Spotlight on the Early Years

Using National Clinical Audit reports to harness cross-cutting lessons

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About HQIP

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies. www.hqip.org.uk/national-programmes

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1. Executive Summary

We reviewed **3 audits** looking at the care of women and children

This included **10 reports,** spanning **4 years** and a total of **264 recommendations**

100% of the audits **recorded** information on **ethnicity** or **deprivation**.

0% of the audits **analysed** or **reported** the **impact** of **ethnicity** or **deprivation** on outcomes*

15% of recommendations were **repeated**

51% of recommendations were aimed **locally** - to hospitals, departments or healthcare professionals

There was a clear focus on taking **ownership** and using the audit **data** to drive **improvement**

The mean number of recommendations showed a **downwards trend** over time

*This was not required as part of the audit specification

2. Key messages and recommendations

KEY MESSAGE 1:

None of the audits sampled analysed the impact of ethnicity or deprivation on outcomes. Analysis and reporting of variation in care attributed to ethnicity and/or deprivation has not historically been, nor is presently, a primary focus for these national clinical audits. The potential for the NCAPOP to be a key resource in understanding and supporting the system to address health inequalities is not currently being realised. These findings corroborate the recent governmental review 'The Best Start for Life'.

Recommendation 1.1:

Work with NHS England and NHS Improvement to align an approach for NCAPOP's role in shining a light on health equality. This should include:

- Determination of a minimum dataset of patient characteristics to be collected and reported by every audit
- Ethnicity and postcode should be included in this dataset

Audience: HQIP (NCAPOP team, Executive Leadership Team), NHS England and NHS Improvement (Health Inequalities team, Clinical Effectiveness team)

Recommendation 1.2:

Implement current and future guidance issued by HQIP to ensure health equality is appropriately addressed in NCAPOP programmes.

Audience: NCAPOP Audit providers

Recommendation 1.3:

Work with HQIP to help fulfil the commitments made in 'The Best Start for Life' review. HQIP's input will be vital to work to help improve the quality and timeliness of current data collections[1].

Audience: Department of Health and Social Care ('The Best Start for Life' Review Team)

KEY MESSAGE 2:

Identifying cross-cutting themes between a sample of audits was challenging. Audit measures are specific to each audit/topic area, which makes discerning NCAPOP programme-level learning challenging.

Recommendation 2.1:

Work towards standardising the reporting of key characteristics, such as ethnicity and deprivation, which are universal across audits and care areas. This will improve the scope for programme-level learning.

Audience: NHS England and NHS Improvement, audit providers, supported by HQIP

KEY MESSAGE 3:

Annual reports predominantly make recommendations aimed at local hospitals, departments and healthcare professionals. There is a clear emphasis within these recommendations on local units taking ownership of data and using national clinical audit data for improvement, but there is variability to which audit outputs support improvement. The mean number of recommendations per report has decreased over time, however 15% of all recommendations in the annual reports were repeated in subsequent reports.

Recommendation 3.1:

Work to implement the following changes to the NCAPOP programme:

I. Decommission the annual report
II. Replace the annual report with an annual state of the nation summary (maximum 10 pages and five national recommendations)
III. Replace local recommendations with online improvement resources
IV. Limit the number of performance metrics to 10 per audit workstream
V. Make all audit performance metric results available in an interactive format online to all users
VI. Refresh all audit performance metric results at least quarterly in year two then monthly thereafter

Audience: NHS England and NHS Improvement, NCAPOP audit providers

KEY MESSAGE 4:

Internal projects, such as this, and previous work reviewing health equality in the NCAPOP[2] have generated valuable learning. Such projects are important in the process of continual improvement of the NCAPOP programme.

Recommendation 4.1:

Work with NHS England and NHS Improvement to consider opportunities for co-production of projects related to the NCAPOP and the resourcing for such projects. The Clinical Fellow is well placed to work on and shape these projects.

Audience: NHS England and NHS Improvement Executive Quality Group (EQG) Clinical Audit Sub-committee

3. Introduction

The National Clinical Audit and Patient Outcomes Programme (NCAPOP) includes a number of programmes which evaluate the quality of care provided to women and children. It is well-evidenced[3],[4] that the care provided to children in the early years of life has a critical impact on later life. This report begins by outlining the context to the project and the methodology used. It reviews a sample of audits focusing on the early years of life, with a particular focus on the recommendations from these programmes and the impact of ethnicity and deprivation on the care provided to these patients.

Background

Within the NCAPOP portfolio there are a number of programmes that evaluate the quality of care provided to women and children, aligned with the NHS Long Term Plan (LTP)[5] aims of ensuring 'A Strong Start in Life'. Presently, the 'Early Years' of Life is an area of particular focus, in light of the Government review 'The Best Start for Life – A vision for the 1,001 Critical days'[6] published in March 2021. There is clear evidence in the variability in quality of care provided to women and children, as evidenced by previous NCAPOP reports such as the 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report'[7]. Furthermore, there is clear evidence that infant mortality rates are higher in the most deprived areas[8], and amongst ethnic minority children[9]. The ongoing COVID-19 pandemic has acted to shine a light on the existing inequities amongst patients from different ethnic groups or socioeconomic positions.

Aims and objectives

The aim of this project was to decipher cross cutting themes between NCAPOP audits looking at the early years of life, with the ultimate aim of determining if this could overcome project silos, bring together findings and better utilise the collective assets of the NCAPOP. We focused specifically on the reporting and analysis of the impact of deprivation within these audits, given the current focus on health inequalities and in continuation of work previously completed internally looking at health equality in the NCAPOP[2].

4. Methodology

Programme selection

Within the NCAPOP portfolio, there are nine programmes that specifically report on the quality of healthcare delivered to women and children. For the purposes of the project, these were narrowed down to three audits, to meet time and resource constraints.

Initially, these audits were filtered down based on programme type. Only National Clinical Audits (NCAs) were included in this project, owing to the methodological differences with the Clinical Outcome Review Programmes (CORPs). This left five audit programmes, namely the National Neonatal Audit Programme (NNAP), the National Maternity and Perinatal Audit (NMPA), the Paediatric Intensive Care Audit Network (PICANet), National Paediatric Diabetes Audit (NPDA) and Epilepsy 12. These were further narrowed by care area, to those that focused primarily on both neonatal and paediatric care pathways. This left three audits for in-depth analysis as part of the project, which overlapped with work completed internally looking at health equality in the NCAPOP[2]. These three audits were as follows:

- The **National Neonatal Audit Programme (NNAP)**, provided by the Royal College of Paediatrics and Child Health (RCPCH)
- The **National Maternal and Perinatal Audit (NMPA)**, provided by the Royal College of Obstetrics and Gynaecology (RCOG)
- The **Paediatric Intensive Care Audit Network (PICANet)**, provided by the University of Leeds and University of Leicester.

These long standing audits were felt to provide a strong overview of the clinical landscape, ranging across maternity and perinatal care, neonatology and paediatrics.

Scope

This project utilised existing annual reports from the audits currently in the public domain. We performed qualitative analysis on the outputs produced, looking primarily at recommendations and key findings. All reports published between January 2016 and March 2021 were included in the analysis. These include data from between 2015 and 2019. Further quantitative analysis from data collected by the audits, or in depth review of other outputs was out of scope of this project.

We collated all recommendations and key findings from a sample of reports (NNAP, NMPA and PICANet), published from January 2016 to March 2021. This was 10 reports in total.

Table 1 – List of all the audit publications involved in the analysis
Note: Dates in brackets denote cohort year

Programme/ Publication year	NNAP	NMPA	PICANet
2016	✓ (2015)		*
2017	✓ (2016)	✓ (2015 – 2016)	**
2018	✓ (2017)		✓ (2015 – 2017)
2019	✓ (2018)	✓ (2016 – 2017)	✓ (2016 – 2018)
2020	✓ (2019)		
2021			✓ (2017 – 2019)

*Covers a cohort of January 2013 to December 2015, which is out of scope for this project
**Covers a cohort of January 2014 to December 2016, which is out of scope for this project

Part 1 - Analysis of recommendations

Initially, a numerical analysis was undertaken on the collated recommendations. This focused on their target audience and the number of repeated recommendations. Repeat recommendations were defined as recommendations which were either explicitly stated to be repeated, or where the meaning was deemed to be identical. Those deemed similar were felt to bestow the same message with slight changes to wording. The initial recommendation was not counted but every repeat thereafter was. For example, if there was a recommendation that was made three times within this period this counted as two 'repeated' recommendations.

A qualitative thematic analysis was then undertaken on the recommendations. This was done independently by two investigators until a consensus was reached on themes. These were then summated into four main themes.

Part 2 - Content analysis – health inequalities and variation

Following the thematic analysis of recommendations, a content analysis was performed specifically to focus on health inequalities. Our research question was:

What information regarding the impact of ethnicity and/or deprivation on the audit measures can be gathered from the annual report above what is mentioned in the key findings or recommendations?

A preliminary search through all 10 reports was made using the terms 'deprivation' and 'ethnicity' and the number of times this was mentioned was recorded. These terms were widened following a review of the literature to produce the search terms used in the analysis.

Table 2: Search terms for content analysis

Characteristic	**Search terms**
Deprivation	Deprivation
	Deprive
	IMD
	Socioeconomic
Ethnicity	Ethnic *(group)*
	Ethnicity
	Race
	Racial
	Nationality
Inequality	Inequity/inequities
	Inequality/inequalities

Finally, an in-depth review of the most recent report across each audit (NMPA 2019, NNAP 2020, and PICANet 2021) was performed to further discern additional information regarding ethnicity or deprivation in the reports.

5. Key findings

Part 1 – Analysis of recommendations

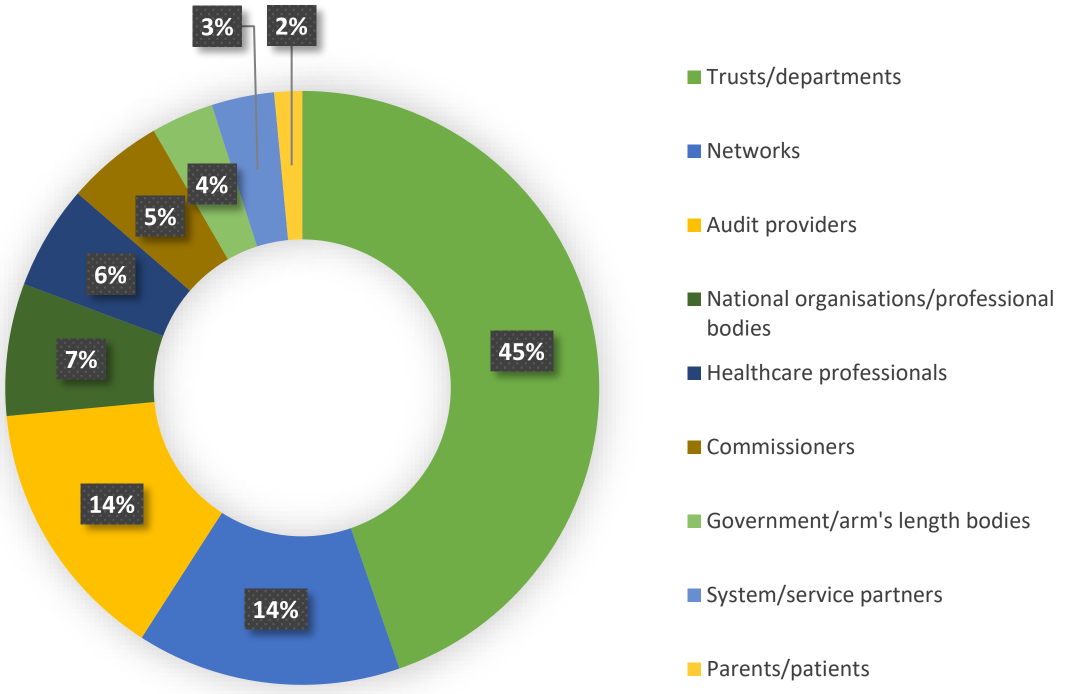
Analysis of recommendations – Numerical

In total 264 recommendations were identified, from 10 reports, spanning four years. 39 of these recommendations were repeated (either explicitly, as stated by the audit, or as identified through the review process) accounting for 15% of all the recommendations. A further 14 were deemed to be 'similar' to recommendations that had been made previously, offering very closely related messages with differing wording. Totalled together this made up 20% of all the recommendations.

These recommendations were aimed at nine groups. These were, in order of frequency:

1. Trusts/ Departments – 45%
2. Networks – 14%
3. Audit providers – 14%
4. National organisations / professional bodies – 7%
5. Healthcare professionals – 6%
6. Commissioners – 5%
7. Government and arm's length bodies – 4%
8. System / service providers – 3%
9. Parents / Patients – 2%

Figure 1: Pie chart showing the audience to whom recommendations are aimed at

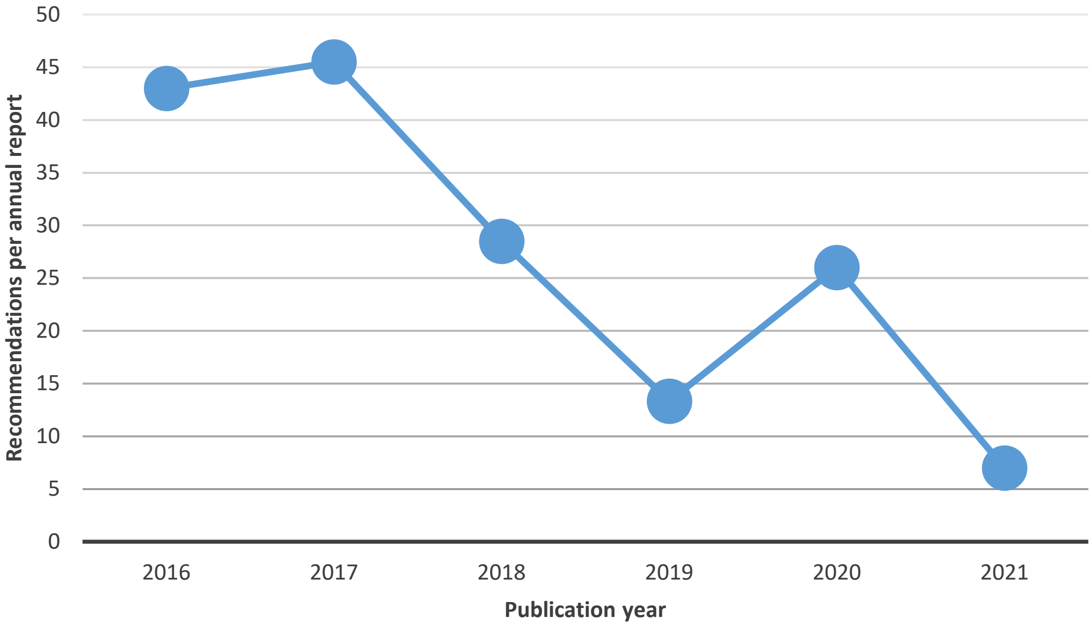


The numerical analysis demonstrated that recommendations were predominantly aimed locally, with 51% of recommendations aimed at either trusts/departments or healthcare professionals. A relatively small proportion of the recommendations (11%) were aimed at national/professional organisations or government/arm's length bodies (7% and 4% respectively).

Surprisingly, 14% of all recommendations were aimed directly back to the audit provider themselves, or to another audit provider working in a similar space. Reassuringly however, a review of these recommendations over time has demonstrated that almost all of these recommendations back were made between 2016 and 2018, with only two recommendations made back to the audit providers since 2019, demonstrating audit providers taking on feedback from HQIP about this.

The collated recommendations demonstrated that the mean number of recommendations per annual report showed a downwards trend across this time period.

Figure 2: Mean number of recommendations per annual report over the sampled time period



PICANet had the lowest mean number of recommendations per annual report (7), followed by NMPA (22.5). NNAP had the highest mean number of recommendations (39.6). The average number of recommendations per report across the period was 26. Guidance issued in the HQIP provider technical manual recommends no more than 10-15 recommendations. These results demonstrate the variation in compliance with this advice across the NCAPOP programme.

Analysis of recommendations – Content

13 key themes emerged from the thematic analysis of recommendations. These were intentionally high-level, given the small sample size, as to not weight the themes to solely reflect the metrics reported by each audit. These themes were grouped into four main areas (listed in order of frequency).

1. **Ownership of data – Using the data to review quality**
    a. Collaboration/shared learning
    b. Benchmarking
    c. Quality Improvement
    d. Wider context – interaction with national initiatives
    e. Addressing variation in care
2. **Data**
    a. Measurement/standards
3. **Care pathways**
    a. Staffing
4. **Patients/parents**
    a. Empowering patients/parents
    b. Maternal health.

Figure 3: Word cloud demonstrating themes from the content analysis of recommendations

Theme: Ownership of data – Using the data to review quality

This was by far the most prevalent theme emerging from the thematic analysis of recommendations. There was a clear sense from the recommendations of the onus on local departments, and healthcare professionals to take note of, and utilise the data from the national clinical audits in order to systematically review the quality of care they provide, and take steps to improve this.

There was frequent suggestion that the data should be used to benchmark against national standards, and other departments, and that departments should collaborate to share best practice and quality improvement initiatives. Indeed, the recommendations often explicitly referred to using the audit data to prompt Quality Improvement (QI) initiatives. The recommendations commonly made reference to the wider context in which the national clinical audits operate, signposting to national publications, guidelines, or initiatives which could further support improvements in care.

Though not formally analysed, the sense was that the focus on using the data for improvement was more prevalent in more recent reports, with some audits making reference to online tools and resources that could be used to facilitate this.

Theme: Data

Perhaps unsurprisingly given the nature of the audits, data was frequently referred to in the recommendations. Most frequently, the recommendations made reference to data completeness and quality. This theme also encompassed data burden – making reference to linkage, routine data and relevant software utilised by the national clinical audits. This theme also encompassed a number of recommendations, predominantly directed back to the audit providers themselves, regarding the definitions of measures and audit standards used for the audits.

Theme: Care pathways

This theme encompassed recommendations regarding the structure and provision of healthcare in the early years of life, for example the provision of intensive care beds for those babies that require this support, or transport systems. Recommendations regarding staffing levels, training and retention were common within this theme.

Theme: Patients/parents

The final theme consists of recommendations that either were directed at parents/patients explicitly, or clearly focussed on educating and empowering parents/patients to actively participate in their care. These recommendations encompassed transparency about audit results, education about care processes recommended for children and effective communication with families. Recommendations regarding prompting maternal health, as example through smoking cessation and weight management, were also included in this theme.

Discussion

The initial aim of this project was to identify cross cutting themes between NCAPOP projects, to eliminate project silos and better utilise the assets of the NCAPOP. This was the first time a project of this type had been undertaken within HQIP and accordingly there were a number of unexpected findings and challenges.

Our project has demonstrated that it was difficult to identify cross-cutting clinical themes across these three audits, and whilst there appeared to be some overlap between the audits we selected, in reality, this was minimal. The metrics and consequently key findings and recommendations are specific to their care areas, and not necessarily generalisable between audits. Looking at clinical themes would have just reflected the audit metrics used by each audit. This was compounded by the variability in the frequency at which audits are able to produce annual reports. We had a sample of audits heavily weighted towards the NNAP measures, simply because NNAP had published more reports that NMPA and PICANet in this time (five versus two and three respectively).

Whilst this moved our project's focus slightly away from what was initially intended, it yielded a number of interesting findings.

The numerical recommendation analysis made clear that the bulk of recommendations are aimed at the local level, implying that the onus for responding to national clinical audit results lies locally with trusts, departments and healthcare professionals. This was further supported by our thematic analysis of recommendations, which clearly demonstrated that the main focus was on using the national clinical audit data to review, and improve services. This reiterates the importance of considering how the NCAPOP outputs can best facilitate local professionals to utilise the national clinical audit data to improve the quality of care provided to patients.

It was interesting, but perhaps not unexpected, to find that a significant proportion of the recommendations were repeated. This has been noted previously, with programmes such as the MBRRACE-UK programme explicitly repeating 'recommendations requiring improved implementation' as part of their reports. This does raise the question about the impact and application of recommendations in annual reports. There is good evidence demonstrating that national audits can drive significant reductions in variation of care and improvements[10],[11] however it is unclear the role of the annual report in such improvements. Furthermore, there is significant variability in the degree of and time taken for improvement across care areas, and it is suggested that the potential of audit and feedback has not been realised[12]. There are a number of reasons why national recommendations may not be acted upon, or improvements not realised. These include insufficient local resource to do so, poor penetration and dissemination of the reports and results and a multitude of factors known to influence response to feedback such as distrust in the data, timeliness of data and lack of incentive to do so[13] [14]. Clearly, HQIP do not have the ability to control all of these factors. However, as the commissioner, there is a responsibility to develop and shape the NCAPOP outputs in a way to maximise their impact.

Previous work has suggested that data based on recent performance (<6 months) and focus on individual team's behaviour (e.g. regional data) are important components of audits which influence feedback[15]. These are rarely, if ever, included in annual reports and recommendations are exclusively made nationally. As more audits are developing capability to present near real-time data on online dashboards, it is important to consider how the annual reports should adapt to best meet the needs of the audiences using them. This work complements work already underway within HQIP, including work looking at how to optimise audit outputs for quality improvement, and a recent virtual webinar series which brought together methodologists and other interested parties during autumn of 2020. This group felt that more frequent outputs from audit providers with web-based results would be a better way of getting the important messages across to the service, and that the annual report might better report more overarching themes from the clinical audit[16].

We were surprised to find that 14% of the total recommendations from this cohort were aimed directly to audit providers themselves. On further review it was evidence that this had significantly reduced over recent years. It is important for audiences that the audit providers are transparent about changes in metric, however this should lie outside the main body of recommendations. This would further support the ongoing work to reduce the total number of recommendations from the reports. Our work clearly demonstrates a downward trend in the average number of recommendations in the annual report, reflecting recent efforts to streamline the number of recommendations. Further work to review this across the whole NCAPOP portfolio was outside the scope of this report but would be interesting to consider in future.

We acknowledge that there are limitations to this work. These projects only represent a small sample of the portfolio of audits that cover ‘Early Years’ across the NCAPOP portfolio, and therefore our findings cannot be generalised across the programme. Undoubtedly, including all nine programmes would have been the preferred way to approach this project, but this would not have been manageable with the timeframe and resource available. Additionally, this project is looking at a small sample of audits over time. It is also important to acknowledge the internal (HQIP) and external factors which have altered the landscape in which these audits have reported over this time period. For example, the Provider Technical Manual (PTM) was launched in 2017, which outlined the expectations for the audit providers. This included guidance on recommendations, which was updated to recommend a maximum of 10 - 15 recommendations per audit in 2019.

Part 2 - Best start in life: health inequalities and variation

The second half of this project was to look further into the annual reports, to determine what information in addition to the key findings and recommendations we could gather regarding the impact of ethnicity and/or deprivation on the quality of care provided to patients across these audits.

The preliminary content analysis demonstrated very limited content related to the impact of ethnicity and/or deprivation across all audit reports.

Table 3: Table demonstrating the number of times the extended search terms related to ethnicity or deprivation were mentioned in the annual reports

Year						
Search term*	2016	2017	2018	2019	2020	2021
PICANet						
Deprivation	-	-	0	0	-	0
Inequality	-	-	0	0	-	0
Ethnicity	-	-	1	0	-	1
NNAP						
Deprivation	0	0	0	0	1	-
Inequality	0	0	0	1	1	-
Ethnicity	0	0	0	3	1	-
NMPA						
Deprivation	-	17	-	14**	-	-
Inequality	-	0**	-	0	-	-
Ethnicity	-	11	-	3**	-	-

*And associated search terms (see Table 2)
**Including mentions in contents/tables/figures, not including references

To further explore this, we undertook detailed reviews of the most recently published reports (NMPA 2019, NNAP 2020, and PICANet 2021) to ascertain if there was further information about the impact of ethnicity and deprivation on the quality of care provided to children across these audits.

In the PICANet report (2021), there was one mention of ethnicity. This was in reference to admission criteria, stating that this demographic information included ethnic group. However, this information was not reported or analysed further in the report. The report demonstrated geographical variation in care, including admission rates and mortality, but did not look into how deprivation and/or ethnicity could have correlated with this. There was no mention of deprivation or inequality in the report.

The NNAP report (2020), made mention of deprivation, inequality and ethnicity. Ethnicity was stated to be 'matched for' when estimating treatment effect on mortality between units, thus acting to correct for any impact this variable might have on mortality, but not exploring this directly. The mention of deprivation was only to demonstrate that this was not matched for in these estimates. Health inequalities are referred to in the context of a case study, outside the main bulk of the report.

The NMPA report (2019) returned the most number of matches on the preliminary content analysis. Whilst the report makes no direct reference to health inequalities, there were numerous references to deprivation and ethnicity. Unlike the other two reports, the NMPA report reported on deprivation (using the Index of Multiple Deprivation (IMD)) and ethnicity in the demographics table of the report. The audit corrects for ethnicity and socio-economic deprivation in the analysis of their results, in order to compare results between organisations. It does not report on, or analyse the impact of these on the outcomes of mothers or babies.

Given there was little further information garnered from the in depth review of the most recent reports, it was decided that further review of older reports was not warranted, as it was highly unlikely to reveal more information than from the initial preliminary analysis.

The in-depth analysis of each annual report yielded very limited further information beyond what was contained in the key findings and recommendations, or what was discerned from the content analysis.

Discussion

This work demonstrates that addressing variation in care attributed to ethnicity and deprivation has not historically, nor is currently, a primary focus for these audits. Our work corroborates the findings of recent work recently published by HQIP[2]. This found that in a sample of 19 NCAPOP audits, 100% of audits collected ethnicity, and 89% collected postcode (thus allowing estimation of deprivation via IMD), however only 33% and 39% of audits reported on these measures respectively, with an even smaller proportion of the audits going on to analyse the impact of these characteristics on outcomes.

Perhaps these findings are unsurprising given that the audit providers were not contractually obliged to by the audit specification. Providers are also contractually obliged to adhere to guidance that HQIP produce in the PTM, which was first brought in in 2017. The guidance in the PTM since 2017, has recommended 'consider[ing]… reporting by demographic sub-groups, such as ethnicity, gender and deprivation'[17]. Whilst this demonstrates effort to prompt audit providers to consider this, again this is not mandatory and not strictly contractual. It is also important to note that in light of the renewed focus to address health inequalities, HQIP are currently in the process of reviewing all internal processes to ensure a clearer position on addressing inequalities.

However, there is an urgent need, accelerated by the exposure of this issue during the COVID-19 pandemic, to further our understanding of the impact that health inequalities, in particular ethnicity and deprivation, have on patients' outcomes. There is evidence of the significant impact of ethnicity and deprivation on the early years of life. For example, the recent MBRRACE-UK report demonstrated women from Black ethnic backgrounds are more than four times as likely, and women from Asian ethnic backgrounds nearly twice as likely, to die from pregnancy associated causes as White women[18]. Similar inequalities exist amongst children, with evidence that babies from minority ethnic groups are less likely to receive mandatory health reviews[19]. Children born into poverty in the United Kingdom are more likely to have low birthweight, die in the first year of life and develop asthma, amongst other consequences[20].

It seems at odds that we have evidence that significant inequalities exist, but that national datasets are not actively reporting and analysing on such characteristics. For example, one of the metrics from the sample of audits looked at parental presence on ward rounds. It seems a reasonable assumption that factors such as not having English as a first language, or lacking formal education may impact negatively on this metric, however the audit did not report on ethnicity or deprivation. Taking action to try and improve these figures without first seeking this information risks widening inequalities and failure to truly address the underlying issue. Given the large scale of the datasets, the NCAPOP is well positioned to improve understanding of the impact of these characteristics, which is a necessary step to be able to address the inequalities that exist.

Our findings are supported by those of the recently published Governmental review, 'The Best Start for Life'[6]. The following excerpt from the report is particularly pertinent:

> Currently, there are concerns that the data used to measure health outcomes in the 1,001 critical days is not capturing the whole picture. Improving the quality and timeliness of current data collections is the quickest way to improve knowledge about outcomes in the start for life period. Doing so will be particularly important when looking at inequalities and the ways in which vulnerable communities need extra support.

The 'Best Start for Life' review makes commitments to "work with others to better understand why existing data collection requirements are not universally met" and "also to consider what other data could prove vital in identifying and reducing inequalities in outcomes such as infant mortality". In light of this report, combined with our findings, it is important that HQIP or NCAPOP are considered in discussions with the government around these issues – particularly improving the use of data to address inequalities. This has the potential to afford mutual benefit – for HQIP, it would raise the profile of the organisation, and provide an opportunity to capitalise on the parliamentary commitments to improve the 'quality and timeliness of current data collections.' For the government, HQIP, as commissioners of the NCAPOP programme have significant influence over the data collection within these large national datasets, which go far beyond the first 1,001 days of life.

We have seen the impact that rapid recording, reporting and analysis of this data can have[21]. During the COVID-19 pandemic, emergency regulations were put in place to ensure the accurate collection and reporting of information relating to patients with COVID-19. This included the impact of ethnicity on COVID-19, and other outcomes such as the effects on births. This allowed NHS England to tailor communications and services to those most at need[22]. Actions to dress inequalities such as this are only possible if appropriate data is collected and reported on in these areas.

We, again, acknowledge there are limitations of this study. These audits only represents a small sample of the NCAPOP portfolio and are therefore not necessarily representative of the whole programme. Additionally, we only reviewed the annual reports, which has the potential to omit short reports which address these areas - indeed, the NMPA is due to publish a sprint audit focused specifically on Health inequalities in November 2021 and the National Child Mortality Database (NCMD) recently published their Child Mortality and Social Deprivation report. We acknowledge that the renewed focus on health inequalities is recent, and that organisations need sufficient time to comprehensively build this work in to programmes, without compromising quality in other areas.

6. Conclusion

This report looks at a sample of NCAPOP audits focusing on the care provided to patients in the ‘Early Years’ of life. This work should be seen in the context of wider work being undertaken at HQIP, including previous work on health equality in the NCAPOP[2], ongoing work to maximise the QI potential of the NCAPOP and our recent virtual Methodology Advisory Group (MAG) webinar series[16].

The thematic review of recommendations clearly demonstrates focus on using the audit data locally to drive improvement, highlighting the importance of producing outputs that best allow the audiences for the audits to use the data for improvement. Our work also demonstrates that the reporting and analysis of ethnicity and deprivation is not at the forefront of the NCAPOP programme. The NCAPOP has the potential to be a key resource in understanding, and therefore supporting the system to address the health inequalities that influence outcomes in the early years of life, and beyond, however, further work is required in order to realise this potential.

This project has provided rich learning, both in terms of the process and findings. A number of the difficulties we encountered arose from having a small subset of audits in one care area. There is clearly scope for further similar work in future, which could focus at a high level across whole programmes or categories of audits.

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Acronyms

CORP	Clinical Outcome Review Programme
COVID-19	Coronavirus 2019
HQIP	Healthcare Quality Improvement Partnership
IMD	Index of Multiple Deprivation
LTP	Long Term Plan
MAG	Methodology Advisory Group
MBRRACE-UK	MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
NCA	National Clinical Audit
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCMD	National Child Mortality Database
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
PICANet	Paediatric Intensive Care Audit Network
PTM	Provider Technical Manual
QI	Quality Improvement

Figures and tables

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