THE KNOWLEDGE SESSIONS

The clinical benefits of corporatisation: podcast transcript

Lara Carim (LC): Hello and welcome to this podcast from RCVS Knowledge, whose mission is to advance the quality of veterinary care for the benefit of animals, the public and society. My name is Lara Carim, and today I have the pleasure of welcoming two leading veterinary professionals to discuss the clinical benefits of corporatisation in the veterinary industry.

Dr Rachel Dean is Director of Clinical Research and Excellence in Practice and Co-chair of the clinical board at VetPartners Ltd, which has more than 4,600 employees in over 400 sites across the UK. Rachel was the Founding Director of the Centre for Evidence-based Veterinary Medicine and Clinical Associate Professor in Feline Medicine at the School of Veterinary Medicine and Science, based at the University of Nottingham, from 2009 to 2018. An internationally recognised leader in evidence-based veterinary medicine, Rachel is passionate about establishing practical ways of enabling decision-makers to use evidence-based medicine to improve care.

Also with me is Professor Ulrika Grönlund, Group Medical Quality Manager at AniCura, one of Europe's leading providers of veterinary care for companion animals. The company was established in 2011 as the first merger of companion animal hospitals in the Nordic region, and was born from the idea that sharing resources creates opportunities for better veterinary care. Ulrika has extensive experience in antimicrobial resistance and infection control within veterinary care from the Swedish University of Agricultural Sciences. And in 2016 she was appointed Sweden's first Associate Professor in Infection Control across all healthcare disciplines, including veterinary and human medicine. Rachel and Ulrika, thank you for joining us today.

Rachel Dean (RD) and Ulrika Grönlund (UG): Thank you.

LC: Rachel, to start with, would I be right in saying that much has been written about the business benefits of the large corporates in areas, such as back office support and procurement, etc., but very little has been written by comparison on the clinical benefits?

RD: Absolutely. The business benefits came first and all the opportunities of coming together to form larger veterinary businesses were definitely focused on first, but I think there's now a real move towards looking at how when we have large groups of clinical teams working together within the same business that we can use that greater breadth of knowledge and experience, and expertise and the data that's generated in those clinics to actually make a difference to veterinary healthcare. So I think you can see that with a number of appointments within some of our corporates and the activities that they're doing now that people are recognising that opportunity.

And that's obviously why we're meeting to talk today about the opportunities it does bring. It's why I moved into the sector away from academia. I spent a long time in university looking at how we could use evidence to influence care, and now my job is definitely about how we implement that. And that is much better and much more impactful on a larger scale.

LC: You're nodding Ulrika.

UG: Yeah, I mean, and much harder, I would say [RD: yes?] to get it implemented, yes, yes.

LC: So if we're looking at quality improvement initially and thinking about introducing this at a corporate level, have you got views and experience on how you secure support and maintain the momentum once that is introduced?

RD: Do you want to go first this time?

UG: Yeah. We started in 2015, launching a medical quality programme. And the first thing that came to our mind was that we have to see what is going on in the clinics. And right now we have 300 clinics; at that point they had 200 but, so it was still too many to be out there and see what they're doing, so we thought we were going to do some simple surveys. So we decided on quarterly measures to measure in different ways how they perform in an area that we think is important and we are focusing on the patient. So it's all about patient safety and that makes them sort of...also the result you get back from this survey also shows where they are in relation to the others in the same country, which makes them sort of think about how we can improve. And they also get improvement tips and tricks back, to really clinically get better in what they are lacking. So that was something we were thinking of, and also then quality coordinators being introduced in each clinic to get more into the clinics, because we are relying too much on the practice managers sometimes and they have a lot of things on their board.

LC: So this is a new role?

UG: Yeah, it's a new role. So we try to engage those and having now our second quality conference in Munich in December, we invited them to discuss mainly change management and implementation in the different areas that we're working in, and we have nine areas that we focus on. So that is some other part that we are trying to elaborate. And also, I was very happy actually that we also got the quality measures into the budget process. So we can sort of also push in the budget process if they want, sort of, new medical equipment, they also are addressed: OK, well how have you been performing when it comes to the surveys, and what have you done with the improvement stuff that has been given to you, and stuff like that.

RD: So it has a degree of incentive.

UG: Yeah exactly.

RD: I think that idea of why you want to do it and then giving people responsibility for it on a practice level is huge. We're much earlier in the process of our quality improvement programme, which is part of our excellence strategy. And in terms of securing support, I would say we get it at all levels. People want to know how good they are, so clinical teams want to know, they also want to know what the next-door neighbours are doing, so that feeds to the competitive nature of veterinary professionals. But the support is definitely there; a lot of people don't know how, so our jobs definitely within our business, by the sound of it, are to create a framework. So it's possible, but it has to come from the top down.

Like all aspects of clinical excellence; I think if you have buy-in from the top that they believe that quality matters (and that can be to do with patient safety or patient outcomes or many different things when it comes to quality improvement) it's part of your culture. You need a culture that is willing to say, we're good and we need to celebrate what's good, but there's also areas where we can improve, and

incentivising that and rewarding people for it. Similarly with our clinical board structure, over time, there'll be somebody in every practice that is associated with the clinical board activities. So it's a way of spreading a message on the very local level, but then also having clinical board champions who can help locally push the momentum along. But it also, I like the idea of the new role because it gives people a new opportunity too, so it's a good bit of career development. But clinical teams want to do well. They want...

UG: They really want to know, yeah. And they have a hard time finding out in some areas what is really the right way. Because there's lots of information and I think veterinary medicine is sort of evolving so fast and the area is so large to be sort of an expert in each area; you can't, you need to get help from the corporate level in some instances.

RD: Yeah. And because of that breadth of so many things, another way that we're working on at the moment to secure support is, there are certain things that we need to know. We need to know how safe the delivery of our care is and what we do, but also using our clinical teams to help us prioritise areas that they think they want to improve. So it's not just top down but bottom up. So there might be certain aspects of clinical care that they're uncertain about what the right thing to do is, or what are the better things to do. So getting them to come with the ideas, we create a framework, which means we can look at the quality of care and then work out how to improve it is definitely, they're not quiet about what they want to get better at. And that's good.

LC: Yes. That leads me on really to something that I was going to ask your opinion on, in terms of the systems and the people that need to be put in place to, to get from a top-down corporate approach to encouraging the adoption and continued use, I suppose, of quality improvement at the practice level.

RD: I think there has to be a clear clinical leadership that prioritises quality of care. And to do that, you have to show that you're constantly learning, because if you know it all already, you can't improve it (or if you think you know it all already, you can't improve). You need the senior management team to walk that walk of a degree of uncertainty, so you can look for improvement. But also that admission of when things don't go right, it's fine and clear to be able to talk about it and together work out a way of improving it. And there's some nice work that's been done in medicine that shows if that comes from the top, everybody has to do it, but if they can see the leaders doing it, then that will improve care, and that will save lives.

So I think a top-down approach is really important. Our CEO is a veterinary surgeon, I don't have to explain to her why quality of care matters. She, she gets it, she understands, she wants it, as does the most junior trainee nurse we've got. But we also want as our senior business development teams to understand why our patient outcomes are important. And so if everybody's talking the same talk from the top down but also from the bottom up, I think that helps. But you know, there's a nice pieces of research that show if you have good strong senior clinical leadership around quality improvement, loads of things improve.

UG: Yes. And the, I think also we're talking more of the technical things like technical systems because I think we are really in big need of a good patient medical record system that can help us out get other data very easily, so the practice manager can really sort of just push a button and then they can sort of get the whole picture, how it's going. Also [that would] help out with following up a patient, so we can easily get data on the outcome. Because today I think the outcome data is really [whoa] up in the air. We don't know really how it goes; it's more the patient or the owner hasn't called back, so it's fine, so

it's fine. So finding out, but we need to have the technical system so it can be an easy task to find out how it's going. And that will be really something. We are not there yet. We have several, several systems or I would say many systems (patient medical record systems) and yeah, so we need help.

RD: The situation is same in the UK. So there is a default idea of success if you don't see the patient again, but we don't actually follow up. But the information that is in the patient record can be hard to extract. Not impossible, and lots of different research groups are doing things with it [UG: Yeah absolutely] but...

UG: …but for a practice manager it really needs to be very easy.

RD: Because if they can see it [UG: Yeah] and they can see that they can put themselves into context of others easily. They want to improve, that's the nature of being a clinical professional, but it is getting the data at your fingertips in a usable way, that's a massive challenge. [UG: Yeah, yeah] Not impossible [UG: No] but it's going to take some time. [UG: It will take some time, yeah.]

LC: In terms of sharing clinical knowledge and data among practices, do you feel there are further benefits to that?

UG: Well, to me that is really sort of fundamental for us to get the knowledge-sharing going. For me from a quality perspective also I would like us to be on the same page. I mean I want to see on the same knowledge level the ones who sort of ended their education 30 years ago will go on the same path or will be on the same page as the ones who are specialised today. Uh, but it's really hard. I think we have a good group that are the clinics that we have bought are into that sort of mindset of evolving and getting better and knowing the latest. But it's not easy to get the information out to everyone and see what they are sort of grasping and, and what they are taking in.

UG: So I think there is a lot of things still to be done in that area. But I think that it's really one of the top things to being a corporate to manage that; from the more specialised diplomates getting easy data on how the latest techniques are for these kinds of procedures, like in surgery or something, and getting that to a more first-line clinic so they don't need to read abstracts or go to a course, that can sort of more easily by some technical system or physical meetings get that information.

RD: I think getting everybody to talk the same language, so when we're talking about quality improvement or what is safety or what is quality, that everybody understands it in the same way that makes it easier for people to talk. But that breadth of experience that now exists in a corporate group compared to a five-vet practice with six nurses, we're now four and a half thousand people in our clinical teams. Harnessing that knowledge and then sharing it is a challenge, but it's something we have to do. Just understanding that there is more than one way of doing it: in certain situations this is probably going to give you the best quality outcome, and in other situations it's this one. When you've worked in just one practice with a few number of colleagues, if you can open those doors and get people talking, advising, networking and educating each other, then that's huge.

In GP practices in the UK they have these things called knowledge circles, which is sort of a ripple effect. So one practice starts doing something, they talk to the neighbouring practice, and then it gets bigger and bigger. And we need to try and find ways of enabling the knowledge to spread through the groups and ideally between the groups to help the profession move forward. It can work and it's a massive asset to know you've got four and a half thousand colleagues rather than four.

LC: So we've talked about the benefits of the technical systems and also the more human side of sharing data. Am I right in thinking that you're probably using a combination of those different means of sharing data broadly at the moment to try and maximise the actual proportion of people who are open and receptive?

UG: Yeah, exactly. Yeah, we are trying, we are using, I would say a sort of Facebook, it's called Yammer, where we try to exchange information easily, quickly, like the younger generation really wants. Like it can be on the smartphone and then you can easily tap and then you would get the sort of really quality answers to your questions in your, if you have a case that you want to present or something like that. So I think we are, but still I don't think we...I fall back to the patient medical record system because I think that one could really help us.

Also, I think if we could get a good connection between that one and also some kind of knowledge base, if they can sort of talk to each other and that you can easily find you don't need to do the Google search or something like that. I mean, in a corporate you should only be able to look at the data that we have that should be enough, and we would know that it will be good. I would look at the computer screen and you'd flip between these two pages very easily and you'd find out what you need to do with this patient or what you should not forget or…but that's a challenge.

RD: Yeah, we use multiple methods of communicating. But if you could find one route in that, if you're already doing your day-to-day job and if you just clicked the hyperlink it would get you… or you start typing a word and it would get you into all of the resources and all of the data within, ideally within your corporate group, but then potentially any external data sources that are useful, so it's there in the hands of clinicians when they make decisions.

That is definitely the holy grail, but it's difficult and it takes time to look for any kinds of information. And the easier you can make that the better. And again, when you become a bigger company, the IT support, the potential for getting investment in the way you handle data is so much more than you can do in a practice. And I've obviously worked from the academic side of things, trying to get data from practice. You can, gosh, vets want to share what they know and what they have, but it is difficult to bring that together in a usable format. Whereas if it's your data within your corporate group, we should be able to find a way of making it more useful than it is at the moment – and timely. [UG: Exactly.]

LC: So we've focused a lot on talking about sharing data. Are there different nuances or different ways that you might consider that are actually in use at the moment in terms of sharing clinical knowledge more broadly? I don't know if you would see that as a as a different thing or whether that's part of the bigger picture, complementing the data itself?

RD: Ten years at the Centre for Evidence Based Veterinary Medicine was a fabulous experience, but it did teach me that in many areas where people have clinical queries, the traditional published evidence is lacking either in quality or in absolute existence. Often there's nothing there. So what we're starting to do is find ways of harnessing people's expert opinion, but when I say experts, I don't mean someone with lots of letters after their name. I mean someone that has treated over their lifetime 2,000 dogs for a certain disease. If we have 10 people that have treated 2,000 dogs and they can talk together or input into one system how they deal with it, then we can say 80% of vets do this, 20% of vets do that. There's no evidence to say one is right or wrong, but we can at least share those opinions.

And we're starting to do it around some of the common procedures, to find out what everybody does and what everybody thinks is right and wrong. And that is the first steps of evidence-based medicine, so that knowledge, expertise and experience is hugely valuable. We're trying to use it at the

implementation stage, so we use it as some raw evidence sometimes when everything else is lacking. But also particularly with quality improvement and finding out what has worked and what has not worked in terms of how you actually implement what is known, is a huge bit of knowledge and science that we are not tapping into.

UG: And I think for me I would also like to more go into the area of measuring outcomes, because now we are focusing maybe a bit more on processes and seeing what processes are in place, but then to go to, like we have done, monitoring surgical site infections and we're looking to really see the distribution among the clinics. And I think if we go to the ones that are doing really good and we can find out what they are doing (we don't need to find out exactly), but they have some good procedures that we can sort of document, we can take them to the ones that are not performing that well and say, 'Hey, you guys, can you look into this, and see what you can do about it?' Or we can do audits, but going from the outcome really, how is the patient doing and from that into sort of a more quality improvement.

RD: Yeah, I think that's a really important part of knowledge that again, we, I think as a group, we have an obligation to share the fact that we have a range of outcomes, but it's much better if the people that are doing really well help the people for certain things that aren't doing so good. It's much better that they help each other than we try to, because they know what works and sometimes it's because it's a completely different clinical setting that it works better in one than the other. But as we start to produce more resources within VetPartners, we want to put together virtual implementation teams that will help share that knowledge. So, 'We've done it', 'Oh gosh, we're a bit scared, we've never done that before' 'Well, this is how we did it', which is why I liked the idea of people within the practices having that role of quality, because they will end up with a whole load of tacit knowledge that we just need to share somehow. And it's not a big scientific trial and it's not lots of data; it's actually how you do something. And if we could share that, that would be great.

LC: So how can the resources, the sheer scale – we've already kind of touched on that a little already – of corporates have this beneficial impact on data capture and analysis?

UG: Well, I come back to saying, it's all about measuring outcomes. I mean, you get the data so easily and we get sort of an international multicentric setting that I think is very hard to get anywhere else. And also the publications that we are now for the surgical site infections… they will come out. I think it's great to get those data very fast and out and the (and we don't have it), but I would like us also to have an epidemiologist that we can sort of hire from the group level and help all the clinicians that have sort of small data projects or studies that they want to do, and sort of facilitate this work that can be really hard and take a long time if you're going to approach a university or something like that. So to me it's more about getting the surveys and the measurements going and then helping out with the analysis.

RD: Yeah, I think finding those new partnerships and we're in the early stages of what will be our clinical research programme at VetPartners, but some of it is when you find something out, we need to tell the wider world. So there is a benefit there. So a proportion of our practices in the UK will remain independent and that's brilliant. But equally others will be in other corporate groups and if we find something useful out, we should share that, whether that's through peer review publication, the veterinary press, with people like RCVS Knowledge, to say, 'We found this thing, we need to now talk about it' and so everybody can benefit is really important. [UG: Yes, absolutely] But also I think finding partnerships with others, whether they be from the pharmaceutical industry or university or other

corporates, to work together, so that we need to make sure the data we generate from our patients is used to the benefit of our patients.

But there is a bigger picture to that too, that's so long as the research we're doing with our data does that, can we also then contribute to other groups that are generating knowledge for different reasons? What's tended to happen in the past, is that people have used practice data to find stuff out that's academically interesting or commercially interesting. We can flip that a little bit now and we can do research because it's clinically relevant and interesting, but that shouldn't be a barrier to also contributing to the other types of research that we still need; we need to relate it back to benchtop research or genetics or pathology. And we can't do those within our businesses, but we have all of that beautiful clinically relevant data and trying to find ways of partnering there would be brilliant.

And it's a strength that individual practices can't gather on their own because they don't have the infrastructure, the central support teams or the expertise. They're experts at being clinicians, and we can't all be experts at everything. So they need to carry on doing that great job but get the support, as Ulrika said, from other people to maximise that, and it's really hard as a small independent practice to do that.

LC: In terms of the scale of the corporate groups, we've talked a lot about the benefits, there are challenges presumably to ensuring people are working from the same evidence?

UG: I'm not sure how much evidence we use every day. So I don't know if they know if the evidence you're using, if it's good or bad. I think they are, they are doing a lot of things upon their clinical expertise, clinical experience. But if that really is based on something, I don't know. That is sort of what I struggled with being a vet; I didn't know, I just did what I was thought was right because I was taught that way and I was trained and it worked well. But at the same time we know that the follow-up, the outcome follow-ups, the health of the patients after surgery or a medical treatment is not that well performed. Maybe on the individual patient it's well performed but not on the, how could we say, the herd level. [RD: the population level] Yeah, the population, because we don't get the good overview. And once again we need a system that can help us with that. And from that we can build up more evidence that we are doing the right thing. So if we can provide that information, I think we can really sort of sort this out and get us moving.

RD: I think it's really variable how much – between individuals – how much evidence they use or don't use. So the bigger question of 'Are they?' is one question, and definitely I have those conversations all the time, and we have the extremes of people that will do a fabulous structured bibliographic search, to people that don't at all search for anything other than potentially in a textbook, or talk to their clinical colleagues – and there's value in that too.

But obviously we have differences of opinions between vets, and some of that is sometimes evidence based, sometimes that's experienced based, sometimes it's a mixture of the two. But certainly, for example, when new products arrive on the market, the evidence base can be variable but they can still be licensed. And so one of the things that we want to do is when we produce resources within VetPartners, they're structured in a similar way, which includes some of the same language around how big the study was, or how similar the population was, to what we have. So people start to – again – talk the same language, but also by reading something that's clinically useful, they gain some skills of evidence-based medicine, which is how to critique what is there. Because yeah, sure, some people read a weak study and think it's great. Other people read a weak study, they get halfway through and put it in

the bin. And that's partly skills and training; so if you don't, have never been taught, you're probably not even going to realise that you need to do it and that you can do it.

UG: Yeah. You have to have the time to do it. [RD: You need the time, yeah.] And that is, it's usually a lack of time.

RD: And to read a primary research paper and then distil it into something that actually helps you make a clinical decision while using the art of veterinary medicine too, is a real challenge. And we need more secondary resources, I would call them – so like the Knowledge Summaries of RCVS Knowledge or BestBets, or critically appraised topics that do some of that work for the clinician. But then it's still our job to make sure it gets into the clinic and it's available. [UG And implemented.]

And implemented, yes. But there's, there's many challenges for people using evidence because sometimes they don't even know it exists; if it doesn't, you can't use it; but then you can't access it; or when you can access it, you realise it's not very useful after all.

UG: We have started now with journal clubs over Skype [RD: Have you?] Yea, so we've tried to do it that way and to get more of the critical thinking starting at least in some groups, and hopefully we can evolve that even further, very easily, the technical…

RD: Some of our practices are doing them already. We would like to, I'd like to moonlight on some of them to see which bits work for them, but they really like them and it's a good way of drawing people together when you do it virtually from different centres. So you don't necessarily have to get up at half past seven to get to work for 8am in the morning; you can do it from the road or from home. But yeah, I think that is a good way of learning.

UG: The only thing we have is issues with the language barrier sometimes. And yeah, we tried to do it in English of course, but I mean [RD: you have 11 countries], yeah.

LC: Just to add to the challenge! So can we look now at, in the corporate context, accountability – who is more accountable for clinical outcomes? Is it the corporate, is it the practices (the constituent elements)? And how (you talked a little bit about this already) but how is evaluation, to the extent that it is, conducted across the piece?

RD: I think it's all of our responsibilities, to answer the first question. Every time an animal walks into a clinic, whichever part of our clinical team sees them, that makes them responsible. We, we feel within our group that we are responsible for supporting our teams and helping them do that. We're not going to tell them what to do, so they can keep their autonomy, but we have a professional code of conduct and we are as individual clinicians responsible for clinical outcomes on an individual level. And then I think as a group, I think we have a professional and corporate responsibility to make sure the care we're giving is good for the things that are most important, which are our patients. So it goes at all levels, which is why I think more of these roles are being, like Ulrika's and mine, are being developed in corporate groups.

UG: Yeah, well, I agree. I mean it's just different levels, but still it's always the vet or the nurse that has the first responsibility or the major [responsibility] for the patient they actually…but then we do the support.

RD: Yeah. And they are, they don't, I don't think they realise their, I don't know whether power is quite the right word, but they're the only ones that can implement change and make a difference to their patients. And they want to make them better. And we, without them, we could do all the structures and the ideas in the world and it won't make a difference. So it's the true clinical decision-makers that impact care. But we do have a responsibility to look at that variation and look at why it exists, and help them to constantly improve. And that is a group responsibility, but they have the power and they are the brilliant, brilliant ones that make the difference.

LC: We've talked a lot about data and the importance of using evidence, but you also mentioned the art of veterinary science and care. And so how do we, I suppose we need to be aware of data being part of the full picture in terms of determining a treatment or care approach. So how do we avoid treatment and diagnoses becoming too data led? Is that an inflammatory question? Is that possible?

RD: I think if you, to use a word I used earlier, if you become too formulaic, you'll get into the danger zone. So if you start becoming too prescriptive about how a certain condition should be treated, then you will start to do a disservice to some patients. So trying to get everybody to do the same thing has no benefit; it has a benefit to some patients, but not all patients. So population data should inform our knowledge about a disease or the way we treat it, but then you have to turn that into individualised medicine. So people need to know what the data is, but then also as an active clinician, be able to look at their patient and see where within that population this particular individual sits, so then you can… or not – sometimes they're not; they're outliers from whatever data we have, or we don't have any data. So again, it's treating that patient as an individual, but applying the knowledge of the population – the definition of epidemiology when you're looking at it clinically – taking the population data, but not using it in a prescriptive fashion, but using that to work out this individual, where in that range within that population does it sit, therefore what the right thing to do is. We need more data, but what we don't want to do is have the tyranny of the data or the evidence dictating to clinicians what we do.

UG: No; I think that is not a risk today at all. I mean, we more lack data and so I think to be too dependent on data and telling people what to do, that is not on. And also I think from a recruitment perspective, people do not want to work in such a place where you're sort of told exactly what to do. I mean, that is if you're a veterinarian or you're a nurse. So, no, I think that that the risk of that is low.

RD: Some days it would be nicer to get closer to that [laughs. UG: Exactly!] We need more data, but then we mustn't let it overtake how you as a clinician use it. But when we do have more data, we need to make sure people understand that…

UG:…and work accordingly or maybe need to move towards some different approaches.

RD: Yeah, there's a lovely Venn diagram of evidence-based medicine where one circle is, I call it patient and customer values, and circumstance slash outcomes (it used to be just 'patient' in medicine). But then there's the clinician's experience and expertise and then there's the evidence, or you could call that data. And the holy grail is where those three circles overlap in the Venn diagram. And sometimes when you have too much data or you get a bit skewed in evidence-based medicine and you think it's all about the evidence, but it's not: the way you do that cleverly is look at your patient, your customer, client, pet, parent, whatever we're going to call it [not it]. And then know the background data for the disease or the test, but then have good clinicians with experience and expertise to implement it.

LC: Well, you just mentioned there in that, one of the elements in that diagram: the client. And I wanted us to spend some time, if we can, thinking about benefits of corporatisation or effects of corporatisation on the animal owner.

UG: Mmm, yeah. I see it as, well, you get the quality assurance along the whole chain of clinics that you provide for the owners, for us in Europe. But at the same time, of course I realise that it is utopia to get them on the same level everywhere. But I know, for instance, that we are only buying clinics that are really, sort of, good: they have top marks when it comes to certain outcomes, recordings and stuff like that. So I think I would like to start to see us as a quality signum that will help the owner. At the same time we also know that the owner is not really into quality thinking; they think if you're a vet, you're good [RD: Yes] so we need, we as a corporate also need to work much more in informing what the corporates are really doing and what kind of support the practices are getting from the group level. And we have just started that work. We have a long way to go to get more information out, and I don't mean about selling it, like commercialising it; it's more about really just telling what we are doing and why, and then it's, it's for their pet and to get the best treatment and care.

RD: Yeah, the animal-owning population put an awful lot of trust in our professions. And that's great; we need to make sure that we maintain that trust. And in the world where you can find out many facts, we need to start providing some of the information of the risk of anaesthesia or post-surgical site infection and be completely honest about that, so people start to demand it. But we do need to work with the animal-owning population; so you can still trust us, but we're now able to show in a more numerical or consistent way, that this is just how good we are. So you *can* trust us, so don't turn to get help for your animals from other groups. [UG: Yeah, transparency] Because transparency leads to trust. So if we start talking about things that need improving and we're honest with our clients about it, they should be able to still trust us. If we, if we hide that, then that makes us more untrustworthy. But there are other people competing for animal healthcare and we need to make sure we are the trusted professions to come to. And that does involve owner engagement and not letting them be fearful that things go wrong sometimes, but talk about error and risk and that we will openly accept it. And that does lead to better outcomes.

UG: And we do everything to prevent it. I mean, we have the whole preventive work behind this kind of incidents or what do you call them, patient safety events.

RD: Yes. And I think that for clinicians it's usually comforting to be able to go, 'we know this is the risk of (we can't do it very well for most things at the moment, most procedures), this is the risk of this, so actually, that's really low and your dog is in a certain demographic that it hardly ever happens' and that makes everybody feel better. Whereas at the moment, we talk about anaesthetic deaths being very rare. How rare, if you start to ask, yeah? But clients should demand a standard of care for their animals and we should provide that [UG: Yes].

LC: Is that something that you're seeing more of, do you have clients coming to you increasingly?

RD: I think they're becoming more challenging. That might be because they're more informed, ill-formed or well-informed. And we need to give, I think, our clinical teams the armour to be able to talk to that. So I think they are. There's lots of data in the UK, I don't know how it is across Europe, that people will ask their neighbour and check Google before they'll ask a vet about their pet and [UG: or the breeder] or the breeder or the pet shop or the person on the dog walk, who may or may not know something or

everything. And so if we, we need to start showing why we're the trusted place to come, and that will help. That will obviously help business too, but it'll help the patients more importantly [UG: Exactly].

LC: So at the start of the podcast, we touched briefly on the importance of culture, top-down leadership in the area of QI. Can we return and close with looking at the importance of culture, and nature of culture, in corporates, particularly in relation to quality improvements.

RD: I mean, it's huge. It's as important at corporate level as it is at practice level. And we see a variety of different types of cultures, and it's important that we put emphasis on that. As part of our clinical excellence strategy we have an initiative called the healthy clinical culture at VetPartners, and it overlaps with HR to a lot of extent. But it also, it's about creating an environment where you feel safe and everybody talks about the things they're unsure about. And everybody also talks about error. So one bit of the work that we will do, is to work with the Veterinary Defence Society in their Vet Safe initiative where people can confidentially report error. And what we'll be able to see is – practices can see their practice-level data, and we'll also be able to see corporate-level data and when you're in a big group there might be some catastrophic errors that have occurred.

Mistakes are fine, we can get through them. But it might have happened to two or three practising in the group but not others. And rather than wait for it to happen to all the others in the group, we can look at that, put interventions in place, and nobody ever has to experience the catastrophic events that follow a significant error in practice. And that's what quality improvement is about. Catastrophic error drives quality improvement, but in a big corporate group, it might have happened in two or three practices, but we can absolutely prevent it in others. But you can only do that if you've got a culture of trust and strong values that are patient centred.

UG: Yeah, I mean you really need to have a, a climate in the clinic where you sort of strive for getting better, but you scrutinise what has happened, what has been done yesterday, nightshift, and recorded. And we also have now our own computerised system where you enter the medical incidents or the patient safety events, and we get a data from the whole group into one server and we can pull out. And also, I think it was really neat that you sort of, if you find if the practice manager finds this incident relevant for others, you're clicking the box and they immediately just spread to everyone, so that you can find out very quickly that this is that 'Be aware this can happen.' And I think that is an excellent tool to prevent major damage, but also to give more information about really smaller things that you can show to others that we have solved this routine in, this way and you get the sort of the everyday practice life more smooth and easygoing. So I think we need the open culture really coming on, to bring in the quality improvements in place.

RD: And again, that has to go all the way through every practice, and all the way through the group. So people who might be the most junior vet in the practice needs to be able to talk, as openly as the senior vets in the practice, as openly as the whole of the support team. And that relies on trust, again, so if we trust each other that mistakes happen, but we will do something about it. But equally we will trust each other with and if something goes really well, we'll talk about it too [UG: Yeah, exactly].

LC: Well, great to end on a positive note; regrettably our time is coming to a close. So are there any areas of discussion today that you'd like to highlight, any closing remarks? Do you have any predictions for benefits of corporatisation in the future?

UG: I'm really looking to the digitisation area to help me, us out when it comes to quality improvement; I want to have it easy for our eager practice manager, for our eager vets and nurses that want to improve

and make it, sort of, really good tools for them to work with. I think that would be amazing – that is my own, my wishlist.

RD: I think we need to make sure we realise the idea of safety in numbers and that can be data, but that's also as coming together as a group to have a stronger voice. And corporatisation gives you that, if you all stand together and push forwards. So our patient outcomes improving, giving our clinical teams out in practice the realisation that they have that power: not just to change clinical care, but also to contribute to something that directly comes back at them, to help them improve care.

And that comes best from a clinical setting, and that clinical setting has just got bigger, so the impact should be bigger. And rather than feeling fearful of that size, actually let's look at the benefits of safety in numbers and use that to maximise the healthcare that we give. I think it's a really exciting opportunity. [UG: Super exciting, yeah.]

RD: It's why we do what we do. And that doesn't mean you can't do it as an individual veterinary practices, but they will actually get some support from us and we will get insight from them – and that is a good thing too.

LC: Rachel and Ulrika, thank you so much for your time.

RD and UG: Thank you.

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