

2024 EDITION



HQIP

Healthcare Quality
Improvement Partnership

A **FREE** publication for those who are passionate about evidence-based healthcare improvement, including:

Quality Improvement (QI), audit and clinical effectiveness professionals as well as those who plan, deliver and receive healthcare

CORNERSTONE

LAYING THE FOUNDATION FOR IMPROVEMENT IN HEALTHCARE



Avoiding 'lost in translation'

Using national healthcare data to support meaningful change

ALSO INSIDE THIS ISSUE

- Patient and Public Engagement in practice
- A review of benchmarking in healthcare
- An 'umbrella approach' to audit: sharing, efficiencies and results
- 20 Years of the National Joint Registry
- Taking an effective and sustainable approach to clinical audit

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ABOUT HQIP

A long-term partner of NHS England, the Healthcare Quality Improvement Partnership (HQIP) is an independent organisation with the primary aim of improving health and care quality and, in turn, health outcomes for patients. We achieve this by supporting robust Quality Improvement (QI) through national clinical audit, clinical outcome review programmes and registries as well as providing a wide range of reports, guidance, benchmarking and related services. While always evidence-based, our work – and its value in supporting targeted improvement – goes far beyond data collection. By identifying where resources are needed most, and where they would make the greatest difference, our approach offers maximum impact for those who plan, deliver and use health and care services. For further information, go to www.hqip.org.uk.

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WELCOME TO

CORNERSTONE



A smarter approach to Quality Improvement (QI)?

We all recognise the need to continuously improve services to improve patient outcomes - but, in the current climate of post-pandemic recovery and overstretched resources, how can this be achieved in practice?

Many agree that the answer lies in taking a targeted approach. Identifying where resources are needed most, and where they would make the greatest difference, to achieve maximum impact. In other words, we need to 'follow the data'. At the [Healthcare Quality Improvement Partnership \(HQIP\)](#), we believe that data from the [audit and clinical outcome review programmes](#) we commission on behalf of NHS England are an essential part of the 'cornerstone' (the foundation, if you will) of evidence-based service evaluation and improved patient outcomes.

If we have a detailed understanding of what is happening, where and to what extent, then we can adopt a 'smarter' approach to quality improvement; we can see where change is needed and where resources need to be directed. Importantly, we can also see where they are not required. But, there is a large amount of healthcare data 'out there' and it can be difficult to know what to look at (and to find the time to do this!). Then, there's the additional challenge of how to translate that knowledge into actions and meaningful change.

That's why we have introduced a number of changes to HQIP-commissioned outputs - to reduce the number of metrics, make [reports](#) more succinct, and improve the timeliness of data. We are also delighted to start taking a new approach to the commissioning of audits, as exemplified by the [National Cancer Audit Collaborating Centre](#). This Centre encompasses multiple cancer audits, and offers efficiencies as well as opportunities for greater knowledge and best-practice

sharing. You can find out more about this ground-breaking approach in the article on page 19.

This publication itself is another part of the HQIP toolkit to support the healthcare community to navigate, and implement changes based on, the data available. With short, easy-to-read articles on topics such as benchmarking and influencing organisational change, as well as information about further resources and exemplar projects, we hope that there is something for everyone. As such, we encourage you to share this free resource with colleagues across the health and care sector, whether actively involved in quality improvement or not: www.hqip.org.uk/magazine.

I will conclude on a personal note. Having only recently taken the helm as CEO at HQIP (from August 2023), it is heartening to see the way that the audit and wider healthcare communities are working together to take an evidence-informed approach to improvement, and reduce burden. And that doesn't just apply to healthcare professionals and policy makers - patients, too, play an important part in designing services that are meaningful and fit-for-purpose. In the words of Owen Thurston, a Youth Advocate from the Epilepsy12 audit (Patient and Public Engagement in Practice on page 4): "It's essential to keep the patient at the centre of healthcare at all times. If we do that, then the sky's the limit!"

I speak for the whole of HQIP and our commissioned programmes, when I say that we look forward to working with you all to reach for 'that sky'. To realising the value of audit and clinical outcome data, and supporting improved health outcomes for patients.

I hope you find this publication useful (please do share any feedback you have via communications@hqip.org.uk).

Best wishes,

Chris Gush, CEO

Healthcare Quality
Improvement Partnership (HQIP)



Patient and Public Engagement in practice

A win-win for healthcare providers and patients alike

There are many well-documented reasons as to why it's important to work with the people and communities we serve, not least improved health outcomes. But these benefits apply to both care-givers and -receivers alike. **Kim Rezel, Head of Patient and Carer Engagement at the [Healthcare Quality Improvement Partnership \(HQIP\)](#)**, talks to both the staff and volunteers from the two winning projects of the Patient and Public Involvement category of the [2023 Clinical Audit Heroes Awards](#) (Epilepsy12 and Side-by-Side) about their experiences of effective patient engagement, in the hope that others may be inspired to think about how they could include patients and carers in their projects...

Introducing the winning projects from the Patient and Public Involvement category of the 2023 Clinical Audit Heroes Awards:

Epilepsy12 is an audit delivered by the Royal College of Paediatrics and Child Health (RCPCH) that is supported by a group of epilepsy experienced or interested children, young people, families, and an epilepsy specialist nurse. They volunteer to shape the Epilepsy12 clinical audit and lead improvement activities with patients, families, and epilepsy services. They bring their voices, experiences, hopes and wishes to life, together, through youth-led project work and advocacy.

Interviewees:

- Dr Colin Dunkley, Clinical Lead
- Owen Thurston, Youth Advocate

Side-by-Side is a partnership between the Solent Academy of Research and Improvement team and a dedicated group of patient and public involvement representatives who support the integration of clinical audit, service evaluation, quality improvement, research and library teams within the Solent NHS Trust. Support comes in many forms, such as co-designing and co-delivering training workshops, supporting improvement projects, reviewing reports, sitting in interview and award panels, and organising an annual conference.

Interviewees:

- Sian Lloyd Jones, Side-by-Side member
- Juliet Mosney, Side-by-Side member
- Sarah Rowcliffe, Side-by-Side member
- Colin Barnes, Head of Improvement
- Carl Adams, Head of People Participation
- Natalie Royston, People Participation Facilitator

The **healthcare professional** perspective...

Q: What motivated you to set up a patient group to support your audit?

Epilepsy12: We weren't getting through to patients' "real voices"; there was a distance. We were beginning to get some sense of people's views through the patient experience measures that we'd built into the audit, but there was a strong sense that they wanted more direct "contactability" with our service. At the same time, we realised the irony that our patients had limited involvement in the design and running of the audit, and so we needed an approach that would address that.

Q: Do you have any hints or tips on how to get started?

Side-by-Side: Ask people to be involved and provide a genuine offer of real involvement; don't just pay lip service to patient engagement. Side-by-Side was created from when we held a traditional research conference in 2014, in which we invited a group of patients to provide feedback. It wasn't positive. We apologised and asked them to help us to make it "better" next time. This was the start of building relationships and working together to put patients at the heart of what we do.

The **patient** perspective...

Q: Why did you become involved?

Side-by-Side: Having the opportunity to add a community perspective into projects within Solent NHS Trust, to provide a patient voice, is really important. We have something extremely valuable to add into discussions around our care.

Epilepsy12: We wanted to make sure that young people and their families were heard, since discussion and patient engagement means better care. In a nutshell, we wanted to create a gold standard in epileptic care.

Q: How did you become involved?

Epilepsy12: Initially, I became associated with different epilepsy charities, completing feedback forms etc. Then, I became involved in this programme's Board, speaking at a conference and working with a group of others to help launch the [Epilepsy Passport](#). But then we became keen to be more involved, to put our views into practice. Following a conference in 2019, we realised that we wanted to reach out to clinicians to look for the best ways to speak out about epilepsy care, which we did. Consequently, several clinics from across the UK got in touch and said "yes, please come and visit us". Unfortunately, because of the COVID-19 pandemic, we weren't able to go out and speak to people in person; however, we still made contact, but using online methods instead.

Q: How does it work, in practice?

Side-by-Side: We have a group of patients and service users who work alongside us. They meet regularly (every 6 to 8 weeks) and we present involvement opportunities to them, while they hold us accountable to all the things we said we were going to do. We are very fortunate to be in a position where we have a participation team to support liaison such as sending email updates etc. It can take some time to set up in the first instance, but it's so worth it – and now we've got to a point where the group is happy to be contacted via a quick text or WhatsApp message. We genuinely see them as part of the team; they have this wealth of experience, skills and ideas that we feel really privileged to utilise in what we do.

There's no divide between volunteers and paid members of staff, and that's why I think it works really well

Q: What do you see as the main benefits of setting up a patient group?

Epilepsy12: The quality of the feedback we get has exceeded my expectations. For example, at first, when we sent the group a patient-facing report to review, I was expecting something fairly light touch, but actually the feedback was much more profound than that. Because it comes from a patient, the information comes with experience and passion. It made me realise that there isn't anything the group can't do. Now there isn't a part of the process that they're not involved with; they're involved in the full methodology, from design to delivery.

Side-by-Side: This has completely transformed the way I work, even to the point where our patients contributed to my appraisal. Working with patients means you can come out with something entirely different, but also better and more fit-for-purpose and with greater longevity.

Q: And what about the challenges?

Epilepsy12: If you're not careful, you can be pulled in different directions. We needed to ensure that everyone involved was aware of each other's visions and perspectives. So, we focused on getting a 'balance of autonomy' among the different groups. But it's a delicate balance; a dance between autonomy and empowerment. When you start to empower others, you are admitting that you might move the power base elsewhere – and there's a vulnerability to that. You've got to accept that you are not always in control of where you're going.

Q: What happened next; what did your involvement look like, in practical terms?

Epilepsy12: I went to an initial meeting, and something really clicked. The group started creating videos and analysing different sorts of leaflets, sending them to the doctors to say, "look, this is what young people really want". More and more clinics wanted to come and speak to us, and we ended up embarking on a sort of 'youth advocate road trip'. We worked out how we could make a difference going forward. Since then, we've been able to think about good practices, such as making a welcoming environment and having good conversation starters.

Side-by-Side: We are involved in a lot of different ways, for example in the recruitment of staff. I helped to interview for a research nurse; I was sent all the relevant application forms and was able to adapt the interview questions. During the interviews, I was given the opportunity to ask a set of questions, and then I was involved in the discussion afterwards. We are also regularly involved in co-producing training on research, improvement and working alongside people. I have been involved in the content and planning from the outset, and in the delivery on the day. It was clear that the attendees genuinely valued our input too. A lot of opportunities can be fulfilled online, which really helps.

Q: What do you enjoy about participating in a project like this?

Side-by-Side: It's a great opportunity to be part of a panel of people who are all very lovely and positive; all with different backgrounds and different skill sets, which is what makes it so interesting. We have the ability to get involved in lots of different sorts of activities, which is great. It's really enjoyable and rewarding to see the difference our contribution makes.

Q: Are there other benefits to being involved, particularly those you hadn't envisaged at first?

Epilepsy12: We have managed to find our own unique way of engaging with doctors. Our discussions are interactive, and we get to hear their views. By being part of this work, I've been exposed to so much and learnt a huge amount about the epilepsy world.

Side-by-Side: The more I've become involved, the more I have gained confidence, and that seems to stand for the group as a whole. We understand more and more the important part we can play, and we're always made to feel such an integral part of the team. There's no divide between volunteers and paid members of staff, and that's why I think it works really well. There's a great level of mutual respect.

Q: How do you ensure appropriate representation in the project?

Side-by-Side: Over the last year, we have expanded the group by involving people from across Solent NHS services. We did this by reaching out to different charities and communities. As a group, we continuously review and work together to improve the diversity of Side-by-Side.

Q: What are your main learning points now that the project has been running for some time?

Epilepsy12: We've had a growing perspective of how to engage and embed young people directly in the audit. Initially, we had quite a narrow view of what an audit was, thinking it was about young people. But now we think of it as being **with** young people. In fact, we don't really think of it as an audit anymore; it's more of an improvement project with young people that uses audit methodology.

Side-by-Side: We have come a long way but we have made mistakes along the way (I actually [wrote a blog](#) about when it goes wrong). The thing I love most about our group is that we have an open and honest relationship, where they can feed back to us 'in the moment' and we learn how to improve. We're still learning but I do think that having a relationship where people can give constructive feedback is really, really important.

Q: What are your visions for the future of your patient engagement work?

Epilepsy12: I'd like to see participation on every level. We have really strong involvement in the team and at national level, but I'd like to see participation move to more of a network model so that we can link to professional networks. There are different layers of influence, and it would be good to see our young patients involved in all those layers. For example, embedded in local teams, Integrated Care Systems (ICS), and at a regional level. Then, these networks could link up with young people with other health problems. However, while it's not entirely within our gift to solve, we can build patient networks in the same way that we can build professional networks. Another aspiration with the audit is to build patient-facing elements into the data streams. To that end, we're trying to get automated data flow for whole populations, to support research as well as clinical care. We'd also like to see more joined-up data - so it feels like it's the patients' data, not the hospital or the professionals' data. Ideally, we'd even see 'live involvement' from the person with epilepsy in the audit eg with them filling in their forms, not just clinicians doing it for them.

Q: What have been the most challenging aspects of being involved?

Epilepsy12: Epilepsy care can be a very difficult subject for young people to talk about when they are going through it. It can make you feel very vulnerable, and you need to be sure that the group is a safe space. I needed to be happy that I would be able to talk about my experiences honestly, as well as try to change policy and improve epilepsy care. In truth, it can also be quite challenging to get through to clinicians sometimes – you need to work out the best way of communicating, whether it's sending emails, communicating by post or using social media.

We genuinely see them as part of the team; they have this wealth of experience, skills and ideas that we feel really privileged to utilise

Q: Are you paid for your involvement?

Side-by-Side: Payment was never an expectation when I became involved, but actually it does serve to reinforce the value that we bring, recognising that we are giving not just our experience, but also our time. It does make a difference and reinforces the notion that I'm worth something because I work really hard at this. Receiving payment for my contribution enhances my self-worth and, for some people, payment is what makes involvement possible.

Q: In hindsight, what would you change?

Side-by-Side: Definitely get patients involved from the start of any project, and don't make it a retrospective activity. We can provide valuable input right from the start. A lot of people think, well, that's a lovely idea, but I wouldn't know where to begin. But you can start small – maybe just through an informal conversation – and work from there, so it isn't insurmountably difficult or time consuming.

Q: How do you see this work developing in the future?

Epilepsy12: We're already starting to see the sorts of changes we want to see – for example, having families and youth advocates lead the work. From a young person's perspective, we have this group where young people are sharing their views and actually having a say; and I think that will continue. However, we do want our partnerships to grow, joining up with key allies – and that will be the next phase for us.

We hope that others from the health and care sector are able to take inspiration – as well as practical tips – from these exemplar projects. While we recognise that effective patient engagement is not an easy task, particularly in the current climate, these interviews demonstrate the impact it can have on patients’ care (and, in turn, their lives). It’s also true that there’s no magic wand for embarking on patient engagement activities; however, these projects show that small steps can turn into bigger ones, so it’s often a case of getting started, and listening and learning as you go along. Dr Colin Dunkley, Clinical Lead at Epilepsy12, offers a word of caution: “It’s easy to involve people, but it’s also easy to involve them badly. When people share their experiences, they’re giving something of themselves - so that does need careful management to make sure it isn’t tokenistic, non-inclusive or exploitive.” But he clearly thinks that it’s worth the effort: “Engaging with patients properly can take you to unexpected places, but you’ll realise that that’s where you should have been going anyway - so you’ve just got to jump. Otherwise, you might end up in the wrong place.” With that in mind, you may find it useful to look at [case studies of exemplar projects from HQIP’s Richard Driscoll Memorial Awards](#), which celebrate excellence in patient engagement in the [National Clinical Audit and Patient Outcomes Programme \(NCAPOP\)](#). Finally, as this is about patients after all, we would like to give the final word to a young patient, Owen Thurston (a Youth Advocate from Epilepsy12): “It’s really essential to keep the patient at the centre of healthcare at all times. If we do that, then the sky’s the limit for patient voice!”

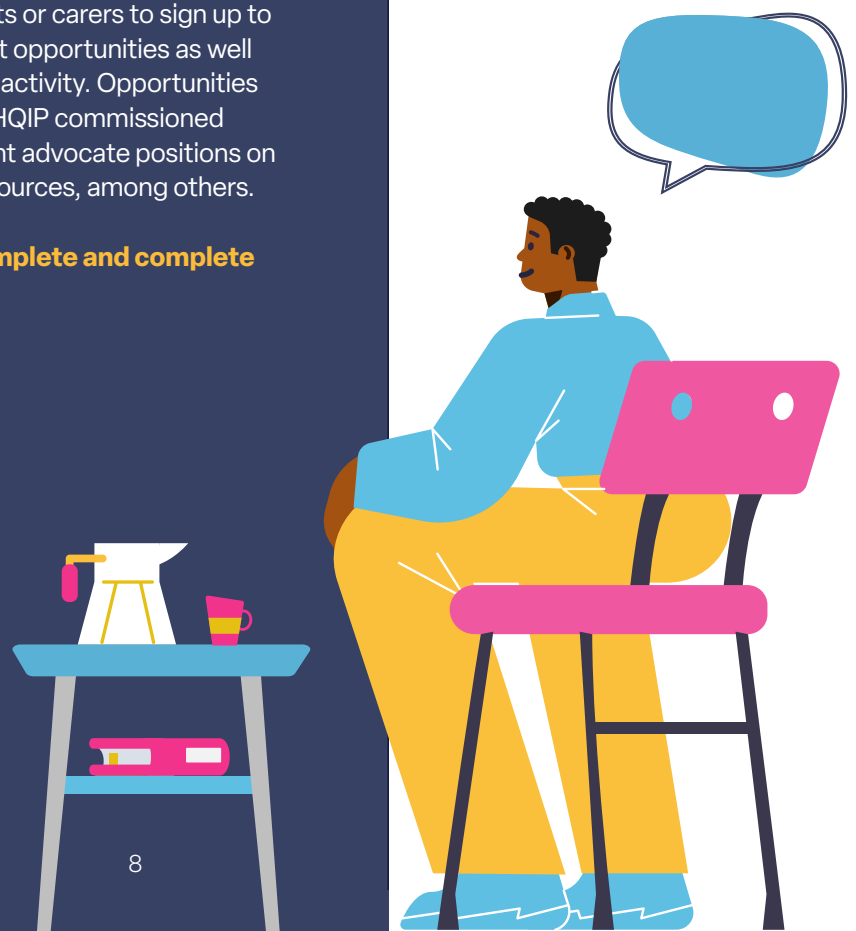
Get involved: Join HQIP’s Service User Network

It is now easier than ever - and without the need for a fixed commitment - to join [HQIP’s Service User Network \(SUN\)](#). We are seeking those with lived experience as patients or carers to sign up to receive regular newsletters about involvement opportunities as well as updates on local and national engagement activity. Opportunities include inputting into the development of an HQIP commissioned programme and new project proposals, patient advocate positions on national audits, and providing feedback to resources, among others.

[Read more about HQIP’s SUN here and complete and complete this form to get involved.](#)

● Patient And Carer Engagement at the Healthcare Quality Improvement Partnership

HQIP is committed to involving, engaging and informing patients and their representative organisations throughout our work. We ensure that patients and carers are reflected in all aspects, from commissioning programmes through to resource development: www.hqip.org.uk/involving-patients



How do I compare thee?

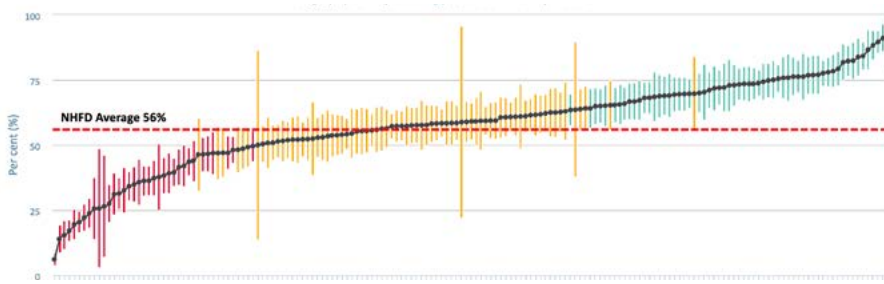


A review of benchmarking in healthcare

Professor Danny Keenan, HQIP Medical Director and Associate Medical Director to the Manchester University NHS Foundation Trust

Benchmarking in healthcare is far more than mere comparison. It is a powerful tool that can support healthcare providers to identify opportunities for improvement and improve patient care. But, in a minefield of data and information, what are the key resources and developments in relation to benchmarking in healthcare, and what steps are the Healthcare Quality Improvement Partnership (HQIP) taking to support effective measurement of performance? HQIP's Medical Director, Professor Danny Keenan, provides a helpful overview...

Your first port-of-call should be audit and similar programme reports and outputs. Be familiar with what is available in your field, and understand how often – and when – data is shared. For HQIP commissioned audits and programmes, the reports and other outputs can be found on the HQIP website, while our publication schedule (which is updated monthly) is here. Importantly, our outputs were changed after the COVID-19 pandemic, following a series of webinars with the national audit providers to explore if the programme was 'digital ready'. As a result, changes – such as shorter reports, less metrics and a move towards near real-time dynamic reporting – were introduced to reduce the burden on Trusts and healthcare service providers. It is also worth noting that, in addition to these commissioned summary reports, many clinical audit and outcome review programmes have websites where further background data can still be accessed.



A benchmarking chart based on data from the National Hip Fracture Database (NHFD) showing ‘prompt surgery’ (surgery by the day following presentation with hip fracture) with confidence intervals. Each hospital is denoted on the x axis (not shown here).

Another starting point is the [National Clinical Audit Benchmarking website \(NCAB\)](#), which provides a visual snapshot of individual Trust audit data set against individual national benchmarks. There is no barrier to use, such as login or an NHS email address, so it’s easy to use and available to all – from healthcare professionals through to policy makers and patients. Created by HQIP in collaboration with the Care Quality Commission (CQC), this resource contains datasets on a variety of clinical disciplines, with additional data being added on an on-going basis (to receive notifications of new datasets as they are added, [subscribe to HQIP’s mailing list](#)). It provides a snapshot view of each healthcare provider, stating whether, for example, they are above, in line or below expectations for each measure.

NCAB also enables Trusts to determine if there are any metrics for which they are a (positive or negative) outlier. This is important for highlighting when patient outcomes fall significantly outside of the norm of what is expected. In light of its significance and in response to the COVID-19 pandemic, HQIP has undertaken extensive consultation with stakeholders, including patients, to revise its guidance relating to outliers. The result is a ‘softer approach’ which retains the principles of benchmarking, and includes:

- The introduction of a ‘non-participation category’ so that Trusts that should be contributing data towards national audits but are not, will be regarded as an outlier.
- Changes to the notification of significant outliers. For key predetermined audit metrics, such as mortality, ‘alert’ level results will be notified directly to the CQC and NHS England. Other less significant metrics with alert outlier results would be available for review when annual reports are published.

The Paterson review made it clear that all patients’ data should be included, no matter where their operation has taken place or how their care is commissioned

In addition to these resources, HQIP is involved in a number of developments to support Trusts and other health and care providers to measure performance, starting with talking to clinicians and analysts to identify better ways of visualising HQIP and NHS outputs (to ensure maximum impact). Work in this area includes making more timely data available on NCAB, and looking at how we could standardise coding systems that are already in use. We are also talking to patient

and service user groups as well as the independent sector, to include the latter in the National Clinical Audit programme. The Paterson review made it clear that all patients’ data should be included, no matter where their operation has taken place or how their care is commissioned. This will ensure that patient care is equally assured, and that their data is available for quality improvement initiatives irrespective of geography.

Of course, performance measurement and benchmarking are of utmost importance to the NHS too. In 2023, I chaired a series of ‘National Clinical Audit for Improvement Implementation Group’ webinars run by NHS England. These explored the development of clinical effectiveness across the service and, in particular, looked at ways to support clinical audit colleagues who are very much on the frontline of this work, with initiatives such as [NHS IMPACT](#), the [Futures NHS platform](#) and the [Model Health System](#). To further support the sharing of innovation, they also coordinate the [NHS Benchmarking Network](#), which helps members to improve patient outcomes, raise health standards and deliver quality health and care services through data excellence, benchmarking and the sharing of innovation."

One area that everyone is interested in (quite rightly), is how to address health inequalities; and audit data and performance measurement is proving to be a powerful tool for this, shining a light on where inequalities exist. The COVID-19 pandemic highlighted inequalities in health outcomes due to ethnicity and deprivation. As a result, HQIP is investigating how the National Clinical Audit programme can track patients’ outcomes better using markers such as ethnicity and deprivation. In particular, we sponsor a National Medical Director’s Faculty of Medical Leadership and Management

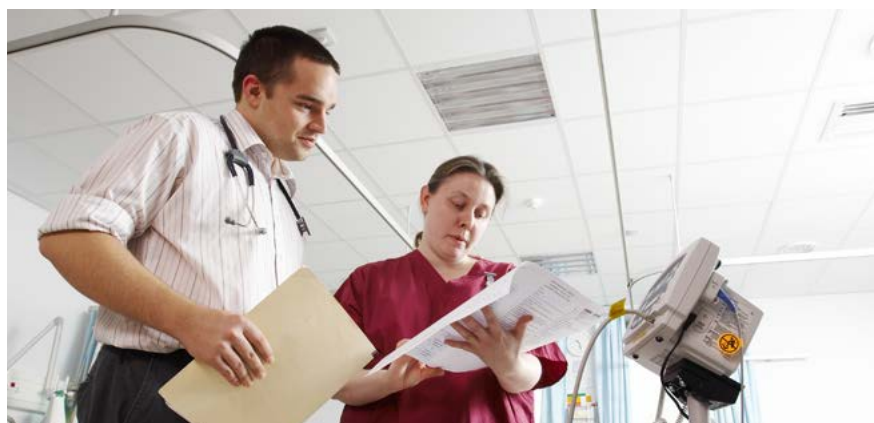
(FMLM) Fellow each year, and they have led a series of reviews on this topic. The 2023 review, due for publication in late 2023, is a survey concerning the obstructions encountered in relation to health inequalities, and includes a number of strong recommendations concerning basic issues such as coding, use of postcode and how to manage small numbers in the audit programme (all of which could make a big difference). We are now working with the Health Inequalities team at NHS England, regarding the plans for implementation of these important recommendations.

Audit data and performance measurement is proving to be a powerful tool for... shining a light on where inequalities exist

All the tools and resources I have mentioned so far are available to support benchmarking here and now (and I do hope you will take a look at them, if you are not already doing so). But I will end on more of a nod to the future. Firstly, we must improve how we celebrate excellence. Currently HQIP works with audit providers to produce “scenarios” concerning units that appear at the ‘excellent end’ of benchmarking charts. But, we

need to raise excellence across the board. One of the downsides of benchmarking is that units sitting in the middle of the chart can become complacent, whereas we all need to keep moving towards the excellent end. HQIP will work with audit providers on ways of celebrating excellence better, so as to promote a ‘move to the right’.

Secondly, to support strategic- and forward-thinking around audit data and performance review in healthcare, HQIP runs a Methodology Advisory Group (MAG), comprised of a broad spectrum of stakeholders including policy makers, healthcare professionals, and patients. In 2023, we hosted a MAG webinar dedicated to Artificial Intelligence (AI) and machine learning. We reviewed the use of these technologies in relation to National Clinical Audit, and discussed what work was already taking place and how we could foster best practice in this area. As a result, we are now exploring how best to share current and proposed best practice using AI. Furthermore, we have also committed to investigate the use of ChatGPT-4, or alternatives, to explore current anonymous datasets to search for disease and outcomes linkages. I’m sure that you, as do I, await news on how these developments can support us in measuring performance and improving outcomes for patients with eager anticipation. Watch this space...



● Further information and resources

- HQIP commissioned audits and programmes, the [National Clinical Audit and Patient Outcomes Programme \(NCAPOP\)](#)
- HQIP commissioned audit and programme reports, with publication schedule (subscribe to notifications [here](#))
- [National Clinical Audit Benchmarking \(NCAB\) website](#), with explanatory video and dummy guides [here](#)
- [NHS IMPACT \(IMproving Patient Care Together\) programme](#)
- [FutureNHS platform](#)
- [NHS Benchmarking Network](#)
- [NHS Model Health System](#)



Quality Improvement (QI) Resources from HQIP

HQIP commissions and hosts circa 40 programmes and audits on a range of clinical disciplines, as part of the [National Clinical Audit and Patient Outcomes Programme \(NCAPOP\)](#). Find below highlights of key resources resulting from this and other work, to support Quality Improvement (QI) and evidence-informed healthcare services.

REPORTS AND INFOGRAPHICS

From asthma and cancer through to respiratory and vascular health – and much more – the reports and infographics from our programmes provide robust data and actionable recommendations. In the year up to 31 March 2023 alone, we produced 64 reports with almost 400 recommendations. Following are just a few examples of what is available:

Maternal, newborn and child health

- MBRRACE-UK: [Perinatal Mortality Surveillance report](#) from the Maternal, Newborn and Infant Clinical Outcome Review Programme; Published Sept 2023
- National Paediatric Diabetes Audit (NPDA) Admissions report; Published July 2023

- [Epilepsy12 organisational and clinical audits report](#) for England and Wales (2020-22); Published July 2023
- [Deaths of children and young people due to traumatic incidents](#), The National Child Mortality Database (NCMD); Published July 2023

Care for the elderly and related

- [15 years of quality improvement](#), National Hip Fracture Database (NHFD); Published Sept 2023
- [Dementia Care in General Hospitals Round 5 Audit 2022](#), National Audit of Dementia (NAD); Published Aug 2023

Gastric health

- [Socioeconomic differences in the impact of oesophago-gastric cancer on survival in England](#), National Oesophago-Gastric Cancer Audit (NOGCA); Published July 2023
- [Making the cut? Review of care of patients undergoing surgery for Crohn's Disease](#), The National Confidential Enquiry into Patient Outcome and Death (NCEPOD); Published July 2023

- ❗ More reports and infographics on a wide range of clinical disciplines can be found on the [Reports](#) section of the HQIP website. For further information about up-and-coming reports, take a look at our [publication schedule](#).

STAY UP-TO-DATE: For notifications when new reports become available, sign up to [HQIP's mailing list](#).

BENCHMARKING

The National Clinical Audit Benchmarking (NCAB) website provides a visual snapshot of individual Trust audit data set against national benchmarks. Originally a collaboration between HQIP and the CQC, its aim was to enable not just inspectors, but also Medical Directors, local clinical audit teams and others, to access national audit performance data.

Registration is not required, and users can access audit data benchmarked by speciality, Trust, hospital or unit (subject to availability). The site contains data on a wide range of clinical disciplines including maternity and paediatrics through to joints and fractures.

- 📌 National Clinical Audit Benchmarking website: <https://ncab.hqip.org.uk/>.

ELEARNING

HQIP offers free online education packages on subjects related to clinical audit and healthcare Quality Improvement to both healthcare professionals and patients:

- Trainee doctors: How do we know we are doing a good job?
- Introduction to quality improvement for healthcare professionals
- Introduction to quality improvement for patients and public.

- 📌 To access these resources, go to the e-learning section of the [HQIP website](#).

CLINICAL AUDIT AND QUALITY IMPROVEMENT (QI) GUIDANCE

From top tips for trainee doctors and an introduction to analysing quality improvement and assurance data, through to a quality improvement-based governance guide, we have a range of guidance and materials to support NHS Boards, managers, commissioners and regulators to support the implementation of Quality Improvement (QI) initiatives.

- 📌 Further information on the [Guidance section of the HQIP website](#).

THEMED UPDATES

If you have a specific interest in a particular clinical discipline, but wonder what information is available to support Quality Improvement from HQIP and beyond, then we have created a series of themed updates to signpost to relevant information. A work-in-progress, so far the following themed updates are available:

- [Maternity and newborn care](#)
- [Children & young people's health](#)
- [Mental health](#)

- 📌 More updates in this series will be available in due course - for notifications when new updates become available, sign up to [HQIP's mailing list](#).

NHS ENGLAND QUALITY ACCOUNTS LIST

The NHS England Quality Accounts List is a list of national audits, clinical outcome review programmes and other quality improvement projects that NHS England advises Trusts to prioritise for participation and reporting. The List is published in advance of each financial year and supports the 'Quality Account' (a report about the quality of services and improvement) that Trusts must publish each year. HQIP facilitates and supports the development of the List each year.

- 📌 Further information on the [Quality Accounts List](#).

THE HQIP 'DIRECTORY'

HQIP maintains the 'Directory'; a guidance document that collates high level information supplied by project providers. The Directory is a tool/resource designed to assist healthcare service providers in planning their audit activity each year. It includes:

- NCAPOP projects (commissioned by HQIP)
- Projects included in the NHS England Quality Accounts List (and operated by other organisations)
- Other national quality improvement projects operated by other organisations.

- 📌 Further information on the [HQIP 'Directory'](#).

For further resources relating to national clinical audit and Quality Improvement, including case studies and impact reports, go the Resources section of the [HQIP website](#).



Avoiding 'lost in translation'

Using national healthcare data to support meaningful change

Jill Stoddart, Director of Operations (National Clinical Audit and Patient Outcome Programme), HQIP

What keeps you awake at night? When I worked in clinical practice, questioning whether I'd provided the very best care for patients kept me awake. Now I commission national clinical audits and other patient outcome programmes, this is still a primary concern - but the focus is on whether the data we collect supports the best care for patients. How can we ensure that evidence derived at a national level is well received and implemented at Trust level? And, critically, are we really making a difference to patient care?

I understand the pressure and challenges that Trusts face with increasing demand, financial constraints, bed shortages, recruitment freezes and preparing for winter pressures – all in addition to national and regional scrutiny. Against this backdrop, it can be extremely difficult to make sense, and practical use, of the vast array of national healthcare data available. Between April 2022 and March 2023, the National Clinical Audit and Patient Outcome Programme (NCAPOP), commissioned by the Healthcare Quality Improvement Partnership (HQIP), published 64 reports and 368 recommendations alone. Factor this up across the national clinical effectiveness

landscape - including National Institute for Health and Care Excellence (NICE) guidance, Getting It Right First Time (GIRFT) reports, Healthcare Safety Investigation Branch (HSIB) investigations and multiple other national enquiries - and we can safely say that Trusts are awash with reports and recommendations.

This is why, in 2023, HQIP reshaped its outputs. We undertook discussions with policy makers and healthcare providers, which identified a need to reduce the burden and increase the timeliness of data, culminating in:

- Shorter user-friendly 'state of the nation' reports

- Quality Improvement (QI) resources, replacing local recommendations in reports
- A focus on approximately ten metrics, and
- Near real-time dynamic reporting, refreshed at least quarterly.

However, while these changes were welcomed by healthcare providers, we know that information provision alone does not change behaviour. It takes much more than knowledge to leverage change. The starting point for transformation at a Trust level is to continually question the quality of care provided. Questions are vital, they do not mean resistance and should be actively encouraged. These questions can take many forms, and can help to clarify understanding.

Widely disseminate information about both negative and positive outliers – share the learning!

Questions that healthcare organisations can ask themselves about their performance* were highlighted in the [2023 edition of CORNERSTONE by Mirek Skrypak \(pages 22-23\)](#) and are worth reiterating here, since they are the starting point for a Trust:

1. Do we know how good we are?
2. Do we know where we stand relative to the best?
3. Do we know where, and understand why, variation exists in our organisation?
4. Over time, where are the gaps in our practice that indicate a need for change?
5. In our efforts to improve, what's working?

Alongside asking key questions about clinical effectiveness performance, all Trusts need to

also invest time in building an open and transparent data and quality improvement culture. NHS England's approach to improvement is outlined in their [NHS IMPACT \(IMproving PATient Care Together\)](#) programme. It includes five components which form the 'DNA' of all evidence-based improvement methods, and which underpin a systematic approach to continuous improvement:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity, and
- Embedding improvement into management systems and processes.

NHS England also makes a wide variety of useful [improvement resources](#) available to health and other care providers. These include good practice pathways and guidance documents as well as cross-cutting workstreams such as GIRFT, intensive support and national clinical audit.

So, what difference can clinical audit make? The audit cycle includes taking action to bring clinical practice in line with evidence-based standards, to improve the quality of care and health outcomes. Healthcare providers need to consider the link between the evidence base, national policy, national clinical audit and local implementation. This can take many forms, but here are some top tips that are useful when considering how best to use data intelligently and achieve change at a local level:

1. Share information widely across the Trust, understand variation, make data available and transparent but don't stop there – discuss it and agree the changes required. Widely disseminate information about

- both negative and positive outliers – share the learning!
2. Report by exception to the relevant assurance committees and Board – ensure regular Board airtime is given to discussing the data, its meaning and the required QI actions.
3. Remove Trust level obstacles – bureaucracy stifles innovation.
4. Remember the 80:20 rule (Pareto Principle) - 80% of outcomes (or outputs) result from 20% of causes (or inputs) for any given event.
5. Always set deadlines and agree who is responsible for delivering actions, following up on progress. Set regular small milestones – these are much more likely to be successfully implemented.
6. Action plans need to be robust and identify system actions which remove the reliance on individuals. Where possible, use standardised and permanent (physical or digital) designs to eliminate human error, sometimes referred to as 'forcing actions' (as cited in the Perinatal Mortality Review Tool (PMRT)'s [infographic relating to their 2022 annual report](#)).
7. Be aware of national clinical audit [publication schedules](#) – and make plans to receive reports and data as they are published.
8. Know your Trust plan and timetable for the [national clinical audit programme](#).
9. Monitor your own internal Trust data and take actions to unpick and explore early, using [NHS England Making Data Count](#) resources.
10. Make an explicit Trust link between data and Quality Improvement (QI) and avoid silo working.

* Source: [Doi:10.1136/bmj.m213/BMJ2020;368:m213/thebmj](https://doi.org/10.1136/bmj.m213/BMJ2020;368:m213/thebmj)

All seemingly obvious and sensible. But, in fact, it's easy to get this wrong. The [Kirkup report on maternity services at the East Kent University NHS FT](#) was published in October 2022. It highlighted several important points when it comes to understanding variation, and presenting and interpreting data, stating *"The unit-level information that is available tends to be presented in the form of 'league tables'... These serve to conceal the variation between different units, with no indication of whether one or more units are outliers"*.

To address this, Kirkup noted two requirements:

1. From Section 6.9: The first [requirement] is the generation of measures that are:
 - meaningful - that is, related clearly to outcomes
 - risk adjustable
 - available - they are available from data already routinely collected
 - timely.
2. From Section 6.10: The second requirement is that the measures:
 - are analysed and presented in a way that shows both random variation and trends
 - use sound, statistically based approaches to detecting the signal among the noise
 - are presented graphically to show variation, significant trends and outliers in the form of statistical process control charts and funnel plots
 - are extended to clinically relevant outcome measures.

These, and many other messages in the Kirkup report, can be extrapolated and applied across Trusts and other healthcare providers. Data are everywhere, often difficult to interpret, can be complex and, at times, additional information is required to get a clear picture of what is happening. As such, it can be difficult for Trusts to understand where they need to improve. The tool on pages 17-18 offers a suggested approach:



Do you need help with Quality Improvement?

As a long-term partner of NHS England, delivering clinical audit and Quality Improvement programmes, HQIP has the expertise to support your organisation to implement meaningful improvement at national, system and local levels. We have experience of helping healthcare organisations of all sizes to improve care using data-driven, patient-centric evidence-informed Quality Improvement projects.

Whether you need support with evaluation or improvement strategy (or anything in between), contact us for a free, no-obligation conversation, to find out how we can help: communications@hqip.org.uk.

Further information: www.hqip.org.uk/advisory-services.

Further information and resources

- HQIP commissioned audit and programme [reports](#) (subscribe to notifications [here](#))
- [Information and resources](#) to support the use of the National Clinical Audit and Patient Outcome Programme (NCAPOP) to stimulate healthcare Quality Improvement (QI)
- Support with [Developing a clinical audit programme](#)
- NHS England [Quality Accounts \(QA\) List](#) of clinical audits/programmes
- [HQIP 'Directory'](#) with high level and key information for each work programme
- National Clinical Audit Benchmarking (NCAB) [website](#)
- Article: When is data 'good data'? HQIP [CORNERSTONE 2023](#) (pages 22-23)
- [NHS IMPACT](#) (IMproving PATient Care Together) programme
- NHS England [IMPACT resources and materials](#)
- NHS England [Making Data Count](#)

Questions for Trusts to ask themselves about how they use data

Limited use of data across the Trust	Intermittent and fragmented use of data across the Trust	Strong commitment demonstrated to using data across the Trust with sustainability
1. Is the use of data hardwired into the Trust's core business or does it take a reactive approach to the use of data?		
Limited and sporadic use of data. Data are reviewed but only when a problem has occurred.	Pockets of data used across the Trust, clear QI peer leaders – the Trust is on a journey, but work is needed to embed a culture of data use across all workstreams.	Commitment to improving patient care and active understanding that clinical audit is a key element in that process. Consistent and regular use of high-quality data, both qualitative and quantitative, with data triangulation across all directorates, and with a proactive approach where ideas are shared collaboratively.
2. Is there evidence that the Trust is aware of the requirement to participate in NHS England's <u>Quality Accounts (QA) List of clinical audits / programmes</u>?		
Limited understanding of the NHS Contract requirement to participate in national clinical audit. The Trust has no comprehensive and accurate record of the audits it has / hasn't participated in, with no plan to address this.	The Trust is aware of the QA List but: <ul style="list-style-type: none"> • does not participate in all of the relevant listed audits / programmes • has poor case ascertainment. Has a plan but lacks annual achievement, and lacks ability to move forward with the plan to full implementation.	There is a Trust clinical audit plan in place that is aligned with the annual national publication date of the QA List, with evidence of Trust Medical Director support that demonstrates: <ul style="list-style-type: none"> • 100% participation in all relevant QA List audits • 100% case ascertainment. There is a Trust annual clinical audit report where progress is discussed quarterly at the relevant Quality Committee and reviewed annually by the Trust Board (with an indication of whether the Board is assured or not assured).
3. Is there evidence that using data are included in relevant staff training / Learning and Development (L&D)?		
The use of data is not incorporated into Trust L&D programmes. There is no evidence that the Trust is investing in data / QI skills and capabilities.	Training is in place but there is no carry through to staff objectives and appraisals.	The Board has evidence of an annual presentation by the <i>Making Data Count</i> NHS England team, and all relevant Trust staff are required to watch the <i>Making Data Count</i> virtual presentation as part of their mandatory training. The use of data is incorporated into relevant staff objectives and performance and personal development reviews. There is evidence of a commitment to develop the skills and capabilities for improvement across the Trust.
4. What data are used?		
Scant use of national or local data.	Uses monthly dashboard 'sound bite' data with limited use of longitudinal trends from statistical process control charts. Limited data triangulation and lacks awareness of data sources available.	Understands and appropriately uses: <ul style="list-style-type: none"> • National data that has been quality assured and risk adjusted (tends to lack timeliness given the linking and extra analysis required) • Uses near real-time local data (timely but not risk adjusted) and watches for 'smoke signals' (eg at a -2 standard deviation alert level and takes early proactive action to head off -3 standard deviation alarm outliers) • Proactively uses local surveillance data where this is made available by national audit providers • Triangulates data • The Trust rapidly reacts to national data notifications (for example -3 SD outlier status notifications from audit providers and/or the CQC). Transparently escalates alarm level outliers to relevant governance committees and the Board with a plan for address • The Hqip 'Directory' is used to identify high level and key information for each work programme.

5. What format is the data presented in?		
There is no distillation or synthesis of the data – huge amounts of confusing data are presented with no attempt to synthesise or interpret the findings, lacks focus.	Data are presented in a succinct, clear and meaningful way but there is limited discussion, with no conclusion drawn and no link to QI.	Data are presented where relevant using a combination of: <ul style="list-style-type: none"> • Longitudinal trends in the form of Statistical Process Control charts (SPC) updated monthly • Regional or national dashboards. There is understanding and management of variation. Data are clearly benchmarked. Data are discussed, interpreted, and conclusions made with explicit links to QI.
6. How are the data interpreted?		
Directorates work in silos with no clear allocation of lead responsibilities for the data interpretation, no triangulation of data, and no cross-fertilisation of QI ideas and activities. Does not act upon the data. Knee jerk reactions to isolated data points.	Understands which key metrics need to be reported but lacks clear roles and remits for monitoring, reporting and interpreting the trends - ‘data rich, information poor’.	There is a dedicated Trust data intelligence group who proactively INTERPRETS longitudinal trends for pre-agreed key Trust metrics / data outputs, with joined-up messages across workstreams, triangulation of data and an understanding of the bigger picture.
7. There is a clear audit trail from national clinical audit, longitudinal data interpretation, with active discussions and links with QI		
There is limited use of data, and QI mechanisms are yet to be fully developed and implemented – there is no joined-up approach.	Data are available but there is no agreement about the key metrics, and data outputs are not linked to the Trust strategic objectives or QI initiatives. The Trust lacks a clearly articulated approach for using data and linking it effectively with QI.	There is a seamless, consistent, standardised, harmonised and coherent approach to data collection, interpretation and QI. Information is actively shared across the Trust in relevant committees and the Trust Board.
8. The Trust Board reviews and discusses data		
The Trust Board receives ad hoc clinical effectiveness reports with limited discussion about the meaning and interpretation of data outputs. Not linked to QI and no indication in the Board papers about whether the Board is assured / not assured.	Clinical effectiveness issues and data are escalated to the Board by exception.	There is an agreed clinical effectiveness strategy linked to the Trust’s vision and objectives that describes how the Trust will intelligently interpret data and indicates how this data will be used across the Trust with seamless links to QI initiatives. Regular Board airtime is given to reviewing and discussing clinical effectiveness data. Quality improvement is a clear leadership priority for the Trust Board. The Board gives regular feedback with an indication of whether the Board is assured / not assured.

The starting point for innovation and change at a Trust level is to continually question the quality of care provided

Trusts can either internally review these questions to judge where they might sit, or it may be helpful to ‘buddy’ with a peer Trust for independently reviewed opinions, such that a relevant professional team, external to the Trust / Board, provide ‘fresh eyes’ and an independent perspective.

Translating national data into effective change at a local level isn’t easy. It may be littered with potential pitfalls and difficulties, but it is, of course, vitally important. So, I will leave you with just one take-

away thought, a lightbulb moment (neatly inspired by the inventor of the lightbulb, Thomas Edison): *“I have not failed 700 times. I have succeeded in proving that those 700 ways will not work. When I have eliminated the ways that will not work, I will find the way that will work”*. Here’s to continuing to work together, and supporting each other, to find the ‘right way’ to use national clinical data to support meaningful change at a local level.



An 'umbrella approach' to audit: sharing, efficiencies and results

The National Cancer Audit Collaborating Centre (NATCAN) – one year on

Caroline Rogers, Associate Director, Quality and Development (NCAPOP), HQIP and Dr Julie Nossiter, Director of Operations, NATCAN

In 2023, Professor Peter Johnson, National Clinical Director for Cancer at NHS England acknowledged the transformative power of healthcare data, saying: “We’re in the middle of a real data revolution in the health service”. It goes without saying that the clinical audit community plays a pivotal role in that ‘data revolution’. However, to best realise the potential of data in healthcare, it too is going through a transformation. We look at the National Cancer Audit Collaborating Centre (NATCAN), which takes a truly collaborative approach to clinical audit...



Healthcare improvement strategies will be the guiding light for each audit, providing targeted, measurable goals for cancer outcomes and patient experience

NATCAN was set up to make the most effective use of the cancer data available, in order to bring about improvements in the care provided to patients. The Centre, which celebrated its one-year anniversary in October 2023, heralds a new approach to commissioning national clinical audits; one with collaboration at its heart. The Royal College of Surgeons of England (RCS) - in partnership with the London School of Hygiene and Tropical Medicine - was contracted to run the Centre by the [Healthcare Quality Improvement Partnership \(HQIP\)](#) on behalf of NHS England and the Welsh Government.

Experts in relevant clinical disciplines, methodology, statistics, organisation, data, epidemiology and logistics have been brought together, with the aim of large-scale healthcare assessment and improvement. More specifically, NHS England and the Welsh Government are providing £5.4 million over an initial three-year period for the Centre to manage new clinical audits covering all NHS hospitals in England and Wales that care for patients with:

- ▶ Ovarian cancer
- ▶ Pancreatic cancer
- ▶ Non-Hodgkin lymphoma
- ▶ Kidney cancer
- ▶ Primary breast cancer
- ▶ Metastatic breast cancer.

In addition, the following [established audits](#), already hosted by the RCS, were also incorporated into the Centre:

- ▶ Oesophago-gastric cancer
- ▶ Bowel cancer
- ▶ Prostate cancer
- ▶ Lung cancer.

Within NATCAN, each clinical discipline has its own audit.

The Centre focuses on 'the three Rs' of clinical audit best practice, ensuring that all its activities are:

- ▶ clinically **Relevant** (asking the right questions, as a result of close collaboration between clinical and academic experts)
- ▶ methodologically **Robust** (using the best epidemiological and statistical approaches to carry out fair comparisons between hospitals), and
- ▶ technically **Rigorous** (making sure data science is put to the best use, in order to drive quality improvement).

About NATCAN

The National Cancer Audit Collaborating Centre (NATCAN) was established as a new national centre of excellence in October 2022. It is a partnership between the Royal College of Surgeons of England and the London School of Hygiene and Tropical Medicine, and was commissioned for an initial three-year period by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England and the Welsh Government. NATCAN brings national cancer audits together in one place, enabling the sharing of best practice and clinical excellence as part of the overall strategy of improving healthcare.

Find out more: www.natcan.org.uk.



What are the aims of the new Centre?

The aim of NATCAN is to strengthen NHS cancer services and, ultimately, improve patient outcomes. People who have experienced, or are experiencing, cancer are important in this endeavour; and patients and patient charities are involved in all aspects of the Centre and its work. Each audit has its own Patient and Public Involvement (PPI), enabling patients to have a strong voice within the clinical committee. Everyone involved in cancer treatment knows it is complex. There may be multiple treatment options, including combinations of treatments, for different types of cancer. A patient's treatment plan needs to take into account the stage of their cancer and how they respond to treatment. A key aim for each audit is to ensure that the information produced for cancer services recognises these differences, and supports hospitals to focus on specific parts of the care pathway. The Centre uses and links together the existing national datasets that are already routinely collected, reducing the burden and costs on the system as a whole. Organising clinical audits in this way creates a critical mass and capacity of experts, meaning that best practice can be shared.

So, what has been happening so far?

As of late 2023, each audit is drawing up its healthcare improvement strategy, which contains explicit quality improvement goals. These will be the guiding light for each audit – a set of targeted, measurable goals for cancer outcomes and patient experience. Meanwhile, staff and experts have been appointed, and applications made for the data required. As you would expect, the Centre will operate with the highest level of expertise in information governance and the rules

surrounding the use of patients' data; and robust processes are being put in place to support this.

When will we see the data?

The existing audits (lung, prostate, bowel and oesophago-gastric cancers) will continue to report data, while the new audits will produce analysed benchmarked results for each Trust and Health Board in 2024, to be released quarterly thereafter. From September 2024, summary annual 'State of the Nation' reports will be produced by each audit, containing key findings and national recommendations for improvements in cancer care. Alongside the data releases, the audits are each developing improvement tools that services can use to improve the care they provide.

Organising clinical audits in this way creates a critical mass and capacity of experts

As with any transformative change, taking a new approach in setting up this national centre of excellence has not been without challenges. But with benefits as significant as greater knowledge and best practice sharing, as well as efficiencies and economies of scale - and, of course, improved outcomes for patients - at stake, the team has worked hard to overcome them. We now look forward to strengthening NHS cancer services, using joined-up thinking and data to provide a wider understanding of cancer treatments and patient outcomes across the country.

● Further information and resources

- HQIP commissioned audits and programmes - [National Clinical Audit and Patient Outcomes Programme \(NCAPOP\)](#)
- HQIP commissioned audit and programme [reports](#) (subscribe to notifications [here](#))

CLINICAL AUDIT 'HALL OF FAME'

Meet the 2023 Clinical Audit Heroes

Following is a showcase of exemplar projects from the [Clinical Audit Heroes Awards 2023](#), which were a key focus of [Clinical Audit Awareness Week \(CAAW\)](#). Hosted by HQIP, in collaboration with the National Quality Improvement (incl. Clinical Audit) Network (N-QI-CAN), CAAW is a national campaign to promote and celebrate the benefits and impact of clinical audit and quality improvement in healthcare.

PATIENT SAFETY

WINNER: Robert Oakley, Senior Pharmacist at St George's University Hospitals NHS Foundation Trust. Recognised for work to improve safety in the use of vancomycin, an antibiotic that treats serious infections. The judges were impressed by the structured approach to identifying the problem and to finding multi-faceted solutions, as well as evidence of improvement and commitment to patient safety in a complex environment. Of particular note, was the use of innovative protocol integration through a 'PowerPlan'. [Further information.](#)

PATIENT AND PUBLIC INVOLVEMENT

JOINT WINNER: Solent Academy of Research and Improvement Side by Side group. A group of patient and public involvement representatives that supports the integration of clinical audit, service evaluation, quality improvement, research and library teams within the Solent NHS Trust. Support comes in many forms, such as co-delivering training workshops, supporting improvement projects, reviewing reports, sitting in interview and award panels, and organising an annual conference. The judges were impressed by evidence of co-leading and advising on future audits, and so supporting long term change. [Further information.](#)

JOINT WINNER: Epilepsy12 Youth Advocates, Royal College of Paediatrics and Child Health. A group of epilepsy experienced or interested children, young people, families, and an epilepsy specialist nurse. They volunteer to shape the Epilepsy12 clinical audit and lead improvement activities with patients, families, and epilepsy services, bringing together their voices, experiences, hopes and wishes to life through youth-led project work and advocacy. The judges were impressed by how this project demonstrates the prioritisation of patients, with young people involved in all elements of the audit. [Further information.](#)

COMMENDED: Laura Hall, Quality and Audit Midwife at Southport and Ormskirk NHS Trust. Commended for a number of innovations involving patients in maternity services, an example of which was asking patients about their experience of the Trust's caesarean section pathway. The results from this were shared with the Maternity Voices Partnership (an NHS working group comprising women and their families, commissioners and providers), to review and contribute to the development of local maternity care. [Further information.](#)



HEALTHCARE INEQUALITIES

WINNER: Isabel Cowling, Michelle Fleeman, Menik Upatissa & Indu Mahabeer from Sandwell & West Birmingham NHS Trust. Recognised for a study to assess the health needs of Unaccompanied Asylum-Seeking Children, in order to identify gaps in practice and seek opportunities for improvements for this group of disadvantaged children and young people. The project's results highlighted significant rates of unmet physical, mental and emotional health needs, and resulted in patient communications, changes to pathways, and important information sharing, among other innovations. [Further information.](#)

COMMENDED: Mikaela Wardle, Senior House Officer at Sandwell & West Birmingham NHS Trust, in partnership with the Homeless Patient Pathway and Alcohol Care teams. Recognised for their audit of homeless patients presenting to City Hospital Emergency Department – a population which has high rates of substance and alcohol dependence, hepatitis C and multiple morbidity, compared to the general population. This project identified multiple areas where changes to processes could significantly improve outcome including staff education, collaboration and resources. [Further information.](#)

INFLUENCING ORGANISATIONAL CHANGE

JOINT WINNER: Amy Baker, Patient Outcomes Manager, and the Patient Outcomes Team at Cambridge University Hospitals. Recognised for designing and populating a National Clinical Audit Benchmarking (NCAB) database, to record whether clinical teams have performed better, worse or similarly to the national average performance for all important clinical outcome measures. Presented as a dashboard with charts, it allows the hospital's teams to easily compare and learn from peers across the country. [Further information.](#)

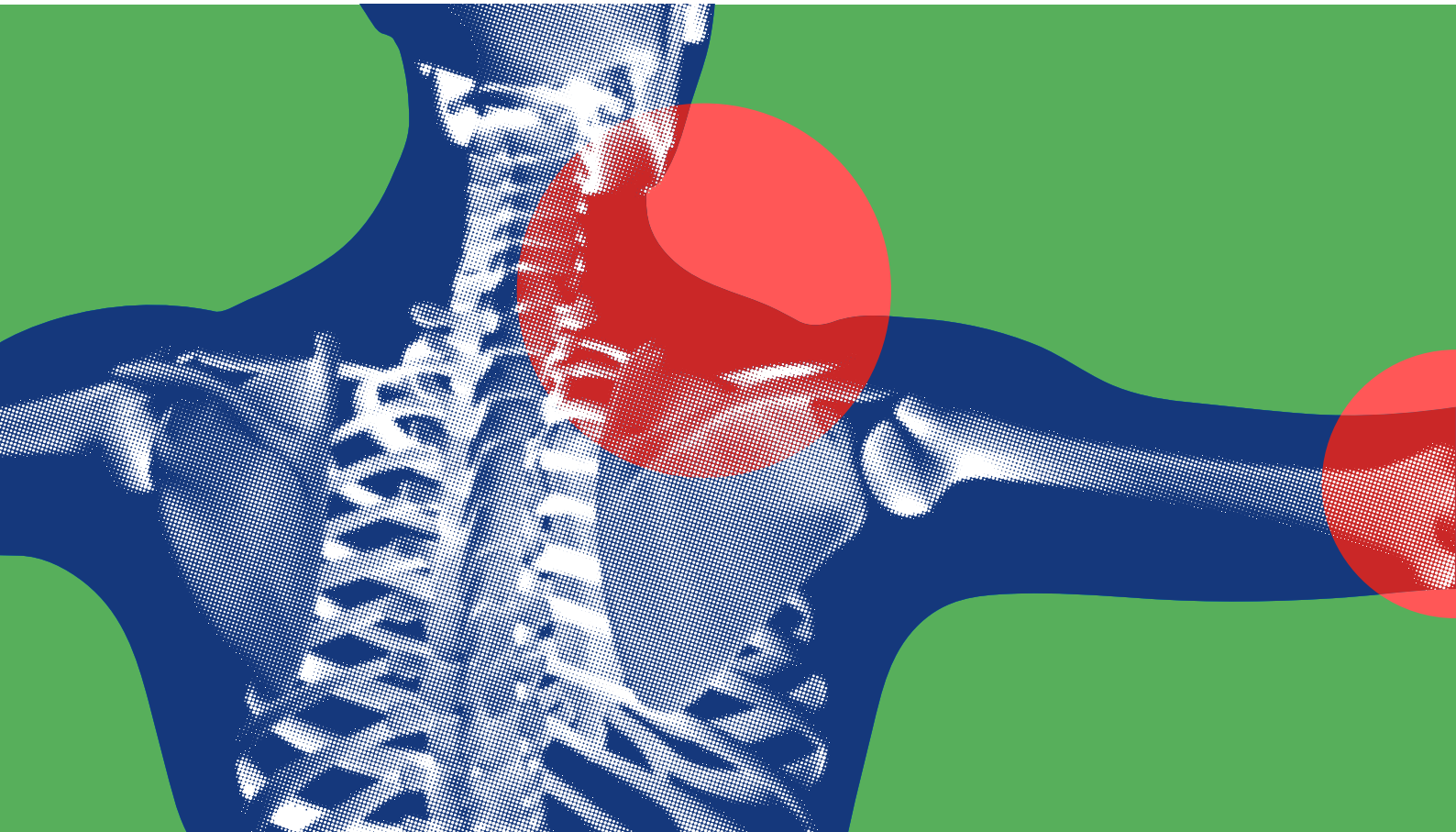
JOINT WINNER: Ella Howard, Emotional Health and Wellbeing Service Assistant Psychologist at Cambridgeshire Community Services. An audit which focused on what could prevent clinicians producing quality documentation, to determine what the "gold standard" looked like. The audit programme was designed around gaining buy in, everyone knowing what they were aiming for, and creating actions where they could see results that made a difference. Examples of the work involved include focus groups to refine the questions, and the development of a training document. [Further information.](#)

COMMENDED: Dementia and Delirium Team at Southport and Ormskirk NHS Trust. A reaudit against the SIGN 157 guideline *Risk reduction and management in delirium* (2019) and the NICE guideline NICE CG103 *Delirium: prevention, diagnosis and management* (2019). Of particular note is an innovative *Keep Me Here* initiative, created to prevent inappropriate hospital bed moves of patients with complex symptoms of dementia and slow to resolve delirium. [Further information.](#)

SUSTAINABILITY

WINNER: Amanda Van Vuuren, Darshana Dhaka, Mat MacDonald and Connor Brown, Consultant (Anaesthetics) and Junior Doctors at Sandwell & West Birmingham NHS Trust. Recognised for identifying an opportunity to increase the number of Total intravenous anaesthesia (TIVA) cases in Theatre 1 City and Theatre 2 Sandwell, and in doing so, having a significant impact on the reduction of volatile-gas based emissions (in support of the NHS long term plan and 'net zero' campaign aim for the NHS to be net zero by 2040). [Further information.](#)

For more information about Clinical Audit Awareness Week and the Clinical Audit Heroes awards, including recordings of five Lunch & Learn events (one on each award category), go to the [HQIP website](#).



20 YEARS OF THE NATIONAL JOINT REGISTRY

How the NJR benefits hospitals

The National Joint Registry (NJR), which is hosted by the [Healthcare Quality Improvement Partnership \(HQIP\)](#), was founded in 2002 and started collecting data to monitor the performance of hip and knee replacement surgery in England and Wales in 2003. Since then, they have expanded their scope of both joints and territories covered. **Elaine Young, Chris Boulton and Deirdra Taylor from NJR's Management Team**, explain more about the Registry's interactive reporting tools and the benefits they offer to hospitals..

The NJR has invested in the development of a wide range of interactive reporting tools over the years for both hospitals and surgeons. Most of these can now be accessed through our dynamic software reporting platform NJR Connect - Data Services, which includes Annual Clinical Reports on joint-related procedure performance outcomes.

Regular reporting mechanism enables hospitals to reflect on best practice and address any issues relating to worsening outcomes

SUPPORTING BEST PRACTICE

We support local clinical governance through the provision of hospital- and surgeon-level reports, providing an independent assessment of the safety and effectiveness of local practice compared to national benchmarks. We alert hospital Medical Directors of any adverse patterns in patient outcomes attributable to their hospital and provide data and analysis to support local investigation of root causes for raised alerts.

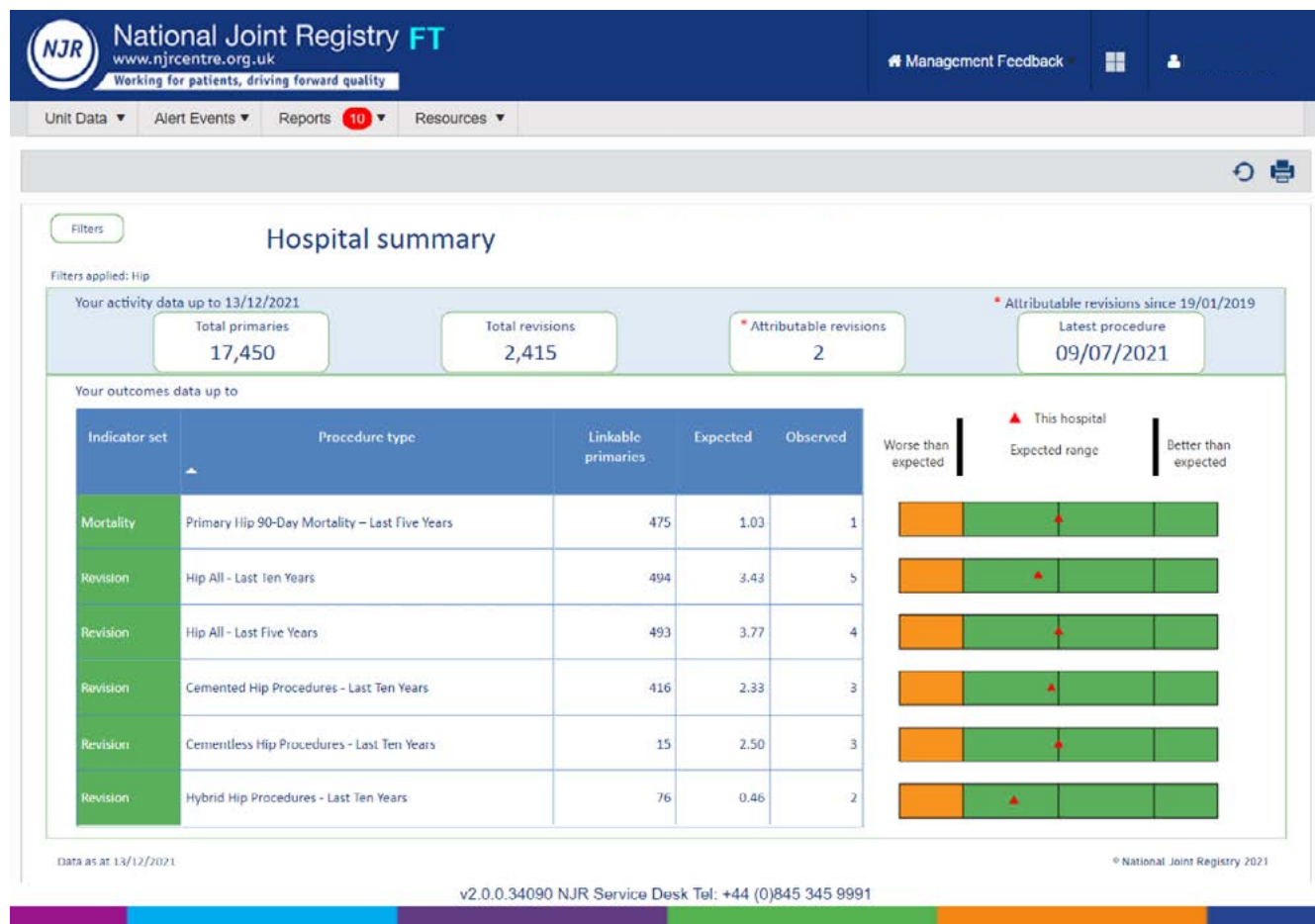
In 2022, we launched the NJR implant scanning app to support medical device implant checking during an operation, to help prevent the occurrence of 'never events' where incompatible implants are inadvertently used in patients. Every six months, a comprehensive

analysis is undertaken of the performance of all surgical units undertaking joint replacement in the NJR's operational areas. Each hospital, regardless of their performance, receives a comprehensive in-depth analysis of their practice, including a list of all revisions and deaths. This regular reporting mechanism enables hospitals to reflect on best practice and address any issues relating to worsening outcomes.

NJR ANNUAL CLINICAL REPORTS (HOSPITAL-LEVEL REPORTS)

Annual Clinical Reports are provided for all hospitals submitting data to the registry, enabling a detailed analysis of activity and outcomes across joint replacement services. This also provides Medical Directors with a summary of

Example extract from NJR Management Feedback reporting function in NJR Connect – Data Services



the performance outcomes for each surgeon operating in their units. This is supplemented by analyses that provide indications for revision across their hospital so that trends can be identified, in addition to a summary of how individual surgeons are contributing to a hospital's overall outcomes. This data is supplemented by customisable reporting tools within our NJR Connect platform, as well as a detailed appendix of individual patient outcomes, which means

that data can be analysed locally. In summary, key benefits include:

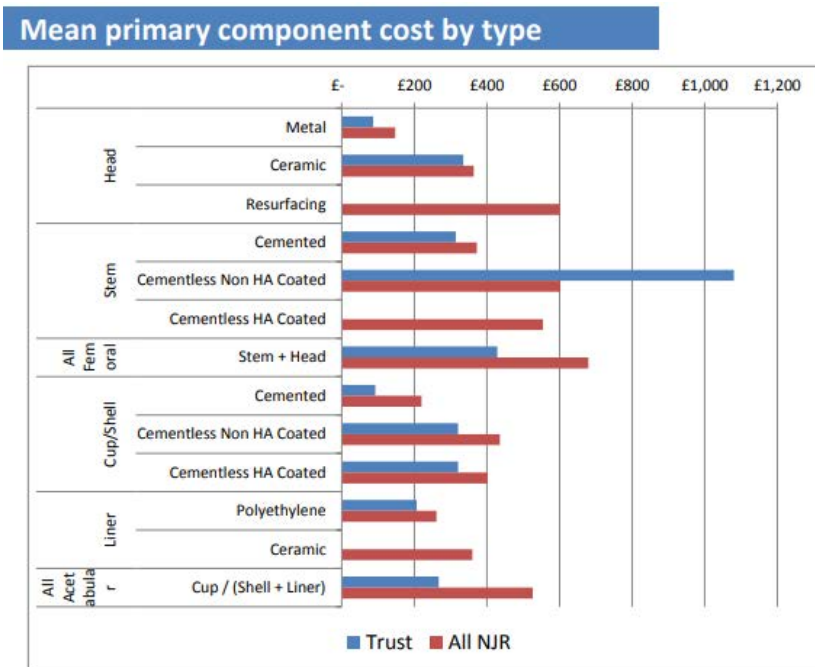
- The ability to monitor and identify 'never events' such as use of the wrong implant, or wrong body side (and increasingly prevent them from happening with use of the NJR scanning interface).
- Poorly performing units and surgeons are identified and supported to improve.
- Poorly performing implants are identified and this information is escalated to regulators.

PRICE BENCHMARKING

With a view to improving the cost-effectiveness of joint replacement surgery, the NJR's implant price-benchmarking service gives hospitals the information they need to benchmark the price they pay for hip, knee, ankle, elbow and shoulder implants against the 'best' national prices achieved across all hospital implant procurement services.

This service enables hospitals to drill down into their pricing data, including the additional capability to give surgeons individual reports relating to their own implant use. The NJR's enhanced implant price-benchmarking service, EMBED, supports hospitals to understand, in greater detail, their use of joint replacement implants in terms of cost, evidence and trends in comparison to the national picture. This service provides clinicians, management, procurement and finance teams with an objective set of data and analysis to inform their decision-making. With a focus on cost and value alongside procedure outcomes, it also underpins the Getting It Right First Time (GIRFT) and NHS England's Model Health System initiatives.

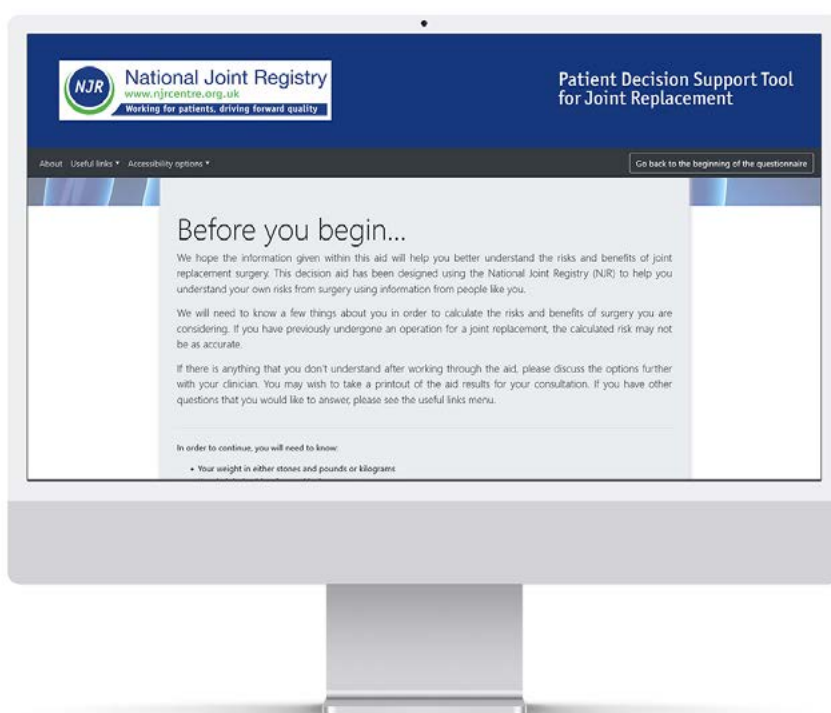
A sample of the EMBED price bench-marking report



Component	Type	Implanted	Mean		Median	
			Trust	All NJR	Trust	All NJR
Head	Metal	1053	£ 87	£ 147	£ 86	£ 127
	Ceramic	140	£ 335	£ 364	£ 335	£ 363
	Resurfacing	0	£ -	£ 601	£ -	£ 459
Stem	Cemented	1188	£ 314	£ 372	£ 306	£ 344
	Cementless Non HA Coated	6	£ 1,080	£ 603	£ 1,080	£ 484
	Cementless HA Coated	0	£ -	£ 554	£ -	£ 547
All Femoral	Stem + Head	1195	£ 429	£ 680	£ 392	£ 641
Cup/Shell	Cemented	578	£ 92	£ 220	£ 86	£ 226
	Cementless Non HA Coated	34	£ 320	£ 435	£ 320	£ 410
	Cementless HA Coated	572	£ 320	£ 402	£ 320	£ 380
Liner	Polyethylene	647	£ 207	£ 261	£ 191	£ 209
	Ceramic	0	£ -	£ 360	£ -	£ 355
All Acetabular	Cup / (Shell + Liner)	1195	£ 267	£ 526	£ 86	£ 557

SHARED DECISION-MAKING IN A CLINICAL SETTING

Patient information and knowledge is vital for hospitals to ensure understanding, confidence, manage expectations and contribute to shared decision-making. We publish hospital-level information about patient outcomes following joint replacement surgery that enables patients to understand what to expect from their treatment and to inform their decision about where to be treated: [The National Joint Registry - Surgeon and Hospital Profile \(njrcentre.org.uk\)](https://www.njrcentre.org.uk).



We also produce guidance from NJR's Annual Report to provide patients with digestible data on the type and quality of joint replacement surgery undertaken, to increase patient awareness and patient choice: [The National Joint Registry reports \(njrcentre.org.uk\)](http://TheNationalJointRegistryreports(njrcentre.org.uk))

THE NJR PATIENT DECISION SUPPORT TOOL

Additionally, the [NJR Patient Decision Support Tool](#) is a freely-available online tool that was developed using NJR data on hip and knee surgery, to help those considering joint replacement surgery to better understand the risks and benefits of having a hospital procedure. The patient enters simple details such as age, sex, height, weight, general health and how their joint disease affects them. The tool then uses NJR data from similar patient experiences to calculate how much better the patient will be likely to feel after surgery. The tool also calculates the risk of death after surgery, as well as the likelihood of repeat surgery

being needed. Patients with a better understanding of their surgical procedure, their own risk level, and what will be happening to them are likely to be better prepared for their hospital procedure and to thereafter have better outcomes.

The Patient Decision Support Tool is an example of how both patients and surgeons can make informed decisions jointly in their hospital consultation time, as an important part of patient-centered medicine. Developed as part of NJR's supported research programme, it has been accessed by many tens of thousands of patients across over 110 countries to better understand their risks and benefits before surgery.

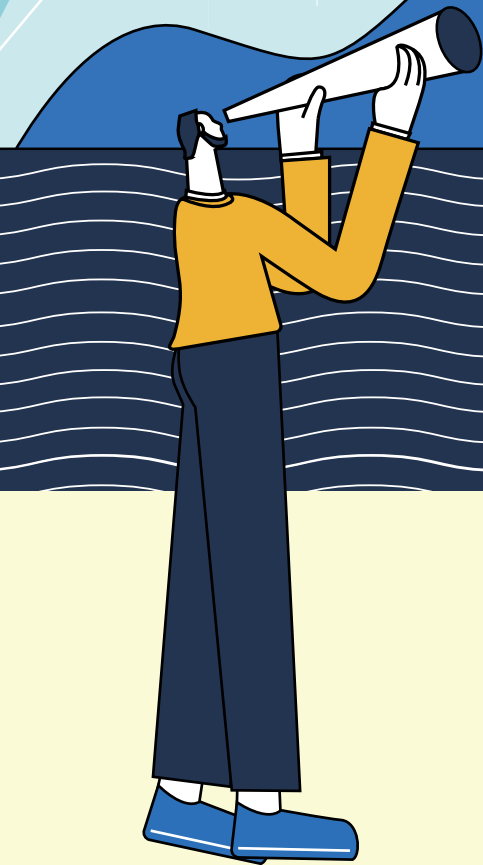
With this brief overview, we hope we have given a flavour of some of the benefits that the NJR delivers to hospitals. By recording, monitoring, analysing and reporting on performance outcomes in joint replacement surgery, we are committed to supporting a continuous drive to improve service quality and enable research analysis – and, ultimately, improve patient outcomes.

● About the National Joint Registry

Described as a global exemplar of an implantable medical device registry, the National Joint Registry (NJR), which covers England, Wales, Northern Ireland, the Isle of Man and Guernsey continues to be the largest orthopaedic registry in the world, with an international reputation and over 3.7 million procedure records submitted. They collect information on hip, knee, ankle, elbow and shoulder joint replacement surgery and monitor the performance of joint replacement implants.

More information:
www.njrcentre.org.uk

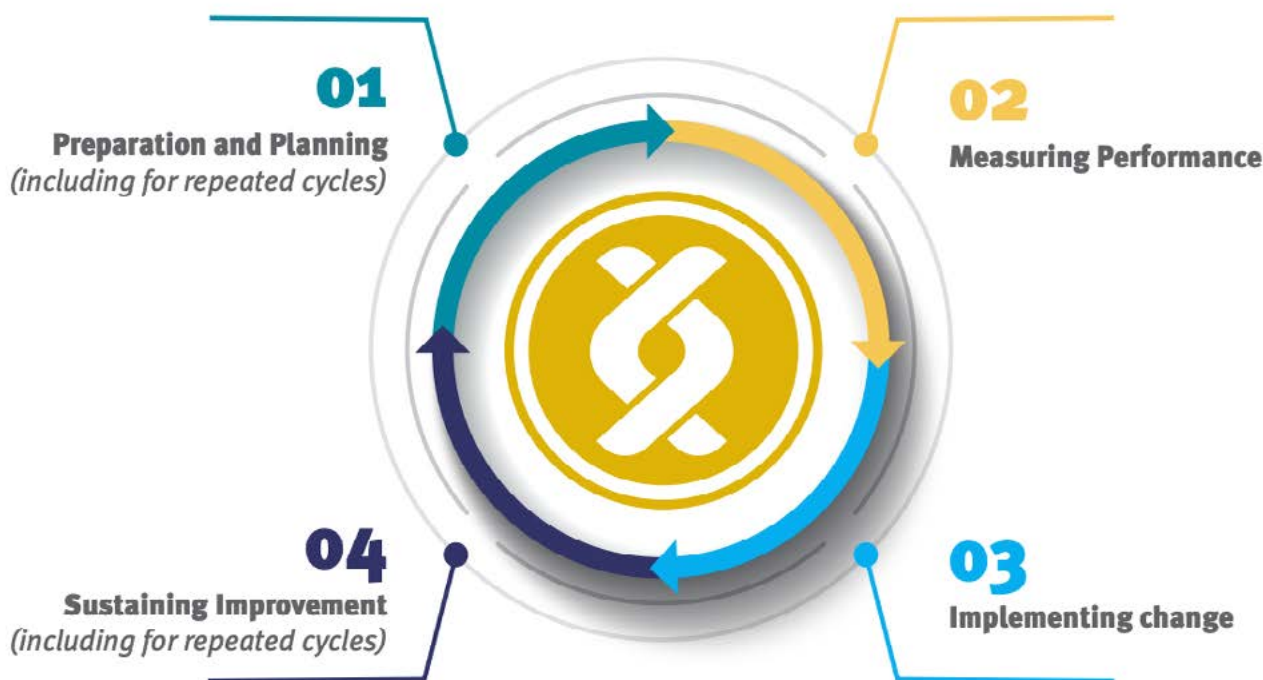
IN FOR THE LONG HAUL



Taking an effective and sustainable approach to clinical audit

Vicky Patel, Chair, National Quality Improvement (incl. Clinical Audit) Network (N-QI-CAN)

Any commissioner or provider of health and care has a duty to review and monitor the quality of the services delivered, making improvements, where appropriate, that are sustainable. The clinical audit community fully supports this responsibility, and there are a number of **exemplar projects** that have made a difference to patient care and outcomes that take sustainability into consideration. However, this comes with challenges, and these need addressing if we are to enable teams to strengthen and future-proof our systems. Here, we outline some considerations and approaches that could support you in overcoming these challenges...



From Best Practice in Clinical Audit, published by the Healthcare Quality Improvement Partnership (HQIP)

Firstly, there's the sheer volume of clinical audits that health and care organisations are eligible to participate in, in order to review, monitor and improve health and care. This highlights resource issues that, if not understood and addressed, can impact on

Do not see each clinical audit as an additional workload or task, but find ways to embed the activity as business as usual

the ability to be both effective and sustainable. Then, even once resources are in place, there are a number of other considerations to take into account...

Clinical audit topic selection is based upon the health and care priorities for our nations at a national

level, and for our local communities at a local level. Patients and service users should be involved to bring a 'lived experience voice' to the topics for inclusion but, most importantly, they should inform the metrics for measurement. They can provide the 'what matters to me' that we need to embed into our decision-making, to improve and further strengthen health and care. But, once we know what the clinical audit programme should include, how do we ensure that it delivers on what it sets out to achieve effectively?

Principles of Best Practice

For many years the clinical audit community has promoted *Stage One – Preparation and Planning* – from the above illustration, as the most important stage to take time to get right. The other three stages will be more easily achieved if we have planned and prepared for the right data being collected in the right way at the right time - and then validated, triangulated and

translated for the right audience(s), to inform timely decision making. For example, we need to ensure that the workforce has the capability and capacity to implement an improvement plan and evidence the impact. We also need to plan for measuring over time, to ensure the improvements implemented have sustained impact.

The National Quality Improvement (incl. Clinical Audit) Network (N-QI-CAN) encourages health and care staff to not see each clinical audit as an additional workload or task, but to find ways to embed the activity as *business as usual*. Make a pledge to undertake a Quality Improvement (QI) project after reviewing the processes for participating in each clinical audit in your programme. This supports a focus on reducing the data burden and releasing resources for taking action for improvement as well as evidencing the impact on improving patient and service user outcomes. Also, don't forget to share your

learning with each other, celebrating success. With most organisations experiencing a high number of projects on their programme, this could all feel like an overwhelming task, but take it one step at a time. Focus first on the highest priority section of your programme. Follow the 'Do One Thing' approach, start with *Just One Clinical Audit* and consider the following top tips:

1. When planning, don't start at the beginning. Identify where the vision is going to take you and where the journey will end. If this is a national audit, agree where the priority fits within the local picture. Clarify the drivers both nationally and locally. Buy-in at all levels is key. Link the clinical audit topic to the wider QI plans and work streams within your own organisation and across the system. If the QI function is not part of your team, protect some time with those colleagues and align the clinical audit to patient pathways and other QI workstreams, to ensure the wider improvement plan includes the clinical audit and a move towards continuous measurement. Additionally, ensure that any further QI as a direct result of the clinical audit measurement, is taken forward collaboratively with all relevant stakeholders.

2. Build your team and supporters. Identify and engage an individual who will be the 'Clinical Champion' for the clinical audit. In addition, identify and include leadership roles for those who will be the decision makers. They need to sponsor the project, committing to actively reviewing the outcomes and resourcing actions needed to improve. There will also be further individuals who will need to undertake QI projects as part of training programmes, curriculums, revalidation, appraisals and Personal Development Plans. Implement

local processes to involve and engage them in improvement work that matters, and which is a priority for the organisation and local system.

3. Embed data identification, collection, validation and submission into everyday practice. Implement processes to ensure that all eligible audit or QI cases are identified for inclusion, to ensure a valid review of the selected population. Build in a validation process to confirm that the data for submission is accurate. Confirm which roles will take responsibility, and ensure deadlines are made known and committed to. Then, map the dataset and work with your Informatics team to automate the extraction of metrics from existing systems, working to add further fields to collect data where they don't currently exist. Consider building forms and reports within Electronic Patient Records (EPRs) to prospectively collect the data that can be extracted electronically, where these don't already exist. Leave any metrics remaining that may have to be collected prospectively at the point of contact or retrospectively from case notes. For organisations not yet on EPRs, consider designing an electronic form to collect the data and use software with queries set up to analyse the data automatically. Confirm the skills required to collect and interpret the information. You will need to establish the project team based upon capability as well as capacity.

4. Plan and agree both the timeline and process for review of data and actions for improvement, moving to a proactive rather than reactive approach. Forward plan the clinical audit timeline of data submission as well as publication releases of data and reports. Agree in advance

the forums where the data will be reviewed and discussed with the right level of roles to inform decision making for QI plans. Plan in wider triangulation with data and information, to understand the context and further inform actions required to improve. Make contact with relevant partner organisations within the local system and agree how to take forward a QI plan across the system that improves both health and care along the Patient and Service User pathway. This should support

Identify at the start what measurement needs to be built in, to evidence the impact of any changes made

effective and efficient access of data and reports, to inform decision making and enable timely action on improvements.

5. Evidence the impact. Identify at the start what measurement needs to be built in, to evidence the impact of any changes made. For a number of national clinical audits that continuously collect and present data over time, this is already incorporated into the design of the audit - but there may still be measures you want monitoring in more real time locally. For local audits and those that are not continuously measuring and monitoring, consider what available metrics you can access to evidence the impact. Where these are not already available, take action to build this in. Ensure that there is a focus on timely identification of unwarranted variations, continuous decision-making and an improvement journey; not just on one point in time.

Clinical audit agreement processes

So, to bring this full circle, we should go back to the beginning and urge you to consider these two questions when potential audit topics are identified:

- ▶ Why this topic?
- ▶ Why now?

Determine the real driver behind the selection, and who is driving it. Is there an urgency to measure and improve now? Make informed decisions on a truly prioritised clinical audit programme. Place additional emphasis on sustainability in terms of cost, efficiency and environment, while still achieving the best possible outcomes, keeping patients safe and providing the best experience for each individual patient at the time of need. Consider utilising Clinical Audit as a tool for measuring the impact of adopting technologies that can release efficiencies in the system while improving health outcomes and experience for patients and service users.

This model of thinking and action-taking aligns with the [NHS IMPACT](#) strategy. It links clinical audit with wider Quality Improvement while automating data where possible, to free up resources

to influence improvements that are sustainable across the pathway. In summary, a clinical audit should be sufficiently resourced to ensure both efficiency (in relation to undertaking the project) and effectiveness (in relation to delivering on its purpose). In other words, for sustained improvements to be achieved, clinical audit resources must be available throughout all stages. Furthermore, taking the time to effectively plan and prepare each clinical audit to measure health and care that address all the domains of quality - effectiveness, safety, experience (responsive and person-centred), well led, sustainably resourced and equitable - alongside data-driven discussions and decision-making on improvement plans, will contribute to future-proofing our healthcare system.

To conclude, it is imperative that we work collaboratively across our systems to implement *sustainable* improvements, measuring over time to evidence the impact of any change in practice or service. If we focus on ensuring sustainability, any changes made will be embedded in practice and support the achievement of all domains of quality, both now and into the future.

The 2023 Sustainability Clinical Audit Hero

The [Clinical Audit Heroes Awards](#) are part of [Clinical Audit Awareness Week](#), which is run by the Healthcare Quality Improvement Partnership (HQIP), in collaboration with [N-QI-CAN](#), to celebrate excellence in clinical audit. One of the categories in 2023 was Sustainability, with the winning team being recognised for identifying an opportunity to support the NHS Long Term Plan aim for the NHS to be 'net zero' by 2040:

WINNER: Amanda Van Vuuren, Darshana Dhaka, Mat MacDonald and Connor Brown, Consultant (Anaesthetics) and Junior Doctors at Sandwell & West Birmingham NHS Trust

The team increased the number of Total IntraVenous Anaesthesia (TIVA) cases and, in doing so, had a significant impact on the reduction of volatile-gas based emissions. They aimed to make TIVA a more routine part of clinical practice in theatres, with the long-term aim of creating a shift in the clinical culture to make TIVA a more common choice across all the theatres in the Trust, where appropriate.

Further information:

- [The 2023 Sustainability Clinical Audit Hero Award winner](#)
- [The 2023 Clinical Audit Heroes Awards](#)
- [Clinical Audit Awareness Week](#)
- [Healthcare Quality Improvement Partnership \(HQIP\)](#).

National Quality Improvement (Incl. Clinical Audit) Network (N-QI-CAN)



N-QI-CAN is a professional network of colleagues undertaking clinical audit and other healthcare improvement work across England, which was founded in 2000 (originally as the National Audit Governance Group). They have over 1000 active members from more than 500 organisations that provide care to patients in the NHS and hospices, which are organised across 11 regional networks.

To find out more, visit the [N-QI-CAN website](#).

Need help with Quality Improvement?

HQIP



As a long-term partner of NHS England, delivering clinical audit and Quality Improvement programmes, HQIP has the expertise to support your organisation to implement meaningful improvement at national, system and local levels. We have experience of helping healthcare organisations of all sizes to improve care using data-driven, patient-centric evidence-informed Quality Improvement projects.

Our services include:

- Clinical audit and outcomes review
- Insight and evaluation
- Quality planning, Quality Improvement (QI) and Quality Assurance
- Clinical effectiveness
- Strategy development
- Facilitation and networking
- Culture change
- Delivery against national healthcare policy

Contact us for a free, no-obligation conversation, to find out how we can help: communications@hqip.org.uk.
Further information: www.hqip.org.uk/advisory-services.