HQIP
Healthcare Quality
Improvement Partnership

How audit topics and proposals will be prioritised

November 2008

The process
HQIP will periodically invite proposals for new audits on topics suggested by applicants (this will be in addition to commissioning of topics decided by NCAAG).

Under responsive funding, the National Clinical Audit Advisory Group will advise which suggested topics should be invited to proceed to a full invitation for tender.

The proposals should set out the topic to be audited, and the specific approach for audit within that topic. Detailed criteria will be available during the invitation period.

What are the criteria for being chosen as a national audit topic?
In making an assessment about which audit topics and proposals shall be approved for funding, NCAAG will take into account a range of factors. It will be the case that not all audits meet all the criteria and may only meet some of the criteria cited. However an audit which meets the majority is more likely to be funded over one which meets only one or some.

The first criterion is obviously the most important and most weighting will be given to this factor. However the second criterion is also important, as even for a topic which has overwhelming health or social policy importance needs to be able to demonstrate that the audit is possible and will lead to a specific outcome or change in practice. NCAAG will seek to assess the degree to which these various criteria are addressed.

The following are proposed as the criteria by which various topics will be assessed:

1.1 Clinical/health and social policy importance:
What is the incidence/prevalence of the condition? What impact does the condition have in terms of mortality, morbidity, disability, reduced quality of life (for patients and/or for family/carers)? What is the burden imposed by this condition on the NHS and on health and social policy as a whole?

In making assessments against this criterion, NCAAG will seek to review whether the condition is one that has a particular pressure on NHS resources and on social and health policy as a whole. Does its care have implications for other aspects of social and health care if not treated effectively by the NHS? Even if not, does it have particular significance simply by its prevalence?

NCAAG will seek to ensure that there is a range of audit covering all major areas of health and social care; in secondary and primary care; in physical and in mental health care surgery; in work which is delivered by the NHS and the independent sector. We will explicitly seek to fund audits which address care that spans sectors across the care pathway.

1.2 Evidence of significant variation in quality of care:
How much variation is there in the quality of care between providers in England? Examples of such variation need to be given. The audit must show what effect such variation has upon patients/carers/families.

Some evidence needs to be presented as to current variation in the quality of care being provided in terms of inputs, processes and/or outcomes.

1.3 What is the purpose of the audit:
What are the specific aspects of the treatment or care of a condition or intervention that the audit seeks to look at? How will the audit improve these areas?

NCAAG will seek to identify exactly what the proposed audit seeks to achieve. Even if the topic involved meets the criterion set out in 1, what is the purpose of the audit? An audit must be able to demonstrate that it will lead to a specific outcome – such as better treatment, a reduction in the burden of disease, the alleviation of a particular weakness in current service delivery, the adherence to a specific recommended practice, the provision of information that will assist or inform patient choice or behaviour.

The proposed audit must be able to demonstrate that it is not simply a matter of describing the incidence or prevalence of a condition, and also that it is not research (ie generating evidence as to how patients should be best managed) but that it is audit (ie providing data that assesses the quality of current services).

1.4 Is it input, process or outcome audit:
If it is input or process audit, what is the evidence for defining good quality care? What scientific evidence is there of the clinical and cost effectiveness of inputs or interventions to treat or care for the condition? Evidence needs to be cited. If it is outcome audit, which outcomes will be compared (eg mortality, morbidity, disability, QoL)?

Many local audits seek to assess practice against a standard set by national guidance, such as from NICE. National audits also follow this pattern, working from national service frameworks etc. However they have other functions as well, such as auditing outcomes. Additionally, they help define standards where there is no national guideline. Nonetheless the audit must be able to cite the research or best practice underpinnings of the outcome being audited. Whichever measurement criteria are used, they need to have a scientific validity.

1.5 Broader policy objectives:
Does the topic fit with any current major policy objectives eg transferring the primary burden of care out of hospital and into the community; supporting informed choice for patients; consistent with NICE audit priorities; improving commissioning of services; supporting revalidation of health care professionals?

It is likely that any audit which meets the condition of impact on the NHS would also fall into this category, as any condition that places a heavy burden is generally one for which there is a policy direction that care needs to be provided more intensively in primary care settings. In addition, any audit proposal should be able to demonstrate that it is concerned with maximising patient choice, information or participation in their own care. It should be able to demonstrate this through the ways in which it seeks to engage patient engagement in their own treatment, through compliance and through their own understanding of their condition, but also through their involvement in helping to set their own treatment goals. Any audit must also involve patients in governance of the audit, and seek patient views on their treatment.

Criteria against which proposals will be assessed
When we come to assess proposals that meet the topic criteria, we will also be looking at a range of other criteria. When proposals are being drafted, we will require each proposal to address how they will meet these.

2. Inputs
2.1 *Extent of participation of providers*: what evidence that relevant practitioners/ providers will participate? What will be the additional local workload? Who will undertake it? How much time will it take? Does the topic fit with existing national or local audit topic?

2.2 *Patient/carer recruitment (ascertainment) rate:* what rate is expected? What mechanisms will be used to monitor the rate? What strategies will be used to enhance the rate?

3. Processes
3.1 *Data completeness and quality:* how will these be monitored? What standards will you aim for?

3.2 *Continuous/intermittent patient/carer recruitment:* is the aim to recruit all patients /carers or a sample? If sampling, how will the sample be selected? For how long will recruitment continue?

3.3 *Adequacy of risk adjustment*: how will case-mix be adjusted?

3.4 *Methodological rigour*: how will questionnaires/instruments be selected? How will sample sizes be determined? How will comparisons of quantitative data be made? What statistical techniques will be employed? What role will qualitative data play?

3.5 *Exploitation of existing data:* are existing databases being exploited to avoid unnecessary duplication of data collection?

3.6 *Linkage to other data sources:* are opportunities to link to other databases being fully exploited, such as HES and QOF?

3.7 *Data security:* are adequate security measures in place to avoid loss of data? Copy of security policy needs be included.

3.8 *Data confidentiality:* is good practice being followed in ensuring patient confidentiality is maintained?
- Which data items are to be collected?
- Does section 60 /section 251 Health and Social Care Act / NHS Act apply?
- Is PIAG approval required?
- Is there a plan for the PIAG process?
- Are data sharing agreements required?

4. Outcomes
4.1 *Collection of outcome data:* when are outcomes being assessed? Are both clinician-reported and patient-reported outcomes being collected?

4.2 *Inclusion of patient experiences:* are data being collected on the quality of the process of care via patient experiences? When and how are such data being collected? What is the purpose of collecting such data?

4.3 *Timeliness of feedback to participating clinicians:* how frequently will data be fed back? How timely will the feedback be?

4.4 *Presentation of output*: how will data output be presented to different audiences and on what timescale? How will outcomes / outputs be fed back to all groups? Explain the varying mediums for communication. Will reports be fixed or will there be local manipulation of data?

4.5 *Disclosure policy:* what data will be publicly available? If it is in the public interest and does not cause harm then all data should be available in a format which is relevant to the audience.

4.6 *Management of outliers:* how will information on providers identified as outliers be managed?

4.7 *Impact on clinical activity*: How will the audit seek to influence clinical activity? How will the proposed audit develop action plans for improvement activities?

5. Availability of output
5.1 *Locally for quality improvement*: how will data be made available to clinicians and trust managers for local quality improvement?

5.2 *Revalidation of professionals*: how will output contribute to revalidation of clinicians? Which clinicians does the audit affect?

5.3 *Regulation of organisations*: will data be available for regulation of providers?

5.4 *Risk management*: will participation contribute to providers' risk management?

5.5 *Research*: how will the data be exploited for research purposes? How will external researchers gain access to the data? Data sharing agreements and PIAG proposals need to be explicit about the purpose of data collection.

5.6 *Commissioners:* how will data be made available to commissioners of services?

5.7 *Patients*: how will data be made available to the public to help informed choices?

5.8 *International comparisons:* are there opportunities for meaningful international comparisons?

5.9 *Incorporation in Quality Metrics/Quality Accounts:* will output contribute to national quality metrics and provider's Quality Accounts?

6. Organisation/governance
6.1 *Relevant clinical leadership*: Is the audit led by clinicians? Are all the relevant professions and specialties involved in the proposed steering group for the audit?

6.2 *Other essential team members:* are public/patients involved? Are methodologists (eg statisticians, epidemiologists, qualitative researchers, health psychologists) with appropriate scientific skills and experience involved at the right level of engagement and in clear and appropriate roles? Are IT/data managers involved?

6.3 *Management arrangements:* how will the audit be managed and governed? How will the project steering group be organised and who will chair, who will provide the secretariat and how will decisions be made? Appropriate project management tool to be used relevant to the project size?

6.4 *Communications policy:* how will the audit be publicised, including to various groups – patients, clinicians, commissioners etc? How will participating providers and their staff be involved and informed? Will regular national meetings be held?

6.5 *Cost*: what is the central cost of the audit? What is the local cost for participating providers? What is the estimated cost per patient recruited? Bidders must identify costs according to the supplied template, setting out clearly the costs solely applicable to the audit concerned. What are the respective costs of clinicians and data management?

6.6 *Plans for sustainable funding*: what plans are there for longer-term funding if central funding ceases?

6.7 *How will risk be managed*? What systems are in place to address risks and organisational failures with the audit?

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