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| **NATIONAL CLINICAL AUDIT OF PSYCHOSIS** |  |  |  |
| **SPECIFICATION** |  |  |  |

**Internal Ref: HQIP National Clinical Audit 2123**

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# SECTION A: Project-specific requirements

# Introduction

## HQIP and the National Clinical Audit and Patient Outcomes Programme

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement, and in particular to increase the impact that clinical audit and clinical outcome review programmes have on healthcare quality in England and Wales. HQIP holds the contract to manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising more than 30 clinical audits as well as a number of clinical outcome review programmes. These national projects cover care provided to people with a wide range of medical, surgical and mental health conditions. They are funded by NHS England and Improvement, the Welsh Government and in some cases other devolved authorities.

National comparative projects stimulate healthcare improvement and support organisations to find out if healthcare is being provided in line with nationally agreed standards. These projects let care providers and patients know where their service is doing well, and where there could be improvements.

## Background

The National Clinical Audit of Psychosis has been running since 2017 with the aim of increasing the quality of care that NHS Mental Health Trusts in England and Health Boards in Wales provide to people with psychosis. It follows on from the previous National Audit of Schizophrenia. The current contract held with the College Centre for Quality Improvement at the Royal College of Psychiatrists to manage the audit will come to an end in July 2022. Building on the achievements of this audit, NHS England and Improvement has asked HQIP to recommission an audit in this area. An open procurement process will be managed by HQIP.

The first year of the current psychosis audit looked at care provided to people with psychosis by inpatient and outpatient services. From year two, the audit has focused on the quality of care provided by Early Intervention in Psychosis teams. To date data has been collected via case-note audits and service-level questionnaires. The outputs produced have included national and organisation-level findings and recommendations for improvement. Key performance areas have included the assessment and treatment of physical health, health promotion, prescribing practice, use of evidence-based psychological treatments and access to services at times of crisis.

The standards for the psychosis audit have been based on Implementing the Early Intervention in Psychosis Access and Waiting Time Standard guidance ([NHS England, NICE & NCCMH, 2016](https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf)), which details a National Institute for Health and Care Excellence (NICE) recommended package of Early Intervention in Psychosis (EIP) care ([NICE Quality Standard [QS] 80, 2015](https://www.nice.org.uk/guidance/qs80); [NICE QS102, 2015](https://www.nice.org.uk/guidance/qs102)). All NHS Early Intervention in Psychosis teams with a total caseload size of fewer than 100 patients were asked to submit data on all patients meeting the criteria. Teams with a caseload size greater than 100 were asked to submit data on a random sample of 100 patients meeting the criteria.

Details of the current audit can be found [here](https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis).

## Specification development

In order to develop a specification, HQIP held a specification development meeting (SDM) in September 2021, inviting key stakeholders. The meeting agenda, notes and papers for Part 1 of this meeting are made available to all bidders during the tendering process. Part 2 of the meeting was a closed session attended by funders, programme commissioners, and their advisors only. The resulting specification takes account of the feedback, along with funder priorities.

## Contract opportunity

The contract will initially be delivered for NHS-funded care in England and Wales, for a period of three years, at a maximum total budget of up to £1,230,000 GBP excluding VAT. Bids exceeding this limit will be rejected. There is potential to extend the contract for up to two additional years.

**The maximum budget ‘core’ value is £1,230,000 GBP excluding VAT. This excludes the potential two year extension and the aspirational intent elements listed below.**

Any contract award will include payment linked deliverables.

HQIP’s intention is to sustain continuous programme delivery, with efficient and seamless transition between contract periods. If the contract is awarded to a new supplier, HQIP will engage with both the outgoing and incoming suppliers after contract award to identify and agree transition tasks. Transition would be estimated to take place over a period of four to eight weeks immediately prior to 31 July 2022.Anticipated transition activities are not listed in this specification. Tenderers are invited to explain clearly and comprehensively how they would meet the scope of work described in this specification, excluding specific transition activities.

**Potential future aspirational intent**

The future aspirational intention of this opportunity could potentially include:

* Different topics
* Combining NCAPOP projects/programmes, including alignment across the programme, and/or joint working with other similar NCAPOP programmes
* Transitioning to different models of data collection and operational methods for the audit, e.g. different sources of routine data
* Devolved nations/authorities in the UK, Channel Islands or Isle of Man that do not currently participate
* Extending service coverage to include non-NHS funded care
* Additional, associated or enhanced delivery of any aspect of the project
* Other healthcare improvement initiatives either related to or linked with the project.

Please note, there is no commitment by the Authority at this stage to include any of these. Taking this aspirational intent into account, as well as the possibility that a contract extension may be offered for an additional two years, the potential ceiling value is £7,000,000 GBP excluding VAT.

# Aims and objectives of the project

* 1. The role of a national clinical audit is to stimulate healthcare improvement through the provision of timely and high quality information on the organisation, delivery and outcomes of healthcare, together with tools and support to enable healthcare providers and other audiences to make best use of this information. Outcomes are benchmarked against national guidance and standards e.g. quality standards from the National Institute for Health and Care Excellence (NICE), and those from other established professional and patient sources.
  2. The overarching aim of this audit is to stimulate improvements in care that NHS Mental Health Trusts in England and Health Boards in Wales provide to people with psychosis by measuring and reporting variations in quality of care and patient outcomes. During this contract period, the successful tenderer will need to build on the achievements of the audit so far, including the 2021 bespoke children and young people audit[[1]](#footnote-2), and enhance the ability for the audit to be used for healthcare improvement. To do this, the supplier will need to engage with clinicians, patients and commissioners (both local and national) and regional networks.
  3. Successful national audits are those where the individuals providing the data are also in a position to improve the system, and where there is a shared understanding of what good care looks like. Data is most useful locally for healthcare improvement when its provision to clinical teams is timely, the data is refreshed regularly, and appropriate tools, support and guidance accompany the data outputs. The intent is for all of these features to be implemented and improved during the period of this future contract.
  4. The data-driven healthcare quality improvement three year aims of this project are to:
* Facilitate all psychosis care teams to become quality improvement teams meaning that they engage with the data and resources to improve patient outcomes, e.g. through collaborative care planning, supervision and service improvement
* Reduce the wide variations in care between different providers and increase the proportion of patients who take up the recommended package of Early Intervention in Psychosis (EIP) care ([NICE Quality Standard [QS] 80, 2015](https://www.nice.org.uk/guidance/qs80); [NICE QS102, 2015](https://www.nice.org.uk/guidance/qs102))
* Reduce the persistent inequalities in access to care, especially among ethnic minority service users
* Increase the number of Early Intervention in Psychosis teams (or Children and Young People’s Mental Health teams where required) that meet the [Psychosis Access and Waiting Time Standard](https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf)[[2]](#footnote-3)
* Increase the number of people identified with at-risk-mental-state (ARMS) who have access locally to appropriate interventions
* Increase the number of service users who are offered physical health monitoring and who take up relevant interventions
* Increase the number of people with psychosis moving into employment and/or educational or occupational activities
* Increase access to and take up of psychological therapies, namely cognitive behavioural therapy (CBT) for psychosis
* Promote the recording of clinical outcome measures[[3]](#footnote-4) for every patient at the start and end of treatment and throughout care
* Provide data to understand the Early Intervention in Psychosis service offer to 14-18 year olds from Children and Young People’s Mental Health teams
* Improve outcomes for children and young people with a first episode psychosis
* Increase the number of young people with psychosis who receive family interventions

The audit supplier will work with commissioners and funders to create a coherent strategy for how the improvement goals listed above, or similar, will be achieved.

* 1. The overarching quality improvement objectives of the National Clinical Audit of Psychosis are to:
* Assess and report quarterly and in a timely way on the care service users receive when measured against adherence to standards and guidance
* Provide data to enable NHS England and Improvement to assess services’ progress towards the aims and targets in the [NHS Long Term Plan 2019](https://www.england.nhs.uk/long-term-plan/) and the [NHS Mental Health Implementation Plan 2019/2020 – 2023/2024](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf)
* Support improvements in the Mental Health Services Data Set (MHSDS) data by driving compliance with national coding standard and quality indicators so that it can be used more widely for the audit, e.g. give feedback, identify gaps in the data
* Indicate to healthcare providers where assessing and recording of patient outcomes is lacking and drive increased recording of outcome measures in local patient records
* Identify and notify outlier organisations using the appropriate guidance so that they have the opportunity to put interventions in place
* Share best practice and quality improvement examples, and signpost to resources available
* Adapt quality improvement priorities in line with new evidence based practice and guidance
* Develop quality improvement resources for use by providers
* Work together with regional NHS structures to support change
* Share findings, conclusions and recommendations with service users, charities, commissioners, regulators, NHS England and Improvement, Welsh Government and Improvement Cymru so that others can support the improvement aims
  1. This audit programme is expected to:
* Develop a robust, high quality audit designed around key quality indicators likely to best support local and national quality improvement
* Achieve, articulate and maintain close alignment with relevant NHS England and Improvement and NICE national guidance and quality standards throughout the audit, as appropriate
* Enable improvements through the provision of timely, high quality data that compares providers of healthcare, and comprises an integrated mixture of named Trust or Health Board, commissioner, multi-disciplinary team, possibly consultant or clinical team level and other levels of reporting
* Engage service users and families in a meaningful way, achieving a strong patient voice which informs and contributes to the design, functioning, outputs and direction of the audit
* Consider the value and feasibility of linking data at an individual patient level to other relevant national datasets either from the outset or in the future, and plan for these linkages from the inception of the contract
* Ensure robust methodological and statistical input at all stages of the audit
* Identify from the outset the full range of audiences for the reports and other audit outputs, and plan and tailor them accordingly
* Provide audit results in a regular, timely, accessible and meaningful manner to support quality improvements, minimising the reporting delay and providing continual access to each unit for their own data
* Share findings with service users to support their understanding of the care they should expect to receive
* Utilise strong and effective project and programme management to deliver audit outputs on time and within budget
* Develop and maintain strong engagement with local clinicians, networks, commissioners, service users and their families and carers and charity and community support groups in order to drive improvements in services

# Scope of the project

The scope of this national clinical audit programme comprises a prospective audit of key measures on the processes and outcomes of care provided by Early Intervention in Psychosis (EIP) teams to people with psychosis in England and Wales.

As with all our contracts, HQIP prioritises the minimisation of local data entry/submission burden and the impact of data flows on patient privacy, and the maximisation of quality, timeliness and cost-efficiency of reporting of data. To avoid burden on the healthcare system, the audit will use electronic patient record data and/or routine data (e.g. hospital episode statistics (HES) and Mental Health Services Data Set (MHSDS)) whenever available, rather than collect bespoke data. Where data items are collected from providers/services, these must be directly aligned with the audit quality improvement intent in order to minimise collection burden.

HQIP will continue to work with NHS Digital and the Welsh Government to explore future opportunities to meet these ambitions. The supplier of this contract must be willing to work with HQIP to scope, adapt to and adopt new arrangements as and when they are required. We note that the data sources available will differ between England and Wales and hence both situations will need to be considered in the proposals put forward. The supplier must be prepared to implement changes flexibly and within budget where possible, and to evidence to HQIP should future increased costs be identified which would be unavoidable due to the factors outside of the control of the supplier. In this situation HQIP will work with the supplier in line with the contractual terms and conditions to identify a solution.

## Inclusion criteria

* People with first episode of psychosis aged 14-65 years
* All NHS-funded Early Intervention in Psychosis teams in England and Wales
* NHS-funded Children and Young People’s Mental Health / Child and Adolescent Mental Health Services in England where Early Intervention in Psychosis teams do not extend their offer to Children and Young People

## Exclusion criteria

* Adults treated by other services (i.e. not Early Intervention in Psychosis teams)
* People experiencing psychotic symptoms due to an organic cause, for example, brain diseases such as Huntington’s and Parkinson’s disease, HIV, syphilis, dementia, brain tumours or cysts

## Audit measures and dataset design

The following general commissioning principles underpin this section:

* Whilst a degree of continuity will be essential in order to be able to report year on year trends, some measures will be refined or stepped down to improve the utility of the audit outputs to support change. The focus should continue to be on the quality of care and outcomes for patients.
* Minimum possible dataset: every item in the dataset must be justifiable, essential to the analysis and reporting of the audit measures, and utilised effectively. Collecting items unique to the audit represents additional local burden, would need specific justification and will require authorisation by HQIP. There is likely to be a need for different methods of data collection in England and Wales.
* The audit should align with current and, where possible, forthcoming national guidance and quality standards of best practice.
* Service users and carer voices should be central to decision-making about what to measure and to the data collection, analysis and reporting.

Tenderers should outline:

* How the move towards routinely collected data will be established and implemented in both England and Wales (nothing the differences in the data sources available)
* How structures, process and outcomes of care will be reviewed, including which measures could be stepped down or measured at different frequencies
* How best to capture service users and carers’ experience in the design of the audit
* How data outputs will be developed from existing data to support bundled care elements
* How serial output graphics for individual units against comparator groups will be produced
* How data will be used as an early warning system
* How to remove/reduce the effect of teams/Trusts/Health Boards appearing better in audit outputs if data is omitted

The audit will move to use routine data (noting that different timescales will need to be adopted in England and Wales). It is anticipated that the current supplier will indicate their findings on the feasibility of using available routine data before the end of the current contract. Areas therefore **not** expected to be covered by the audit include:

* The development of patient reported experience or outcome measures (PREMs/ PROMs) unless specifically requested by funders
* The organisation and structure of services and staffing levels that do not utilise routine datasets or reports on data already available
* Bespoke ‘spotlight’ topics which require collection of additional data (although spotlight audits making use of routine data could be considered)
* Deep-dive focussed thematic areas (unless specifically requested by funders)

Tenderers will be expected to engage in appropriate stakeholder consultations during dataset development and review, including (but not limited to):

* Funders
* Service users and carers
* Commissioners (local and national)
* Clinicians
* Third sector organisations
* Organisations setting professional standards and users of the data for quality improvement and benchmarking, e.g. NHS England and Improvement, NICE, Care Quality Commission (CQC)

The dataset should continue to be developed and revised on a regular basis, ensuring relevance and local burden are always considered. The relationships between the quality measures selected and the standards and guidance must be made explicit via appropriate project information documents.

## Participation and case ascertainment

Tenderers will be required to propose case ascertainment rate targets across England and Wales. The participation rate across England and Wales is expected to be 100%, which has shown to be achievable.

The tenderer is expected, where possible and where they exist, to utilise routine national data sources, (e.g. hospital episode statistics (HES), Mental Health Services Data Set (MHSDS) and Patient Episode Database for Wales (PEDW)) to ensure case ascertainment is complete.

Where national data sources are not available, the tenderer is invited to discuss how case ascertainment could be evaluated and reported.

## Data capture, data completeness/quality, and data flows

Tenderers should outline how data items will be collected and submitted locally and the data flows which will enable central analysis (by the supplier and/or their sub-contractors). The audit must not introduce a data capture mechanism that duplicates those already in use, although a new mechanism which accepts uploads from existing systems would be acceptable.

Functional and efficient IT provision is essential. This should facilitate:

1. Simple data entry, potentially on a variety of devices to maximise usability;
2. Support local data providers in entering complete and good quality data; automated validation should be designed into the system as far as possible;
3. Minimisation of local burden through use of existing data sources, importing data from other sources;
4. Responsiveness to changes if the dataset requires revision, such as removing data items that are no longer clinically relevant;
5. Meaningful data are able to be extracted by local providers, for purposes of local quality improvement, quality assurance and benchmarking. This includes the provision of online reports that present results, in graphical, tabular or other usable format. These reports should enable providers to determine if they are an outlier when compared to their peers; and
6. Data extraction at different health geographies to meet the needs of different stakeholders, e.g. commissioners, Trusts, Health Boards.

## Data linkage

Having considered the aims, objectives and possible audit measures, the tenderer is expected to identify and define the existing sources of data and the data linkages at individual patient level required to deliver this audit. The intended route of access to the datasets should be made explicit as well as an appreciation of the information governance permissions required.

## Central analysis

Strong methodological statistical analysis must be a core component of this audit design and delivery. Tenderers should briefly but clearly articulate their analysis plan and how it will be delivered.

Expectations from tenderers:

1. An analysis plan will be developed and carried out with the aim of producing data and resources interpretable by all relevant stakeholders, particularly local teams, clinicians, commissioners, and service users and carers, to improve the quality of clinical services. The analysis plan will be submitted to HQIP as part of the contract management reviews.
2. The approach to managing missing data or variability in the quality of data submitted to the audit will be explicit in the analysis plan and adhered to.
3. A person or group with appropriate statistical expertise will carry out and supervise the analysis of data.
4. Data will be analysed and presented at the most appropriate levels of granularity, e.g. consultant, team, service, Trust/Health board, commissioner, or regional levels.
5. The interpretation and presentation of the analyses will be a joint enterprise between the statistical analysis team and clinicians, with specific regard for the needs of the stakeholders who will use the reported analyses to implement change in their services.
6. The supplier must risk adjust outcomes using a validated method. A validated model must already be available or be able to be delivered within the available resources.
7. Risk adjustment must be applied by a person or group with the appropriate statistical expertise.
8. English and Welsh data should be fully integrated for the purposes of audit analyses, wherever possible, so that all benchmarks derive from the totality of the provider population contributing data.

## Audit outputs

Audit outputs should be tailored to meet different stakeholder, audience needs and better support local, regional and national quality improvement. Data should be made accessible, for example through infographics and interactive web tools which can be used for run charts or similar. All results produced are expected to be available in full in the public domain.

The following outputs are expected:

* Replace the annual report with an annual state of the nation summary (maximum of 10 pages and 5 national recommendations)
* Replace local recommendations with online improvement resources
* Limit the number of performance metrics to 10 per audit workstream
* Make all audit performance metric results available in as near-real time as possible in an interactive format online to all users
* Refresh all audit performance metric results at least quarterly in year two then monthly thereafter.
* Tailored reporting formats and frequencies to the requirements of each audience.
* A breakdown of analysis by ethnicity and socioeconomic deprivation to support local and national initiatives to reduce health inequalities and promote parity of care.

Tenderers should propose the level of granularity of presentation of audit data most likely to increase the impact of the audit. These may change during the contract and in consultation with HQIP, depending on the use of the data as well as changing health geographies.

Reporting should ensure that the results are benchmarked across all teams, as well as allowing easy comparison of English providers with other providers in England, and Welsh providers with other providers in Wales.

All reporting of data produced are expected to be available in full in the public domain, at named provider level, excluding any information that might make individual patients identifiable. Data at the level of granularity available in the data reporting will be made available in .csv format to data.gov.uk.

## Target audience and settings

The main audiences should be carefully targeted, and with the move towards increased support for quality improvement, so that the focus will be on teams. There will also be a need to closely engage with groups at a broader level, such as Integrated Care Systems (ICSs), Accountable Care Systems (ACSs) and/or Sustainability and Transformation Plan (STP) footprints in England, and health boards in Wales depending on the quality improvement goals set.

The following audiences should be considered whenever relevant:

* Healthcare organisations (such as Trusts and Health Boards)
* Service users and families
* Care commissioners (e.g. STPs, ICSs, ACSs, Clinical Commissioning Groups (CCGs) and regulators e.g. CQC, Health Inspectorate Wales (HIW)
* National level – NHS England and Improvement, Welsh Government and Improvement Cymru
* Relevant charities and voluntary organisations

## Designing and delivering a Healthcare Improvement Strategy

The Healthcare Improvement Strategy should:

* 1. Develop up to five specific improvement goals for the audit – these may change over time;

* 1. Include explicit, measurable ambitions/objectives for each specific improvement goal and monitor achievement against these over time;
  2. Prioritise audit measures which are underpinned by a vision of how their reporting will support these improvements;
  3. Identify the key audiences targeted to receive audit reporting and ultimately to achieve the improvement goals;
  4. Design and develop (from the outset) outputs and activities which enable each audience to contribute to improving patient outcomes;
  5. Engage with and involve local clinicians, networks, commissioners, charities, community support groups, service users, carers and families in all aspects of the audit with a view to enhancing their uses of the data for improvement;
  6. Create effective partnerships with other organisations working at local, regional and national levels.

Consideration is expected from the outset as to how the audit outputs could be used to stimulate quality improvement. Tenderers are expected to develop and articulate a Healthcare Improvement Strategy for this project at tender. This strategy will then be developed into a Healthcare Improvement plan early in the contract. The plan should normally include information on the following and how they will be resourced:

* Specific healthcare improvement goals and how these will be developed
* Methods for stimulating healthcare improvement at national, regional and local level
* Patient and public involvement
* Evaluation of healthcare improvement impact

The subsequent plan will be core to contract delivery. Evolving project design should be consistent with the plan and the improvement goals. Progress against them should be fully integrated into the project’s communications, reports and other outputs as well as being used to guide future dataset reviews. It is expected that progress against the plan will be reported to the project governance board and made publically available via the project’s website.

# Alignment with health policy, standards and guidelines

## Health policy

HQIP requires that all audits ensure their project design and data items remain aligned with, and responsive to, contemporary health policy directives.

* NHS England’s Long Term Plan (2019)

<https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>

* NHS Mental Health Implementation Plan 2019/2020 – 2023/2024

<https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf>

* Welsh Government (2010)

Review of the Together for Mental Health Delivery Plan 2019-2022 in response to Covid 19

<https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf>

## Standards and guidelines

The tenderer is expected to review the standards and guidelines below and their relevance to the project. It is expected that a regular review of standards is performed so that the project’s datasets can be updated if appropriate. Alignment of the project with the relevant aspects of the NICE quality standards and guidelines must be considered for aspects which fall within the scope of the project.

* Early Intervention in Psychosis Access and Waiting Time Standard guidance (NHS England, NICE & NCCMH, 2016) <https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf>
* Psychosis and schizophrenia in adults [QS80] (NICE, 2015) <https://www.nice.org.uk/guidance/qs80>
* Bipolar disorder, psychosis and schizophrenia in children and young people [QS102] (NICE, 2015) <https://www.nice.org.uk/guidance/qs102>
* Psychosis and schizophrenia in adults: prevention and management Clinical guideline [CG178] (NICE, 2014) <https://www.nice.org.uk/Guidance/CG178>
* Psychosis and schizophrenia in children and young people Evidence Update March 2015 (NICE, 2015) <https://www.nice.org.uk/guidance/cg155/evidence/evidence-update-pdf-188452621>

# SECTION B: Overarching requirements for the National Clinical Audit and Patient Outcomes Programme (NCAPOP)

# Organisational structure, governance and management

## Clinical leadership

Effective clinical leadership must be integral to the project delivery. In this context, clinical leadership means that individual(s) have relevant clinical expertise, appropriate experience of national project delivery, and demonstrably high professional peer authority, in order to be integral to the project’s governance to lead the project. It is essential that clinical leaders represent the specialties responsible for delivery of the care that is being reviewed; as these are the clinicians who will need to accept the findings and lead service improvements. It is required that the tenderers will include resourced, dedicated clinical time in the costings for the bid. The time and costs allocated to clinical leadership should reflect sufficient time commitment and expertise of the individual(s).

## Healthcare improvement expertise

Expertise and leadership in healthcare improvement must be available to the project from the outset and throughout the duration of the contract. This expertise may be provided by an individual who is a member of the project team or sourced through a subcontract with an individual or organisation expert in healthcare improvement. The expert will lead the development, implementation and impact measurement of the project’s Healthcare Improvement Plan, drawing on their knowledge of local healthcare provider culture, resources, and skills, and the breadth of local improvement methodologies currently in use (or lack thereof). Expertise should also include effecting improvement through regional and national approaches as well as through meaningful public and patient involvement.

## Methodologist involvement

Appropriate methodological input must be integral to the planning and delivery from the outset. Projects pose various challenges related to the definition of the patient inclusion criteria, the definition of the dataset and the robust collection of the data, including the linkage of project data to information from other databases. Methodological input is also required during the analysis and interpretation of the project findings. These individuals will have a key role in the design of the project, ensuring that it meets the requirements of the project aims and objectives.

## Statistician involvement

Appropriate statistical input is integral to the successful delivery of the project. Statistician input will be essential to the drafting and delivery of a comprehensive analysis plan which should be developed jointly with the clinical lead(s), the methodologist(s) and other experts on the team. The analysis plan must be designed to support the specific improvement goals and anticipated published comparisons, which have been identified for the project during development. HQIP will review the analysis plan alongside the project plan throughout the contract.

## Patient and public involvement

Patient and Public Involvement (PPI) refers to patients, service users, carers and families, young people and the general public. Refer to HQIP’s Patient and Public Involvement Strategy (on HQIP’s website).

HQIP adheres to seven principles of patient and public involvement:

Representation

Early and continuous involvement

Clarity of purpose

Feedback

Inclusivity

Transparency

Cost-effectiveness

Effective and meaningful PPI in the governance structure is required and the above principles should be integrated appropriately throughout every stage of the design and delivery of the work.

Ensure wherever relevant that:

1. There is appropriate PPI representation on relevant governance groups including the project board; and that resources are defined to support this
2. Service users and carers are involved in developing the tender and when defining specific project improvement goals and audit measures to ensure that they will address issues of importance to service users and carers
3. Service users and carers understand their continuing role and purpose in contributing to different stages of the project
4. Information is accessible (e.g. via a project website) to facilitate service user and carer engagement with the project throughout its lifetime
5. Service users and carers are included in the development of the project report and actively influence the format of the reporting, working towards achieving co-production and co-design of outputs and recommendations that are aimed at patients
6. Service user groups are communicated with appropriately and that effort is made to reach people and community groups who are seldom heard
7. There is transparency about how service user and carer involvement will influence project activity, e.g., there is evidence of a collaborative approach to the development of tools and resources that will support the project. Planning is in place to measure impact of PPI.

## Project governance structure and strategy

The project must be governed by a robust management structure with defined governance groups, designed to maximise effectiveness. The decision making, reporting, and accountability hierarchies must be explicit. HQIP must be included in the membership of the supplier’s highest level project governance group, normally the Programme Board. Details of the structure should be included along with any other proposed mechanisms for achieving project governance.

## Programme and project management

There should be robust programme and project management throughout the contract, ensuring that all deliverables are met on time, on budget and to high quality. HQIP’s Provider Technical Manual should be consulted throughout the contract to ensure all aspects of delivery are in line with the requirements set out by HQIP. This must include development and maintenance of a project plan.

Bidders are also required to appropriately manage risks and issues in the programme, including monitoring risks, highlighting and managing risks and issues appropriately, and supplying an updated risk/issue log.

## Editorial input

All reports must be reviewed by an individual with editorial expertise, fully quality assured and corrections made **before** the draft is submitted to commence the Standard Reporting Process (SRP) review by HQIP and funders. Timelines for report production should include an allowance for the time required to complete these tasks.

Editorial review and quality assurance includes, but is not limited to:

* Overall report structure flows clearly and logically and all references to the findings are consistent across different report sections.
* Proofreading has been completed to a high standard and errors corrected.
* Other requirements set out in the Provider Technical Manual have been complied with.

## UPCARE tool

The Understanding Practice in Clinical Audit and Registries (UPCARE) tool is a protocol to describe the key features of clinical audits and registries. Project providers are expected to maintain a publically available, dynamic and regularly refreshed UPCARE document online.

## National Clinical Audit Benchmarking

The project supplier must lead the National Clinical Audit Benchmarking for their project, in collaboration with HQIP and CQC: <https://www.hqip.org.uk/national-programmes/clinical-audit-benchmarking/>

## Sustainability beyond national funding

The project supplier must give consideration to self-sustainability and explore methods, processes, and solutions to ensure the continuation of the project after national funding has ceased.

# Data collection, IT systems and data analysis



## Assessment of equity and equality of care

HQIP aligns with the Department of Health and Social Care’s identified duty to promote equality through the health and care system, paying particular attention to groups or sections of society where improvements in health and care outcomes are not keeping pace with the rest of the population. The predicted equality and diversity impact of all project tools and patient recruitment strategies developed must be systematically reviewed and reported publically by the supplier, with associated commentary as required.

Project outputs should support local and national initiatives to reduce inequalities and promote parity of care.

## Parity of esteem

Parity of esteem is best described as: ‘valuing mental health equally with physical health’ and it is expected that the project will promote this equity through conscious design under the contract to ensure there is a holistic approach to improving the quality of care and to achieving equal status in the measurement of health outcomes.

## Local contributor requirements

The project design must take into account the workload anticipated locally during participation in the project and minimise this wherever possible. The dataset size should be the minimum required to effectively meet the requirements of the project.

The platform supplied for data entry must provide a fast, secure and user-friendly interface, with real-time data entry facilitated wherever possible. Data input by each service should be extractible locally and supported by appropriate tools to facilitate its use in relevant local activities, such as presentations, or for comparisons with other local data sources. The platform should also supply real-time relevant information for data completeness.

## Exploitation of existing data

Tenderers are expected to identify any existing data collections of relevance. Unnecessary duplication of data entry must be avoided and the provision of upload facilities from local databases or hospital patient administration systems should be considered. All efforts must be made to locate any pre-existing national data collections with overlapping datasets that might provide an appropriate source of data for the project.

Where a performance measure essential to the project’s improvement goals cannot be achieved from existing digital data collections, the additional fields required should be identified and the justification articulated clearly. All datasets and associated measures will be subject to review and sign off by HQIP on an annual basis.

## Data quality

Tenderers must illustrate how they will ensure that the highest standards of data quality and completeness, including mechanisms to check inter-rater reliability and identify missing data.

## Linkage to other databases

Tenderers must consider in detail how linkages to other national databases including HES, PEDW, and other national projects, registries and databases will be used to enhance the project. Consideration must also be given, from the outset, of the related information governance requirements for such linkage.

## Data protection and security

Comprehensive measures must be developed and implemented to mitigate the risk of loss of data. The future project supplier will be required to undertake Data Protection Impact Assessments (DPIA) on behalf of HQIP. Tenderers must be able to show a full understanding of the Data Protection Act (2018), General Data Protection Regulation (GDPR), Common Law Duty of Confidentiality (and any other relevant data protection legislation) and its relevance to project processes, as well as all other relevant security policies and legislation, and illustrate their future approach by completing a provisional DPIA as part of their tender submission. The confidentiality, integrity, availability, and resilience of processing systems and services must be ensured and so tenderers are also expected to carefully review the data security and data processing requirements reflected in HQIP’s standard contractual terms and conditions and demonstrate in their tender how these will be met.  Tenderers should note that all data processors delivering projects on behalf of HQIP are required to demonstrate appropriate security arrangements by maintaining accreditation against the Data Security and Protection Toolkit, achieving a minimum ‘good’ against all requirements, (or demonstrate compliance equivalence) and HM Government Cyber Essentials Scheme. Future project suppliers will be required to comply with data subject rights and to manage data subject requests (such as, but not limited to, access, rectification, erasure and portability) on behalf of HQIP and in accordance with HQIP policy and processes.

## Confidentiality and consent

A comprehensive information governance policy must be developed for application to this project. Tenderers must state whether any patient-identifiers will be extracted for central processing or linkage purposes and the proposed mechanism for gaining the required permissions. Where any processing is to be based on consent this must meet standards of active, informed consent, and that such consents are recorded and auditable. A data flow map is required, illustrating all planned data flows anticipated for the delivery of the project. It must include the source and destination of each dataset, the data controller, the level of patient anonymity of the dataset (identifiable/ pseudonymised/anonymised) and the legal basis for each data processing activity. This must be provided at tender (as specified in Schedule B) and must be updated and shared with HQIP throughout the contract).

# Communications, reports and change initiatives



## Accessible digital content

It is expected that suppliers of national audit and clinical outcome programmes commit to making their digital content accessible. This means making content and design clear and simple enough so most people can use it without adaptation, while supporting others as needed. We expect suppliers to comply with UK government requirements for public sector organisations.

Your website or app will meet these public sector requirements if it:

1. Complies with the [Web Content Accessibility Guidelines](https://www.gov.uk/service-manual/helping-people-to-use-your-service/understanding-wcag-20) (known as WCAG 2.1). These are an internationally-recognised set of recommendations for improving web accessibility. They explain how to make digital services, websites, and apps accessible to everyone, including users with impairments to their:

* Vision - like severely sight impaired (blind), sight impaired (partially sighted) or colour blind people
* Hearing - like people who are deaf or hard of hearing
* Mobility - like those who find it difficult to use a mouse or keyboard
* Thinking and understanding - like people with dyslexia, autism or learning difficulties.

1. Works on the most commonly used [assistive technologies](https://www.gov.uk/service-manual/technology/testing-with-assistive-technologies), including screen magnifiers, screen readers and speech recognition tools
2. Includes people with disabilities in [user research](https://www.gov.uk/service-manual/user-research)

More information is available online at: [www.gov.uk/guidance/accessibility-requirements-for-public-sector-websites-and-apps](http://www.gov.uk/guidance/accessibility-requirements-for-public-sector-websites-and-apps)

## Communications plan

Comprehensive information about the project including the commissioning body, project aims and objectives, design, geographical cover, timelines, and project tools / data set (including terms and conditions of their use) must be publically accessible via a dedicated section of the supplier’s website, with links wherever possible from relevant stakeholders’ websites.

A comprehensive communications plan will form part of the project delivery and must be provided for review by HQIP during the early stages of the contract. Dissemination of project results are expected to be to the full range of interested parties including clinical service providers; service commissioners; patients, carers and the public; policymakers and regulators. Dissemination should take place through a variety of formats and activities appropriate to the needs of the target audience. The interpretation of the project results for all reports must reflect the same integral clinical leadership, methodological/statistical input and patient and public involvement as other stages of the project, to ensure the data can be used by the clinical community for healthcare improvement and remains grounded in the needs of the patients.

All reports produced under this contract must be publically accessible unless they are reporting pilot or developmental work. Adaptations may be required to remove the risk of patients being individually identifiable. Findings and recommendations should be accessible to all relevant audiences.

All national comparative reports will be subject to HQIP’s Standard Reporting Procedure (SRP). Early in the contract, a progress report may be relevant rather than publication of comparative data, and in this case the requirement to follow the SRP may be waived.

National Clinical Audit Benchmarking must be included within the communications plan.

## Professional audiences

It is expected that the project supplier will ensure that comparative data are presented to the relevant professional and commissioning groups in a timely manner and via a format which is informative and appropriate to the needs of the group concerned. Each unit’s data should be extractible locally and supported by appropriate tools to facilitate its use in relevant local activities such as for presentations or for comparisons with other local data sources.

## Public audiences

The needs of patients and the public must be fully assessed and appropriate activities undertaken. Any public reports containing project results should be made available in a public-friendly format. Additionally, project data in the public domain is expected to be made available to relevant organisations.

## Management of outliers

For all NCAPOP projects, it is expected that the latest HQIP guidance on the detection and management of outliers will be adopted for organisations located in England, and equivalent Welsh Government guidance adopted for Welsh participants. Should an alternative approach be considered, the reasons and details should be fully explained by the Tenderer.

## Cause for concern

For all NCAPOP projects, it is expected that the latest HQIP guidance on the identification and management of cause for concern in National Clinical Audits and Clinical Outcome Review Programmes in England and Wales will be followed and the projects will each produce and apply their own policies in line with this.

## Requirements specific to contracts covering Wales

Welsh Language Provision

Welsh translation should be achieved for any NCAPOP-commissioned document designed to elicit a direct response from a patient or carer in Wales, or designed to support that direct response. This includes consent materials, questionnaires, and patient information sheets. These should be publically accessible on the project website.

Reporting requirements for Wales

1. Annual reports and other summary outputs should normally include data for both England and Wales so that both nations benefit from wider benchmarking; if there is a specific reason for a separate report of Wales-only data, this should be discussed and agreed with HQIP
2. Performance indicators and other measures that report a full cohort mean/median, should also report England-only and Wales-only figures wherever possible
3. Where individual healthcare providers are benchmarked, English and Welsh providers should appear in a separate list or section of the table
4. Recommendations should be checked for their applicability in Wales and be clear if applicable only one nation.

# Uses of the data



## Incorporation in NHS outcomes framework, quality accounts and on data.gov.uk

The programme is expected to align where appropriate with the NHS Outcomes Framework and the Clinical Commissioning Group (CCG) Outcomes Indicators, including the collection of data for relevant Framework Indicators and/or contributing to the development of new Framework Indicators if required.

Where relevant, projects may be requested to flow data to support other publically funded reporting mechanisms, such as data dashboards, to support commissioning and to gather information on quality and outcomes from a variety of sources.

In addition, participation rates and patient recruitment rates (at the level of granularity by which they appear in the annual reports) will be made available to HQIP in accordance with the Standard Reporting Procedure to facilitate inclusion in Quality Accounts. CSV versions of data, once published, are also required to be made available via the supplier’s website under the government’s transparency agenda for inclusion on the Data.gov.uk website.

## Synergies between the project and other national initiatives

Through the provision of analysed data, information and support, and in accordance with any relevant information governance permissions, it is expected that the project will also directly contribute to:

1. Getting It Right First Time (GIRFT): <http://gettingitrightfirsttime.co.uk/>
2. National Clinical Audit Benchmarking: the project supplier must lead the National Clinical Audit Benchmarking (NCAB) for their project, in collaboration with HQIP and CQC: [http://www.hqip.org.uk/national-programmes/clinical-project-benchmarking/](http://www.hqip.org.uk/national-programmes/clinical-audit-benchmarking/)
3. Model Health System (Model Hospital): <https://model.nhs.uk>

NCAPOP data are increasingly being included in the Model Health System dashboards which increases the reach and impact of the data. Early pilots have been successful and wider rollout is anticipated. The supplier is expected to work collaboratively at HQIP’s request wherever possible to enable this.

And where requested and agreed:

1. NHS England RightCare programme: <https://www.england.nhs.uk/rightcare/>

## Revalidation of professionals

HQIP supports the expectation that individual clinicians can use project data as part of their revalidation portfolios.

## Regulation of organisations

The project supplier will be required to make available aggregate data for regulatory and improvement bodies e.g. the Care Quality Commission and Healthcare Inspectorate Wales, subject to appropriate data sharing agreements. The supplier needs to take account of the methods by which regulators, such as CQC, utilise the project outputs to deliver on their obligations.

## International comparisons

It is expected that the supplier will take into account the potential for ongoing international comparisons of care quality and form appropriate links with those developing and leading relevant overseas projects if appropriate.

## Research

HQIP encourages the use of the data for epidemiological studies and health services research. Such requests must be the subject of an appropriate data sharing agreement and information governance support.

1. <https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-clinical-audit-of-psychosis/cypmheipsurvey2021> [↑](#footnote-ref-2)
2. The Standard states that more than 50% of people with first episode psychosis should be treated with a NICE-approved care package within two weeks of referral. [↑](#footnote-ref-3)
3. E.g. Using the Health of the Nation Outcome Scale (HoNOS)/HoNOS for Children and Adolescents (CA), DIALOG, Questionnaire about the Process of Recovery (QPR). [↑](#footnote-ref-4)