

2023 EDITION



HQIP

Healthcare Quality Improvement Partnership

A FREE publication for anyone passionate about evidence-based healthcare, 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

INSIDE THIS ISSUE

The invisible power of health data

How can we involve patients to improve healthcare?

The role of data in addressing health inequalities

Taking a holistic, evidence-based approach to patient safety

When is data 'good data'?

Interview with Professor Danny Keenan on changes to national clinical audit

Plus quality improvement case studies, resources, benchmarking support and more

Please share this NEW publication with colleagues: www.hqip.org.uk/magazine

 hqip.org.uk
 @HQIP

ABOUT HQIP

The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to increase the impact of clinical audit on healthcare quality improvement, and support improved outcomes for patients. We are an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices. Currently we commission circa 40 audits and programmes on behalf of NHS England, the Welsh Government and others, to collect and analyse healthcare data in order to provide a national benchmarked picture of care standards for a wide range of conditions.

For further information, go to www.hqip.org.uk.

STAY IN TOUCH

Sign up to HQIP's mailing list: To stay abreast of new reports and resources related to Quality Improvement (QI) in healthcare (and to be notified of future editions of this magazine), go to www.hqip.org.uk/subscribe-form or email communications@hqip.org.uk.

Website: To access this magazine online, go to www.hqip.org.uk/magazine or access our complete range of reports and resources: www.hqip.org.uk.

Social media: Find out the latest from HQIP by following us on [Twitter \(@HQIP\)](#) and [LinkedIn](#).

YouTube: You can watch video resources from HQIP on our [YouTube channel](#).

Healthcare Quality Improvement Partnership (HQIP)
27A Harley Place
London W1G 8LZ
E: communications@hqip.org.uk
W: www.hqip.org.uk
T: [@HQIP](#)

Edited and produced by: Lacia Ashman
Designed by: Shirine Watts

© HQIP 2022 (all rights reserved).
We welcome circulation of this magazine and its articles, as long as it's not for monetary gain and HQIP is acknowledged.

CONTENTS

- 04 The invisible power of health data**
Describing to patients how their data saves lives can be tricky but rewarding
- 07 Safety in numbers**
The importance of taking a holistic, evidence-based approach to patient safety
- 10 Resources from HQIP**
A summary of the key resources available from HQIP to support Quality Improvement (QI); includes reports, guides, videos, benchmarking and more
- 12 National Clinical Audit: Change, improvement and impact**
Interview with HQIP Medical Director, Professor Danny Keenan, on changes to national clinical audit and its importance in ensuring that resultant services lead to improved outcomes for patients
- 14 Mind the (health) gap**
The role of data and quality improvement (QI) in addressing health inequalities
- 16 Meet the Clinical Audit Heroes**
Be inspired by case studies from the Clinical Audit Heroes Awards, designed to promote and celebrate the benefits and impact of clinical audit and quality improvement work in healthcare
- 18 Congratulations on your engagement!**
How can we involve patients to improve healthcare?
- 22 When is data 'good data'?**
Using the right data to support robust healthcare services
- 24 Advisory services**
Find out how HQIP can help with Quality Improvement (QI)

WELCOME TO

CORNERSTONE



It is my pleasure to welcome you to the very first edition of CORNERSTONE, a free annual publication from the Healthcare Quality Improvement Partnership (HQIP). As commissioner of circa 40 healthcare audits and quality improvement programmes on behalf of NHS England and others, we are committed to evidence-based service evaluation to improve patient outcomes. Hence the name Cornerstone...

Looking up the definition of this word throws up many variations on a consistent theme. Namely that it is the first stone laid in construction, and sets the foundation for everything that comes after. More specifically, one well known reference site says: 'All other stones will be set in reference to this stone, thus determining the position of the entire structure'. Since we commission data and hard evidence that we believe should be the basis for healthcare design and change, how could we call this magazine anything else?

So, if you weren't already aware of HQIP and its vision (and, if you weren't, you will almost certainly be aware of the [programmes we commission](#)), I hope that I've enlightened you sufficiently, without 'overstaying my welcome' information-wise. But I'd like to know more about you and your role in building a clinically effective health service – for, if you're reading this, you're almost certainly involved in some way. If we were at a barbeque, at this point I'd be turning to you and uttering that well-worn phrase, "so, what do you do?"! Well-worn it may be but, in this context, it's important. For we are keen to open up a two-way dialogue with you, the readers of this magazine, to understand who you are and what you might need from a publication like this.

We work closely with audit teams and clinical effectiveness professionals, but we also seek to resonate with a broad range of people across the health and social care sector. After all, whether you're a policy maker, commissioner, clinician, healthcare administrator or patient (or anything in between), you are the people who deliver and receive the very care we measure. As such, we have a shared aim to improve health outcomes, but we must make sure that the mechanisms by which we achieve this also align.

So, back to that two-way dialogue. I will finish with a double plea. Firstly, that you share this magazine with colleagues and stakeholders across the sector (you can simply send them the link www.hqip.org.uk/magazine). And secondly, that you tell us what you think. You can take part in this short [online survey](#) (it takes less than 5 minutes to complete) or you can email communications@hqip.org.uk. Not only would we like to hear what you think; we need your feedback. After all, what good is a cornerstone, if it's laid on the wrong foundation?

I do hope that you enjoy this publication, and look forward to hearing from you.

Best wishes,

Jane Ingham, CEO

Healthcare Quality
Improvement Partnership (HQIP)

The *invisible* power of health data



Describing to patients how their data saves lives can be tricky but rewarding

Yvonne Silove
Associate Director (NCAPOP), HQIP

My friend's elderly father has had a tough time recently, with a run of serious health problems that landed him in hospital on and off for most of the year. We've had many telephone conversations during this time, but there is a limit to how often you can ask 'how are you feeling?' when things are taking so long to improve. So, on

ment service at your hospital is performing safely and well.

► After your hip operation, you needed an emergency laparotomy to fix a sudden blockage in your bowel caused by radiotherapy you'd had for bowel cancer some years ago. You quickly became quite unwell and the bowel surgeons

and other patients in the future. I mentioned how interested people are these days in where their data is held and how it is used, and how people generally find it easier to understand how their personal details and health information are shared so they can receive treatment. They tend to be less aware of these other types of important uses, although most people seem delighted when they realise that their data can be so powerful.

By way of example, we talked about his new hip again. I explained that the National Joint Registry also uses his identifiable information so that if, for example, he has a complication with his new hip treated in another hospital, then his Registry record can be updated through a process of 'data linkage' using data submitted from other hospitals and from national datasets such as the national register of deaths. For now, the audits and registries use things like his name, date of birth and NHS number to link up the records coming from different places (though his personal details are removed before the data is analysed and reports are written).

He then asked if people wonder whether they gave consent for their data to be shared and used, and if not, was it still included? Answering



Data saves lives – and the government thinks so too

that question is fairly complicated. Where possible, people are asked for their consent, but taking consent for so many, sometimes quite ill patients, often can't be achieved in practice without disrupting their medical care. So, there are provisions in law to allow that 'duty of confidentiality' that all patients are owed, to be legally set aside (in fact,

Most people seem delighted when they realise that their data can be so powerful

one recent call, we talked instead about his data and how it impacts the quality of patient care.

Did he know, I wondered, that he now featured in a whole smorgasbord of national data collection programmes and audits that aim to improve healthcare? "I had no idea," he said, and I could detect a sense of pride. "What do you mean?" So I told him...

► When you fell at home and broke your hip, your data went to the [National Hip Fracture Database](#) and helped the hospital to understand whether: you were admitted to the recommended ward; saw the specialist for older people; had the right operation at the right time; and whether steps were taken to consider medication to protect you from future fractures.

► When they operated on your hip, you had a replacement joint fitted, so that data was also sent to the [National Joint Registry](#). The serial numbers of your new hip were checked by the Registry to make sure they were the right ones for you, and the unique codes were stored safely, so that if any problem is identified with a component in the future, the hospital can be told and you can be reached. Your information will also be used by the hospital and the Care Quality Commission (CQC) to check that the hip replace-

were called to your ward. They used a special 'calculator' built into the [National Emergency Laparotomy Audit](#) to measure whether your life was at risk and to help them decide how quickly to operate. By using the audit as they planned your care, they could check and record that you went to theatre quickly enough and the right seniority of surgeon and anaesthetist were booked for your operation. The calculator also helped them to confirm that you needed a bed in the High Dependency Unit afterwards. Combined with data from similar patients, the audit plays an important role in helping hospitals, commissioners and regulators review and sustain good survival rates from this serious operation.

► And before all this, when you had your original cancer treatment, your data was again used to check and report on the quality of care you, and patients like you, received. This contributed to greater understanding of healthcare services for your type of cancer as part of the [National Disease Registration Service](#) and it was also included in the [National Bowel Cancer Audit](#).

He was amazed. It hadn't occurred to him that his data could be so useful. As a scientist himself, he loved that he was providing evidence that helped both him



HQIP made [a film](#) about how that works!). Sensing some confusion, I ploughed on, trying to explain as clearly as I could...

Data that identifies us that is used for our own, individual health care can be used without asking for our consent because it is recognised that is what patients reasonably expect would happen. But when data is used in national projects to help measure and improve the services that treat us, then either people must be asked for their consent or there must be a specific legal provision that means the requirement to ask for consent will not apply.

However, there is a way for people to register to exclude themselves from one of these legal provisions, and so prevent their data being used for planning and research without their consent. This is known as the [national data opt-out](#). But this can be problematic, because the 'line' is sometimes really hard to draw. By preventing data being used for research and planning, it is possible that the mechanisms to safeguard the person's own, safe care or the safe care of others could be compromised. This is why HQIP, our audits and the National Joint

Registry made the case that national data opt out should [not apply](#) to our national audits and registries in cases where this might happen.

I paused, trying to think how to relate this back to my friend and his own experience. "If your team couldn't use your data to learn that the number of deaths in the emergency bowel surgery service was creeping up, or to calculate whether theatres were staffed correctly and ITU beds were available, then how could they take the steps they needed to make sure the next patient's care was delivered safely? After all, given your penchant for popping up in so many of the audits, that next patient might be you!" He laughed, and then sighed: "Right, well you've lost me now with all this consent, setting aside and opting out. I think I'm just going to focus on how my data can help save my life and that of other patients in the future. I guess I hadn't thought about the sorts of things that might not happen if my data couldn't be used. I know some people are really worried about their data, but I'm also worried about being treated by a service that doesn't have all the data it needs to keep doing a great job." I agreed: "Data saves lives – and the government thinks so too, as that's what they have named their new 2022 [health and social care data policy](#)."

"I'm so glad," he said. "Over all these months of the NHS looking after me, I've been helping them too – and I didn't even realise!"

Further information and resources

- [National data opt-out \(NHS\)](#) – projects that have exemptions can be found here: <https://digital.nhs.uk/services/national-data-opt-out/programmes-to-which-the-national-data-opt-out-should-not-be-applied>
- [How patient data is used](#) (Understanding Patient Data)
- [Patient data saves lives: The bigger picture animation](#) (Understanding Patient Data)
- [Understanding Health Data Access – The Duty of Confidentiality animation](#) (HQIP)

● Data collection at the Healthcare Quality Improvement Partnership

HQIP commissions and hosts circa 40 programmes and audits that produce robust results and actionable recommendations, in the form of reports, infographics and other resources that can be used to improve patient care: www.hqip.org.uk/resources.



SAFETY IN NUMBERS

The importance of taking a holistic, evidence-based approach to patient safety

Tina Strack, Associate Director for Quality and Development (NCAPOP), HQIP

Patient safety is defined by the World Health Organisation as “...an event or circumstance that could have resulted, or did result, in unnecessary harm to a patient”. The discipline has developed as health care systems have become more complex, but a key element has always been continuous improvement based on learning from mistakes. Mistakes are rarely the fault of one individual or incident – systems, processes and culture all play their part. As such, learning from mistakes requires an environ-

ment without blame and fear, as well as an openness to doing things differently. It also requires knowledge and information, which can tell us not only what happened but also highlight how similar incidents might be avoided in the future.

The HQIP-commissioned [National Clinical Audit and Patient Outcome Programme \(NCAPOP\)](#) includes several programmes that gather data and help the health service to learn from mistakes. These include the [National Child Mortality Database \(NCMD\)](#) and the [Clinical](#)

[Outcome Review Programmes](#). The latter, in particular, all involve a form of confidential enquiry, which is a ‘deep dive’ into the care provided, usually related to adverse events. An important aspect of this is that it is confidential in nature, and so it enables those close to the care delivered to share information, even that which is clear only with hindsight. The aim is not to assign blame or deem who is at fault, although there is a clear process for rare occurrences when there is a significant cause for concern. Rather, it is about assessing the care provided against best practice, identifying whether the right clinical decisions were made, and where things went wrong. Critically, its main purpose is to establish how mistakes can be avoided in future. Following are some examples of how these programmes have been instrumental in highlighting opportunities to improve care:



Maternal, Newborn and Infant Clinical Outcome Review Programme

■ There is much collaboration between the programme and a number of maternity safety initiatives. For example, the [Clinical Negligence Scheme for Trusts \(CNST\) maternity incentive scheme](#), which allows trusts to recoup some of their annual CNST fees if they can demonstrate that they meet the required safety standard. This

includes a requirement to notify all eligible perinatal deaths to the programme within seven working days, and ensure that all required information is completed within one month of death.

■ Cardiac disease remains the [leading cause of women's deaths during and after pregnancy](#) and the programme has made many

recommendations around cardiac care. Working with the Resuscitation Council, the Obstetric Anaesthetists Association developed an [Obstetric Cardiac Arrest Quick Reference Guide](#) which addresses several recommendations from the programme's findings regarding modifications required for the resuscitation of pregnant women as well as causes of cardiac arrest.

■ The 2020 report, [Saving Lives, Improving Mothers' Care](#), highlighted a statistically significant increase of Sudden Unexpected Deaths in Epilepsy (SUDEP) in pregnant and recently pregnant women, and reviewed these cases in detail. The report made several recommendations for how care for women with epilepsy could be improved, including a call for them to receive risk minimisation advice as well as support to ensure that medications are optimised to control seizure frequency. This work was noted as an important case study in the government policy paper [Data Saves Lives](#). In addition, the programme has been working with the charity SUDEP Action to present findings from [Saving Lives, Improving Mothers' Care](#) to several groups, including the All Party Parliamentary Group on Epilepsy.

“ Mistakes are rarely the fault of one individual or incident – systems, processes and culture all play their part ”

Medical and Surgical Clinical Outcome Review Programme

■ The programme's 2015 report [Just Say Sepsis!](#) highlighted issues relating to the prompt identification and treatment of sepsis. This work led to the publication of [Improving outcomes for patients with sepsis: A cross-system action plan](#) and the follow-up 2017 [Second Sepsis Action Plan](#) by NHS England.

■ Based on recommendations from its [Know the Score](#) 2019 report, further research was undertaken to incorporate the use of artificial intelligence to standardise CT pulmonary angiogram (CTPA) reporting. Their study was well received and published as a peer-reviewed [article in European Radiology](#), which prompted some acute trusts to consider utilising this software.

■ At the request of the Medical Director of NHS England and NHS Improvement, the authors of the programme's [Delay in Transit](#) 2020 report were invited to the National Quality Board to discuss findings and consider how improvements could be made. The development of pathways for acute bowel obstruction, working alongside other Royal Colleges, is also being considered.

All of this work is underpinned by the [NHS Patient Safety Strategy](#), an over-arching document that describes how the NHS will continuously improve patient safety by building on the foundations of a safer culture and safer systems. This includes a [Patient Safety Incident Response Framework \(PSIRF\)](#) which represents a significant shift in the way the NHS responds to patient safety incidents, by changing the focus from a reactive and somewhat bureaucratic process to one which is more proactive and risk-based. In PSIRF, there is no distinction between incidents and ‘serious incidents’. Instead “unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving health-care” are seen as opportunities for learning and, importantly, not for any other purpose (for example, individual performance management, assessment of liability or determining cause of death).

It goes without saying that patient safety is of extreme – if not

utmost – importance. There are over 11,000 avoidable deaths in the UK annually from unsafe care (this estimate was prior to the COVID-19 pandemic), with many thousands more patients seriously harmed each year. It is also necessarily complex and multi-faceted. The safety researcher, Professor James Reason, states that a safe culture depends on five sub-cultures: Informed, Reporting, Just, Flexible and Learning. In health, the [Clinical Outcome Review Programmes](#) provide invaluable intelligence in relation to all of these aspects of safety. Its importance can be summed up by the following quote from a colleague who works in patient safety in NHS England, who says: “The clinical outcome review programmes is a vital part of patient safety across the NHS. The evidence it provides supports learning from mistakes and, crucially, leads to improved care for patients in the future.”

Perinatal clinical quality surveillance model

The Morecambe Bay review, and several other high-profile reviews over the past decade, have highlighted examples of poor maternity care that were not recognised until significant harm had occurred. This led to a renewed focus on how to proactively identify organisations that require support before serious issues arise. The perinatal clinical surveillance model in England is intended to do just that, providing consistent and methodical oversight of all maternity services. More specifically, it aims to gather ongoing insights, to inform learning and improvements in the delivery of perinatal services.

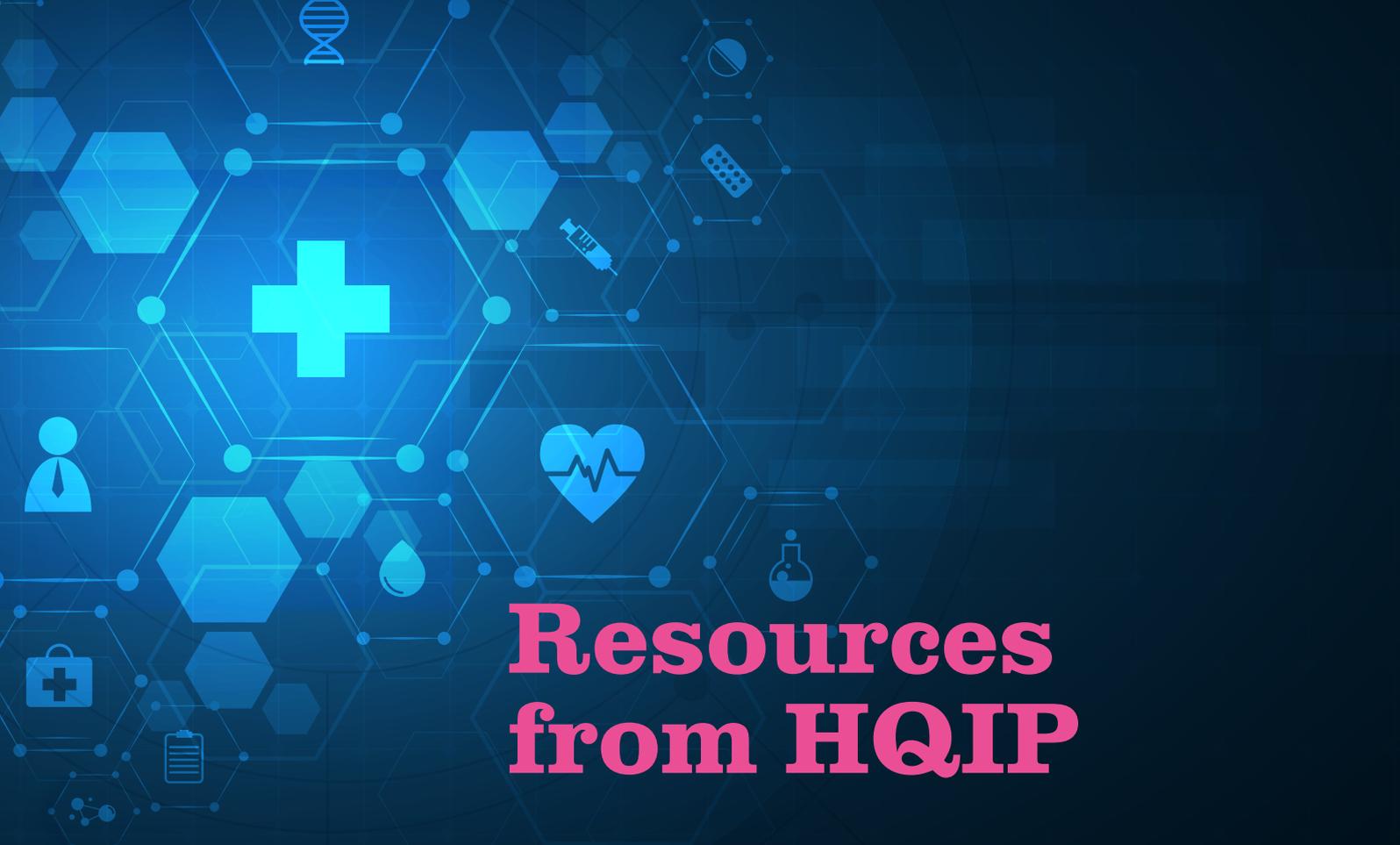
The system is designed to provide oversight at all levels, ranging from local hospitals, Local Maternity Systems (LMS) and Integrated Care Systems through to regional and national levels. The work of [MBRRACE-UK](#), who run the [Maternal, Newborn and Infant Clinical Outcome Review Programme](#), forms part of discussions at Trust Boards - and then the lessons learned and themes emerging are used by both healthcare providers and planners to inform change. Any trust, where there is a cluster or outlier of cases, is flagged to the surveillance system, so that support can be provided. MBRRACE-UK also sits on the national Maternity Safety Surveillance and Concerns Group (MSSCG), ensuring that the intelligence and learning from the outcome review programme feeds into national strategy.

● HQIP Clinical Outcome Review Programmes

The Clinical Outcome Review Programmes are part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by HQIP on behalf of NHS England, the Welsh Government and, in some cases, other devolved authorities. They include:

- Child health clinical outcome review programme
- Maternal, newborn and infant clinical outcome review programme
- Medical and surgical clinical outcome review programme
- Mental health clinical outcome review programme
- National Child Mortality Database (NCMD)
- Perinatal Mortality Review Tool (PMRT)

For more information, go to: www.hqip.org.uk/clinical-outcome-review-programmes (or click [here](#), to read the resultant reports).



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 evidence-informed healthcare services.

Reports and infographics

From asthma, cancer and epilepsy through to maternity, newborn and child health – and much more – the reports and infographics from our programmes provide robust data and actionable recommendations. In the year up to 31 March 2022 alone, we produced 70 reports with almost 400 recommendations. Following are just a few examples of what is available:

Maternity and newborn care

- Perinatal Mortality Review Tool (PMRT) [annual report](#), Sept 2022
- National Child Mortality Database (NCMD): [The Contribution of Perinatal Events to All-Cause Child Mortality report](#), July 2022
- National Maternity and Perinatal Audit (NMPA): [Clinical report](#), June 2022
- National Neonatal Audit Programme (NNAP): [Annual report on 2020 data](#), March 2022
- Paediatric Intensive Care Audit Network (PICANet) [Annual Report 2021](#), January 2022

The 'So What' of Maternity Data

This report from HQIP aims to explore how the multiple national data sets and national audits are used in maternity services across the UK.

READ IN FULL:

[The 'So What' of Maternity Data](#)

Mental health

- National Audit of Care at the End of Life (NACEL): [Mental health spotlight report](#) (July 2022)
- National Clinical Audit of Psychosis (NCAP): [Early intervention report, England](#) (July 2022)
- National Clinical Audit of Psychosis (NCAP): [Early intervention report, Wales](#) (July 2022)
- National Confidential Enquiry into Patient Outcome Death (NCEPOD): [A Picture of Health? report](#) and [infographic](#) (May 2022)
- National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) [annual report](#) and [infographic](#) (April 2022).

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](#).

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 [HQIP website](#).

Access to health data resources

Complex rules govern how health and care data can be shared for research, innovation, healthcare improvement and other uses beyond individual patient care. Making sense of the permission process and legal requirements can prove daunting, both for new data applicants and for any patients and the public interested in understanding how the system works in practice.

HQIP's Understanding Health Data Access (UHDA) project offers a suite of short films and written resources designed to improve accessible, introductory information to these rules and processes, providing:

- An overview of how to design projects which both protect patient privacy and meet legal requirements
- An understanding of how to construct data applications clearly, thereby improving the chances of success and reducing the risk of avoidable delays.

The video resources available are:

- Introduction to developing good data applications
- The duty of confidentiality
- An introduction to applying for HQIP datasets.

To find out more, and to access these free resources, go to the [UHDA section of the HQIP website](#).

For further guidance and materials relating to national clinical audit, including top tips, guides and governance, go the [guidance section of the HQIP website](#).

NATIONAL CLINICAL AUDIT:

Change, improvement and impact



In this interview, HQIP Medical Director and Associate Medical Director to the Manchester University Hospitals, Professor Danny Keenan, explains the role of the national clinical audit programme in influencing improvements in healthcare. In particular, he focuses on changes to the [National Clinical Audit and Patient Outcomes Programme \(NCAPOP\)](#) and its importance in ensuring that resultant services are both relevant and meaningful and, critically, lead to improved outcomes for patients.

Q: First, for those who are less familiar, please explain the National Clinical Audit and Patient Outcomes Programme (NCAPOP)?

A: The NCAPOP comprises of circa 40 audits and programmes on a range of clinical disciplines that collate healthcare data and other evidence, and are commissioned by the [Healthcare Quality Improvement Partnership \(HQIP\)](#) on behalf of NHS England, the Welsh Government and, in some cases, other devolved authorities. These programmes align closely with the aspirations of the [NHS Long Term Plan](#).

Q: What are the benefits of the NCAPOP to patients and the healthcare service?

A: The programme will only flourish if it continues to show that, by its presence, outcomes for patients continue to improve. To do that, it needs to continue to provide the knowledge-base that our patients and others, such as clinicians, service providers and commissioners, need in order to effect meaningful change. We keep a record of improvements, as do the audit providers. The impact of these benefits can be viewed on four levels: National; system; local; and public (see this [impact report](#) from 2022, by way of example).

Q: Can you be more specific about, for example, the national improvements that have been realised as a result of programme?

A: Sure; here are some examples:

- **Interventional:** 1. An increase in the numbers of breast cancer patients with positive oestrogen receptors having surgery which implies increased surgery in the elderly; 2. Decreasing mortality after bowel cancer surgery with an increasing use of robotic techniques; and 3. In response to NICE guidance, 96% of patients with prostate cancer received specialist radiotherapy while increased numbers received specialist chemotherapy.
- **Patient outcomes:** 1. Maternal deaths have dropped due to hypertensive pregnancy disorders; 2. The wait for stroke patients to

see a consultant has dropped by 4.5 hours; and 3. There has been an improvement in the attainment of the three key standards for inflammatory arthritis.

- **Use of Data:** 1. Hip fracture services have developed SPC charts showing units their performance both at high and low levels; 2. COVID-centred data has been used by PICANet to characterise the disease in children; and 3. We have seen an increased uptake of the audit and data acquisition in psychosis.
- **Process improvements:** 1. A doubling of access to palliative care at the end of life; 2. Transition for those with epilepsy improved with involvement of adult neurologists; and 3. 91% of patients rated their prostatic cancer treatment as 8/10.

Q: What changes are taking place in the NCAPOP?

A: During the early days of the pandemic, we undertook a critical review of the programme and considered if it was still fit for purpose, asking if it was ready to move into the truly digital era? In consultation with our audits and data providers, we concluded that some things needed to change, to make it more effective at supporting improvement in patient outcomes. These were:

- **Reducing burden:** 1. Reducing the number of metrics down to ten and, if there is a requirement for more than this, requiring justification; and 2. Ensuring that routine data is used if at all possible (currently 67% of input is routine). This requires link-

age with NHS Digital to ensure the smooth flow of such data and linking with electronic patient records in the future.

■ **Outputs:** 1. Changes to slim down annual reports so that they are much more succinct, more easily readable, and focused on a major finding from the latest review (with complementary websites used to display more in-depth findings and data); and 2. Increasing impact by using infographics and getting outputs out via as many different partners as possible.

■ **Timeliness:** A further output from the review was the need to get data back to the service as quickly as possible. This was hotly debated, as faster data is likely less assured. But we have reached a solution, with getting prompt data out (which may be subject to subsequent adjustments), while still having the assurance of annual data. Specifically, we are specifying that, whilst there should be an annual report focusing on the main message of the year, quarterly online data outputs should also be made available.

■ **Patient outcomes:** There are very important outcomes currently included such as mortality, post-operative sepsis and readmission, but there are omissions and we intend to help audit providers to bridge this gap as we re-commission audits within the NCAPOP. In addition, we need to include many more patient reported outcomes in the programme.

Q: Which developments in the healthcare system will the changes to NCAPOP address?

A: We have made these changes to respond to a wide number of developments across the system in recent years, including: The merger of NHS England and NHS Improvement; NHS Digital and X moving into NHS England; the move of Public Health England to the UK Health Security Agency; the transfer of the National Disease Registration

Service from PHE (as was) to NHSD (as was); and the transfer of the National Cardiac Audit Programme, including TAVI, run by NICOR, from Barts, to be managed by Arden & Gem CSU. However, above all, the changes to NCAPOP come in response to the COVID-19 pandemic.

Q: Why was COVID-19 a key factor in changing the NCAPOP?

A: It was inevitable that the effect of the pandemic and, in particular, what we learned about the use of data, would escalate change. For example, it proved the necessity for more immediate data (as was necessary with the [National Child Mortality Database \(NCMD\)](#), which moved to live surveillance during the COVID-19 pandemic). We are now able to determine how, with strategic thinking, we can reap important benefits for our patients by the wise use of such data. These lessons have led to this wholesale reorganisation.

Q: Why are the changes to the NCAPOP important?

A: Change is only useful if it leads to improvement and, for us, that means better outcomes for patients. We monitor outcomes and, to be honest, these improvements are often now minimal, as big gains as a result of national clinical audit have often been realised. There is one key exception to this: Health inequalities and, more specifically, the influence of ethnicity and deprivation on healthcare outcomes. That is something that we, in national clinical audit, believe we can have a positive impact on, working with data providers to highlight differences exposed by the pandemic and enabling us to tailor services to address them.

HQIP programmes and audits, 2021-22

NATIONAL CLINICAL AUDITS

- **Adult Diabetes:**
 - National Diabetes Foot Care Audit
 - National Diabetes Inpatient Audit
 - National Diabetes Transition
 - National Pregnancy in Diabetes
 - National Core Diabetes Audit
- **Breast Cancer in Older Patients**
- **Cardiovascular Disease Prevention Audit, CVDPREVENT**
- **Care at the End of Life**
- **Chronic Obstructive Pulmonary Disease with Asthma:**
 - COPD secondary care
 - Pulmonary rehabilitation
 - Adult asthma
 - Paediatric asthma
 - Primary care (Wales only)
- **Dementia: Care in General Hospitals**
- **Early Inflammatory Arthritis Audit**
- **Emergency Laparotomy**
- **Falls and Fragility Fracture:**
 - Fracture Liaison Service Database
 - Inpatient Falls
 - National Hip Fracture Database
- **Lung Cancer**
- **Maternal and Perinatal**
- **National Cardiac Audit Programme**
 - Adult Cardiac Surgery
 - Congenital Heart Disease Audit
 - Heart Failure Audit
 - Heart Rhythm Management Audit
 - Myocardial Ischemia Audit Programme
 - Percutaneous Cardiac Intervention Audit
- **National Gastro-intestinal Cancer Audit:**
 - Bowel Cancer Audit
 - Oesophago-Gastric Cancer Audit
- **National Joint Registry**
- **National Vascular Registry**
- **National Neonatal Audit Programme**
- **Obesity**
- **Paediatric Diabetes**
- **Paediatric Intensive Care Audit**
- **Prostate Cancer Audit**
- **Psychosis Audit**
- **Seizures and Epilepsy in Children and Young People**
- **Sentinel Stroke Audit Programme**

CLINICAL OUTCOME REVIEW PROGRAMMES

- **Mental Health**
- **Child Health**
- **Medical and Surgical**
- **Maternal and Newborn Infant**

MORTALITY REVIEW PROGRAMMES

- **National Child Mortality Database**

MIND THE (HEALTH) GAP

The role of data and Quality Improvement (QI) in addressing health inequalities

Dr Josie O’Heney, 2021/22 National Medical Director’s Clinical Fellow, HQIP

As a clinician, the human response is to focus on the problems right in front of you - the patient that has just arrived, the lack of beds or staff to care for people, the crisis in the moment et cetera... However, it is also important for healthcare providers to be aware of data. Unless you understand where there are problems, you can’t work towards solving them. Data informs us about the strategic changes that we need to make to improve care pathways and, importantly, reduce inequalities.

Findings from [MBRRACE-UK](#) (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) reports show stark differences in mortality rates amongst women from black-ethnic backgrounds compared to white women. While there has been greater investment in both research and policy changes (with the hope of improving outcomes for disadvantaged groups), we are still a long way from ‘levelling up’. However, without the data to highlight the problem, it is highly unlikely that we would have even started.

The reports mentioned above

was produced as part of the [National Clinical Audit and Patient Outcomes Programme \(NCAPOP\)](#), which is commissioned by HQIP – and this is one of the tools that has been instrumental in identifying health inequalities. The [National Child and Mortality Database \(NCMD\)](#) is another, with its data also highlighting stark inequalities. For example, over a fifth of all child deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived.

To tackle this issue, NHS England has developed the [Core20PLUS5](#)

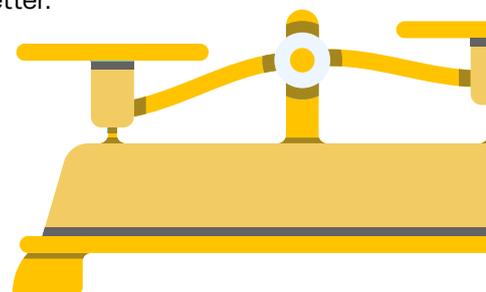
To reduce inequalities we need to start thinking smarter

approach to health inequalities, which focuses on areas where stark inequalities in outcomes have been identified (in maternity, continuity of care for black, Asian and minority ethnic communities and those from the most deprived groups has been prioritised). The PLUS in Core20PLUS5 relates to identifying who in your local population is experiencing poorer than average health access, experience and/or outcomes, and targeting intervention to address it. While most healthcare professionals will have a broad understanding of this issue, it is important to scrutinise local data to really understand it. For example, is a particular population group missing appointments?

Then they need to work out why, and target interventions accordingly. In other words, to reduce inequalities we need to start thinking smarter.

The Health Inequalities workspace on the [FutureNHS](#) platform is another useful tool. It has excellent resources, including recorded webinars that explain the priority areas in addition to examples of good practice. The [Health Inequalities Improvement Dashboard](#) is also helpful, and can support the creation of actionable insights for reducing health inequalities. It enables you to review your data by region and by Integrated Care System (ICS), broken down by ethnicity, age and deprivation - helping you to identify where inequalities exist.

We have always known that inequalities exist, and COVID-19 has shone an even more intense light on them (for example, [black and South Asian people were “hit hardest” by the pandemic](#)). So, think of this article as a call to arms for all healthcare colleagues... Think about your clinical area and where the inequalities may lie. Look at your local data, and ensure you are breaking down by ethnicity, deprivation and other protected characteristics. Above all, where inequalities exist, think about why, and what each and every one of us can do to instigate change for the better.



The role of national audits in addressing health inequalities

In 2022, HQIP hosted a series of four online workshops with audit and clinical outcome review programme providers and other guests including patients, NHS England, the Care Quality Commission (CQC), NICE and NHS Digital. We explored collaboratively how we can use our audits and programmes - specifically the National Clinical Audit and Patient Outcomes Programme (NCAPOP) - to identify, measure and address health inequalities. We heard evidence of inequalities revealed by the NCAPOP, for example:

- ▶ A lower proportion of people of Asian and Black ethnicity, as well as those living with deprivation, with type 1 diabetes are prescribed insulin pumps (recommended).
- ▶ Hypertension prevalence was 3.4 percentage points higher in the most deprived group of the population, compared with the least deprived.
- ▶ Effective treatment for hypertension was lower in black (63.9%) and mixed-race people (63.6%), compared with Asian (71.7%) and white people (68.2%).

This webinar series identified seven themes:

1. There is plenty of opportunity for impact

The evidence tells us that there is room for improvement in reducing health inequalities. Data from the NCAPOP can help to identify this, and distinguish between healthcare services.

2. There is widespread support for the work

The [NHS Long Term Plan](#) commits to tackling health inequalities, and all the NCAPOP projects were in support.

3. Addressing health inequalities is a broad challenge

System-wide developments are required, from data collection and coding, through to analysis and reporting.

4. We need to tackle the challenge of missing data

Chasing missing data is time-consuming and difficult.

5. Data quality could be improved

We need to be consistent about what the NCAPOP is collecting and how it is presented, and we need up-to-date information and census data.

6. Obtaining and using routine data presents challenges

Data and analysis are not as costly and requires skilled people, so consideration needs to be given to how we might unblock barriers.

7. We need to support the use of outputs by healthcare services

The data presented needs to be reliable and relevant for local populations, while healthcare services need the capacity to act on the data received.

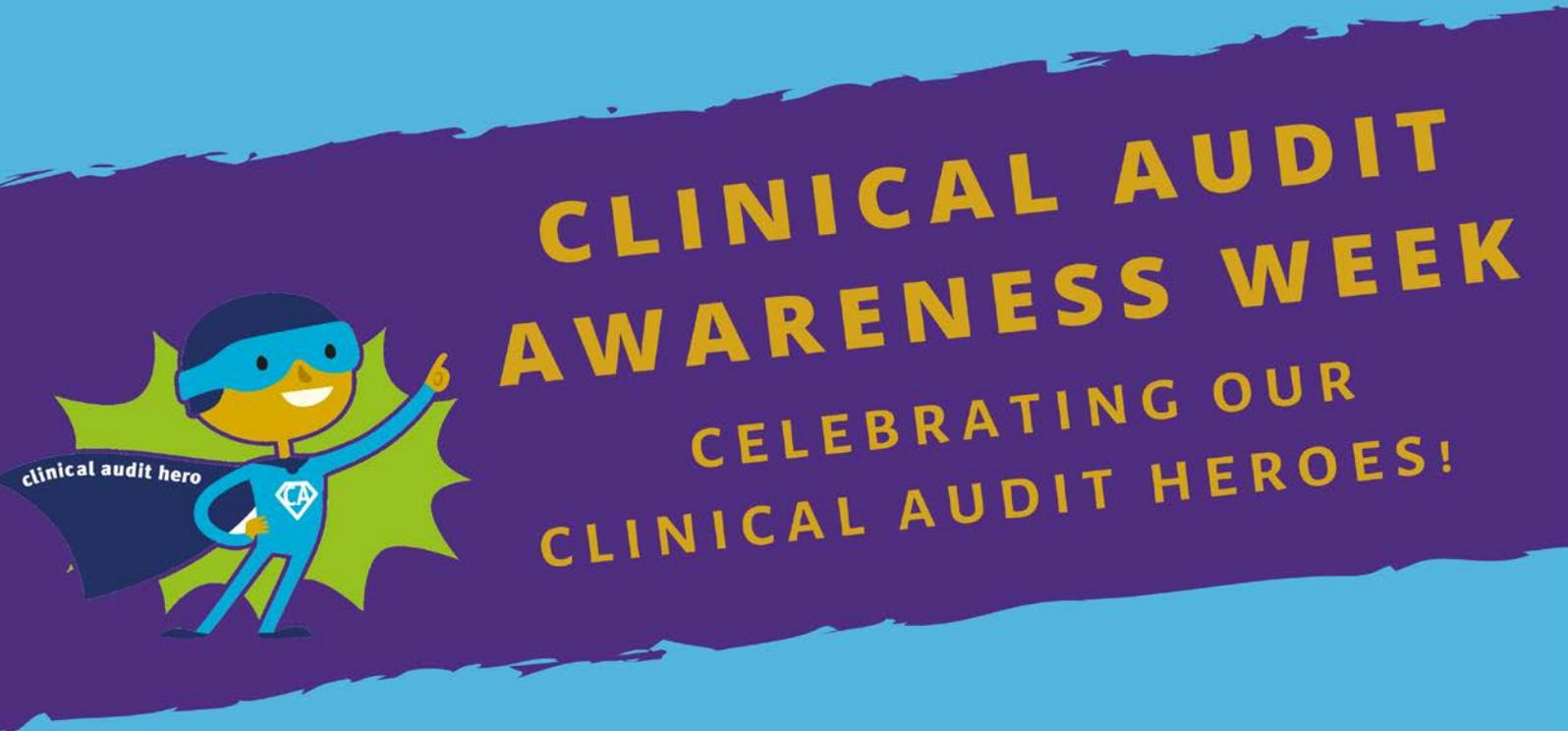
In summary, these events were an excellent opportunity to work together with our NCAPOP project leads, providers of data and patients in order to focus on supporting the drive to reduce known health inequalities. Together, we can define the patient characteristics that need to be collected and reported on. And we can work with patients and system partners to influence better quality of reporting, and demonstrate the value of this to patients and the NHS.

● HEALTH INEQUALITIES: Spotlight on the Early Years

This report from HQIP aims to identify cross-cutting lessons relating to early years health-care with a focus on health inequalities and variation in care, by reviewing a selection of audit reports from the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

To read it in full: www.hqip.org.uk/resource/spotlight-on-the-early-years

Meet the Clinical Audit Heroes



Following is a showcase of exemplar projects from the Clinical Audit Heroes Awards, which were a key focus of Clinical Audit Awareness Week (CAAW) 2022. 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 HERO

WINNER: The Critical Care Audit Team at East Kent Hospitals University NHS Foundation Trust.

The team was nominated for their quality improvement project focusing on preventing never events occurring from misplaced nasogastric and feeding tubes into the lung, which demonstrated sustained improvements in patient safety. The judges were impressed by the team's structured approach to identifying the problem and seeking to find a solution, as well as their evidence of improvement and commitment to continuing improvement of patient safety.

COMMENDED: Corrine DaCosta, Advanced Neonatal Nurse Practitioner. Corrine was nominated for an audit project that concentrated on safe sleeping in the neonatal unit that resulted in improved patient safety, not only whilst patients were in the neonatal unit, but also when the patient was discharged home. The judges heard how Corrine thought outside the box: "An innovative aspect of this project is that it was identified that supporting parents at the earliest opportunity was more likely to create a sustainable improvement."

INFLUENCING CHANGE HERO

WINNER: Trauma Team at Walsall Healthcare NHS Trust.

The team were recognised for their work to improve the care of patients admitted to hospital with a fractured femur, utilising audit data collected for the National Hip Fracture Database. Their award submission detailed how the audit led to the development of a new fracture femur pathway, which was used to standardise care and embed a consistent approach to the initial management of patients.

COMMENDED: Deborah Douglas, Clinical Fellow. Deborah was com-

mended for her audit focusing on getting major urological post-operative patients drinking, eating and mobilised through the introduction of a new digital platform. The judges heard how the audit resulted in the reduction of complications that patients suffer after surgery, improved healing and recovery, and reduced the length of stay.

COMMENDED: PIMS-TS at Sheffield Children's NHS Foundation Trust.

The PIMS-TS team were commended for their audit focusing on children and young people with suspected Paediatric Multisystem Syndrome temporally associated with COVID-19 (PIMS-TS), the findings of which went on to inform the development of a regional clinical guideline for managing PIMS-TS.

HEALTH INEQUALITIES HERO

JOINT WINNER: National Paediatric Diabetes Audit. The audit was nominated for its work to reduce health inequalities in paediatric diabetes care through reporting outcomes broken down by ethnic category and deprivation quintile to enable a focus on closing the gap.

JOINT WINNER: Maternity Cultural Transformation Team at Epson and St Helier NHS University Trust.

The team were recognised for their work on reducing health inequalities with the Trust's maternity services. The nomination details their use of quality improvement methodology to identify areas of inequality in their maternity population as well as efforts to improve access, remove the language barrier, increase information provision, and address staff cultural sensitivity.



FUTURE-PROOFING HEALTH-CARE HERO

WINNER: Sustainable Respiratory Care Audit Team at Newcastle Hospitals NHS Foundation Trust.

The team was recognised for their work improving care for individual patients while also reducing the environmental impacts of health-care. Their nomination detailed how the project provided a structure for the audit of patients' techniques, preferences and knowledge about inhalers, and the need for a clinical review – interventions that can reduce the carbon footprint of healthcare while improving the quality of care.

COMMENDED: Enhanced Care and Support Team at Bolton Hospital NHS Trust.

The team was commended for their work to improve dementia care in the Trust. The nomination details how the team has introduced sensory boxes on the wards and a discharge passport, as well as how they are working with the Integrated Discharge Team, ward and clinical staff and families/carers.

For more information about – and, in some cases, more detailed case studies from – Clinical Audit Awareness Week and the Clinical Audit Heroes awards, go to the [HQIP website](#).

CONGRATULATIONS ON YOUR ENGAGEMENT!

How can we involve patients to improve healthcare?

Kim Rezel,
Head of Patient and Carer Engagement, HQIP

Has the way we engage with patients, carers, people and communities changed? Well, the first thing to say is that I hope so! There are some great examples of best practice across health and social and community care, but they're not widespread. So, how can we learn from these exemplars and what are the reasons and benefits behind engaging with patients, carers, people and communities?

When I first started working in the area of 'service user involvement' it was in social care, and the focus was on service users advocating to be involved in their own long-term treatment plans, and having a role in improving the services they use. On moving into healthcare - and specifically quality improvement (QI) - I realise that the same role can apply to patients and carers. However, we can go even

further; helping patient advocates by giving them the knowledge, data and resources to improve their own care, and champion improvements, both locally and nationally.

We can ask the question 'what are the areas of concern for you?' and incorporate their responses into national clinical audits, so that the results support patient champions on the ground. Their involvement ensures that the services provided are meaningful to those who use them, and it enriches the work we do. And this is mutually beneficial. Adrian Hardy, a member of HQIP's Service User Network (SUN) comments: *"Being involved in improving the quality of our care and services makes me feel like I'm making a difference for not only myself but for other patients and carers. I believe that my experience brings a relevance to what could otherwise be considered as meaningless numbers. It can also*

ensure that recommended actions have a real impact on patient care and outcomes."

In fact, there are a number of well-documented reasons as to why it's important to work with the people and communities that we serve. The NHS England statutory guidance [Working in partnership with people and communities](#) complements HQIP's [guide to patient and public involvement in quality improvement](#) regarding the benefits of involvement, namely:

- Improved health outcomes – Ensuring that the care provided meets people's needs can improve both experience and outcomes. We all have knowledge and skills to contribute to our own health and wellbeing, and working in partnership with service users contributes to shared aims that meet the needs of the communities we serve. This is particularly relevant in reducing health inequalities.

Involvement ensures that the services provided are meaningful to those who use them

■ Value for money – Engaging people to design the care and services they use will more effectively meet their needs, and is therefore a better use of NHS resources. This improves health outcomes, reducing the need for additional care or treatment because needs weren't met the first time around.

■ Better decision-making – When insight from local people is used alongside financial and clinical information to inform the case for change, it adds practical 'weight and context' to data and fills gaps through local intelligence and knowledge.

■ Improved quality and safety – Community engagement results in services that are designed and delivered more appropriately, and personalised to meet needs of local people (you can't make the right changes without their insights). It also improves safety by giving people a voice to raise problems which can be addressed early and consistently.

■ Accountability and transparency – Organisations should be able to explain how decisions are made and how people's views have been taken on board. Getting patients involved in governance helps to make the service providers accountable to communities.

■ Participating for health – Involving patients can reduce isolation, increase confidence, and improve wellbeing. Involvement in your own care can be the start of wider involvement at service or organisational level, and can even lead to employment in services. Being part of a community and in control is good for our health.

All of these benefits encourage patients to speak up and legitimises their views, but we must then ensure that their voices are heard and actions followed. If that isn't enough reasons, we also have a legal duty to engage with patients, people and communities. In fact, failure to do so risks legal challenge and substantial costs, not to mention damaging relationships between providers and the communities they serve. The table below is reproduced from NHS England's [Working in partnership with people and communities guidance](#) and is a useful reminder of our duty of care in relation to public involvement:

NHS England	Status: Policy	Public involvement duty: Section 13Q, NHS Act 2006
Integrated Care Board	Status: Statutory guidance	Public involvement duty: Section 14Z44, Health and Care Bill 2021
NHS trust and foundation trust	Status: Statutory guidance	Public involvement duty: Section 242, NHS Act 2006
Integrated Care System partners	Status: Good practice	Public involvement duty: N/A

So, that's the 'why', but what about the 'what'? Let's bring our attention back to those examples of best practice we referred to at the beginning. For some fantastic case studies, take a look at the [Patient Experience Network National Awards](#) or the [NHS England resources](#). Here are a few choice examples that relate to recent trends in healthcare.

Firstly, healthcare inequalities. We are more aware than ever that people experience health care differently, so more effort is being made to ensure that people from marginalised communities are involved to support better understanding of how all people experience care.

SPOTLIGHT: Healthcare inequalities

The [Health and Wellbeing day](#) for the Black community in Lambeth offered residents the chance to receive COVID-19 and flu vaccinations, key health checks, and important advice and support – all at an event aimed at bringing people together. Music, food stalls and family activities kept things fun and feedback from the event in October 2021 was so positive that the organisers hope to do it regularly.



Next, there's digital Inclusion. While there have been some real benefits to moving online and being able to receive healthcare services without leaving our homes, we need to ensure that those who are digitally excluded are taken into consideration.

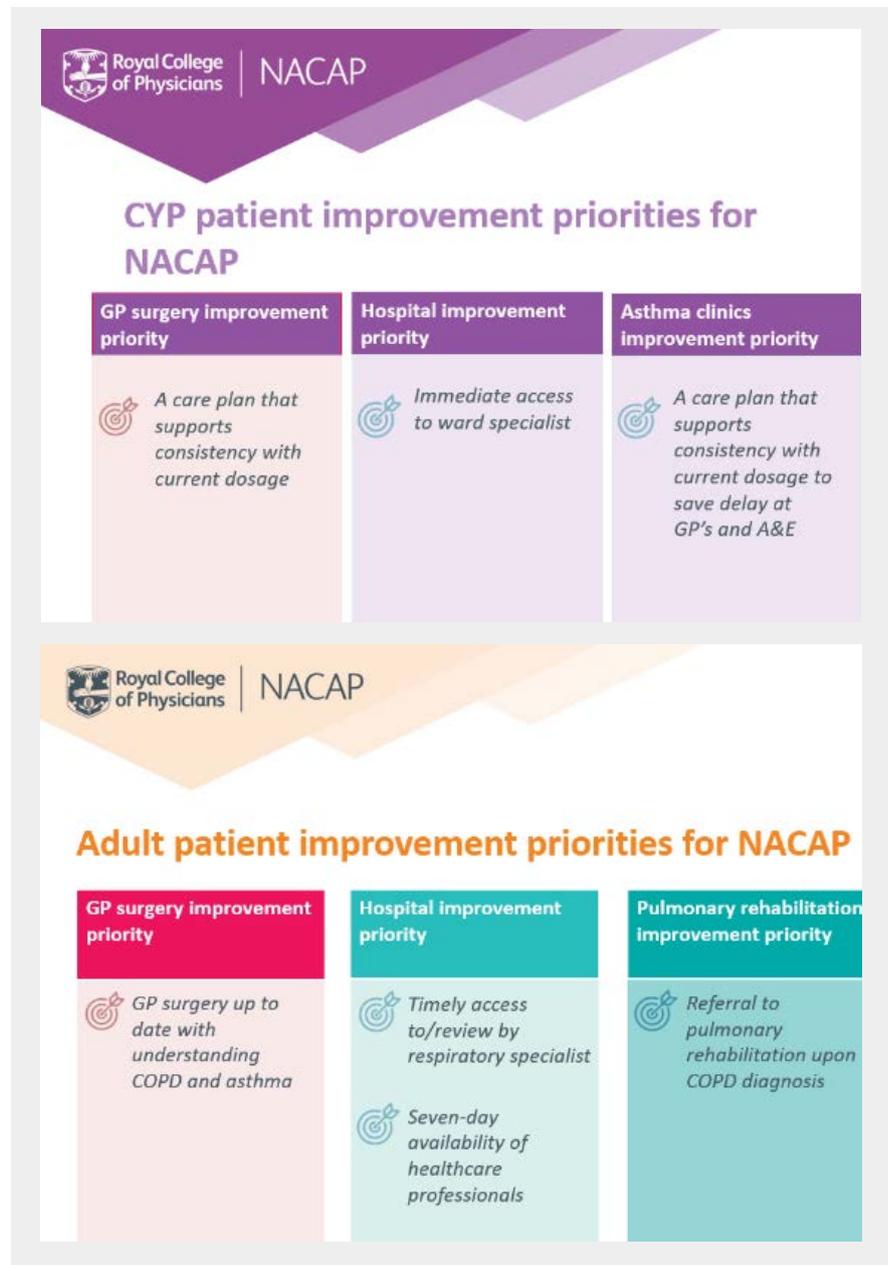
SPOTLIGHT:
Digital inclusion

Through the [Picture This](#) project, the Mental Health Foundation created fun ways to teach basic IT skills to people through art and drawing. Focusing on training people over 65, the project teaches them how to send an e-mail, how to connect with family and friends remotely and attend events, how to use Facebook and other social media channels, and how to order shopping online. These skills enhanced social interactions for participants, and supported mental wellbeing.

Then, there is a growing trend around reward and recognition. Much involvement work offers out-of-pocket expenses only (which is the least that should be done when working with volunteers). However, there is a trend towards changing how we pay people for their time eg many organisations have offered varied honorariums for certain types of work. [Guidance from the National Institute for Health and Care Research \(NIHR\)](#) from 2021 should be considered in the project design. For more case studies from national audits and data collection programmes, you could take a look at the winners of HQIP’s [Richard Driscoll Memorial Award](#). These awards have seen some fantastic examples of involving patients and carers.

Being involved in improving the quality of our care and services makes me feel like I’m making a difference

The 2021 winning entry was from the [National Asthma and COPD Audit Programme \(NACAP\)](#), which demonstrated a genuine collaborative approach to working with charities, forums and patient panels. NACAP asked their patients and carers about what matters to them, and produced the following resources to empower patients of all ages to know what to expect from their care (which, in turn, improves the quality of the care they receive):



The image contains two infographics from the Royal College of Physicians NACAP. The top infographic is titled 'CYP patient improvement priorities for NACAP' and lists three priorities: GP surgery improvement (care plan consistency), Hospital improvement (immediate access to ward specialist), and Asthma clinics improvement (care plan consistency to save delay). The bottom infographic is titled 'Adult patient improvement priorities for NACAP' and lists three priorities: GP surgery improvement (surgery up to date with understanding of COPD and asthma), Hospital improvement (timely access to/res review by respiratory specialist and seven-day availability of healthcare professionals), and Pulmonary rehabilitation improvement (referral to pulmonary rehabilitation upon COPD diagnosis).

Finally, I want to finish with a few words from a patient (this is all about patients and carers, after all!). This quote, from a patient representative in the NACAP award entry, sums up perfectly why we should put patients and carers at the heart of healthcare design, and reminds us that their health is the very reason for the service in the first place: *“The surgery is my first port of call when my asthma is playing up, and I need to be sure that the doctors and nurses are going to be able to give me the best care possible. I want to get the most I can out of life despite having a lung condition, and I know that if the GPs are up to speed with new interventions and treatments, I have a better chance of doing so”*.



How to engage patients and carers

How do we go about effectively involving patient, carers and communities in the healthcare services they receive? In HQIP's guide [Developing a patient and public involvement panel in quality improvement – 2017](#), we outline some simple steps to engage communities (and this can be used as the basis for an action plan):

Leadership buy-in

- ▶ Make sure you have all your 'ducks in a row' before taking a proposal/business plan to senior teams.
- ▶ Consider what you want to involve people in.
- ▶ Draft out the process of how the involvement will work.
- ▶ Consider what it will cost.
- ▶ Talk to patients and other key stakeholders, and ask what they might want from this involvement.

Recruitment

- ▶ Where will you find people to involve?
- ▶ What communication channels already exist that you can use initially?
- ▶ Where can you share information (posters/bulletins/leaflets/events) that will enable you to reach out to wider communities?
- ▶ Again, talk to people; what will people want and gain from being involved, and ask community leaders to support recruitment.

Training

- ▶ HQIP has developed an [eLearning tool](#) in collaboration with our Service User Network (SUN). This is a helpful introduction to QI and methodology, with examples of involving patients in QI projects.
- ▶ Set out a realistic plan about how you and your team can support the people involved.
- ▶ Make sure you have a clear expenses policy, with guidance for volunteers on how and what to claim for.

Impact

It's very important to measure the impact of patient and carer involvement to demonstrate success and identify lessons learned for:

- ▶ The project
- ▶ The team
- ▶ The people involved, and
- ▶ For the long term (can the project be repeated or extended to other areas of work?).

● 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: <https://www.hqip.org.uk/involving-patients/>.



WHEN IS DATA 'GOOD DATA'?

28

5

Using the right data to support robust healthcare services

Mirek Skrypak,
Associate Director for Quality and Development, HQIP

As I was gearing myself up to write this article about using data to develop robust healthcare services, I took receipt of a rather unusual delivery: A golden microphone with Bluetooth and a voice synthesiser. It proved momentarily inspirational, though how is that relevant, you might ask? Well, it prompted me to think about change and, in particular, how using the right data can support the *right* change.

On seeing my delivery (which was a present for someone else, by the way), I was struck by how much microphones have changed. I researched early microphones. Although it still performs the same essential function as the original from 1878, my new microphone differs significantly. This golden one with buttons, Bluetooth and charging cable etc shows many visible signs of change, most of which are in response to modern-day needs. Which led me to think about change in healthcare services.

The NHS is about 70 years younger than the microphone. Just like the microphone, you could say that it still performs the same function (to improve outcomes for those needing medical care). It also needs to change in order to respond to current need (not least in response to an increasingly ageing population). But how do we ensure

that any change implemented is relevant, targeted where it's needed most, and meaningful to service users? In response, I will share some learning that I think is invaluable in relation to data-informed service design within healthcare...

First, practice won't change if you don't have the right data. Whatever tools or techniques you use - whether process improvement, error reduction, waste trimming, agile scrum meetings etc - all of it needs to be done within context. In addition, you need to be curious; you need to ask questions and have ideas. Assuming you have all that, knowing what and how to measure is crucial. Simple right? Well, no! There are a number of variables, models, systems, frameworks and

lar process measure which evidence suggests will improve outcomes. There are circa 170 NHS sites, and let's assume that 75% are achieving this 80% target for a particular clinical area and pathway. Then, let's say that, in this pathway, there are 100,000 people who receive this care per year. That means 60,000 patients will achieve the target. But, what about the other 40,000? Suddenly this is not so positive. I know which side - or cohort - I would like to be on as a patient.

So how can we improve these numbers? Here at HQIP, we help service providers to find the right data, to take an effective approach to measuring, and to use that knowledge to build consensus for change.

Practice won't change if you don't have the right data

contexts etc that you also need to think about. However, I suggest that there is one other consideration that is more important than all others: There should be no data without stories and no stories without data. The percentages or figures in charts, tables, recommendations and p values etc are all people. Think about it in terms of this fictional example... Let's say that there is a national target of 80% for a particu-

We strongly advocate the synchronisation of Quality Improvement (QI) with national clinical audit and confidential enquiries to enable improvement in outcomes at a national level. Find below what I hope is a useful summary of the key questions that need to be addressed by healthcare leaders and their teams when doing this:

As a manager or clinician:

- Have you collected the data in the right way to be able to identify trends?
- Do you have the right roles reviewing the data? Who owns it?
- Do you know your audience? What is it they need to know?
- Are you at risk of decision makers reacting unnecessarily?
- How are you presenting your data? Have you presented the data to show a true picture over time?
- Is there variation, and is this normal or the result of an exceptional circumstance?
- Do you need to consider if it's actually the system that needs reviewing, or does the target need to change?
- Do you need to measure for a longer duration?

As a team or service:

- Do we know how good we are?
- Do we know where we stand relative to the best?
- Over time, where are the gaps in our practice that indicate a need for change ie improvement?
- In our efforts to improve, what's working (and what isn't)?
- Do we know/understand where variation exists in our organisation? Why are we measuring all this and what difference is this actually going to make to the quality of services?

That's a lot of food for thought. And I don't suggest, for one moment, that it's an easy task. But it is necessary. While I'm not sure that we need a golden, 'Bluetooth-enabled' (or the equivalent) healthcare service, we do need to instigate change.

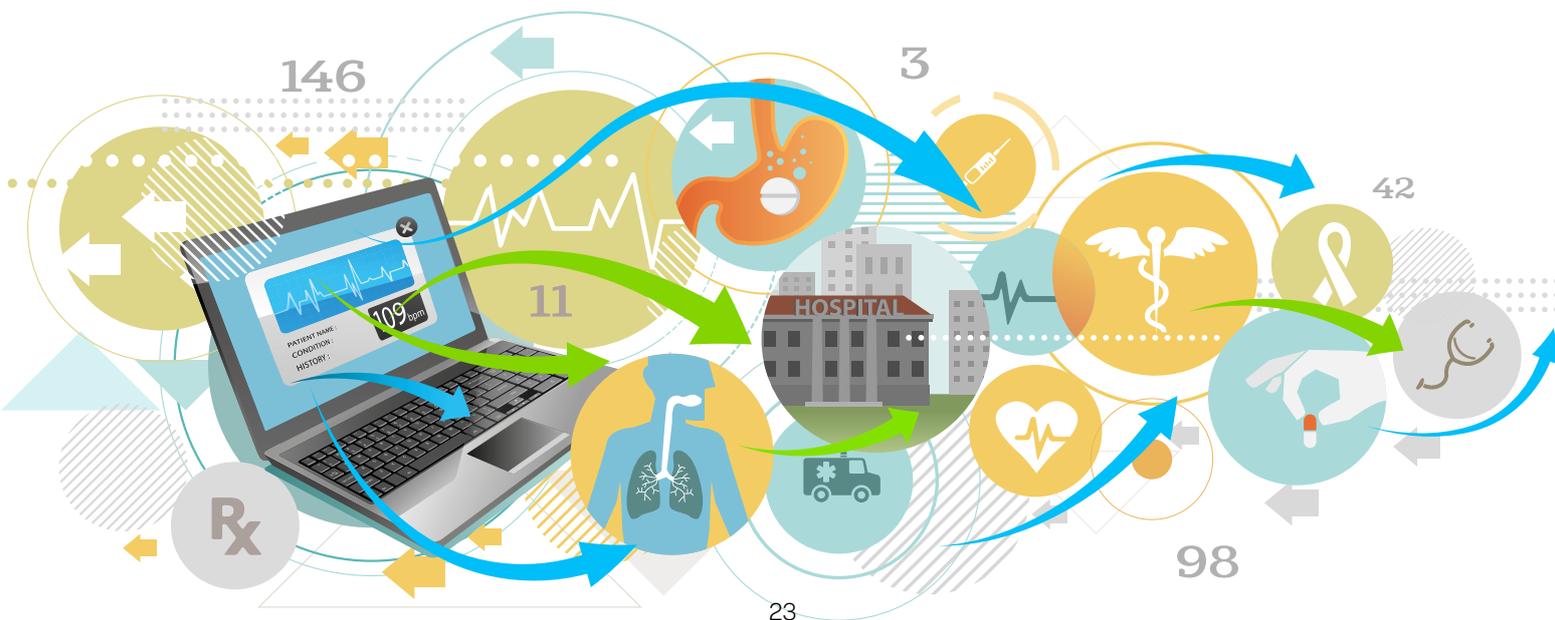
I'm convinced – and I wish I had my gold microphone to hand to make this point – that the right data is the way forward in ensuring that those changes are relevant,

“**There should be no data without stories and no stories without data**”

meaningful and, above all, deliver maximum impact. However, I'm going to give a final word of caution to the renowned statistician David Spiegelhalter, who says: “Signals always come with noise: It is trying to separate out the two that makes the subject interesting.”

● **Advisory services at the Healthcare Quality Improvement Partnership**

As the UK's largest national clinical audit commissioner, HQIP is uniquely placed to support evidence-based clinical effectiveness and data-informed service design. As such, we provide a range of training courses and advisory services, including half day online courses through to bespoke guidance. Find out more: www.hqip.org.uk/advisory-services.





Need help with quality improvement?

As the UK's largest national clinical audit commissioner, HQIP is uniquely placed to support evidence-based clinical effectiveness and data-informed services as well as provide advice around innovation and opportunities to connect with the healthcare sector.

For more information, go to the [Advisory Services](#) section of the [HQIP website](#) or contact communications@hqip.org.uk.

How can we help?

Our advisory services range from half day online courses through to bespoke guidance, and are designed to support quality improvement at all levels. Examples include:

Using data for improvement

- Clinical audit foundation half-day induction course
- Data, data, data: Full-day interactive training
- Bespoke support to develop Quality Improvement (QI)

Innovation and solutions for data-driven services

- Testing for impact: Feasibility studies and pilot projects
- Research for impact: Developing research that investigates and evaluates new solutions

Harnessing expert insights

Advice and support to:

- Engaging with patients, carers and the community
- Connecting with policy