National Clinical Audit Advisory Group

Annual Report 2008-9

Executive Summary

During our first year we have successfully established working arrangements, including three sub-groups, and sought to communicate our activities and emerging policies through members' participation in national meetings and through our website.

We have pursued four principal strategies:

• improving the quality of clinical audit
• clarifying the commissioning of national clinical audits (NCAs)
• responding to national and local needs
• increasing the impact of clinical audit

To achieve these we have:

• defined the role of clinical audit, clarifying its relationship with research, service reviews and quality improvement
• established criteria for assessing the quality of NCAs
• established an annual commissioning cycle for funding renewals of NCAs
• proposed transparent, equitable entitlements for funding for NCAs
• established a dialogue with local and national clinical audit staff via meetings
• set up a responsive funding scheme for new NCAs which resulted in six new audits
• sought to align clinical audit with the bodies that define good quality care (eg NICE, royal colleges, national clinical directors, ) and those that seek to improve quality (regulation, performance management, education, revalidation, legislation)

In 2009-10 we plan to: create portfolios of good quality local and national audits; establish an advisory service for NCAs; develop strategy for education and training of clinical audit staff and clinicians; refine the criteria for selecting topics for NCAs; extend the scope of NCAs to encompass primary and social care, and patient reported outcomes; establish funding policies for NCAs to allow the development of new audits from the NCAPOP budget; and encourage wider participation in clinical audit policy making, management and delivery through support for the National Clinical Audit Forum.
Background

History
The establishment of the National Clinical Audit Advisory Group in April 2008 marked the creation of a voice for clinical audit in the Department of Health and at the centre of the NHS. Unlike the two other core professional activities aiming to enhance health care quality, namely education and research, clinical audit had lacked a national strategy and a coherent programme of activities. NCAAG will endeavour to meet that challenge by enhancing the existing programme of national clinical audits and seeking to support the many NHS staff involved in local audits in their own Trusts. It will also seek to improve connections - between the centre and the periphery; between national clinical audits, regardless of their source of funding; between audit and quality improvement initiatives such as revalidation, regulation and commissioning; and between clinical audit and other routine data collection in the NHS.

Responsibilities
NCAAG's responsibilities are:

- to drive the reinvigoration of clinical audit, both nationally and locally, yielding new publicly available information to support improvements to clinical practice and service delivery

- to be steering group for the expanded National Clinical Audit and Patient Outcomes Programme (NCAPOP), providing advice and guidance on the overall programme of work, and in particular to consider proposals for new audits or for discontinuing existing audits

- to advise on clinical audit issues as requested by the Department of Health.

The National Clinical Audit and Patients' Outcomes Programme (NCAPOP), previously managed by the Healthcare Commission, has from April 2008 been managed by the Healthcare Quality Improvement Partnership (HQIP) - a charitable company established by a consortium comprising the Royal College of Nursing, National Voices (previously, the Long Term Conditions Alliance) and the Academy of Medical Royal Colleges.

Membership
To achieve these goals, the members of NCAAG reflect the diverse range of backgrounds, skills and interests that are needed to understand the challenges and devise appropriate policies:

Nick Black (Chair)  Professor of Health Services Research, London School of Hygiene & Tropical Medicine
Boo Armstrong  Managing Director, Get Well UK
Martin Ferris  Head, Clinical Audit and Effectiveness, Sheffield PCT
Mick Peake  Consultant in Respiratory Medicine, University Hospitals of Leicester NHS Trust
Pauline Ong  Professor of Health Services Research, Keele University; Chair, Central and Eastern Cheshire PCT
Andrew Middleton  Ex-CEO Stamford College of Further Education; Non-Executive Director, Lincolnshire PCT; Lay Member, NMC
Geraldine Walters  Director of Nursing; Director of Patient Involvement, Governance, and Infection Control, St George's Healthcare NHS Trust.
Mark Gritten  Ex-CEO NHS acute Trusts
Jan van der Meulen  Professor of Clinical Epidemiology, London School of Hygiene & and Tropical Medicine; Director, Clinical Effectiveness Unit, RCS
Danny Keenan  Consultant Cardiothoracic Surgeon, Manchester Royal Infirmary; National Clinical Advisor, Healthcare Commission
Terry Butler  Ex-Director of Social Services, Hampshire; Non-Executive Director, NHS South Central; General Social Care Council member
Sarah Schofield  General Practitioner, Southampton; Clinical Director, Hampshire PCT

The Group recognises that success will only be achieved by listening to and working with all those already engaged in clinical audit both locally and nationally. Together, clinical audit can be invigorated and enhanced so that it takes its rightful place at the centre of health care delivery and policy.

Working arrangements
NCAAG meets quarterly to discuss policy and strategy for clinical audit and to make recommendations to the DH. In addition, three sub-groups have been established to undertake aspects of operational management of national clinical audits (NCAs) and make recommendations to the full Group:

- New NCAs Sub-Group: chaired by Pauline Ong; responsible for considering and assessing expressions of interest and tenders for new NCAs in both the centrally commissioned scheme and the responsive scheme
- NCA Renewals Sub-Group: chaired by Mark Gritten; responsible for considering the case for renewal and assessing tenders for renewals of NCAs
- NCA Advisory Sub-Group: chaired by Jan van der Meulen; responsible for providing comments and advice on NCAs being funded by the Department of Health but not part of the NCAPOP

The work of NCAAG is supported by a secretariat provided by HQIP.

Communication
A website (www.advisorybodies.doh.gov.uk/ncaag/) provides information on the work of NCAAG including the agenda and minutes of its quarterly meetings.

Members have described the work of NCAAG at many national and regional meetings including: National Hospital for Neurology & Neurosurgery, London; Strengthening Clinical Leadership Meeting, London (Health Foundation); SE Clinical Effectiveness Network; W Midlands SHA; Clinical Audit Meeting, Manchester; Clinical Audit 2020, Leicester; Medical Directors Conference, London; Welsh Clinical Audit Conference; NICE Conference, Manchester; National Clinical Audit Conference 2009, London; Reinvigoration of National Clinical Audits, London; Local Clinical Audit Reinvigoration, Sutton Coldfield; Mid Yorkshire Hospitals; East Midlands Clinical Audit Network; Greater Manchester Clinical Audit Network.
Strategies
During the first year we have been pursuing four broad strategies:

1. Improving the quality of clinical audit

Defining 'clinical audit'
To ensure consistency, we have defined 'clinical audit' and clarified how we see it contributing to the quality management framework described in the Next Stage Review. The latter identifies three dimensions to quality of care:

- safety
- effectiveness
- humanity/responsiveness (experience)
(We would also include 'equity' as a fourth dimension)

Achieving high quality care requires three activities:

- defining what constitutes good quality care (usually described in guidelines, based on scientific evidence and clinical experience)
- assessing the quality of care provided (clinical audit; patient experience surveys; critical incident enquiries; qualitative methods)
- improving the quality of care provided (education; performance review; incentives; regulation; redesign; legislation)

Clinical audit is the quantitative assessment of the quality (principally the effectiveness) of care being provided compared either to agreed, documented evidence-based criteria or to the performance of other providers or commissioners. Its aim is both to stimulate quality improvement interventions and to assess their impact.

It is important to distinguish clinical audit from three other related activities:

- quality improvement
  Clinical audit is limited to quality assessment and does not encompass activities employed to improve quality (such as redesign of services, regulation, education, legislation). The responsibility of clinical audit is to identify shortcomings in quality of care, stimulate quality improvement and subsequently assess the impact of any quality improvement activities. The important implication of this is that clinical audit should not be judged in terms of improvements in the quality of care.

- research
  Clinical audit aims to assess the quality of care being provided, in particular the extent to which care is consistent with best practice and achieving expected outcomes. In contrast, research (evaluation) aims to establish and define what constitutes best practice. Research plays a valuable role in enhancing quality by producing knowledge to inform guidelines of best practice.
• service review
Clinical audit differs from service review which aims to provide a snapshot
description of the state of a service, usually in one locality (though it
may take a nationwide perspective) and is often concerned with inputs rather
than processes or outcomes. Such reviews are generally one-off with no
attempt to re-review.

Criteria for assessing NCAs
We have assisted HQIP in establishing explicit criteria by which tenders for new
NCAs and renewals of existing NCAs will be assessed. Use of these criteria will
contribute to improving the quality of NCAs. The criteria cover:

• Participation
  Extent of participation of provider; Local workload; Patient/carer recruitment
  (ascertainment) rate; Duration of data collection; Recruitment strategy

• Data and analysis
  Data completeness and accuracy; Analysis; Exploitation of existing data;
  Linkage to other data sources; Data security; Data confidentiality

• Criteria assessed
  Input and/or process audit; Outcome audit; Patient experience audit

• Output
  Professional audiences; Presentation; Patients; Management of outlier
  providers

• Additional uses of the data
  Incorporation in Quality Metrics/Quality Accounts; Revalidation of
  professionals; Regulation of organisations; Research; Commissioners;
  Patient safety; International comparisons

• Organisation/governance of the project
  Relevant clinical leadership; Other essential team members (methodologists,
  patients, IT specialists); Management arrangements; Communications policy;
  Plans for sustainable funding; Risk management.

• Cost
  Value for money; cost per patient recruited.

2. Clarifying the commissioning of NCAs

Annual commissioning cycle (renewals)
Renewals for one year were undertaken during 2008-9 to ensure there were no
damaging delays for existing audits. HQIP have now established an annual planning
cycle for renewals for 2009-10. For NCAs with contracts that are due to end in March
2010, the renewal cycle will commence in April 2009 and recommendations will be
made by NCAAG to the DH in late September. The process will encompass external
peer reviewers (clinical and methodological) to help the NCAAG Renewals Sub-Group in its deliberations.

Commissioning new audits
There are three groups whose views are key in helping us identify new topics for auditing: the National Clinical Directors, together with DH Policy Leads; the Royal Colleges and specialist associations; and the National Institute of Health & Clinical Excellence (NICE). Together with HQIP, we have established a formal Memorandum of Understanding with NICE.

Less formal communication has been undertaken with the other groups. The Chair of NCAAG has met collectively with the National Clinical Directors twice, plus individual discussions with those responsible for Renal Services, Women & Child Health, Cardiovascular diseases, and Diabetes. Discussions have also been held with the presidents of several royal colleges (Physicians; Obstetrics & Gynaecology; Paediatrics & Child Health; Surgeons; Anaesthetists).

Consistency of funding entitlements
To ensure consistency in funding NCAs, funding entitlements have been made explicit and NCAAG has recommended that these are introduced for all new and renewed contracts:

- overheads (indirect costs) will be paid based on 46% of staff costs
- local data collection costs will not be met (though consideration will be made to fund the cost of collecting new data in primary care)
- senior clinician salaries will be paid for time spent on practical involvement (such as analysing data and preparing outputs) but not for providing leadership and clinical advice

Many successful audits already operate within these entitlements and their universal adoption will ensure consistency and enable the number of NCAs that can be supported to be maximised.

3. Responding to national and local needs

Local audit staff
Although much of the attention and work of NCAAG during its first year has focused on NCAs, of equal importance in leading the reinvigoration of clinical audit is the support and development of local clinical audit. Some of the NCAPOP budget (previously exclusively for NCAs) has been allocated to the latter. Work has been led by HQIP, which has been identifying the needs of local staff (both clinical and non-clinical) and starting to develop support mechanisms. HQIP are holding a national meeting for local staff in April 2009 in which proposed ways of providing support will be presented and discussed.

National clinical audit staff
There has been relatively little contact between those managing NCAs. Both those running the audits funded by the NCAPOP and the 20 or so NCAs funded from other sources (such as Trust subscriptions, charities, NHS Special Health Authorities, other sources in the DH) have tended to tackle all the challenges in isolation. There will be mutual benefit for all NCA organisers from sharing their experiences and skills. As a
first step, HQIP organised a national meeting in November 2008 which was attended by clinical and non-clinical representatives of most national audits.

In addition, NCAAG has met with several of the ‘independent’ NCAs (ie those not funded by the NCAPOP) to discuss emerging national policies, such as the criteria for good quality audits outlined above: Parkinson’s Disease Society; National UK Registry of Barrett’s Oesophagus; National Hip Fracture Audit; Renal Registry; National Health Promotion in Hospitals Audit; ENT UK; Cardiac Rehabilitation Audit; and Intensive Care National Audit & Research Centre.

**Responsive funding scheme for NCAs**

Traditionally, topics for new NCAs have been decided centrally and commissioned. Whilst this has led to many successful audits on key topics and needs to continue, there is also a need for NCAPOP to fund ideas and initiatives developed by groups of clinicians and patient groups. To meet this need, we introduced a responsive funding scheme to complement the commissioning scheme. This resulted in 59 expressions of interest of which 11 were short-listed and six were recommended to the DH. Subject to final agreements, funding will begin in 2009-10 for the following topics:

- Chronic pain (British Pain Society & Royal College of Anaesthetists)
- Childhood epilepsy (Royal College of Paediatrics & Child Health)
- Inflammatory bowel disease (Royal College of Physicians)
- Heavy menstrual bleeding (Royal College of Obstetrics & Gynaecology)
- Treatment-resistant schizophrenia (Royal College of Psychiatrists)
- Hip fracture (British Orthopaedic Association & British Geriatrics Society)

**4. Increasing the impact of clinical audit**

Clinical audit is only of value if it leads to initiatives to improve the quality of care. The latter is the responsibility of a myriad of other DH, NHS and other related bodies with a remit to improve quality of care. It is therefore imperative that, in leading the reinvigoration of clinical audit, NCAAG liaises closely with these bodies to ensure an alignment of priorities and goals. To these ends, we have met with senior staff in the following organisations:

- Regulation: Healthcare Commission; Care Quality Commission
- Revalidation: AMRC; several Royal Colleges
- Risk management: NHS Litigation Authority
- Quality metrics: NHS Information Centre; NHS Medical Directorate
- Education: Medical Schools Council; Royal Colleges

We have also met with others with an active involvement in quality improvement: The Health Foundation; NHS Quality Improvement Scotland; Chief Medical Officer; National Patient Safety Agency; CEMACH; National Information Governance Board; and National Cancer Information Network.

**Plans for 2009-10**

7
While several of the activities established in 2008-9 will need to be continued and developed further, the following are the principal topics that NCAAG will be addressing in 2009-10.

1. Improving the quality of clinical audit

*Create portfolios of good quality national and local audits*

There is a need for readily available examples of good quality local and national audit. These would serve both to inspire other auditors and also provide evidence to demonstrate the value of clinical audit. We will be asking HQIP to create such portfolios during 2009-10.

*Advisory service for NCAs*

Both those already running NCAs and those aspiring to do so often need advice and support. One particular area of need is assistance with establishing sustainable funding given that long term central funding from NCAPOP will not usually be available. We will be looking to HQIP to establish an advisory service to meet such needs.

*Education & training for clinicians and CA staff*

The need for more education and training both of clinicians and clinical audit staff is apparent. HQIP have been identifying specific needs and are already preparing ways of meeting those need. We will support and encourage the establishment of a training strategy.

The undergraduate and postgraduate training of clinicians currently includes little in the way of audit training. We intend to explore and map what training is provided and then address unmet needs with those responsible for curricula, such as The Medical Schools Council and Deans of Health (Nursing Schools). In addition, we plan to discuss with Medical Education England ways in which HQIP might help support and enhance the clinical audits that Foundation Programme doctors’ carry out.

*Support for ‘independent’ NCAs*

Our responsibilities extend to reinvigorating all NCAs regardless of their funding source. We will encourage HQIP to work with all funders to help them adopt the quality criteria established for the NCAPOP. This will help the establishment of a wide portfolio of high quality NCAs.

2. Clarifying the commissioning of NCAs

*Annual cycle for commissioning new audits*

A planning cycle for commissioning new audits will be instituted for 2009-10 by HQIP. The cycle will commence with consultation with National Clinical Directors, NICE and professional associations (royal colleges, faculties, associations) to help identify topics. Prioritisation of topics will be undertaken by the NCAAG New Audits Sub-Group using explicit criteria (see next section) before invitations to tender are issued.

*Enhancing transparency of decision-making*
To help enhance the transparency of selecting new topics (and topics for renewal), NCAAG are considering the following criteria for introduction in 2009-10:

- **Clinical/health and social policy importance of condition**
  What is the incidence/prevalence of the condition? What impact does the condition have for patients and/or for family/carers? What is the impact of this condition on the NHS and on health and social policy?

- **Evidence of need for improvement in quality of care**
  What evidence is there that current care is sub-optimal? How much variation is there in the quality of care between providers/populations in England?

- **Sufficient evidence to establish criteria of good quality**
  If it is input or process audit, what is the evidence for defining good quality care?

- **Supports broader DH/NHS policy objectives**
  Does the topic fit with and support current major policy objectives?

3. **Extending the scope of NCAs**
One of our aims is to extend the scope of NCAs, which have tended to focus on secondary (hospital) care. While appropriate for some areas such as surgery or critical care, this focus is increasingly inappropriate for the care of most long-term conditions.

**Primary care**
Discussion and collaboration with the National Clinical Director for Diabetes have resulted in the development of a new brief for the NCA for adult (Type II) diabetes which will be centred on primary care. This presents demanding challenges as regards provider participation and data collection on individual patients but should provide a template for audits of other long-term conditions. We anticipate this new diabetes audit (plus a hospital-focused audit for diabetes in children) starting in 2010-11.

**Social care**
The challenge of auditing across health and social care needs to be addressed. We hope to pioneer such an initiative with a new audit on one aspect of care – nutrition for elderly hospital inpatients and residents of nursing homes.

**Patient reported outcomes**
While some local and national audits already involve patients in the assessment of the outcome of their care, there is scope for other audits to involve patients in this way. We will be requiring new and existing audits to consider whether greater involvement of patients is appropriate and, where feasible, expecting the inclusion of patient reported outcomes.

**Budgetary constraints**
It is inevitable that financial constraints will limit the extent to which NCAPOP can support both national and local audit. We have, therefore, asked HQIP to investigate the full range of funding methods that national audits outwith NCAPOP are successfully employing so that well-founded policies can be developed to help
existing NCAs in the NCAPOP be sustainable in the long term. This will enable new audits to be supported both through our commissioned scheme and responsive scheme.

4. Creating widespread participation and involvement

It is apparent that there is widespread enthusiasm, experience and skill among health care staff engaged in clinical audit locally. There is often also a sense of isolation and a perceived lack of support, despite several enterprising initiatives over the last few years by NHS staff, higher education institutions, professional associations and private sector organisations.

As the third aspect of NCAPOP (alongside NCAs and local audit support), HQIP has been preparing a web-based National Clinical Audit Forum which will be initiated in 2009. Its aim is to bring together, virtually, all those with an interest in clinical audit including clinicians, clinical audit staff, patients and carers, methodologists, health care managers, policy makers. The ways in which it develops will depend to a great extent on those who participate but it is envisaged that networks of people with common interests may emerge. It will serve as a very useful sounding board for NCAAG both to identify issues of concern and to consult widely on new policies.