Paper 2

NATIONAL QUALITY BOARD

For meeting on: 10 August 2018

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Paper for:

Decision	Discussion	Information
X	X	

ESTABLISHING THE NATIONAL CLINICAL AUDIT AND PATIENT OUTCOMES PROGRAMME PARTNERS GROUP

SUMMARY

This paper outlines a proposal for the establishment of a National Quality Board (NQB) sub-group which would bring together NQB member organisations to advise on the content of the National Clinical Audit & Patient Outcomes Programme (NCAPOP) and consider ways of implementing national clinical audit recommendations to improve care quality.

PURPOSE

The NQB is asked to:

1) **Consider** the opportunities to stimulate quality improvement in heatlhcare services in England presented by national clinical audit;

2) **Endorse** the establishment of a national clinical audit (NCAPOP) Partners Group which will both ensure the NCAPOP portfolio best supports the collective aims of the NQB's members and consider national clinical audit recommendations on a regular basis, to maximise opportunities to improve the quality of patient care. As a sub-group of the NQB, the group's Terms of Reference and Work Plan will be shared with the NQB for approval and regular progress updates will be provided; and

3) **Nominate** representatives from NQB member organisations to join the NCAPOP Partners Group.

ALB Involvement in development and sign-off of paper:

NHS England	Care Quality Commission	NHS Improvement	NHS Health Education England
X	X	X	

Public Health England	NICE National Institute for Health and Care Excellence	NHS Digital	Department of Health
X	X		

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1. INTRODUCTION

1.1 This paper follows up on a discussion at the NQB's November 2017 meeting. At that point there was general support for this proposal to establish a National Clinical Audit & Patient Outcomes Programme Partners Group however it was decided to postpone a decision until the contract to manage the NCAPOP was awarded. The contract has since been awarded to the Healthcare Quality Improvement Partnership (HQIP) and so work on this has been re-invigorated.

1.2 This paper also provides more examples of national clinical audit content and recommendations to illustrate the opportunity presented to the NQB.

2. BACKGROUND

2.1 Clinical audit offers a way to find out if healthcare is being provided in line with standards, such as NICE clinical guidelines, and lets care providers and patients know where their service is doing well, and where there could be improvements.

2.2 National clinical audit brings together data on clinical process, structure and outcomes from various sources (e.g. HES, ONS and bespoke locally collected data) but, crucially, is only instigated when the clinical question cannot be reliably answered by any other single national dataset, or where national data needs expert analysis and presentation to make sense of it for quality improvement purposes. It is particularly useful in providing comparative measurements of healthcare quality.

2.3 NHS England funds the National Clinical Audit and Patient Outcomes Programme (NCAPOP) with a financial contribution also made by Welsh Government. It consists of up to 40 audits and outcome reviews, also known as national confidential enquiries, on the most commonly occurring conditions. Each of these audits is commissioned and managed, on behalf of NHS England, by the Healthcare Quality Improvement Partnership (HQIP – a registered charity set up to advance healthcare quality). A list of audits and outcome review programmes in the NCAPOP portfolio can be found at Annex A.

2.4 NHS England assumed responsibility for the NCAPOP contract from the Department of Health in 2013, on the basis of its statutory duty to promote quality improvement. NHS England relies on national clinical audit for:

- monitoring and stimulating improvement in care associated with clinical corporate priorities, for example, adult and child diabetes, cancer, maternity and psychosis audits;
- supporting commissioners to identify and tackle variation through Rightcare, for example the diabetes audit;
- informing the development of payment mechanisms, for example the national hip fracture database, stroke and cardiac audits, or evidencing national CQUIN compliance, for example the psychosis audit;
- identifying and responding to serious national incidents or areas of concern, for example the new child mortality database, the learning disabilities mortality review and the national confidential enquiry into patient outcome and death; and
- supporting commissioning of specialised services, for example the specialised cardiac care and paediatric intensive care audits.

2.5 National clinical audit is also used:

- by local care providers for quality improvement – it is particularly valuable for providing benchmarked data to identify variation in healthcare;
- for local quality assurance, for example in annual Quality Accounts;
- by the Care Quality Commission in quality inspections;
- by the National Quality Board to support Quality Surveillance Group work;
- by NHS Improvement – particularly to support Getting it Right First Time'GIRFT products;
- for research into clinical effectiveness; and
- to stimulate improvements in data quality through audit results publication.

2.6 Whilst national clinical audit should be seen as a key resource or tool to stimulate quality, more could be done to shape clinical audit so it answers the key questions relating to major challenges in healthcare. For example those relating to the safety of particular services.

2.7 National clinical audits routinely produce quality improvement recommendations based on their findings and many are aimed at national organisations. However it is not clear whether these are always responded to. Moreover other programmes also produce recommendations on similar topics, for example the GIRFT and patient safety programmes and these may benefit from closer alignment. Some recent examples of national clinical audit recommendations can be found at Annex B.

2.8 We now have an opportunity to both help define the clinical audit questions audit asks and help shape and respond to recommendations.

3. PROPOSAL

3.1 Representatives from NHS England, NHS Improvement, Care Quality Commission, Public Health England and HQIP met to discuss the value of establishing a forum in which to do this. There was consensus that such an NCAPOP Partners Group could be usefully convened to address this matter.

3.2 The group recommended the new NCAPOP Partners Group should do two things. It should help to shape the NCAPOP portfolio, where there is opportunity to do so. And it should also review the ways in which clinical audit recommendations can sustainably support delivery of the objectives of the NQB members to improve patient care. This should include an assessment of any work already being done to address clinical audit findings.

3.3 The group felt that there was an opportunity for national clinical audits to: play a more central part in helping to monitor safety; go further to integrate audit data with information to support CQC quality inspections; and support individual doctors to maintain professional standards through alignment with medical revalidation.

3.4 The following principles or parameters were also raised by the review group:

- Policy leads should be more involved in the design of future clinical audits to ensure audit questions are better aligned with the objectives of the NQB's members and the forthcoming 10 year NHS plan.
- Where possible recommendations should be aligned with other national reports such as GIRFT and patient safety reports.
- The Partners Group should also distil audit recommendations so they are concise and able to have more impact.
- Communications representatives should be involved in the work to help target key messages from national clinical audits to those who are able to effect improvement.
- Whilst the group's membership should be stable with comprehensive representation from NQB representatives, the attendance of relevant experts and clinical audit providers should be dynamic according to the topic.
- Because of capacity constraints it may not be possible to review all audit reports regularly and so thought should be given to criteria for prioritising the attention given to clinical audit recommendations.
- The Group should be aware that much of the ability to effect change recommended in clinical audits sits with clinical and professional groups and

therefore the attendance of professional bodies/ royal colleges, who are often also audit providers, will be important.

4. PURPOSE

4.1 The NQB is asked to:

1) **Consider** the opportunities to stimulate quality improvement in heatlhcare services in England presented by national clinical audit;

2) **Endorse** the establishment of a national clinical audit (NCAPOP) Partners Group which will both ensure the NCAPOP portfolio best supports the collective aims of the NQB's members and consider national clinical audit recommendations on a regular basis, to maximise opportunities to improve the quality of patient care. As a sub-group of the NQB, the group's Terms of Reference and Work Plan will be shared with the NQB for approval and regular progress updates will be provided; and

3) **Nominate** representatives from NQB member organisations to join the NCAPOP Partners Group.

Welsh Government co-fund NCAPOP and as such, they will also be represented on the NCAPOP Partners Group.

ANNEX A: List of clinical audits and outcome review programmes

AUDIT	**Contract end date**
Head and Neck Cancer (HANA)	May 2017
Venous Thrombo-Embolism	Dec 2017
Chronic Kidney Disease	Dec 2017
Inflammatory Bowel Disease	Jan 2019
Mental Health Clinical Outcomes Review Programme (NCISH)	Mar 2019
Learning Disability Mortality Review Programme	May 2019
Specialist rehabilitation for patients with complex needs	Dec 2018
National Maternal & Perinatal Audit	June 2019
Ophthalmology	Aug 2019
Dementia	Dec 2019
Child Health Clinical Outcomes Review Programme	Dec 2019
Medical & Surgical Clinical Outcomes Review Programme	Mar 2020
Lung Cancer	Mar 2020
Breast Cancer	Mar 2020
Cardiac 1	June 2020
Cardiac 2	June 2020
Cardiac 3	June 2020
Cardiac 4	June 2020
Cardiac 5	June 2020
Cardiac 6	June 2020
Diabetes: Paediatric	Apr 2020
Psychosis	Apr 2020
Anxiety & Depression	May 2020
Maternal and Newborn Infant Clinical Outcomes Review Programme	June 2021
Emergency Laparotomy (NELA)	Nov 2020
National Vascular Registry	Dec 2020
Chronic Obstructive Pulmonary Disease (COPD) & Asthma	Feb 2021
National Neonatal Audit Programme (NNAP)	Mar 2021
Epilepsy 12	Mar 2021
Paediatric Intensive Care Audit (PICANET)	Mar 2021
Falls & Fragility Fracture Audit (FFFAP)	Mar 2021
Sentinel Stroke (SSNAP)	Mar 2021
Oesophago-gastric Cancer recommissioned as part of the GI portfolio programme	May 2021

Bowel Cancer recommissioned as part of the GI portfolio programme	May 2021
Prostate Cancer	June 2021
End of Life	Sept 2020
Diabetes: Adult	June 2020
Rheumatoid & Early Inflammatory Arthritis	Sept 2020
National Child Mortality Database (NCMD)	Mar 2022
National joint registry	Ongoing

ANNEX B: Recent examples of national clinical audit and outcome report programme recommendations for quality improvement

Maternal, Newborn and Infant Clinical Outcome Review Programme

Published by: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester on behalf of Mother and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) collaboration.

Perinatal Mortality Surveillance Report

UK Perinatal Deaths for Births from January to December 2016

This is the fourth MBRRACE-UK Perinatal Mortality Surveillance Report and provides information on extended perinatal deaths in the UK and Crown Dependencies arising from births during 2016.

This report focuses on the surveillance of all late fetal losses (22+0 to 23+6 weeks gestational age), stillbirths, and neonatal deaths.

There are 11 recommendations in the report:

1. In order to achieve Government ambitions renewed efforts need to be focussed on reducing stillbirths and continuing the slow but steady decline in neonatal mortality rates observed since 2013.

2. In order to facilitate the close working between MBRRACE-UK and the PMRT, within Trusts and Health Boards all stillbirths and neonatal deaths should be entered onto the joint web-based system as soon as possible following the death.

3. Commissioning organisations should review both their crude and stabilised and adjusted mortality rates to facilitate the identification of high risk populations and to target interventions for existing inequalities.

4. Trusts and Health Boards with a stabilised and adjusted stillbirth, neonatal mortality or extended perinatal mortality rates that falls into the red or amber band should carry out an initial investigation of their data quality and local factors. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should engage with the use of the PMRT to review their stillbirths and neonatal deaths.

5. Trusts and Health Boards should ensure that the data provided to MBRRACE-UK is of the highest quality. This is of particular importance for those providing the most complex care to particularly high risk mothers and babies as this will permit more appropriate sub-analyses and comparisons.

6. A national forum should be established by NHS England, NHS Scotland, NHS Wales, and Health and Social Care in Northern Ireland, in conjunction with professional bodies and national healthcare advisors responsible for clinical standards in relevant specialties, to agree an appropriate benchmark for monitoring stillbirth and neonatal mortality rates for the UK.

7. Public health initiatives should continue to be developed to reduce the impact of known risk factors on mothers and babies.

8. Trusts and Health Boards should identify a small local team of health professionals to focus on the quality of cause of death coding.

9. All parents of babies who die should be provided with unbiased counselling for post-mortem to enable them to make an informed decision.

10. Placental histology should be undertaken (if possible) for all stillbirths and anticipated neonatal.

11. All Trusts and Health Boards should endeavour to improve the quality and completeness of data reported to MBRRACE-UK and for routine in patient, and birth and death registration purposes. Children's hospitals should continue to develop and embed systems that allow for consistent liaison with birth hospitals to facilitate the collection of maternal details.

Asthma Audit Development Project (AADP)

Published by: Healthcare Quality Improvement Partnership (HQIP) – provider Royal College of Physicians (RCP).

Asthma is the most common lung disease in the UK, with approximately 8 million diagnosed cases (12% of the population), up to 5.4 million people actively receiving treatment and around 160,000 new diagnoses each year. Asthma accounts for 60,000 hospital admissions, 200,000 bed days, approximately 6.4 million GP and nurse consultations and an estimated cost of £1.1 billion a year to the UK health service.

There are 18 recommendations in the report as follows:

1. Patient representatives should be identified and embedded into the audit governance structure; this should include a PPI group if possible.

2. The areas of asthma care identified by the Patient Focus Group as of most importance should be considered and included in the content and structure of the National Asthma Audit.

3. That clinical datasets are subject to continued streamlining, with an aim for completion of 5–10 minutes, to reduce clinical burden further. As additional time may have been required to complete the pilot Excel data templates, time to complete should be re-tested once the audit webtool has been fully developed.

4. That organisational datasets are also subject to refinement and streamlining activities to reduce the time and resource required to complete them.

5. Work around integration with the COPD component of the joint audit should continue as this may lead to efficiency gains and further reduce clinical burden.

6. To build a robust webtool, with sound and effective validations to ensure that the risk of missing or illogical data is reduced and to house both the clinical and organisational datasets enabling online data entry and efficient data reporting.

7. Identify SNOMED CT translation for the Read codes for each query in preparation for the transfer over to this coding system in May 2018.

8. Work around integration with the COPD component of the combined audit continues in order to ensure the extraction process for both components is robust, efficient and facilitates joint extraction of asthma and COPD to reduce resource and cost.

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10. Joint extraction of asthma and COPD data enables investigation of Asthma COPD Overlap (ACO); therefore, exploration should take place as to how data is analysed for patients with both asthma and COPD.

11. Each of the datasets outlined above (HES APC dataset, Emergency Care Data Set, ONS mortality dataset, National Business Authority – Prescription Information Services) should be considered and their use planned for by the National Asthma Audit.

12. Continue to review status of currently unusable (eg ambulance, HES outpatient and pharmacy) datasets. If status changes, consider incorporation.

13. Continue to liaise with Asthma UK and PPEP around how their existing data could be used and integrated into the audit.

14. Carry out a pilot using the Friends and Family test data in order to provide some insight into its usability and the conclusions which could be drawn from it.

15. Explore webtool development, and the costs and resources required to develop a bespoke national PROMS/PREMS audit.

16. Work around integration with the COPD component of the combined audit should continue to ensure that, where possible, joint information governance arrangements are made to reduce cost and resource.

17. Investigate how the Information Governance approach for the National Asthma Audit will be affected by the National Data Opt-Out (England only) and the new General Data Protection Regulation (GDPR) and provide the information and support necessary in all Information Governance materials.

18. Webtool development deliverables are identified and outlined within a formal document. A webtool developer is identified and the requirements (using the deliverables as a basis for this) agreed.

Paper 2

National Clinical Audit of Psychosis

Published by: Healthcare Quality Improvement Partnership (HQIP) in collaboration with the Royal College of Psychiatrists.

People with psychosis often require intensive, long-term treatment and care from a multi-professional team and a range of service types. This means that the quality of care they receive is an indication of the overall quality of mental health services. Thus, this report is a valuable source of information about the quality of NHS mental health care across England and Wales. The fact that all Mental Health Trusts and Health Boards in England and Wales participated is a testament to the work of the audit team at the Royal College of Psychiatrists and the commitment of NHS staff towards assessing and improving quality of care.

The results of this audit will help local services identify priorities for local quality improvement and will support the work of Care Quality Commission and other regulators in efforts to ensure that people with severe mental illness receive the safe and effective services they deserve.

There are 6 recommendations in the report as follows:

1. Ensure that all people with psychosis:

    - have at least an annual assessment of cardiovascular risk (using the current version of Q-Risk)
    - receive appropriate interventions informed by the results of this assessment
    - have the results of this assessment and the details of interventions offered recorded in their case record.

2. Ensure that all people with psychosis are offered CBTp and family interventions, by:

    - deploying sufficient numbers of trained staff who can deliver these interventions
    - making sure that staff and clinical teams are aware of how and when to refer people for these treatments.

3. Ensure that all people with psychosis:

    - are given written or online information about the antipsychotic medication they are prescribed

- are involved in the prescribing decision, including having a documented discussion about benefits and adverse effects of the medication.

4. Ensure that all people with psychosis who are unable to attend mainstream education, training or work, are offered alternative educational or occupational.activities according to their individual needs; and that interventions offered are documented in their care plan.

5. An Annual Summary of Care should be recorded for each patient in the digital care record. This should:

    - include information on medication history, therapies offered and physical health monitoring/interventions
    - be updated annually
    - be shared with the patient and their primary care team.

6. NHS Digital, NWIS, Commissioners, Trusts and Health Boards should work together to put in place key indicators for which data can easily be collected, perhaps using an Annual Summary of Care (see Recommendation 5, above). This work should be informed by the NCAP results and the experience of the NCAP team.