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Background

1. The Healthcare Quality Improvement Partnership (HQIP) funds a programme of national clinical audit projects each year. Programme development, commissioning and contract management is the responsibility of HQIP's Contracts & Procurement (CAP) team. The individual projects are carried out by external organisations, including a number of the royal colleges and the NHS Information Centre.

Delivery of individual projects to the quality, timescales and costs as set out in contracts is the responsibility of the supplying organisations, quality assured by the CAP team. The goals of the national clinical audit programme are to provide assurance to the public that care is safe and effective, and to promote improvements for patients by identifying where professional practice and the quality of services delivered could be better. The programme is designed to allow clinicians to take responsibility for auditing the quality of their own care.

2. The purpose of this document is to share good practice in writing plain-language reports, suitable for a wide audience, developed by some of the more experienced project teams within the national programme. It is also intended to make HQIP's requirements about communications clear, and sets out policy and guidance concerning:

- communications arrangements at the start of a new project, and relative responsibilities of HQIP and project suppliers
- the content and style of national reports (including coverage of Wales, patients' viewpoint, highlighting of findings relevant to NSFs and NICE guidance, audiences and the use of plain language)
- the arrangements and timing for the approval of draft reports, and for press releasing and publishing
- content of, and updating of the national clinical audit section of the HQIP website
- the division of responsibilities within HQIP.

Programme-level arrangements

HQIP website

3. There is a national clinical audit section within HQIP's website, where information about the programme as a whole, plus each individual project will be posted. Our aim is to provide:

- a list of all audits in the current programme
- a calendar that sets out key details of each project, including data collection and report publication schedules, to help local clinical audit departments plan their annual programmes
- downloadable guidance about various aspects of the programme (eg, funding applications, involving patients and the public, quality assurance framework, NSF and NICE guidance)
- for each individual project, a project brief and link to the supplier's project homepage
- annual programme progress reports
- HQIP quarterly newsletters which will feature the latest National Clinical Audit and Patient Outcomes Programme (NCAPOP) news.

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Annual progress update

4. HQIP is required to identify and allocate a budget that over time provides a significant national clinical audit programme and commissions new audits in areas of clinical priority.

Newsletter

5. HQIP publishes a quarterly newsletter for healthcare professionals covering all aspects of HQIP's work, including clinical audit matters and the national programme.

Publication schedule

6. Within the contracts for each audit will be a requirement for projects to report and disseminate their work actively. A list of projects that are contracted to deliver a national report within the current financial year will be prepared by the CAP team, giving the contracted month of publication (see example, Box A). Project suppliers should contact HQIP's communications team to agree an exact date of publication (an example is given later).

Box A

Extract from the publication schedule

		<i>Last report</i>	<i>Next report</i>	<i>Type</i>
Cancer	Bowel cancer (NBOCAP)	Jun 08	Jun 09	Professional report
	Head & neck cancer (DAHNO)	May 08	May 09	Professional report
	National lung cancer (NLCA)		Mar 09	Findings
	Mastectomy and breast reconstruction	Mar 08	Mar 09	Early findings
	Oesophago-gastric (stomach) cancer	Mar 08	Mar 09	Early findings
Child & Maternity	National Neonatal	Feb 08	Dec 08	Findings
Heart	Myocardial ischaemia (MINAP)	Jun 08	Jun 09	Findings

HQIP's communications team

7. Publication of reports is primarily the responsibility of the organisation contracted to provide each audit. However, HQIP's association with the audits as their funding body, and with overall responsibility for ensuring that the public money spent on the Programme provides good value for money, means that no publication should take place without our agreement and with 'sign off' for the key messages, the press release and publication plan. Furthermore, the potential for audits highlighting deficiencies in healthcare may have political implications for which handling needs to be managed as they are made public.

8. Some project teams have been unaware of these arrangements in the past, leading to reports coming out without the Department of Health or the Welsh Assembly Government being aware of them. This can lead to difficulties when the press ask for comment, and can mean a lost opportunity for the project's findings to be publicised.

9. In order to avoid any such difficulties, each project manager must make early contact with HQIP's Communications Manager, in order to:

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- liaise over press releases at the launch of a new audit, including identifying how the audit fits into HQIP's other areas of work
- help with identifying and wording the emerging themes and key findings, for use in press releases at report time; and subsequently agree the wording of joint press releases, ensuring that comment from our Chief Executive or other appropriate representative is available for the press release
- identify and liaise over the exact publication dates (an example of a detailed schedule is given below, Box B)

Box B

Extract from Communication team's detailed schedule

Cancer			
Bowel Cancer	Public Report		w/c 28 August 08
Lung Cancer	Main report		December 08
Head and Neck	Findings		September 08
Oesophago-gastric	Findings		March 09
Heart			
MINAP	Findings		June 09
Child & Maternity			
Neonatal	Early findings		December 08

Source: HQIP

- identify an HQIP representative for press comment on the day of publication
- provide guidance on making national reports accessible (where appropriate Welsh translation, children's versions, large print, minority ethnic language translation)
- establish a procedure in which HQIP will distribute an agreed briefing to top level stakeholders, including the Department of Health and the Welsh Assembly Government.

10. HQIP's communications team will assign a named contact for each report in advance of publication time. For general enquiries, and as a point of initial contact when beginning to discuss publication plans, the key contact is Alison Percival.

Annual Health Check

11. HQIP has made it clear that participation by local bodies in clinical audits and outcomes monitoring of relevance to their patients is an indication of good governance that will feed into the Care Quality Commission's (CQC) Annual Health Check (AHC). Information is collated about NHS trusts' participation in the national programme, and participation by Trusts in all relevant national audits was amongst the information used to risk profile Trusts and identify which should receive inspection visits, as part of the cross-checking process for the NHS Core Standard C5d ("Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services"). Participation in clinical audit is also covered by Welsh national standards, and Healthcare Inspectorate Wales are taking this into account in their assessment programme.

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12. Findings from the programme will be used to cross-check developmental standards in 2009/10. In this year, HQIP will concentrate on cancer, heart disease and stroke. Project suppliers in these areas are already in discussion with HQIP about which findings could be used and how they can be interpreted. At the time of writing, the exact timetable for providing information for use in the AHC has not been finalised.

Individual project arrangements

Launching a new project

Project website

13. A project website, linked to or within the host royal college or specialist association's website, should be established immediately. The website becomes the main method of communication between the project and its management team, participants and the wider world. Links are to be provided to and from the HQIP website. Examples include the NCASP website,¹ and those of the RCP CEEU² and the RCPsych CCQI.³

Press release

14. HQIP will usually undertake communications work to publicise the launch of a new audit. This will be done in consultation with the contractor, and materials should initially be prepared by the contractor. Press releases must be approved by HQIP before release.

Project brief

15. A short description of the aims of the audit and how it will be conducted will be placed on the national clinical audit section of HQIP's website. Examples can be found there that give an idea of the style and headers that can be used – the initial draft should be prepared by the project team.

Clinician and patient leaflets

16. Leaflets that can be downloaded from the project website and/or provided to clinical departments for distribution should be prepared and approved by HQIP. The patient leaflet should also contain 'fair processing' information.

17. Examples include DAHNO, which has produced both types of leaflet, and the National Audit of Continence Care for Older People, which has produced a leaflet mainly aimed at clinicians and clinical audit staff. These are available on the relevant project websites.

18. Where the audit will involve a substantial local data collection effort, recruitment to the audit will be helped if the leaflet explains how the benefits will exceed local costs and improve on the information already available from other sources. For example, the 2006 NLCA national report contains phrasing that could help make the case:

“National clinical audits are an important tool for driving up the quality of care delivered in routine clinical practice. The crucial day-to-day collection of detailed patient-related data in

¹ <http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp>

² <http://www.rcplondon.ac.uk/clinical-standards/ceeu/Pages/Clinical-Effectiveness-Evaluations.aspx>

³ <http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement.aspx>

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busy clinical settings requires the efforts and commitment of a very large number of people... doctors, nurses, audit staff, MDT co-ordinators, data clerks, etc. The advantage of the NLCA database is that it collects more detailed information about the care provided than is available from existing sources of data such as the Cancer Registries and Hospital Episode Statistics (HES). The dataset was developed to be clinically relevant and therefore has professional ownership. It is also able to provide comparative reports to local service providers within a short timescale including tools to produce summary reports for each of the variables recorded. These reporting tools were revised in 2005, allowing users to review their own information benchmarked against the national average on a real-time basis.”

Local feedback

19. The primary output of all national audits is the findings for local trusts, and such feedback is a basic requirement for all projects. Feedback format varies between projects. We have not yet made a systematic assessment of what format local participants find most helpful, but in general feedback should be:

- *Informative:* findings should be fed back in a way that allows each participating body to compare themselves with the national average performance and against good practice standards. Every trust has to monitor their implementation of NICE guidance and NSF requirements. Considerable external pressure is applied to check on this (including from the CQC as part of the Annual Health Check). This is especially important to chief executives and central clinical audit/governance departments that usually have the task of evaluating implementation, as well as to all healthcare professionals and patients. These central departments are also influential in determining local participation. It is essential, therefore, that national projects are explicit about the benefits to participating local trusts in relation to NICE guidance and NSFs.
- *Timely:* timely data collection and feedback is essential if participants are to rely on the audit as a credible source of information on which to plan improvements. If the feedback is too out of date things may have ‘moved on’ and its usefulness is diminished. Some audits provide real-time feedback as soon as a trust enters data online (eg, some of the cardiac and cancer audits) and this is a preferred function. The snapshot audits managed by the Royal College of Physicians (eg, stroke, continence, falls) aim to ‘collect data within two months, return it with comparisons within two months’.⁴ For historical reasons, a few of the national projects have data collection arrangements that make it impossible to feed back timely information (for example, one gave participants a whole year in which to submit – ie, trusts could take until the following year to submit. By the time the data has been analysed and fed back, some of the patient treatment episodes could have occurred two to three years previously). Some trusts have been reluctant to fund data clerks for projects where feedback has been too late to be of much use in planning service improvements. These projects must actively explore ways to move to real-time feedback.
- *Corrective:* it should give data quality information, for example indicating whether patient records are probably missing (eg, by comparing with HES or PEDW records), and which data fields within records are missing.
- *Downloadable:* all projects must make the full, by-trust, dataset available to participating trusts to download (eg, in excel format) so that they can produce their own bar charts, etc showing

⁴ M. Pearson, *Clinical Audit 2007 presentation*.

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between-trust variation and their comparative position, rather than simply the comparison with the average.

- *Manipulable*: Data must be capable of a level of interrogation and manipulation as specified in the contract. In addition, it is preferred that data is made available for online manipulation, producing graphical output within an analysis package (an example is ‘Piano’ for diabetes audit results). Because of the cost involved, we do not normally make this a contractual requirement, but very much see this as good practice.
- *Widespread*: in addition to the nominated clinical lead, other local stakeholders, for example local quality improvement staff, need to see the feedback or know it has been given. Local reports should either be sent to this wider audience or, if this is not possible because they are provided via a secure online system, an alerting letter stating that results have been fed back to the clinical lead should be sent. If the IT system provides for continuously available feedback, and so there is no obvious single feedback point in the year, an alerting letter sent to correspond with the time of national report publication should be sent (eg, the Continence audit sent a copy of their executive summary to each trust chief executive and head of clinical audit/governance, along with the name of the local clinical main contact who had contributed to the audit). The list of who needs to be informed will vary according to the healthcare area being audited, but should include the trust chief executive, medical director, central clinical audit or governance department, local PALS, PCT, clinical network, SHA, local ground level staff and patients.

In addition, and more generally, projects must communicate actively with local providers regarding the timetabling of data collection and arrangements for data collection. Enquiries and complaints made by local providers should be responded to promptly and proactive dialogue maintained with each participating authority.

Action plans

The responsibility for making sure that any improvements identified via audit findings are made lies with each local participating body. However, audits must take steps to stimulate or support local improvement, including:

- The production or facilitation of a generic action plan, such as that produced by the ‘Falls’ audit (Box C).

Box C

Example of the first part of a generic action-planning tool provided by the National Falls Audit, to assist local trusts to plan improvements

National Audit of the Organisation of Services for Falls and Bone Health in Older People Action plan Toolkit		
National report: Section 1 – Commissioning		
Audit Indicator	Suggested choice of action	Suggested people to lead or involve

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<p><i>Presence of a current Public Health Strategy which includes:</i></p> <ul style="list-style-type: none"> - Falls and Bone Health (BH) - reporting criteria and mechanisms 	<p>Map local needs (population) and services - incorporate patient views and wishes (identify pre-existing local data/sources, e.g. tariffs/multi agency sources).</p> <p>Cost benefit analysis</p> <p>Identify drivers:</p> <ul style="list-style-type: none"> - local - national (audit, NSF's, guidelines, NICE) 	<p>Senior management / Director responsible for admission avoidance</p>
<p>Presence of a current Integrated Specialist Falls Service which includes:</p> <ul style="list-style-type: none"> - Falls - Bone Health - reporting criteria and mechanisms - clear referral pathways - identified budgetary & staffing requirements - identified performance indicators 	<p><u>Drivers:</u></p> <ul style="list-style-type: none"> - admission avoidance - long term conditions - identify local drivers (e.g. fracture rates, mortality 28 days after fractured neck of femur, number of attendance at A&E with falls) - link costs via tariffs - identify local population data (fracture rates / recurrent falls admissions) - patient choice / QOL 	<p>Suggested timeframes</p> <p>3 Months</p>

Source: RCP, <http://www.rcplondon.ac.uk/college/ceeu/fbhop/AuditFbhopActionPlanToolkit.doc>

- Improvement case studies shared with other participants: the Violence in Mental Health Settings audit held local topic-based workshops to support ward and unit teams in developing and implementing action plans based on their local findings. Examples of such action plans and case studies of changes brought about as a result of participation were collected by the audit team.
- Setting up of peer review schemes, where a team visits a local organisation to help identify how improvements could be achieved (eg, such links are developing between the cancer audits and the Cancer Action Team's peer review system; the stroke audit is developing a linked peer review scheme).
- The development of an implementation toolkit, and a generic slide presentation into which individual results can be added for local presentation.

Involving the board

20. As discussed elsewhere in this document, by informing the chief executive and other, wider stakeholders at the start of an audit and when feedback reports and a national report are published, each audit can try to ensure that audit findings will be played into the performance management processes within a trust. A further extension of this was taken by the Violence in Mental Health Settings audit. Participating trust chief executives are asked to sign a Memorandum of Understanding (MOU) on joining the audit, agreeing that an action plan will be produced. In this case, the MOU also stated that action plans would be collected centrally and shared with the CQC, as the timing coincided with an 'Improvement Review' being undertaken into adult inpatient mental

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health services by our Mental Health Strategy Team. In other audits a similar MOU is desirable, with the action plan shared with HQIP.

National reports

21. The core, most important aspect of reporting remains how findings are fed back to local participants. But there is a need beyond this to report more widely to patients, the public, commissioners and boards. The normal expectation is for an annual national report - when the project is in development, the report may take the form of a technical report. This report must be sent to HQIP for review no later than 6 weeks before the publication date.

Public and professional reporting

22. Historically, some of the national audits were begun by interested clinicians acting through their professional association. Examples include the adult cardiac surgery audit begun in 1998 by the Society for Cardiothoracic Surgery, and the bowel cancer audit, begun in 2001 by the Association of Coloproctologists of Great Britain and Ireland. The first national reports were aimed at their clinical membership, and were mainly written in technical/clinical language, with extensive use of detailed tables, graphs and other statistical reporting. Some projects continue to publish very detailed reports aimed largely at the clinicians involved in providing care. Clinicians studying such reports, and their local feedback, are able to identify from the comparative outcome information whether they can further improve the quality of their care. The lessons to be learnt do not need to be spelt out for this audience, and there are many anecdotal reports that such comparative feedback prompts clinicians to identify and adopt best practice as they strive to match or better the results of their peers, leading to an overall improvement in the care and outcomes for patients.

23. It is of course both commendable and essential that projects are founded in rigorous data collection and analysis. Wider audiences will note this and know that they can take the findings seriously but the number of people who will actually read and use the full detailed findings in a report are limited. For these other audiences (patients, the wider public, all healthcare professionals, and others not directly involved in clinical care but who have a part to play in improvement, such as trust chief executives and boards) it is the improvement messages that need to be spelt out. They need a plain English report. It is necessary to approach this issue by producing one annual, national report that, in addition to clinical participants, is also aimed at patients, the public, trust boards and other interested non-clinical parties and is in a language that can be readily understood by everybody.

24. Generally speaking, to provide patients and the public with an understandable assessment of the quality of care in a particular area of healthcare, a report needs to answer these four questions:

- What is the clinical issue and how important is it to patients?
- Are all hospitals providing the quality of service that standards expect?
- If quality is variable, why is it that some are able to provide good quality and not others?
- What do the services that are of a lesser quality need to do to improve, what actions are recommended?

25. A national report that answers those four questions will:

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- *Reassure*: every healthcare organisation should take proper steps to audit the quality of its care, and be able to show to patients and the wider public that it provides safe and effective services and that any deficiencies are being rectified. A national report, in language understandable to this wider audience, is a very important step in providing that public assurance - in this case at a national, summary level. In due course, a 'public portal' approach, similar to that used for adult surgical outcomes, would be a better way of providing this public assurance for all national audits, because it can give local results. In the meantime, a national report is the best way of helping trusts demonstrate this in a general way (always provided they are taking part in the audit).
- *Encourage*: timely and useful feedback, together with suggested action plans and examples of good practice, act as a spur to those that need to improve to begin to act.
- *Advise*: providing professional feedback is a stimulus for improvement for those clinicians who are both willing and able to interpret the findings and identify how (if at all) they are able to further improve their services to patients. For the few who do not take the opportunity presented, spelling out how the trusts need to improve is necessary. A national report, in plain language, enables chief executives, boards and patients to question whether their clinicians are using the audit findings in the way intended.
- *Increase participation*: Trusts are under continual financial pressure, and time is precious. A concise national report with an executive summary is a good medium for demonstrating to chief executives and boards why they need to support clinicians in being able to find the time needed for audit, plus any data clerk/IT costs, if there are any.
- *Give value for money*: demonstrate to HQIP that the audit suppliers have done all in their power to ensure that the public money invested will lead to improved patient care.

26. As well as needing to see a good draft of the report at least 6 weeks in advance of publication, HQIP have a number of other requirements in relation to national reporting (Box D). This is not designed to be a content list for a report, or a 'cook book', its purpose is to make explicit some of the specific requirements that HQIP has concerning style and content.

Box D

National reports – what HQIP expects to see

Aspect	Explanation
1. Annual publication	The minimum contract expectation is for an annual public report.
2. Plain language	National reports should be written in plain language, and consideration be given to any translations relevant to the topic. Some projects may choose to publish an extension of the report aimed at a professional audience, with the main report aimed at a wider audience. This allows the extended report to contain more technical language and statistical presentation while making the key findings and improvement messages accessible to patients, the public and trust board members. The MINAP report is a good example of plain language – starting with the title, which is “How the NHS manages heart attacks”.
3. Audiences identified	If separate sections of the report are aimed at different audiences, signpost appropriately.

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<i>Aspect</i>	<i>Explanation</i>
4. Summary	Provide a short summary. The summary should pick out the key messages for different audiences – these might be those working to provide services, chief executives/boards of participating organisations and patients/the public. For the first two audiences, this should help them to identify their priority actions. The summary can ‘sell’ the purpose and benefits of the audit to non-participating trusts.
5. Sample sizes	Clearly identified in the report and in tables. Exclusion rules explained. Comment on the confidence of national messages that are possible given the sample size or biases in coverage/participation.
6. Wales	Separate data analyses for Wales must be included, and compared with English results. Where they differ, include separate recommendations for Wales. Consideration must be given to necessary translation (HQIP will inform at draft consultation stage).
7. Statistical analysis	Reports should include confidence intervals and/or other appropriate statistical results to back up any recommendations made or statements about differences in performance (or it may be appropriate to refer to a more detailed report containing the statistics). Tables should either state each sub-group’s sample size, or give CIs.
8. Standards	Where findings relate to a standard (eg, derived from NICE guidance or an NSF) the accompanying text should state what percentage of providers have achieved the standard.
9. Participation	Include an annex that names participants AND eligible but non-participating organisations. Patients have a right to know whether their local trust has taken the opportunity provided to them to audit the quality of their care.
10. Open reporting	Openly publish results to trusts. Again, patients and the public have a right to know how good the quality of the care being offered to them is, and to be able to ask trusts how they plan to put right any deficiencies identified via the audit.
11. Sub-group analysis	Report on findings by key sub-groups. In addition to providing a table of results for each named participating organisation, commonly the sub-groups might include: <ul style="list-style-type: none"> • key levels appropriate for the topic, eg, SHA, network, PCT • ethnicity • deprivation • any key organisational measures you have (eg, presence/absence of a specialist service coordinator).
12. Key indicators	If a large number of findings are reported, highlight the most important in the summary. Consider computing some kind of overall score or indicator of quality. Consider whether the way results are presented can allow a patient to assess whether a particular local service is safe and effective and, where relevant, aid them in choosing between alternative providers.

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<i>Aspect</i>	<i>Explanation</i>
13. Recommendations	If recommendations are included, ensure that they: <ul style="list-style-type: none"> • follow from the findings • are SMART (specific, measurable, achievable, realistic, time-limited – and identified as the responsibility of a specific post to address) • address the key findings.
14. Improvement	Comment on the scope for improvement identified by the audit results, and what is being done to foster it. If too early to report on achieved improvements, then comment on the arrangements in place to foster improvement. This may be by referring to programmes of work outside the audit project. A useful device is to include case studies describing improvements to patient care/services achieved by local participants acting on the audit's findings.
15. Glossary	Where technical terms are unavoidable (eg, procedure names) then a glossary, such as that provided in the National Stroke Audit report, should be provided.

Source: HQIP

HQIP may choose to specify further requirements to individual audits as to the content and structure of annual reporting. For example, clinical directors for specific conditions, as part of the audience and policy owners for the report, may from time to time require reports to be produced in a variant or different way. The individual requirements will be discussed with each audit team and teams are encouraged to be flexible in preparing audit reports.

Executive summary

27. In a busy world, the reality is that many of the people a project needs to influence in order to stimulate improvements in patient care will not read the whole report. The Executive Summary will be extracted and may well be the only thing that will be read by trust chief executives, patients and the public, journalists, those who support or sponsor the project (eg, a 'Tsar', Cancer Action Team), those who pay for the project (chief executive of HQIP and DH or WAG), clinicians that do not already take part. Project leaders need to convince these people that the project is worth funding and worth the effort of taking part. In order to achieve this, a plain language summary of between 1 and 4 pages in length, emphasising the key findings and how patient care can be improved, must be produced. As with the National Report, a good draft of the Executive Summary must be provided to HQIP at least 6 weeks in advance of publication.

28. Because the Executive Summary will be extracted, it needs to stand alone. This means straightforward matters such as repeating the title of the report at the start of the Executive Summary, and including a sentence stating what the project is about and its main aims (even though a lengthier discussion of this is probably included in the full report), is needed.

29. The most important part of the Executive Summary is the brief statements of key findings and how patient care could be improved. Some examples of how projects have reported key findings in national report summaries are given in Box E. One way to structure each key finding is:

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- this is the issue
- this is what best practice/guidance says should be happening [these two points can be combined, as in 'all patients [of a specified diagnosis] should receive drug X']
- here are our findings/data, and they show that... (the degree to which good practice is, or is not, actually happening)
- this is why it is important for patient care, and the consequences for patients where good practice isn't being met are...
- and so this is the recommendation for improvement (who needs to do what by when).

Box E

Examples of key findings, as reported in executive summaries

MINAP:

"The percentage of hospitals in England providing thrombolytic treatment to 75% of their eligible patients within 30 minutes of the patient's arrival at hospital has decreased from 89% to 86% since the last report in June 2005. In Wales the percentage has decreased from 56% to 47%."

"Prescription of secondary prevention medication continues to increase: The proportion of heart attack patients prescribed secondary prevention medication on discharge from hospital continues to exceed the targets, remaining at 97% for aspirin, 92% for beta-blockers and 96 % for statins in England, with a corresponding increase to 98%, 91% and 94% in Wales." "The use of secondary prevention medication has continued to exceed the national targets." (Source: Myocardial Infarction National Audit Project (MINAP), *How the NHS Manages Heart Attacks, Fifth Public Report 2006*)

Cardiac intervention:

"The number of angiograms and PCI treatments both exceed the numbers expected by the National Service Framework (NSF) for Coronary Heart Disease, but are less than that recommended by the British Cardiovascular Society (BCS). For PCIs, the NSF target in 2000 was 750 per million population (pmp), and the BCS 2003 target was 1,400 pmp, with expectations that the level might need to be 2-3,000 pmp. The actual number in England in 2005 was 1,169 pmp and in Wales 873 pmp. These numbers are also less than in most other developed European countries." (Source: P. Ludman, *A Rapidly Evolving way to Treat Patients with Heart Disease: 2005 report of the National Audit of Percutaneous Coronary Intervention in the United Kingdom*)

Bowel cancer:

"The permanent colostomy (stoma/pouch/bag) rate after surgery for rectal cancer is a measure of the quality of surgical care, in that it should be performed in as few cases as possible. The rate has fallen from 25 per cent to 18 per cent over the 5 years of audit." [No evidence-based standard has yet been suggested for what the rate to aim at should be; comparative results provide the prompt for clinicians and trusts with relatively high rates to examine their practice.] (Source: M Thompson & K Greenaway, *National Bowel Cancer Audit Report 2006: Public and Executive Summary*, HSCIC/NCASP)

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Head and neck cancer:

“67.5% of patients were confirmed as having been discussed at a multi-disciplinary team (MDT) meeting. These results may reflect treatment decisions for some patients being made outside of MDTs, which is not in line with [NICE] Improving Outcomes Guidance where it is a standard that all patients are discussed at an MDT meeting.” (Source: *DAHNO first annual report: Key findings from the National Head and Neck Cancer Audit*, BAHNO/HSCIC/NCASP)

“Where this information is recorded, in over 50% of cases, primary care notification occurred on the same day [that a careplan was agreed]. However, only one-third of cases had this information recorded. Best practice would be supported by confirmation that this standard is being achieved for all patients.” (Source: *DAHNO first annual report: Key findings from the National Head and Neck Cancer Audit*, BAHNO/HSCIC/NCASP)

Wales

30. The Welsh Assembly Government has asked HQIP to ensure that Wales is included in all national audits within our Programme. This means that separate Wales analyses are expected in national reports and, where the findings for Wales differ markedly from England, that appropriate separate recommendations for improvement are included.

31. Payment for separate analyses are included within contract prices. However, in some circumstances special negotiation may be required between a project’s sponsors, the Welsh Assembly Government and HQIP if, for example:

- complicated interface arrangements with local, Wales-specific, IT systems are identified within a contract period that will incur significant extra expense
- a separate, detailed report is requested by the Welsh Assembly Government
- a separate public report is warranted, with Welsh translation.

32. Our Welsh language scheme commits us to translating press releases into Welsh and publishing a Welsh language translation of any report with particular recommendations for Wales. Early discussion with HQIP and our key contact within the Welsh Assembly Government is necessary to ensure that Welsh expectations are agreed, and to identify how this will be achieved (including any funding considerations over and above that already specified in the contract costings).⁵ For example, the executive summary of the Continence Audit is available in Welsh.⁶

Diversity

33. Audits are asked to report their findings broken down by gender, age and ethnicity. A number currently report routinely by the first two, but reporting by ethnicity is as yet uncommon. An example includes the Violence in Mental Health Settings audit which asked staff whether the gender

⁵ At the time of writing, the initial point of contact within the Welsh Assembly Government is Mr Ken Alexander (ken.alexander@wales.gsi.gov.uk).

⁶ <http://continenceaudit2006.rcplondon.ac.uk/website/files/exec%20summary%202006%20welsh.pdf>

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and ethnic mix of the staff on their ward/unit was appropriate to the resident population, and reported some audit findings by ethnic group.

Deprivation

34. Audits are also asked to report their findings broken down by deprivation. Examples include:

- the first DAHNO annual report shows that in patients with either larynx or oral cavity cancer, the median interval from referral to first treatment was 45 days in the least deprived, whilst in the most deprived this was 78 and 65 days respectively
- the heart rhythm management report gave findings within each Welsh Local Health Board (LHB) and cardiac network by deprivation status:⁷
 - Overall, the report noted that the variability index across Wales was 24.5%, suggesting “very high variation in implant rates between LHBs”. Compared with the Western European average, now adopted as the recommended rate by Heart Rhythm UK, all LHBs show a lower casemix-adjusted pacemaker new implant rate, varying from a deficit of about –35% in one LHB to a deficit of about –75%. “The new implant rate for pacemakers, ICDs and CRTs are all very low compared with the UK averages and even more so compared with the Western European averages.”
 - The report gives pacing rates by deprivation score and noted that although “It is generally the case that provision of therapy for heart disease is biased towards areas of greater affluence, and deprived areas receive relatively less therapy compared to need [for this aspect of CHD therapy] pacing rate is NOT related to deprivation. This is the same for the English cardiac networks that have been studied to date.”

Reporting against criteria and/or standards

35. There are many straightforward examples from national reports of reporting against criteria and/or standards. For example:

- Cardiac Intervention audit: “The National Institute for Health and Clinical Excellence (NICE) recommend that ‘stents should be used routinely where PCI is the clinically appropriate procedure for patients with either stable or unstable angina or with acute myocardial infarction’. The great majority of procedures do now involve stent insertion (94%), suggesting that this aspect of good practice is being met.”⁸
- NLCA: “The NICE target for the proportion of patients with lung cancer reviewed by an MDT is 100 per cent. Peer Review suggests a less ambitious target of 95 per cent. The median of 85 per cent [the actual performance reported by the audit] falls below these targets. 25 per cent of

⁷ *A review of pacemaker and ICD implantation practice in 2003 and 2004, Wales*, commissioned by the Cardiac Networks Co-ordinating Group and prepared by the Cardiac Networks Device Survey Group, Health of Wales Information Service, March 2006

⁸ P. Ludman, *A Rapidly Evolving way to Treat Patients with Heart Disease: 2005 report of the National Audit of Percutaneous Coronary Intervention in the United Kingdom*.

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hospitals managed to record a value greater than 94 per cent and thus show that the target set by Peer Review is achievable.”⁹

36. A more extensive example from the National Stroke Audit, which structures its whole report as a set of NSF or Royal College standards statements, is given in Box E. The example given states the wording of the standard, tabulates the summary findings, explains the implications for patients where the standard is not being met, and makes a recommendation.

Box F

Example of how the National Stroke Audit reports against NSF standards

“The NSF for Older People (which applies to England only) set out that all hospitals caring for people with stroke should have ‘a specialised stroke service’ by April 2004.” In-patient specialist care has made enormous progress... However, we should not be satisfied until nearly all patients are managed on high quality stroke units for both their acute care and rehabilitation... The time has come to start addressing the problem that similar services in the community have failed to develop in parallel. There have been no targets or similar imperatives for this to happen and this should be an area that the Department of Health Stroke Strategy should address.”

	England (203)	Wales (20)
% of sites with stroke unit 2006	96% (195/203)	45% (9/20)
% of sites with stroke unit 2004	82%	45%
Median (IQR) number of stroke beds in stroke units 2006	24 (18 – 31) (n=195)	20 (15 – 25) (n=9)
Median number of stroke beds in stroke units 2004	20	21
Ratio: Median (IQR) number of stroke unit beds per stroke inpatient (on site on the day the audit form was completed)	0.9 (0.7 – 1.1) (n=195)	1.0 (0.5 – 1.3) (n=9)

Source: National Sentinel Stroke Audit: Phase 1 Organisational audit 2006, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians of London, July 2006

37. As a further example of ‘reporting against standards’, NICE recommend¹⁰ that the number of lymph nodes examined in surgical specimens from patients treated with curative intent for intestinal cancer should not fall below 12 in patients with Dukes’ stage B or C colon cancer (the ‘stage’ is a measure of how far advanced the cancer is). The criterion has been set at 12 because scientific research has established that increasing the number of lymph nodes examined will improve the accuracy of ‘staging’ the disease, which therefore helps to identify the most appropriate form of treatment to offer, which in turn will tend to increase long-term survival rates (outcomes). The National Bowel Cancer Audit (NBOCAP) is able to report against this criterion (Figure 1), although in these relatively early days of the project many trusts are failing to take this opportunity to audit the

⁹ National Lung Cancer Audit: Key findings about the quality of care for people with Lung Cancer in England incorporating headline and completeness data from Wales Report for the audit period 2005, NCASP 2006.

¹⁰ NICE, *Improving Outcomes in Colorectal Cancers, Manual Update* (2004).

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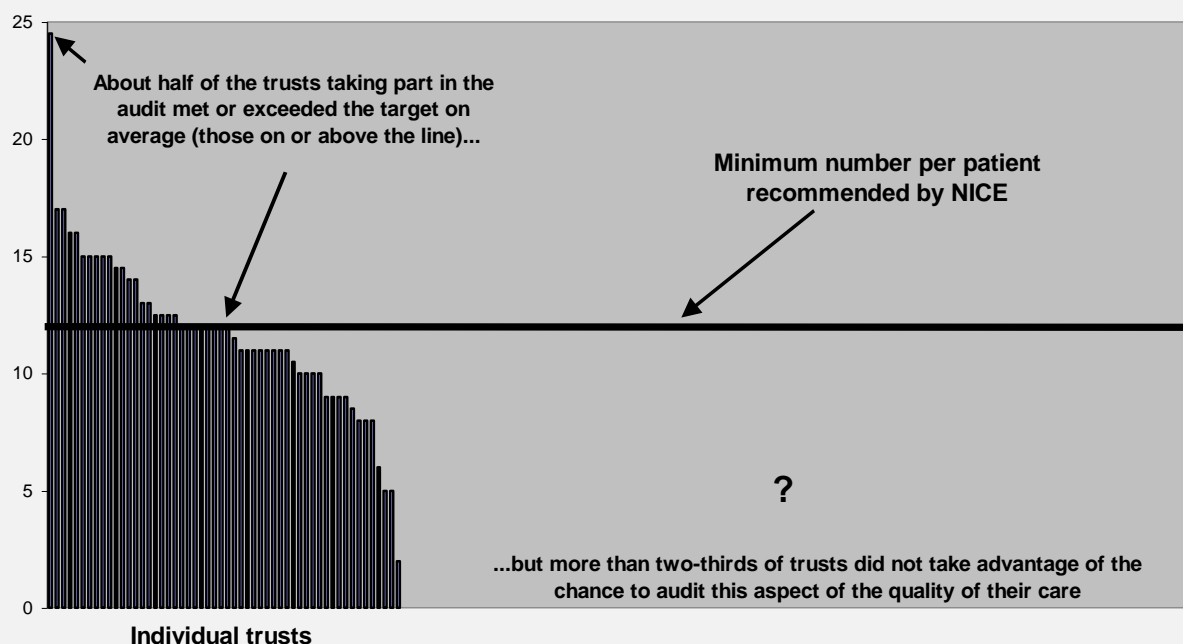
implementation of NICE guidance. The purpose behind the style is to provide those not involved in bowel cancer work with an idea of what is important, and how services were performing, with a good degree of impact and making the key message clear.

Figure 1

Example of graphical depiction of performance against NICE guidance: the average number of lymph nodes collected from bowel cancer patients

National report text: "The thoroughness of examination of the lymph glands that drain fluid from the cancer has been identified ... as a marker of care. This examination, by the pathologist, has a key impact on deciding whether chemotherapy would be of additional benefit following surgery. The proportion of units meeting the NICE target of an average of 12 lymph nodes to be examined per case has risen from 28 per cent to 50 per cent between 2001 and 2005."

Average (median) number of Lymph Nodes taken during 2004/05



Source: drawn from information in the bowel cancer national report 2006

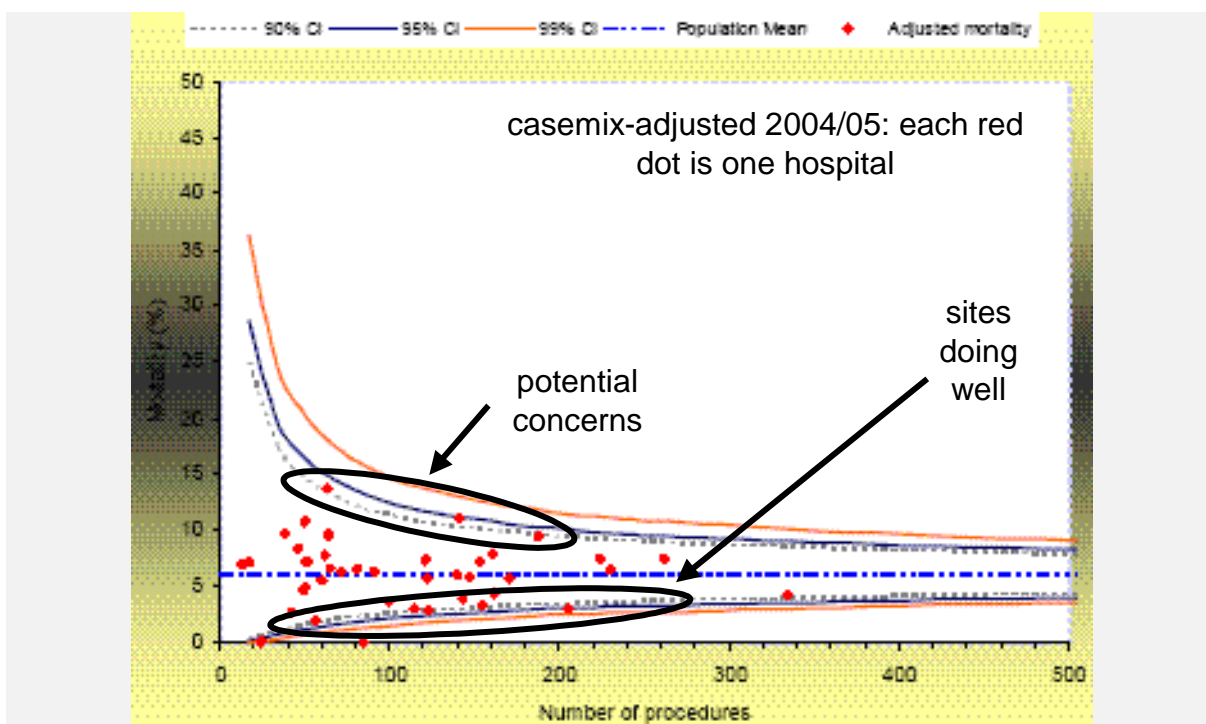
Reporting outcomes

38. The most frequently-used way of presenting casemix-adjusted outcomes is via funnel plots (Figure 2). To avoid misinterpretation of statistical 'blips', such information is either averaged over several years or presented additionally as trends across years. The adult cardiac surgery 'public portal', described elsewhere, has introduced a new format designed to help patients and the public interpret outcomes information.

Figure 2

Example way of reporting casemix-adjusted outcomes in a national report: funnel plot of deaths after surgery for bowel cancer

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Source: National Bowel Cancer Audit Report 2006, annotated by the Healthcare Commission

Case studies

39. A useful device is to include case studies describing improvements to patient care/services achieved by local participants acting on the audit's findings (Box G).

Box G

Example case studies of improvement prompted by national audit findings

[a] Violence in mental health settings:

"A manager at one trust noted that trust board members participated in the environmental audits, helping to get their attention to all of the audit's findings and recommendations in the action plan. Specific examples of change included:

- insight into the need for privacy, dignity and respect, and the link to violence
- improved staff knowledge of how to reduce and manage violent behaviour
- agreement of a Challenging Behaviour Strategy
- adaptations to the ward environment."

(Source: Healthcare Commission, *Progress in Assessing National Clinical Standards: achievements to 2005/06 of the National Clinical Audit and Patient Outcomes Programme*)

[b] Stroke:

One specialist stroke consultant interviewed said that the audit findings had been crucially important in gaining the resources to set up such specialist units within his trust. In his experience, chief

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executives tended to view professional and NSF standards as aspirational, when faced with so many competing priorities. But the comparative evidence provided by the audit, showing that some trusts had been able to provide these services, was an important factor in convincing the trust board that progress could be realistically achieved.

(Source: Healthcare Commission, Progress in Assessing National Clinical Standards: achievements to 2005/06 of the National Clinical Audit and Patient Outcomes Programme)

Identifying reasons for varied performance

40. It helps boost improvement if the report includes analyses that help identify the reasons for performance differences – eg, cross-tabulations with organisational variables such as type or size of trust. In some audits, sophisticated statistics are used to control for differences in casemix when comparing survival. But even simple descriptive statistics can be used to begin to understand what might be the reasons for under-performance, and so identify where to direct attention. For example, results from the Organisational Audit of Services for Falls and Bone Health show that for many trusts, as might be expected, there is a relationship between whether a specialist service has been set up, and whether key aspects of service are in place across the whole patients' pathway (areas A and B of Figure 5). However, the findings also suggest that setting up a specialist falls service is necessary, but not sufficient, to ensure that the key pathway elements all exist:

- *'necessary'* because it is very rare for cross-pathway services to be all in place when a specialist service has not been identified (area D of the figure – suggesting specialism might be a necessary pre-condition)
- *'not sufficient'* because there are also a large number of trusts that have identified specialists, yet this has yet to follow through into ensuring all pathway aspects are in place (area C).

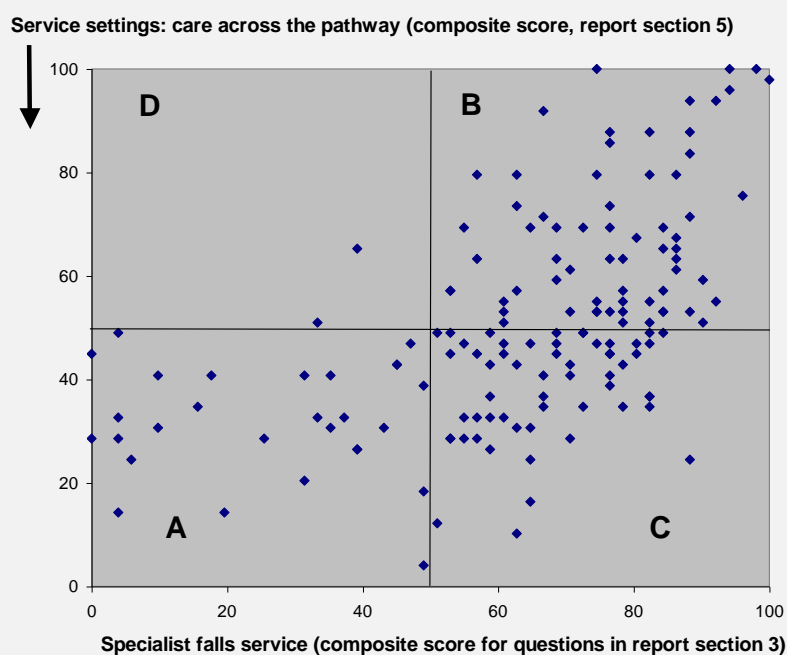
41. This is not a scientifically rigorous attempt to assign cause and effect – but the use of such simple cross-tabulations, and other forms of 'descriptive statistics', can help trusts along the path to identifying what they need to do to improve services and care for patients.

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Figure 3

The relationship between specialist 'Falls' service organisation and the elements of care across the patients' pathway¹¹

Each diamond represents the results for one trust. The project team computed an overall composite score, expressed as a percentage, from the answers in each section of the questionnaire. For example, in section 3, the score is based on the answers to 46 separate questions about elements that make up a specialist falls service. The scattergram has simply been divided into four quadrants (labelled A to D) by drawing lines at the 50% mark.



Source: re-drawn from data in the Falls national report 2005

Making recommendations

42. National reports must make explicit recommendations for improvement. Examples include:

- the 2006 NBOCAP public report: given that there is still room to improve participation rates and the completeness of data necessary for casemix-adjustment, the report's recommendations included that "Patients should ask if their unit participates in the National Audit", "Cancer Networks should encourage trusts to submit their data to the audit and use this data for local audit" and that "Hospitals need to provide better data on Circumferential Resection Margin Involvement, Local staging, MDT discussions, Excision of lymph nodes, ASA grade".

¹¹The National Stroke Audit has reported a similar, though less stark, relationship between organisational and process scores (Section 1.4, *National Sentinel Stroke Audit 2004, Concise reports Part 2 – Results for the process of stroke care audit*, Clinical Effectiveness and Evaluation Unit, Royal College of Physicians of London, March 2005).

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- the 2006 LUCADA (NLCA) national report: having reported that 78% in England, and 90% in Wales had been reviewed by an MDT, it included the recommendation that “All patients should be managed by a specialist multi-disciplinary team”
- LUCADA also reported that 64% of patients in England, and 75% in Wales, had a histological and/or cytological diagnosis recorded. “The histological confirmation rate is probably a good surrogate marker of the overall standard of a lung cancer service, the optimal rate perhaps being 80-85 per cent... [therefore]... “Local services should be using the histological confirmation rate as a prime marker of the overall quality of their services; those with a low value should ensure that this is not due to poor data quality and then take appropriate action”
- on the basis of 2007 DAHNO report findings: “Multi-disciplinary teams (MDTs) should:
 - ensure timeliness of pathways to meet national access targets
 - ensure the awareness and involvement of general dental practitioners and community dental services in urgent cancer referral processes
 - ensure that tumour staging (TNM) is confirmed and recorded prior to care planning and following surgical procedures
 - ensure that good dental health is maintained throughout treatment
 - ensure provision of surgical voice restoration counselling, pre treatment, for all patients having a laryngectomy
 - ensure provision of swallowing counselling, pretreatment, for all patients who are about to undergo oral/oropharyngeal resective and reconstructive surgery with free tissue transfer or partial laryngo-pharyngeal surgery
 - should ensure that delays in commencement of radiotherapy/chemotherapy, either as primary or adjunctive treatment are minimised.”
- examples from the 2007 Stroke Audit report:
 - “76% of patients with minor stroke, staying in hospital less than 2 days, are not being managed on specialist units. These are often patients at very high risk of stroke recurrence and it is particularly important that they receive expert care and investigation. This is more likely to occur on a stroke unit and improvement of services for these patients should become a priority in the development of stroke services in the UK.”
 - “There are a large number of patients whose admission to hospital is delayed. It is likely that this adversely affects outcome and it highlights the need for a public and professional awareness campaign... Stroke should be treated as a medical emergency. This means raising the profile of stroke amongst the general public and health professionals and the rapid transfer of stroke patients to hospitals able to provide the best quality of specialist acute care including thrombolysis and diagnostics.”
 - “There are large variations in the numbers of nurses, junior doctors and therapists employed on stroke units that are unlikely to be explained on the basis of case mix alone. Research is needed to identify what the ideal numbers of staff are from both the perspective of clinical and cost effectiveness.”
- the pacemakers and implantable defibrillators 2006 report’s recommendations included “Networks should review their commissioning strategies for pacemakers, ICDs and CRT in respect of level and equity of provision, investment in implanting and follow-up services, and in education of health professionals at all levels of the referral chain to ensure that the ability to recognise, refer and act upon an indication for device implantation is optimised.”

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43. An example of the style adopted by LUCADA to tabulate its recommendations, which follows good practice by identifying who needs to take action, is given in Box H. (A further refinement would be to give a target date by when each should be achieved.)

Box H

Example recommendations from the 2006 LUCADA report

Issues	Recommendations	Action
All patients should be managed by a specialist multidisciplinary team	All patients should be discussed at an MDT meeting which should be the focal point for data collection for both clinical care and audit	P
Good data on activity performance and outcomes are essential components of clinical governance	Clinicians must facilitate high quality data collection covering key elements of patient care. Recording of stage, performance, status and co-morbidity is of particular importance.	P
Local services should use the histological confirmation rate as a prime marker of the quality of care	All organisations should review their histological confirmation rate, those with low values should check whether this is 'real' or due to poor data quality and take appropriate action.	PTN
The public should have access to accurate and risk-adjusted clinical information	<p>The provision of risk-adjusted data-requires a high level of data quality and completeness.</p> <ul style="list-style-type: none"> • Networks should help to increase local awareness and encourage compliance with audit • Trusts and hospitals should support the local provision of data collection throughout the entire patient journey from referral to treatment • Users, healthcare professionals and management should contribute to support both data collection and maintain consistency and quality of data collected. 	NPTU N T UPT

Key **N**= network **P** = professions **T** = Trust/Hospitals **U** = users **L** = LUCADA project

Source: National Lung Cancer Audit: Key findings about the quality of care for people with Lung Cancer in England incorporating headline and completeness data from Wales Report for the audit period 2005, NCASP 2006.

Public portal

44. As part of the 'making information accessible' initiative, the Society for Cardiothoracic Surgery developed a website ("public portal") to allow patients, GPs and the public to look up adult cardiac surgical outcomes for their local hospital.¹² The website also provides general information about different operations, the benefits of having heart surgery, what to expect after having an operation, and details about each hospital and the heart team. It is an important development for the Programme as a whole. Not only can these projects stimulate improvements in the quality of care by providing feedback to clinicians, they can also allow patients to ask questions about their care,

¹² <http://heartsurgery.healthcarecommission.org.uk>

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providing public reassurance where results are good, and allowing challenge where they are not. In some cases, where a realistic choice exists, such accurate information, presented in an understandable way, can help patients and their GPs make well-founded choices. Each existing audit should seek to identify how the data it produces can be analysed and presented in this way and contracts for new audits will specify this capacity within the design.

Draft reports, publication arrangements and press releases

45. A good draft of each National Report and Executive Summary must be sent to HQIP's CAP and Communications teams at least six weeks in advance of publication, and sufficiently in advance to allow changes or comments to be incorporated:

- The date on which the draft will be sent must be notified in advance to allow HQIP staff to plan their diaries. HQIP will normally return comments within three weeks of receipt of the draft, provided that prior notice has been given. HQIP will engage relevant stakeholders in the Department of Health and Welsh Assembly Government, including the policy owners for specific conditions, in completing this review.
- The HQIP Communications team may suggest stylistic amendments or require factual amendments relating to HQIP, and will wish to agree which are the key messages with the contractor.
- The CAP team will check that the report meets quality standards, provides a summary that identifies the key messages, and that those key messages and recommendations identify what needs to improve to bring benefits for patients.
- HQIP may ask for comments from independent clinical advisors.
- HQIP will wish to share in any publicity planned for the material, including HQIP comments in press material. Press releases must be shared in advance with sufficient time given to allow for comment and sign-off by HQIP.
- HQIP may decide to publicise reports independently and issue material under its logo in consultation with the organising body.
- HQIP will liaise with policy owners for specific conditions in relation to publication schedules and processes.
- Reports and any publicity material must acknowledge the support of HQIP (further details are given in a following section).
- The HQIP communications team are happy to assist or advise in media, external relations, marketing and publishing of reports where appropriate.

46. The HQIP's communications team will:

- Receive contact from the project supplier well in advance of publication, to enable partnership over messaging
- Exercise influence over exact publication dates
- Liaise with internal strategy teams to ensure links with internal work and messages are made
- Organise internal sign off on key messages, the press release and publication plan.

47. The draft report for comment should be sent to:

- HQIP's CAP team (contact Helen Laing, helen.laing@hqip.org.uk)

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- HQIP's Communications team (contact Alison Percival, alison.percival@hqip.org.uk)
- Welsh Assembly Government via HQIP.

48. Contractors are responsible for publishing national reports. HQIP expects to receive a small number of hard copies for its own use (if a paper version is published).

49. Contractors must publish reports on their website and on the HQIP website, together with a reciprocal link on each project's homepage. Press releases issued by HQIP are accessible via the HQIP website. The reports may also be published within broader information dissemination plans and strategies of policy owners within the Department of Health and flexibility to accommodate their timetables may be needed.

Standard contract terms

50. The standard contract terms introduced at the start of 2006/07 state the following, along with the date by which each is planned.¹³ Future contracts and renewals may alter or strengthen these requirements.

- A calendar of events, including data collection timetables and report publication/press release dates
- Draft of national report sent to HQIP's CAP and Communications teams (at least six weeks in advance of publication, and sufficiently in advance to allow changes to be incorporated)
- National report published. The normal expectation is for an annual report - when the project is in development, the report may take the form of a technical report. Separate data analyses for Wales must be included, and compared with English results. Where they differ, separate recommendations for Wales must be included. Where appropriate, Welsh translations must be provided. Reports must include confidence intervals and/or other appropriate statistical results to back up any recommendations made or statements about differences in performance (or refer to a publicly available source document containing such information)
- Patients involved in analyses and presentation of findings
- Findings leaflet aimed at patients
- Central project team compile a generic local action plan, examples of good practice of local action planning and improvements, and an implementation toolkit and generic slide presentation in which local data can be added, as well as setting up of peer review schemes, where a team visits a local organisation to help identify how improvements could be achieved.
- Data Sharing - access to data for additional reporting and analysis, as specified in the contracts.

Scoping reports

51. HQIP have a long-term aim to re-shape the national programme to better reflect national priorities. Periodically we invite tenders for projects intended to scope the potential benefits for patients that might be prompted by commissioning an audit in an area of healthcare not currently covered. The purpose of such 'scoping' projects is to safeguard public money by not committing

¹³ Depending on circumstances, there may be some differences to the exact terms included in each project's contract.

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large-scale expenditure until a solid business case has been made setting out how improvements for patients will happen. Such scoping studies:

- Evaluate the feasibility of a national audit process, professionally led but supported by HQIP. All relevant parties are invited to give their views, including consultation with all types of staff involved at all stages of the patient's pathway, patients' representatives, and representative local clinical audit departments
- Review the scope for a national project, including which topics offer most room for improvement. Aims and objectives are developed for the audit, listing the questions that the audit will seek to answer and the standards against which it will assess the care provided. Relevant outcomes for measurement and the associated evidence base are identified, taking into account how the project would fit into existing data collection systems and datasets, avoiding duplication and identifying how a new project could add value. The scoping report comments on the likely scale and cost of data collection and analysis, and identifies possible barriers to progress and the risks to success
- Provide a report that, after wide consultation, could be used as the basis for a specification against which to invite tenders to supply a full audit.

Requests for information, including FOI

Academic and similar requests

52. Each project should draw up a policy and process for how to deal with requests for access to information (MINAP, for example, have a committee to consider requests). Such requests must also come to HQIP which, in most circumstances, agrees to access if a project's governance board deems it a reasonable request.

Freedom of Information Act (FOI) requests

53. FOI requests are managed jointly by the project manager and HQIP. Separate, detailed guidance is issued by HQIP relating to both FOI and other aspects of information governance.

Acknowledging HQIP

Standard wording

54. Suitable wording is: "This project was commissioned and funded by HQIP on behalf of the Department of Health". A longer description is:

The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and the National Voices.

HQIP has been commissioned by the Department of Health to manage the National Clinical Audit Programme. The programme currently comprises more than 20 clinical audits that cover care provided to people with a wide range of medical, surgical and mental health conditions. Their purpose is to engage clinicians across England and Wales in systematic evaluation of their clinical

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practice against standards and to support and encourage improvement in the quality of treatment and care.

HQIP also works towards the revitalisation of clinical audit by:

- promoting and enabling participation in clinical audit and quality improvement initiatives by healthcare professionals of all disciplines and specialties, as well as by patients and service users
- creating national and local partnerships between clinicians and patients/service users to optimise the impact of clinical audit
- supporting local audit staff and creating seamless links between national and local audit
- fostering active dissemination and implementation of audit results within a broader quality agenda
- ensuring that evidence about participation in audit, and the results of audit, are used for secondary purposes. These include work-based learning and support of revalidation of healthcare professionals
- encouraging and enabling audit in areas of low activity
- developing and promoting links with audits outside of the NCAPOP framework
- engaging all relevant stakeholders.

Logo

55. The HQIP logo can be used on reports and leaflets with prior approval by the communications team. High-resolution logo and branding guidance are available on request.

Contact: communications@hqip.org.uk

Information: www.hqip.org.uk