National Advisory Group on Clinical Audit & Enquiries

27th June 2012
Alexander Harvey Room, RIBA, 66 Portland Place, London, W1B 1AD

Minutes

In attendance
Nick Black (NB) – Chair
Steven Berg (SB)
Amanda Edwards (AE)
Mark Gritten (MG)
Danny Keenan (DK)
Jan van der Meulen (JM)
Andrew Middleton (AM)
Mick Peake (MP) – until 12.30

Apologies
Katherine Birch
Pauline Ong (PO)
Geraldine Walters

Observers
Robin Burgess (RB) – HQIP
Clare Callaghan (CC) – DH
Shaun Chainey (Welsh Government)
Helen Laing (HL) – HQIP
Karen Noakes (KN) – DH
Karen Dooley (KD) – Social Care, DH (for item 5)

Alex Henderson (AH) – Secretary

1. Welcome

NB welcomed everyone to the meeting and apologies were noted. In her absence, KB was thanked for her contributions as a member of NAGCAE over the past year.

2. Minutes from the meeting on 14th March 2012

The minutes were accepted as a correct record.

3. Matters arising from the previous minutes

3.1. The use of clinical audit in commissioning

Action: DH contacts to be sent to PO and AM. ***KN***

3.2. Cancer audit review

MP had contacted Mike Richards but had not yet heard back. Retendering would proceed while awaiting a response.

Action: MP would contact Mike Richards again. ***MP***

3.3. Government Transparency Policy

The review of NCAPOP NCAs (commissioned by HQIP) had completed the first phase which covered the provision of provider level data via data.gov by the end of April 2012. This had presented no problems for most established NCAs which are already providing or planning to provide such data. Concerns about how published data could be misinterpreted were expressed, however it was a requirement by those publishing data to present it in such a way which would reduce the likelihood of this occurring.

The review was discussed at the DH Health and Social Care Transparency Panel on 2nd May which accepted the need for careful consideration when releasing more detailed patient-level data (the focus of the next phase of this work). The Panel agreed to establish a Sub-Group to identify how best to take forward the second phase.

NAGCAE members were concerned that there was a lack of clarity as to what the Panel meant by 'raw data' in their Minutes. It was also felt that the work of the Sub-Group would benefit from some members with experience and understanding of national clinical audits. KN would convey these suggestions to the Panel Chair/Secretariat. She also thought it likely that NAGCAE would be involved in future work of the Panel.

Action: NAGCAE would be approached to suggest members. ***KN***

3.4. Data Sharing Agreements

Concerns about current data sharing arrangements for some NCAs funded by NCAPOP had been discussed at a meeting on 21 May of representatives from the DH, HQIP, NCA suppliers, ONS and NHS Information Centre. The minutes of that meeting were presented by KN.

Members reconfirmed that NCA suppliers should seek to maximise the use of NCA data, subject to meeting legal requirements. It was recognised that if the NIGB Section 251 approval that a NCA supplier obtained was very restrictive, the subsequent uses of the data would inevitably be limited. It was therefore important that NCA suppliers negotiated the most flexible terms possible with the NIGB when obtaining approval. It was suggested that HQIP should assist NCA suppliers by sharing other suppliers' experiences and know-how regarding applications.

Once NCA data are linked to other databases (eg HES or ONS mortality data), the data controllers of those databases must also be involved in decisions regarding legal use of linked data.

Judgment as to whether or not NCA data may be used for a secondary purpose rests with HQIP (for those NCAs funded by NCAPOP) as the Data Controller. Any potential user must sign a Data Sharing Agreement with HQIP and then submit a request for each specific use they want to make of the data. A flow chart describing the steps required for NCA suppliers to use NCA data, and the required forms are on the HQIP website. Members stressed the need for HQIP to ensure that requests were dealt with rapidly so as to facilitate maximum use of NCA data.

Some follow-up action was being undertaken by the DH with ONS.

Action: Update from DH at September meeting ***KN***

3.5. Audit of care pathways

Action: Deferred to September meeting. ***MP/SB***

3.6. Methodological development

JM presented a summary of responses from members and from NCAPOP NCA suppliers outlining their methodological concerns. Several concerns could be addressed from existing knowledge and experience rather than requiring research. Of the remainder, members suggested that priorities need to be identified that could be used to shape an initial programme of research.

Action: Priority topics to be agreed. ***JM/NB/DK/SB***

3.7. Audit in Trusts

A Roundtable meeting had been held on 17th April from which initial ideas were drawn up by KB and NB. These were subsequently discussed with some Trust chief executives. The draft proposal will be circulated to members for comment. A public consultation will then be held with responses required by mid-September.

Actions: Draft proposal to be circulated to NAGCAE for comment. ***NB***
Public consultation on NAGCAE website ***NB/KN***

3.8 New NAGCAE member

Applicants for a local clinical audit member would be interviewed on 16th July.

3.9 Clinical Audit & Enquiries management contract retendering

A DH project board was overseeing the retendering. A bidders' meeting was held on 25 June and the ITT will be issued on 9 July. The evaluation will be held in September/October with the contract awarded in November.

4. Presentation: The Trauma Audit & Research Network

Maralyn Woodford, Executive Director for the Trauma Audit & Research Network

(TARN), provided a background and overview of trauma care in the UK and the research and development undertaken.

5. Audit in Social Care – the way forward

AE presented a paper on behalf of a small working group on how audit practice could be developed in social care. This was supported by a paper from HQIP on the work they have undertaken.

Members felt that the key elements of NCAs of health care (quantitative measurement of processes and/or outcomes to permit statistically meaningful comparisons of providers) were not appropriate for social care. It was felt that the role of a national supplier was to provide standard, agreed instruments (e.g. adherence to quality standards) that providers might be encouraged and helped to use for local audit. In addition, groups of providers might chose to collaborate to share and compare their data, a task that could be facilitated by a national supplier. This would be akin to existing multi-site audits in the health sector. Such activities would usefully be supplemented by other methods based on reflective practice.

Further development of 'social care audit' needs to recognise the imminent publication of the social care White Paper. While the development of options should proceed, clear advice needs to await the White Paper to ensure it is consistent with wider policy developments. Similarly, funding any developmental or feasibility project should be deferred.

While recognising that the White Paper will probably refer to 'audit', members suggested that maybe this term was not the most appropriate and other options (such as practice review) should be considered.

Action: Topic to be considered further after White Paper published. ***AH***

6. Update on development of wider DH policy

KN reported that the NHS Commissioning Board had set up a webpage: http://www.commissioningboard.nhs.uk/. The Board will be fully established from April 2013.

David Behan will be leaving the DH at the end of June for his new appointment as CEO at the CQC.

NB reported that applications for the Academic Health Science Networks (AHSN) was underway. They may emerge as the principal drivers of innovation and service improvement in the reformed NHS and thus be of considerable relevance and interest to NAGCAE. While improvement science was recognised as a key element in AHSNs responsibilities, there is no mention of clinical audit in the guidance (available on the DH website). It was agreed that NAGCAE needed to monitor developments to ensure AHSNs understood and made use of clinical audit.

Action: AHSNs to be discussed at September meeting. ***NB***

7. Time-limited NCAs

The DH requested NAGCAE reconsider the contribution of time limited NCAs (i.e. one period of quality assessment only). In December 2009 NCAAG agreed:

"... that while most new NCAs plan from their inception to be long-term (whether using continuous or intermittent data collection), this should not be automatically assumed to be appropriate and the duration of an NCA needs to be justified. Some NCAs might choose to defer the decision as to whether or not repeated assessments were undertaken until after the first quality assessment period had been completed, analysed and presented."

Members agreed with their earlier policy advice and that the continuation of all NCAPOP NCAs should be rigorously scrutinised when their existing funding contract came up for renewal. Given that the expansion in funding from the 2010 Comprehensive Spending Review is unlikely to be extended beyond the 11 new NCAs currently being commissioned (and the previously expected 'new' funds resulting from some NCAs shifting to subscription funding no longer being made available to NCAPOP because of the changed financial situation for the DH/NHS), there will be a need to discontinue NCAPOP funding from some existing topics if new ones are to be commissioned. (The former could continue if funded from other sources, such as subscription).

8. National Pain Database

The National Pain Database Audit will reach the end of its contract in August 2013. HL presented a brief progress report which highlighted the national policy importance of pain control and the publication of NICE quality standards. Members felt they could not provide an informed view about the future of this NCA without more information on progress to date. The NCA Annual Report will be published in August.

Actions: To consider the future of this NCA in September meeting ***HL***
Further information to be sought from NICE ***KN***

9. New Audits Sub-Group update

Contracts for NCAs for Chronic Obstructive Pulmonary Disease and Emergency Laparotomy were being finalised.

Tenders for Peripheral Vascular Interventions and Prostate Cancer would be considered on 12th July.

Specification development meeting for a study of the feasibility of a NCA of health care for those with learning disability was held on 27th March and an ITT will be issued shortly.
Specification development meetings for a NCA of chronic kidney disease will be held on 3 July and for arthritis on 12 July.

10. Renewals Sub-Group update

Specification development meetings will be held for three cancer NCAs in September, for dementia in October, and for continence care and psychological therapies in November.

KN noted that inclusion of pancreatic cancer would need to be considered when the bowel cancer audit was reviewed.

11. HQIP Annual Report 2011-2012

The DH requested members' views. RB felt that the report was best viewed with the HQIP business plan for 2012-2013 which included more communication with commissioners.

KN felt it would be useful for NAGCAE to review the Annual Report each year.

Actions: Members to email NB with any comments by 13th July. ***All/NB***
Annual Reports and Business Plans would be reviewed annually. ***KN***

12. NCA Heavy Menstrual Bleeding (HMB)

(JM left the meeting to avoid a conflict of interest).

HL presented her brief summary of the progress this NCA had made since February 2010. The Royal College of Obstetricians and Gynaecologists have a four year contract to conduct this time-limited audit. It consists of five phases, the first two of which were completed and reported in the 1st Annual Report (May 2011). The third phase has been completed and reported on in the 2nd Annual Report (June 2012). HL reported that HQIP were concerned about several aspects of the audit design and progress. Three options were suggested.

Members recognised that this NCA was pioneering and challenging in that it is the first (and only) hospital-based NCA to try and recruit patients in outpatient departments rather than inpatients. Members also recognised that the disappointing recruitment rate of about 30% was despite the NCA supplier pursuing exemplary methods to maximise uptake. In addition, the NCA is ambitious in trying to collect patient reported outcomes (PROMs) rather than rely solely on clinicians' views of outcome.

Members felt that despite the low recruitment rate, the supplier has what is probably the largest database on the management of HMB in the world. Even if some of the original objectives cannot be fully realised, great value could be gained from the resources invested if the follow-up of the 16000 patients proceeds (completion spring 2013) and the data are fully analysed. HL suggested this goal could be achieved if the contract end date were brought forward from January 2014 to August 2013 (saving £125k).
Based on those figures, members recommended the option to terminate the contract in August 2013.

Action: Proposed early termination to be discussed with NCA supplier to confirm outputs and cost savings. ***HL***

13. Any Other Business

DK suggested that NAGCAE could invite an audit lead from NICE to a future meeting.

Action: NICE audit lead to be invited to the September meeting. ***DK/AH***

14. Next meeting

Wednesday 19th September 2012, 11 am – 4 pm.
RIBA, 66 Portland Place, London, W1B 1AD.