Quality Improvement, EBVM and contextualised care

Pam Mosedale, Sally Everitt and Rachel Dean

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Pam Mosedale:
Hi everyone, lovely today to be talking to Rachel Dean and Sally Everett. We're going to talk about those three topics, evidence-based veterinary medicine (EBVM), quality improvement and contextualised care, which you all heard a lot about, but hopefully we're going to make it a little bit clearer how they all fit together. We're going to start with Rachel talking to us, telling us about evidence-based veterinary medicine.

Rachel Dean:
Thank you, and thanks to RCVS Knowledge for including me in this podcast and it's great to be talking to you too. I'm Rach, I've been a vet for nearly 30 years now and I currently work for Vet Partners as the Director of Clinical Research and Excellence in Practice. It's all about evidence-based medicine in real life. Before that, I directed and founded the Centre for Evidence-Based Veterinary Medicine at Nottingham, which was the more academic side of evidence-based medicine and evidence-based practice. And so what is evidence-based medicine?

To me, it's a concept, but it also includes quite a lot of knowledge and skills that when you become more practiced in them, it actually makes each and every decision you make easier. Because evidence-based veterinary medicine is about decision-making. And it's about understanding what we do and don't know about a particular clinical scenario, whatever the animal is you're treating, whether it be a herd of beef cows on the Outer Hebrides, a posh racehorse, or a rescue cat in Barnsley.

We make lots of different decisions all of the time. And when you're thinking about it in an evidence-based way, what you're doing is keeping the patient at the focus of what you do. And you combine the evidence, which doesn't really change much over time. So that's only one part of it. What we also add to that is our clinical experience and understanding of the case, and then the circumstances, value, and context of the client and the owner. And what we're doing is bundling all of that together so each and every decision we make is different and the most appropriate one for that patient.

The evidence from one case to another will not change. Over time, it changes, and that's progress, and that's good. But evidence-based medicine is understanding what we do and don't know and how we then apply that to the patient in front of us. It's a lot about uncertainty, which people don't like very much, but we all live in the grey. But it's also about transparency, being very clear about what we do and don't know.

Pam Mosedale:
Thanks, Rachel. And I'll just input what I think about Quality Improvement (QI). Well, Quality Improvement, I like the definition about it being there to, being the combined efforts of everybody. And I think that's why it's so important because it's a whole team effort to improve care for our patients, to improve outcomes, to improve the delivery of care, but to improve outcomes and to improve learning for the team. And I think those are the things most people go to work for in veterinary practice.

Because it's improvement, some people might think that is trying to find the best way to do something, but it's not at all. It's using the evidence base that Rachel's just talked about, and it's using quality improvement tools to measure what you do and make changes. But the most important thing is the quality aspect. We sort of say Quality Improvement without thinking necessarily about quality. But if you think of the domains of quality that we've, veterinary ones that we've brought together at Knowledge, it's about care that's safe, it's about care that's animal welfare focused, it's about care that's efficient, but it's also client focused and veterinary team focused as well as being timely and sustainable.

Quality Improvement is about balancing all those things and not doing something in one area that's going to make it worse in another area. It's very much not about finding just a best way to do things. It's about teams looking at how they do things and trying to improve them.

So, Sally, what about contextualised care?

Sally Everitt:
I'm Sally Everett. I'm the Clinical Lead for Evidence at RCVS Knowledge and also leading on the contextualised care work. Probably the most important thing in my past, apart from a lot of years in primary care veterinary practice, was I did a PhD at Nottingham looking at the factors influencing clinical decision making in veterinary practice, which has really sort of come back to the fore with a lot of this discussion.

For RCVS Knowledge, we think of contextualised care about being an approach to how we deliver veterinary care and it acknowledges that there are different ways to approach the diagnosis and treatment of animal depending on the individual circumstances, but also the context in which the care is delivered. The word context refers to all the relevant circumstances that can influence or explain a situation.

And one thing that we've started doing is thinking about this in terms of sort of concentric rings. At the centre of this, we have the animal and outside that, their owner, caregiver. And that's all the things that we already cover in evidence-based veterinary medicine explicitly, that the individual circumstances of the animal and the owner. But outside that, there are a whole lot of other rings. So next we go through to the circumstances, the context around the individual nurse or vet.

in the consultation, what are their values and experience? And then the practice, are there any particular things about the practice that impact our decision making? So that may be things like the facilities that are available within the practice, the business model, the culture of the practice, and all of these can impact things. And outside of that, we start to have things like professional regulation and ethics, legal and moral frameworks, including the status of the animal we're treating.

My favourite one here is to think about a rat which could be a very dearly loved child's pet, it could be a laboratory animal, it could be a pest and all of those things massively impact the way that we might think about it. The actual clinical bit about what's wrong with the animal may be very similar. And outside that still we have other things we need to think about.

We also have to work within the remit of public health, one health, and think about antimicrobial resistance. If we have a case that is a bacterial infection, is sensitive to various antibiotics, we may make our decisions not just based on that individual animal, but wider circumstances. And our outer ring we call sustainability, and that looks not just at environmental sustainability, but how everything within that has to be sustainable. So that's workloads, business models, being able to provide care to individual animals and their owners.

It's something that people have said perhaps we've always done, but it's also something that is quite difficult for some people. Some people feel this is a difficult way to do it. And perhaps the problem is that although we've done it in the past, we haven't done it explicitly. We haven't talked about those things explicitly. And by making the conversation explicit, we can start to talk about how we do it and how we can do it better. Sorry, I've talked too much.

Pam Mosedale:
No, not at all. That's absolutely fine. And I didn't introduce myself, which is really good when I was hosting it. I'm Pam Mosdale. I'm a vet too, and I've been qualified more than 40 years and worked always in first opinion practice and was a Practice Standards as Lead Assessor and also QI clinical lead at RCVS Knowledge. So like Sally, I've been in practice a long, long time. And like Sally, I do think of it in a way as what we've always done. But how can we help?

Those people haven't always done that. What can we do to bring this concept more to life for people?

Rachel Dean:
I think it's really interesting this idea that it's difficult. I think because our professions and our veterinary practices that are made up of a very diverse teams have always worked within these contexts. Every single patient which fits with the concepts of evidence-based medicine and contextualized care arrives with its own unique context, in its own unique context with its owners. The practice and whatever the animal health environment is politically or sustainability wise or whatever. And to me, when I think about the trial of evidence-based medicine, contextualized care fits into all of those three bubbles, because all of those rings that Sally talked about are all of the things that influence you as a clinician in making a decision that's specific to this animal, not all animals.

I don't know whether we know who's been doing contextualised care or been practicing in an evidence-based way. I don't think we've got a particularly good way of measuring that. I think where we sit at the moment is people are feeling a degree of, I work with 12,000 people. They're my current colleagues at the moment in our big organisation and I work a lot outside my organisation as well. And we have lots of people making clinical decisions all of the time. And I think some of the pressures that are going on in the profession at the moment are making people feel like they're doing the wrong thing, they're not doing the right thing.

Okay, and I think contextualized care and evidence-based health care and then using some of the QI tools and activities help us show that there is no one way. There is no right or wrong way. Nothing is covered in gold. There is no gold standard because what is, I think I used the word appropriate maybe earlier. What's appropriate for this animal, this rat that belongs to this little boy is completely different to the lab rat that you might treat in your other half of your day job, which is in the home office vet or something in the laboratory.

I think one thing we need to be careful of is that when we talk about these concepts, there is no suggestion of right or wrong. What there is a suggestion is of a variation. And it's absolutely critical to us as individual autonomous clinicians, our patients, the regulatory framework in which we work and animal health in general is that we don't start doing everything the same way because that will stop us serving public health, planet health, animal health. And actually what we need to understand is there is a choice and there is an evidence base behind those choices. And the choice that's right for this rat, I love this idea of a rat. I've got a name in my head, it's called Bert. But anyway, Bert the rat.

Sally Everitt:
That's the pet one.

Rachel Dean:
I can't help it, you who am I calling in for my consulting room? But pet Bert the rat has a whole different set of needs to elaborate or a rat in a different situation. And therefore, whilst the evidence might be the same, and it's probably a bit shaky if we're talking about rat medicine, to be honest, what we do might be different. And that's fine. What I think I probably see people misuse evidence-based medicine in the way that they think that's going to tell us what to do. But actually, we don't really want to be told what to do. We want to know what our choices are. And when we have a range of choices for any case, most of those choices will be hugely valid, OK, whether we've got an evidence base or not. Some of them, so there would be what I call the warranted variation of choice or the different decisions we make. What we have on the edges of that is something called unwarranted variation, which is where people are making decisions which are a little bit out with probably what is accepted general practice. Generally we're either under doing or over doing things and that applies to a treatment or a diagnostic or a management process. I don't know how many tangents I took us on there.

Pam Mosedale:
Quite a few. Well, that's made me think about something that I worried about a little bit in Quality Improvement is in Quality Improvement, we talk about audit and measuring and looking at the outcomes of procedures, but we also look at how people are following guidelines or complying with protocols. And I think there's still, this is one of the bug bears that Sally and I have, there's still a lot of confusion out there between guidelines and protocols for a start off.

Protocols might be something like control drug protocols, which have to be followed in, well, complied with in that way because it's a legal requirement. But when it comes to guidelines, it worries me a bit that if people are measuring how people are following guidelines, there's a kind of implication that you've got to and that's not what they're about, is it Sally?

Sally Everitt:
No, I mean guidelines are that they provide you with a sort of an area within which it's fine to work. Now that's not always in veterinary medicine how they've been written but there's some shift towards that, but I think one of the things that would be really interesting first of all the published guidelines are really, really, really unlikely to be helpful to you in your practice. They're too broad, they give too many options and you need to sit down and think about how you would want to be applying guidelines, and they could be quite broad within your practice.

But I think something that would be really interesting is not just to count the number of people who do or don't follow the guidelines but why people actually audit, why people aren't able to follow the guidelines and not assume that it's because they're

doing something wrong, but for some reason perhaps it's the guideline that needs to shift rather than the person.

Rachel Dean:
I couldn't agree more. When I think of a guideline, right, a good guideline is like a Sat Nav, okay? It's based on what we know at the moment. There might be a traffic jam on the M6, but there isn't one on the M1. So maybe the route I would go east rather than west because the M6 is broken and I want to go to Scotland. Okay, I might make that choice. But on a different day, I might make a different choice. And at times when things go wrong, you need an opportunity to be able to reroute in a different direction.

A protocol to me is like traffic lights, when it's red you stop, when it's green you go. Okay, very clear, very simple, very precise, always the same. Okay, never drive when it's red, okay, unless you're in an ambulance maybe. Maybe there's always a get out. But a guideline is a Sat Nav. And so our Sat Navs are based on maps and current knowledge coming in all of the time. A good guideline is evidence based. And the majority of guidelines that I see presented to the 12,000 people I work with every day and the rest of the professions that I work with, the rest of the time, are not very evidence-based.

They are eminence-based and opinion-based and experience-based. And in the absence of evidence, that's okay. But actually, they're not created in an evidence-based way either. There are evidence-based ways of producing guidelines. And the bit where we're often missing relates to what Sally just said, is why people are not using them. That's because most of the time they don't have utility, so they're not actually directed to the right stakeholders.

Also whatever it's talking about isn't very relevant, but also there's rarely an implementation tool. A good guideline has an implementation tool, which might be the little flex between your phone and the thing in the car that connects the Sat Nav to your car. That's the implementation tool. You actually need to be able to connect it to everyday practice. And it's only when you create a guideline that has enough choice and broad enough scope to meet the patients and the clinicians and the clinical teams and the different countries with different regulatory frameworks, when you've got a guideline that can actually fit the context and the stakeholders involved, can it be used? Can you then audit the effect of that guideline? I went to a great meeting. I often go every year, run by NYSE, to create the guidelines for human health. And they'd been going for 20-something years before they went, we haven't done any Quality Improvement.

Rachel Dean:
We've written all this beautiful evidence-based guidance with lots of choice. They hadn't really focused on implementation, and they certainly hadn't created a system

that audited. If you implement a guideline and that implementation leads to a change, we need to audit and check that that's improved the quality of care. Which is why I constantly cancel on my Sat Nav and go, are you sure you really want me to go up that road? Okay, you know, I'm always going stop route, start again. And that's how we should approach guidelines.

They're not a rule book. They won't tell you what to do in every situation, in every journey you take in your car or in your clinic.

Sally Everitt:
They can be helpful a bit like a map they can show you the alternative routes and they can give you some really useful information, but no do not follow them blindly when it tells you to turn down a one-way street or into a river or as with my Sat Nav one day told me to turn left off a gorge.

I live in the middle of nowhere and the road opposite is tiny and there's a sign that says do not follow your Sat Nav because I've watched cars reverse back onto the main road off it, but yeah absolutely.

Pam Mosedale:
I'm glad that I'm not the only one who shouts at my Sat-Nav. It's giving people the confidence, isn't it, to look at all those alternatives, because it's easier to have something to be told this is the way you must do it, but then when you can't do it because of various things, is not good for the person, for the vet involved, is it? Because they start to worry that they're not doing the right thing.

Sally Everitt:
I've certainly come across a lot of discussion, far more than I thought I would, about gold standards since I've been doing this contextualised care work. I thought it was a myth. I still think it's a myth. It's not even as good as a unicorn, not as useful as a unicorn, not a very good thing to think of at all. But there are a lot of people who use the term, now I don't think they're even thinking about it as the absolute best, but they are looking at it as the safe way to do things. It's a textbook way, it's something that if you do it you won't be criticised for and I think that is because a lot of what we're doing is dealing with uncertainty, particularly in first opinion practice.

While we might talk about approaching diagnosis, the idea that we always get a definitive diagnosis in first opinion practice is another one that probably needs to be put in the myth category. We do sometimes and sometimes it's useful but quite a lot of our patients will actually recover long before we've got as far as a definitive diagnosis. And I think there's a lot of things we need to think about and give people the confidence that they're doing a good job without having to revert to concepts of gold standard or best practice or thinking that that is the right thing to do.

Rachel Dean:
Absolutely. And that's why these discussions, I think, are so important. And I suppose after the RCVS Knowledge Day that we had in February, it made me think, right, it's time to talk about this again, because we see a lot of moral stress and injury and people really struggling with their professional identity, particularly when we've got so much pressure on us at the moment. And I find evidence-based veterinary medicine liberating, because it makes me realise it's not just me that doesn't know. We don't know yet.

Sally Everitt:
Yes.

Rachel Dean:
That's why we continue to do Quality Improvement. We continue to research because we don't know yet what the answer is. And the answer might change over time. People talk a lot about fear-based medicine. And we worry that we're practicing in a defensive way, sometimes searching for that absolute diagnosis. But we did some research at the centre way back in 2010 to 2013 that showed in first opinion consults, we only really have a diagnosis up to 30 % of the time.

You don't need a diagnosis to create an action. It's the actions that make the difference, not the diagnosis. I talk about evidence-based veterinary medicine and the concept and the thought process of being a security blanket. It helps you when you feel uncomfortable with, or helps you get used to uncertainty. But when you're fearful that something's not right, it helps you realise why we have this uncertainty and that there is no one great way. And even if there is, it will change hopefully with time, because we're a progressive industry, it's scientific industry. And therefore, our knowledge will change over time.

But I think we need to, I often talk about taking your superhero pants off. Like we're not superheroes, take them off, put your pants back on the inside and think about making great recommendations about a certain degree of choices, making it very clear with a client that there's no one perfect way. But we do have choice and that's really reassuring actually that there's not one way, there's many ways.

And I think we need to, I think a lot of people say don't use the word gold standard. And then I hear it's okay in diagnostic testing. It's not. We don't call it that either. We call it the reference test when we're comparing a new test to what we've been doing for a long time. There's no place for it. But I think we need to be careful that we don't walk, making it look like we know it all and look like we're a superhero. We all need to recognise that there's more than one way of doing something. What works in one scenario won't work in another and isn't appropriate in another. But both choices are great options for those clients. So yeah, put your pants on the inside, forget about gold. Go searching for choice and progress.

Pam Mosedale:
And I just, yeah, that so resonates with me because I've never, don't think I've ever been a superhero in practice, but I think the job satisfaction I got from being a GP vet was very much around sorting things out when the circumstances weren't ideal, either be it financial or be it owners who couldn't do certain things for their pets. I think, I think there's more job satisfaction in being able to explore all those and resolve a situation which might not easily be resolved by an obvious gold standard care plan.

Sally Everitt:
I think relating it to lot of the work that's being done with QI and about blame free cultures and just cultures, what we need to do is create environments in practices where it's okay to have these discussions. And the thing that's really important, we must have it with clients as well. It's not just for the team, the client is involved in this part of the conversation. We can't deliver the care we want to without the client, either as the person who's paying for it or, in a lot of the time, actually delivering the care to the patients. They're an integral part of what we're doing, and we must get them involved in this conversation.

Rachel Dean:
I totally agree. Again, with the evidence-based triad thinking, that's why it's so critical. If you think about it from the healthcare pathway perspective, from the moment someone calls the practice, whatever type of practice you work in, all the way through to the point at which you leave the farm, the yards, or the client leaves your consulting room and goes back out to the waiting room or leaves the practice, we need them in the decision-making journey and we take them with us.

Helping them see that there is choice and they're autonomous in it. Just like Palmas to me, it made me think of the word autonomous. Sometimes it would be great if we did have a rule book that we could just follow, and it would work every single time. But after a while that would get a bit boring and dull. And I mean, I've worked as a specialist and that really narrows your caseload. Everything becomes a lot less surprising when you're a specialist, okay? When you're a generalist, everything is surprising.

And that makes it exciting to me. That's probably why I'm taking this wonky, weird career route. And I mostly now work with people working in general practice. And when we do our Quality improvement, what we see is that variation in healthcare. Lots of people are making lots of really great, different decisions all of the time. They can make progress, all of those decisions, and make a difference on a quality improvement kind of journey to their clients, to their patients, and for themselves.

If we take away the autonomy that, OK, well, this Sat Nav route is not working. I need to now work with my client, work with my patient, work with my team, work within my professional framework, and make a different decision. That's cool. And I think that is when people start to get a bit fearful again, because the plan A didn't work, so we need a new plan B. Plan B is just as cool. And actually, if plan A was never going to work, forget plan A. Let's do this one instead. It's a really good thing.

Pam Mosedale:
It's interesting that you say about farm and equine practices there, Rachel, because I think that people are thinking about this at the moment very much through a sort of lens of small animal practice, but it's absolutely just as relevant. I think in farm practice, it's probably always been more contextualized, or is that just my opinion?

Sally Everitt:
I think there are a few reasons why it has focused on the small animal side at the moment. And a lot of that has been to do with the Competition and Markets Authority and the fact that they picked up the terminology and lots of the responses to that. The focus has been on companion animals, but I 100 % agree, it does apply to everybody. And in fact, the RCVS now having their supporting guidance that all vets and nurses should be practicing and they can texturize wear and they don't say just in small animal practice.

Rachel Dean:
I think you're right, Sally. I think some of the focus, some of the light has been shone on the small animal sector of our professions because of the CMA and other things. Potentially that it's a different type of clients. If you compare a small animal, often an equine client to a farm client, they're different kinds of relationships. They're more business to business in farm.

There are differences, but yes, the RCVS are saying, let's look at Quality Improvement, evidence-based medicine, contextualized care across all of the work in which we do, whatever you do. And I think it's really appropriate and helpful in all dimensions of care. And I was really delighted to bring one of my farm colleagues to the meeting in February, because I was told we needed more farm people. I'm like, no, I'll bring a friend. And we did and she enjoyed it very much. And what I currently love about my job, I've worked in many different species areas, and I now work in all of them and all disciplines again, it's really important that we learn from each other.

Yes, contextualized care, I think looks different in farm because it is business to business. There's maybe a stronger commercial production animal health lens, but still at the end of the day, the vet's responsibility on the farm or the vet tech's responsibility, whoever from the practice is working there still remains animal health and welfare. They were just working in a different context and whether they've done it better, more differently, I don't really know. But I think when we are challenged in

the way we are at the moment, let's not segment ourselves. Because I always learn loads, whichever group of people I'm with, I always learn something that I can take to a different group of people. It's that strength within our profession of when we come together is important.

Sally Everitt:
Being old enough to remember the previous competition or monopolies view, which focused to a large extent on farm animal side of things that eventually led to the low report and a whole review of how farm animal practice should be delivered. It's a challenging time in small animal practice, but it's also an amazing opportunity to look at what we're doing and think about whether we are aligned with what our clients need.

Rachel Dean:
Yeah, to me, it's like one big evidence-based veterinary medicine question at the moment, because the biggest question is why. And those people that know me, I'm like a toddler and I still haven't grown up, right? I always want to know why. And so it's really, this is an opportunity to look at why we do it this way. Why is the veterinary surgeons act the way it is? Why are we dispensing medicines the way we do? Because times change and we need to change too.

So yes, it can feel very challenging and threatening. But again, if we understand why we do what we do, where the choice and opportunities are, and where the opportunity for Quality Improvement and development is, then I think it can bring a really interesting future. And that's the whole concept of evidence-based medicine, Quality Improvement and probably contextualized care is making sure we move with the situation we're in and our situation has changed, which is good.

Pam Mosedale:
Yeah, all three are constantly evolving, aren't they? All three things. But can I just ask, Sally, some of these terms that we hear, spectrum of care, pragmatic care, what do they mean?

Sally Everitt:
Okay, so yeah, there are lots of terms all around, say, contextualised care has probably risen to the top because of other people picking it up. Spectrum of care and pragmatic care have probably both evolved to look at fairly similar issues about is there one way of doing it or should we be looking at a range of ways of doing it?

Spectrum of care has largely developed in the States. It came up particularly to do with issues about access and affordability of veterinary care. But the work that the American Association of Veterinary Medical Colleges have done on this has taken it way beyond that to encompass a lot of what's covered in contextualized care. They

talk about a spectrum, and it's largely divided into sort of low intervention, low cost, medium intervention, medium cost, high intervention, high cost.

But that's a very simplistic way of looking at it. And while it can be a useful way of looking at the evidence, I think we should look in a bit more detail about what they're really talking about. Pragmatic care, Rach and I once wrote a chapter on pragmatic decision making and actually understanding what it means is quite hard. In definitional terms, pragmatic means sort of practical real world as opposed to theoretical. Well, everything we do in veterinary practice is in the real world, we're having to do practical stuff. There may be some theory behind it, but I think although it's talking about many of the same things, I think the only thing I'd be a bit nervous of is it sort of become associated with particularly charity practice. And that's a very important context, but it's not the context that applies to everything all the time. And you can absolutely apply pragmatic decision making in other contexts as well, including referral practice.

Rachel Dean:
Yeah, think terminology is a very interesting thing. And I think you're right, Sally, contextualized care has floated to the top and is now being used in lots of places. And at times I see Quality Improvement and evidence-based medicine kind of used and abused to fit whatever context we happen to be talking in. And I think there's that bit of work that RCVS knowledge did with the University of Nottingham trying to sort out some of the terminology around QI and actually trying to define QI itself was really rather tricky, wasn't it?

I think we always need to be careful when we're naming things because people then want to know what it is and then they put their superhero pants on and want to just do that because that's perceived as best. if we're not careful, we then go, well, now you have to do it this way. And you're going, well, it looks a bit like I've always done it, or it looks totally different. And that's frightening. And I think we've already covered that they're not particularly new concepts, but we're, think, again, if we start saying contextualized care is the right way and everything else is the wrong way, or pragmatic is right, then we're not being very evidence-based anymore.

What we again need to think about is the patient in front of you, the context in which we're sitting, what evidence is behind that, and actually what is in the best interest of the whole partnership of patient, client, clinician, planet, law, and move forwards, which makes it very difficult and a bit messy. But I don't see any of these things as particularly different things apart from Quality Improvement is a thing that we do and are expected to do. And there are methods and frameworks to work on. Contextualized care and evidence-based veterinary medicine are ways of approaching care. And there are some skills and knowledge with all of them. But QI, can do however you choose to practice.

Sally Everitt:
The other thing I'd say is perhaps with both QI and evidence-based medicine, there was at least an outline in the medical profession that we could look at and see how we adapted. Contextualised care, although there is discussion about these things in the medical profession, is not really the same thing that we're talking about at all. And we are building this from scratch rather than bringing in something else.
I suppose one thing I ought to talk about now is the fact that RCVS and Orange are doing some research into this.

We are, as Rach has already mentioned, we had a day initially in February and we've got another one in July, but in the meantime, we're doing some research, mixed methods research with both pet owners and veterinary professionals to try and understand what's important to all of these groups in this, what they perceive contextualised care to be, what would help everybody to do it better. And that doesn't mean there's a best way of doing it, but to enable them to adapt it and apply it in their own circumstances and context.

Rachel Dean:
And I mean, I would, I think a lot of different professions, including the human healthcare profession, work in a very contextualized care way. They just might not have used that terminology. And it might be because we're a private, in the UK anyway, we're a private health industry, whereas human health is generally the public. So approaches might be different, but I think when you look at core commissioning groups in human healthcare, they are adapting it to local areas and environments.

I think it's there. just maybe hasn't got a tagline. The fifth step, the fourth step, sorry, of evidence-based medicine is how you apply what your clinical expertise, the circumstances, context value of the client, patient, farm, whichever country you're in. And you have the evidence base there as well. So once you know your question and you've looked for the evidence, you critique the evidence, you then have to apply it. And it's that application process when you're practicing in a contextualized way, because the way you apply the same evidence will vary. The QI bit is then when you audit the effect of what you've done, which we touched on earlier. I think it's being done in other healthcare settings beyond the veterinary profession, but I don't think it's sort of caught on as quite the phenomena that it seems to be at the moment. I don't know, but I really enjoy the rings, because to me, that enables you to think about all of the different things when you're applying this bit of knowledge and you've already added it to your patient and blah, blah, and blah, blah. You then have to think about all these other things. I think they're critical if you're going to apply evidence effectively.

Pam Mosedale:

And balancing them up against each other, I think that's really, really important. But I do think, Sally, that it's great that RCVS research is involving pet owners and animal owners as well, because I think that's something we probably haven't done as much as we should in the past. in Quality Improvement, we haven't really, although we do have things like client reported outcome measures around like canine cruciate registering, but involving the clients more. And I think that is something that they are trying to do more in human healthcare.

Sally Everitt:
Yeah, there are definitely lots of things in human health care that parallel but there isn't a sort of model that we can say this is how we do. And probably because the context within which we work, if we just look at the veteran profession in the UK is so much vaster than the NHS, which sort of standardises quite a lot of things, albeit there's some variation in there.

Again, I don't want to think there's going to be one way to do things. What I think we need is more tools and resources to help people do this. And I absolutely agree. I think RCVS knowledge are as guilty of this as anybody about we've got lots of tools to help with the sort of first three stages of evidence-based medicine. But the applied bit is quite difficult and it's difficult to work out exactly what tools we need. But talking about the tools that both vets and pet owners would find useful is part of our research. So hopefully we'll get through the rest.

Rachel Dean:
Yeah, and we've certainly found that in the work that I do. As I said at the beginning, so I worked in the more academic aspects of evidence-based medicine. It's now the practical bit. Often I find that people have the knowledge already and the understanding, I know I need to reduce my use of this antibiotic because of AMR and because of this and because of that. It's actually quite hard for me to change. So how do I change? And that's when Quality Improvement, I think, becomes, it's become really powerful for the people that I work with because actually, if you look at the variation, someone's already made the change that you want to do. And so, if you see that and you see that someone's done it and measured their outcomes and they're still as good, even though they've made this change already, it gives you the confidence to do it. And that's when you get that connection and you're able to change. And I think evidence-based medicine, contextualized care, QI is all about progress and change.

We have to enable people to able to do things. it's just having the, again, using the security blanket of evidence-based medicine to overcome the fear of, don't actually need to do that test, because I know not everyone does. I'm going to make the active decision not to do it this time, to be able to progress this case in the best way possible. And I think that that's where all of the things start to overlap a little bit, is where Quality Improvement can show you the quality of care amongst all of those

dimensions that you talked about at the start. These options are equally safe, equally welfare centred. They might have differences in efficiency or be less timely in some way, but they all have value and are all good.

Pam Mosedale:
Absolutely, and I think that's so important, isn't it? And change management is a fascinating subject all in itself, isn't it? That we could talk about for ages. But think having tools is really important. And we have got even already one or two practical tools, haven't we, Sally, around questionnaires that we can use for...

Sally Everitt:
We've just started some very basic discussion guides which are really to help structure the conversation. The first thing to do is to pre-warn our clients. If you ask them a lot of these contextual factors when they're in the consulting room, they're going to get overwhelmed and look like rabbits in the headlight because they haven't come in expecting to do this. We've got some tools that you can use with your clients. They can be downloaded from the website.

Show them access, can give them the links, you can download them and hand them out or send them out. But they're really to help the clients think about what their values and expectations of a consultation are before they get there. They're sort of prepared. We're all a bit time poor in all of this, trying to do everything in a consultation. So have a look at the discussion guides. Absolutely. Look out for when our research results come out. We hope that they will be out published by the Autumn and we will then start to look at how we can develop some tools out of all that. And perhaps the first, really first and easy step that doesn't require anything else is just think when you're in a consultation, when you're thinking about these things, think about what are the contextual factors, all these different layers that are impacting your decision in this individual case. Because you'll be surprised how many there are.

Rachel Dean:
Reminds me of the What Matters to You campaign that they did in the NHS, which again, that really helps you with the context and your ability to apply. Working with your client about what really matters to them, because you might be worrying about the lump, but they really care about the cough. And sometimes you don't know that unless you ask some of those contextual questions. And I think the increasing amounts of research we see with our clients and around decision making from RCVS knowledge and other groups is really critical to understanding.

Pam Mosedale:
So talking about being time poor, I'm afraid we're coming to the end of our discussions now, but Sally, thank you. That was a really good summary and Rachel. And What Matters to You, we've also got loads of resources around that at RCVS

Knowledge, Quality Improvement, which is about talking to your team about what matters to them as well.

Thank you very much. We hope that we've started you thinking about the subject.

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