HQIP Healthcare Quality Improvement Partnership

#CAAW26

Data-Informed Improvement: From Insight to Impact

Friday 26 June 2026, 10am-12pm

THIS EVENT STARTS AT 10AM

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CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data

www.hqip.org.uk/caaw26

Data-Informed Improvement: From Insight to Impact

Welcome to Clinical Audit Awareness Week, 22-26 June 2026: www.hqip.org.uk/caaw26

Today's agenda:

- **How National Audit Underpins Safety and Better Care for Patients**

Dame Celia Ingham Clark, *HQIP Chair and former NHS England Deputy Medical Director*

- **From Insight to Impact: What CQC and HSSIB Teach Us About Using Audit Data for Improvement**

Professor Ted Baker, Chair of Health Services Safety Investigations Body (HSSIB)

- **Registry to Results: Aligning with the 10-Year Plan and NICE Early Value Assessment to Improve Outcomes**

John McGrath, National Clinical Director, Robotics Registry

- **Seeing Through the Patient Lens: Turning Data and Audit Findings into Meaningful Improvement**

Kate Cullen, National Paediatric Diabetes Audit (NPDA) Patient Representative

- **Panel Discussion**

Before we start…

Being seen and heard

- Event recorded
- Mics off for background noise
- Cameras on, if you are happy to

Asking questions

- Use the Q&A to post your questions
- Contact us via HQIP website if Q&A unavailable for you

Recommendations

- Laptop/PC, not phone
- Try browser version, not app
- If needed, rejoin using rejoin button on screen or original Teams link

Don't forget to share on social media: #CAAW26

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Dame Celia Ingham Clark

HQIP Chair and former NHS England Deputy Medical Director

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From Insight to Impact: What CQC and HSSIB Teach Us About Using Audit Data for Improvement

Professor Ted Baker

Chair of Health Services Safety Investigations Body (HSSIB)

From Insight to Impact:

What CQC and HSSIB teach us about using audit data for improvement

Ted Baker
Chair, Health Services Safety Investigations Body

HQIP Clinical Audit Awareness Week
26 June 2026

Health Services Safety Investigations Body

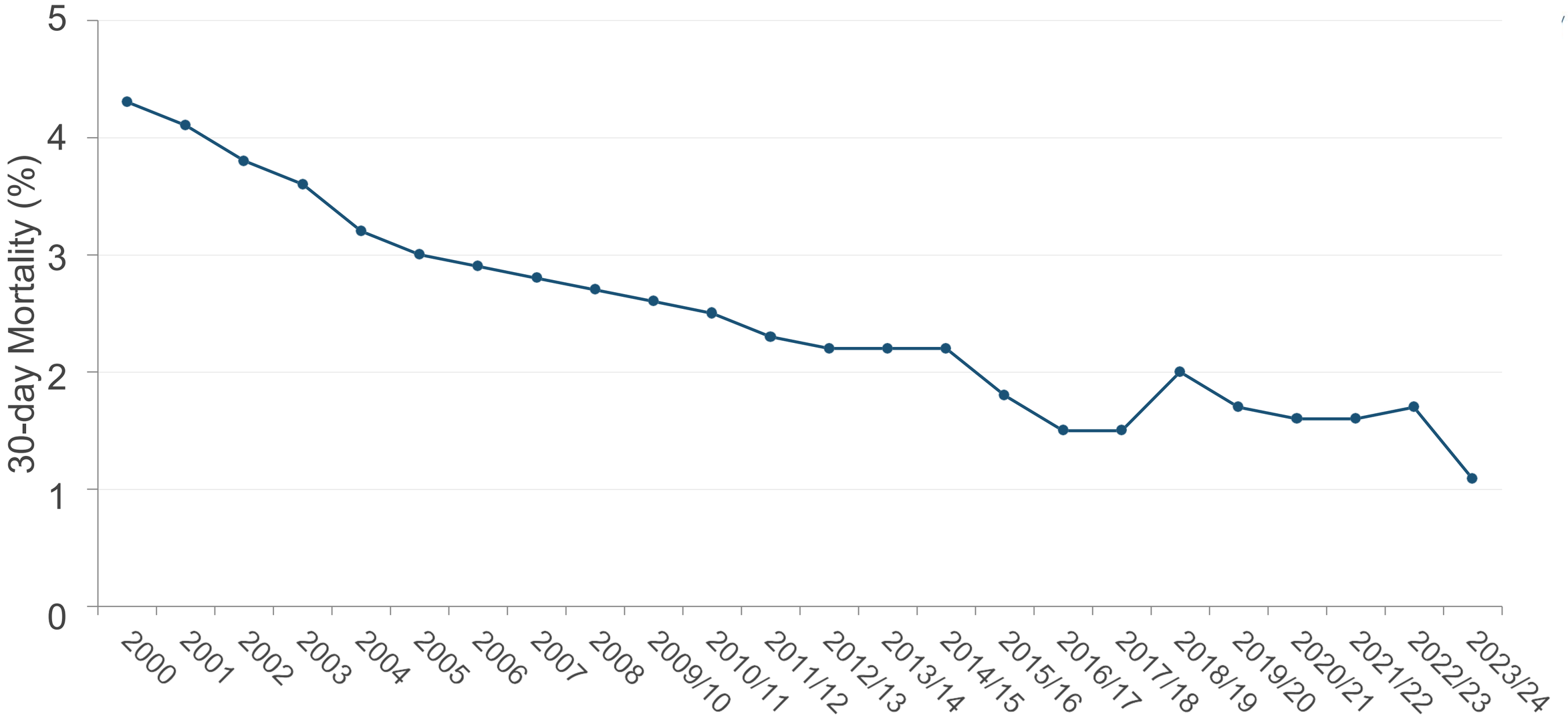
BRI Inquiry, 2001, on openness:

…awash with data.

Little, if any, of this information was available to the parents or to the public. Such information as was given to parents was often partial, confusing and unclear.

For the future, there must be openness about clinical performance. Patients should be able to gain access to information about the relative performance of a hospital, or a particular service or consultant unit.

UK Paediatric Cardiac Surgery: Unadjusted 30-day Mortality (Children < 16)



Sources: 2000–2009/10: Brown et al., Open Heart 2015 (NICOR/NCHDA data, under 16s). *2010/11–2013/14: interpolated (data not yet published in peer-reviewed form).* 2014/15–2023/24: NCHDA Interactive Report, NICOR 2024 (unadjusted, under 16s).

Transparency of audit has witnessed improved outcomes

Health Services Safety Investigations Body

Bowel Cancer (NBOCA)

- 90-day post-op mortality: 3.1% → 2.5% | 2-year survival: 82.3% → 84.9%

Hip Fracture (NHFD)

- 30-day mortality halved: ~11% → ~5% | 94% now survive beyond one month

Lung Cancer (NLCA)

- Median survival: 281 → 372 days | Early-stage diagnosis: 32% → 40%

Heart Failure (NHFA)

- Beta-blocker prescribing +10% | Length of stay: 9 → 8 days

The paradox

Health Services Safety Investigations Body

Extended perinatal mortality fell from 6.09 to 4.88 per 1,000 total births between 2013 and 2023

Alongside:

- Rising maternal morbidity
- Persistent inequalities
- Escalating negligence costs
- Repeated accounts by women of harm, dismissal and trauma

Headline indicators can improve even as underlying conditions remain unsafe

- Maternity outcomes arise from long, relational pathways involving multiple professionals, shifting risk and complex social contexts
- Harm is often cumulative and systemic, not procedural

Reassurance Without Understanding

Health Services Safety Investigations Body

- CQC inspections repeatedly found quality dashboards awash with green that bore little relation to frontline reality
- This is not a measurement problem — it is a cultural problem
- Dixon-Woods et al. (2014): many NHS organisations had 'comfort-seeking' cultures
  - *Valued indicators that reassured; discarded indicators that showed problems*
  - *Validated by CQC's own inspection findings at scale across all NHS hospitals*
- Safety ratings were consistently the poorest of the five key questions
- Leaders often did not know, or did not want to know, what was actually happening

The problem

Health Services Safety Investigations Body

- Clinical audit has never been more comprehensive, or more technically sophisticated
- Yet the gap between what data shows and what organisations do about it remains stubbornly wide
- That is the gap is between insight and impact

Three organisations, one shared insight

- CQC sees the gap from outside, through assessment and inspection
- HQIP measures the gap, through national audit and outcomes data
- HSSIB examines the gap after harm has occurred, through independent investigation
- None can close the gap alone — but together they might

National Clinical Audit Benchmarking

Health Services Safety Investigations Body

Risk adjusted standardised mortality ratio (0-15 years)

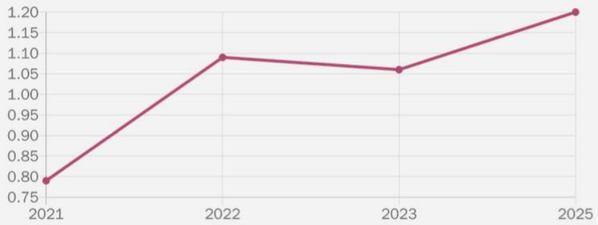
Updated on NCAB: 03 Mar 2026

1.2

2025 Report

Comparison: Within expected range

Trend graph



N/A	1.0	Effective	944
National Aggregate	National Standard	CQC Key Question	Cases

Notes: From the PICANet National Paediatric Critical Care Audit State of the Nations Report 2025, with a data collection period from January to December 2024 and published 11/12/2025 (referred to here as 'the 2025 report'). The target of a standardised mortality ratio is 1 (i.e. the number of observed deaths should be equal to the number expected). More up to date data may be available at: https://www.picanet.org.uk/picanet-data-dashboard/

Managing outliers

Alert zone (2–3 SD)

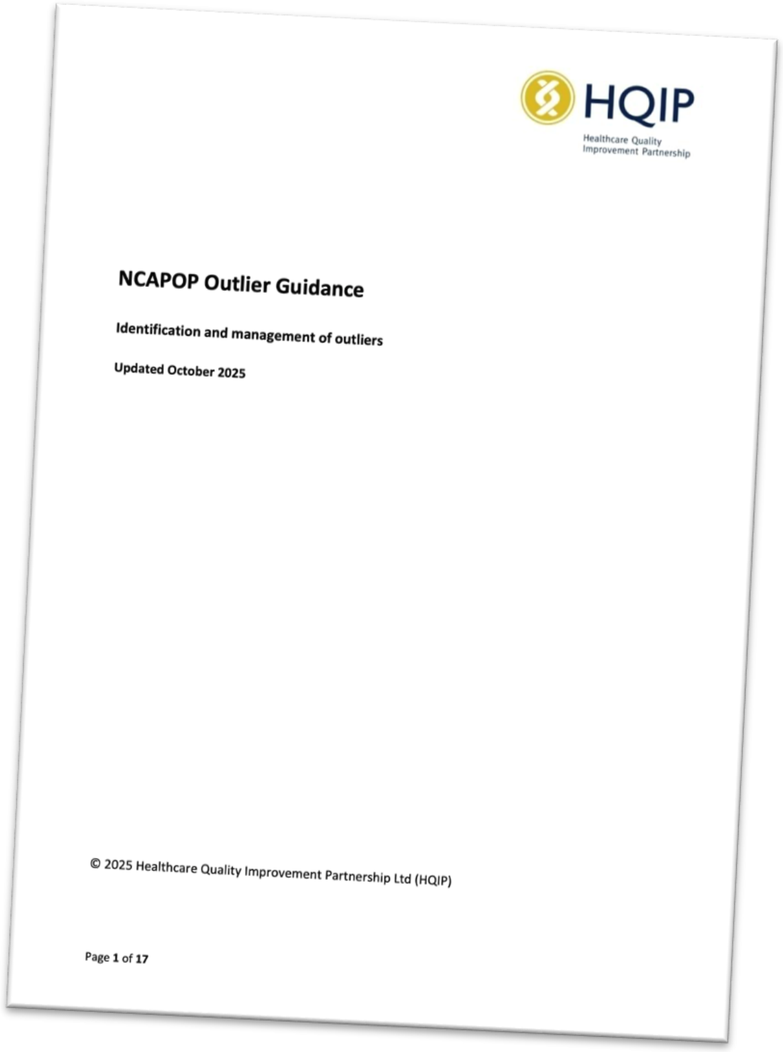
- Signal for local learning and inquiry
- Check data accuracy; identify and share improvement actions
- No external sanction — this space must feel safe

Alarm zone (>3 SD)

- Formal review, accountability and escalation
- May trigger CQC regulatory attention
- Response plan and external scrutiny expected

The risk

- When organisations cannot tell which is happening, all outlier signals feel punitive
- Result: defensive response, data managed rather than used, learning suppressed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NCAPOP Outlier Guidance

Identification and management of outliers

Updated October 2025

Health Services Safety Investigations Body

“Well-led” predicts safety

Health Services Safety Investigations Body

- The well-led rating was the strongest predictor of safety performance across all NHS hospitals
- Staff survey scores on speaking up and feeling listened to were even more predictive
- Stronger than any process or compliance measure
- This is direct evidence that psychological safety is a measurable precondition — not a cultural aspiration

Implication for audit programmes

- How outlier data is framed and followed up either supports or undermines psychological safety
- Audit programmes are not neutral — they shape the culture they depend on

What is accountability?

Health Services Safety Investigations Body

COUNTING	GIVING AN ACCOUNT
Producing metrics	Honest narrative explanation
Compliance	Understanding
Disclosure	Communication
From the Latin computare: to count	

"Can trust be restored by making people and institutions more accountable, or do complex systems of accountability and control actually damage trust?"
Onora O'Neill, BBC Reith Lectures, 2002

What transparency achieves and what it cannot

Health Services Safety Investigations Body

What transparency achieves

- Public reporting of cardiac surgery outcomes transformed the specialty — outcomes improved, variation narrowed
- National audit data has driven measurable improvement across multiple programmes

Its limits

- Maternity: perinatal mortality falling, yet persistent harm, rising morbidity, escalating negligence costs
- Headline indicators can improve while underlying conditions remain unsafe
- Disclosure is not the same as understanding

O'Neill's distinction (Clinical Medicine, 2004)

- Transparency as currently practised often requires disclosure without genuine communication
- Intelligent accountability requires communication, not just the production of counts

Safe space is not optional

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- Safe space: conditions under which staff can describe uncertainty, error and workarounds without fear of blame or sanction
- Not an expression of organisational benevolence, but a structural mechanism to protect the integrity of learning

HSSIB's statutory safe space

- Legal protections separate learning from disciplinary, regulatory and legal processes
- Comparable arrangements in aviation, nuclear and rail where they not considered soft, considered essential

The parallel with alert/alarm

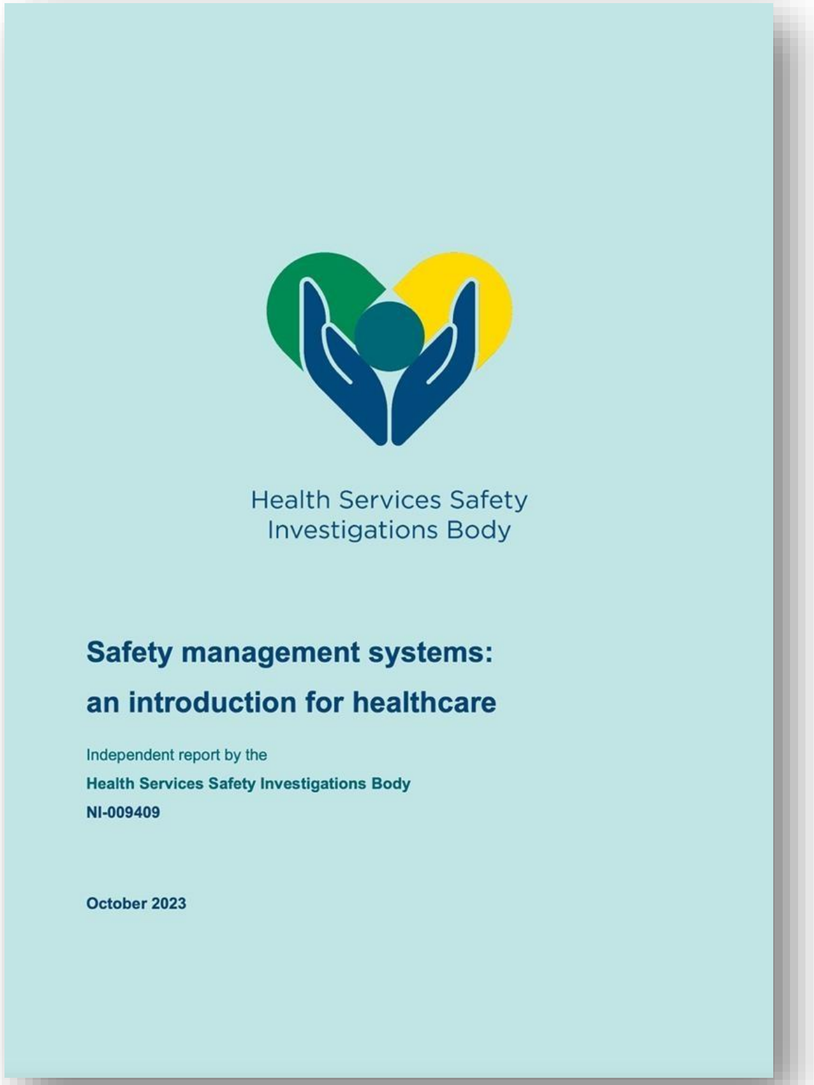
- Alert-level data belongs in a protected learning space: honest local inquiry, no immediate sanction
- Alarm-level data belongs in the accountability space
- How do these work together?

Managing safety in health services

Health Services Safety Investigations Body

- The structural answer to this challenge is a safety management system
- Healthcare is provided by a variety of complex systems working together
- Safety management is not coordinated
- Accountability, priorities and learning are often unclear
- Safety recommendations are often not implemented effectively

We recommended a national initiative to develop **Safety Management Systems** in healthcare, with the intention that they will become a regulatory requirement



Audit is vital, but culture is key to improvement

Health Services Safety Investigations Body

- The evidence that audit improves outcomes is clear
- Tens of thousands of lives saved across hip fracture, bowel cancer, lung cancer, heart failure and beyond
- The question is not whether audit works — it is why improvement is still so inconsistent

The answer

- Data without psychological safety produces compliance, not learning
- Transparency without safe space produces disclosure, not understanding
- Accountability without trust produces performance, not genuine improvement

The harder work

- Creating the psychological safety, the protected learning environments, and the leadership culture that make honest accounts possible has barely begun
- Until it does, transparency will continue to fail to deliver its full potential, and patients will continue to pay the price

Health Services Safety
Investigations Body

www.hssib.org.uk

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Registry to Results: Aligning with the 10-Year Plan and NICE Early Value Assessment to Improve Outcomes

John McGrath

National Clinical Director, Robotics Registry

GIRFT
GETTING IT RIGHT FIRST TIME

NHS England

Registry to Results: Aligning with the 10-Year Plan and NICE early value assessment to Improve Outcomes

Mr John McGrath

Co-chair of NHS England Robotic Steering Group

NCD for SDM of National Registry of Robotically-Assisted Surgery (NRRAS)

National Clinical Advisor in Urology – NHS England Cancer Programme

HQIP

CLINICAL AUDIT AWARENESS WEEK

Improving lives with healthcare data

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Background & scale of RAS in England

Robotic-assisted surgery has been used in the NHS for nearly 20 years, historically concentrated in complex cancer surgery

13×

growth in RAS procedures
2011/12 → 2023/24

41,134

RAS procedures per year
(2023/24)

140+

RAS systems installed
across NHS England

11

specialties now conducting
50+ RAS procedures p.a.

WHAT IS RAS?

- Robotic technologies used to support the surgeon
- Historically limited to complex cancer surgery; now expanding into benign conditions and orthopaedics
- Majority of conventional laparoscopic procedures expected to transition to RAS over time
- Wide, unwarranted variation in access across England

SPECIALTY BREAKDOWN (% OF ALL RAS ACTIVITY)

Specialty	2011/12	2018/19	2023/24
Urology	80.3%	76.4%	42.2%
General Surgery (colorectal)	5.7%	7.2%	24.7%
Gynaecology	4.9%	8.1%	12.7%
Trauma & Orthopaedics	1.5%	1.5%	8.3%
Cardiothoracic	0.4%	2.6%	7.2%

Advantages of robotically-assisted surgery

Benefits extend beyond the operating table to the workforce, the system, and the wider economy

Patients

- Shorter stay
- Faster recovery
- Less pain

Surgeons

- 3D vision – 4 arms – dexterity
- Faster training
- Higher % competent
- Ergonomics

NHS

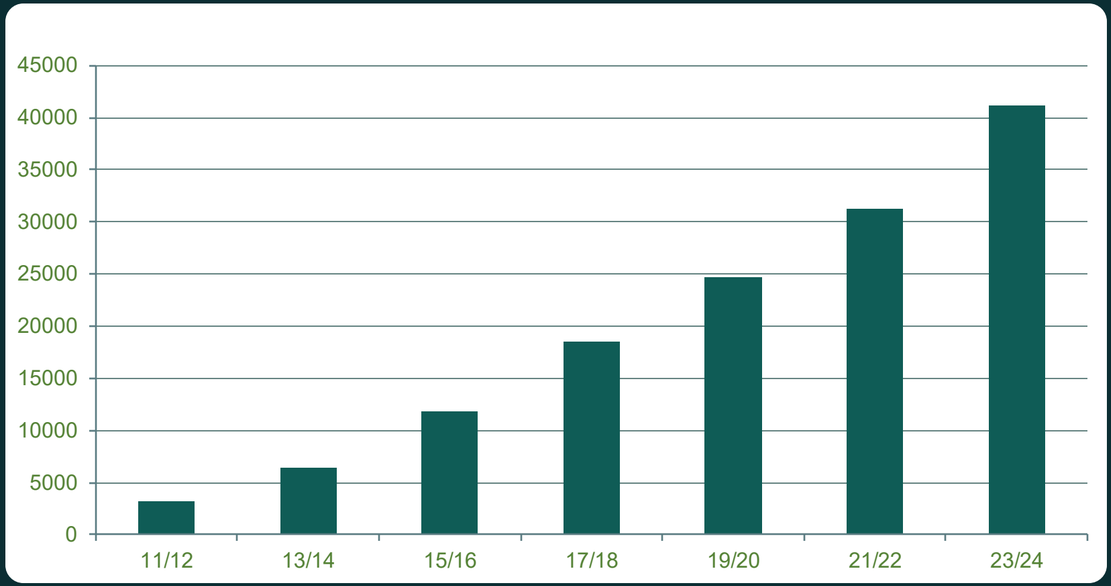
- Less bed days
- Potential to increase efficiency
- Recruitment

UK PLC

- Life sciences sector
- Med tech industry
- NHS as an incubator for RAS

RAS growth and unwarranted variation

Sustained year-on-year growth nationally, but adoption varies widely between individual NHS trusts



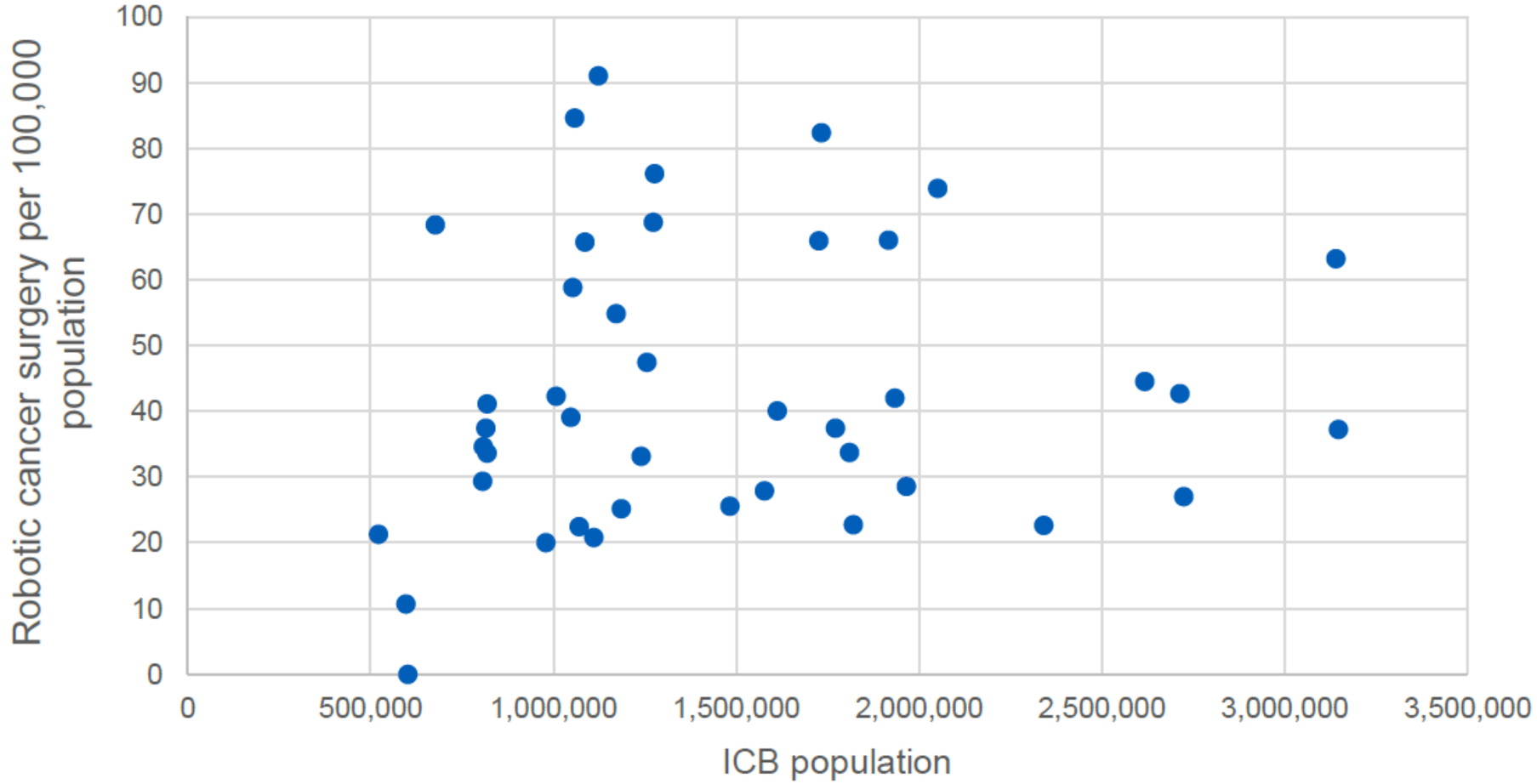
Variation across NHS trusts

- RAS activity per trust ranges from near zero to several thousand procedures a year, even after accounting for population served
- ICB-level analysis shows no consistent relationship between population size and access to robotic surgery
- This unwarranted variation is a core justification for a national registry: it can't be addressed without comparable, standardised outcome and activity data

Specialty mix is shifting fast: urology fell from 80.3% to 42.2% of activity (2011/12 → 2023/24) as colorectal surgery, gynaecology, orthopaedics and cardiothoracic surgery scaled up — broadening the range of outcomes the registry will need to track.

NHS England

Figure 4 ICB population and RAS utilisation, 2023/24



NHS England

GIRFT GETTING IT RIGHT FIRST TIME

NHS IMPACT Improving Patient Care Together

Implementation of robotic-assisted surgery (RAS) in England

July 2025

GIRFT is part of an aligned set of programmes within NHS England

Supporting organisations

The following organisations and teams have contributed to the development of this guidance:

NHS England

Including: Getting It Right First Time, The National Elective Recovery Programme, NHS Supply Chain and The National Cancer Programme.

NICE National Institute for Health and Care Excellence

Department of Health & Social Care

Department for Science, Innovation, & Technology

Royal College of Surgeons of England

Royal College of Physicians and Surgeons of Glasgow

The Royal College of Surgeons of Edinburgh

RCSI Royal College of Surgeons in Ireland

JCST Joint Committee on Surgical Training

ASiT The Association of Surgeons in Training

NHS England

Configuration of RAS programmes

Procurement – linking to NETIS

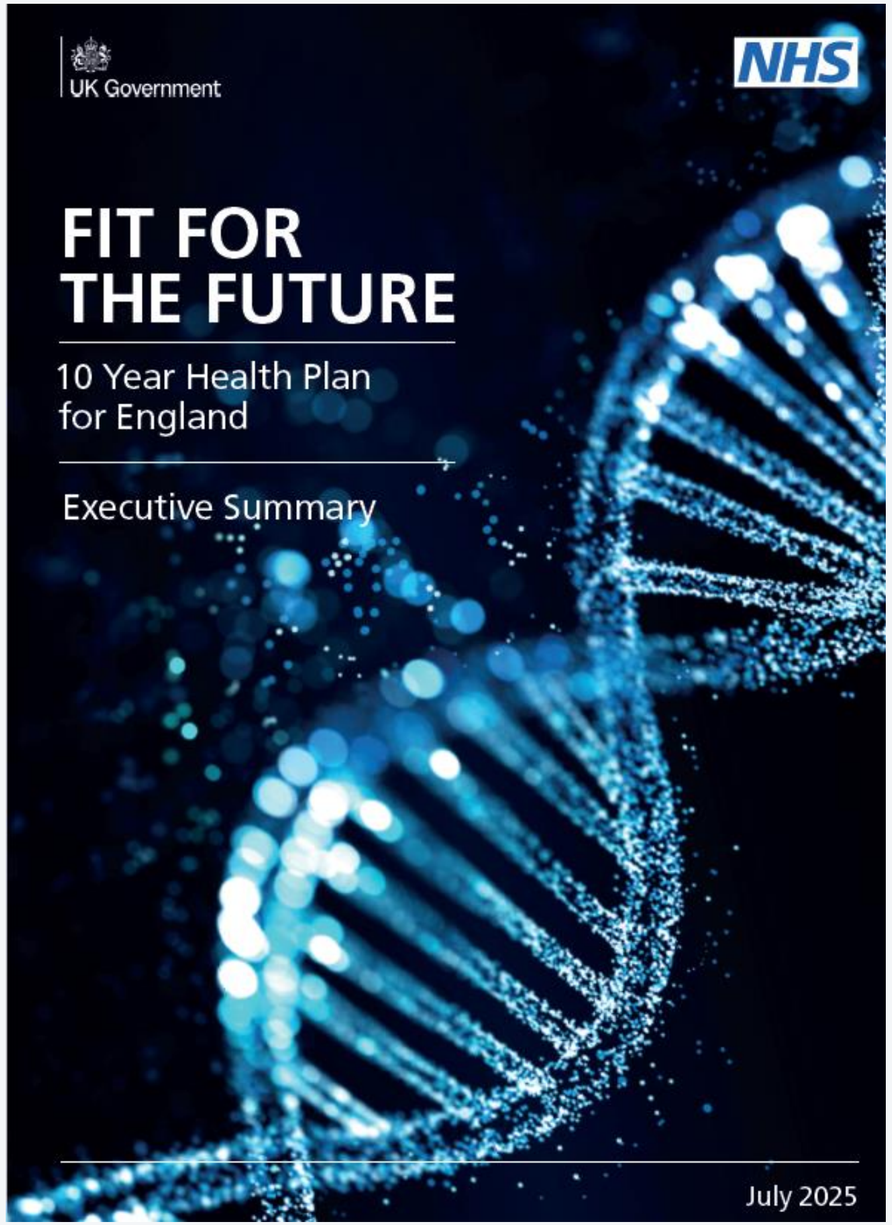
Training and proctoring

Safe implementation

Evaluation / registration

Research environment

GIRFT GETTING IT RIGHT FIRST TIME



Big bet 5: By 2035, robots will deliver care with unprecedented precision

The Future of Healthcare: surgeons will perform complex procedures with ever more sophisticated robotic assistance, enhancing precision, minimising invasiveness, and speeding up recovery. Pharmacy automation will ensure medication gets to patients quickly, easily and safely.

Current application: Bristol Southmead Hospital is using state-of-the-art surgical robots to carry out a range of procedures, including gynaecology and urology[255]. These robots have 3D visualisation and instruments with more degrees of motion than the human wrist. This has made more complex operations possible with minimally invasive techniques, translating to fewer complications and shorter hospital stays.

The NHS is committed to the adoption of robotic-assisted surgery as standard for an expanded range of procedures, over the next 10 years. In addition to enhancing surgical precision, robots can help automate operational processes in hospitals. That is, they can help deliver supplies, courier medications and samples, or deliver environmental sanitisation.

Beginning next year, we will expand surgical robot adoption in line with NICE guidelines. We will also support NHS trusts to increase robotic process automation. This is technology where robots mimic human actions to automate repetitive, rule-based tasks. In the NHS, that might mean they help with data entry, inventory control, referral management - and a range of other tasks that can free up the healthcare professional to focus on their patients.

From 2029, we will establish national registries for robotic surgery data and develop telesurgery networks. This will help us scale successful trials of assistive robotics. As outlined in chapter 2, we will also scale the use of robotics in pharmacy - where they can fill prescriptions far more quickly and accurately than humans.

> "In August 2023 I had a total hysterectomy at [Hospital A] by robotic surgery and it's the best surgery I have ever had. Only 1 night in hospital and next day only needed paracetamol it was much better and easier than expected. Well done the NHS"
>
> *Bronwen, public participant via Change NHS website*

Enabling global excellence

These 'big bets' offer an opportunity to align research, investment and innovation to the technologies that have the greatest potential to transform healthcare. However, they will only realise their full potential if the NHS trials and adopts the science. We need to build the infrastructure to draw on all our assets - including the NHS - to deliver genuine global excellence.

To support this, we will run a new bidding process for new Global Institutes. Supported by NIHR funding, these institutes will be expected to marshal the assets of a place - industry, universities, the NHS - to drive genuine global leadership on research and translation. Their aim will be no less than becoming the world leading centre for their area of focus and attracting the most talented academics and innovators from around the world. They

NHS England

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GETTING IT RIGHT FIRST TIME

The Plan's five “big bets”

Five technology levers the Plan backs to transform care delivery — robotics is one of them, and the registry is its evidence engine

Data

Joined-up data and interoperability for research, innovation, and care

AI

AI to drive productivity, personalised care, and patient choice

Genomics

Genomics and predictive analytics for early, tailored intervention

Wearables

Wearable technologies for continuous monitoring outside hospital

Robotics

Robotics to transform surgical care and outcomes

▲ REGISTRY FOCUS

Where this tender fits: the registry directly operationalises the “robotics” bet — generating the outcome evidence needed to scale robotic surgery safely and demonstrate its value to the wider system.

Implementing RAS: the programme lifecycle

The registry sits within a wider system of activities needed to roll out robotic surgery safely and at scale

1

Configuration

Configuration of RAS programmes

2

Procurement

Linking to NETIS

3

Training

Training and proctoring

4

Implementation

Safe implementation

5

Evaluation

Evaluation / registration

6

Research

Research environment

This tender sits at the “Evaluation / registration” stage — the national registry is the system's mechanism for generating the comparable evidence the other five stages depend on.

NICE — Early Value Assessment

A conditional, faster route to NHS adoption for promising technologies — paired with a requirement to keep generating evidence

NICE
National Institute for Health and Care Excellence

WHAT EVA DOES

Early conditional green light for promising MedTech, while real-world evidence accumulates

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“Cutting-edge robotic surgery gets green light” — 11 systems recommended under EVA for soft-tissue procedures

Source: NICE HTG742 / HTG743 guidance

Conditional, not permanent

EVA recommendations come with evidence-generation requirements — NICE expects data back to confirm safety and effectiveness at scale

Registry is the evidence route

The tender explicitly asks the registry to address evidence gaps the NICE Medical Technologies Advisory Committee has identified for robotic surgery (EvGen)

Two related assessments

Separate EVA guidance covers orthopaedic procedures (HTG743) and soft-tissue procedures (HTG742) — both feed metric requirements into the registry design

Read-across: the NHS 10 Year Cancer Plan

Robotic surgery's roots in cancer care give the registry a direct line into national cancer ambitions

World-class cancer care

The Cancer Plan commits to delivering world-class cancer care for England, with earlier diagnosis and better treatment outcomes as central goals.

RAS began in cancer surgery

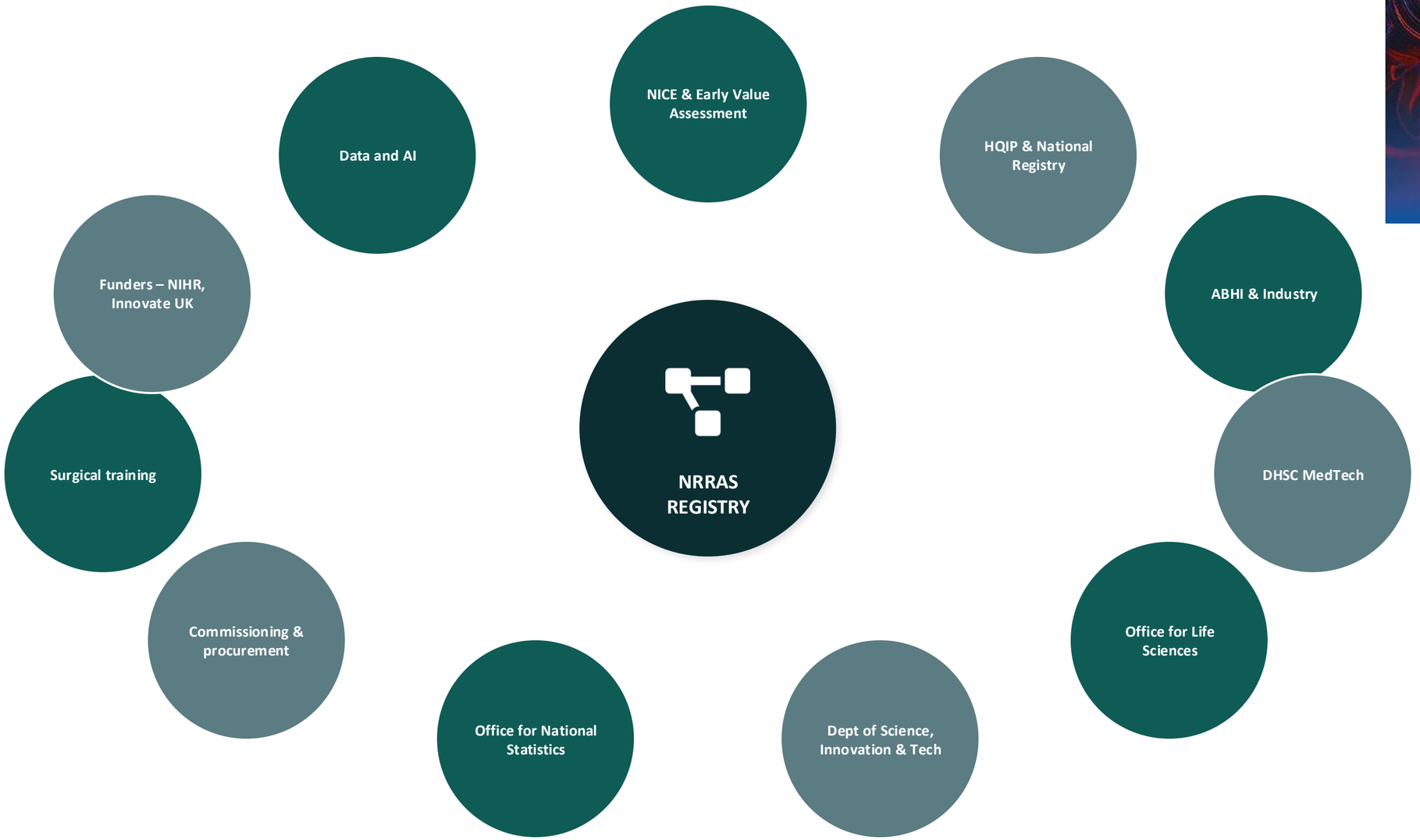
Robotic surgery in the NHS was historically concentrated almost entirely in complex cancer procedures — still 42% of all RAS activity (urology alone) in 2023/24.

Outcomes evidence for cancer pathways

Registry data on recovery times, complication rates, and longer-term outcomes feeds directly into demonstrating whether RAS is delivering on cancer-care ambitions.

Joining it all up: the Life Sciences opportunity

The registry doesn't sit in isolation — it's one node in a wider national ecosystem of bodies, funders, and data flows



UK Life Sciences Sector Plan

Robotics, MedTech & Innovation • Published 16 July 2025

AMBITION: Leading life sciences economy in Europe by 2030 • Top 3 fastest for patient access to medicines & medtech • 3rd globally by 2035

01

World-Class R&D

£600m Health Data Research Service (Govt + Wellcome) • Trials ≤150 days by Mar 2026 • New Global Institutes; UKRI/NIHR SME support

02

Outstanding Place to Scale

£4bn BBB growth capital + £12bn private co-investment • No.1 life sciences FDI in Europe by 2030 • Support for 10–20 high-potential UK firms

03

Health Innovation & NHS Reform

Rules-Based Pathway for NICE-backed MedTech access • NICE appraisals expand to devices & diagnostics (Apr 2026) • NHS Innovator Passport (2026)

ROBOTICS SPOTLIGHT

One of the NHS 10-Year Plan's Five Big Bets for transformative care

- National RAS guidance published July 2025; procedure-specific pathways
- 41,134 procedures/yr; 140+ systems; 11 specialties
- NICE evidence review 2029 — routine adoption decision
- Industrial Strategy: £4.3bn Advanced Manufacturing Plan; £2.8bn R&D in robotics & automation

MEDTECH SPOTLIGHT

Rules-Based Pathway: consistent NICE-backed route for devices, diagnostics and digital

- Pilots end-2025; mandated NHS funding from April 2026
- NHS Innovator Passport (2026): assessed once, deployable nationally
- MHRA–NICE parallel approvals save 3–6 months to market
- NHS HealthStore and regional Health Innovation Zones for test-and-scale

Source: UK Life Sciences Sector Plan, 16 Jul 2025 • NHS 10-Year Health Plan, Jul 2025 • GIRFT/NHS England RAS Guidance, Jul 2025

NHS TENDER SUMMARY

National Registry of Robotically Assisted Surgery

Healthcare Quality Improvement Partnership Ltd • Procurement Act 2023 Open Procedure

NOTICE ID	PUBLISHED	TENDER DEADLINE	CONTRACT START
2026/S 000-019354	4 March 2026	13 April 2026, 12:00pm	1 October 2026

What's being procured

HQIP is commissioning a national, clinically-led registry to track outcomes of robotically assisted surgery across NHS-funded care in England.

£

CORE CONTRACT VALUE

£1.30m

inc. VAT (£1,083,600 ex. VAT) — bids above this may be rejected

3 years

core term, with option to extend up to 24 months

Ceiling value incl. all aspirational measures: £10.8m inc. VAT

Contracting Authority

Healthcare Quality Improvement Partnership Ltd (HQIP), London

Category

Health services (CPV 85100000), UK-wide scope

Contract dates

1 Oct 2026 – 30 Sep 2029 (+ up to 24 months extension)

Suitability

Open to SMEs and VCSE organisations

Why the registry exists

Core aims set out in the specification — built around patient safety, evidence generation, and equity of access.

Patient safety

Track short- and long-term outcomes of robotically assisted surgery

Quality metrics

Capture metrics aligned with NICE Early Value Assessment (EVA) requirements

Standardisation

Support standard practice and surface variation in outcomes across hospitals

Evidence base

Inform clinical guidelines, commissioning, and regulatory decisions

Equity of access

Understand current provision and inform future strategic decisions

Live data access

Near real-time data so authorities can evaluate effectiveness vs. conventional techniques

Core delivery requirements

What the supplier must build, fund, and govern over the contract term

1

Live registry by 2029

Prospective data collection on robotically assisted surgery delivered before the end of year three

2

Self-sustaining funding model

Designed in years 1–3, with funder/commissioner sign-off; shifts from public funding to self-sustaining by contract end

3

Controlled data-to-manufacturer flow

A mechanism for contributing manufacturers to access outcome data — strictly excluding commercial or marketing use

4

Interoperability, no duplication

Design must account for existing registries and data holdings, avoiding duplicated collection or reporting

5

HQIP & NHSE remain central

Governance must keep HQIP and NHS England as non-negotiable partners through and beyond the contract

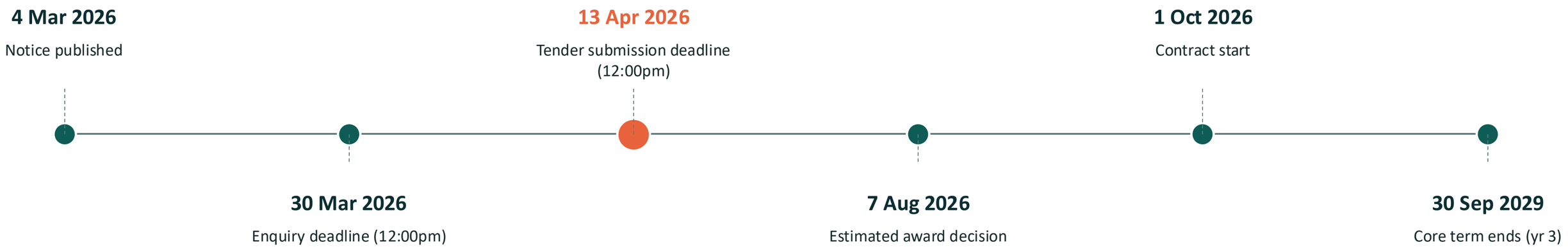
6

Portable, IP-compliant platform

Treated as proof of concept; the technical solution must be portable between providers under clause 20 (IP)

Procurement timeline

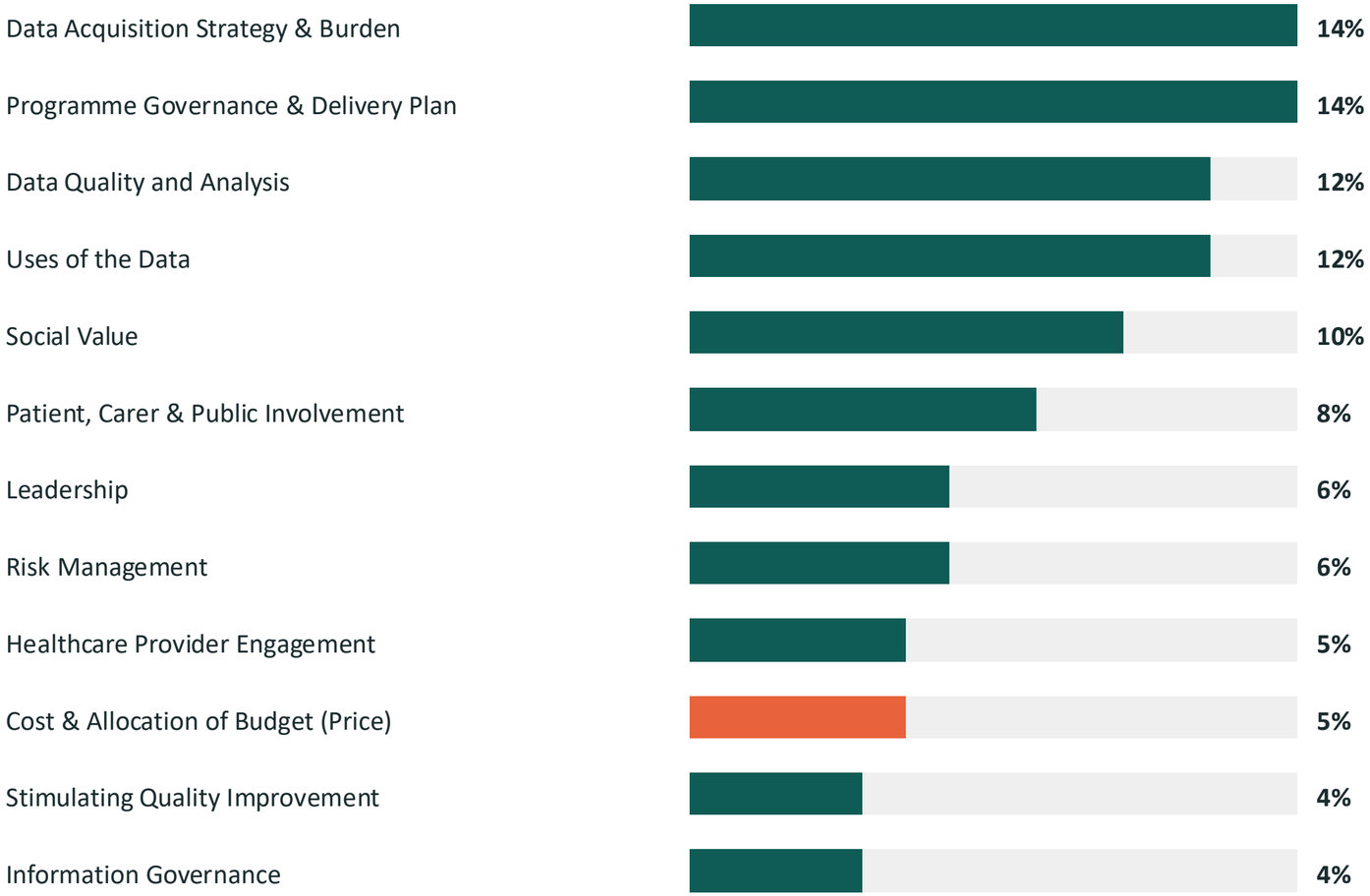
Open procedure under the Procurement Act 2023

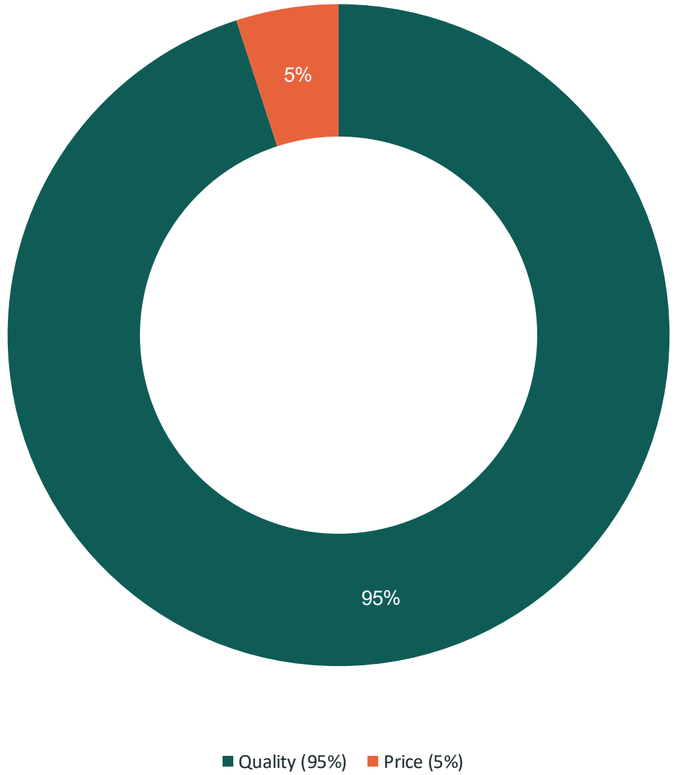


Submit via the Delta eSourcing portal. Electronic submissions only, in English.

Award criteria

Weighted 95% Quality / 5% Price across 12 scored criteria





Aspirational intent measures

Optional, funder-discretion measures that could extend scope and value beyond the £1.30m core (full detail in Annex A, section 13.2)

24-month extension (NCAPOP-aligned)	**£840,000**	Additional national/international funders	**£935,340**
Transition to different data collection models	**£600,000**	Changes aligned to national policy	**£1,200,000**
Inclusion of privately funded care	**£600,000**	Development of PROMs and PREMs	**£1,200,000**
Additional / enhanced project delivery	**£1,200,000**	Tracking innovative surgical techniques	**£1,200,000**
Quality improvement incl. surgeon-level outliers	**£500,000**	Dev. costs for additional/international funders	**£144,000**

These are ceiling figures at the funder's discretion — not committed spend. Core pricing must exclude all aspirational and extension costs.

Supporting the NHS 10 Year Health Plan

How the registry's aims connect to the Plan's strategic shifts — this mapping is analysis, not a claim made in the tender itself

Hospital → Community | **Analogue → Digital** | **Sickness → Prevention**

Digital-first data infrastructure

The Plan leans on data and technology to manage risk and access to care. The registry's near real-time outcomes data is a concrete building block of that ambition.

Outcome-based quality measurement

National priorities call for clinically credible outcome measures, moving away from activity counts. The registry generates exactly this kind of patient-level outcome evidence.

Evidence for earned autonomy

Top-performing trusts may gain more autonomy, even managing local budgets. Robust comparative outcome data is the evidence base that kind of differentiation needs.

Safe scaling of AI-adjacent technology

Ambitions to make the NHS highly AI-enabled require careful monitoring. Tracking robotic surgery outcomes provides exactly that post-deployment safety surveillance.

Summary

1. Robotic surgery is scaling rapidly in the NHS and worldwide
2. The NHS 10 Year Health Plan commits to planned scale-up and national registry
3. The NRRAS will support:
   Outcome-based delivery – Safety – Equity of access – Service design and funding – Evidence base
4. Significant international interest. Industry support.
5. Underpins the Life Sciences opportunity

AT A GLANCE

£1.30m

Core contract value (inc. VAT)

3 yrs

Core term, +24mo possible extension

95/5

Quality vs. price weighting

7 Aug

Estimated award decision, 2026

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HQIP Healthcare Quality Improvement Partnership

#CAAW26

Seeing Through the Patient Lens: Turning Data and Audit Findings into Meaningful Improvement

Kate Cullen

National Paediatric Diabetes Audit (NPDA)

Patient Representative

A Parent/Carer Perspective on Audit in Paediatric Diabetes

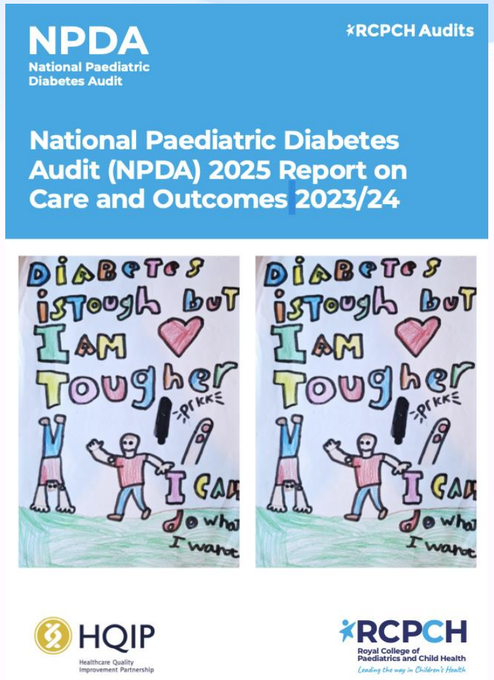
Kate Cullen June 2026

Diagnosis Story- Type 1 Diabetes

- Son diagnosed out of the blue at 8yo
- Crash course in Type 1 diabetes at hospital
- Insulin injections , finger pricking, blood glucose levels, counting carbohydrates…
- Sent home to continue
- Great paediatric diabetes team but still a stressful time -12+ finger prick tests a day for blood glucose, insulin injections whenever ate & a painful overnight basal insulin injection
- Overnight blood testing as no hypo awareness

- Soon moved to an insulin pump, supported by our diabetes team
- Self funded continuous glucose monitor
- Now at age 22 - on a hybrid closed loop system
- Throughout our team were supportive in accessing the newer technologies although funding always an issue

- Chatting on various forums soon discovered that not all diabetes care was equal (15 years ago)
- Became involved with National Children &Young Peoples Diabetes Network (CYPD) as a parent rep (& later NPDA) as felt access to equal quality of care important.
- Lots of work done by CYPD & NPDA led by Dr Fiona Campbell
- Professor Partha Kar, national lead for diabetes has pushed forwards to increase access to technology rtCGM & HCL
- Huge improvements in care & access to technology in the last 10 years



What matters most to parents & carers when we talk about improvement?

Good diabetes care from their team - continuity & relationships

Regular appointments & recommended health checks

Access to diabetes technology & support in how to use
- Continuous glucose monitors (CGM)
- Closed loop technology - automated pump & CGM (HCL)

Psychology support for the whole family

Transition care - important that care/support is tailored to older teenage & young adult age groups

Diabetes care & support in school

DKA at diagnosis - levels static

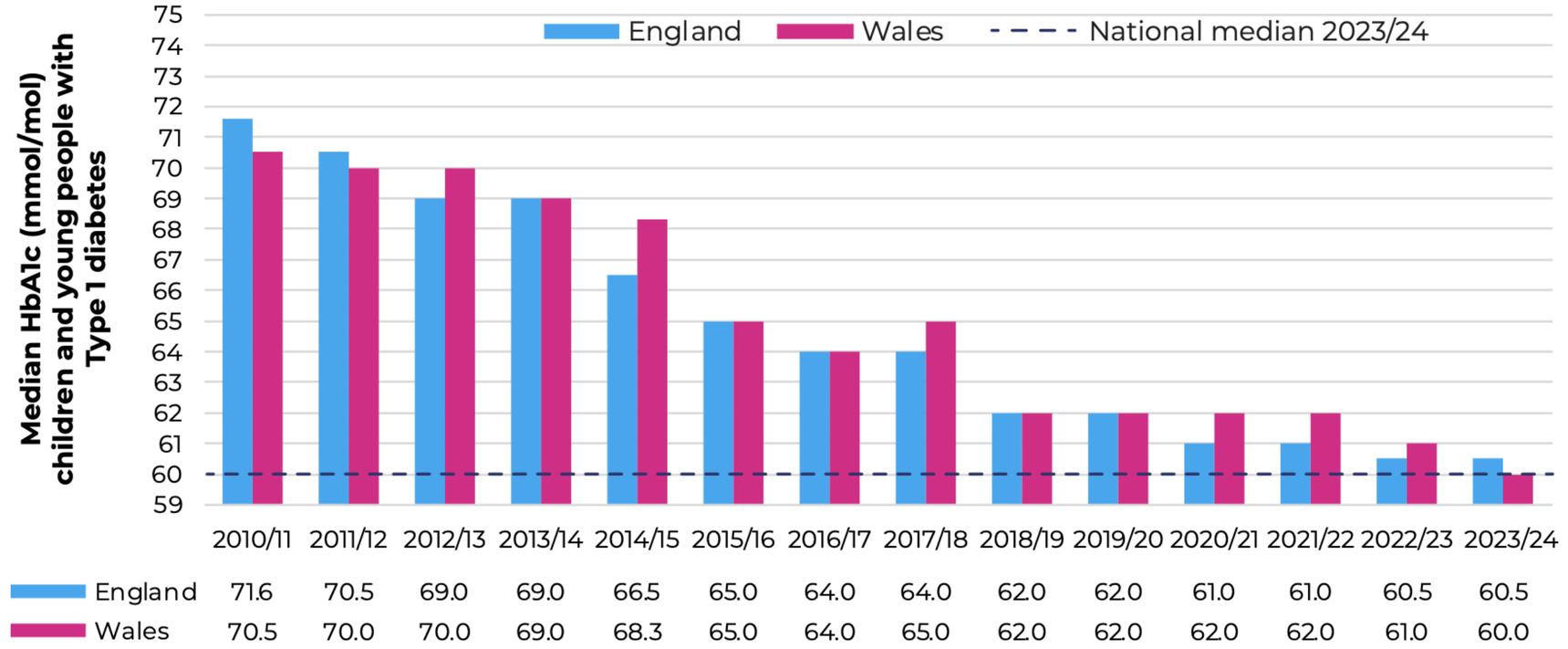
What does meaningful improvement look like in practice?

Improving HbA1c but variation & outliers

Technology access improving

Inequalities improving- ethnicity & deprivation

Improvements in HbA1c since 2010/11
-from 71.6 to 60.5 mmol/mol



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
England	71.6	70.5	69.0	69.0	66.5	65.0	64.0	64.0	62.0	62.0	61.0	61.0	60.5	60.5
Wales	70.5	70.0	70.0	69.0	68.3	65.0	64.0	65.0	62.0	62.0	62.0	62.0	61.0	60.0

Figure 5: Median HbA1c for children and young people with Type 1 diabetes in England and Wales, 2010/11 to 2023/24

However - there is still variation

Figure 6 shows considerable variation in mean HbA1c for Type 1 diabetes at PDU level after case mix adjustment†. The national HbA1c mean after adjustment was **63.5 mmol/mol**.

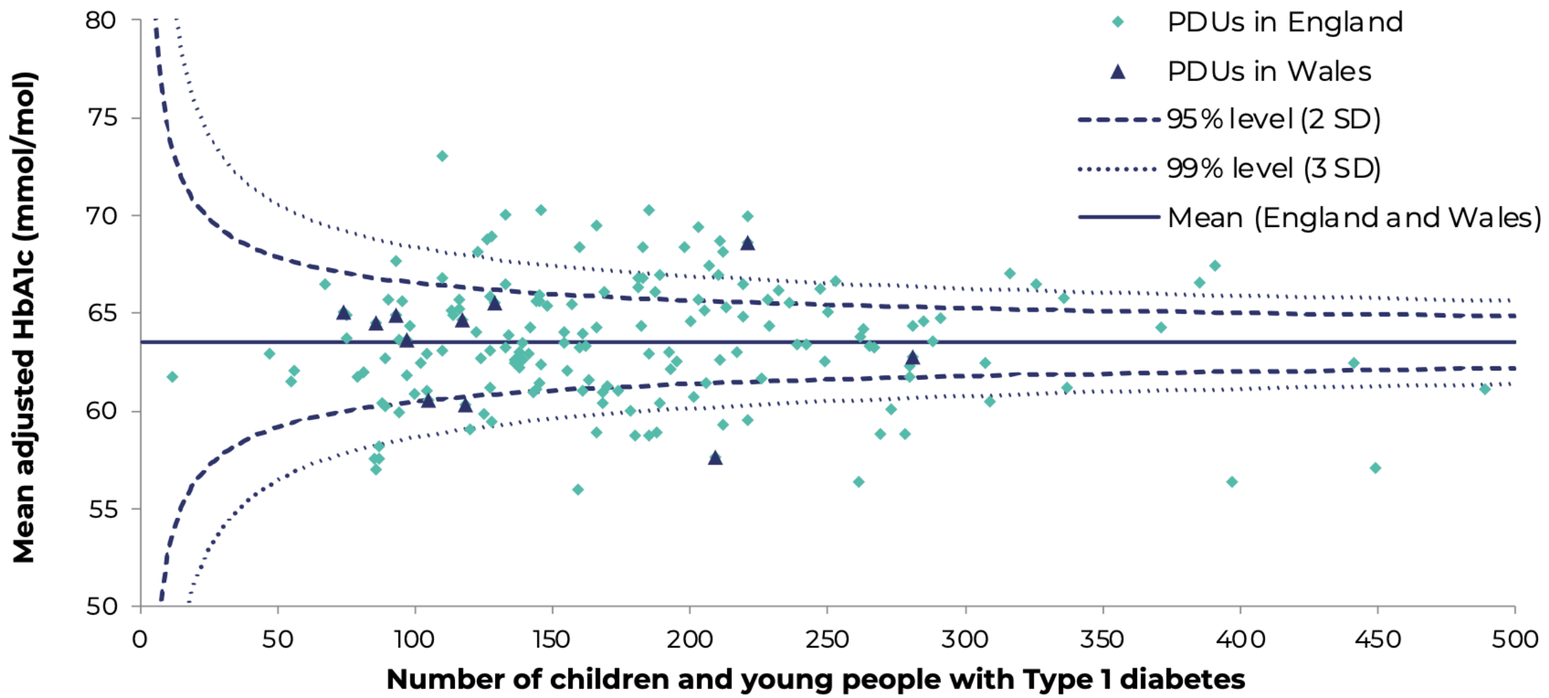
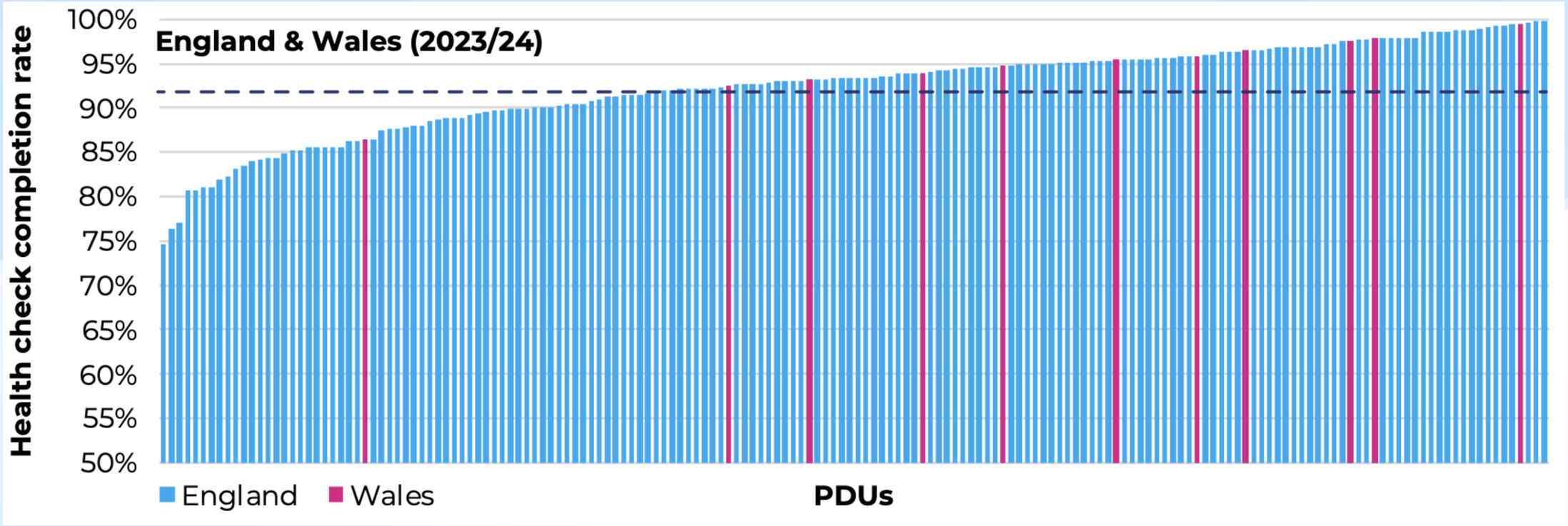


Figure 6: Funnel plot of mean adjusted HbA1c by PDU for those with Type 1 diabetes, 2023/24

†Characteristics such as age, duration of diabetes, sex, ethnicity and level of deprivation were utilised in a regression model to adjust HbA1c to take into account different case mixes between PDUs.

Health Check Completion 23/24

- still variation by paediatric diabetes unit



Access to diabetes technology 2023/24

Use of diabetes-related technologies
(Type 1 diabetes)

55%

were **using an insulin pump**, compared to 45% in 2022/23.

36%

were using a **hybrid closed loop system**, compared to 15% in 2022/23.

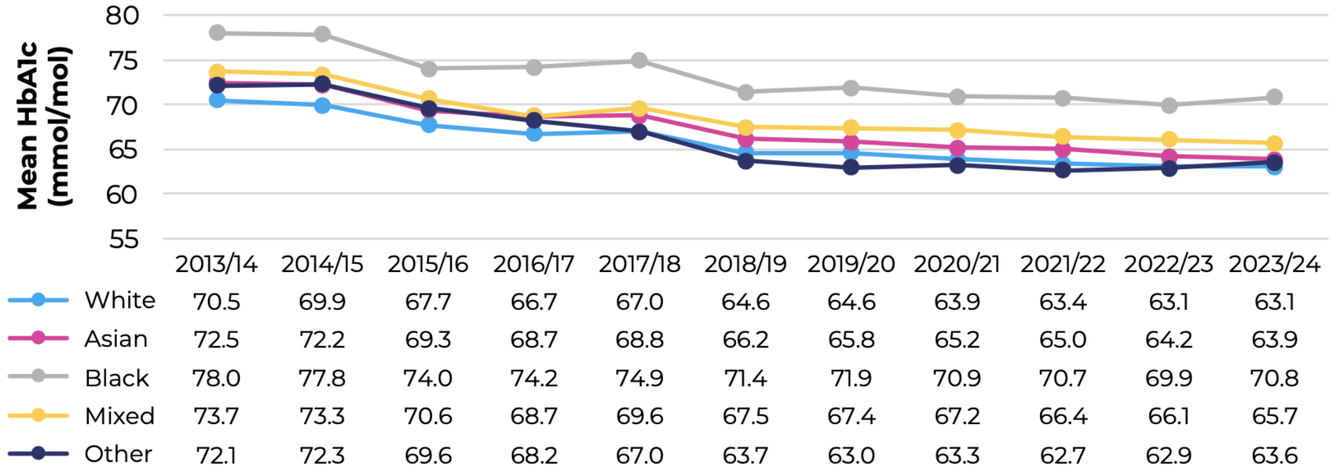
79%

were using a **real time continuous glucose monitor** (rtCGM); either combined with insulin injections or a pump, compared to 49% in 2022/23.

Only 15% were using a **flash glucose monitor** in 2023/24, compared to 37% in 2022/23.

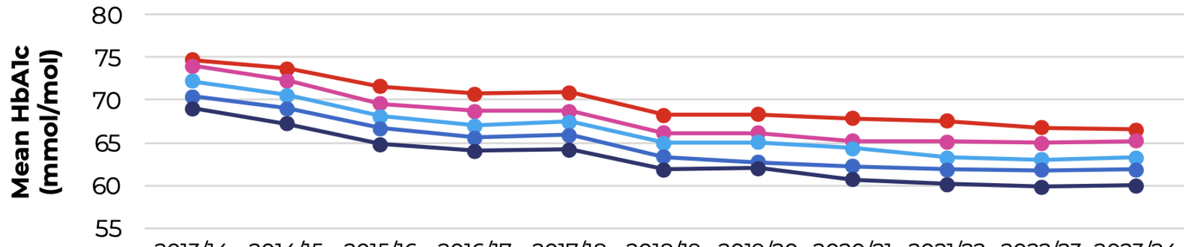
Lower HbA1c was associated with use of a rtCGM or hybrid closed loop. Technology usage is less prevalent amongst ethnic minority groups and those living in deprived areas.

Mean HbA1c by ethnic group & deprivation quintile since 2013/14



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
White	70.5	69.9	67.7	66.7	67.0	64.6	64.6	63.9	63.4	63.1	63.1
Asian	72.5	72.2	69.3	68.7	68.8	66.2	65.8	65.2	65.0	64.2	63.9
Black	78.0	77.8	74.0	74.2	74.9	71.4	71.9	70.9	70.7	69.9	70.8
Mixed	73.7	73.3	70.6	68.7	69.6	67.5	67.4	67.2	66.4	66.1	65.7
Other	72.1	72.3	69.6	68.2	67.0	63.7	63.0	63.3	62.7	62.9	63.6

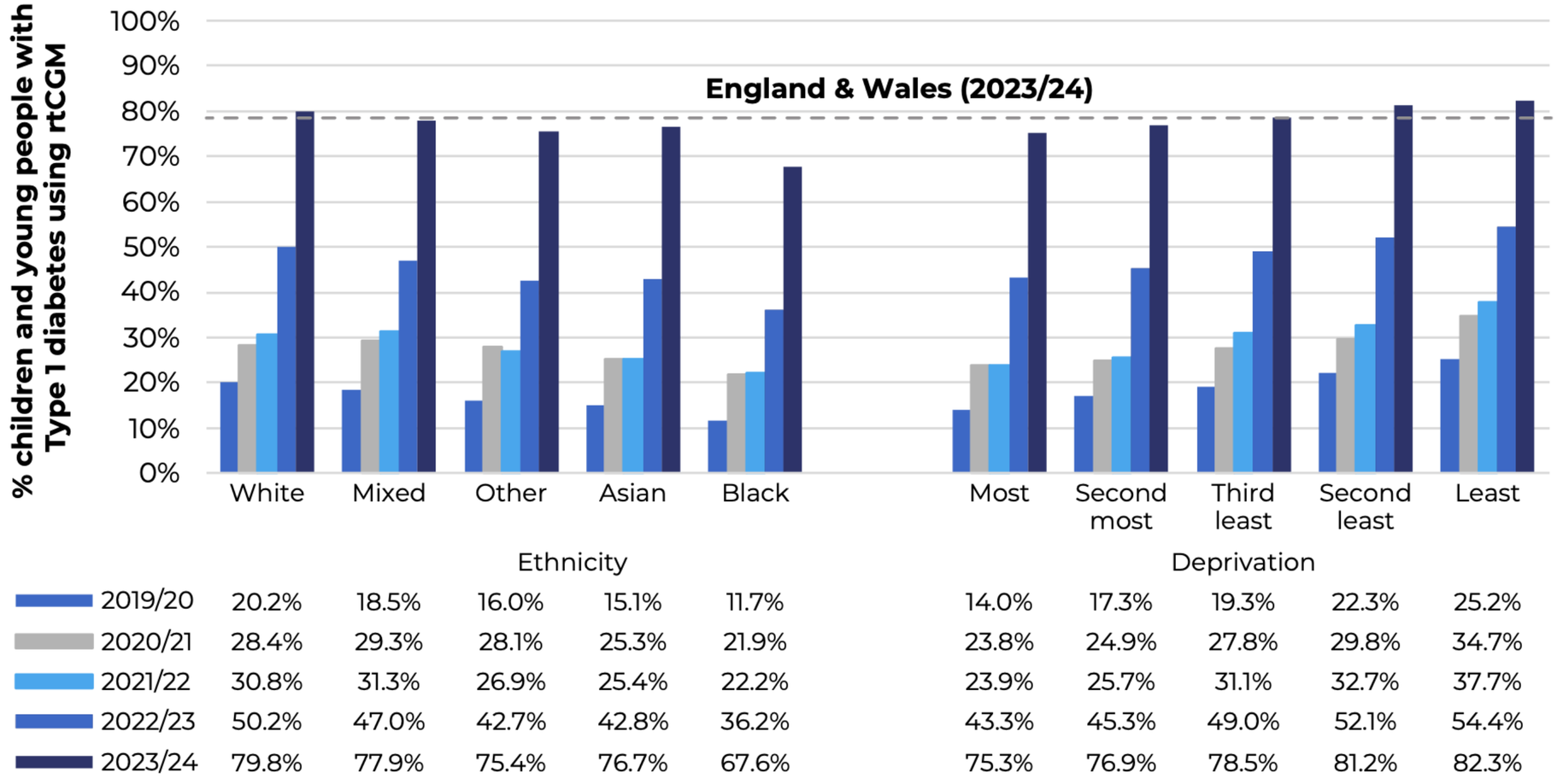
Figure 10: Mean HbA1c by ethnic group for children and young people with Type 1 diabetes, 2013/14 – 2023/24.
In 2019/20, 166 out of 173 PDUs submitted information to the audit.



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Most deprived	74.7	73.7	71.6	70.7	70.9	68.2	68.3	67.8	67.6	66.8	66.6
Second most deprived	74.0	72.3	69.6	68.7	68.7	66.2	66.1	65.2	65.1	65.0	65.2
Third least deprived	72.2	70.6	68.1	67.0	67.5	65.0	65.1	64.4	63.3	63.0	63.2
Second least deprived	70.4	69.0	66.7	65.6	65.9	63.4	62.7	62.3	61.8	61.8	61.8
Least deprived	69.0	67.2	64.8	64.0	64.2	61.9	62.0	60.7	60.1	59.9	60.0

Figure 11: Mean HbA1c by deprivation quintile for children and young people with Type 1 diabetes, 2013/14 – 2023/24.
In 2019/20, 166 out of 173 PDUs submitted information to the audit.

Use of CGM



	White	Mixed	Other	Asian	Black	Most	Second most	Third least	Second least	Least
2019/20	20.2%	18.5%	16.0%	15.1%	11.7%	14.0%	17.3%	19.3%	22.3%	25.2%
2020/21	28.4%	29.3%	28.1%	25.3%	21.9%	23.8%	24.9%	27.8%	29.8%	34.7%
2021/22	30.8%	31.3%	26.9%	25.4%	22.2%	23.9%	25.7%	31.1%	32.7%	37.7%
2022/23	50.2%	47.0%	42.7%	42.8%	36.2%	43.3%	45.3%	49.0%	52.1%	54.4%
2023/24	79.8%	77.9%	75.4%	76.7%	67.6%	75.3%	76.9%	78.5%	81.2%	82.3%

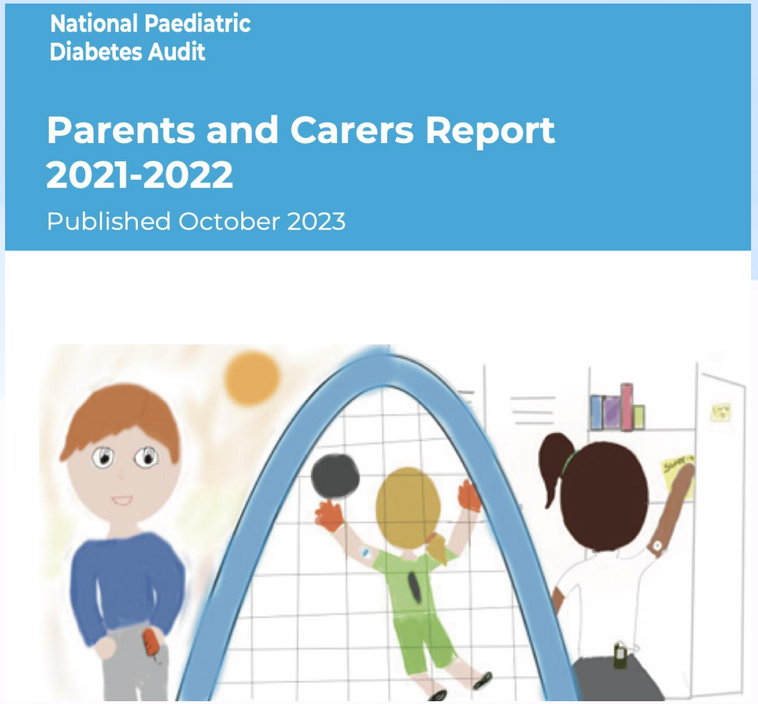
Figure 12: Use of rtCGM by ethnic category and deprivation quintile amongst children and young people with Type 1 diabetes: 2019/20- 2023/24. In 2019/20, 166 out of 173 PDUs submitted information to the audit.

How data & audit findings feel from patient side

As a parent rep involved in CYPD - great to see improvements & equity of care

Wider parent /carer group ?
Do they see audit findings?

Just want to know getting good care



How to ensure QI programme insight genuinely leads to impact for families

Leadership - good leaders that understand what life is like with diabetes as a family & leaders that run with it.

Diabetes teams on the ground - review & use data, QI projects

Funding - presenting data to funders to show benefits

Outliers -more work needed to understand & support to improve

DKA at diagnosis -how to get awareness to other areas of healthcare, eg GPs, public - still too many, 26% DKA at diagnosis

How data can empower rather than overwhelm ?

Need to ask the right questions

Increased use of HCL —better HbA1c

CGM - common sense to use but always told no evidence therefore no funding. Now we have data to show what parents felt they knew all along. ? didn’t use to measure

Removing inequalities - focusing on difference in outcomes related to deprivation & different ethnicities

Access to diabetes technology

National Paediatric Diabetes Audit (NPDA) 2025 Report on Care and Outcomes 2023/24

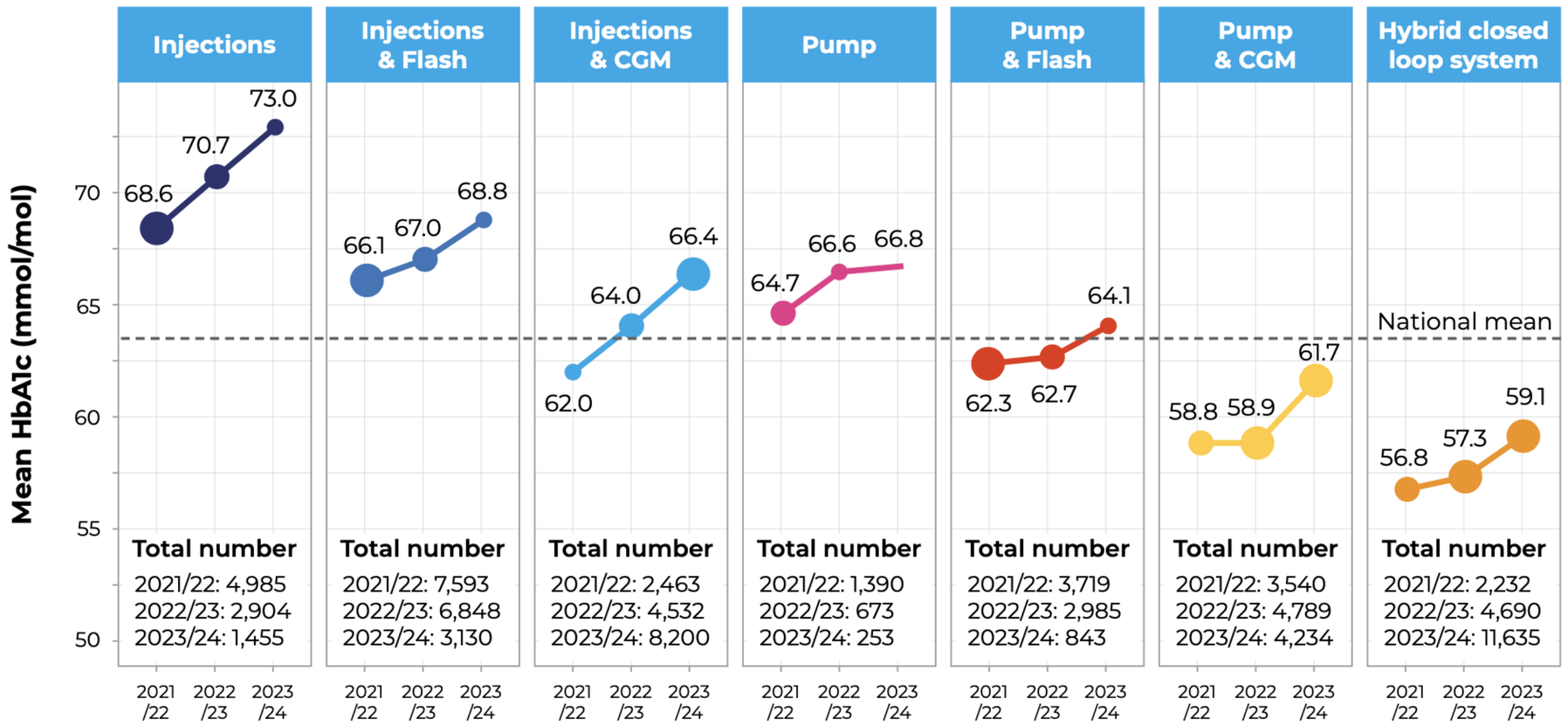


Figure 8: Mean HbA1c for children and young people with Type 1 diabetes using different combinations of treatment regimen and glucose monitoring in 2021/22 - 2023/24. Circle size represents the number of children and young people.

How national audits can better reflect lived experience?

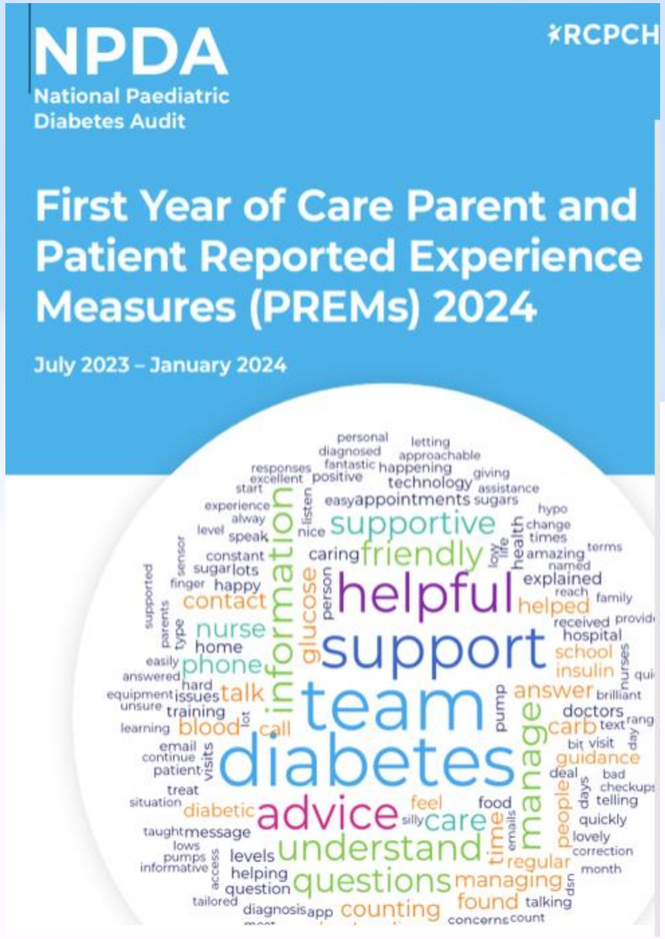
Asking some different questions
Not everything is measurable eg quality of life/sleep(HCL)

<u>PREMS</u>
-1st year of care - more targeted
-Diabetes in schools upcoming

<u>Spotlight audits-</u>use of tech, Type 2 diabetes

<u>FWD NN surveys (parent rep group)</u>
- Psychology support
- CGM access
- Outcomes - what matters?

More parent/carer & patient voice
How to get better response rate?



PREM First Year Of Care

Diabetic Ketoacidosis (DKA) at Diagnosis

DKA is a life-threatening complication of diabetes where **there is a severe lack of insulin** in the body.

44% of parents and carers stated that their child had DKA at diagnosis. **15%** didn't know whether they or their child had DKA at diagnosis.

Input from Diabetes Professionals

Percentage of parents and carers who were able to **see diabetes team members at every visit:**

Impact on Parents' Employment and Sleep

11% reported that they or their **partner left employment due to their child's diabetes care needs.** 30% reduced their hours.

47% had **disrupted sleep over 3 times a week** due to attending to their child's diabetes care needs.

RCPCHAudits

What good co-production really looks like?

How to reach different groups - a challenge -financial/educational

Involving children & young people too

Often mums involved but dads important too

Need engagement of different groups & help via diabetes teams to do that

Thank you

Jack, after finishing our charity London to Paris Cycle Ride with a group of mums & dads

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Panel Discussion

Dame Celia Ingham Clark

Professor Ted Baker

John McGrath

Kate Cullen

CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data

www.hqip.org.uk/caaw26

This Afternoon's Clinical Audit Awareness Week Webinar

- **Winner(s) of the Evidence into Practice category of the Excellence in Clinical Audit Awards 2026**
- **From Data to Practice: How Audit Insights Shape Local CAMHS Care**, Tom Hunter, *Mental Health Nurse and Plymouth CAMHS* and Dr Salbu Krishnan, *Clinical Lead for South-West CAMHS Eating Disorders, Consultant Eating Disorders and CAMHS Psychiatrist*
- **Building the National Audit of Eating Disorders (NAED)**: Barriers, Data Quality, and Impact on Services, Dr Karina Allan and Philippa Nunn, *NAED*
- **Winner of the Resident Doctor Showcase 2026: Turning Audit into Improved Patient Care**, Dr Alexandra Tebbett, *Resident Doctor, South Warwickshire University Foundation Trust*

Find out more and register here - or scan the QR code:

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