These include: cultural changes, team meetings/team-based approaches, communication with public about QI, collaboration between practices, structured RCVS QI programme/more recognition of good practice, communication, a more structured approach to QI, better leadership in vet sector, implementation support, NHS approach, comparing practices, insurance companies not capping prices, compliance from practices, client satisfaction, prioritising high risk areas and simplicity.

The most frequently identified enablers and barriers from the survey are discussed in more detail in the following sections, bringing in information from the interviews and the focus groups. How the supporting factors can be enhanced, and the barriers overcome, are discussed in Chapter 7.

5.2. LACK OF TIME WAS FREQUENTLY HIGHLIGHTED AS THE BIGGEST BARRIER WHEN TRYING TO ENGAGE WITH QI

When the survey respondents were asked what the main barriers and challenges were that they faced while engaging with QI activities, 55 per cent reported that they felt they did not have the time for QI activities in their work. When asked to suggest what would support and enable their future involvement in QI, the second most frequent suggestion was having more time or time dedicated specifically to getting involved with QI (23 per cent).

A number of interviewees expressed the same sentiment (INT1 QIAB, INT11 profession, INT12 profession, INT14 profession, INT16 profession). This included finding time for actual QI activities and finding time to have team meetings and plan QI activities among clinical activities (INT1 QIAB, INT11 profession, INT12 profession, INT14 profession, INT16 profession). To some extent, this was exacerbated by a disparity between the number of job roles and the number of vets and nurses able to fill them, which was considered likely to increase as a result of Brexit (INT1 QIAB). Because of this, implementing and sustaining QI practices was seen as less of a priority.

> *'Some is a perception of a lack of time but people are under a massive amount of pressure to do as much as they can as quickly as they can. People forget paperwork and focus on animals in busy situations – need to be able to focus on both.'* (INT16 profession)
>
> *'When vet time is short, they feel like they should concentrate on frontline services rather than providing greater priority on QI.'* (INT1 QIAB)

Introducing activities that require minimal time commitment or activities that can be distributed among the team within a practice were thought to be helpful at overcoming some of these barriers. An example of where this is working well is provided in Box 7.

Box 7: Example of introducing QI activities that place a minimal time burden on the veterinary team

An animal charity has introduced a weekly survey for all clinics to complete (see Section 4.2.5 for more information). To encourage high completion rates for this survey, it can be filled in by any team member in the clinic, so the time burden doesn't fall on one individual every week. A PDF of the questions is sent out to clinics ahead of time so the team knows what they need to be looking out for during the week to make filling in the survey easier. Finally, the survey itself only takes four to five minutes to complete (INT4 charity).

5.3. SUPPORT FROM COLLEAGUES AND MANAGEMENT WAS IDENTIFIED AS AN ESSENTIAL FACTOR IN IMPLEMENTING QI ACTIVITIES

Lack of support from senior members of the team or management was considered a barrier to implementing QI activities (INT10 profession, INT11 profession). While it is acknowledged that team members of any age can also have a fixed mindset and set of practices, one interviewee described the 'senior partner syndrome' of 'we've always done it this way' but also considered that this was lessening as new vets joined practices and as corporatisation of practices increased (INT10 profession). Three interviewees identified that having senior management support was considered particularly important (INT5 animal owner, INT6 LPG, INT11 profession). Managers could facilitate the use of QI resources and provide a framework that makes it easier for practices to implement QI activities (INT5 animal owner, INT11 profession).

As well as senior management support, interviewees and survey respondents considered that having the support and buy-in of the wider team was important. When asked to suggest what would support and enable their future involvement in QI, 12 per cent identified that support from both colleagues and employers was important. Conversely, survey respondents reported that a lack of support from the team could be a significant barrier when implementing QI activities; 55 per cent identified that difficulty getting others in their practice on board was a challenge that they faced. Interestingly, a much lower number of respondents reported that a lack of management support acted as a barrier to engaging with QI (18 per cent). This may suggest that it is more difficult to get colleagues on board with QI than it is to get management engagement.

Two interviewees explained that having a team who are interested in QI and Clinical Governance activities is crucial to being able to implement and sustain such activities (INT6 LPG, INT11 profession). A team that recognised all members of the team as professionals and valued each contribution, including those of veterinary nurses, was also thought to be crucial (INT2 complaints, INT4 charity, INT5 animal owner, INT13 profession).

5.3.1. Support from colleagues was thought to stem from their dedication to the caring profession

Several interviewees expressed that such buy-in was achieved because veterinary professionals' personal will and desire to provide the best possible care was an important enabler in implementing and sustaining QI activities (INT14 profession, INT7 profession, FG2). Attendees at one of the focus groups also considered that this was a particular driver for nurses (FG2). In addition, two interviewees considered that 'having the right people' was the most important factor in implementing and sustaining QI (INT10 profession, INT14 profession).

> *'If you've got the right people, hopefully there is the will to keep improving.'* (INT14 profession)

5.4. THE AVAILABILITY OF PRACTICAL AND QI-RELATED RESOURCES AND GUIDELINES CAN INFLUENCE THE EASE AT WHICH QI IS IMPLEMENTED

30 per cent of survey respondents considered that not having resources, such as money and enough team members, was a barrier they faced in implementing QI activities. Two interviewees highlighted the need to consider the financial implications of QI activities, as this was a priority that senior management, particularly

owners of smaller practice groups, have to consider, as well as the care for the patient (INT11, INT13). It was thought that senior vets were sometimes resistant to QI activities as a result of the financial cost (INT11 profession, INT13 profession). Such problems may be less of a concern in larger practice groups as they often have more resource to invest in activities such as QI (see Section 5.6.3 for more information).

Due to commercial sensitivities, sharing knowledge and data between practices was also identified as a barrier for practices within the veterinary sector, particularly smaller practice groups (INT11 profession). While usually mentioned in relation to a benefit held by large practice groups within their practices (these groups may not always share data to other practice groups), 25 per cent of survey respondents identified the lack of capturing the necessary data as a barrier and challenge to implementing Quality Improvement.

Access to QI resources, such as toolkits and checklists, was identified as an important enabler of QI by two interviewees because these could then be adapted to individual practices to increase the likelihood of success (INT8 LPG, INT6 LPG). One interviewee noted that RCVS Knowledge resources were very helpful (INT6 LPG), although the results of the survey indicate that these are not widely used by members of the profession (see Chapter 1).

Two interviewees also identified the importance of access to academic research on QI, such as through academic journals (INT8 LPG, INT9 profession).

When asked to consider what would support and enable their future involvement in Quality Improvement, 21 per cent considered that more guidance/tips/resources would be helpful, while another 3 per cent identified better PMSs as important. To some extent, this enabler may be a factor that could address the barrier of not knowing where to start that was identified as a challenge by 25 per cent of survey respondents.

5.5. RELEVANT AND HELPFUL TRAINING ON QI WAS CONSIDERED IMPORTANT, ALTHOUGH CHALLENGES TO MAKING THIS WIDELY AVAILABLE WERE ACKNOWLEDGED

The most frequently cited potential enabler of QI by survey respondents was training or CPD (28 per cent). 29 additional comments focused on the need to have greater understanding and awareness of QI and its benefits (6 per cent of total), while another 5 per cent considered that some sort of mentoring would be helpful. As with the availability of tools and guidance, such training could also help address the barrier of not knowing where to start (35 per cent), not having the necessary skills (24 per cent) and not understanding what QI is (15 per cent).

Training was also discussed by some interviewees. Receiving training through courses was considered to help implement QI because it 'gave [veterinary professionals] the tools to get started' (INT6 LPG). However, one interviewee considered that, because such training was non-mandatory, those who were less engaged with or interested in QI were less likely to attend and benefit from this (INT9 profession).

However, attendees at another focus group had some discussion around the disadvantages of corporatisation in terms of QI. Some felt that corporatisation brought about a loss of experience and expertise: because they get corporatised when a lead vet or owner retires (INT5 animal owner) and because they are 'dead-end jobs for senior vets' (FG1). Further information on how corporatisation influences QI can be found later in this section (Section 5.6.3).

5.5.1. Establishing dedicated QI leads within practices can help to sustain improvement activities

In addition to providing practical resources to help practices get involved with QI, the interviews and review of QI documentation highlighted that many practices, including smaller practice groups, have introduced dedicated QI leads to oversee all QI activities. These can be informal roles adopted by those who are motivated to progress and improve QI within their practice, or formal roles that are officially recognised as an additional aspect to an individual's responsibilities. In some cases, new roles can be created that are dedicated to overseeing QI, although these seem to be less common and only occur in large practice groups, who are in a better position to hire an individual solely for this purpose. Alternatively, rather than an individual QI role, some large practice groups have introduced a committee at senior management level to oversee QI activities, such as the creation of new guidelines and protocols.

Two interviewees from smaller practice groups discussed how they have established informal QI leads. One interviewee, as the practice owner, had taken on this responsibility himself. This involves discussing any adverse events with the team and coming up with solutions to reduce the risk of a similar incident happening again (INT14 profession). Another interviewee from a smaller practice group commented that the practice has informal QI leads who are regular members of the team that are more interested in QI and that these tend to be clinical team members (INT7 profession), which may be because non-clinical members of the team are unaware of the ways in which they can get involved with QI, such as reducing waiting times. However, the importance of involving the whole practice team in QI was reflected by many interviewees, so non-clinical roles may also be able to lead QI within the practice.

The information the research team collected from those working in large practice groups indicates that these types of practices are more likely to have formal QI roles (INT6 LPG, INT8 LPG, CVS Group plc, 2018). For example, since 2017, each CVS practice has appointed a head of QI, who is providing QI training by a member of the RCVS Knowledge QIAB. Three hundred people have received this training so far, with more planned for 2019–2020. The purpose of these roles is to lead QI and governance within the practice and coordinate significant event reporting, disseminate QI information and support and encourage practices to carry out local audits.

Both of the QI leads also discussed the more formal QI-specific roles they have in place. One of these practice groups has introduced Heads of QI in each of their practices (or across multiple practices), which has helped to keep momentum going for the QI activities. These roles are taken on by veterinary surgeons or nurses as part of their day-to-day role. Part of this role involves communicating learning to wider team members across practices within the group through a variety of channels, including QI reports and the outcomes of significant event audits (INT6 LPG). This practice is also launching a learning platform to support this sharing further and make it easier for practices to access this information, as it will be accessible through smartphones (INT6 LPG). The other QI lead reported a similar role, although that focuses specifically on clinical audits (and is called a clinical audit coordinator), working at a regional level (INT8 LPG). In addition, one member of the profession, based in a large practice group, outlined that each practice has an internal PSS team whose full-time role is to help practices get up to the standards required for PSS accreditation, including the awards (INT7 profession).

Finally, large practice groups can also have senior management committees set up to support QI implementation across the practices. One interviewee discussed in detail the clinical standards committee that had been established, which is made up of veterinary nurses and vets, managers and internal PSS teams. This committee is responsible for updating clinical guidelines and protocols, which in part is influenced by feedback from team members (INT7 profession). Relatedly, CVS have established a Central Quality Improvement Committee, which meets every two to three months and reviews a range of processes and documents, and monitors their practices against set standards, such as reviewing complaints and client

feedback; ensuring practices are meeting legal and professional standards as well as following ethical processes and audits, including the suggested changes needed in light of the outcome of these (CVS Group plc, 2018). It would be interesting to learn what all practices do in terms of structure and function; however, most have not published anything in relation to their approach to Quality Improvement. It is hoped that they will in the future so that this can be shared more broadly.

5.6. VARIATION IN BARRIERS AND ENABLERS EXPERIENCED BY DIFFERENT TYPES OF PRACTICE

Interviewees and attendees of a focus group were asked to consider whether there were any differences between practices in terms of barriers and challenges to implementing QI. Differences asked about were of the animals they treat, the type of practice they are (e.g. those that might be considered practising to core, general practice, hospital or emergency services standards) and whether they are part of a smaller or large practice group.

A few interviewees considered that there were no real differences in terms of the barriers and enablers for different types of practices (INT16 profession, INT18 profession, INT9 profession) or for those that treat different species specialisms (INT14 profession, INT18 profession, INT9 profession). However, on the whole, three main trends emerge:

- more specialised practices may find it easier to implement QI activities
- farm and equine vets face additional barriers to QI
- larger practice groups face fewer barriers and more enablers to QI than smaller practice groups.

5.6.1. More specialised practices may find it easier to implement QI activities

A number of interviewees and focus group attendees reported that they considered QI activities to be easier to implement in hospitals (INT7 profession, INT6 LPG, FG1). This was perceived to be because team members tended to have specialist training and practise at a 'higher standard' in hospitals and emergency service clinics (INT6 LPG, INT7 profession).

> *'Hospitals are used to working at a higher standard…they are used to that sort of thing [QI].'*
> (INT6 LPG)

For similar reasons, another interviewee considered that QI activities implemented in referral practices benefited from 'specialists having their own opinions which can also be helpful sometimes as they are all very experienced and have seen things done in different places and can bring this into the mix' (INT11 profession). However, the same interviewee also noted that this could cause challenges, as specialists were also more likely to resist suggested changes as a result of QI (INT11 profession). It should be noted that although this interviewee was discussing this point in relation to referral practices, it is likely that this can be extended to all types of veterinary practices. Others considered that enablers such as good communication and sufficient resources were magnified in this type of practice; the fact that everyone was in the same place and that resources might be more plentiful may also mean that hospitals were more likely to implement and sustain QI activities (INT4 charity, INT7 profession).

Some interviewees from a mix of smaller and larger practice groups considered that smaller and more general practices might, therefore, have some advantages when implementing QI activities, as they may have more time available to carry out QI activities (INT12 profession). Larger practices, such as hospitals,

may struggle more because of the difficulties of communication across a large number of people (INT11 profession). In addition, hospitals may face additional time barriers compared to other types of practices due to the continual high business of hospitals and the uncertainty of schedules caused by regular emergencies (INT12 profession, INT11 profession, INT16 profession). However, although this particular challenge was raised by the interviewees in relation to hospitals, it is likely that this also applies to other types of veterinary practices, particularly in light of staff shortages in the workforce.

5.6.2. Farm and equine vets are believed to face more barriers to QI

Several interviewees (including members of the profession working across small, farm and equine animals) and focus group attendees identified that vets who dealt with large animals (including farm and equine vets) faced more barriers than those who dealt with small animals (INT6 LPG, INT10 profession, INT13 profession INT16 profession, INT7 profession INT15 animal owner, FG2).

Several considered that it was very challenging to get these large animal and equine vets to attend a team meeting or to analyse and use data because these vets were largely working alone and travelling (INT6 LPG, INT7 profession, FG1, FG2). In addition, the lack of an office and proper theatre meant that farm vets have to carry around paperwork rather than having it necessarily ready at hand (INT16 profession, INT6 LPG). One interviewee who worked with horses considered that this meant it was even more important that QI was implemented in the equine veterinary sector because they otherwise did not have a peer or colleague to talk through problems with, to question their assumptions and to ask for justification (INT7 profession), while a small animal professional suggested that the practical difficulties of 'filling out paperwork in a field' mean that there was an increased need for alternative and technological solutions to recording information (INT16 profession). Attendees of a focus group mentioned strategies that they had seen which tried to overcome these barriers, including by using breakfast meetings and WhatsApp groups, for example, to share pictures of a challenging case (FG2). This highlights the importance of not having a one-size-fits-all approach, as discussed throughout this report, and QI approaches will need to be adapted to the type of animal species a veterinary practice treats. It is important to find what works best for equine and farm practices to ensure they are able to successfully implement QI tools.

In addition, the long-term commitment that farmers and their vets have, as well as the relatively high-level grasp of veterinary knowledge of some farmers, can cause resistance to changes in practice as a result of QI (INT10 profession, INT15 owner). This is possibly because farmers become used to receiving the same treatments for their animals (and may request certain treatments), but QI may lead to evidence suggesting a different treatment approach should be used, which the farmer may be resistant to (INT10 profession). One interviewee considered that the difference in culture meant that equine and farm vets struggle more with accepting and following rules and requirements, including those related to QI (INT6 LPG). An interviewee who worked with farm animals felt that the lack of farm animal coverage at university made developing and delivering support structures for farm vets quite difficult (INT10 profession).

However, a few focus group attendees felt that QI was nonetheless embedded in the farm sector but just required some additional leadership (FG2). Points raised included that pig medicine was quite advanced in its use of QI, that farm vets' focus on herd health meant that they were more involved with QI, and that farm and equine vets were frequently better at using technology than small animal practices (FG2).

5.6.3. It is believed that large practice groups face fewer barriers and more enablers to QI than smaller practice groups

The majority of interviewees and focus group attendees considered that implementing and sustaining QI activities may be easier in large practice groups than in smaller practice groups. Wider discussions on the potential benefits for QI of increased corporatisation were also discussed.

Several interviewees (all from large practice groups) reported that large practice groups had more available resources (both financial and QI-related, including access to tools, support and training), which helped them to both implement and sustain QI activities (INT1 QIAB INT4 charity INT6 LPG, INT8 LPG, INT9 profession INT11 profession, INT17 profession). As a result of their more comfortable financial states, they could afford to focus on activities that were not solely concerned with business viability (INT1 QIAB, INT4 charity, INT7 profession, INT11 profession, INT17 profession). Veterinary professionals working within large practice groups also had access to more support through management structures (INT4 charity). Attendees at a focus group identified that some large practice groups have therefore taken an active role in creating QI templates as a result of these additional resources available (FG1).

One of the more significant barriers to QI was accessing data from other practices, which was difficult to obtain due to commercial sensitivities. Since competition between practices was removed when they joined a large practice group, practices within large practice groups had more opportunities to share knowledge, take part in training, discuss particular activities and cases and share data across practices, which could help with benchmarking and running Quality Improvement activities (INT11 profession, INT14 profession, INT18 profession).

Interviewees also reported that large practice groups tend to put a large value on QI because they need to be concerned with their reputation (INT8 LPG, INT17 profession, INT18 profession, FG1), although that is not to say that smaller practice groups do not need to build a good reputation locally. Some attendees at a focus group also felt that there was more desire for accreditation within large practice groups (FG1), while one interviewee felt that large practice groups' responsibilities to their stakeholders to uphold professional standards also led to a greater focus on QI (INT1 QIAB).

The nature of PSS accreditation means that all practices within a large practice group that has opted in to the scheme had to go through accreditation, to ensure all the practices are providing a standard level of care, which is more likely to mean a focus on QI (INT1 QIAB). This was also noted by an interviewee from practices that had recently joined a large practice group (INT11 profession) (discussed in more detail in Chapter 3).

One interviewee from a large practice group felt that the management structures that go beyond an individual person managing a practice mean it is less likely that QI can be slowed or stopped by a practice owner (INT9 profession). However, another interviewee considered that the extent of QI varies within large practice groups as well, depending most on the practice management (INT6 LPG).

One interviewee from a recently corporatised practice reported that they had seen positive changes in their practice relating to QI (INT11 profession). The interviewee noted that there was a push to get all nurses from different practices to meet and share different approaches and experiences.

Some interviewees from large practice groups, however, felt that smaller practice groups may have some additional enablers in terms of implementing and sustaining QI activities compared to large practice groups:

- As independent practices tended to be smaller and run by one vet, QI could be done in a more informal way rather than requiring more specific processes to be put into place (INT11 profession).
- Smaller practices with smaller teams can communicate better with all members of the team (INT8 LPG).

5.6.4. Corporatisation may have mixed effects on QI in the veterinary sector as a whole

A few of the interviewees and focus group participants felt that the increasing number of large practice groups in the sector has had an overall enabling effect on QI:

- One interviewee considered that smaller businesses were following the example of larger practice groups in terms of implementing QI due to increased exposure and the need to keep up with these larger groups (INT1 QIAB).
- In a similar vein, another interviewee felt that larger practice groups have shown others how practices could consider case safety over corporate finances (INT4 charity).
- Attendees at a focus group considered that the size and centralisation of large practice groups meant that focusing on these larger groups would be a fast way of educating people about QI (FG1).

6. CLIENT INVOLVEMENT IN QI

Within human healthcare, there is an increasing focus and priority placed on involving patients and the public in the design and delivery of healthcare services (including QI) and research. This is based on the belief that involving patients in their own care can support improvements in patient outcomes and increase the efficiency of the healthcare system, reducing costs (NHS England, n.d.). Related to QI, human healthcare has involved patients in a number of ways, for example by supporting the community to find solutions to their healthcare problems through setting up patient-led audits and by providing patients with a voice in their healthcare decisions. This has resulted in the sharing of new and different perspectives, creating healthcare services that are more aligned to the needs of the patient and using better indicators to improve healthcare (HQIP, 2017). The involvement of clients (i.e. the animal owner) in veterinary care QI has not been researched before and, therefore, the project provides some of the first insights into how much clients know about QI, and whether they and members of the profession feel as though clients should be involved in QI activities. For example, could clients be involved in non-clinical veterinary education (which is already starting to be seen in one university, which will be discussed later in this section), could they have more involvement in audits, or have more involvement and decision making abilities in the care provided to their animals?

This chapter will cover client awareness of QI initiatives, including the PSS, and the extent to which QI activities are communicated to clients. It will also explore whether clients should be involved in QI and what this might look like. Finally, this chapter will cover the awareness of the complaints procedure among clients and how complaints can be used to support QI. The box below provides a summary of these results.

- In general, clients are not familiar with the QI activities that take place within the practices they visit. This is partly due to practices not communicating these activities to their clients or the wider public. This lack of awareness also extends to the complaints procedure, which clients often only become familiar with when something goes wrong with their animal's care.
- There are mixed opinions as to whether clients should be involved in QI and, if they are, what this would look like in practice.
- It was felt that complaints, although to be avoided, can play a helpful role in QI, through identification of trends in complaints that can highlight areas for improvement.

6.1. CLIENTS ARE GENERALLY NOT FAMILIAR WITH THE COMPLAINTS PROCEDURE, OR WITH QI ACTIVITIES THAT HAPPEN IN THE PRACTICES THEY VISIT

Throughout the interviews with members of the profession, those involved with client complaints and animal owners, it became clear that clients are generally not made aware of the QI activities in the veterinary practices they visit and that these activities are more often seen as internal activities (INT3 complaints, INT4 charity, INT5 owner, INT7 profession, INT9 profession, INT10 profession, INT11 profession, INT14 profession, INT15 owner, INT16 profession, INT17 profession). One animal owner interviewed reported that the communication of QI activities was 'very half-hearted' and the other owner had heard about QI through their involvement with RCVS but was not aware of the specific activities implemented in the practice they use (INT5 owner, INT15 owner).

> *'Maybe because I've been a client for a long time, I know that they are PSS accredited…but I might only know that because they're a teaching practice and this is required.'* (INT5 owner)

A variety of reasons were given as to why QI activities are not communicated to clients. Two interviewees commented that they had just never thought to share this type of information with their clients (INT7 profession, INT11 profession). There was also a concern that clients lack the knowledge needed to understand the care provision for their animal and the reasoning behind the decisions made for their care (INT1 QIAB, INT11 profession, INT17 profession). This may mean clients are led to believe that there was something wrong with the practice and so QI activities were introduced to mitigate this: for example, an infection control audit might lead a client to believe that the practice has a higher than average infection rate (INT11 profession, INT17 profession).

This lack of awareness also extended to the PSS. Although some members of the profession reported that they advertised their PSS accreditation within their practice (INT8 LPG, INT17 profession), the general feeling across the interviewees was that clients are not very familiar with the PSS and what it represents, and that owners do not select which practice they visit based on PSS accreditation (INT5 owner, INT10 profession, INT14 profession, FG2). This was seen as a particular problem for one interviewee who took part in the PSS early on primarily because of the advertisement and marketing opportunities RCVS said it would provide and the subsequent benefit to the business (INT14 profession). However, this interviewee felt that this never came to fruition; a client has never asked them if they are accredited and, as a result, they have not put the plaque showing their accreditation in their new practice building (INT14 profession).

> *'Animal owners are not aware of the PSS…the public probably think that all practices are inspected, which they're not.'* (INT5 owner)

Conversely to awareness of the PSS, both animal owners interviewed were aware of the Code of Conduct. For one owner, this was through conversations with vets (INT15 owner), whereas for the other animal owner this awareness was through working with RCVS (INT5 owner).

Two interviewees did report that they shared some QI activities with their clients through social media, particularly Facebook (INT4 profession, INT12 profession). For example, the practice might share details of a training course a vet is attending to raise awareness that the practice is investing in the vet's knowledge (ITN14 profession).

Clients may become aware of QI activities if the treatment prescribed to their animal changes or if they make a complaint. Clients frequently request the same treatment or procedure that the veterinary practice has provided in the past, but this may not be possible if QI activities have led to changes which result in different treatment plans. They then may be made aware of the QI activities that led to this change (QIAB INT1, INT10 profession). This has been seen with antibiotic prescriptions, for example where there had been local outbreaks of antibiotic resistance and so practices emphasised to the client the importance of reducing the use of antibiotics or prescribing a different treatment (INT10 profession). Alternatively, clients may only become aware of QI activities after they make a complaint (INT3 complaints, INT 16 profession). For example, complaints may mean the paperwork related to the case is made available to clients, such as the forms used to track the animal and their progress (INT16 profession). QI activities can also be used to resolve complaints, as the practice is able to demonstrate the measures they have put in place to show they have responded to the complaint and they are trying to prevent the same incident happening again (INT3 complaints). However, although this can be a useful way of communicating the QI initiatives a practice has introduced, the interviewee who deals with complaints commented that these changes are often introduced after a complaint, but aren't shared with the client (INT3 complaints).

6.1.1. The complaints procedure has become more formalised over time, although clients are generally unaware of the process unless something goes wrong

It appears as though clients are generally unaware of the complaints procedure within the veterinary sector until something goes wrong (INT5 owner).

> *'I think the public today are more aware of making a complaint, but only when an issue arises…they don't expect things to go wrong.'* (INT5 owner)

The interviewees also discussed how the complaints procedure has changed, in particular the two animal owners who had made complaints a number of years ago and reflected on what the process would look like today if the same incident were to occur. Both complaints made by these two interviewees were not formally reported. The outcome of one was to move practice. The outcome of the other was a payment to recuperate the loss of livestock that had occurred (INT5 owner, INT15 owner). These interviewees felt that, if these incidents were to happen today, that they would have made a more formal complaint and the process would be handled better, tracked, and taken more seriously (INT5 owner, INT15 owner).

There is also evidence to suggest that the number of complaints is increasing over time (INT3 complaints, INT15 owner). One of the interviewees who deals with client complaints commented that the mediations service they offer used to receive 50 complaints a month but this is now closer to 200 (INT3 complaints). This increase was suggested to be due to greater awareness of the standard of care that should be provided, and so clients are more confident in challenging vets' decisions, but also a better understanding of the complaints procedure (INT3 complaints, INT5 owner, INT15 owner). It may also be because clients are more aware of the mediation service available to them, as this is a fairly new service. Although the interviewee from the mediation service has reported an increase in complaints, the number of complaints which have been raised with RCVS has dropped since 2016. The number of complaints raised in 2016 was 983, which has dropped to 556 in 2018. This difference in trends between the mediation service and RCVS is due to the need for individuals raising complaints to first contact RCVS and these are then directed to the appropriate forum to be dealt with, which may be the mediation service but not for all complaints.

6.2. THERE ARE MIXED OPINIONS AS TO WHETHER CLIENTS SHOULD BE INVOLVED IN QI, ALTHOUGH COMPLAINTS WERE THOUGHT TO PLAY AN IMPORTANT ROLE

There were mixed opinions as to whether clients should be involved in QI going forward. Only 8 per cent of the survey respondents felt as though animal owners have a role to play in QI going forward (see Figure 19 in the following chapter). The interview with a member of the QIAB noted the asymmetries of knowledge that inevitably characterise this area. (INT1 QIAB). It may be that the knowledge held by a client on QI activities, such as audits, determines the extent of their involvement in QI activities (INT11 profession).

Despite this evidence suggesting many members of the profession do not think owners should be involved in QI, the majority of the interviewees felt as though clients should at least have an understanding of the QI activities that take place in their practice, even if they are not directly involved with these (INT3 complaints, INT5 owner, INT14 profession, INT15 owner). Awareness of the PSS was deemed to be important as it means clients can make a more informed decision about which practice to attend (INT5 owner, INT15 owner). This may also lead to more practices getting PSS accredited and thus increase the standard of veterinary care across the country (INT14 profession). However, it was noted that it is important for the PSS to be marketed well to clients for this to work to ensure they are encouraged to visit the accredited practices (INT10 profession).

Awareness of QI activities other than the PSS could be shared through regular, short updates from practices to clients, for example, their progress towards getting PSS accredited and what QI activities have been introduced recently (IN15 owner). In addition, animal owners could take part in training/education presented in a lay language to understand what veterinary care involves. This could involve a mixture of practical seminars and shadowing a vet (INT15 owner). This interviewee (who worked on a farm) referred to this specifically for farm animal owners as it was felt as though they needed to have a better understanding of their animals and the care they receive.

Some interviewees did feel as though clients could directly contribute to QI activities within the veterinary sector and provided examples of what this might look like. One interviewee involved in dealing with client complaints felt that clients should be involved in QI by identifying areas for improvement that may not be picked up by veterinary professionals (INT3 complaints). This could help practices understand why certain complaints occur and why they are escalated, and could help clients understand the processes in veterinary care (INT3 complaints). In individual practices, this could be implemented through setting up an owner working group, which is likely to come naturally over the next few years with the increasing corporatisation, as it was felt as though practices from larger groups are more likely to dedicate resources to hearing client experiences (INT3 complaints). Support from RCVS Knowledge was thought to be helpful in implementing these activities, particularly those introduced at a national scale (INT15 owner).

> *'Lay perspective and veterinary perspective are very different sometimes…the veterinary perspective is so used to seeing a particular issue…the lay perspective brings a totally different perspective.'* (INT5 owner)

One of the priorities with patient involvement in healthcare QI is to ensure it is meaningful and does not become a tick-box exercise, which will also need to be considered if clients are to be involved in veterinary QI. Some of the interviewees provided some ideas on how to ensure that client involvement is meaningful (INT3 complaints, INT15 owner). One of the interviewees involved in client complaints felt it was important to make clear what the goal is when involving clients and what the intended outcome is, for

example, if it is a consultation, then it is important to create clear plans and keep in touch with the clients involved rather than just having a one-off conversation (INT3 complaints). It is also important to manage the expectations of clients, emphasising that it is not possible to implement everything they suggest but communicating clearly what is possible (INT3 complaints, INT10 profession).

One of the animal owner interviewees who worked on a farm thought that farm animal owners' involvement in QI could be made meaningful by offering incentives for livestock owners to get involved with QI within a practice. For example, national livestock quality assurance schemes, such as the National Register of Sprayer Operators, require livestock owners to reach a certain number of points over three years to demonstrate high-quality conduct. RCVS could work with schemes such as these to offer animal owners points for their involvement with their veterinary practice in QI activities, acting as an incentive for animal owners (INT15 owner).

One of the animal owner interviewees provided examples of where efforts are already in place to both increase client awareness and involvement in QI activities (INT5 owner). A vet school's initiative to include clients with undergraduate training in client communication involved the use of scenarios in which clients use their experiences to create situations that the students have to deal with, and these increase in difficulty with each year of university. This aims to provide a different perspective that students may not have been aware of before to make them aware of the importance of client communication and how to do it effectively early on in their careers. Although this is only a recent initiative, it has received positive feedback from both the clients and students involved and it will be expanded going forward to introduce mentoring groups for students and focus groups. The interviewee felt that, with backing from the RCVS, a programme like this could be rolled out on a larger scale (INT5 owner). In addition to this work by the university, the PSS Client Service Award has plans to introduce client focus groups as part of the requirements to achieve the award. The aim of these focus groups will be to collect information on where the clients think improvements can be made to the services provided by the practice, and to make changes based on these, for example how well the veterinary surgeon explained what was happening to the animal.

6.2.1. Complaints can play an important role in identifying areas for improvement

Although veterinary practices want to avoid receiving complaints from clients, they are inevitable and can have a beneficial role to play in improvement. For example, collecting feedback on the types of complaints (at a local practice level and national level) can provide useful data on what the complaints are about, to see if there is a higher number in a particular area, what triggers complaints and how complaints can best be resolved to improve the relationship between clients and veterinary professionals (INT3 complaints). There have only been anecdotal reports of how complaints can lead to improvements in practice, as this positive approach to complaints is still in its early stages (INT3 complaints, INT5 owner). However, if multiple complaints arise based on similar areas, these are passed to the RCVS Standards Committee to explore whether more can be done on a national scale to address these problems (INT2 complaints). An example of how this has impacted change at a national level, along with a similar example from another interviewee at a local level, is outlined in Box 8.

> *'I think it's all very well that practices learn from complaints, but they need to put something in place to make sure that it's actually changing.'* (INT5 owner)

Box 8: Examples of how learning from complaints can lead to changes in practice at a national and local level

It was clear that the number of complaints, which were being received regarding out-of-hours care and informed consent, could be reduced by providing improved guidance in this area. Since the RCVS Standards Committee provided this guidance, there has been a drop in the number of complaints in these areas. (INT2 complaints).

During one complaint procedure, the client informed the practice of the information that would have been useful to receive during the consent process, including more details on the risk of procedures. As a result, the practice reviewed the consent forms they used to provide more details to clients so they could make better informed decisions about their animal's care (INT3 complaints).

Involving the client who submitted a complaint in the learning and changes in practice after it has been dealt with can be beneficial (INT3 complaints). For example, the client can provide their experience of the incident and handling of the complaint to ensure the veterinary team are aware of their perspective and how the process affected them. This could then extend to more formal sharing of experiences, for example client involvement in training veterinary professionals to have bereavement conversations (INT3 complaints).

7. THE FUTURE OF QI: WHAT CAN VETERINARY STAKEHOLDERS DO TO SUPPORT QI GOING FORWARD?

The results from this research have so far shown the veterinary profession's perceptions and understanding of QI, the current QI activities in use across the profession and the enablers and barriers to the profession engaging in QI. What is important to understand next is, based on these results, what can be done going forward, and by whom, to continue to support QI across the veterinary sector.

Based on data collection across this project, this chapter will focus on what each key stakeholder in the veterinary sector can do to support QI going forward. These stakeholders include: RCVS; RCVS Knowledge; individual veterinary practices (including animal charities); professional organisations; universities and educators; the Veterinary Client Mediation Service[29]; CPD providers; and PMS providers.

[29] This independent service offers support to veterinary professionals and clients to resolve complaints.

- RCVS's role could include improving the QI guidance and signposting to resources for practices, mandating certain aspects of QI (although this received mixed views), ensuring there is a focus on improving team wellbeing and continuing to strengthen the QI aspects of the PSS.
- RCVS Knowledge's role could include continuing to promote more widely the existing resources and guidance already available, as well as creating new resources, demonstrating the importance and benefit of QI, and simplifying the QI language.
- Individual practices, including large and smaller practice groups, could have a role in appointing QI leads (which could involve those from both clinical and non-clinical roles) to help implement and sustain QI activities, introduce QI into HR processes, introduce initiatives to encourage communication across the practice and create dedicated QI time.
- The role of professional organisations could include supporting RCVS Knowledge to develop and disseminate QI resources, as well as continuing to develop their own resources.
- Universities and educators could have a role to play in introducing a greater focus on developing the skill-set required to deliver QI in education, including modules on QI.
- The Veterinary Client Mediation Service has a role to play in supporting practices to learn from complaints and educate them on how to deal with complaints.
- CPD providers, which includes a range of organisations including individual practices and RCVS Knowledge, have a role to play in incorporating QI into training and CPD to a greater extent.
- PMS providers could incorporate QI tools, such as incident reporting, into their systems.

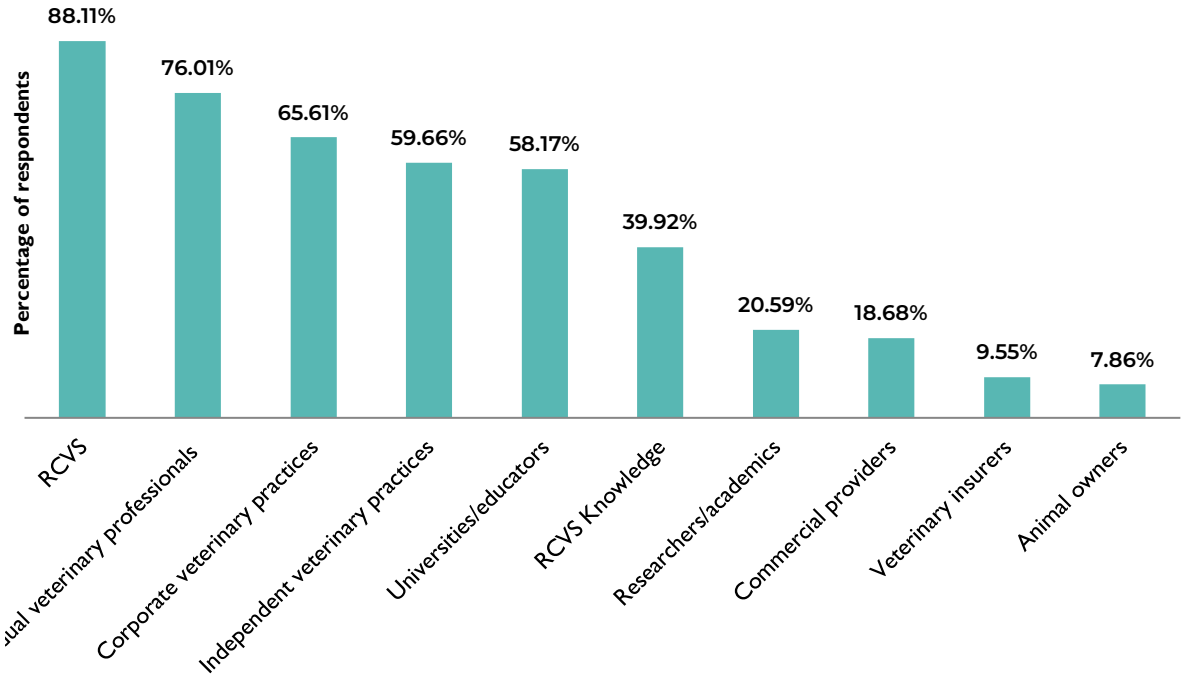
7.1. A RANGE OF STAKEHOLDERS HAVE A ROLE TO PLAY IN SUPPORTING QI

The survey explored the extent to which the profession thought various stakeholders (and others) in the veterinary sector have a role in supporting QI (Figure 19). As this graph shows, the majority of the respondents (88 per cent) thought that RCVS is responsible for supporting QI in the veterinary sector. Many respondents also felt individual veterinary professionals, individual practices (larger and smaller practice groups) and universities and educators have a role to play. Fewer (less than 50 per cent), thought RCVS Knowledge[30], researchers/academics, commercial providers, veterinary insurers and animal owners have a role to play in supporting QI. Subsequent to the research, key informants emphasised the value of engaging with universities and educators to introduce QI, to first map what is happening as a prelude to taking QI in academia further.

The remainder of this chapter will explore in more detail what roles each of the stakeholders listed above could play to continue to support QI across the sector.

[30] Many participants in this research were unclear on the differences between the role and responsibilities of RCVS and RCVS Knowledge

FIGURE 19: SURVEY RESPONSES TO THE QUESTION: WHO DO YOU THINK IS RESPONSIBLE FOR SUPPORTING THE VETERINARY SECTOR WITH EMBEDDING QUALITY IMPROVEMENT, AND OVERCOMING THE BARRIERS OF QUALITY IMPROVEMENT?[31]



7.2. THE ROLE OF RCVS

As Figure 19 shows, RCVS was thought to have a role in supporting QI by the majority of our survey respondents. However, it is important to note here that many participants in this research were unclear on the differences between the role and responsibilities of RCVS and RCVS Knowledge. The role of RCVS is to create, review and advance the standards in veterinary care for both surgeons and nurses, including ethical, professional and clinical standards, as well as the standards set out in the PSS. RCVS also holds the registers for veterinary surgeons and nurses who are qualified to practice in the UK. RCVS Knowledge is the charity partner of RCVS that supports the advancement of the quality of care delivered by the veterinary professions. It offers multiple sources of information and guidance on how to improve the quality of veterinary care, including QI support for veterinary professionals. The recommendations for RCVS and RCVS Knowledge have been separated out based on these different roles and remits, which the research participants did not always make clear, or they suggested recommendations for one of these organisations which fall under the remit of the other.

Our interviewees and attendees at the summit suggested multiple ways in which RCVS could support QI, including providing clarity on RCVS's QI message, possibly mandating some aspects of QI, focusing on using QI to improve team well-being and continuing to make improvements to the PSS.

7.2.1. Providing clarity on RCVS's standards for QI

It was felt as though RCVS need to set out what they want to see from practices in terms of QI and provide clearer standards for what activities practices should be doing beyond what is in the Code of Conduct and

[31] 4.25 per cent of respondents thought stakeholders other than the ones listed in the question were responsible for supporting QI. 0.21 per cent (one respondent) thought none of these groups were responsible.

the PSS, and the importance of communicating this clearly to the profession (INT8 LPG, INT11 profession, INT13 profession).

What was thought to be most effective is closer collaboration between RCVS and RCVS Knowledge in terms of RCVS creating the need for resources. Although progress has already been made in this area, for example introducing Clinical Governance as part of the Code of Conduct and PSS, making it clear that QI is a priority for the College and creating a clear message around the importance of QI was seen to be important. RCVS Knowledge can then create guidance and resources based on this need (INT2 complaints, INT10 profession). More detail on the role of RCVS Knowledge developing guidance and resources, which could be based on these QI standards, is in Section 7.3.

7.2.2. Mandating (or not) certain aspects of QI

Our interviewees, focus group participants and summit attendees had mixed opinions as to whether QI should be made more mandatory in practice, with concerns raised that this could have a detrimental effect, in that practices feel forced into implementing improvement activities that could make them more resistant to QI.

For those in favour of making QI compulsory, this was often discussed in terms of making the PSS mandatory for all practices, or just making the Clinical Governance section of the PSS mandatory (FG2, INT7 profession, INT17 profession), although it should be noted that the Clinical Governance section of the Code of Conduct is already mandatory. This could also be linked to the PSS awards, for example only practices scoring highly in the mandatory QI module are able to achieve the awards, or introducing an award specific to QI (FG1, FG2). It was commented that this could help practices to understand the importance of QI and improve the clarity from RCVS as to the priority they have placed on QI, helping it to become embedded across the sector (INT7 profession, INT17 profession). It was felt during one of the PSS assessors' focus groups that once practices start working towards PSS accreditation or the awards, they are often so motivated and focused on reaching this goal that they would not be opposed to having to undergo a compulsory QI module (FG1). These participants also felt that strengthening QI as part of the basic PSS by offering a QI module would particularly benefit independent practices as it would allow them to benchmark their QI activity against other local practices and demonstrate how they are better than others (FG1).

Alternatively, others felt as though mandating QI could have a negative impact on the progression of QI in the sector, again often linking this to the PSS (summit, INT2 complaints). Making the whole PSS mandatory would be highly complex and require a change in legislation, which one interviewee felt would be very difficult to achieve and would require practices to be regulated more closely (INT2 complaints). This interviewee and the summit attendees also felt mandating the PSS would go against the ethos of the scheme of encouraging practices to adopt QI and go further than the minimum standards set out in the PSS (setting mandatory standards would make it more likely that practices only work to meet these, seeing it as a tick-box exercise, rather than appealing to intrinsic motivations) (summit, INT2 complaints).

Discussions held during the summit also suggested that mandating QI would have a negative impact on QI more generally and highlighted that evidence from the NHS suggests it does not help in encouraging engagement with QI (summit).

7.2.3. Increasing the focus on QI as a way of improving the well-being of veterinary teams

Improving the wellbeing of veterinary teams is an important focus for all veterinary organisations today due to the evidence indicating that the veterinary sector has very high rates of suicide. Data from the British Veterinary Association (BVA) shows that suicide rates for vets are four times the national average and double that seen in doctors and dentists, in part due to the pressures of long working hours, stress, low

pay and job dissatisfaction (BVA, n.d.). Evidence also suggests that poor mental health may arise during veterinary education, with one study that surveyed veterinary students finding that 54 per cent had experienced a mental health problem, which was significantly higher than the general population (Cardwell et al., 2013). Our interviewee from the QIAB suggested that the change in the workforce is adding to this pressure, for example, a greater desire for part-time work and not wanting the same job for life (INT1 QIAB).

Therefore, it is perhaps not surprising that some of our interviewees felt as though QI could be incorporated into RCVS's efforts to improve the well-being of the profession, as well as the patient, and respond to the changing workforce (INT1 QIAB, INT6 LPG, INT13 profession). Although, it is important to note that multiple factors contribute to poor mental health and human healthcare has a large role to play in supporting veterinary professionals suffering mental health illness; QI alone will not overcome mental health conditions, although it may contribute to improved overall well-being.

RCVS already do a lot in supporting team well-being, for example the RCVS's strategic plan for 2017–2019 outlined how it will explore the impact of the professional conduct system on mental health, and it funds the Mind Matters Initiative which aims to improve the well-being of veterinary staff and students. However, more could be done in connecting this with QI activities, such as CPD (INT6 LPG; Mind Matters, n.d.; Royal College of Veterinary Surgeons, 2017). For example, as we have discussed throughout this report, part of the aim of many QI activities and initiatives is to move away from a culture of blame to a culture of learning. Reducing the fear and concern around reporting mistakes and serious incidents could result in reduced anxiety in veterinary teams. The aviation sector goes significantly further than human healthcare in this respect:

> *'As happens in safety-critical industries such as aviation, human factors training and related psychological training in patient safety and staff well-being need to be an integral part of all NHS staff work plans, from the boardroom to the bedside, with dedicated human factors/patient safety psychologists in post. Most major airlines have well-established departments that are staffed by a large team of psychologists/human factors specialists, while this is the exception rather than the rule for major NHS hospitals.'* (Kapur et al., 2015)

7.2.4. Continuing to strengthen the QI aspects of the PSS

Making improvements to further strengthen the QI standards in the scheme will ensure it can support and encourage practices to engage with QI. Various possible improvements were suggested by our interviewees and focus group participants, which are discussed here.

It was suggested by some interviewees that the link between the outcome of the PSS inspection and subsequent changes in practice is not always clear, as the changes are not mandatory, and so it would be helpful to specify that practices need to demonstrate the changes that have been implemented on the back of the PSS assessor's recommendations (INT8 LPG, INT10 profession).

It may be more helpful for practices to have a score-based ranking system so they are able to see how well they are performing, and the PSS assessors could provide advice and recommendations on how to reach a higher rating (FG1, INT8 LPG). Practices would still be either PSS accredited or not, however those that are accredited would receive a score as to how well they meet each criteria, rather than having a single pass or fail approach, which would highlight to the practices areas in which they could improve for their next assessment.

Our focus group participants discussed how it would be helpful if the PSS moved towards practices self-assessing themselves against some easier to measure standards of the PSS, such as the presence of litter

trays for cats. This would allow PSS assessors to focus on the more complex factors that can't be assessed, such as the Veterinary Medicines Directorate requirements, and provide them with the time to provide guidance on introducing or improving existing QI activities (FG2). Self-assessments would also provide practices with greater responsibility for the assessment process and understanding the importance of each standard (FG2). However, self-assessments should be approached with caution, and measures put in place to verify these assessments.

Finally, participants from one of our PSS assessors' focus groups felt that there was not a clear award related to QI (FG2). Making the PSS QI award more visible to the profession as well as clients would be beneficial.

7.3. THE ROLE OF RCVS KNOWLEDGE

The role of RCVS Knowledge in supporting and progressing QI in the veterinary sector was discussed across our interviews and was a frequently discussed point during the summit. Almost 40 per cent[32] of survey respondents felt as though RCVS Knowledge have a key role to play in supporting QI. The suggested roles RCVS Knowledge could play included continuing to promote more widely the QI resources already available to practices, demonstrating the benefit of QI by sharing good examples, simplifying the language surrounding QI, creating new guidance and resources, and creating a centralised audit system (which is already in progress). The good position RCVS Knowledge is in to support QI was noted, as, unlike many veterinary organisations, it supports all veterinary nurses and surgeons, rather than a subset, to advance veterinary care through QI and evidence-based veterinary medicine (INT10 profession).

7.3.1. Raising greater awareness of the QI resources already available

As discussed in Section 4.3.1, RCVS Knowledge has produced a wide range of resources to support practices to understand and implement QI activities. However, it was felt by our interviewees and summit attendees that these resources need to be made more visible to the profession, which would ensure RCVS Knowledge is the go-to place for this type of support (INT6 LPG, INT9 profession, INT11 profession, INT16 profession, summit).

It was suggested that RCVS Knowledge could use professional publications such as Vet Times, apps or other types of technology interfaces, or social media to make the profession more aware of what is available to them, and also help to get the message across as to the importance and benefits of QI, as well as help to normalise QI (INT16 profession, summit). Apps could also be used to access QI resources and tools (summit), for example VetSafe is offered through an app and allows veterinary professionals to record significant events. It was thought that raising awareness would be a fairly easy change to introduce by RCVS Knowledge while having a large impact; however, as with resources produced by RCVS, there is some role for veterinary professionals to play in actively looking for these resources and being motivated to look for them (INT9 profession).

7.3.2. Demonstrating the benefit and importance of QI

Through the summit, the attendees outlined the role RCVS Knowledge can play in communicating the importance and potential benefits of introducing QI into practice, for example encouraging the use of process audits by emphasising the timesavings in using a process audit while seeing an impact sooner, and highlighting the financial benefits of a fully embedded QI approach (summit).

[32] Eighty-eight per cent of respondents thought that RCVS is responsible for supporting QI in the veterinary sector. Many participants in this research were unclear on the differences between the role and responsibilities of RCVS and RCVS Knowledge

The importance of sharing examples of where QI has been implemented, how it was done and the impact of this was thought to be important in demonstrating the importance and benefit to practices, such as the timesavings and examples of 'quick QI' (INT4 LPG, INT6 LPG, INT10 profession, INT11 profession, INT14 profession, summit). Although RCVS Knowledge does encourage practices to submit case examples on how QI has made an impact,[33] this could go further, for example by increasing the visibility of existing case examples and creating a larger number of these examples (summit). Sharing examples of where things can go wrong as well as when they work well can also be beneficial. This can help members of the profession to feel more comfortable, as they can often relate to mistakes that have been made and find it helpful to see what the outcome of an incident was and how to stop it happening again in the future (INT6 LPG).

Sharing examples and creating case examples was thought to be relatively easy for RCVS Knowledge to implement and could have quite a large impact on encouraging adoption of QI (summit). However, there will need to be consideration of confidentiality, for example by anonymising case examples to ensure they can be shared among the profession. It is also important to consider the audience of these outputs as they may need tailoring for different job roles, such as receptionists, managers, nurses and surgeons (summit).

7.3.3. Simplifying the language around QI

Many of the discussions during the summit often linked back to the importance of having a simple, clear language for QI in the veterinary sector, which attendees felt was the role of RCVS Knowledge (summit). The language used in QI can often be confusing and can act as a barrier to engaging with it (summit). This was reflected in our survey with many respondents reporting they did not understand what QI is and how to use the tools available to them (see Chapter 5 for more information). Part of this lack of clarity is the difficulty in defining QI, which may be a contributing factor to many members of the profession not fully understanding what is meant by QI. RCVS Knowledge could help to create a QI definition that fits with the veterinary profession, for example by using a Delphi approach with senior bodies in the sector (summit). This definition would then have to be reflected across the RCVS and RCVS Knowledge, including updating the Code of Conduct to ensure the definition and description of QI fits within practice (summit).

Having a shared understanding of what QI is and the language used to describe QI makes communication easier, and so if RCVS Knowledge focuses on language first, it was thought that this could make their and the RCVS's role in communicating about QI easier (summit).

The summit attendees thought that clarifying the language around QI was fairly easy to implement but may have a slightly lower impact than some of the other possible roles of RCVS Knowledge discussed in this section (summit).

7.3.4. Creating new resources and methods of engagement for practices to get involved with QI

As discussed earlier in this chapter, a potential role of RCVS is to create clearer standards on what is expected of practices in terms of QI. In response to this, RCVS Knowledge has a role to play in developing new guidance and resources to help practices in meeting these standards and in understanding how to implement QI in practice. It was felt by one interviewee that having the knowledge to implement QI means it can be managed within existing capacity and resources (INT4 charity).

> *'It would be nice to have guidance on what good Clinical Governance means and looks like.'* (INT11 profession)

[33] See https://knowledge.rcvs.org.uk/document-library/case-study-form/

This could include, for example, RCVS Knowledge sharing guidance on what data practices should be recording, the types of CPD they should be engaging with and guidance on running a morbidity and mortality meeting (INT7 profession, INT11 profession) based on standards set up by RCVS on what QI should look like in practice. It could also be helpful for RCVS Knowledge to share information on what has worked well in practice (INT14 profession). Other suggestions of resources RCVS Knowledge could develop included:

- Toolkits: RCVS Knowledge could produce more toolkits to support the practical implementation of QI, such as toolkits to introduce practices to QI (summit, INT11 profession). However, it is important that these are flexible so that they can be adapted to individual practices, as one-size-fits-all approaches can be difficult to implement locally (INT11 profession). This is particularly relevant for farm and equine veterinary practices that, as discussed in Section 5.6.2, have different barriers to engaging with QI and so it is important that QI tools can be successfully adapted to work in these different circumstances. It was thought by summit attendees that creating new toolkits could be fairly easy for RCVS Knowledge to implement but have a large impact (summit).
- Standardised documents and computer codes: reviewing data could be made easier if RCVS Knowledge, working with computer companies, produced standardised documents or computer code which could support activities such as benchmarking. For example, it may be beneficial to have computer codes and drop-down fields in PMSs. This was thought to have a potentially large impact but would be very difficult to implement across the profession (summit).
- Resources to support the embedding of QI in CPD: RCVS Knowledge could provide resources to organisations designing CPD to help them incorporate aspects of QI into this training, such as slides on QI to use at the start or end of training days (summit).
- Provide QI mentors: RCVS Knowledge could appoint QI mentors, such as PSS award holders or provide training to specific individuals to act as mentors and travel around practices, which could be very impactful for individual practices and could accumulate to have a positive impact across the profession if enough practices were engaged (summit).

This guidance does not necessarily have to be in written form. For example, one interviewee suggested that RCVS Knowledge could have a more proactive role in sharing examples of QI by appointing spokespersons for QI who visit practices across the country to share ideas and examples of improvement activities that have been used in other practices (INT12 profession). It could also be through the use of formal lectures, webinars or workshops (INT11 profession). It should be noted that work is already ongoing to introduce this type of event by RCVS Knowledge. In 2017, RCVS Knowledge introduced sessions at major veterinary congresses and ran QI roadshows in collaboration with large veterinary organisations.

It was thought by one interviewee that the profession could be involved in putting together this QI guidance, with the example provided that the Association of Veterinary Anaesthetists could support the development of standards relating to anaesthesia (INT11 profession). It was felt that this would help the standards to become embedded into the veterinary professions' day-to-day work and would lead to better quality standards, as they were developed based on the expertise of leaders in the field (INT11 profession).

It is important that these resources have a wider focus than just targeting veterinary surgeons, which interviewees felt was often the case, to ensure the whole team, particularly veterinary nurses and support staff, are also engaged (INT2 complaints, INT4 charity, INT13 profession). This interviewee highlighted the importance of celebrating achievements as a whole practice team and ensuring all staff in a practice can support each other with QI, and RCVS Knowledge could play a large role in ensuring that the support they provide through QI resources and guidance reaches veterinary staff other than surgeons (INT4 charity).

It was also highlighted by one interviewee the importance of not only focusing on the clinical and business outcomes of QI but also creating resources that support the well-being of staff (INT10 profession). This can be through continuing to create resources that emphasise the move towards a learning culture, rather than a blame culture (i.e. creating a just culture). RCVS is already making efforts to move towards a just culture, for example by working with the establishment of the Mind Matters Initiative discussed earlier in this report, and RCVS Knowledge can help to strengthen this link. One interviewee discussed the potential for RCVS Knowledge to work with the VDS in this, as the VDS has been doing a lot of work recently related to promoting well-being and resilience in practice (INT10 profession). RCVS Knowledge already work to support aspects of developing a just culture that are outside the remit of the VDS, however RCVS Knowledge and VDS could work better together to ensure that the links between the two are simplified for users of their services. It should be noted that RCVS Knowledge have expressed to VDS that they are willing to collaborate on this.

7.3.5. Creating a centralised audit system

One of our PSS focus groups and our interviewee from the QIAB discussed the value of vetAUDIT, provided by RCVS Knowledge, and VetSafe, set up by the VDS, and said that it would be even more valuable for additional resources to be directed by RCVS Knowledge in creating further centralised audit systems across the veterinary sector (FG1, INT1 QIAB). Our summit attendees discussed the importance of making data collected through this audit system (and other audits) available on a national and a local scale to allow practices to see where they fall compared to other practices (summit). Although, as discussed in Chapter 5, sharing data between practices is difficult due to competition and confidentiality issues. Creation of further centralised audit systems would involve anonymised data being collected from practices and sent to a neutral organisation (FG1).

Our interview with a member of the QIAB outlined some potential challenges in implementing central audit systems. This includes a lack of adequate technology to record and analyse data and the time it takes for members of the profession to supply the required data (INT1 QIAB), in addition to the difficulties in sharing data between practices.

7.4. THE ROLE OF INDIVIDUAL PRACTICES AND PROFESSIONALS

Individual practices and veterinary professionals were thought to be important stakeholders in supporting QI within the sector (76 per cent for individual professionals, 66 per cent for large practice groups and 60 per cent for smaller practice groups, see Figure 19). On exploring this in more detail during the interviews, focus groups and the summit, it indicates that there is a role at the practice level in introducing support for improvement through the creation of QI leads, incorporating QI in HR processes, introducing initiatives to encourage communication within the practice team and prioritising dedicated time to spend on QI. As discussed in the previous section, the importance of engaging all team members in the practice, including receptionists, support staff and veterinary nurses, as well as veterinary surgeons, was highlighted by interviewees (INT13 profession, INT2 complaints, INT4 charity).

Focus group participants discussed the importance of not having a one-size-fits-all approach for these resources (FG1). It is important that practices use QI resources from RCVS Knowledge and others, but that they are tailored to fit individual practices to increase the likelihood of sustainable use and impacts. Participants felt this was the role of the Clinical Standards Director in large practice groups (FG1) and in smaller practice groups would most likely be the responsibility of the QI lead, should this role be introduced.

7.4.1. Providing support to veterinary professionals to engage with QI through appointing QI leads

As discussed in Section 5.4, the introduction of QI leads is already being seen in some practices, particularly large practice groups. Appointing a QI lead can demonstrate the importance the practice places on QI and that it is willing to invest in methods to support teams to get involved and have the time to engage with QI (INT6 LPG). The focus group participants also suggested that having a QI lead could encourage the practice to take responsibility for their work and be proud of the QI work they do (FG1). However, it is important that these roles do not detract from the wider team engaging with QI; it is important that the whole team is involved in QI activities, with the QI lead overseeing these processes.

The structure of this could take many forms, for example there could be one individual in charge of QI for the whole practice (FG2) or there could be an individual acting as the QI lead for different areas, such as surgery (FG1). Appointing QI leads could be particularly beneficial for the PSS inspection, as it would be within their roles to coordinate the assessment and be available during the day of inspection (FG1).

How easy it is to implement QI leads will depend on the QI knowledge and skills within the practice and the existing hierarchies within the team (summit). VetSafe is already introducing these types of roles as it encourages practices to nominate a team member to be a VetSafe champion for the practice; however, practice must go further to ensure that the reporting is just one step that leads on to continuous Quality Improvement.

7.4.2. Introducing QI into HR processes

Discussions during the summit highlighted the possibility of introducing aspects of QI into HR processes, including performance reviews, job interviews and as a job role requirement.

QI could be integrated into clinical progress reviews or appraisals to explore what QI activities professionals have been involved in. The summit attendees felt as though this would be moderately difficult to implement and have a moderate impact (summit).

QI-related questions could be included in job interviews to focus on employing individuals who are open to getting involved in QI even if they are unaware of it, or if they have an understanding of QI already (rather than those who are antagonistic towards QI). Similarly, job role descriptions could include the need to be involved with QI so it becomes a part of day-to-day working and isn't added on top of existing tasks. This could also help with the way QI is communicated among practices, to demonstrate that it is part of the practice culture rather than an add-on (summit). It was thought that both of these would be fairly easy and inexpensive to implement but have a large impact, and some example questions that employers could ask during interviews could be provided to practices, perhaps by RCVS Knowledge (summit).

7.4.3. Introducing initiatives to encourage communication across the practice

Communicating within a practice is important in encouraging QI, particularly in sharing learning and examples. During the summit, the benefit of introducing daily huddles and empowering all members of the team was thought to be particularly helpful in supporting communication, as well as moving away from a culture of blame.

'Daily huddles' were thought to be very useful by summit attendees, particularly when they are multidisciplinary and held at the start of the day. Although these have been shown to be effective in the NHS, attendees felt as though daily huddles were not as frequently seen in the veterinary sector, possibly due to the nature of large practices and number of emergencies making it difficult for all team members to attend a meeting every day (summit). It was thought that introducing daily huddles would be fairly simple for practices yet could have a large impact on supporting communication; however, it may be challenging to get the team together at the same time, particularly during busy periods.

Empowering all members of the team in practices to facilitate communication was thought to be important by summit attendees. It is important to have a hierarchy that ensures all the roles and responsibilities of each member of the team are clear, while ensuring there is no fear of blame and there is a distributive leadership structure (i.e. anyone can demonstrate leadership when necessary). This was thought to be quite difficult and complex to introduce, particularly at scale, but could have a high impact (summit).

Not blaming individual members of the team was thought to be important in encouraging communication around mistakes and to enable learning to be taken from these (INT6 LPG, INT16 profession). One interviewee suggested that the veterinary sector could take learning from human healthcare in this respect, as it was thought that the NHS accepts that mistakes occur and focuses on learning from these to prevent them happening again (INT16 profession). It was thought to be more helpful to have a message shared with the practice as a whole after an incident, rather than targeted at single individuals (INT6 LPG).

7.4.4. Set aside dedicated QI time for veterinary professionals

As discussed in Chapter 5, time was considered to be one of the main barriers in the veterinary profession engaging with QI. It is important that both larger and smaller practices set aside time for their team to work on QI activities (summit, INT6 LPG). Attendees at the summit suggested that this could link with the creation of QI leads in practices, in that this individual not only leads the QI work within the practice but also engages the team with QI and ensures this time is set aside (summit). It was thought by one interviewee that practices, particularly larger practices, need to have a formal message that the team should set time aside for QI so veterinary professionals can understand the importance the practice is placing on this issue (INT6 LPG).

It was highlighted by the interviewee from an animal charity how these organisations can help change attitudes towards creating dedicated time (INT4 charity). It was suggested that if charities can be seen to create time (and provide resources) for QI by relying on donations only, then this will highlight the importance of QI to other practices and demonstrate that it is possible to dedicate time to it (INT4 charity).

7.5. THE ROLE OF PROFESSIONAL ORGANISATIONS

Although only a small number of the survey respondents and interviewees felt professional organisations had a large role to play in supporting QI, it was suggested that they could play a role in supporting RCVS Knowledge in developing and disseminating QI resources (INT2 complaints, INT10 profession, INT11 profession, INT14 profession). This includes, but is not limited to, organisations such as the BVA, the British Small Animal Veterinary Association (BSAVA), the British Veterinary Nursing Association (BVNA), the Veterinary Management Group (VMG) and species-specific and specialism-specific organisations.

These professional organisations are often involved in their own QI initiatives, whether that is aimed at specific groups within the veterinary sector or the profession more widely. As has been suggested for RCVS Knowledge, it would be helpful for this work to be communicated more widely to raise awareness of what is being done by these organisations, as well as providing support to RCVS Knowledge in developing QI guidance and resources (INT2 complaints, INT10 profession, INT11 profession). This could be professional organisations providing QI support specific to their area of expertise, for example the Association of Veterinary Anaesthetists could help put together Clinical Governance guidance for anaesthesia. This could help create 'more bang for the buck' as experts in their field would be inputting into the development of these resources and guidance (INT11 profession).

One interviewee highlighted the challenge in professional organisations being involved in communication around QI and developing resources, in that they need to represent each group within the veterinary sector

equally. This interviewee felt as though this could lead to outputs from these organisations not 'really hitting the point they are trying to make' through concerns over offending a particular group (INT10 profession).

In addition to providing support to RCVS and RCVS Knowledge in creating and disseminating QI resources and guidance, it was discussed during the summit that the VDS could keep developing and improving VetSafe. For example, although it is helpful in being able to record significant events at the moment, it could be developed further to include reporting of incidents that have been handled particularly well and sharing this information across practices, and to cooperate with RCVS Knowledge (summit).

7.6. THE ROLE OF EDUCATIONAL ESTABLISHMENTS (UNIVERSITIES AND COLLEGES)

Educational establishments, including universities and colleges, were thought to have a role to play in supporting QI by 58 per cent of survey participants. The interviewees and attendees at the summit discussed the possible ways in which educators could help to support QI by increasing the emphasis and priority of developing the skill-set required to deliver QI, including communication and teamwork, instead of focusing only on clinical skills. Educators also have an important role in educating veterinary students and student veterinary nurses in QI, to give them an introduction to the topic so they understand what it is, how it is beneficial and how to go about implementing QI activities before they start working in practice.

The interviewee from the QIAB thought that educators do not include enough education on general practice and often do not view it as a specialism in itself, which deters students from going down this path (INT1 QIAB). General practice includes the development of QI-related skills, which this interviewee felt was important for students, such as communication, professional development, team working and Clinical Governance. Although some progress has been made in this area with the creation of the Advanced Practitioner Certificate and more general practice surgeons are now involved in teaching veterinary students, more could be done to ensure universities and students value the development of the skill-set required to deliver QI. For example, the general practice specialism course could be extended in duration (INT1 QIAB).

Multiple interviewees and attendees at the summit suggested that universities could introduce more QI education within their veterinary courses (INT6 LPG, INT8 LPG, INT11 profession, INT16 profession, summit). As mentioned earlier in this section, the majority of veterinary education is focused on the development of clinical skills, and a greater emphasis is needed on students gaining skills related to QI, for example QI teaching could be introduced at Level 6 degree level and in the nursing curriculum (summit, INT8 LPG, INT11 profession). Exposing students early in their veterinary careers to QI will make it part of their role, not an additional task on top of their day-to-day work, and make it clear that it is not about blaming individuals for any incident that arises but about learning from that experience to prevent it happening again (INT6 LPG, INT16 profession). The summit attendees also highlighted the importance of making it clear to veterinary students why QI is beneficial and that it isn't only about management (as attendance rates for courses which are seen to be non-clinical are often very low).

The attendees at the summit felt as though this could be introduced relatively easily and have a medium-sized impact, although it may take around five years to see changes in the system (summit). To support educators in implementing changes more rapidly they suggested that vet school councils should be able to support the implementation of QI teaching, and RCVS Knowledge could also provide support by appointing a QI lecturer to visit veterinary schools across the country (summit). To encourage students to see the value of taking part in QI courses, it was suggested that this education could be integrated into clinical rotational training in the later years of university courses so that it is not seen as something that is separate from clinical practice (summit).

7.7. THE ROLE OF THE VETERINARY CLIENT MEDIATION SERVICE

The interviewee involved in the independent Veterinary Client Mediation Service for the UK provided an overview of the complaints procedure (INT3 complaints). This interviewee outlined how most complaints are dealt with at a practice level (either formally or informally, as covered in Chapter 6); however, those that do not get resolved can be referred to the Veterinary Client Mediation Service who are an independent organisation (Nockolds Solicitors) (INT3 complaints). Information and feedback on complaints (from the veterinary professionals and clients involved) do not need to be shared by the practice and are not made publicly available by Nockolds Solicitors on an individual basis; however, Nockolds does publish an annual report which includes trends in complaints (INT3 complaints).

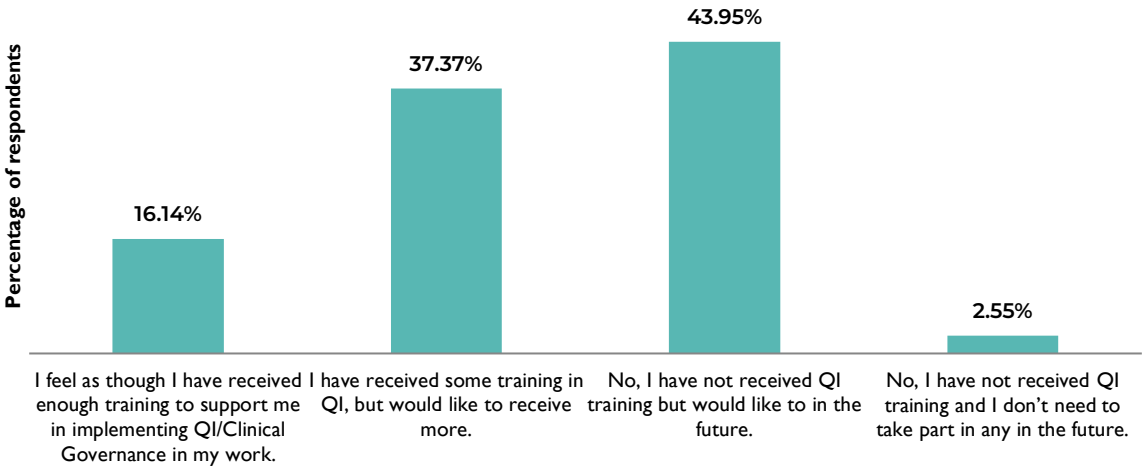
Nockolds Solicitors have a potential role to play in supporting practices to learn from complaints. They can help the veterinary profession to understand that dealing with complaints effectively is essential, and can provide guidance on how to deal with them in a more constructive way. Nockolds are also in a position to identify the common trends in complaints and track these over time to identify potential problems before they arise, and share best practice for dealing with these types of complaints (INT3 complaints).

7.8. THE ROLE OF CPD PROVIDERS

The importance of integrating QI into CPD was seen as important across the interviews and one of the focus groups, and it is one of the main enablers in supporting engagement with QI; however, there are many owners of this action due to the multiple providers of CPD, including individual practices, RCVS Knowledge and others. This means they all have a role to play in increasing the amount of QI coverage in CPD and training.

The desire for training specific to QI is emphasised in the survey results (Figure 20). As this figure shows, the majority of respondents reported that they hadn't received QI training (47 per cent), but 44 per cent of these reported that they would like to receive QI training in the future. Although this suggests there is a strong desire for QI training among the profession, the summit attendees found these results surprising, as the uptake of training is often higher for more focused clinical topics. RCVS Knowledge has been endeavouring to provide blended clinical and QI CPD, for example at BSAVA Congress. However, it is likely that this is linked to some of the barriers to engaging the profession in QI as is discussed in Chapter 5, such as a lack of time and understanding of the importance of QI. One interviewee also highlighted how it was unlikely they would attend a training day that only covered Clinical Governance and didn't touch on any clinical topics (INT14 profession), which links back to what was discussed in Section 7.6 about how the profession can hold what they see as non-clinical skills in lower esteem compared to clinical skills.

FIGURE 20: SURVEY RESPONSES TO THE QUESTION: WHICH OF THE FOLLOWING STATEMENTS ABOUT TRAINING TO SUPPORT THE IMPLEMENTATION OF QUALITY IMPROVEMENT/CLINICAL GOVERNANCE BEST APPLIES TO YOU?



Existing CPD and training opportunities could include a greater emphasis on QI and the benefits of engaging with QI (INT13 profession, INT16 profession, INT17 profession). This training could take a variety of different formats including both face-to-face, such as workshops, and online, such as through webinars (INT13 profession). The facilitator of this training would need to be carefully considered, and this was discussed in detail with one particular interviewee. This individual highlighted how education from external organisations (with knowledge of the veterinary sector) may be helpful in providing an independent perspective, although there may be resistance from the profession in that they feel as though they are being told how to do their jobs by someone who does not work in the sector. Alternatively, it could be delivered by someone who works in the veterinary sector and has a lot of experience with QI; training delivered by someone within the veterinary sector might have more weight behind it than an external individual (INT16 profession).

It was discussed during one of the PSS assessor focus groups that it may be beneficial to focus this QI training and CPD on large practice groups initially, as engaging one large group would have a bigger impact than trying to engage a number of smaller practices (FG1). However, this may contribute to a widening of the gap in QI between small and large practice groups, as discussed in Section 5.6.3.

7.9. THE ROLE OF PMS PROVIDERS

Veterinary PMSs are used for a range of functions across a practice, including accounts, staff scheduling, tracking inventory and tracking and recording animal data, and there are many different systems available (Pat Research, 2018). The attendees at the summit highlighted multiple ways in which PMS systems could be improved to support QI activities.

PMS systems could be updated so that they incorporate different QI tools, such as the ability to record significant events, and it was suggested more specifically that VetCompass could make changes to their system to allow practices to access data from national audits (summit). Alternatively, it was thought that a Kitemarking system could be introduced, which would require all PMSs to work at the same, high standard (summit). It was thought by summit attendees that changes to the PMS could have a large impact on supporting QI, however, this would be highly complex (due to a large number of different PMS systems) and expensive (summit).

8. DISCUSSION AND CONCLUSIONS

8.1. THE CASE FOR DEVELOPING QI IN THE VETERINARY SECTOR IS STRONG

Animal healthcare faces a variety of challenges that were alluded to during the interviews, survey and focus groups, and which are apparent in wider discussions. QI is clearly not the sole answer to these new challenges but it should be seen to be part of a coherent set of responses. Key challenges relevant to QI include:

- As animal owners become more informed and often have higher expectations, it becomes more important to have a formal system to show how quality issues are addressed.
- Similarly, there will be strong professional motivations to keep as narrow a gap as possible between what is made possible by new treatments and technologies and what is delivered by 'treatment as usual'. Word of mouth, keeping up with journals and mentoring will no longer be sufficient to support a nimble and improving sector.
- As veterinary practices grow in size, there are new opportunities to routinise QI, and more risks in not doing so. Larger practices will also bring greater specialisation, and generalist expertise may not be enough to keep all care up to the standards of the best.
- New technologies are already leading to apps and other devices that can make QI easier to implement and spread.
- All of this will happen in the context of growing cost pressures reinforcing the need to identify wasteful practices that do not add value in the care of animals; QI is also concerned with stopping unnecessary procedures and reducing the time between procedures that add unnecessary costs or suffering to the animal.

In the light of these challenges, it is therefore perhaps not surprising that the survey results, interviews, focus groups and summit registered such a strong appetite for QI. In addition, enthusiasm also reflects a view that QI has delivered value to human healthcare.

8.2. THE POSITIVE WIDER EVIDENCE FROM HUMAN HEALTHCARE IS RELEVANT BUT SHOULD BE TREATED WITH A DEGREE OF CAUTION, AND THE VETERINARY SECTOR SHOULD ACCUMULATE MORE SOLID EVIDENCE AND PRIORITISE EFFORTS ACCORDINGLY

In Section 1, the evidence from systematic reviews were summarised to highlight many specific examples where QI practices have been successful and where these have relevance for QI in animal healthcare. However, the evidence for this is, at best, patchy. Furthermore, however patchy the evidence from QI in human healthcare is, it is clear that no single approach will work in all contexts. Rather, there is a need to carefully tailor particular QI techniques to the particular circumstances of the improvement efforts. For example, it would be foolhardy to attempt to introduce a sophisticated approach to improving patient flow into an environment where there was little prior experience of QI. Furthermore, the systematic reviews throw up a further problem: there have been few systematic studies of the costs and benefits of QI.

This is certainly not a reason to argue against implementing QI in animal healthcare. However, in addition to urging caution, it also offers the opportunity to 'leapfrog' the study of QI in human healthcare by ensuring, from the outset, that the implementation of QI in the veterinary sector supports both reliable data on the activities and clarity about impacts. This would also support cost–benefit analyses and help make the case for taking QI forward, where appropriate, based on evidence of the impact on animal health and business efficiency.

It is also important to recognise that there are relevant differences between engaging with animal owners and engaging with human patients. This is particularly relevant for euthanasia, in which the client's wishes and what is thought by the veterinary team to be optimal care for the animal can differ. In addition, there are very different funding models and financial drivers. Furthermore, animal owners are customers in a way that is not the case for human patients, and the dynamics around this relationship would need to be considered (along with an understanding that consumerist behaviour is likely to be increasingly important in both settings).

8.3. LEADERSHIP AND ENGAGEMENT IS NEEDED (AND PREPARED) TO MAKE SENSE OF QI TO STAKEHOLDERS AND EXPLAIN WHAT IT MEANS IN PRACTICE

The survey also shows that support for the idea of QI is greater than the understanding of what QI involves. At the summit, it was agreed that across the sector this was indeed the case. The summit also expressed a willingness on the part of sector leaders to support greater understanding. Having engaged with the idea in principle, there is now a need to engage with it in practice.

In part, this should be achieved by the careful presentation of evidence, as discussed in Section 8.4. However, the evidence is not enough to create meaning and to change behaviour. Therefore, without it becoming a marketing exercise without substance, by drawing on examples from elsewhere, evidence from the sector, thought leaders and so forth, QI should be branded and communicated, for example through narrative case examples of how and why QI has worked well. The view was expressed in the summit and in a focus group that 'overselling' QI and giving it a 'cult status' would most likely lead to resistance. On the other hand, branding it as 'the way we do business around here' and as a helpful and practical way to provide better care within the available resources was seen to be a more likely route to success.

Professional identity is an important driver of behaviour (Godin et al., 2008). Furthermore, QI involves changing not only how professionals work, but how whole teams work together and interact. Medical knowledge is an important driver but so too is knowledge about tools to implement change, to understand

the context and to measure results (Batalden and Davidoff, 2007). In this sense, all those working in animal healthcare have two jobs: one to deliver healthcare and the other to improve it.

Training has a particular role to play in shaping professional identity. Where QI is established as part of the expertise and knowledge professionals need to do their job well and this informs the core curricula (rather than optional extras), new recruits to the veterinary workforce will more readily engage with QI activities.

However, throughout the research, the point was made repeatedly that if QI is to become the routine way of working, it needs to be made easy for those new to QI to engage, and with clear routes to participate. Supporting practices to have a package of QI activities and creating a community of practice whereby more experienced improvers can support new starters could have a high impact.

The Q Initiative,[34] led by the Healthcare Foundation and NHS England, is an effort to bring a community of improvers from across the UK together to provide mutual support and practical guidance. Its activities include free access to journals, webinars, site visits, 'Randomised Coffee Trials' creating one-to-one virtual meetings with a (real) cup of coffee, Special Interest Groups, and national and local events. Members appreciate the virtual offer but also highly rate the face-to-face events. As seen elsewhere (Ling and Soper, 2010), site visits are also highly appreciated. A particular activity, Q Exchange, involves groups competing and collaborating to secure funding for specific improvement projects. Q is also a 'co-designed' initiative involving members in designing how it works. As such, it is a vehicle for combining leadership from above and engagement from below. It generates strong loyalty and high levels of approval among members (Garrod et al., 2016; Ling et al., 2018). The scale of Q (currently over 3,000 members) is greater than may be wanted (or afforded) but the principle of an approach that involves elements of a social movement for improvement could be replicable.

8.4. EVOLUTION NOT REVOLUTION – FIRMLY NUDGING THE DIAL

Whatever the merits of a social movement for improvement in the veterinary world, the view from the sector (and the evaluation team would strongly support this) is that there should be evolution not revolution. The reasoning behind this is that there are already in place important parts of an improvement architecture, although they would have to be nudged and reshaped. A set of relatively easy changes were identified:

- Strengthen the visibility and use of RCVS Knowledge products; much material is already available, but the survey showed that while these were appreciated, they needed to be given greater visibility.
- The PSS should be extended and reshaped to give greater prominence to QI.
- Clinical audit is already being developed and could over time be rolled out – possibly using technology to facilitate uploading results and providing feedback.
- Mentoring can be an effective way of community building that could easily be integrated with the idea of adopting a Q-like approach.
- Job descriptions, appraisals and interviews were mentioned as inexpensive and impactful changes that could reinforce the importance of QI.
- Build linkages with universities to encourage QI to have a greater role in university teaching and research. Similarly, work with providers to ensure an appropriate provision of CPD.

[34] For more information, see: https://www.health.org.uk/what-we-do/supporting-health-care-improvement/partnerships-to-support-quality-improvement/the-q-community

- Apps need to be used with care in improvement and are not always the right choice,[35] but in the right circumstances they allow data inputting, analysis and sharing at a fraction of the cost of more traditional approaches, as is seen with the use of VetSafe, which allows reporting of significant events via an app.

8.5. PURSUE CONSISTENT, PRIORITISE AND SEQUENCED ACTIVITIES THAT RECOGNISE THE IMPORTANCE OF TIME-CONSTRAINTS AND BUSY LIVES

Mirroring findings from the human health sector (Ling et al., 2018), the survey for this research shows that time is a crucial barrier to engaging with QI. So too is the lack of clarity around how to easily engage with QI. Visible and predictable routes should be flagged along with the time commitment they involve. For example, different activities might be offered depending on how much time there is available in any one week. This can be as little as two minutes or as much as half a day.

The experience of improvers is that persistent packages, given enough time and addressing the whole flow of patient journey, trump one-off 'heroic' and narrowly-focused interventions. Creating a rhythm of learning alongside stability of practice allows lessons to be absorbed and improvements routinised. Doing good things well is better than doing perfect things sporadically and helps address the widespread concern that there is insufficient time for QI by making the time commitment more predictable and manageable.

The benefit of persistence over time is also relevant to the improvement architecture more widely. RCVS Knowledge has identified five key areas for action, and focusing in this way should help achieve stability. The example of human healthcare improvement in Scotland is instructive in showing that it can take many years for an improvement approach to mature within a healthcare system. As is the case with human healthcare improvement in Scotland, stability is not only about organisations and systems; it is also about human relationships. Networks, mentoring, site visits and communities of practice can all achieve this. Providing a platform to support interpersonal engagement (for example, through the sorts of Q activities described in Section 8.3) are reported by participants to be very powerful (Ling et al., 2018).

There is an important exception to the general benefit of consistency. From time to time there may be particular issues (perhaps identified through clinical audit) that identify a problem of quality but appear to be immune to existing QI approaches. This is often because they are incompletely understood or if key stakeholders cannot be aligned. Under these circumstances, a one-off Improvement Lab designed to fully interrogate the problem and co-design solutions with key stakeholders has the potential to unlock chronic and deep-set problems.[36] However, this would require additional resources, including the skills required to deliver such an approach.

[35] The research team have experienced low response rates when using apps and would recommend only using them when the incentive to participate is high and with relatively immediate rewards.

[36] For information, see: https://q.health.org.uk/q-improvement-lab/

9. RECOMMENDATIONS

In this final chapter, the recommendations suggested in previous chapters are consolidated into four themes, while identifying the likely 'owner' of each recommendation (Table 3).

TABLE 3: LIST OF SHORT-, MEDIUM- AND LONG-TERM RECOMMENDATIONS BY THEME

THEME 1: ACCUMULATE SOLID EVIDENCE AND PRIORITISE EFFORTS ACCORDINGLY

RECOMMENDATION	OWNER	SHORT/ MEDIUM/ LONG TERM
Provide guidance and support for QI approaches that collect information about costs, activities and benefits in consistent ways	RCVS Knowledge working with university researchers and research funders	LONG
Identify selected QI interventions for cost-benefit analyses to identify the business case for further expansion (or not)	RCVS Knowledge with health economists	LONG
Sequentially roll out clinical audits using apps or other types of technology and interfaces to minimise effort and costs	RCVS Knowledge with app developers and clinical audit leaders	MEDIUM
Systematically use complaints to prioritise issues and areas for improvement	Veterinary Client Mediation Service with RCVS Knowledge	MEDIUM
Set up a workshop involving RCVS and RCVS Knowledge along with other key stakeholders to engage with QI experts from human health (including Health Foundation, THIS Institute) to extract key lessons from human health	Collaboration with RCVS and RCVS Knowledge	MEDIUM

THEME 2: DELIVER LEADERSHIP AND ENGAGEMENT TO MAKE SENSE OF QI TO STAKEHOLDERS AND EXPLAIN WHAT IT MEANS IN PRACTICE

RECOMMENDATION	OWNER	SHORT/ MEDIUM/ LONG TERM
Develop a brand and communications strategy for QI with simple, direct language	RCVS Knowledge with stakeholders	MEDIUM
Consider establishing an improvement community, drawing on Q Initiative as an example, and develop a suite of activities such as site visits, webinars, etc. However, the funding model for this remains unclear	RCVS and RCVS Knowledge	SHORT
Identify business benefits (including well-being and morale of the workforce) of engaging with QI to encourage team retention and attraction to vacancies	Researchers and funders	MEDIUM
Emphasise learning through QI and clinical audit rather than blame	PSS assessors, professional bodies, practices	LONG
Develop a package of activities at practice level for easy routes to engaging with QI	Collaboration with RCVS Knowledge and individual practices	LONG
Encourage charities to mobilise resources behind QI and engage the public	Animal charities	LONG

THEME 3: RESHAPE EXISTING ACTIVITIES AND ORGANISATIONS TO MAKE QI AS EASY AS POSSIBLE; EVOLUTION NOT REVOLUTION

RECOMMENDATION	OWNER	SHORT/ MEDIUM/ LONG TERM
Increase the visibility of RCVS Knowledge QI products including toolkits and standardised documents; embedding QI in CPD	Collaboration of RCVS Knowledge with all stakeholders	LONG
Extend PSS to give greater prominence to QI and changes in practice, with a greater role for self-assessment in QI, with practices providing more self-assessment of improvement plans and their progress towards meeting their self-identified goals	The Practice Standards Group and RCVS Standards Committee and Council	MEDIUM
Introduce an award for QI	RCVS Knowledge	SHORT
Build on current experience to extend the role of clinical audit	RCVS Knowledge with clinical audit leaders	MEDIUM
Explore formal mentoring opportunities to entrench QI among those new to it	Employers/individual practices	MEDIUM
Write QI into job descriptions, appraisals and interviews (to assess attitudes towards adoption) and HR practices more generally	Individual practices	MEDIUM
Give QI a greater role in teaching and research	Universities, educators and research funders; journal editors	SHORT
Establish QI leads within each practice, with specific tasks subdivided and allocated amongst the team.	Individual practices	MEDIUM
Establish communication around QI across practices	Individual practices with RCVS Knowledge	MEDIUM
Better integrate the principles and practices of QI as a specialism within the Advanced Practitioner Certificate and Advanced Veterinary Nursing qualifications.	Universities and educators	MEDIUM
Integrate QI with CPD training and all education	CPD delivery organisations, universities, colleges and other educators	MEDIUM

THEME 4: PURSUE CONSISTENT, PRIORITISED AND SEQUENCED ACTIVITIES IN A STABLE IMPROVEMENT LANDSCAPE

RECOMMENDATION	OWNER	SHORT/ MEDIUM/ LONG TERM
Establish a strategic direction that prioritises a stable commitment and consistent approach to QI techniques	RCVS Knowledge	LONG
Focus on providing opportunities to engage, that use small amounts of time	RCVS Knowledge	LONG
Allocate protected time to all team members for QI	Practice strategy leaders and practice owners/managers	MEDIUM
Encourage improvement approaches that are delivered continuously rather than one-off 'heroic' interventions	RCVS Knowledge	SHORT
Establish a balance between e-enabled activities and face-to-face activities	RCVS Knowledge	SHORT
Consider establishing an Improvement Lab for one-off, focused improvement challenges	RCVS Knowledge plus potential funders	MEDIUM

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Annex A. EXISTING QI INITIATIVES IDENTIFIED FROM THE DOCUMENT REVIEW

This Annex provides a summary of the examples of QI initiatives the research team identified from the 45 QI documents sent by RCVS Knowledge (Table 4). This is not an exhaustive list of all QI initiatives within the veterinary sector, rather examples identified during the document review. This table does not include references to human healthcare systematic reviews.

TABLE 4: EXAMPLES OF EXISTING QI INITIATIVES IN THE VETERINARY SECTOR

AREA	EXAMPLES OF EXISTING ACTIVITIES
Moving from a culture of blame to a culture of learning	• The RCVS Code of Conduct[37] for veterinary surgeons and nurses highlights the importance of not blaming individuals for incidents and emphasises the need to hold 'no-blame' meetings after a serious incident (Royal College of Veterinary Surgeons, n.d.). • CVS practices are encouraged to conduct significant event audits when an animal is harmed or a near miss occurs and reflect on the incident without blaming any individuals (CVS Group plc, 2018)[38].
Having fit-for-purpose guidelines, protocols and regulations	• The PSS and Code of Conduct support veterinary practices to work towards high-quality care for animals as well as support and development opportunities for team members (Royal College of Veterinary Surgeons, n.d.). These are both refreshed on a regular basis to keep up to date with changes in the profession. • CVS has set up a Central Quality Improvement Committee that meets every two to three months to review a range of processes and documents and monitor their practices against set standards. In addition, in response to evidence highlighting the high number of medicine errors in CVS practices, they created a Medicine Errors Working Party consisting of the Heads of Dispensary across UK practices to create guidelines and provide advice on how CVS practices can reduce these errors (CVS Group plc, 2018).
Sharing and disseminating best practice, ideas and experiences	• CVS has recently appointed a PhD student to investigate QI methods in equine clinical practice. This project should provide the veterinary profession with a better understanding of the challenges they may face in implementing QI techniques and possible methods of overcoming these (University of Nottingham, n.d.). • RCVS Knowledge provides professionals with the opportunity to submit case examples of how QI has helped in their practice and share examples of their QI projects, enter to win Knowledge Awards, explore what other professionals have written about QI and read RCVS Knowledge's commitment to QI (RCVS Knowledge, n.d.). • Various events have been held to share best practice and QI knowledge throughout the sector.

[37] For more information on the RCVS veterinary Code of Conduct, see here for veterinary surgeons: https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/ and here for veterinary nurses: https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-nurses/.

[38] It is important to note that we were aware of only CVS having published a QI report at the time the document review was conducted. Therefore, the research team were unable to reference QI reports from other practice groups.

AREA	EXAMPLES OF EXISTING ACTIVITIES
Supporting implementation of QI practices	• RCVS offers a Certificate in Advanced Veterinary Practice which contains one module on Clinical Governance. The aim of this module is to encourage clinical evaluation of Clinical Governance, how it is applied in veterinary practice and how it contributes to maintaining and improving quality of care (Royal College of Veterinary Surgeons, n.d.). • RCVS Knowledge onCOURSE provides free courses on different QI activities, including clinical audits, guidelines and significant event audits (RCVS Knowledge, n.d.). • RCVS Knowledge's Quality Improvement website provides an introduction to QI for veterinary professionals new to this area and links to resources for implementing QI in their practice (RCVS Knowledge, n.d.). • RCVS Knowledge has developed multiple ways for veterinary professionals to access high-quality research to support this, including Veterinary Evidence, inFOCUS and the library (RCVS Knowledge, n.d.). • CVS has implemented QI specific roles to provide advice/training on implementing QI and oversee the QI activities in the practice (CVS Group plc, 2018).
Improving higher education and professional development opportunities	• RCVS and the Work Psychology Group are also running a Graduate Outcomes Project 'to shape the future direction of veterinary education in the UK' (Royal College of Veterinary Surgeons and Work Psychology Group, 2018). • RCVS has created multiple initiatives and schemes to increase the number and breadth of professional development opportunities available to a range of veterinary professionals, such as offering the Advanced Practitioner Status and are in the process of developing a new framework for nurse post-registration qualifications (Royal College of Veterinary Surgeons, 2019, 2018).

Annex B. METHODOLOGY: ADDITIONAL INFORMATION

B.1. DOCUMENT REVIEW SEARCH STRATEGY

RCVS Knowledge Library and Information Services' search of academic literature

CAB Abstracts on the OVID interface	1. ("critical event* review*" or "critical event* report*" or "critical event* audit*" or "critical event meeting*" or "critical inciden* review*" or "critical inciden* report*" or "critical inciden* audit*" or "critical inciden* meeting* significant event* review*" or "significant event* report*" or "significant event* audit*" or "significant event* meeting*").mp 2. ("chart audit" or "chart audits" or "chart auditing" or "clinical audit" or "clinical audits" or "clinical auditing" or "clinical governance" or "medical record* audit*" or "medical audit*" or "outcome* audit*" or "process audit*" or "prescription* audit*" or "medicines audit*" or "liability audit*"). 3. auditing.mp. 4. quality controls/ or quality assurance/ or "quality improvement*".mp. or QI.mp 5. "clinical governance*".mp 6. exp veterinary practice/ or exp veterinary services/ or exp veterinary science/ or exp veterinary medicine/ or exp veterinarians/ or exp veterinary profession/ 7. (veterinary or veterinarian* or "small animal practice*" or "large animal practice*" or "equine practice*" or "bovine practice*" or "dairy practice*" or "beef cattle practice*" or "mixed practice*") 8. 1 or 2 or 3 or 4 or 5 9. 6 or 7 10. 8 and 9
Date of coverage	2008 – current

B.2. DEMOGRAPHICS OF MEMBERS OF THE PROFESSION WHO CONTRIBUTED TO THE INTERVIEWS

TABLE 5: DEMOGRAPHIC OF PROFESSION INTERVIEWEES

Interview number	Animal species treated			Type of practice		PSS accreditation		Level of PSS accreditation			Role				Years since graduation				
	Small animal	Farm animal	Equine	Smaller practice group	Large practice group	PSS accredited	Non-PSS accredited	Core	General Practice	Hospital	Veterinary surgeon	Veterinary nurse	Practice manager owner	Practice owner	<5 years	5–10 years	10–20 years	20–30 years	30+ years
INT7			✓		✓	✓		✓		✓	✓							✓	
INT9	✓				✓	✓		✓		✓		✓					✓		
INT10*		✓		✓		✓		✓	✓		✓						✓		
INT11	✓				✓		✓	-	-	-		✓	✓				✓		
INT12	✓			✓		✓		✓	✓			✓			✓				
INT13	✓			✓		✓		✓	✓	✓	✓						✓		
INT14	✓			✓		✓		✓	✓		✓			✓				✓	
INT16	✓			✓			✓	-	-	-		✓							✓
INT17	✓				✓	✓		✓	✓		✓					✓			
INT18	✓				✓		✓	-	-	-	✓				✓				

*After starting interview 10, it became clear that this individual had recently left practice to work for a professional body; however, this was very recent and they were still able to provide valuable insights into the profession. The table has been filled in based on the interviewee's previous role and practice.

TABLE 6: DEMOGRAPHIC OF FOCUS GROUP PARTICIPANTS

Participant	ANIMAL SPECIES TREATED			TYPE OF PRACTICE		PSS ACCREDITATION		LEVEL OF PSS ACCREDITATION			ROLE			YEARS SINCE GRADUATION			
	Small animal	Farm animal	Equine	Smaller practice group	Large practice group	PSS accredited	Non-PSS accredited	Core	General Practice	Hospital	Veterinary surgeon	Practice manager	Practice owner	5–10 years	10–20 years	20–30 years	30+ years
1	✓	✓		✓		✓		✓	✓		✓			✓			
2	✓			✓		✓		✓	✓		✓				✓		
3*	✓			-	-	-	-	-	-	-	✓					✓	
4†	✓	✓	✓	-	-	-	-	-	-	-	✓						✓
5	✓	✓		✓		✓		✓	✓	✓	✓						✓
6†	✓			-	-	-	-	-	-	-	✓	✓					✓
7		✓		✓		✓		✓	✓		✓		✓	✓			
8	✓			✓		✓		✓	✓		✓						✓
9	✓			✓		✓		✓	✓		✓					✓	
10	✓			✓		✓		✓		✓	✓						✓
11	✓			✓		✓		✓	✓		✓						✓
12†	✓			-	-	-	-	-	-	-	✓						✓
13	✓				✓	✓		✓	✓		✓	✓			✓		
14†	✓			-	-	-	-	-	-	-	✓						✓

*This assessor works across a number of different practices.

† These assessors are no longer working in practice or work as locums.

B.3. INTERVIEW PROTOCOLS BY STAKEHOLDER GROUP

B.3.1. Protocol for interview with animal owners

1. Can you briefly introduce yourself and your experience with the veterinary sector?
    a. What type of animal do you own?
    b. How long have you been going to your local practice?
    c. What are your views and experiences of the veterinary practices you have used in the past?
    d. What do you look for when you choose a particular veterinary practice?
        i. Does quality of the care provided play a role in your decision?
        ii. How do you judge the quality of care provided?
2. Are you aware of any Quality Improvement activities going on in your local practice? Examples include: clinical audit, benchmarking, checklists, significant event audit and guidelines.
    a. *If familiar with these activities:* Do you think they support in the delivery of improved veterinary services?
    b. *If not familiar with these activities:* Do you think animal owners should be aware of these activities in their local practices? *Prompt as to why they think this.*
3. Are you aware of the Codes of Conduct veterinary practices must abide by and the Practice Standards Scheme accreditation they can apply for?
    a. *If familiar with these:* Do you think they support in the delivery of improved veterinary services?
    b. *If not familiar with these activities:* Do you think animal owners should be aware of these codes of conduct and schemes in their local practices? *Prompt as to why they think this.*
4. Have you ever made a complaint to your local practice?
    a. *If no:* Proceed to question 4c.
    b. If yes:
        i. Could you provide an overview of the process you went through? Ask specifically if the complaint was dealt with at the local practice level or escalated.
        ii. Other than providing detail on the particular incident you made the complaint about, were you involved in any other area of the process, such as providing feedback on the complaints procedure or suggesting ideas for improvements?
    c. Is there a role with QI and complaints, for example, helping to ensure veterinary professionals don't receive as many complaints, or if when they do, there are QI measures in place to avoid reoccurrence? Could a well-established QI system potentially help prevent some of the issues reaching the complaints system?
5. Do you think animal owners should be involved in Quality Improvement in the veterinary sector?
    a. *If no:* Why do you think that?
    b. If yes:
        i. How do you think animal owners could be involved in QI?

ii. Would animal owners be involved in activities at a local practice level, a bigger scale (such as working with the Royal College) or both?

iii. We have seen with Quality Improvement in healthcare that involvement of patients can be seen as a 'tick-box' exercise. What do you think could be done to ensure animal owner involvement in QI activities is meaningful?

B.3.2. Protocol for interviews with large practice group QI leads

1. Can you briefly introduce yourself and your role in your veterinary clinic?
2. What Quality Improvement activities take place in your clinic(s), if any? Examples include: clinical audit, benchmarking, checklists, significant event audit and guidelines.
    a. If they use QI activities
        i. How long have these activities been used in your clinic(s)?
        ii. Why have you implemented these improvement activities?
        iii. Have you seen any improvements as a result?
    b. If they don't have any:
        i. Is there a particular reason you have not implemented improvement activities?
        ii. Do you hope to introduce QI activities into your clinic(s) in the future?
3. How do you think Quality Improvement is viewed by professionals working within large practice groups? What does 'Quality Improvement' mean to you and your work?
    a. Do you think 'Quality Improvement' is seen as a more relevant and user-friendly term than 'Clinical Governance'?
    b. The **Clinical Governance standards** set within the Code of Conduct outline the guidelines for continual reflection and improvement in professional practice for the benefit of the veterinary professionals as well as clients.
        i. How familiar do you think the vets within your practices?
        ii. Do you think they understand the requirements set within these?
        iii. Do you think these requirements are appropriate?
        iv. Do you think these support and encourage QI processes?
            1. *If not:* What could be done to improve this?
            2. *If yes:* What is it that provides this support?
    c. The **Clinical Governance** module of the PSS accreditation outlines the requirements for continual improvement in practices, e.g. referring cases when deemed necessary, monitoring cases, regular morbidity and mortality meetings etc.
        i. How familiar do you think the vets within your practices?
        ii. Do you think they understand the requirements set within these?
        iii. Do you think these requirements are appropriate?
        iv. Do you think these support and encourage QI processes?
            1. *If not:* What could be done to improve this?

2. *If yes:* What is it that provides this support?

4. We'd now like to explore what supports QI in veterinary clinics and what some of the barriers are.
    a. What do you think are the enablers of implementing QI in veterinary clinics in particular?
    b. What do you think are the challenges of implementing QI in veterinary clinics?
    c. Do you think there is any difference in your answers to the previous few questions based on practices:
        i. Treating different species?
        ii. Operating in Core, General Practice, Hospital or Emergency Services Clinics?
        iii. That are not part of a large practice group?
5. What do you think is needed for QI to progress in the veterinary sector?
    a. Who do you think is responsible for each of these actions?
    b. Do large practice groups need different QI support than smaller practice groups? If so, what would this look like?

B.3.3. Protocol for interviews with veterinary professionals

1. Can you briefly introduce yourself and your role?
    a. Are you based in large or smaller practice group?
    b. What species of animal do you primarily work with?
    c. Is your practice PSS accredited?
2. What Quality Improvement activities take place in your practice, if any? Examples include: clinical audit, benchmarking, checklists, significant event audit and guidelines.
    a. If they use QI activities
        i. How long have these activities been used in your practice?
        ii. Why have these particular techniques been implemented?
        iii. Have you seen any improvements as a result?
        iv. Have you communicated this to your clients? Have you had any feedback, and if so, what?
    b. If they don't have any:
        i. Is there a particular reason you have not implemented improvement activities?
        ii. Do you hope to introduce QI activities into your practice in the future?
3. How do you think Quality Improvement is viewed by veterinary professionals?
    a. What does 'Quality Improvement' mean to you and your work?
    b. Do you think 'Quality Improvement' is seen as a more relevant and user-friendly term than 'Clinical Governance'?
    c. The **Clinical Governance standards** set within the Code of Conduct outline the guidelines for continual reflection and improvement in professional practice for the benefit of the veterinary professionals as well as clients.

i. How familiar are you with the Clinical Governance standards in the Code of Conduct?
ii. Do you understand the requirements set within these?
iii. Do you think these requirements are appropriate?
iv. Do you think these support and encourage QI processes?
    1. *If not:* What could be done to improve this?
    2. *If yes:* What is it that provides this support?

d. The **Clinical Governance** module of the PSS accreditation outlines the requirements for continual improvement in practices, e.g. referring cases when deemed necessary, monitoring cases, regular morbidity and mortality meetings etc.
    i. How familiar are you with these Clinical Governance requirements?
    ii. Do you understand the requirements set within these?
    iii. Do you think these requirements are appropriate?
    iv. Do you think these support and encourage QI processes?
        1. *If not:* What could be done to improve this?
        2. *If yes:* What is it that provides this support?

4. We'd now like to explore what supports QI in the veterinary sector and what some of the barriers are.
    a. What do you think are the enablers of implementing QI activities in the veterinary sector?
    b. What do you think are the challenges of implementing QI in the veterinary sector?
    c. Do you think there is any difference in your answers to the previous few questions based on practices:
        i. Treating different species?
        ii. Operating in Core, General Practice, Hospital or Emergency Services Clinics?
    d. What could be done to support and encourage your involvement of QI in the future?
5. What do you think is needed for QI to progress in the veterinary sector?
    a. Who do you think is responsible for each of these actions?
    b. Do you think that the College has a role in helping QI to become embedded in the profession (and if so, how)?

B.3.4. Protocol for interview with the member of the QIAB

1. Can you briefly introduce yourself and outline your role as a member of the QIAB?
2. We will discuss your more general thoughts on QI in a moment, but first to help orient our work we would like to now focus on your experience as a member of the QIAB.
    a. Could you provide a brief overview of the QIAB and what it aims to do?
        i. Could you briefly describe your role as a member of the board?
        ii. How does the QIAB link to RCVS Knowledge?

   b. What main activities has the QIAB been working on since it was set up in 2016?
   c. What do you hope the QIAB can achieve in the future in relation to driving QI in the veterinary sector?
   d. What added benefit do you think this project will provide the QIAB and QI in the veterinary sector more widely?

3. We'd now like to focus on QI more generally in the veterinary sector.
   a. How do you think QI is viewed by those in the profession?
   b. What do you think are the more general enablers of QI in the veterinary sector?
   c. What do you think are the greatest challenges to QI in the veterinary sector?
   d. Do you think there is any difference in your answers to the previous few questions based on practices treating different species or those operating in Core, General Practice, Hospital or Emergency Services Clinics?
   e. What do you think is needed for QI to progress in the veterinary sector?
      i. Who do you think is responsible for each of these actions?
      ii. What do you think is the role of the QIAB now and in the future to support QI?
4. Do you think that the College has a role in helping QI to become embedded in the profession (and if so, how)?

B.3.5. Protocol for interviews with QI lead at an animal charity

1. Can you briefly introduce yourself and your role at your animal charity?
   a. What kind of veterinary services do you offer at your animal charity?
   b. Are your veterinary clinics PSS accredited?
2. What Quality Improvement activities take place in the veterinary clinics at your animal charity, if any? *Examples include: clinical audit, benchmarking, checklists, significant event audit and guidelines.*
   a. If they use QI activities
      i. How long have these activities been used at your animal charity?
      ii. Why have these particular techniques been implemented?
      iii. Have you seen any improvements as a result?
      iv. Have you communicated this to your clients? Have you had any feedback, and if so, what?
   b. If they don't have any:
      i. Is there a particular reason you have not implemented improvement activities?
      ii. Do you hope to introduce QI activities into your practice in the future?
3. We'd now like to explore what supports QI and what acts as barriers.
   a. What do you think enables QI in the veterinary sector?
   b. What do you think acts as barriers?

c. Do you think there is any difference in your answers to the previous few questions based on large/smaller practice groups and veterinary services offered by animal charities?

4. We have talked about your views on the quality of the sector and about how QI might progress. Could you now tell us where you think QI efforts should be focused and what are your priorities for improving quality in the veterinary sector?
    a. Who do you think is responsible for these actions?
    b. What role can animal charities play in supporting Quality Improvement for veterinary services?

B.3.6. Protocol for interview with individual handling complaints (1)[39]

1. Can you briefly introduce yourself and outline your role?
2. We will discuss how your experiences relate to QI in a moment but first to help orient our work we would like to now focus on your experience with the Practice Standards Scheme
    a. Could you provide a brief overview of the PSS and what it aims to do?
    b. What do you think are the drivers for practices to get accredited by the scheme?
        i. What do you think motivates practices to get accredited?
    c. Around one third of practices are not accredited by the scheme, what do you think is preventing these practices from gaining accreditation?
    d. Are there any others barriers to practices engaging with the scheme?
    e. Is there a difference in accreditation rates across practices treating different species or those operating out of practices which would be considered Core, General Practice, Hospital or Emergency Services Clinics?
        i. Also delve into – is there any difference for the large practice groups vs smaller practice groups?
        ii. *If yes:* Why do you think this is?
    f. Where do you think the Scheme is heading in the future? What do you hope it will achieve in the near future with regard to Quality Improvement and how will this be done?
3. We'd also like to discuss your role and experience with complaints in the veterinary sector.
    a. How are complaints usually handled in the veterinary sector?
        i. Are they usually settled at a practice level or are they more frequently taken higher?
        ii. What learning is taken from complaints and are any changes to practice made based on this?
    b. Is there a role with QI and complaints, for example, helping to ensure veterinary surgeons/veterinary nurses don't receive as many complaints, or if when they do, there are QI measures in place to avoid reoccurrence? Could a well-established QI system potentially help prevent some of the issues reaching the complaints system?
4. We'd now like to focus on QI more generally in the veterinary sector.

[39] The research team used two slightly difference protocols for the two interviewees with experience of the veterinary complaints procedure. These have been denoted here as (1) and (2).

a. How do you think QI is viewed by those in the profession?

b. What do you think are the more general enablers of QI in the veterinary sector?

c. What do you think are the greatest challenges to QI in the veterinary sector?

d. Do you think there is any difference in your answers to the previous few questions based on practices treating different species or those operating in Core, General Practice, Hospital or Emergency Services Clinics?

e. What do you think is needed for QI to progress in the veterinary sector?

    i. Who do you think is responsible for each of these actions?

    ii. Do you think that the College has a role in helping QI to become embedded in the profession (and if so, how)?

    iii. Is there potential for a synergy between the College regulations and Practice Standards Scheme Accreditation, and the work that RCVS Knowledge does? How can the two better work together?

B.3.7. Protocol for interview with individual handling complaints (2)

1. Can you briefly introduce yourself and outline your role?

2. Could you provide an overview of how complaints are handled in the veterinary sector and what the mediation process involves?

    a. Follow-up questions to explore if not answered already:

        i. How often are complaints resolved at a practice level?

        ii. What would cause a complaint to be taken to a mediation service?

    b. We'd like to know more about the feedback received after a complaint.

        i. Is feedback collected for all complaints that go through your organisation?

        ii. Who is the feedback collected from and what kind of feedback do you collect?

        iii. What is done with this feedback once it has been collected?

    c. Are you aware of any learning, other than the feedback you collect, that takes place after complaints have been dealt with or of any resulting change in practice after a complaint?

    d. Is there a role with Quality Improvement and complaints in helping to ensure veterinary professionals don't receive as many complaints, or if when they do, there are improvement measures in place to avoid reoccurrence?

        i. Could a well-established QI system potentially help prevent some of the issues reaching the complaints system?

        ii. What role, if any, do you think your organisation could have in supporting QI in the veterinary sector?

        iii. Do you think the veterinary Codes of Conduct and their associated guidelines, and the Practice Standards Scheme, support QI in the veterinary sector?

            1. *If yes:* How are they supportive?

            2. *If no:* What could they be doing to better support QI?

3. We'd now like to focus on animal owners' feelings towards Quality Improvement in the veterinary sector.
    a. Do you think animal owners are aware of the Quality Improvement activities that take place in the practices they use, such as clinical audits or benchmarking?
    b. In your experience, have you come across any involvement from animal owners in the learning implemented after complaints or any other Quality Improvement activities?
        i. *If yes:* Could you provide some examples of this? Do you think there involvement was meaningful?
        ii. *If no:* Do you think animal owners should be involved in improving the quality of veterinary services going forward?
            1. *If no:* Why do you think that?
            2. If yes:
                a. How do you think animal owners could be involved in QI?
                b. Would animal owners be involved in activities at a local practice level, a bigger scale (such as working with the Royal College) or both?
                c. We have seen with Quality Improvement in healthcare that involvement of patients can be seen as a 'tick-box' exercise. What do you think could be done to ensure animal owner involvement in QI activities is meaningful?

B.4. FOCUS GROUP PROTOCOL FOR PSS ASSESSORS

1. Can you briefly go around the room and introduce yourselves and any other roles you have apart from PSS assessors in relation to improving the quality of veterinary services?
2. We will discuss your more general thoughts on QI in a moment, but first to help orient our work we would like to now focus on your experience as a PSS assessor.
    a. Could you provide a brief overview of your roles as PSS assessors?
        i. What made you want to be an Assessor?
    b. How do you think veterinary professionals view the PSS and the PSS assessors?
        i. What do you think motivates practices to get accredited by the PSS?
        ii. Around one third of practices are not accredited by the scheme, what do you think is preventing these practices from gaining accreditation?
        iii. Do you think the veterinary profession are aware of the RCVS requirements for Clinical Governance in the PSS?
            1. Is there an understanding that these link to QI?
        iv. Do you think the profession feels that the level of standards within the Clinical Governance section of the PSS are appropriate? Do you think they understand what the standards are?
3. We'd now like to focus on QI more generally in the veterinary sector.

a. How do you think QI is viewed by those in the profession?
    i. What do you think motivates veterinary professionals to get involved in wider QI activities?
    ii. What other factors support veterinary professionals to get involved in wider QI activities?
    iii. What do you think are the greatest barriers and challenges to QI in the veterinary sector?
b. Do you think there is any difference in your answers to the previous few questions based on practices treating different species or those operating in Core, General Practice, Hospital or Emergency Services Clinics?
c. What do you think is needed for QI to progress in the veterinary sector?
    i. Who do you think is responsible for each of these actions?
    ii. What do you think is the role of the PSS now and in the future to support QI?
    iii. Do you think that RCVS and RCVS Knowledge have a role in helping QI to become embedded in the profession (and if so, how)?

B.5. NATIONAL SUMMIT FOR SUPPORTING QUALITY IMPROVEMENT IN VETERINARY CARE

Agenda for the national summit

TIME	SESSION	DESCRIPTION
9.30–10.00	Coffee and registration	Delegates to register, take name badge and find table place. Attendees mark on posters which statements they most agree with as to the current state of QI in the veterinary profession: 1. Which statement do you agree with regarding the Quality Improvement (QI) in the veterinary sector today? a. QI is clearly embedded in the work of the veterinary profession b. QI is somewhat embedded in the work of the veterinary profession c. QI is scarcely embedded in the work of the veterinary profession d. QI is not at all embedded in the work of the veterinary profession. 2. Which statement do you agree with regarding the Quality Improvement (QI) in the veterinary sector in the next 5 years? a. QI will clearly be embedded in the work of the veterinary profession b. QI will somewhat be embedded in the work of the veterinary profession c. QI will scarcely be embedded in the work of the veterinary profession d. QI will not at all be embedded in the work of the veterinary profession.
10.00–10.10	Welcome	Welcome from RCVS Knowledge and the Quality Improvement Advisory Board. The role and purpose of RCVS Knowledge's Quality Improvement initiative and the research project.

TIME	SESSION	DESCRIPTION
10.25–11.10	QI, Safety Systems and Just Culture in the NHS	Margaret Mary Devaney, Assistant Director for Quality and Risk at East and North Hertfordshire NHS Trust, and Anita Malana, Team Leader for Trauma, Orthopaedics and Private Theatres at the Royal Free London NHS Foundation Trust, draw on personal experiences to give a thought-provoking overview of quality improvement, approaches to safety and a learning culture in the NHS.
11.25–11.55	The project so far	Presentation on what the project has found so far across the interviews, document review, focus groups and survey.
11.55–12.10	Group discussions	Each table discusses these results- are they surprising, do they agree, is something missing?
12.10–12.30	Group presentations	The spokesperson from each table gives a short presentation on their discussion.
12.30–1.15	What does the veterinary sector need to improve QI? Group discussions	Each table discusses the possible solutions and who is responsible for these actions for each of the five key challenges: How do organisations get to a position where dedicated time can be prioritised for teams to implement QI in practice? For each solution, which stakeholder/s can fill this role? How and what training/education/professional development is needed/can be provided? For each solution, which stakeholder/s can fill this role?) What resources (physical/technical e.g. better tools/PMS/national audits/universal nomenclature etc.) will make embedding QI more likely to take place, easier to embed and more likely to have impact. For each solution, which stakeholder/s can fill this role? How can we better communicate and demonstrate its importance and benefit (to patient care and business)? For each solution, which stakeholder/s can fill this role? How do we secure buy-in from employers and colleagues (organisationally/professionally/contractually inc. locums)? For each solution, which stakeholder/s can fill this role?

TIME	SESSION	DESCRIPTION
2.15–2.45	How can we make a difference? What are the next steps? Group discussions	Each table will have the Post-it notes with the suggested areas of action for each of the roles identified from the previous session and any others identified from the research. They will discuss in their groups where to place each Post-it on a graph of ease of implementation vs. possible impact.
2.45–3.30	Group presentations and group discussions	RAND Europe to invite feedback on each item from each table host to gain consensus from the room. Focus on the actions that are easier to implement with medium impacts, but also on actions with large impacts that are more difficult to implement.
3.30–4.00	Wrap-up	Executive Director of RCVS Knowledge summarises what has been decided and next steps for the project. Delegates complete the same activity used in the registration session to see if their views on where QI is now, and where it might be in five years, has changed.

B.6. ORGANISATIONS INVITED TO PARTICIPATE IN THE SURVEY OF VETERINARY PROFESSIONALS AND THE NATIONAL SUMMIT

Various veterinary organisations were invited to participate in the *National Summit for Supporting Quality Improvement in Veterinary Care 2019*, and the survey was open to all veterinary professionals to participate. The opportunity to attend the summit and participate in the survey was promoted widely through a press release, newsletters, social media and direct mailing. The table below shows those veterinary organisations who were sent direct mail to participate in the survey and/or summit (note that not all organisations invited were necessarily represented in the survey or summit).

TABLE 7: VETERINARY ORGANISATIONS DIRECTLY INVITED TO PARTICIPATE IN THE SURVEY AND THE NATIONAL SUMMIT

The British Association of Veterinary Emergency and Critical Care (BAVECC)	Nockolds Solicitors
British Cattle Veterinary Association (BCVA)	People's Dispensary for Sick Animals (PDSA)
Beaumont Animal Hospital	Queen Mother Hospital for Animals
British Equine Veterinary Association (BEVA)	Royal College of Veterinary Surgeons (RCVS)
Blue Cross	RCVS Knowledge
British Small Animal Veterinary Association (BSAVA)	Royal Society for the Prevention of Cruelty to Animals (RSPCA)
British Veterinary Association (BVA)	Small Animal Veterinary Surveillance Network (SAVSNET)
British Veterinary Hospital Association (BVHA)	The Society of Practising Veterinary Surgeons (SPVS)
British Veterinary Nursing Association (BVNA)	Stowe Veterinary Group
Centre for Evidence-based Veterinary Medicine (CEVM)	University of Liverpool
City Road Vets	University of Nottingham
Companion Care/Vets4Pets	Veterinary Management Group (VMG)
CVS Group plc	The Veterinary Defence Society (VDS)
Department for Environment, Food and Rural Affairs (DEFRA)	VetPartners
Dogs Trust	Vet Schools Council
Veterinary Evidence	VetCompass Animal Surveillance
The Federation of Independent Veterinary Practices (FIVP)	Veterinary Client Mediation Service (VCMS)
Goddard Veterinary Group	VetLED
Independent Vetcare	Vets Now Ltd
InFOCUS	VN Futures
Kernow Veterinary Group	Wendover Heights Veterinary Centre
Linnaeus Group	XLVets UK Ltd
Medivet	Davies Veterinary Specialists
Newnham Court Equine Clinic	Damson House Vets

Annex C. SURVEY OF THE VETERINARY PROFESSION

Figure 21 to Figure 45 below provide the results for each survey question.

FIGURE 21: WHICH OF THE FOLLOWING TERMS DO YOU THINK IS MORE RELEVANT AND USER-FRIENDLY FOR VETERINARY PROFESSIONS?

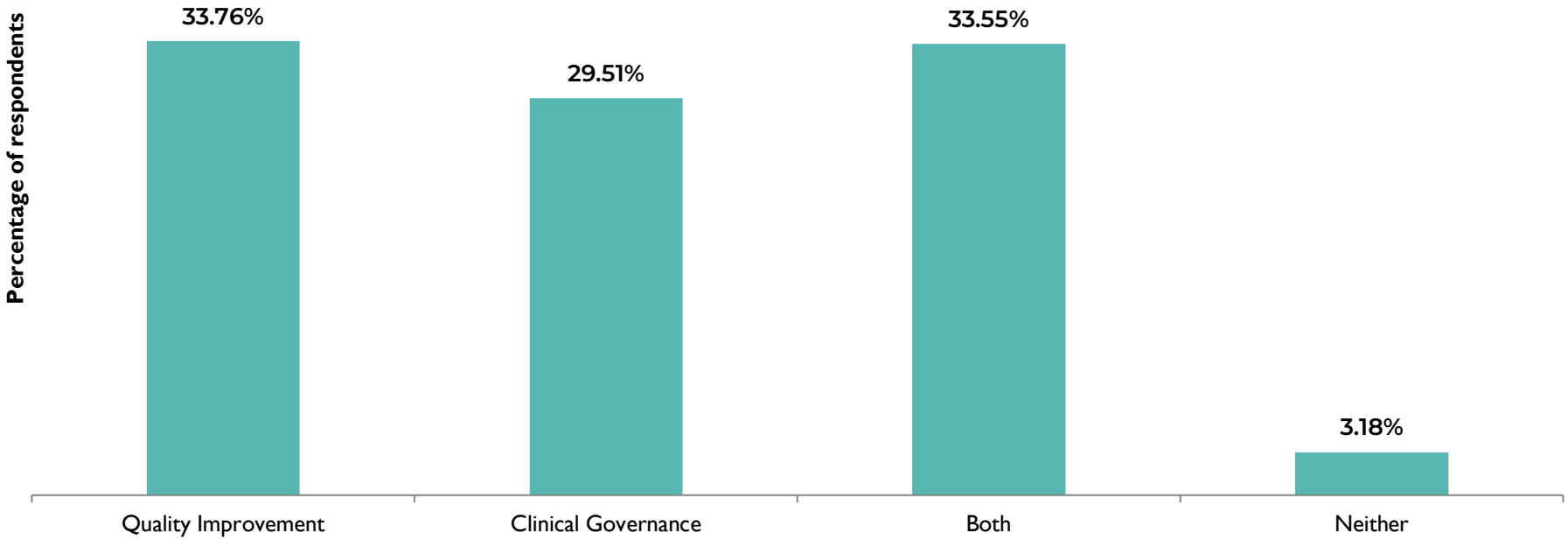


FIGURE 22: IN THE PAST 12 MONTHS, APPROXIMATELY HOW MUCH TIME IN TOTAL HAVE YOU SPENT ON QUALITY IMPROVEMENT ACTIVITIES?

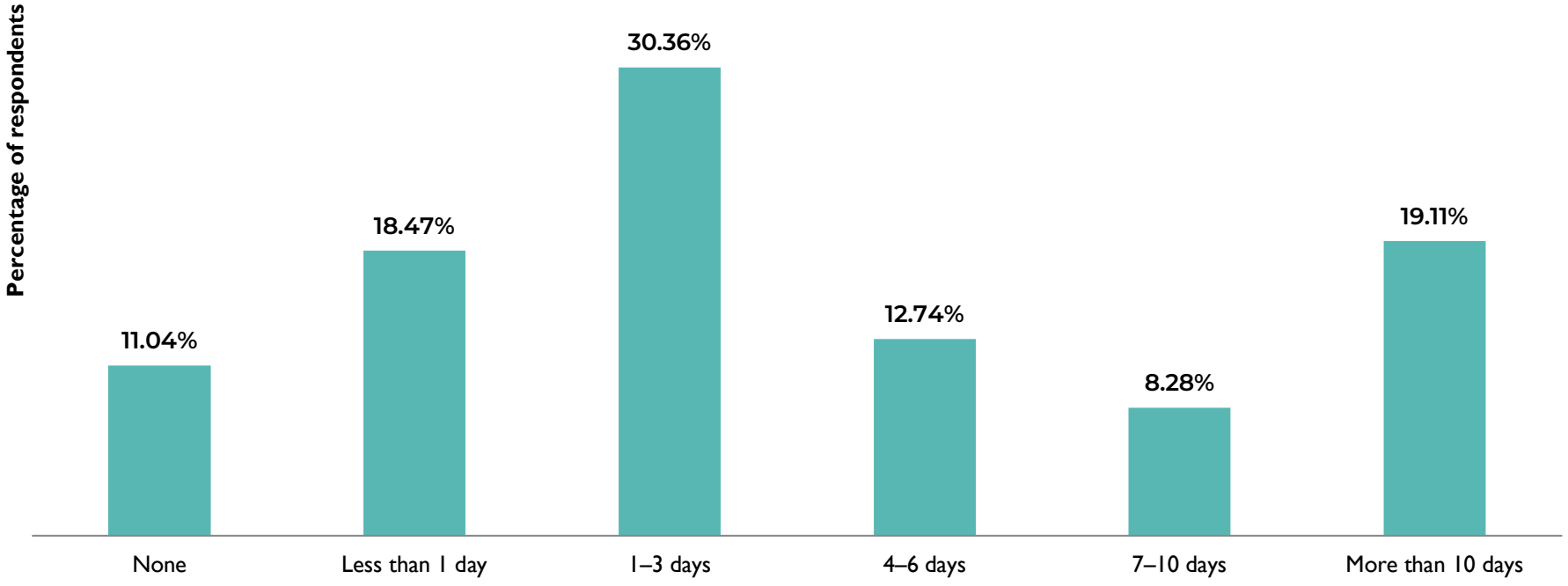


FIGURE 23: HAVE YOU USED ANY OF THE FOLLOWING QUALITY IMPROVEMENT TOOLS FROM THE RCVS KNOWLEDGE QI SITE IN THE PAST 12 MONTHS?

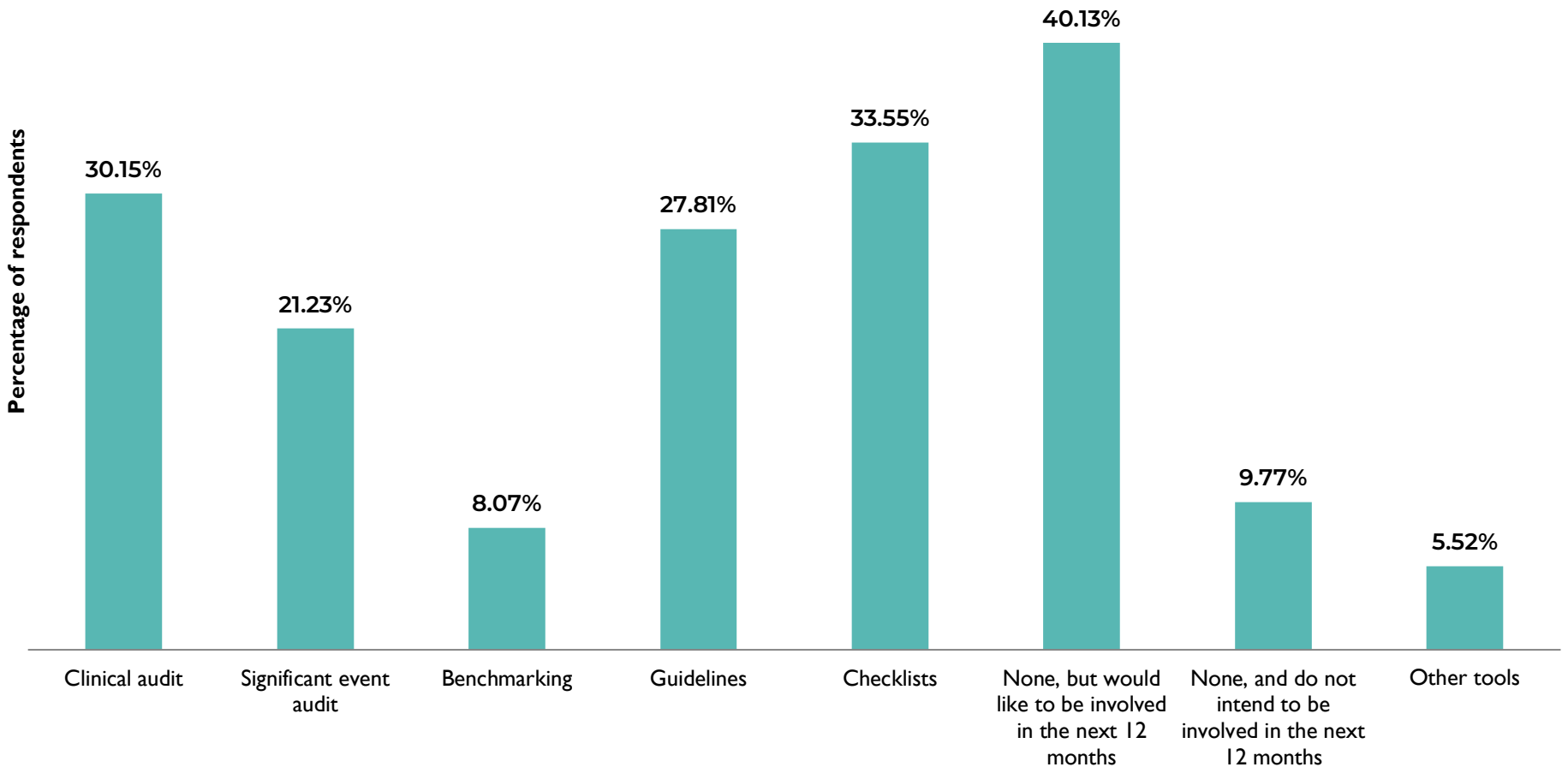


FIGURE 24: WHICH OF THE FOLLOWING STATEMENTS ABOUT TRAINING TO SUPPORT THE IMPLEMENTATION OF QUALITY IMPROVEMENT/CLINICAL GOVERNANCE BEST APPLIES TO YOU?

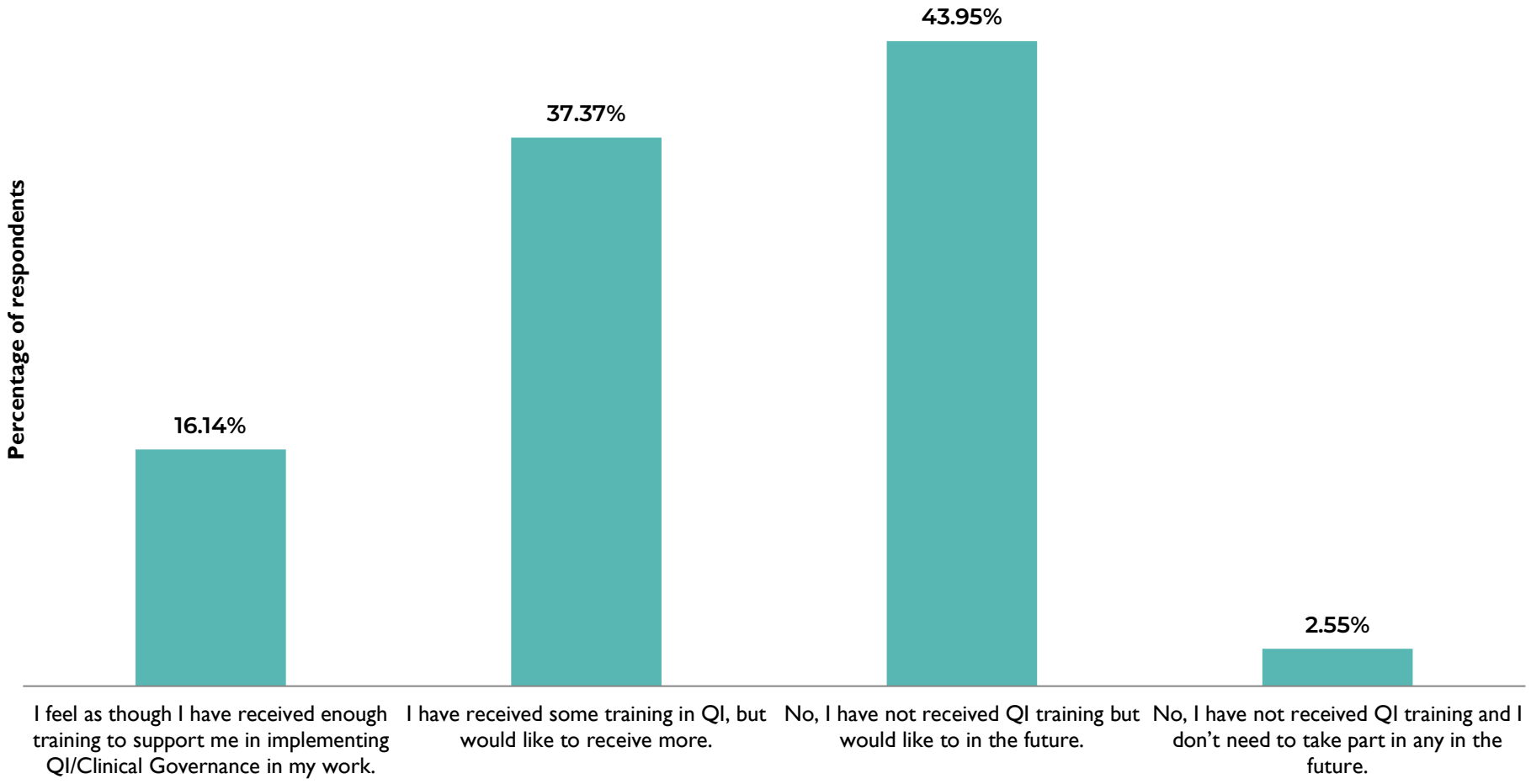


FIGURE 25: IF YOU HAVE TAKEN PART IN TRAINING IN IMPLEMENTING QUALITY IMPROVEMENT/CLINICAL GOVERNANCE, WHERE DID YOU RECEIVE THIS?

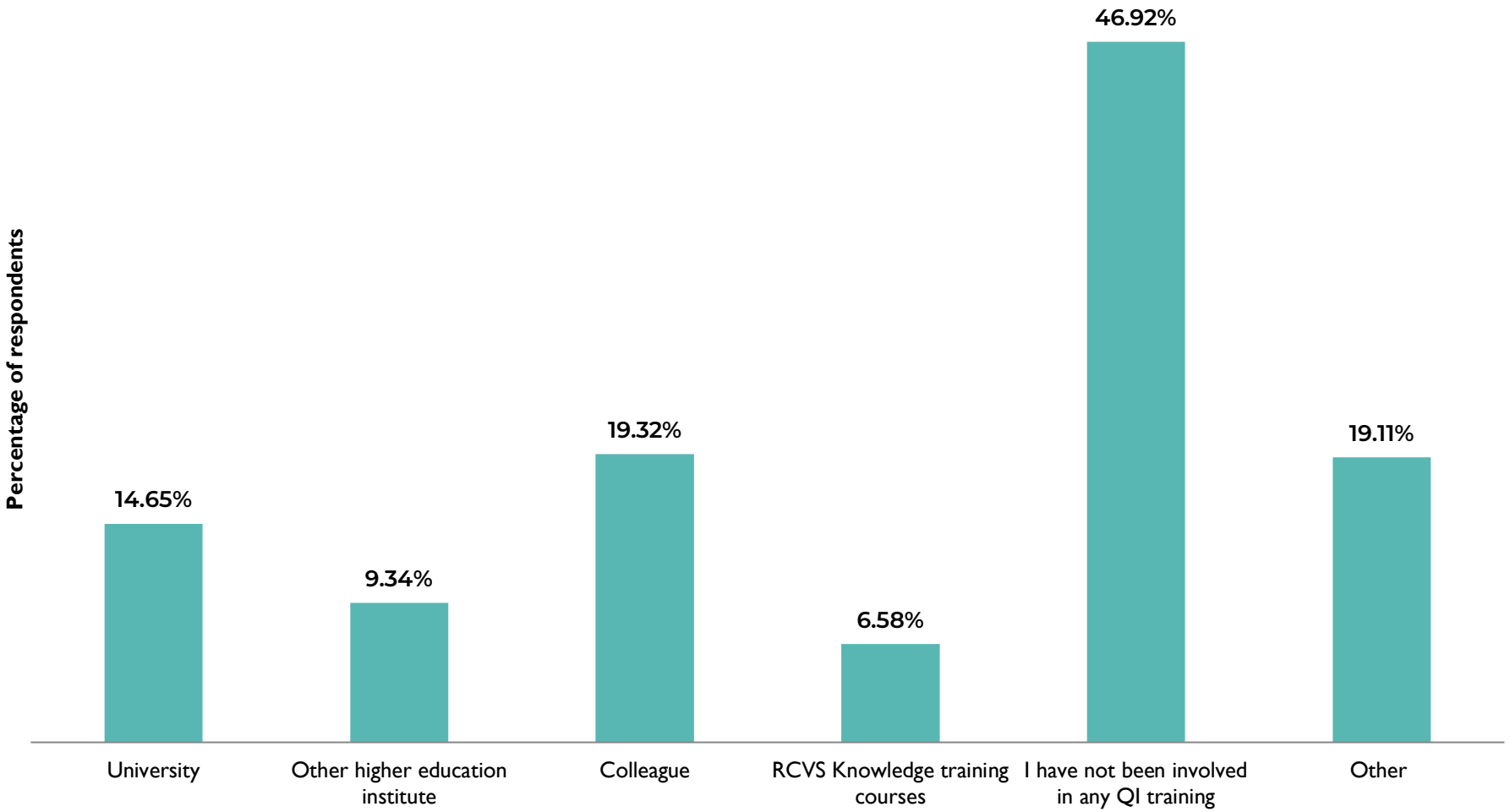


FIGURE 26: WHICH OF THE FOLLOWING STATEMENTS DO YOU AGREE WITH REGARDING THE IMPACT OF QUALITY IMPROVEMENT ON YOUR PRACTICE?

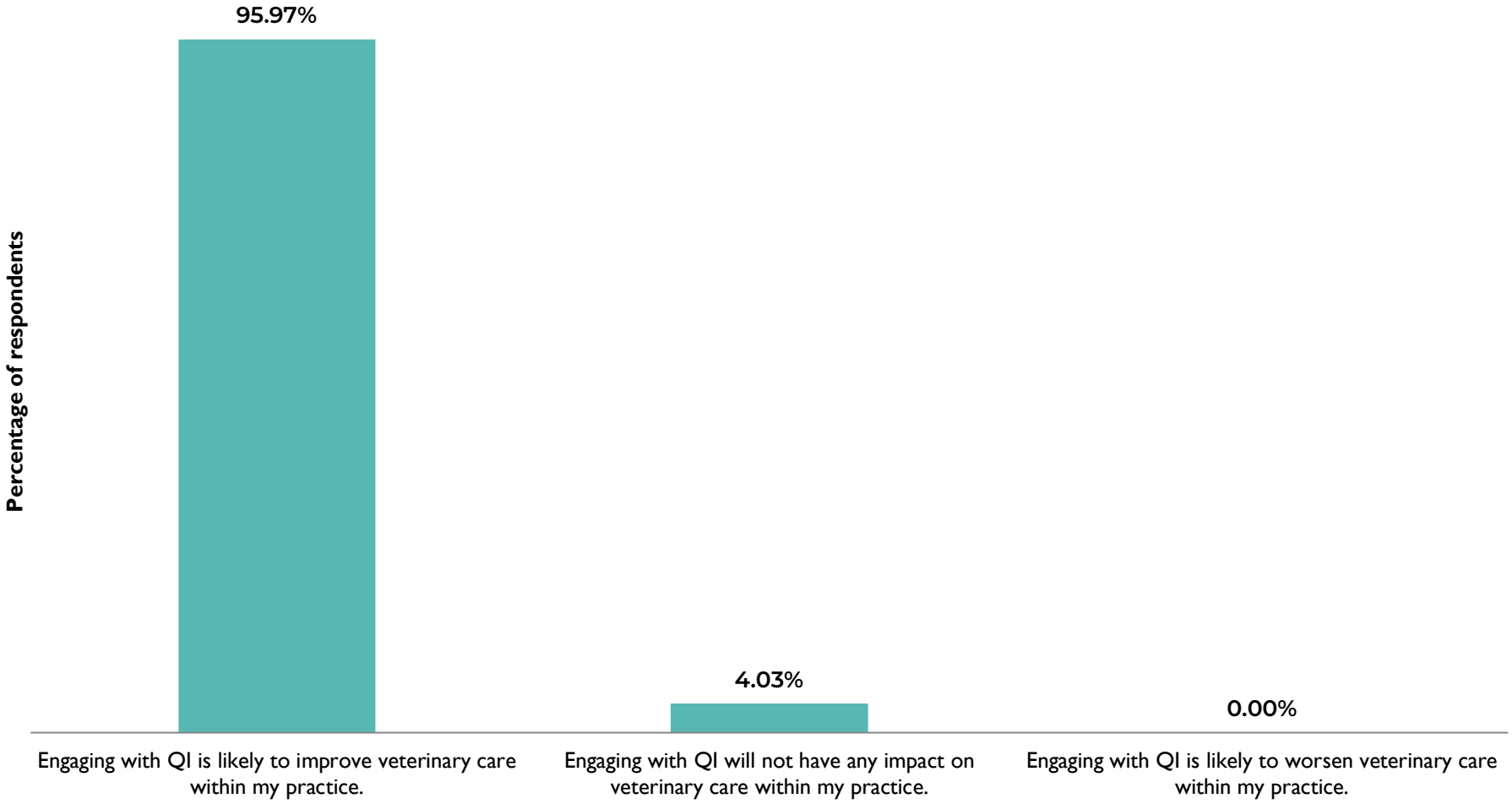


FIGURE 27: WHICH OF THE FOLLOWING STATEMENTS DO YOU AGREE WITH REGARDING THE IMPACT OF QUALITY IMPROVEMENT ON VETERINARY CARE ACROSS THE UK?

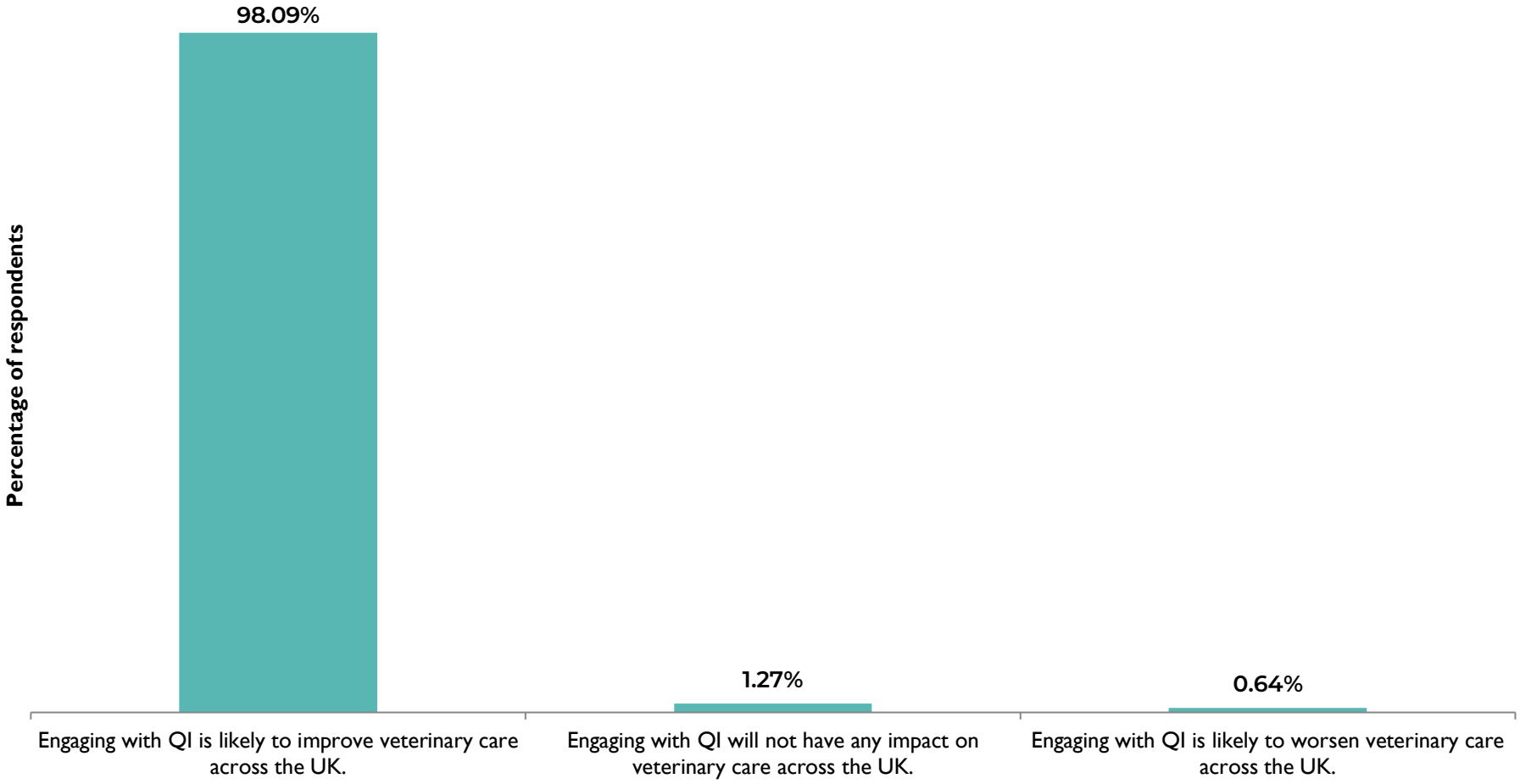


FIGURE 28: WHAT ARE THE MAIN BARRIERS AND CHALLENGES YOU FACE WHEN ENGAGING IN QUALITY IMPROVEMENT ACTIVITIES? PLEASE SELECT ALL THOSE THAT APPLY.

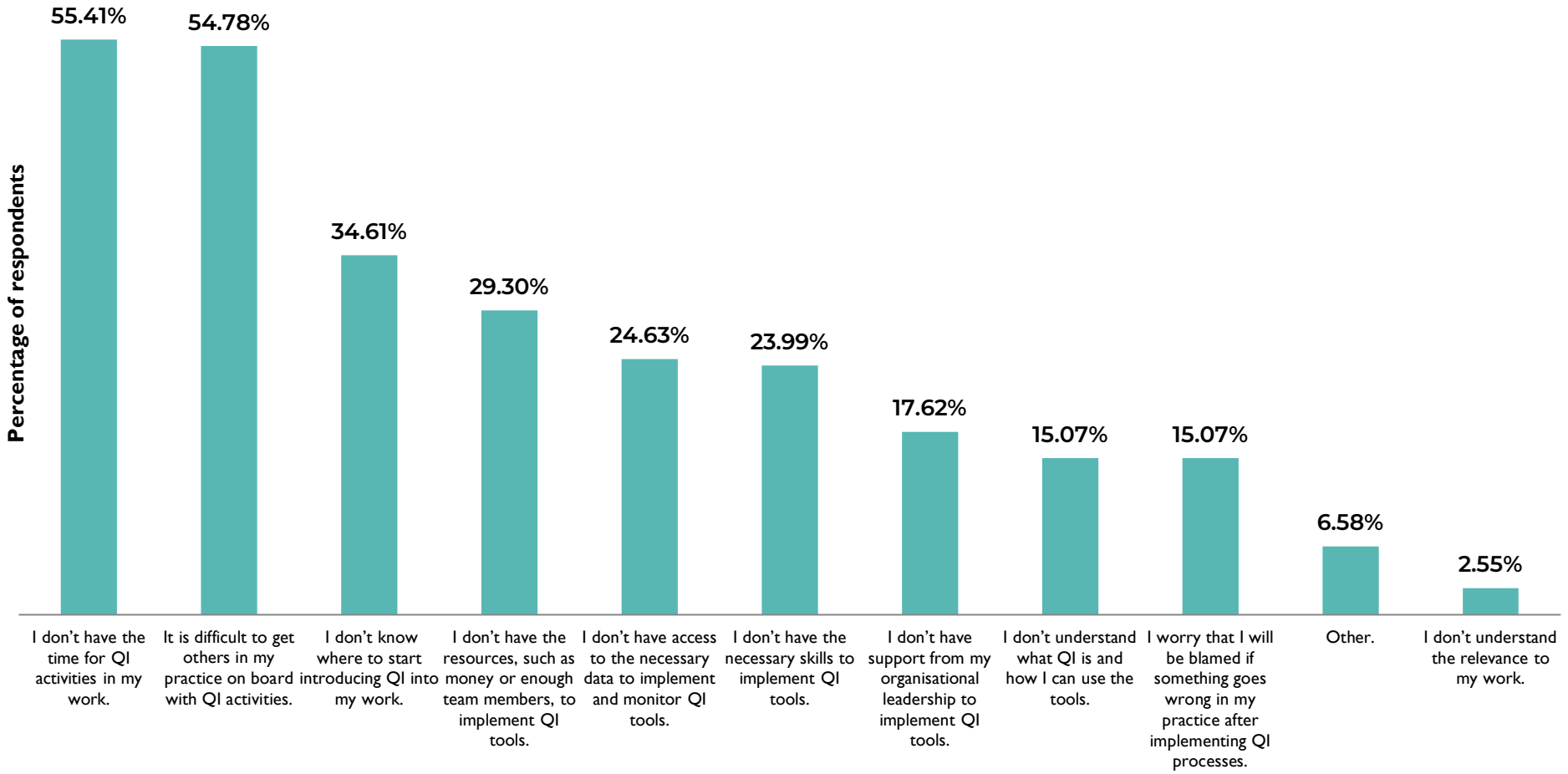


FIGURE 29: WHO DO YOU THINK IS RESPONSIBLE FOR SUPPORTING THE VETERINARY SECTOR WITH EMBEDDING QUALITY IMPROVEMENT, AND OVERCOMING THE BARRIERS OF QUALITY IMPROVEMENT? PLEASE SELECT ALL THOSE THAT APPLY.

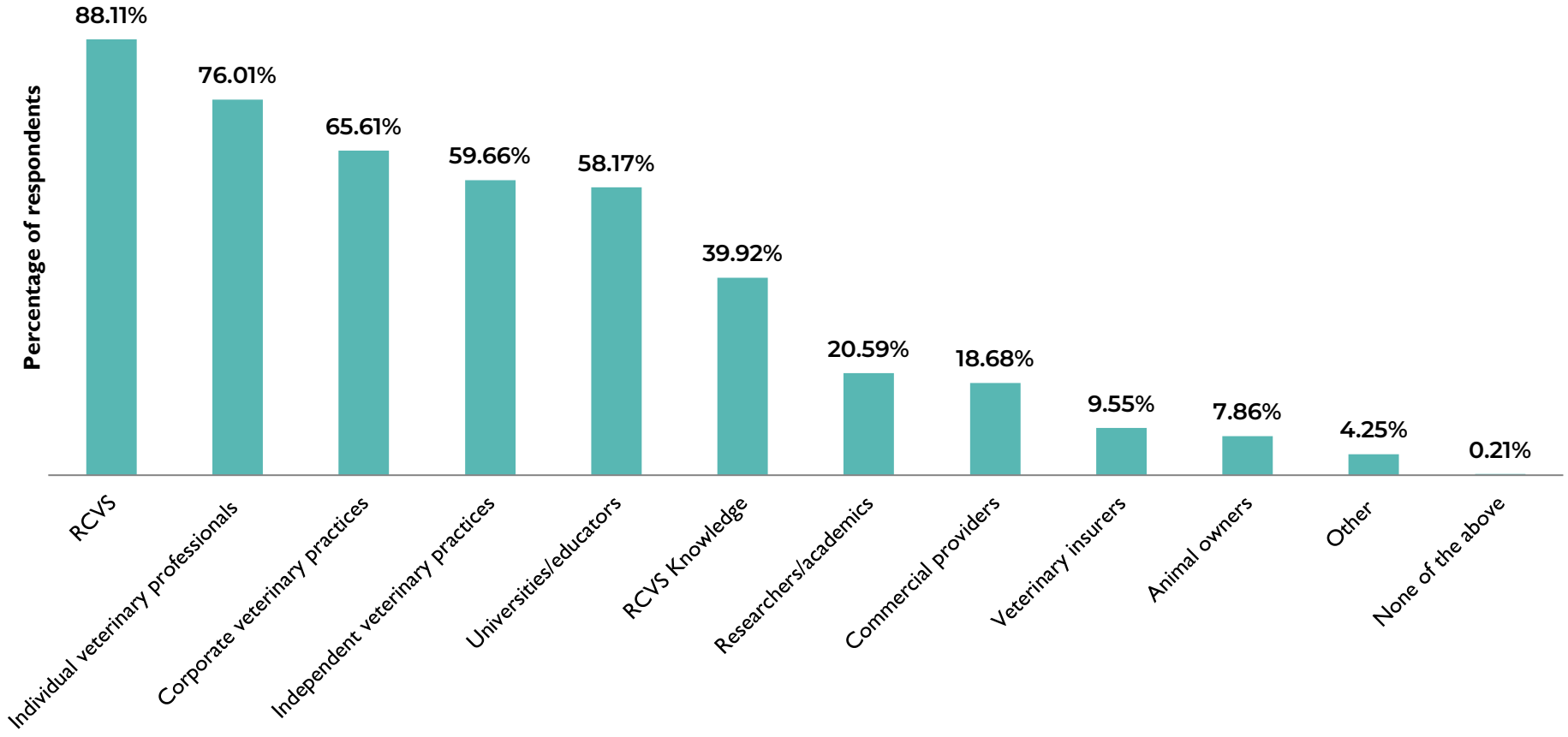


FIGURE 30: WHAT WOULD SUPPORT AND ENABLE YOUR FUTURE INVOLVEMENT IN QUALITY IMPROVEMENT? IF YOU HAVE FEWER THAN THREE POINTS, PLEASE LEAVE THE REMAINING BOXES BLANK

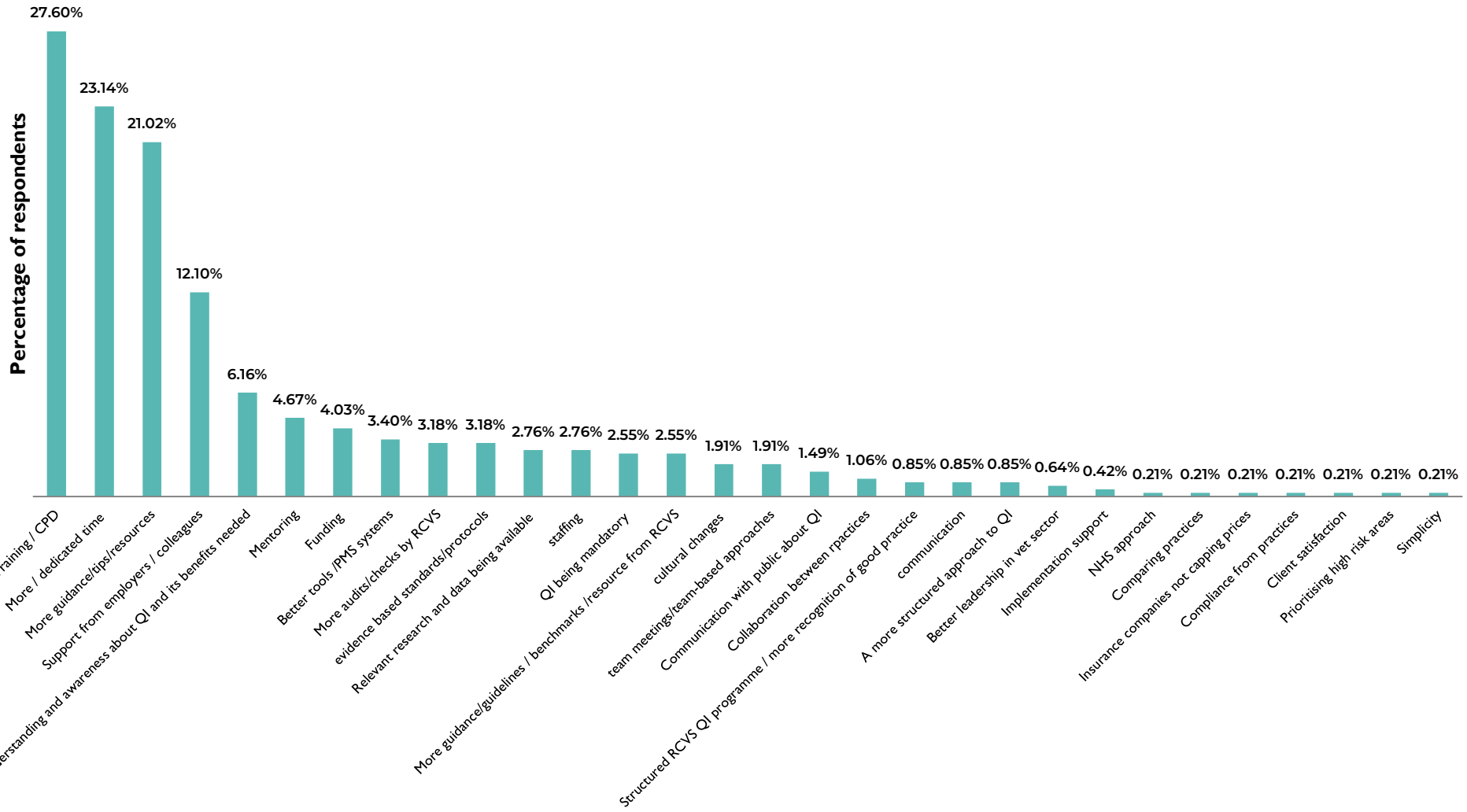


FIGURE 31: ARE YOU AWARE OF THE FOLLOWING ROYAL COLLEGE OF VETERINARY SURGEONS (RCVS) SCHEMES? SELECT ALL YOU ARE AWARE OF

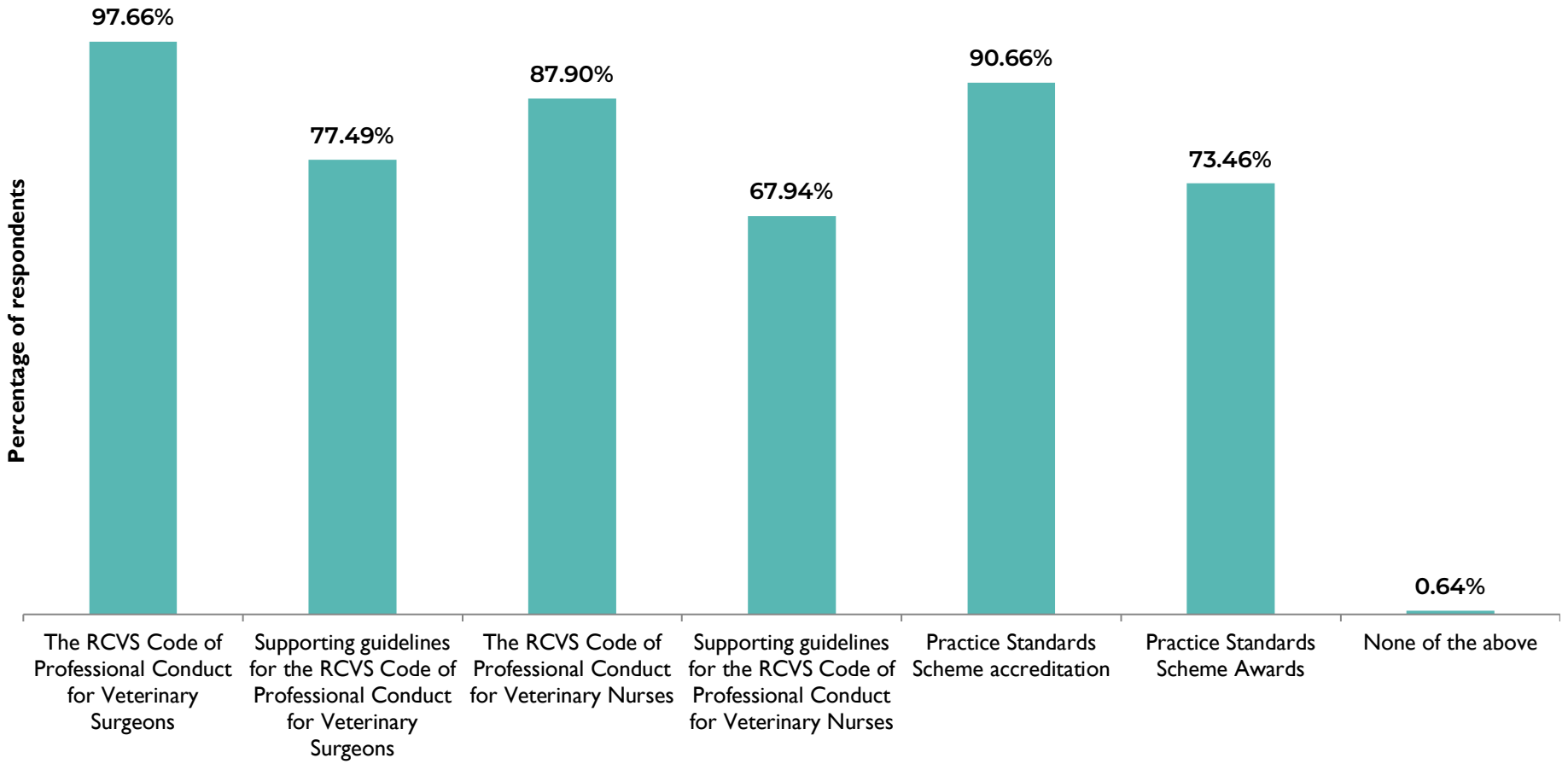


FIGURE 32: WHICH OF THE FOLLOWING STATEMENTS IS MOST APPLICABLE TO YOU ABOUT THE CLINICAL GOVERNANCE STANDARDS OF THE RCVS CODE OF CONDUCT AND THEIR ASSOCIATED GUIDELINES (FOR VETERINARY SURGEONS AND FOR VETERINARY NURSES)?

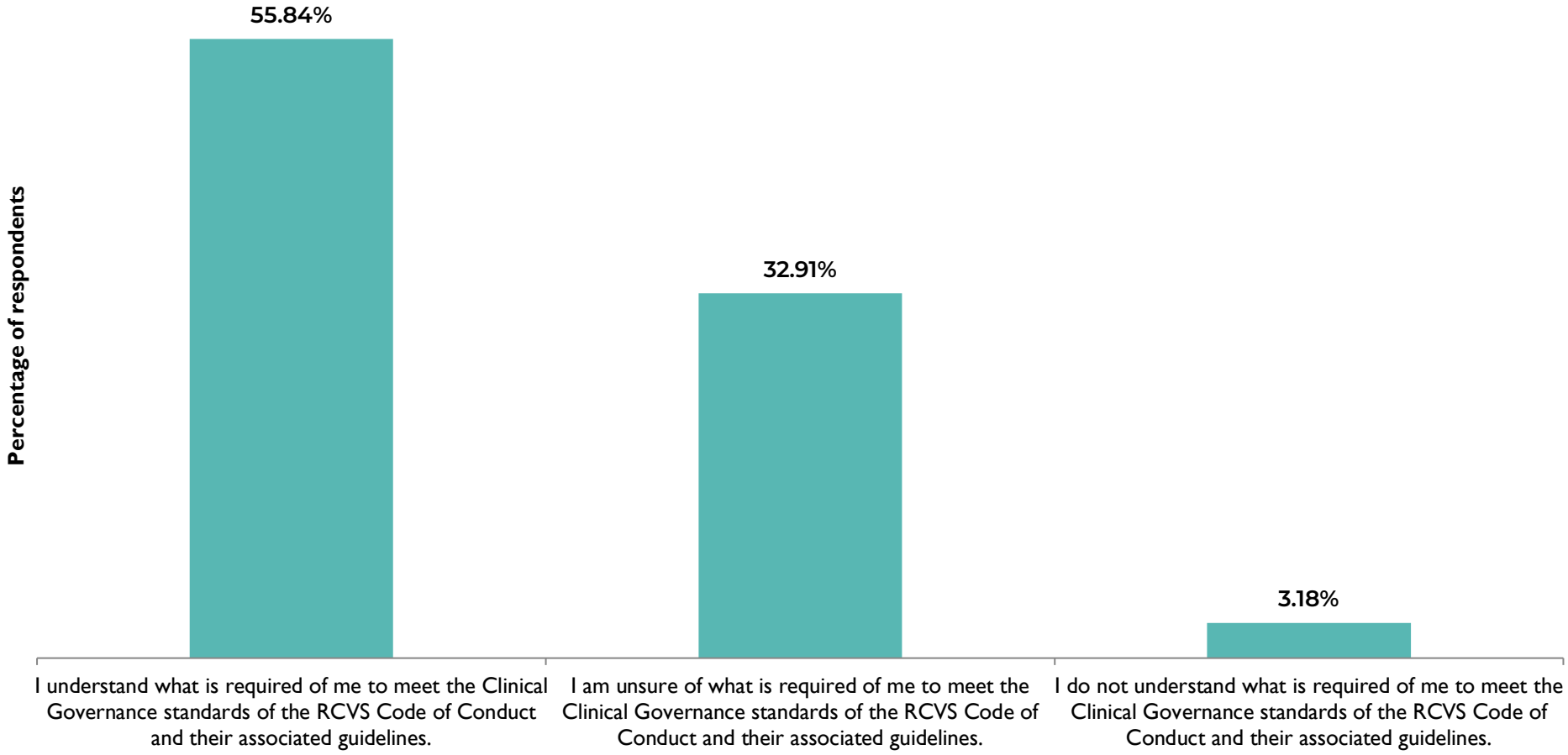


FIGURE 33: WHICH OF THE FOLLOWING STATEMENTS IS MOST APPLICABLE TO YOU ABOUT THE ABILITY OF THE CLINICAL GOVERNANCE STANDARDS OF THE RCVS CODE OF CONDUCT AND THEIR ASSOCIATED GUIDELINES (FOR VETERINARY SURGEONS AND FOR VETERINARY NURSES) TO GENERATE CONTINUOUS IMPROVEMENT IN QUALITY OF CARE?

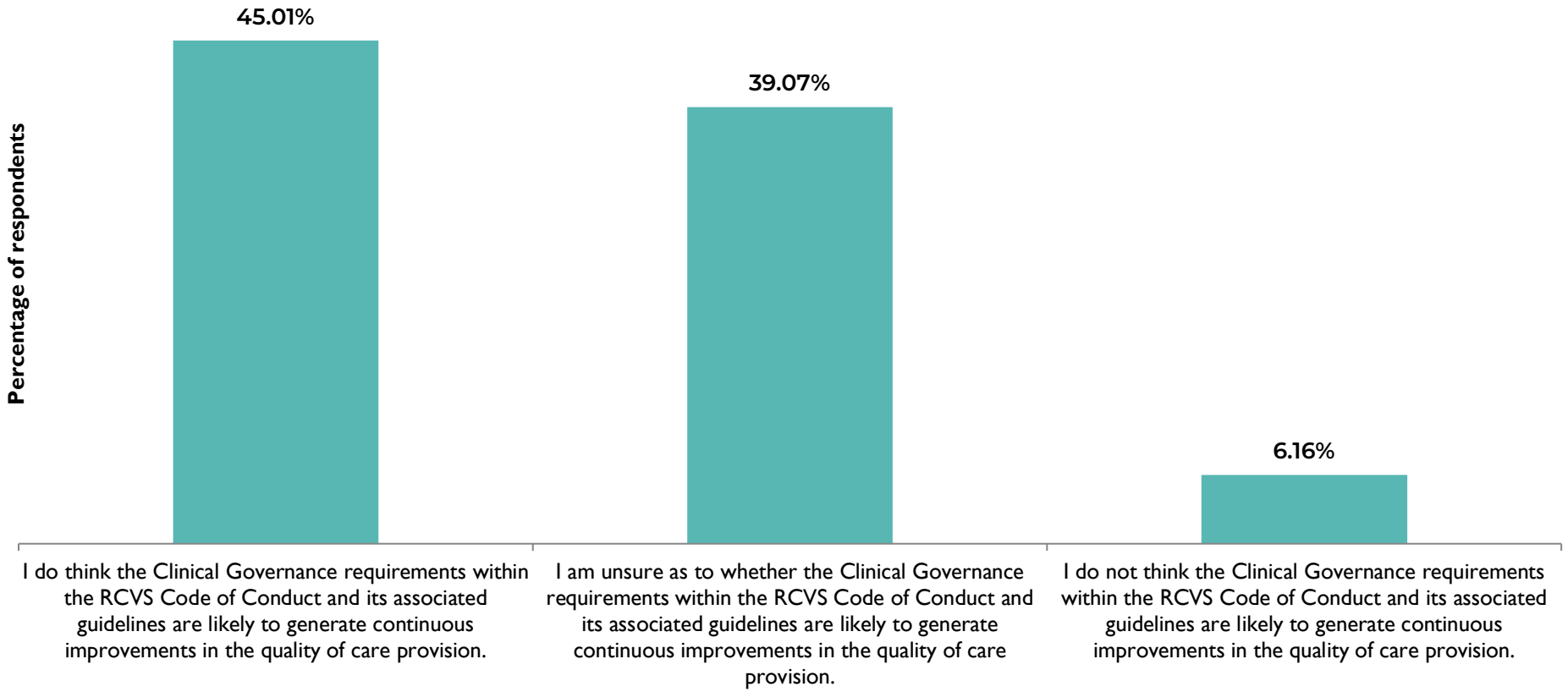


FIGURE 34: PLEASE SELECT THE ANSWER BELOW THAT MOST CLOSELY APPLIES TO YOUR VIEWS OF THE CLINICAL GOVERNANCE REQUIREMENTS WITHIN THE RCVS CODE OF CONDUCT (FOR VETERINARY SURGEONS AND FOR VETERINARY NURSES)

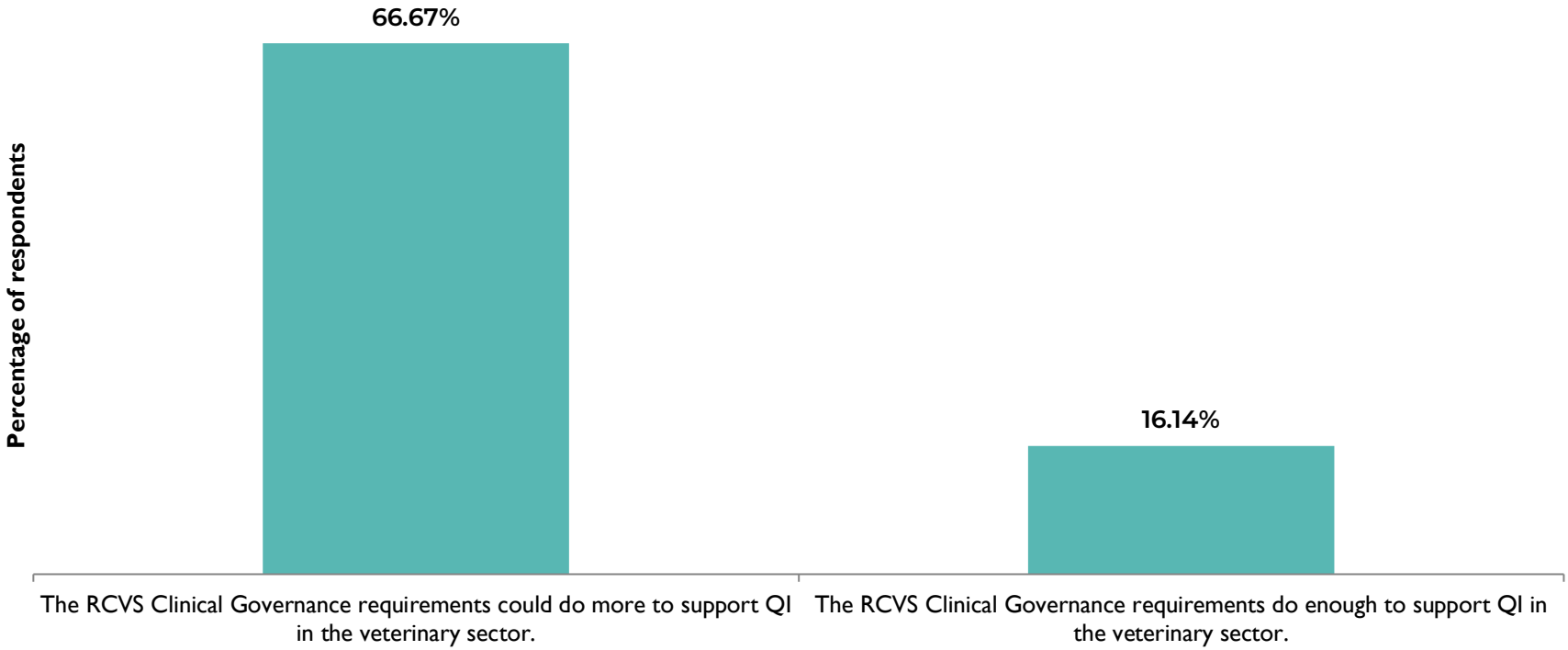


FIGURE 35: WHICH OF THE FOLLOWING STATEMENTS IS MOST APPLICABLE TO YOU AND YOUR PRACTICE ABOUT THE CLINICAL GOVERNANCE STANDARDS SET OUT IN THE PRACTICE STANDARDS SCHEME?

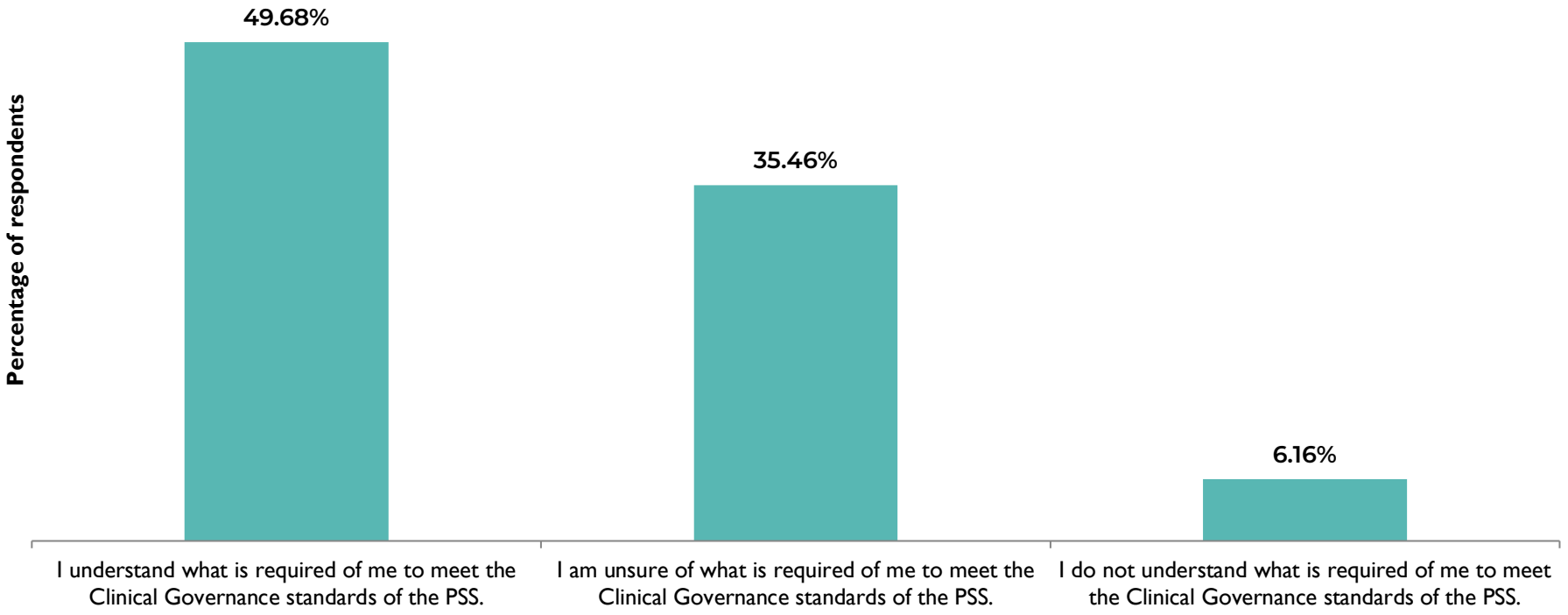


FIGURE 36: ARE YOU AWARE OF THE TEAM AND PROFESSIONAL RESPONSIBILITY AWARD OFFERED AS PART OF THE PRACTICE STANDARDS SCHEME?

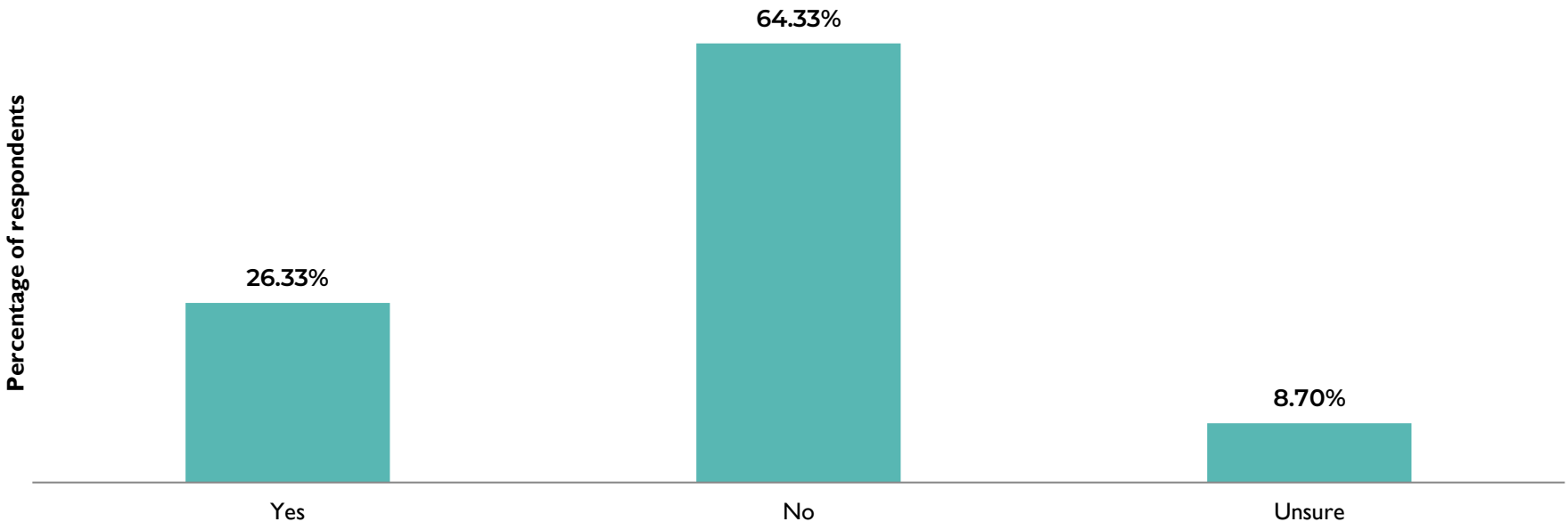


FIGURE 37: WHICH OF THE FOLLOWING STATEMENTS IS MOST APPLICABLE TO YOU AND YOUR PRACTICE ABOUT THE TEAM AND PROFESSIONAL RESPONSIBILITY AWARD WITHIN THE PRACTICE STANDARDS SCHEME?

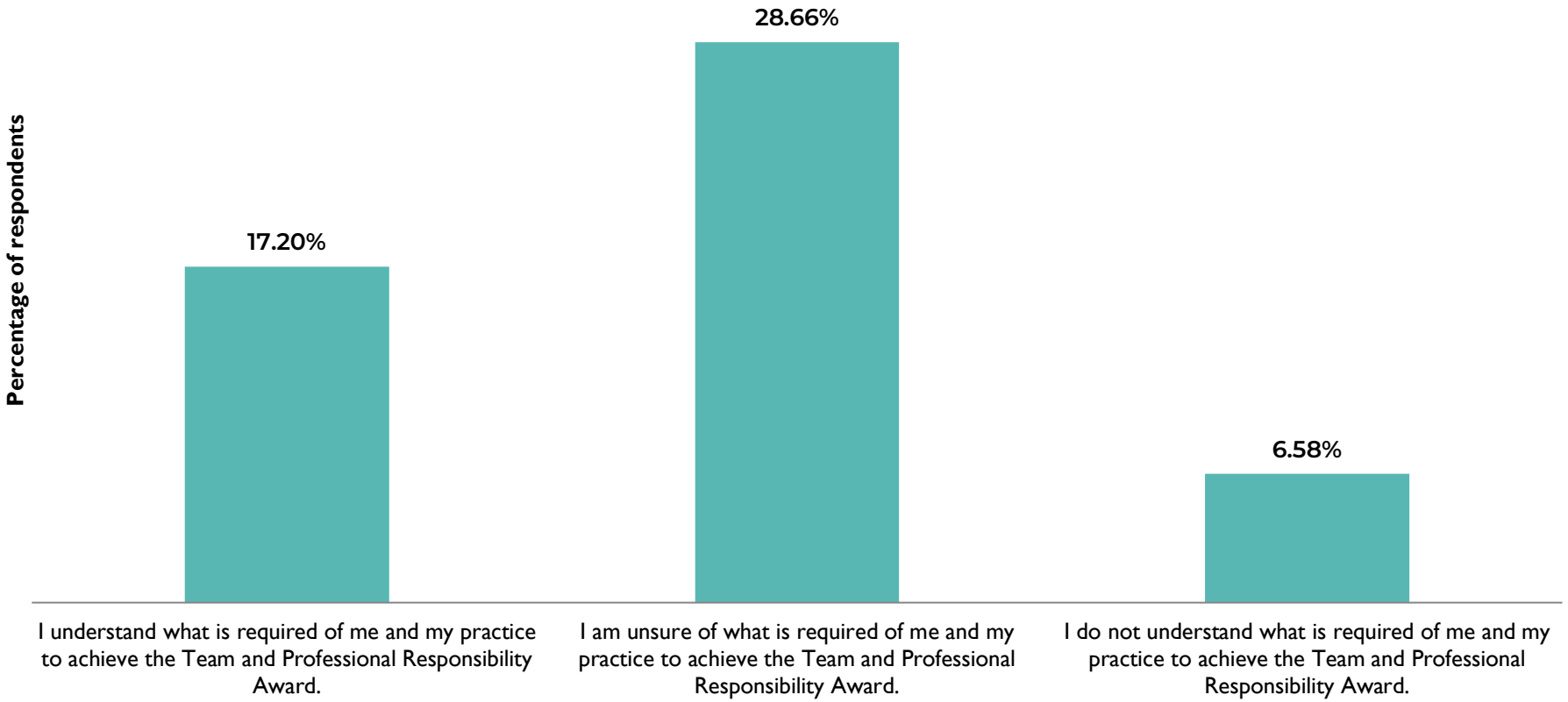


FIGURE 38: DOES YOUR PRACTICE HOLD THE TEAM AND PROFESSIONAL RESPONSIBILITY AWARD OFFERED AS PART OF THE PRACTICE STANDARDS SCHEME?

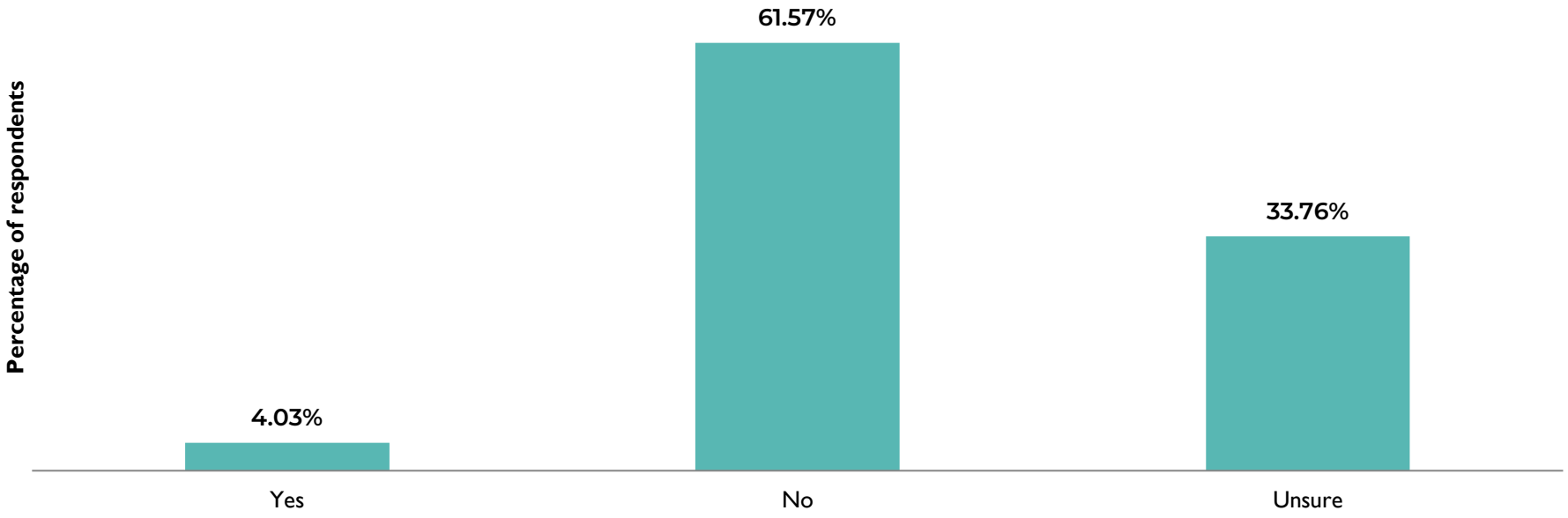


FIGURE 39: DOES YOUR PRACTICE INTEND ON GAINING THE TEAM AND PROFESSIONAL RESPONSIBILITY AWARD IN THE NEAR FUTURE?

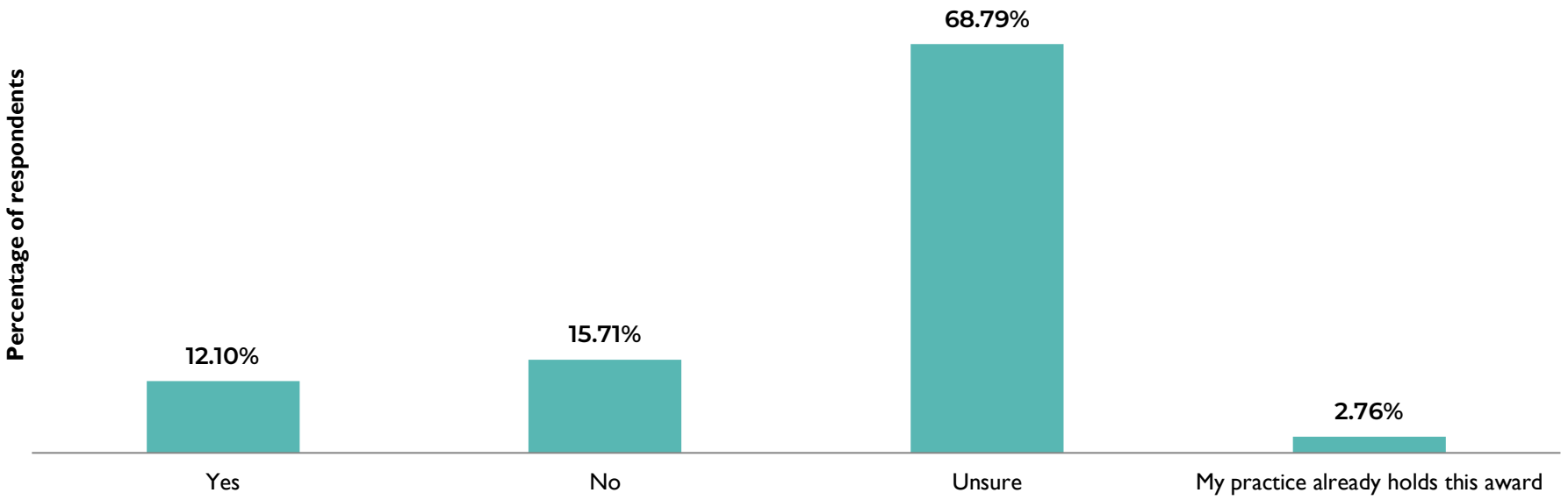


FIGURE 40: PLEASE SELECT THE ANSWER BELOW THAT MOST CLOSELY APPLIES TO YOUR VIEWS OF THE PRACTICE STANDARDS SCHEME CLINICAL GOVERNANCE REQUIREMENTS.

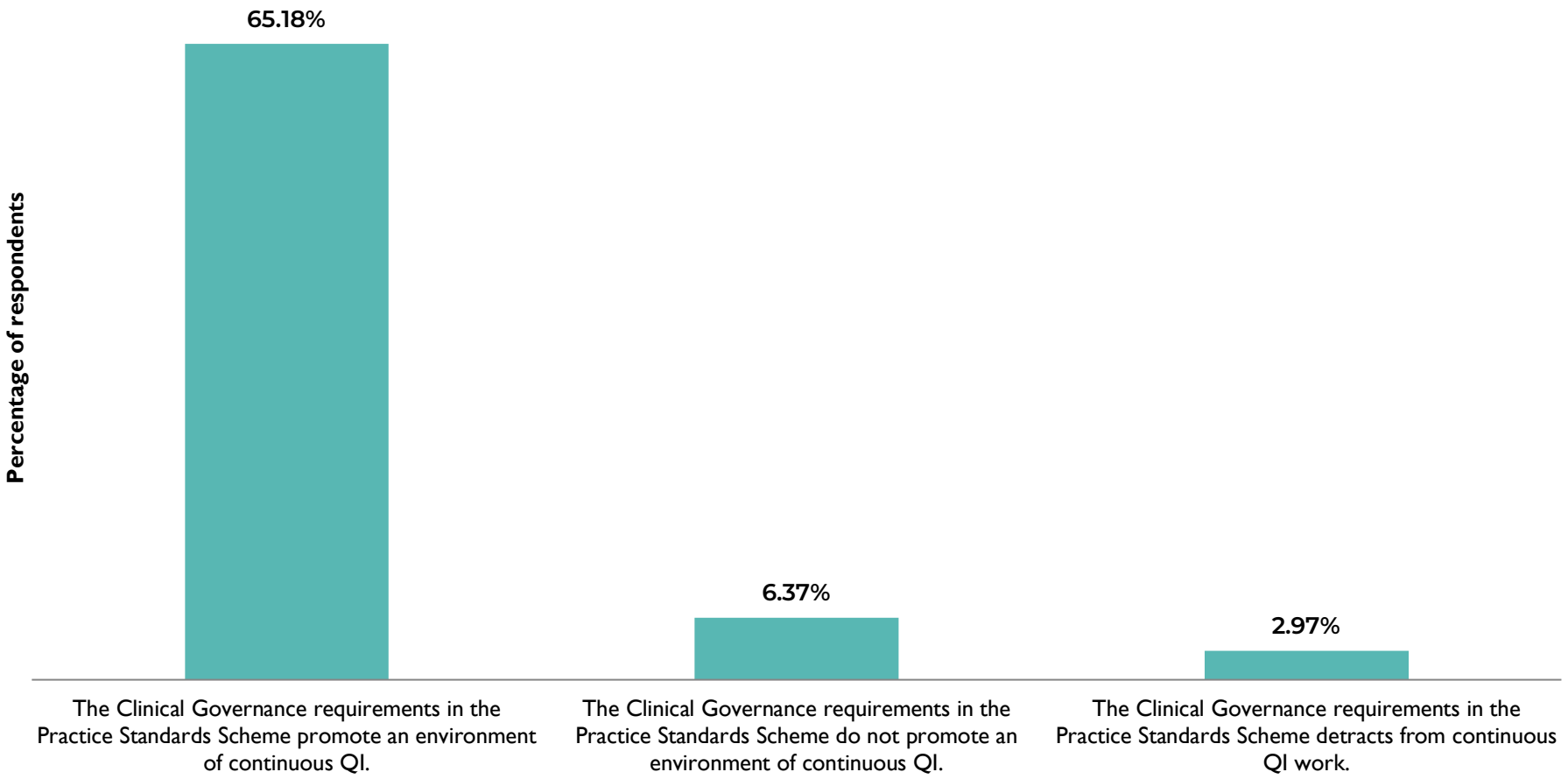


FIGURE 41: WHAT IS YOUR CURRENT JOB ROLE?

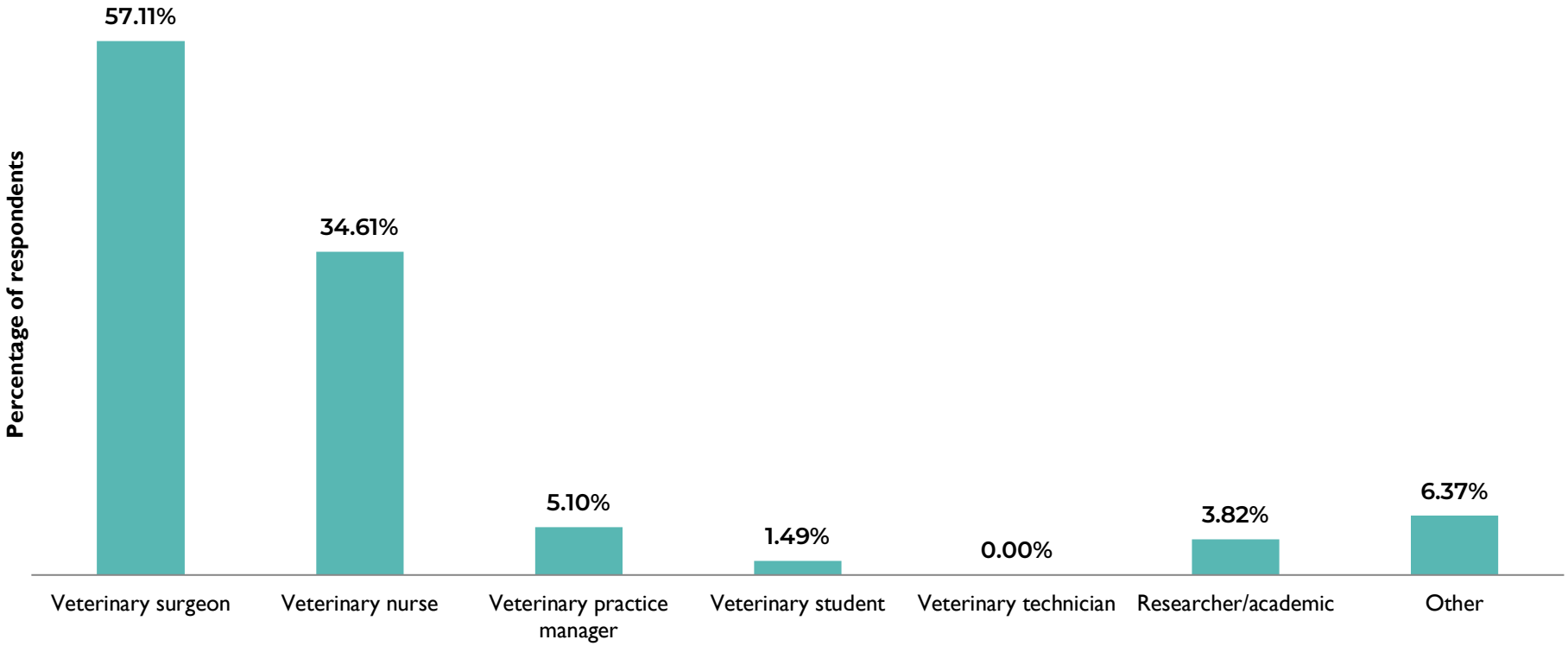


FIGURE 42: WHICH ANIMAL SPECIES DO YOU PRIMARILY DEAL WITH/STUDY? PLEASE SELECT ALL THOSE THAT APPLY.

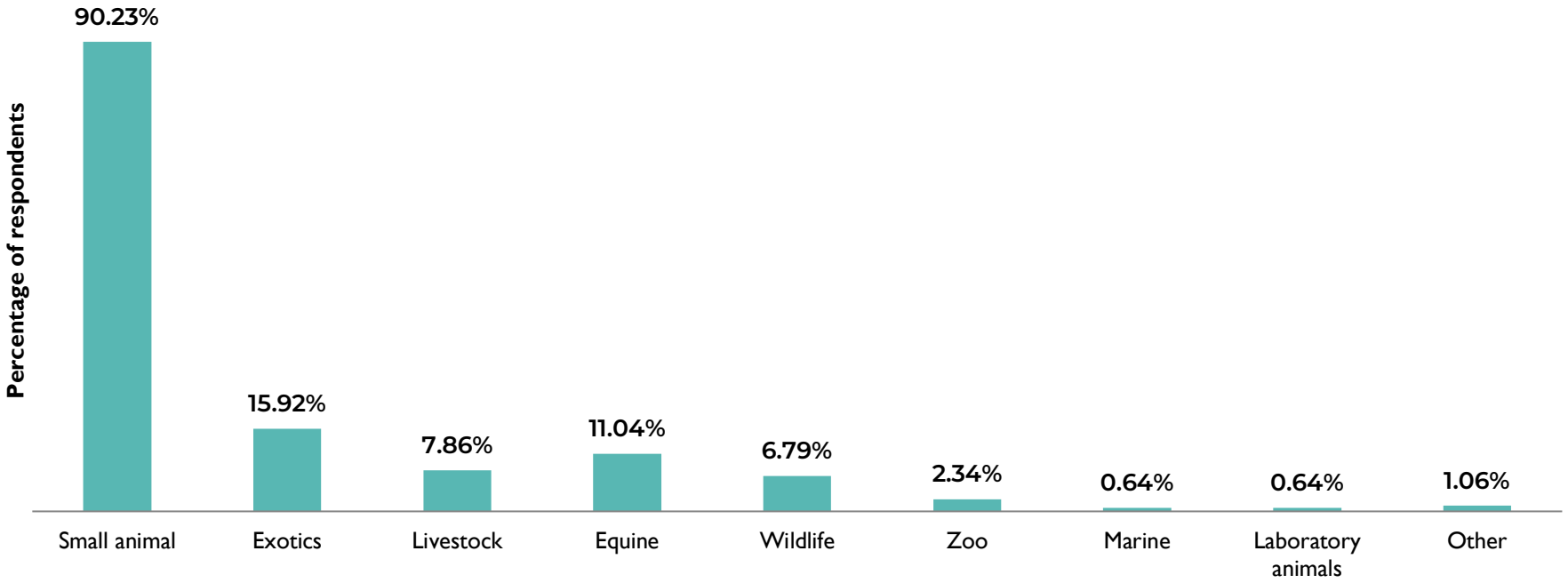


FIGURE 43: WHERE DO YOU CURRENTLY WORK? PLEASE SELECT ALL THOSE THAT APPLY.

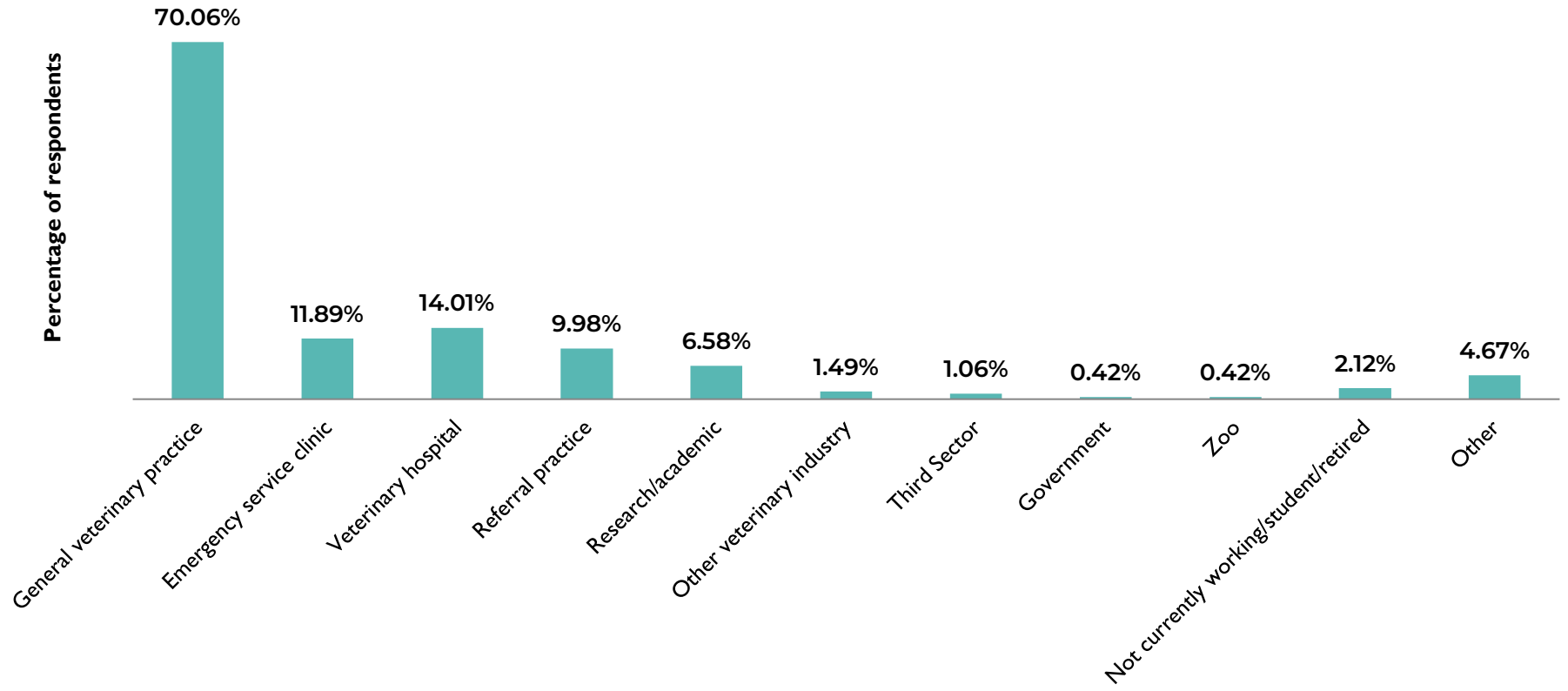


FIGURE 44: WHERE IN THE UK ARE YOU BASED?

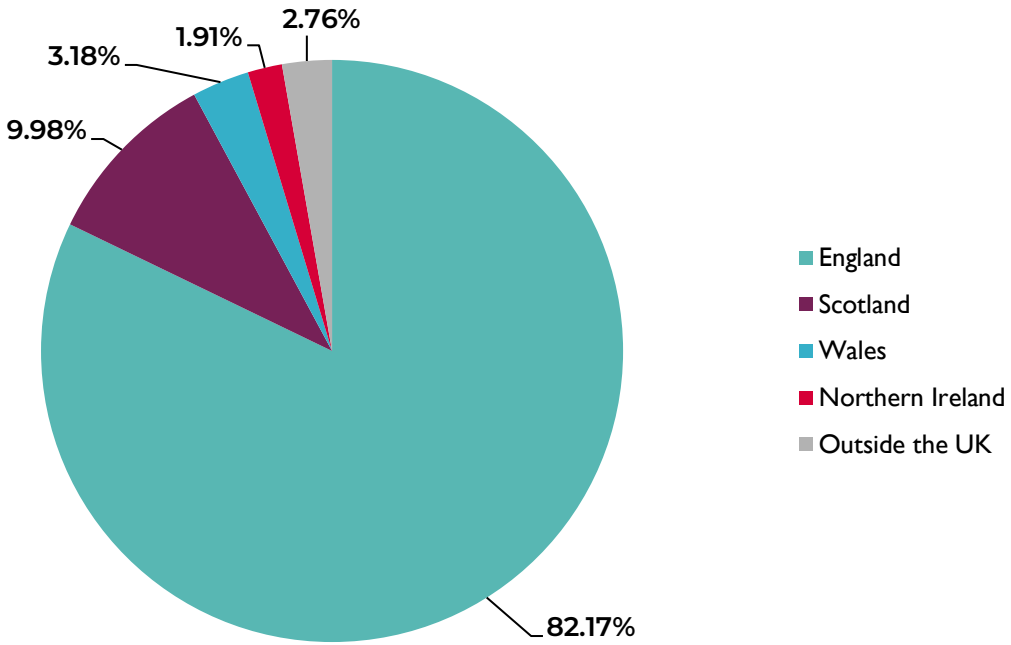
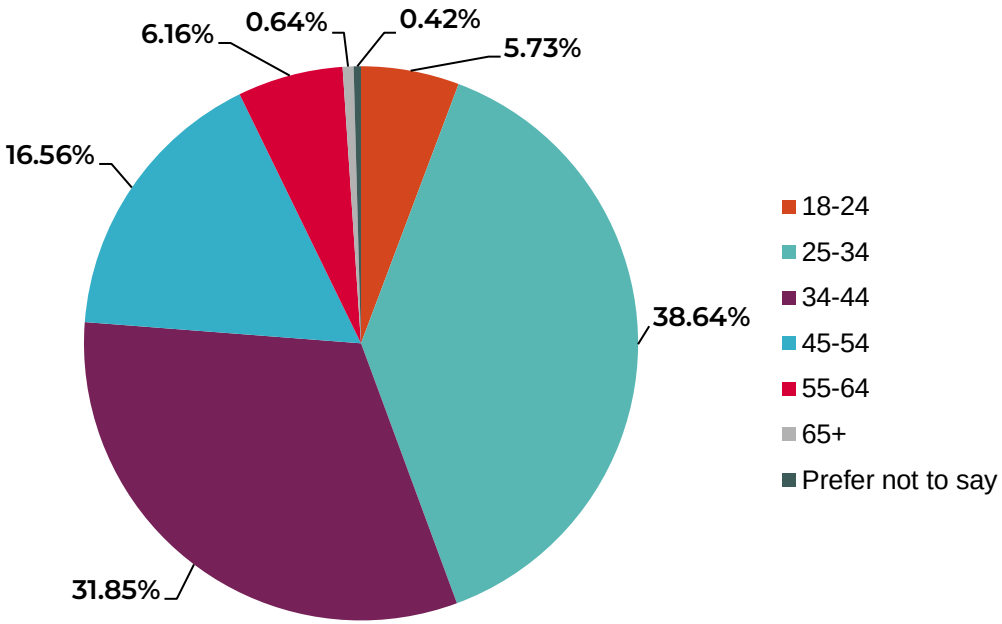


FIGURE 45: WHAT IS YOUR AGE GROUP?



RCVS Knowledge's mission is to advance the quality of veterinary care for the benefit of animals, the public, and society. RCVS Knowledge champions the use of evidence-based veterinary medicine in veterinary practice.

We support the thousands of dedicated veterinary professionals in delivering high-quality evidence-based veterinary medicine to the millions of animals in their care, through our peer-reviewed journal, library, quality improvement activities and historical collections. We are the charity partner of the Royal College of Veterinary Surgeons.

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