National Respiratory Audit Programme (NRAP)

Specification

Internal Ref: HQIP NCA 2145

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1 Introduction

1.1 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.

1.2 Specification development

In order to develop a specification, HQIP consulted with key stakeholders through a specification development meeting (SDM) on 20 April 2022. The resulting specification takes account of trends in the feedback, along with funder priorities.

1.3 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 £2,748,000 GBP excluding VAT. Bids exceeding this limit will be rejected. There is potential to extend the contract for up to two additional years as referred to in section 1.3.1. Any contract award will include payment linked deliverables.

1.3.1 Potential future aspirational intent

The future aspirational intention of this opportunity includes the potential to modify the contract, without altering its overall nature, by including the following potential options:

Table 1: Aspirational intent

Reference number	Options	Description/Specification	Potential Value Range and resultant increase to the contract value	Mechanism for Invoking
1	Up to 24-month extension that mirrors the NCAPOP headline contract	Potential total of 24-months extension to the contract for a maximum term of five years	£305,333.33 - £1,832,000	HQIP may propose an extension if there is evidence that the provider has met the requirements of the specification, deliverables are met in line with requirements (section 11) and the funder agrees with an

				extension. If the provider agrees to the extension the contract shall be so amended provided that such amendment will not change the overall nature and balance of risk of the contract, and on the basis that any increase in costs is on an open-book basis, or uses the same pricing profile as in the initial contract, so as to achieve best value.
2	Inclusion of additional clinical audits and / or Clinical Outcome Review Programmes (CORP) expected to be as outlined in Annex A	As detailed in Annex A of this specification	£80,000 – £4,750,000	To commission a data set (or other methodology) in line with projects of a similar nature, the funder may wish to include the additional projects outlined in Annex A of this specification. In these circumstances, HQIP will propose amending the contract in line with the specification, and if the provider agrees the contract will be so amended provided that such amendment will not change the overall nature and balance of risk of the contract, and on the basis that any increase in costs is on an open-book basis, or uses the same

				pricing profile as in the initial contract, so as to achieve best value.
3	Transition to different models of data collection / outputs & / or operational methods / processes for the audit / CORP.	Section 6 of this specification outlines the known data models. As the programme evolves, it may become relevant to adjust the way in which this data is collected and adjust the methods/processes for routine or bespoke data.	£0-£500,000	In these circumstances, HQIP will propose amending the contract further for programme evolution, and if the provider agrees the contract will be so amended provided that such amendment will not change the overall nature and balance of risk of the contract, and on the basis that any increase in costs is on an open-book basis, or uses the same pricing profile as in the initial contract, so as to achieve best value.
4	Extending specific service coverage to include non-NHS funded care	In line with section 2 of the specification.	£10,000-£500,000	At the request of individual independent sector hospitals and/or a request from the Independent Healthcare Providers Network or other similar organisations. If the provider agrees to the extension, the contract shall be so amended provided that such amendment will not change the overall nature and balance of risk of the contract, and on the basis that any

				increase in costs is on an open-book basis, or uses the same pricing profile as in the initial contract, so as to achieve best value.
5	Additions or enhancements to the service delivery of the project	Under section 2 of this specification, the funder may require non-material changes to the scope of the project to enhance the service provision.	£10,000-£1,000,000	Funder request to be discussed with the provider. In these circumstances, HQIP will propose amending the contract further to the funder's required non-material changes, and if the provider agrees the contract will be so amended provided that such amendment will not change the overall nature and balance of risk of the contract, and on the basis that any increase in costs is on an open-book basis, or uses the same pricing profile as in the initial contract, so as to achieve best value.
6	Additional healthcare improvement initiatives either related to or linked with the project	In line with section 4, HQIP may wish to work with the provider to identify improvements to the programme as objectives change with the maturity of the programme.	£10,000-£500,000	Funder and HQIP collaboration with the provider through contract management meetings and touchpoints. In these circumstances, HQIP will propose amending the contract further to identified

				improvements, and if the provider agrees the contract will be so amended provided that such amendment will not change the overall nature and balance of risk of the contract, and on the basis that any increase in costs is on an open-book basis, or uses the same pricing profile as in the initial contract, so as to achieve best value.
7	Inclusion of additional national or international funders	Under section 8 of this specification, HQIP may amend the contract to include the addition of further Devolved Nations / Crown Dependencies / international funders and participants in the programme commissioned. The thresholds in table 2 are indicative ranges of the percentage proportion that a Devolved Nation / Crown Dependencies would add financially to the contract value. The minimum value range would relate to no aspirational intent being invoked, the higher value range would relate to all aspirational intent being invoked including a 2 year extension. This % has been calculated based upon the Barnett Formula.	£9,160-£1,969,695	Request of Devolved Nations, Crown Dependencies or other international countries. If the provider agrees to the extension, the contract shall be so amended provided that such amendment will not change the overall nature and balance of risk of the contract, and on the basis that any increase in costs is on an open-book basis, or uses the same pricing profile as in the initial contract, so as to achieve best value.

		See table 2 for Devolved Nations and Crown Dependencies. No formula, similar to the Barnett Formula, exists for calculating international % funding. International funding is currently unknown.		
8	Unanticipated changes in response to future changes in clinical standards, service delivery and national clinical policy priorities.	As part of the National Clinical Audit and Patient Outcomes Programme, this project is required to remain responsive to future changes in clinical standards, service delivery and national clinical policy priorities (See Specification Section 2.10 and Section 9). Where these can be identified at the point of tender, details are included. However, it is not possible to anticipate all future changes at the outset, and based on past experience, an additional £1,000,000 is added to the potential ceiling value	£0-£1,000,000	In these circumstances, HQIP will propose amending the contract, and if the provider agrees the contract will be so amended provided that such amendment will not change the overall nature and balance of risk of the contract, and on the basis that any increase in costs is on an open-book basis, or uses the same pricing profile as in the initial contract, so as to achieve best value.

Table 2: Devolved Nations Aspirational Intent

Devolved Nation	Indicative Percentage Contribution	Potential Value Range and resultant increase to the contract value	Mechanism for Inclusion
Scotland	8.37 – 9.11%	£76,669.20 to £1,077,713	Further to a request from the devolved nation HQIP shall propose amending the contract, and if the provider agrees the contract will be so amended provided that such
Northern Ireland	2.89 – 3.34%	£26,472.40 to £395,122	
Guernsey	0.10 – 0.11%	£9,160 to £130,130	
Jersey	0.15 – 0.16%	£13,740 to £189,280	

Isle of Man	0.13 – 0.15%	£11,908 to £177,450	amendment will not change the overall nature and balance of risk of the contract, and on the basis that any increase in costs is on an open-book basis, or uses the same pricing profile as in the initial contract, so as to achieve best value.

Please note, **there is no commitment by the Authority at this stage to include any of the above aspirational intent**. Taking this aspirational intent into account, including the possibility that a contract extension may be offered for an additional 24 months, the **maximum potential ceiling value** is £14,799,695 GBP excluding VAT.

1.3.2 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 28 February 2023. 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.

1.4 Aims and objectives of a national clinical audit

The role of a national clinical audit is to stimulate healthcare improvement through the provision of 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. Successful national audits are those where the individuals engaged with and utilising the audit results are also in a position to improve the system, and there is a shared understanding of what good care looks like.

National clinical audits are expected to:

a. Develop a robust, high quality audit designed around key quality indicators likely to best support local and national quality improvement
b. Achieve, articulate and maintain close alignment with relevant NICE national guidance and quality standards throughout the audit, as appropriate
c. 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, Integrated Care System (ICS), commissioner, multidisciplinary team (MDT), possibly consultant or clinical team level and other levels of reporting

d. Engage service users, patients, parents, carers 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
e. 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
f. Ensure robust methodological and statistical input at all stages of the audit
g. Identify from the outset the full range of audiences for the reports and other audit outputs, and plan and tailor them accordingly
h. Provide audit results in a timely, accessible and meaningful manner to support quality improvements, minimising the reporting delay and providing continual access to each unit for their own data
i. Utilise strong and effective project and programme management to deliver audit outputs on time and within budget
j. 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

2 Scope of the project

2.1 Background and need for an audit

The National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) in its current form covers two of the most common chronic conditions in the UK, which affect approx. 9 million people, and has been delivered by the Royal College of Physicians (RCP) since 2018. The programme covers the care of adults, children and young people (CYP), primary (Wales only), secondary and community (pulmonary rehabilitation) care/services. Prior to the current contract, the RCP (working with the British Thoracic Society and British Lung Foundation) led a series of national COPD related audits since 1997, and undertook the National Review of Asthma Deaths (NRAD) which reported in 2014.

The annual economic burden of asthma and COPD in the UK is estimated at £3 billion and £1.9 billion respectively which could be reduced by reducing variation in care, and NHS England's Long-Term Plan (LTP) has made the case for urgent but sustainable improvement in respiratory outcomes. NACAP has demonstrated measurable improvements in outcomes to date, however there remains significant variation in care for asthma and COPD resulting in poor outcomes and excess healthcare expenditure.

Further details of the current audit programme can be found here.

2.2 Improvement aims and objectives of the project

During this contract period, the supplier will need to build on the achievements of the audit to date and enhance the ability for the audit to be used for healthcare improvement. 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 of the audit to be implemented and improved during the period of this contract.

Subject to NHSE funding, there is an aspirational intent (see 1.3.1) to broaden the reach of the audit into primary care for England with the initial aim of focusing on CYP with asthma (see Annex A).

Suppliers should propose five clinically important, realistic and measurable (SMART) 3-year improvement aims. The audit supplier will work with commissioners and funders to create a coherent strategy for how the improvement goals will be achieved.

The supplier will:

a) **Audit Plan:** Design, pilot and implement a new **audit plan** which:
   - prioritises measuring the most important data (a minimum dataset) *as near to real-time as possible* and presents the lowest possible burden for collecting these data, e.g. by utilising routine data, or reducing duplication
   - feeds back useful, timely and regularly updated audit data findings to promote rapid local healthcare improvement
   - provides outputs (co-created with service users, parents and families) to support patients in their knowledge of the standards of care that should be available to them and how services are performing against these standards locally, regionally and nationally

b) **Healthcare Improvement Strategy:** Design and deliver a **Healthcare Improvement Strategy**, which ensures that the audit itself is designed from the outset, and developed throughout, to facilitate healthcare improvement as well as quality assurance.

2.3 Population inclusion criteria

2.3.1 Services

- Secondary care services providing care for adults with COPD and asthma and children and young people with asthma
- Pulmonary rehabilitation services for people with COPD
- Primary care services covering adults with COPD and asthma and children and young people with asthma in Wales
- N.B. Note the aspirational intent in 1.3.1 and Annex A to potentially extend the audit to cover other services in future

2.3.2 Service users

All users of the services listed above.

2.3.3 Geographical coverage

- England
- Wales

2.4 Population exclusion criteria

No exclusions from the service users outlined above.

2.5 Elements/concepts to be covered by the audit

Audit measures:

a) A degree of continuity will be essential to be able to report key longitudinal trends. However measures will need to be refined, stepped down and improved to reduce burden and aid the utility of the audit outputs.
b) Every item in the dataset must be justifiable, essential to the analysis and reporting of the audit measures, and utilised effectively.
c) The relationships between the quality measures selected and their associated standards and guidance must be clearly, precisely and explicitly described.
d) The dataset should continue to be developed and revised on a regular basis, ensuring relevance and local burden are always considered.
e) There should be careful planning to ensure there is no duplication of effort for participating units. As such, the supplier will need to investigate opportunities for reducing duplication and streamlining and work with relevant partners to create a plan to remove any duplication identified.
f) Patient, parent and family voices should be central to decision-making about what to measure
g) There should be a description of the approach taken to choosing which key measures to collect and report back to local teams. Particular areas for consideration are:
    i. mortality, readmission and quality of life metrics (for all the secondary care workstreams)
    ii. admissions with exacerbation of asthma, ICU admissions and deaths (for the children and young people with asthma secondary care workstream)
    iii. accurate diagnosis and annual key care process completion (for the primary care workstream)

2.6 Elements/concepts excluded by the audit

2.6.1 Patient Reported Outcome Measures and Patient Reported 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.

2.7 Use of routine data and data linkage

Data sourced from existing national data sources for the purposes of this contract will require the contract holder to initiate and lead on data access applications to the relevant data controller. HQIP will review and authorise all data sharing agreements but takes no other role in data acquisition. All data access and processing costs are the responsibility of the contract holder and should be included in the cost schedule.

Consideration should be given as to whether data can be provided to the audit by organisations which might have data from care providers already flowing, such as ICSs.

HQIP recognises that tenders will be developed, and the future contract delivered, during a potential period of transition in national data flows. The flows, legal gateways and access arrangements for acquisition, linkage and analysis of data for this contract may be changing, and will continue to change involving NHS

Digital. Similar changes may also impact data flows from Digital Health and Care Wales (DHCW).

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.

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. 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.

2.8 Outputs

The vision for this contract is to move away from the publication of annual reports as the main outputs, and instead move to the production of near-real time performance feedback. The annual report is expected to be replaced by an annual state of the nation summary (approximately 10 pages and 5 national recommendations). The state of the nation report is expected to be annual, however HQIP will work with the supplier to agree the final reporting dates and any subsequent alterations will be subject to HQIP approval. Other outputs are anticipated to include the following:

- Replace local recommendations with online improvement resources
- Limit the number of performance metrics to a maximum of 10 per audit workstream
- Make audit performance metric results available in an interactive format online to users
- Where possible and appropriate, refresh audit performance 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).

Suppliers should propose the level of granularity of presentation of audit data most likely to increase the impact of the audit. This is anticipated to be a combination of some or all of the following: unit, hospital, MDT, Trust/ Health Board, Integrated Care System (ICS) and national. These may change during the contract and in consultation with HQIP, depending on the use of the data as well as changing health geographies, but it is expected that there would always be at least three levels: local (e.g. hospital), regional (e.g. ICS) and national.

See sections 5.3, 6.2 and 8.2 for further information.

2.9 Target audience and settings

The main audiences, including hospital respiratory care teams, pulmonary rehabilitation teams and primary care services, should be carefully targeted and supported. NHS England and ICSs will also be particular target

audiences whose needs (including access to data) must be considered and addressed.
The following additional audiences should be considered:

- Care organisations (such as Trusts/ Health Boards)
- Patients, carers and families
- Care commissioners (e.g. ICSs) and regulators (e.g. CQC)
- National healthcare bodies (e.g. NICE)
- Relevant charities and voluntary organisations

2.10 Alignment with health policy, standards and guidelines

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

2.10.1 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. The following list captures some of the relevant standards and publications which may inform the audit (please note this list is not exhaustive).

NICE guidance	**Title**
NICE guideline [NG80] Published: 29 November 2017. Last updated: 22 March 2021	Asthma: diagnosis, monitoring and chronic asthma management
NICE guideline [NG115] Published: 05 December 2018 Last updated: 26 July 2019	Chronic obstructive pulmonary disease in over 16s: diagnosis and management
NICE guideline [NG209] Published: 30 November 2021	Tobacco: preventing uptake, promoting quitting and treating dependence
NICE Guidance. In development [GID-NG10186]. Expected publication date: November 2023 [TBC]	Asthma: diagnosis, monitoring and chronic asthma management
NICE standards	**Title**
NICE Quality standard [QS10] Published: 28 July 2011 Last updated: 04 February 2016	Chronic obstructive pulmonary disease in adults
Quality standard [QS15]. Published: 17 February 2012 Last updated: 31 July 2019	Patient experience in adult NHS services
NICE Quality standard [QS25] Published: 21 February 2013 Last updated: 20 September 2018	Asthma
NICE Quality Standard [QS92] Published July 2015	Smoking: Harm reduction
NICE Quality Standard [QS82] Published May 2015, updated December 2021	Smoking: Reducing and preventing tobacco use
NICE Quality Standard [QS43] Published 28 August 2013. Last updated: 30 November 2021	Smoking: Supporting people to stop

Other standards, guidance and useful references	**Title**
All Party Parliamentary Group (APPG) for Respiratory Health. February 2022	APPG Report: Improving Asthma Outcomes In The UK – One Year On
All Party Parliamentary Group (APPG) for Respiratory Health. November 2020	APPG Report: Improving Asthma Outcomes In The UK
All Party Parliamentary Group (APPG) for Respiratory Health. June 2014	Report on Inquiry into Respiratory Deaths

British Thoracic Society (BTS). September 2017	BTS Quality Standards for home oxygen in adults
British Thoracic Society (BTS). April 2018	BTS Quality Standards for acute NIV in adults
British Thoracic Society (BTS). June 2015	BTS Guidelines for Home Oxygen Use in Adults
British Thoracic Society (BTS). May 2014	BTS Quality Standards for Pulmonary Rehabilitation in Adults
BTS/Scottish Intercollegiate Guidelines Network (SIGN) National Clinical Guideline [SIGN158]. First published 2003. Revised edition published July 2019	British guideline on the management of asthma
BTS/ Intensive Care Society (ICS) Acute Hypercapnic Respiratory Failure Guideline Development Group April 2016	Guideline for the Ventilatory Management of Acute Hypercapnic Respiratory Failure in Adults
NHSE. January 2019	The NHS Long Term Plan
Royal College of Physicians (RCP). April 2015	Why Asthma Still Kills: National Review of Asthma Deaths (NRAD)
Welsh Government Quality Statement for Respiratory Disease (to be published Q2 2022/23)	For reference see previous Respiratory Health Delivery Plan 2018-2020

2.10.2 Related national initiatives

- NHSE Best Practice Tariff (December 2021) 2022/23 National Tariff Payment System – a consultation notice
- NHSE GIRFT (October 2021) Getting It Right First Time (GIRFT) national report on respiratory medicine
- NHSE Commissioning for Quality and Innovation (CQUIN) framework https://www.england.nhs.uk/nhs-standard-contract/cquin/ (see specific information on community acquired pneumonia CQUIN: https://www.respiratoryfutures.org.uk/features/cquin-for-community-acquired-pneumonia-returns-for-202223/)

3 Organisational structure, governance and management

3.1 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. An approved representative from each funder (usually NHS England and Welsh Government) should sit on the group which decides on audit metrics, and the ratification of metrics will be by the funders. Details of the structure should be included in 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

3.2 Project technical team

3.2.1 Clinical leadership

Effective clinical leadership must be integral to the planning and 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 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).

3.2.2 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.

3.2.3 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 by HQIP.

3.2.4 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 audit 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.

3.2.5 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 by HQIP. 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.

3.2.6 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

3.3 Engaging and involving patients, carers and the public

'Patients and carers' includes, but is not limited to, charities, service users, parents, families, women, children and young people. Refer to HQIP's Patient and Carer Engagement Strategy.

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:

a. Representation on relevant governance groups throughout the project lifetime including the project board; resources are defined to support this
b. Involvement in developing the tender response and when defining specific project improvement goals and audit measures
c. An agreed role and purpose for patients and carers in contributing to different stages of the project
d. 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
e. An inclusive communication and dissemination plan to support wider engagement of diverse people and communities
f. Transparent evidence of how patient and carer involvement will influence project activity with demonstrated planning in place to measure impact of engagement

4 Healthcare quality improvement

4.1 Healthcare improvement plan

The supplier must plan from the outset how the audit 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:

a. Develop up to five specific, quantifiable improvement goals for each audit topic– these goals may change over time
b. Prioritise performance metrics (audit measures), to a maximum of 10 per audit topic workstream, whose reporting will support these improvements. The use of driver diagrams may help with this
c. Include mechanisms to monitor and report achievement against these improvement goals over time
d. 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
e. Determine the optimal frequency and granularity of reporting and the public accessibility, in keeping with specification section 2.8
f. Communicate with and involve local clinicians, networks, commissioners, charities, community support groups, patients, parents, carers and families in all aspects of the audit with a view to enhancing their uses of the data for improvement
g. 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, Year 1 (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.

4.2 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.

4.3 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.

5 Dataset design and performance metrics

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

5.1 Dataset

The project dataset 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)

5.2 Metrics/measures

The metric/measures development should be guided by the Healthcare improvement plan for each audit topic and should:

- Focus on outcomes of care, and include process measures only where there is an evidence-based link to outcomes
- Be made available in an interactive format to all users
- Have a clear relationship between the healthcare improvement goals, the performance 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. 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 over time, in line with refreshes of the audit's Healthcare improvement plan
- Where a 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

5.3 Data accessibility

Audit outputs should be tailored to meet different audience needs to best support local, regional and national quality improvement and:

a. Made accessible, for example through infographics and interactive web tools which can provide tables, run charts, Statistical process control (SPC) charts or similar.
b. Allow users to choose services or other comparisons as benchmarks relevant to them.
c. Some or all outputs to be available via a data visualisation platform which is freely accessible in the public domain.
d. 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.
e. 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 Welsh providers with other providers in Wales
f. 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

5.4 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 supplier.

5.5 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 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.

6 Data collection, IT systems and data analysis

6.1 Participation and case ascertainment

It is expected that the audit 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)) 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.

6.2 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 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:

- 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 if they are an outlier when compared to their peers
- Data extraction at different health geographies to meet the needs of different stakeholders, e.g. commissioners, Trusts, Health boards

The merger of NHSD into NHSE is likely to impact on the design of many aspects of national NHS data capture and processing, potentially also including databases, registries and audits. The timelines for completion of the NHSD-NHSE merger are not known at the time of this procurement, nor are the precise nature of future aspirations and ambitions. The supplier would be expected to work with funders and HQIP to help develop and deliver future changes where possible.

6.3 Data quality

The supplier must ensure the highest standards of data quality and completeness, including mechanisms to check inter-rater reliability and 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.

6.4 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.

6.5 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.

6.6 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.

6.7 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).

7 Communications, reports and change initiatives

7.1 Audit information webpages

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.

7.2 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.

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

a. Complies with the Web Content Accessibility Guidelines (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
b. Works on the most commonly used assistive technologies, including screen magnifiers, screen readers and speech recognition tools
c. Includes people with disabilities in user research

7.3 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, 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 Audit Benchmarking must be included within the communications plan.

7.4 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 suppliers are expected to maintain a publically available, dynamic and regularly refreshed UPCARE document online.

8 Requirements specific to contracts covering Wales

8.1 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.

8.2 Reporting requirements for Wales

- State of the nation 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
- Performance indicators and other measures that report a full cohort mean/median, should also report England-only and Wales-only figures wherever possible

- Where individual healthcare providers are benchmarked, English and Welsh providers should appear in a separate list or section of the table
- Recommendations should be checked for their applicability in Wales and be clear if applicable only one nation

9 Uses of the data

9.1 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 audit reports) will be made available to HQIP in accordance with the Standard reporting procedure to facilitate inclusion in Quality Accounts.

9.2 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 the project will also directly contribute to:

9.2.1 National Clinical Audit Benchmarking (NCAB)

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

9.2.2 Getting It Right First Time (GIRFT)

Where the audit topic is also a topic included in Getting It Right First Time (GIRFT), 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).

9.2.3 Model Health System (formerly Model Hospital):

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 to enable this.

9.2.4 NHS RightCare programme

In addition to the above initiatives, the audit should engage, where requested and agreed, with the NHS RightCare programme.

9.2.5 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.

9.3 Revalidation of professionals

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

9.4 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.

9.5 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.

9.6 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.

10 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.

11 Contract deliverables

Contract deliverables will be agreed between HQIP and the supplier 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 supplier. 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.

Annex A:

Aspirational intent elements already identified for potential inclusion subject to confirmation of funding

Topic	Scope	Conditions when met	Budget
1) Community acuqired pneumonia CQUIN (British Thoracic Society care bundle)	To cover as a basic minimum the CAP CQUIN scheme elements for 2022-23 and any (as of yet unknown) future chanages to the CQUIN.	When the funder NHSE confirm that money is available to onboard this new workstream. Currently NHSE do not know when funding will be available. OR If funders decide to prioritise this workstream over existing work	£80-100k p.a. OR No additional budget but swapped with other audit work of equivalent budget
2) Community acuqired pneumonia secondary care workstream	Full secondary care workstream, akin to other secondary care workstreams (e.g. COPD)	When the funder NHSE confirm that money is available to onboard this new workstream. Currently NHSE do not know when funding will be available. OR If funders decide to prioritise this workstream over an existing secondary care workstream	c£200k p.a. OR No additional budget but swapped with another audit workstream
3) Primary care for children and young people with asthma (England)	Primary care data collection (via GPES extraction, or other similar primary care data extraction system for example General Practice Data for Planning and Research (GPDPR)), analysis, and reporting for CYP with asthma in England, akin to data and reporting for this element in Wales (but acknowledging there may need to be differences in the measures/data collected). *It is anticipated that the findings for children and young people will provide helpful insight to support improvements in care for adults with asthma and COPD too.*	When the funder NHSE confirm that money is available to onboard this new workstream. Currently NHSE do not know when funding will be available. OR If funders decide to prioritise this workstream over existing work	c£100-250k p.a. excluding data acquisition costs which would be paid directly by funder or commissioner OR No additional budget but swapped with other audit work of equivalent budget
4) Pulmonary rehabilitation for other disease areas such as asthma and bronchiectasis	Extend coverage of pulmonary rehab data collection and reporting to other respiratory diseases in addition to COPD	When the funder NHSE confirm that money is available to onboard this new workstream. Currently NHSE do not know when funding will be available. OR If funders decide to prioritise this workstream over existing work	£80-100k p.a. OR No additional budget but swapped with other audit work of equivalent budget
5) Comprehensive coverage of primary care for England	Extend coverage of COPD and asthma primary care data collection (via GPES extraction, or other similar primary care data extraction system for example	When the funder NHSE confirm that money is available to onboard this new workstream. Currently NHSE do not know when funding will be available.	c£100-300k p.a. excluding data acquisition costs which would be paid directly by

	General Practice Data for Planning and Research (GPDPR)), analysis, and reporting to England (the same as or similar to requirements for Wales, but acknowledging there may need to be differences in the measures/data collected).	OR If funders decide to prioritise this workstream over existing work	funder or commissioner OR No additional budget but swapped with other audit work of equivalent budget