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| **Maternal Newborn and Infant Clinical Outcome Review Programme** |
| **Specification** |

**Internal Ref:** NCA 2141

Table of contents

[1 Introduction 5](#_Toc96418868)

[1.1 HQIP and the National Clinical Audit and Patient Outcomes Programme 5](#_Toc96418869)

[1.2 Specification development 5](#_Toc96418870)

[1.3 Contract opportunity 5](#_Toc96418871)

[1.3.1 Potential future aspirational intent 5](#_Toc96418872)

[1.3.2 Contract transitions 6](#_Toc96418873)

[1.4 Aims and objectives of a national clinical outcome review programme 6](#_Toc96418874)

[2 Scope of the project 7](#_Toc96418875)

[2.1 Background and need for the programme 7](#_Toc96418876)

[2.2 Improvement aims and objectives of the project 7](#_Toc96418877)

[2.3 Population inclusion criteria 8](#_Toc96418878)

[2.3.1 Healthcare providers and service users 8](#_Toc96418879)

[2.3.2 Geographical coverage 8](#_Toc96418880)

[2.4 Programme components 8](#_Toc96418881)

[2.4.1 Surveillance of all maternal deaths 8](#_Toc96418882)

[2.4.2 Confidential enquiries of maternal deaths 8](#_Toc96418883)

[2.4.3 Confidential enquiries of serious maternal morbidity 8](#_Toc96418884)

[2.4.4 Perinatal mortality surveillance 8](#_Toc96418885)

[2.4.5 Confidential enquiries of perinatal mortality and morbidity 9](#_Toc96418886)

[2.4.6 Patient Reported Outcome and Experience Measures 9](#_Toc96418887)

[2.4.7 Call for topics 9](#_Toc96418888)

[2.5 Use of routine data and data linkage 9](#_Toc96418889)

[2.6 Outputs 10](#_Toc96418890)

[2.7 Target audience and settings 11](#_Toc96418891)

[2.8 Alignment with health policy, standards and guidelines 11](#_Toc96418892)

[2.8.1 Related documents 11](#_Toc96418893)

[2.8.2 Related national initiatives 12](#_Toc96418894)

[3 Organisational structure, governance and management 12](#_Toc96418895)

[3.1 Project governance structure and strategy 12](#_Toc96418896)

[3.1.1 Independent advisory group (IAG) 12](#_Toc96418897)

[3.2 Project technical team 13](#_Toc96418898)

[3.2.1 Clinical leadership 13](#_Toc96418899)

[3.2.2 Healthcare improvement expertise 13](#_Toc96418900)

[3.2.3 Methodology expertise 13](#_Toc96418901)

[3.2.4 Statistical expertise 13](#_Toc96418902)

[3.2.5 Programme and project management 14](#_Toc96418903)

[3.2.6 Editor 14](#_Toc96418904)

[3.3 Engaging and involving patients, carers and the public 14](#_Toc96418905)

[4 Healthcare quality improvement 15](#_Toc96418906)

[4.1 Healthcare improvement plan 15](#_Toc96418907)

[4.2 Assessment of equity and equality of care 16](#_Toc96418908)

[4.3 Parity of esteem 16](#_Toc96418909)

[5 Dataset design and performance metrics 16](#_Toc96418910)

[5.1 Datasets 16](#_Toc96418911)

[5.2 Metrics/measures 16](#_Toc96418912)

[5.3 Data accessibility 17](#_Toc96418913)

[5.4 Management of outliers 17](#_Toc96418914)

[5.5 Cause for concern 17](#_Toc96418915)

[6 Data collection, IT systems and data analysis 18](#_Toc96418916)

[6.1 Participation and case ascertainment 18](#_Toc96418917)

[6.2 Data capture and data flows 18](#_Toc96418918)

[6.3 Data quality 18](#_Toc96418919)

[6.4 Exploitation of existing data 19](#_Toc96418920)

[6.5 Linkage to other databases 19](#_Toc96418921)

[6.6 Data protection and security 19](#_Toc96418922)

[6.7 Confidentiality and consent 19](#_Toc96418923)

[7 Communications, reports and change initiatives 20](#_Toc96418924)

[7.1 Programme information webpages 20](#_Toc96418925)

[7.2 Accessible digital content 20](#_Toc96418926)

[7.3 Communication plan 20](#_Toc96418927)

[7.4 UPCORP tool 21](#_Toc96418928)

[8 Requirements specific to contracts covering devolved nations 21](#_Toc96418929)

[8.1 Welsh language provision 21](#_Toc96418930)

[8.2 Reporting requirements for devolved nations 21](#_Toc96418931)

[9 Uses of the data 22](#_Toc96418932)

[9.1 Incorporation in national outcomes/indicator frameworks and quality accounts 22](#_Toc96418933)

[9.2 Synergies between the project and other national initiatives 22](#_Toc96418934)

[9.2.1 National Clinical Project Benchmarking 22](#_Toc96418935)

[9.2.2 Getting It Right First Time (GIRFT) 22](#_Toc96418936)

[9.2.3 Model Health System (Model Hospital): 22](#_Toc96418937)

[9.2.4 NHS England RightCare programme 22](#_Toc96418938)

[9.2.5 Data.gov.uk 22](#_Toc96418939)

[9.3 Revalidation of professionals 23](#_Toc96418940)

[9.4 Regulation of organisations 23](#_Toc96418941)

[9.5 International comparisons 23](#_Toc96418942)

[9.6 Research 23](#_Toc96418943)

[10 Sustainability beyond national funding 23](#_Toc96418944)

[11 Contract deliverables 23](#_Toc96418945)

# 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, the Welsh Government and in some cases other devolved authorities.

## Specification development

In order to develop a specification, HQIP consulted with key stakeholders through a specification development meeting (SDM) on 6 December 2021. The resulting specification takes account of trends in the feedback, along with funder priorities.

## Contract opportunity

The contract will initially be delivered for NHS-funded care in England, Wales, Scotland, Northern Ireland, Jersey, Guernsey and Isle of Man for a period of three years, with a break clause after one year of operation (notice to be provided 3 months in advance if exercised). The maximum total budget is up to £2,670,000 GBP excluding VAT. Bids exceeding this limit will be rejected. There is potential to extend the contract for up to two additional years. Any contract award will include payment linked deliverables.

### Potential future aspirational intent

The future aspirational intention of this opportunity is to potentially include:

* Different topics
* Combining NCAPOP projects/programmes, including alignment across the programme, and/or joint working with other similar NCAPOP programmes for example any system wide desire to potentially join maternity and child health programmes together
* There may be a desire to introduce alignment in the delivery of maternity & perinatal audits and clinical outcome review programmes, in keeping with the Department of Health and Social Care (DHSC) and NHSEI policy. HQIP reserves the right, subject to agreement with the supplier, to add additional maternity and / or perinatal topics to this contract or to request a change of topic (e.g. combining MNI CORP with the Perinatal Mortality Review Tool (PMRT)). These may include topics previously commissioned under separate HQIP contracts, or other maternity & perinatal or related topics
* Transitioning to different models of data collection and operational methods for the programme, e.g. different sources of routine data
* Devolved nations/authorities in the UK, Channel Islands or Isle of Man that do not currently participate
* 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 million GBP excluding VAT.

### Contract transitions

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 30 September 2022.Anticipated transition activities are not listed in this specification. Suppliers are invited to explain clearly and comprehensively how they would meet the scope of work described in this specification, excluding specific transition activities.

## Aims and objectives of a national clinical outcome review programme

Clinical Outcome Review Programmes (previously known as confidential enquiries) are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers and policy makers to learn from adverse events and other relevant data. The programmes aim to complement and contribute to the work of other agencies such as National Institute for Health and Care Excellence (NICE), the Care Quality Commission (CQC), the Royal Colleges and academic research studies with the aim of supporting changes that can help improve the quality and safety of healthcare delivery.

Clinical outcome review programmes are expected to:

1. Assess the quality and safety of health services
2. Better understanding and reporting on the causal pathways to serious morbidity and death, so as to identify remedial factors and routes to prevention
3. Support improvements in service quality through local and national learning
4. Produce evidence-based recommendations and good practice points
5. Influence clinical practice, commissioning, service provision, policy and education by helping understand opportunities to improve outcomes for patients
6. Achieve and maintain close alignment with relevant national guidelines and quality standards throughout the programme, as appropriate
7. Ensure robust methodological and statistical input at all stages
8. Identify from the outset the full range of audiences for the reports and other programme outputs, and plan and tailor them accordingly
9. Utilise strong and effective project and programme management to deliver programme outputs on time and within budget
10. Develop and maintain strong engagement with local clinicians, networks, commissioners, parents and their families and carers and charity and community support groups in order to drive improvements in services

# Scope of the project

## Background and need for the programme

In the UK, maternity care is generally safe and the majority are not affected by serious mortality or morbidity. However, when things go wrong, the impact is devastating and the death of a mother or baby during pregnancy, at birth or after birth, is a life-changing event for the whole family.

About 720,000 women give birth each year in the UK of which approximately 200 women will die as a ‘direct’ result of pregnancy complications or a condition exacerbated by their pregnancy (‘indirect’ mortality). Although maternal mortality in the UK is now at the lowest rate since records began (1847), the maternal mortality rate in the UK exceeds that of many European counterparts.

With regards to perinatal mortality (stillbirths and neonatal deaths up to 28 days) there were over 3,500 stillbirths and neonatal deaths in the UK in 2019, affecting 10 families across the UK every day. Perinatal mortality has reduced by 18% since 2013, equivalent to approximately 770 fewer deaths in 2019. However despite this, babies born to women with health inequalities continue to have an excess risk suggesting that there is room for improvement.

Further details of the current programme can be found at <https://www.npeu.ox.ac.uk/mbrrace-uk>.

## Improvement aims and objectives of the project

The MNI CORP quality improvement aims are to:

1. Reduce maternal and perinatal mortality rates at both Trusts/Health Board and national levels, particularly for groups with health inequalities (non-white, <25 years and >35 years of age, lower socio-economic deprivation quintiles), to meet the national ambitions[[1]](#footnote-2).

2. Improve the care and service delivery for women and people, their babies and families, by assessing whether high quality care is delivered when measured against adherence to agreed guidance and standards.

3. Support Trusts/Health Boards by providing data to support local quality improvements activities.

4. Encourage the implementation of best practice by contributing to guidelines and contract specifications development (e.g. NICE, Royal Colleges and Specialist Associations).

The successful provider will work with commissioners and funders to create a coherent strategy for how the improvement aims listed above, or similar, will support organisations to try and achieve them.

The overarching quality improvement objectives are to:

• Improve quality of care by identifying areas for action in relation to delivery and outcomes, and adapting QI priorities in line with evidence and guidance

• Reduce variation through benchmarking of perinatal mortality rates

• Measure health inequality in relation to impact on the specified measures

• Share best practice and QI examples, and signposting to resources available in the wider maternity landscape

## Population inclusion criteria

### Healthcare providers and service users

All maternal and perinatal deaths are to be included in the programme including home births, deaths in the community, deaths in independent providers or after treatment in an independent provider. However independent providers are not included in the comparative outputs (i.e. there is no expectation to provide independent providers with data on deaths in their organisation).

### Geographical coverage

* England
* Wales
* Scotland
* Northern Ireland
* Jersey
* Guernsey
* Isle of Man

## Programme components

### Surveillance of all maternal deaths

The supplier will continue the collection of surveillance data on all maternal deaths up to one year from end of pregnancy including direct and indirect deaths[[2]](#footnote-3). This involves the identification and notification of all eligible deaths and the timely collection of a limited and tightly defined demographic and clinical dataset. The goal is to identify how many maternal deaths occur, to understand the underlying causes of death and associated factors, and to recommend actions for improvement.

### Confidential enquiries of maternal deaths

Suppliers will conduct a systematic case record review process of all direct and indirect maternal deaths up to one year from end of pregnancy. This will be underpinned by a robust confidential enquiry process which includes selection of reviewers and anonymised review of case records. The goal is to detect areas of deficiency in clinical practice, identify remedial factors and provide suggestions for improvement. This process should take into account burden on the system and consider ways in which to reduce data burden, in particular through the use of electronic patient records.

### Confidential enquiries of serious maternal morbidity

The supplier will conduct a systematic case record review process of a serious maternal morbidity topic following a process similar to that described in 2.4.2.

### Perinatal mortality surveillance

The programme will continue the collection of surveillance data on perinatal mortality. This will include late fetal losses (22-23 weeks’ gestation), stillbirths (24+ weeks’ gestation) and neonatal deaths (up to 28 days after birth). Suppliers will support the identification and notification of all eligible deaths and the collection of demographic and clinical data in order to enable analysis of trends (e.g. number and causes of deaths) and contributing factors as well as timely comparative reporting.

The supplier should also explore ways of including late neonatal deaths e.g. using an adjusted age of 44 weeks gestation or deaths up to discharge from hospital care. A decision regarding the inclusion of this group of babies will be made between the supplier, HQIP and the funders.

It is anticipated that the supplier will utilise the risk adjustment strategy of the current programme in order to allow for meaningful comparison to previous results and information. This information can be found in the [Perinatal Mortality Technical Document](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2019/MBRRACE-UK_Perinatal_Surveillance_Report_-_Technical_document.pdf). Other approaches may be considered but this will need to be justified and approved by HQIP.

### Confidential enquiries of perinatal mortality and morbidity

The supplier will conduct a systematic case record review of stillbirths, infant deaths and cases of serious infant morbidity following process similar to that described in 2.4.2. The following topics have already been agreed for the next two publications:

* Black and Black British whose babies are stillborn or neonatal deaths
* Asian and Asian British whose babies are stillborn or neonatal deaths.

### Patient Reported Outcome and Experience Measures

The experience across the NCAPOP is that Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) are a valuable source of information on the quality of care, but knowledge remains limited on how best to incorporate these measures alongside clinician-reported data. PROMs and PREMs are therefore not currently commissioned as a standard aspect of delivery, but where validated tools exist and their inclusion can be achieved within budget, these measures may be considered. Where they are included, there is a need to be clear from the outset how these measures have been validated appropriately and how they will be used for improvement.

### Call for topics

The supplier will undertake a process to agree topics for the confidential enquires outlined in 2.4.2, 2.4.3 and 2.4.5. This will be annually for maternal related topics for study and bi-annually (twice a year) for perinatal related topics. This should be a pro-active activity, with direct engagement with stakeholders (maternity services, clinicians, policy makers, funder maternity teams, royal colleges and specialist societies) to solicit robust and clinically relevant possible topics. This will include running a call for topics beyond the period of this tender opportunity as topics are normally selected approximately 2 years in advance of the expected report date. Selection of topics is carried out using a designated prioritisation process and approved by the funding bodies.

## Use of routine data and data linkage

The programme should align with current and forthcoming national guidance and quality standards of best practice. To avoid burden on the healthcare system the programme will use routine data (e.g. Hospital episode statistics (HES), Maternity Services Dataset (MSDS), Scottish Morbidity Record (SMR)) where possible rather than collect bespoke data. Where data items are collected from providers / services, these must be directly aligned with the programme quality improvement intent in order to minimise collection burden.

In particular, as Maternity Information Systems, and electronic records, become more established, the supplier should explore possible ways to reduce the financial and time burden when managing data for confidential enquiries.

The supplier should also be willing to share and receive data from other organisations to reduce burden from trusts (for examples see 2.8.2).

## Outputs

The vision for this contract is to move away from producing lengthy, dense reports. The aim is to change the current reporting strategy to one that will stimulate quality improvement across the five work streams. The following outputs are anticipated:

1. A short report for each of the five work streams listed above in 2.5.1 to 2.5.5. Each report is anticipated to incorporate the following:
	1. A lay summary and infographic which should have the appropriate reading age for public facing documents
	2. Replace the long version report with a summary report. NCAPOP aims to limit this summary to approximately 20 pages and 5 national recommendations, however ~~limited~~ additional recommendations can be considered by HQIP and funders if they comply with point three below
	3. Reporting is anticipated to be annual with the exception of the perinatal confidential enquiry (2.4.5) which will report bi-annually. HQIP understands that on occasion there may be delays in preparing and publishing reports and will work with the supplier if this occurs
	4. For the maternal mortality confidential enquiry, it is anticipated that the 3 year rolling series of topics will continue however alternate reporting strategies will be considered
	5. Utilise online functionality – moving from pdf documents to more interactive web-based reports. In order to meet the needs of multiple stakeholders, the report should be constructed with multiple levels. Links can be placed within the summary report so that those wishing to have more information, such as the data in the previous longer reports, are able to do deep-dives into specific areas for more detail
	6. For the confidential enquiries, focus on reporting how the care given compares to the recommended best practice
	7. Summarise key messages and include good practice, as well as sub-optimal care
	8. Is produced in keeping with web based publication guidance[[3]](#footnote-4),[[4]](#footnote-5),[[5]](#footnote-6) (see section 7.2 for additional information)
2. Replace local recommendations with online improvement resources e.g. case studies highlighting good practice.
3. National recommendations should meet the requirements set out in the Provider technical manual[[6]](#footnote-7) and be informed by the principles of the [English Maternity Transformation Programme (MTP) CREATED SMART framework and be informed by the MTP Recommendations Registry](https://www.hqip.org.uk/wp-content/uploads/2022/02/Created-smart-and-recommendations.pdf). Where applicable, they should reference the MTP recommendations registry rather than repeating previously cited recommendations.
4. For the perinatal surveillance work stream only (2.5.4):
	1. Make results available in an interactive format online to all users. The supplier should utilise informatic techniques in order to make data presentation more interactive for example to filter the results by geographical area, organisation (region/ICS/network/unit) and case mix (demographics/ size and capability of unit) and explore the potential benefits of interactive maps
	2. Where possible, feasible and meaningful, refresh perinatal mortality surveillance metric results at least quarterly in year two then monthly thereafter

This list is not exhaustive and HQIP will work with the supplier to agree the final list of performance measures, granularity and frequency of reporting and the corresponding public accessibility. These will be developed and agreed as part of the healthcare improvement plan in year 1 of the contract (see section 4.1).

See sections 5.3, 6.2 and 8.2 for further information.

## Target audience and settings

The main audiences should be carefully targeted. There may also be a need to closely engage with groups at a broader level, depending on the QI goals set.

The following additional audiences should be considered whenever relevant:

* Care organisations (such as Trusts and Health Boards), including primary care
* Women and people, and families and those important to them (e.g. relatives)
* Care commissioners (e.g. CCGs, STPs, ICSs) and regulators
* National and regional level – e.g. NHS England & NHS Improvement, NHS Wales, Scottish government
* Voluntary, Community and Social Enterprise (VCSE) organisations whose work includes maternity and neonatal care improvement (e.g. royal colleges, specialist societies, charities such as SANDS)

## Alignment with health policy, standards and guidelines

HQIP requires that all programmes ensure their project design and data items remain aligned with, and responsive to, contemporary health policy directives. See section 9 for further information.

### Related documents

Regular review of the relevant national standards (e.g. NICE) and guidance must be considered for aspects which fall within the scope of the project including the project’s datasets.

### Related national initiatives

The supplier will be expected to work with, and / or take into account, related national initiatives such as (please note that this list is not exhaustive):

1. The Single Notification Portal (SNP) that is being developed by NHS England & NHS Improvement in order to create one notification of serious incidents, such as maternal mortality, and share data. The supplier will be expected to engage with and align with the SNP programme as it is developed.
2. The Medical Examiner process and any national mortality review process (e.g. Learning from Deaths in England) and to ensure that the programme aligns with these initiatives and data collection.
3. The Health Safety Investigation Branch (HSIB) and the planned Health Services Safety Investigations Body (HSSIB).
4. The Special Health Authority for independent maternity investigations which will be established from 2022-23.
5. In order to support the NHS to further improve patient safety, NHSEI are preparing for the introduction of a new [Patient Safety Incident Response Framework (PSIRF)](https://www.england.nhs.uk/patient-safety/incident-response-framework/), outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted. The supplier will be expected to engage with and align where possible with the PSIRF programme as it is developed.
6. The Saving Babies Lives Care Bundle.

# Organisational structure, governance and management

## 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/project board. Details of the structure should be included in the tender along with any other proposed mechanisms for achieving project governance.

Typical governance structures include:

* Accountable host senior responsible officer
* Programme/project board
* Project steering group/clinical reference group
* Project technical team
* Stakeholder group representing service users and voluntary groups, supported by patient charities

### Independent advisory group (IAG)

High level governance, assurance and oversight of the programme will be provided by an advisory group or similar group. Currently, this group is convened by HQIP and includes representation from the funding bodies for this programme, together with clinical and academic expertise. The role of the MNI-CORP independent Advisory Group (IAG) will be to offer strategic oversight, consider progress and outputs from the core work of the programme, review provider performance, consider the strategic context in which the programme operates (e.g. policy, regulation) as well as supporting key commissioning activities.

## Project technical team

### Clinical leadership

Effective clinical leadership must be integral to the planning and delivery. In this context, clinical leadership means that individuals 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 suppliers 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.

### Methodology expertise

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. HQIP’s Provider methodology manual should be consulted throughout the contract to ensure all aspects of methodology are in line with the requirements set out.

### Statistical expertise

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 HQIP Provider methodology manual should be consulted to ensure alignment with requirements set out by HQIP.

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. The approach to managing missing data or variability in the quality of data submitted to the programme must be explicit in the analysis plan and adhered to.

The analysis plan must include the use of risk adjustment as appropriate. Adjustment must be achieved using a validated method and applied by a person or group with the appropriate statistical expertise. A validated model must already be available or be able to be developed within the available resources.

HQIP will review the analysis plan alongside the project plan throughout the contract.

### 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 and Provider methodology manual should be consulted throughout the contract to ensure all aspects of delivery are in line with the requirements set out. This must include development and maintenance of a project plan.

Suppliers 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.

### Editor

All outputs must be reviewed by an individual with editorial expertise, fully quality assured and corrections made. Before any report (for example a ‘state of the nation’ report) is submitted into the Standard reporting procedure (SRP) for review by HQIP and funders it should be fully edited and quality assured. 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 output structure flows clearly and logically and all references to the findings are consistent across different report sections
* Proofreading of outputs has been completed to a high standard and errors corrected
* Other requirements set out in the Provider technical manual and Provider methodology manual have been complied with

## Engaging and involving patients, carers and the public

‘Patients and carers’ includes and is not limited to charities, service users, parents, families, women, children and young people. Refer to [HQIP’s Patient and Carer Engagement Strategy](https://www.hqip.org.uk/involving-patients/).

HQIP adheres to seven principles of patient and carer engagement:

* Representation
* Inclusivity
* Early and continuous involvement
* Transparency
* Clarity of purpose
* Cost effectiveness
* Feedback

Engaging patients and carers effectively and meaningfully 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 including:

1. Representation on relevant governance groups throughout the project lifetime including the project board; resources are defined to support this
2. Involvement in developing the tender response and when defining specific project improvement goals and programme measures
3. An agreed role and purpose for patients and carers in contributing to different stages of the project
4. A process that sets out how patients and carers can contribute to the development of all project resources and co-produce accessible outputs and key messages that are aimed at patients and carers
5. An inclusive communication and dissemination plan to support wider engagement of diverse people and communities
6. Transparent evidence of how patient and carer involvement will influence project activity with demonstrated planning in place to measure impact of engagement

# Healthcare quality improvement

## Healthcare improvement plan

The supplier must plan from the outset how the programme outputs will stimulate healthcare quality improvement. The supplier is expected to develop a Healthcare improvement plan early in the contract.

The plan should normally include information on:

* 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

Activities during the plan’s development should include, but are not limited to, the following:

1. Develop up to five specific, quantifiable improvement goals for each work stream topic– these goals may change over time
2. Include mechanisms to monitor and report achievement against these improvement goals over time
3. Identify the key audiences central to achieving the improvement goals and design from the outset, outputs and activities which enable each audience to contribute to improving patient outcomes
4. Determine the optimal frequency and granularity of reporting and the public accessibility, in keeping with specification section 2.8
5. Communicate with and involve local clinicians, networks, commissioners, charities, community support groups, patients, parents, carers and families in all aspects of the programme with a view to enhancing their uses of the programme outputs for improvement
6. Create, and make use of, effective partnerships with other organisations working on improvement initiatives at local, regional and national levels

The healthcare improvement plan will be core to contract delivery and must be submitted to HQIP for agreement by end of quarter 3, Year1 (see deliverables). Evolving project design should be consistent with the plan and the improvement goals. Progress against the plan 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.

## 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 (including the project dataset) must be systematically reviewed and reported publically by the supplier, with associated commentary as required.

The project Healthcare improvement plan and 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.

# Dataset design and performance metrics

The datasets and metrics should align to relevant current and where possible forthcoming national guidance (including NICE) and quality standards of best practice.

## Datasets

Programme datasets should be comprehensive enough to support quality improvement and assurance, allow for adequate risk adjustment, while balancing the need to minimise local burden. Relevant patient protected characteristics (e.g. ethnicity and disability) and other information (such as socioeconomic deprivation) must be collected, analysed and reported to permit evaluation of access to services, health inequality and inequity. The reporting of audit findings should include a breakdown of analysis by ethnicity and socioeconomic deprivation.

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

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

## Metrics/measures

The measures selected should be guided by the Healthcare improvement plan for each programme work stream and should:

* Focus on outcomes of care, and include process measures only where there is an evidence-based link to outcomes
* Have a clear relationship between the healthcare improvement goals, the metrics selected and the standards and guidance must be made explicit via appropriate project information documents
* Be reviewed and as revised as necessary on an annual basis, in line with refreshes of the programme’s Healthcare improvement plan
* For the perinatal surveillance work stream only (2.4.4 above), be made available in an interactive format to all users
* Where data 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 will be subject to review and sign off by HQIP on an annual basis

## Data accessibility

Programme outputs should be tailored to meet different audience needs to best support local, regional and national quality improvement. For the perinatal surveillance work stream, only (section 2.5.4) the data should be:

1. Made accessible, for example through infographics and interactive web tools which can provide tables, run charts, Statistical process control (SPC) charts or similar
2. Allow users to choose services or other comparisons as benchmarks relevant to them
3. Some or all outputs to be available via a data visualisation platform which is freely accessible in the public domain
4. If, in addition, service providers need to view their own data at a more granular level that is potentially disclosive, these views can be made available with suitable access controls
5. Reporting should ensure that the results are benchmarked across all providers, as well as allowing easy comparison of English providers with other providers in England and devolved nations providers with other providers in the devolved nation
6. Online healthcare improvement resources must be available to accompany the data and support healthcare providers and other audiences to make best use of the data for patient benefit. These may include improvement toolkits, case studies, vignettes, useful links and outputs to empower patients and the public to use the data to understand and self-advocate for their own care

## Management of outliers

For all NCAPOP projects, it is expected that the latest [HQIP guidance](https://www.hqip.org.uk/outlier-management-for-national-clinical-audits/#.YRYy04hKiUk) on the detection and management of outliers will be adopted, where applicable, 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 supplier. This will only apply for perinatal mortality surveillance (2.4.4).

## Cause for concern

For all NCAPOP projects, it is expected that the latest [HQIP guidance](https://www.hqip.org.uk/resource/identification-and-management-of-cause-for-concern-in-national-clinical-audits-and-clinical-outcome-review-programmes-in-england-and-wales/#.YRYzGohKiUk) on the identification and management of cause for concern in National Clinical Projects 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.

# Data collection, IT systems and data analysis

## Participation and case ascertainment

It is expected that the programme strives for 100% participation across all elements. To influence and drive increases in participation the supplier should engage with key stakeholders, such as clinicians, commissioners and system providers. This is particularly important for elements which rely on manual data entry by clinicians. The supplier is expected, where possible, to utilise routine national data sources (e.g. hospital episode statistics (HES), Patient Episode Database for Wales (PEDW), Maternity Services Dataset (MSDS)) to ensure case ascertainment is complete.

Ascertainment methodology must be included in the analysis plan for each topic, and reported publically alongside the metrics results.

## Data capture and data flows

Suppliers should plan 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 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 and the supplier should 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:

* Simple data entry, potentially on a variety of devices to maximise usability
* Support local data providers in entering complete and good quality data; automated validation should be designed into the system as far as possible
* Minimisation of local burden through use of existing data sources, importing data from other sources
* Responsiveness to changes if the dataset requires revision, such as removing data items that are no longer clinically relevant
* 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 how they compare to their peers
* Data extraction at different health geographies to meet the needs of different stakeholders, e.g. commissioners, Trusts, Health boards

## Data quality

The supplier must ensure the highest standards of data quality and completeness, including mechanisms to identify missing data. Data completeness and quality must be actively monitored and reported. The levels of completeness required to support the subsequent analyses should be identified at the outset and all efforts made to support participants to achieve these.

## Exploitation of existing data

Suppliers 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.

## Linkage to other databases

Suppliers 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. Suppliers must be able to show a full understanding of the Data protection act (2018), UK General Data Protection Regulation (UK 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 prior to contract start date. The confidentiality, integrity, availability, and resilience of processing systems and services must be ensured and so suppliers 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.

Suppliers 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 ‘standards met’ 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 this project. Suppliers 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 (personally identifiable/de-identified/anonymous) and the legal basis for each data processing activity. This must be updated and shared with HQIP throughout the contract.

# Communications, reports and change initiatives

## Programme information webpages

Comprehensive information about the programme including the commissioning body, aims and objectives, design, geographical cover, timelines, and programme 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.

## 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. 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).

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)

## Communication plan

A comprehensive communication 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 but not limited to:

* Clinical service providers – individual clinicians and managers, teams, and their organisations (Trusts and Health boards)
* Patients, carers, relatives and the public
* Charities and voluntary organisations
* Medical Royal Colleges, specialist societies and allied health profession organisations
* Service commissioners
* Integrated Care Systems (ICS)
* Academic health science networks
* Care regulators (CQC and Health Inspectorate Wales)
* Welsh Health Specialised Services Committee
* National policymakers and commissioners including NHS England, NHS Improvement, Welsh Government, Department of Health and Social Care

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 summative / descriptive reports produced under this contract (such as the ‘state of the nation’ reports) must be publically accessible unless they are reporting pilot or developmental work. 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 Project Benchmarking must be included within the communications plan.

## UPCORP tool

The Understanding Practice in Clinical Outcome Review Programmes (UPCORP) tool is a protocol to describe the key features of clinical outcome review programmes. Project suppliers are expected to maintain a publically available, dynamic and regularly refreshed UPCORP document online.

# Requirements specific to contracts covering devolved nations

## 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 devolved nations

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

#  Uses of the data

## Incorporation in national outcomes/indicator frameworks and quality accounts

The programme is expected to align where appropriate with any national outcomes/indicator frameworks including the collection of data for relevant for 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.

## Synergies between the project and other national initiatives

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

### National Clinical Project Benchmarking

The project supplier must lead the National Clinical Project Benchmarking for their project, submitting relevant results data, working directly with HQIP and CQC: [http://www.hqip.org.uk/national-programmes/clinical-project-benchmarking/](http://www.hqip.org.uk/national-programmes/clinical-audit-benchmarking/).

### Getting It Right First Time (GIRFT)

Where the programme is also a topic included in [Getting It Right First Time (GIRFT)](http://gettingitrightfirsttime.co.uk/), the supplier is expected to work collaboratively to help align improvement approaches and enable sharing of relevant data for GIRFT reports (sharing of data subject to HQIP approval).

### Model Health System (Model Hospital):

NCAPOP data are increasingly being included in the [Model Health System](https://model.nhs.uk) 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 to enable this.

### NHS England RightCare programme

In addition to the above initiatives, the programme should engage, where requested and agreed, with the [NHS England RightCare programme](https://www.england.nhs.uk/rightcare/).

### Data.gov.uk

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.

## 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, Healthcare Inspectorate Wales and NHS Improvement, 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 submitted to HQIP data access request group process (DARG) for approval and the subject of an appropriate data sharing agreement and information governance support.

# 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.

# Contract deliverables

Contract deliverables will be agreed between HQIP and the successful bidder following contract award. These deliverables are based on a standard template which is then adjusted as needed after contract award and at the point of contracting. This ensures the final, agreed deliverables are fully aligned with the requirements of this specification as well as the detailed timelines of the project plan submitted by the successful bidder. Some deliverables will be payment-linked. The standard specification template, and information on how payment linked deliverables are applied in practice, are provided as tender documents for information via HQIP’s eTendering portal.

1. [English ambition is 50% decrease in maternal and perinatal mortality by 2025.](https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/maternity-and-neonatal-services/#:~:text=Through%20the%20Long%20Term%20Plan,serious%20brain%20injury%20by%202025.) [↑](#footnote-ref-2)
2. [Direct deaths are those “resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above” and indirect deaths are those “resulting from previous existing disease or disease that developed during pregnancy and not due to direct obstetric causes but were aggravated by the physiologic effects of pregnancy”.](https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4622#:~:text=Indirect%20obstetric%20deaths%20(or%20indirect,the%20physiologic%20effects%20of%20pregnancy%E2%80%9D.) [↑](#footnote-ref-3)
3. [Web Content Accessibility Guidelines](https://www.w3.org/TR/WCAG21/) [↑](#footnote-ref-4)
4. [Content design: planning, writing and managing content](https://www.gov.uk/guidance/content-design/writing-for-gov-uk) [↑](#footnote-ref-5)
5. [Understanding accessibility requirements for public sector bodies](https://www.gov.uk/guidance/accessibility-requirements-for-public-sector-websites-and-apps) [↑](#footnote-ref-6)
6. Bidders wishing to see the Provider technical manual, please raise a clarification question via the HQIP procurement portal and access will be provided. [↑](#footnote-ref-7)