Frequently Asked Questions (FAQs)

Quality Improvement (QI) Queries – all sites:

1. **When will my site find out when they are to receive the Quality improvement intervention?**
   The QI team will give you 12-14 weeks' notice before your cluster is activated. There will be a cluster activation meeting and we will attempt to find a suitable date to fit with the schedules of the majority of local QI leads.

2. **Isn't EPOCH an audit / quality improvement cycle rather than research?**
   At a site level, EPOCH will operate very much like quality improvement cycles combined with audit (NELA). EPOCH is designed to investigate whether these cycles and other QI activities within the EPOCH intervention across our 94 sites improve patient outcome, reduce LOS etc. hence why this is research and requires REC approval etc.

3. **Will the QI team be visiting each EPOCH site?**
   No, there will be one face-to-face meeting with the QI team which will be at your cluster activation education meeting.

4. **Where will the QI meeting be held?**
   It will be held at a local venue within your cluster.

5. **What will happen once we are activated?**
   We will provide you with training and on-line educational resources in the way we would like you to approach your QI activities - this will follow the Model for Improvement
   We will also suggest which of the EPOCH Care Pathway recommendations you start to tackle first. Beyond this, sites will have some freedom to move forward with their implementation at the pace and in the manner that they are comfortable with. Monthly follow up calls with a QI lead from each site will help us keep track of progress and offer support and advice.

   So in short, there will be clear structure for you to work within but local adaptation is certainly allowed.

6. **Would it be advisable to start priming A/E, radiology, recovery, theatres now, and if so will that not affect the validity of the baseline NELA data?**
   'Priming' colleagues and departments and starting to build a consensus about to move forward is good. Actually implementing change and measuring this would have an effect on results obviously and we would discourage that but of course we cannot stop you. We have sites involved in EPOCH that are widely varied in how much their current care looks like the EPOCH Pathway. To some extent the trial design can account for this and secular improvements over time. If your site wanted to start full scale implementation prior to EPOCH activation, we would need to discuss this and consider whether your site could remain in the study.

7. **Why don't we all just introduce this care pathway now, why do we have to do a trial?**
   This care pathway is a modified version of the one developed and published by the RCS in 2011 and hospitals could have adopted that at any time since then. Not a great many have. This now gives us an opportunity to study whether implementing a complex intervention, for which there is broad (but not universal) consensus, using quality improvement methods can be effective. An ethnographic sub-study will also give us answers to facilitators and barriers to improvement to provide learning for the future.

8. **We are worried that there are some recommendations that we'll really struggle with, such as Critical Care admission for all these patients.**

   The important issue from the quality improvement (QI) viewpoint is that you work on *improving reliability.* However, we do not expect sites to have >95% reliability for the EPOCH recommendations by the end of the study period.

Let's use a real life example of 2 sites trying to improve Critical Care admission. At Hospital 1 they have over 80% reliability with their critical care admissions for these patients. At the Hospital 2 they are at about 60%. However the Hospital 1 had started the project with a much higher baseline, around 60%, whilst the other started on around 10%. So in terms of success Hospital 2 has achieved much more, with the potential improvement in outcome potentially much greater.

We are looking for improvement, not perfection. We are, of course, aiming for 'gold standard care' that is reliable 95% of the time, but in the real world we know that can take a long time to achieve.

We will also be seeking to understand the barriers and solutions to implementation, both pro-actively during the trial (to support you as investigators) and also in the post-trial analysis.

9. **Will the 6 hours to theatre from decision to operate recommendation be for all patients? What about those that are expedited rather than emergent?**

   From a QI point of view, a slow decision to operate followed by failures in booking and performing the procedure are what the '6-hour' window aims to prevent. There will always be variations to any pathway. If a sub-acute case, for example, has a consultant led decision to delay surgery and this is clearly documented, then that is of course an acceptable variance.

10. **What are the 'Where are we now' presentations we have to prepare as part of the activation meeting?**

    These presentations will use baseline data from your own NELA data plus a small (5) case note review. About 4-5 weeks before the cluster activation educational meeting we will send out a short but detailed list of pre-activation instructions

11. **Can we continue to use local protocols and guidelines for care covered by the EPOCH recommendations?**

    If local guidelines / protocols exist that can be used to fulfil the components of the care pathway then it will be entirely appropriate to write these into your own pathway. Similarly if there is a desire to create local guidelines then that will be acceptable. There will be several protocols available for sites that wish to use an 'off the peg' item.