# Understanding Practice in Clinical Audit and Registries tool: UPCARE-tool

A protocol to describe the key features of clinical audits and registries

## FAQ

**Who should complete the tool?**

This tool is designed to be completed by individuals and organisations planning and implementing clinical audits and registries. It has been specifically designed for national clinical audits and registries commissioned by the Healthcare Quality Improvement Programme (HQIP; Part of the National Health Service in England) as part of the National Clinical Audit and Patient Outcome Programme (NCAPOP), but can be adapted and used by audits and registries in other settings.

**What is the tool for?**

The tool is a protocol for audits and registries. It has been designed to provide a "one-stop" summary of the key information about how clinical audits and registries have been designed and carried out. It is expected that this will be published openly for anyone to view, and help users of audit/registry data and audit/registry participants understand the methods, evaluate the quality and robustness of the data, and find information and data that is most relevant to them. For national clinical audits and registries commissioned by HQIP, the intention is that publishing this information openly will reduce the requirement for reporting ad hoc and contract monitoring data and information to HQIP and other national agencies.

**What type of information is contained within UPCARE?**

It is intended that the responses to the tool are factual and written concisely. Where possible, documents can be embedded and hyperlinks provided if information is published elsewhere. This document is intended to be a complete account of the information for the audit or registry. Please be vigilant about keeping any links included in the document up to date so readers can access full information about the audit or registry.

This tool is not intended to be used to formally "score" the quality of the responses. The design of this tool has been inspired by reporting checklists used for clinical guidelines (e.g. AGREE[1]) and in reporting research studies (e.g. STROBE[2], SQUIRE[3]).

**Who is the intended audience for the tool?**

The information contained within the UPCARE tool will enable audit and registry stakeholders to access in one place and in a standard format key information about the audit/registry and evaluate the integrity and robustness of the audit.

Examples of audit/registry stakeholders include:

- Patients / Carers / Public / Patient representative organisations
- Clinicians / Allied health professionals / Healthcare providers / Multi-disciplinary teams / Primary, secondary and tertiary care providers
- National agencies
- Commissioners
- Healthcare regulators

[1] AGREE stands for the Appraisal of Guidelines for Research & Evaluation. See https://www.agreetrust.org/about-the-agree-enterprise/introduction-to-agree-ii/, last accessed 24 April 2018.
[2] STROBE stands for Strengthening the Reporting of Observational Studies in Epidemiology. See https://www.strobe-statement.org/index.php?id=strobe-home, last accessed 24 April 2018.
[3] SQUIRE stands for Standards for Quality Improvement Reporting Excellence. See http://www.squire-statement.org/, last accessed 24 April 2018.

## FAQ (cont'd)

**How should the responses be written?**

Please try and write responses clearly as this will help to make the tool accessible and useful. Some tips and suggestions for writing clearly include:

- avoiding technical jargon where possible
- using short paragraphs and bullet points
- using the "active" voice rather than passive
- keeping sentences short

Where information is published openly elsewhere please provide links and references rather than duplicating information that is already available

**When and how often should I complete the tool?**

The tool is intended to provide accurate and up to date information about the audit/registry, and so can be updated whenever and however frequently it is relevant to do so. For national clinical audits and registries commissioned by HQIP it is intended that the tool is updated annually, although audits can update the tool more frequently if they wish to.

Each version of the tool should include a date of publication and version number.

**Where should the completed UPCARE report be published?**

The completed tool should be published online e.g. on the website for the audit or registry.

**How was UPCARE designed?**

HQIP commission, manage and develop the NCAPOP (National Clinical Audit and Patient Outcomes Programme) under contract from NHS England and devolved nations. The work was led by HQIP who set up a Methodological Advisory Group (MAG) consisting of methodological, statistical and quality improvement experts. Meeting were held on a six monthly basis and the structure and content of the eight quality domains and their key items were agreed by the MAG. The tool was piloted by 5 programmes within the NCAPOP and re-edited in light of comments received. Other comments received by MAG members was also considered as part of the re-editing process. The final version of the UPCARE tool was signed off by the HQIP MAG and will be reviewed annually.

**IPR and copyright**

## Contents

## Domain 1: Organisational information

**1.1. The name of the programme**

(in full and if applicable, the acronym used)

National Audit of Dementia (care in general hospitals)
National Audit of Dementia (spotlight audit in community-based memory services)
NAD

**1.2. The name of the organisation carrying out the programme**

The Royal College of Psychiatrists

**1.3. Main website for the programme**

www.nationalauditofdementia.org.uk

https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia

**1.4. Date of publication and version number of the tool on your website**

November 2022 1

## Domain 2: Aims and objectives

### 2.1. Overall aim

*Note:*
*A short description of the overall aim(s) of the programme*

NAD measures the performance of general hospitals against criteria relating to care delivery which are known to impact people with dementia while in hospital.

These criteria (standards) are from national and professional guidance, including NICE Quality Standards and guidance, the Dementia Friendly Hospitals charter, and reports from the Alzheimer's Society, Age Concern and Royal Colleges.

The current round of the audit will involve extensive changes to content and methodology.

The aim is to:

- Move to more rapid and regular reporting, enabling sites to gauge the effect of local quality improvement initiatives
- Move to prospective identification of patients for sampling, to aid above
- Focus on areas where there is lower/variable performance and reduce the total number of items measured
- Introduce regular collection of feedback from patients, as well as from carers on an annual basis

188 hospitals of an estimated 203 eligible in England and Wales are registered for this round of the audit.

In 2023 we will carry out a second round of spotlight audit in community-based memory services in England and Wales

This will focus on waiting times, access to assessments, treatment and post diagnostic support for people with dementia. The reporting will update on the 2022 report which highlighted the impact of the COVID-19 pandemic on services.

### 2.2. Quality improvement objectives

*Note:*
*A list or description of the key quality improvement (QI) objectives of the programme.*
*A brief rationale for how the QI objectives were chosen. Please take into consideration evidence to support the QI objectives, including the COMET (Core Outcome Measures in Effectiveness Trials) initiative[4].*

[4] The COMET initiative, established through funding from the Medical Research Council (MRC) North West Hub for Trials Methodology brings together people who are interested in developing and applying agreed standardised sets of outcomes known as core outcome sets (COS). The COMET website states that *'These [COS] sets should represent the minimum that should be measured and reported in all clinical trials, audits of practice or other forms of research for a specific condition.' (http://www.comet-initiative.org/about/overview, accessed 24 April 2018).*COMET has an online database of projects, trials, research etc., which can be searched to identify COS in a particular health area or population. The use of COMET and COS is endorsed by

The quality improvement objectives of the programme are:

To increase the conversion of 'problems' identified through the NAD into improvement related activities (overarching)

General hospitals:

The dataset includes measures aimed at:

- Improving carer-rated quality of care (carer questionnaire)
- Reducing median length of hospital admission (casenote audit)
- Improving the assessment of delirium and pain (casenote audit)
- Increasing the availability of personal information supporting patients during their admission (mini audit included in Annual Dementia Statement)

These objectives derive from the audit standard set, aiming to reflect priorities for people with dementia and carers as well as to identify key measurable items relating to care delivery and experience.

Memory assessment services:

Dataset key measures are waiting time from referral to assessment and assessment to diagnosis. The 2022 report focussed on the impact of the COVID-19 pandemic on waiting times. QI webinars focussed on diagnosing barriers to improvement and implementing change ideas.

## Domain 3: Governance and programme delivery

### 3.1. Organogram

The organogram is appended here

### 3.2. Organisations involved in delivering the programme

*Note:*

*A list of organisations with a formal role in delivering the programme. This includes organisations which:*

- *Are contracted to carry out elements of the programme*
- *Have a formal role in governing or steering the programme*

*For each organisation list:*

- *Name*
- *Website URL if available*
- *A description of its role in the programme*

organisations such as the Health Research Authority (HRA), the National Institute for Health Research (NIHR), Cochrane Collaboration and other national and international organisations. See http://www.comet-initiative.org/ for full information (last *accessed 24 April 2018*)

**British Geriatrics Society (BGS)**

- www.bgs.org.uk
- "The British Geriatrics Society is the membership association for professionals specialising in the healthcare of older people across the UK. Founded in 1947, we now have over 3,400 members, and we are the only Society in the UK offering specialist expertise in the wide range of healthcare needs of older people. Special Interest Groups within the Society focus on specific conditions including Falls and Bone Health, Oncology, Community Geriatrics, Cardiovascular Disease, Movement Disorders, Diabetes and Dementia."
- The BGS is represented on the project steering group and provides input into the programme design and outputs."

**Royal College of Nursing (RCN)**

- www.rcn.org.uk
- "The Royal College of Nursing is the world's largest nursing union and professional body. We represent more than 435,000 nurses, student nurses, midwives and health care assistants in the UK and internationally. We are a Royal Charter body registered with the Privy Council and, because trade unionism is not our sole activity, we are on a special register of trade unions which means our rules differ slightly to other trade unions."
- The RCN is represented on the project steering group and provides input into the programme design and outputs.

**Age UK**

- www.ageuk.org.uk
- "Age UK is the country's largest charity dedicated to helping everyone make the most of later life…. We provide services and support at a national and local level to inspire, enable and support older people."
- Age UK is represented on the project steering group and provides input into the programme design and outputs.

**Alzheimer's Society**

- www.alzsoc.org.uk
- "Alzheimer's Society is a care and research charity for people with dementia and their carers. It is a membership organisation, which works to improve the quality of life of people affected by dementia in England, Wales and Northern Ireland"
- Alzheimer's Society is represented on the project steering group and provides input into the programme design and outputs.

**John's Campaign**

- johnscampaign.org.uk
- "John's Campaign has a single, simple message: no one should enforce disconnection between family carers and those who need their expert knowledge and their love."
- John's Campaign is represented on the project steering group and provides input into the programme design and outputs.

### 3.3. Governance arrangements

*Note:*
*Governance of the project should include representatives from all key stakeholders. Please describe the governance arrangements including:*

- *A list of individuals within each governance group described in the organogram (or the URL of where this information is available on the programme website)*
- *The process used for sign-off indicating that the audit or registry data/feedback/reports have been quality assured and are ready for release*
- *If available, the URL to publicly published meeting/Board minutes (e.g. by a board or steering group)*

The audit is governed by a steering group (SG) which meets 2-4 times a year. The steering group is chaired jointly by the Consultant Advisers to the project, Dr Oliver Corrado and Ms Elizabeth Swanson.
The steering group advises on all aspects of the project including:

- Standards
- Methodology
- Audit process
- Recruitment of services
- Reports and publications
- Liaison with other key bodies such as the Department of Health and Welsh Government.

A list of SG members can be found here:
https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia/r4-resources/steering-group.pdf?sfvrsn=cfd3bfea_2
The Implementation Group is responsible for delivering the programme and ensuring the quality and accuracy of the data and project outputs.
Individuals for the project implementation group are listed in the organogram under section 3.1 of this document.

### 3.4. Declarations and Conflicts of interest

*Note:*
*Evidence that declarations and conflicts of interest have been considered, declared and where appropriate, mitigated appropriately:*

- *DOI / COI process and policy outlining how DOI and potential conflicts of interest are identified and managed*
- *A web URL to the publicly published DOI/COI register for all individuals involved in the programme and where appropriate, information about how these have been mitigated*

Advisory group members are required to declare conflicts of interest and this is reviewed at each meeting – this is a standing agenda item. Signed declarations regarding conflict of interest are collected from committee members annually/when a new interest is declared, and any interests are registered. The Royal College of Psychiatrists has a standard COI policy for all committee and steering group meetings.

Data collection for national clinical audits is covered by a joint privacy notice, explaining why data is collected and how confidentiality is maintained. This can be found on the website.
Our privacy notice can be found on the following web page:
Privacy notice national audits (rcpsych.ac.uk)

## Domain 4: Information security, governance and ethics

### 4.1. The legal basis of the data collection

*Note:*
*A description of the legal basis for the data collection, specific to each country where the data are collected. Examples include:*

- *Informed consent*
- *Section 251 (NHS Health and Social Care Act 2006) approval*
- *Other types of patient controlled data permission*

*This could include links to:*

- *Consent forms*
- *Information provided to patients about participation and usage of data*
- *Further information about how patients can control the use of their data*
- *Information about ethical committee review*

NAD process data under Article 6(1)(e) of the General Data Protection Regulation (GDPR) which allows for the processing of data where this is carried out in the public interest or in the exercise of official authority vested in our data controller, HQIP.

Patient consent is not required for data collection as pseudonymised data are collected for the purposes of service improvement and aggregate data are reported. NAD operates under the ethical guidelines for clinical audit which is contained in the privacy notice on the following web page: Privacy notice national audits (rcpsych.ac.uk)

### 4.2. Information governance and information security

*Note:*
*Include:*

- *The Information Governance Toolkit score and URL to the organisation's Information Governance Toolkit Assessment Report*
- *If the IG toolkit score is less than satisfactory, indicate how the organisation is improving its security processes to achieve a satisfactory score and when the programme will be re-assessed*
- *Details of any other information governance and security accreditations achieved by the registry (e.g. ISO 27001)*

The Information Governance Toolkit (DSP Toolkit) has been submitted reference 8K304-CCQIC3

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| 8K304-CCQIC3 | THE ROYAL COLLEGE OF PSYCHIATRISTS - CCQI Cluster 3 | 21/22 Standards Exceeded | 06/07/2022 |

## Domain 5: Stakeholder engagement

### 5.1. Approaches to involving stakeholders

*Note:*
*A description of how stakeholders are involved in designing and carrying out the programme*
*Examples of types of involvement that might be listed here include:*

- *Designing the programme*
- *Selecting quality metrics*
- *Defining aims and objectives*
- *Setting priorities*
- *Collecting data*
- *Contributing to data analysis and interpretation*
- *Governance*
- *Disseminating feedback and communications*

Patients and carers are involved by:

- Representatives with experience of living with dementia or caring for someone who has dementia sit on the Steering Group which advises on all aspects of the project
- A Patient/Carer adviser with lived experience is employed on a sessional basis and attends the Implementation Group together with clinical advisers
- Development of the carer questionnaire for Rounds 3 and 4 of the audit was informed by a panel of carers and patients. Carers involved in testing the questionnaire returned comment on content and format. The carer questionnaire was revised with input from the Patient/ carer adviser and patient and carer members of the Steering Group
- Patient and carer representatives reviewed collated information from people with dementia who were asked about their preferences and priorities for giving feedback about the quality of care received in hospital. At these meetings, representatives and the project team reviewed the key domains and then developed question wording for the final questionnaire which was piloted, and then further amended after seeking further input from people with dementia from communities and backgrounds not represented in previous feedback. the final questionnaire was approved for use in R5 by the Steering Group.

Clinicians are involved by:

- Advising on measurement of evidence-based standards for the care of people with dementia
- Being involved in the design of the audit tool and audit methodology
- Interpreting the data from the audit from a clinical perspective
- Presenting key findings from the audit at conferences and events.
- Input at report write-up stage

## Domain 6: Methods

### 6.1. Data flow diagrams

*Note:*C:\Users\CHLOE~1.HOO\AppData\Local\Temp\msoE0D7.tmp (rcpsych.ac.uk)

*A data flow diagram showing each data flow into and out of the audit/registry. The diagram should indicate:*

- *What organisations are flowing data in/out of the programme*
- *What data items are within each data flow in/out of the programme*
- *The legal basis for each data flow, e.g. section 251, consent*

The data flow diagram can be found on the website under Information Governance on this page

Ref: Accessing National Clinical Audit and Patient Outcomes Programme (NCAPOP) data: Guidance for applicants and data providers (v2). Healthcare Quality Improvement Partnership (HQIP), March 2017, https://www.hqip.org.uk/wp-content/uploads/2018/03/hqip-accessing-ncapop-data-guidance-for-applicants-and-data-providers-v2.pdf, *last accessed 4 May 2018*.

### 6.2. The population sampled for data collection

People with dementia whose casenotes are audited should:

- Have a diagnosis or current history of dementia, identified through ICD10 coding |(spotlight audit) OR are identified on admission to the hospital as having dementia or concerns about cognition (audit in general hospitals)
- Have been admitted to hospital during the identification period set out in the guidance for Round 5 of audit in general hospitals

Carers completing the carer survey should

- Identify themselves as a carer, friend or family member visiting a person with dementia in the hospital
- Complete the questionnaire between during the specified data collection period

### 6.3. Geographical coverage of data collection

*Note:*
*A description of the geographical coverage of the data collection. Include details of both:*

- *geographical areas eligible for inclusion*
- *geographical areas that actually participated in data collection*

*This could include:*

- *A text description of coverage*
- *An illustration or map to visualise the coverage*
- *Summary data*
- *Links to data files containing geographical identifiers*

NAD audits services in England and Wales. General hospitals eligible to participate in NAD provide acute care to adults including older adults on more than one of their wards. For the current round 188/203 hospitals are participating.

A map showing the location of hospitals who participated in Round 4 (together with their scores) can be found here:

https://www.rcpsych.ac.uk/improving-care/ccqi/national-clinical-audits/national-audit-of-dementia/nad-reports-and-resources
Memory services eligible to participate in the spotlight audit (follow up round in 2023) will be community-based memory services in England and Wales providing assessment, diagnosis and follow up.

### 6.4. Dataset for data collection

*Note:*
*A list (or web URL to online documentation such as a data dictionary) of the items included in the data collection*
*State how the dataset chosen aligns with the QI objectives and COMET Core Outcome Sets (COS) as described in section 2.2.*

**Links to all tools for the current round of audit in general hospitals can be found here:** National Audit of Dementia Round 5 | Royal College of Psychiatrists (rcpsych.ac.uk)
**Key QI items, casenote audit:**
**1. Delirium screening and assessment**
1.1 At presentation assess people with cognitive impairment and/or dementia for recent changes or fluctuations in behaviour with may indicate delirium (CG103).
1.2 If behaviour changes are present, a healthcare professional who is trained and competent in diagnosing delirium should carry out a clinical assessment to confirm the diagnosis (CG103).
**2. Pain assessment**
2.1 Pain is assessed using an appropriate measurement or tool including self-reported pain and/or structured observational pain assessment tools (NG97).
**3. Discharge Planning initiation within 24 hours**
3.1 Principle 1: Plan for discharge from the start (NHS England: Reducing Length of Stay)
**Key QI items, Annual Dementia Statement:**
**4. Availability of personal information to support care**
4.1 Use a structured tool to assess the views and preferences, likes and dislikes, routines and personal history of a person living with dementia. (NG97)
**Key QI items, Carer questionnaire**
**5. Carer rated quality of care and communication**
5.1 The person living with dementia and their family members or carers (as appropriate) are provided with oral and written information about the condition (NG97).
5.2 After diagnosis, the person with dementia and their family members or carers (as appropriate) should be signposted to relevant support services.
5.3 People with dementia and their families/carers are recognised as partners in their care. This includes choice and control and decisions affecting their care and support whilst in hospital and on discharge. (Dementia friendly hospital charter, Partnership).
**Links to data collection tools for the spotlight audit in community-based memory services can be found here:** NAD 2020-22 (rcpsych.ac.uk)

Key QI items:

1. Time from initial referral to diagnosis (MSNAP 96.17,48 The diagnosis is given with the locally specified target timeframe, unless any further specialist assessments or investigations are required, or other circumstances cause delay. Reasons for delay are recorded and monitored Guidance: In England, the requirement is within 6 weeks of referral. In Wales, the requirement is within 12 weeks of referral. Investigations such as blood tests and brain scans would be considered routine rather than specialist).

## 6.5. Methods of data collection and sources of data

*Note:*
*A description (or web URL to online documentation) of how the data were collected and the sources of data.*
*Examples include:*

- *Online, e.g. webtool or portal*
- *Retrospective case record review*
- *Linkage to existing data sources*
- *Extracts of administrative data*
- *Surveys*
- *Extractions from electronic health records*

**General hospitals:**
Data from patient notes/health records are collected and entered by audit staff and clinical personnel within participating hospitals to a secure online platform designed specifically for the audit. Information is derived from electronic health records, other electronic systems or paper notes, depending on the systems implemented within the hospital.
Information for the Annual Dementia Statement is collected and approved by the designated audit lead and entered on to a form on the secure online platform.
Carer questionnaires are distributed by the audit lead or delegates to carers (family members/ friends/ professional carers) visiting a person with dementia in hospital during the designated data collection period, in hard copy or online link
Patient questionnaires are given to people with dementia if they are medically fit and staff have ascertained that they are prepared to give feedback about care. Members of staff or volunteers who work in patient engagement may assist patients to complete questionnaires, this should not be undertaken by staff involved in care/ treatment of the patient.
**Spotlight audit in community based memory services:**
Data from patient notes/health records are collected and entered by audit staff and clinical personnel within participating services via a form accessed from a secure online link.
Organisational information is collected and entered by audit leads (or delegates) via a form accessed from a secure online link.
Patient/ carer questionnaires for the memory services audit were given to patients and carers by staff at the services at appointments, for voluntary completion
PDFs of all data collection tools are available to download from the NAD website.

## 6.6. Time period of data collection

*Note:*
*The time period for data collection, using a start date (DD/MM/YYYY) and end date as applicable. For a continuous prospective data collection then this may only be a start date.*

General hospitals:

- Mandatory data collection period R5: 19 September 2022 – 3 January (parts one and two, 3 February-17 March (part 3) see timeline
- Flex data collection period (optional) 6 March-14 July inclusive
- Mandatory data collection period R6: September-December 2023 (exact dates tbc)

Memory assessment services:

- Spotlight audit September – December 2023 (exact dates tbc)

### 6.7. Time lag between data collection and feedback

*Note:*
*A description of the time lag between data collection and feedback to participants in the programme – try and be as specific as possible*

*If 'real time' please describe exactly what this means, e.g. monthly, daily, minute-by-minute*

*This could also include details about time intervals for the various steps between data collection and feedback/publication such as waiting for linked data to be supplied or for sign off*

General hospitals: after a 4 week period of prospective identification of eligible patients, data is entered on a sample over the following 2 months, and discharge information entered after a time lag of one month to allow for longer lengths of stay. Current timelines envisage that data cleaning and analysis will be carried out in the first 3 months of 2023 and a draft report submitted in March. Time points may be shortened over iterated phases of data collection if this proves feasible.
Memory services: services will begin submitting data in September based on a cohort of at least 50 patients whose initial point of referral to the service is January 2023. The time period allows for these patients to have completed assessment, diagnosis and post diagnostic procedures. Reporting will take place in May/ June 2024.

### 6.8. Quality measures included in feedback

*Note:*
*A list (or web URL to online documentation) of the quality measures reported by the programme*

*Provide a mapping to classify these as:*

- *Process metrics*
- *Outcome metrics*
- *Organisational/structure metrics*

*Please state what metrics are provided at trust level and how often this trust level information is made available, e.g. quarterly, 6-monthly. If 'real time' please describe exactly what this means, e.g. monthly, daily.*

This will be based on measures at 6.4 above.
Reporting is at hospital or service level.
General hospitals: raw data is available to services as soon as completed and records locked. Reporting based on mandatory data collection periods will take place in June/ July of 2023 and August 2024.
Memory services spotlight audit: reporting will take place in May 2024.

### 6.9. Evidence base for quality measures

*Note:*
*A list or description of the sources of evidence used to define the quality metrics. Examples include:*

- *Clinical guidance (e.g. NICE guidance)*
- *Clinical standards*
- *Systematic reviews*
- *Professional society recommendations*

- *Policy documents*
- *Clinical trials*

Guidance and recommendations associated with measures are shown at 6.4 above.

## 6.10. Case ascertainment

*Describe the level of case ascertainment achieved. Include links or detail for additional information about methodology.*

General hospitals – Part One data collection (total sample of patients with dementia admitted to hosptial over a 4 week period) will demonstrate case ascertainment for the partial sample - based on pilot findings, this will range from 25-100% of patients identified over the period.

Spotlight audit - It is expected that services will return information on the whole of the cohort of patients whose initial referral falls in January 2023.

## 6.11. Data analysis

*Note:*
*A description (or web URL to online documentation) of the methods of data analysis. Important considerations in the analysis of audit and registry data include:*

- *Missing data, and how these were handled*
- *Sources of measurement error and bias, and how these were addressed*
- *Methods and algorithms used for:*
    - *case mix adjustment*
    - *benchmarking*
    - *outlier detection*
    - *visualising and interpreting time series data*
- *Algorithms and statistical models used to process data*

*This might include:*

- *References for peer reviewed publications of methods used in the data analysis*
- *Links to:*
    - *analytical code*
    - *more detailed descriptions of the methods already published elsewhere*

Questions in all online forms are made mandatory to complete, or routing used to ensure that questions which are not applicable are not answered. (E.g. Where it is reported that a patient had died during admission, the form will not allow them to complete the section on discharge). Comments in the carer questionnaire are examined and any identifying information removed as they are entered. Serious incidents reported in comments which indicated an ongoing problem that the hospital should be informed about immediately, will fed back during data collection, with anonymity preserved. All comments will be fed back to participating hospitals as soon as initial cleaning is complete so that they can immediately address issues identified.

### Inter-rater reliability

Previously, the audit has asked hospitals to re-audit five casenotes from the submitted sample using a second auditor so that matching casenotes could be compared for reliability. The Project Team advised that the first five casenotes should be used for this where possible. Where this was

not possible, any five were selected. The inter-rater reliability analysis can be found on the audit's website. Scoring has not been adjusted according to inter-rater reliability results.
Five hospitals were randomly selected to take part in quality assurance visits, during which an audit clinical lead carried out a random check of 10 of the casenotes submitted for the audit. This is an additional reliability check to compare data recording and reporting between hospitals.

### Case adjustment

For previous rounds of audit, the Project Team explored the influence of sample demographics on scoring. For example, the impact of gender, age and ethnicity on scores have been examined. Comparing the unadjusted and adjusted hospital scores, the differences were very small. This meant there were no meaningful adjustments to be made and therefore, all scores were left in an unadjusted format.
This is yet to be determined for the current round of audit.
Changes made to the data
During the process of quality assuring the data received, changes may be made:

- Across all audit tools, when it is possible to confidently identify data errors in comments returned, responses will be changed, and this change recorded. Where it is not possible to identify an error with complete confidence, no change is made.
- Duplicates identified in datasets will be removed.
- Where comments show that there was no diagnosis of dementia (i.e. where a coding error had been made), casenotes will be removed.
- Where it was indicated that patients had not been admitted for the specified period (24 hours+ ) and the hospital cannot confirm a length of stay of more than 24 hours, casenotes will be removed.
- Where two answers are selected on any paper versions of questionnaires, the more moderate response option will be selected. For example, where a respondent selected both "yes, always" and "yes, most of the time", the latter will be entered onto the data collection system. This reflects the fact respondents felt unable to confidently select the more positive response option only.
- All identifying information in comments will be removed from carer/ patient questionnaires.
- Items will be removed from reporting where analysis or expert advice indicates that the data is not of sufficient quality.

Quantitative data cleaning and analysis is completed in IBM SPSS Statistics 21 by the Project Team. Qualitative data analysis is completed in Microsoft Excel using pre-agreed coding frameworks (informed by the data) and cross-checked by coders.

### Outlier policy

The outlier policy can be found here. The outlier policy is informed by the Healthcare Quality Improvement Partnership and Department of Health guidance on outliers (2011).

## 6.12. Data linkage

*Note:*
*A description of any data linkage carried out as part of the audit or registry. Include details of:*

- *Data sources*
- *Methods of linkage*
- *Evaluation of the quality of data linkage*

*If no data linkage carried out, state "No linkage performed"*
*This could include details about the impact of patient opt outs where these apply, e.g. the proportion of patients before and after opt outs are applied; changes in key characteristics of patient group following opt out such as gender, ethnicity*

No linkage performed

### 6.13. Validation and data quality

*Note:*
*A description of how data quality and analyses have been validated. Examples of validation include:*

- *Piloting and refining data collection methods and dataset changes*
- *Building in validation processes at the point of data entry*
- *Validation by clinical teams*
- *Data cleaning*
- *Statistical analyses of data quality (e.g. missing data)*
- *Validation of statistical models and algorithms*
- *Quality assurance and unit testing of analytical code*

General hospitals:

Audit tools were piloted in 20 sites across England and Wales in 2021. Online forms include mandatory questions, routing to ensure that questions which are not applicable could not be answered, and application of masks to certain questions (e.g. to ensure that the date of discharge cannot precede the data of admission).
Some of the main elements in data cleaning are described above in 6.12
Following national data collection, five hospitals are randomly selected to take part in quality assurance visits, during which a clinical adviser to the audit carries out a random check of 10 of the casenotes submitted for the audit.
Spotlight audit:
The tool used for the memory services audit has been implemented in 3 previous rounds, including a national audit (England) in 2019.

## Domain 7: Outputs

### 7.1. The intended users or audience for the outputs

*Note:*
*A list or description of the intended users or audience of feedback data produced by the programme.*
*Examples include:*

- *Clinical commissioning groups or Health Boards*
- *Specialist commissioners*
- *Trust/hospital boards*
- *Clinical teams*
- *Individual clinicians*
- *General public*
- *Patients*
- *Carers*
- *Policy makers*
- *Politicians*
- *Media*
- *National agencies*

In line with HQIP Reporting for Impact guidance, reports are designed to provide information for:

- People who receive care or provide care for someone – people with dementia and their families
- People involved in providing care – professional staff, managers and Trust Boards working in general hospitals in England and Wales
- People involved in commissioning care – NHS England, Welsh Government, clinical commissioning groups
- People who regulate care – including the Care Quality Commission, clinical audit and quality improvement professionals.

Separate reports are produced for:

- Each participating hospital or service with a comparison of key data items with local performance and a full breakdown and comparison of each item in the data set
- Hospital managers and commissioners, providing an overview of audit key messages
- People living with dementia, contain an accessible version of the key findings and recommendations, with advisory input from people with dementia represented on the Steering Group
- Welsh speakers, containing the executive summary including key findings and recommendations translated into Welsh
- Wales and NHS England regions, showing the aggregated results from services in Wales/each region compared with the total data set

### 7.2. Editorial independence

*Note.*

| *A statement about the independence of the programme in regards to the content, e.g. findings, recommendations.* |
|---|
| As an independently commissioned programme, the contents of the outputs are written by the Project Team with the advice and input of the Steering and Implementation Groups and clinical advisors who provide quality assurance and approval of all content. |

### 7.3 The modalities of feedback and outputs

*Note:*
*A description of how data are fed back to participants of the programme. Please also describe how outputs are agreed, i.e. the quality assurance process within the programme such as Board sign off.*
*Examples of types of feedback commonly used in audits and registries include:*

- *Summary written reports*
- *Comprehensive written reports*
- *Online feedback*
- *Dashboards*
- *Slide sets*
- *Data visualisations*
- *Infographics*
- *Data tables*
- *Interactive tools*
- *Maps*
- *Meetings and workshops*
- *Professional conferences*
- *Verbal feedback by a national peer*
- *Verbal feedback by a local peer*
- *Information resources for patients (e.g. NHS Choices)*
- *Data that will be adapted and synthesised by other organisations (e.g. CQC) and programmes (e.g. GIRFT)*
- *Press releases*
- *Case studies*
- *Examples of best practice*

General hospitals:
The data collection platform produces run charts, based on the date of admission, for 3 key metrics: delirium screening, delirium full assessment, and pain assessment.

Local and national reports will be produced as above.
Action planning webinar workshops were held following the conclusion of the spotlight audit. For the audit in general hospitals, these will begin to take place towards the end of data collection, to encourage hospitals to begin the process of diagnosing any problems and action planning as early as possible.

The National Report is quality assured at team level before submission to the Director and Clinical Advisers for sign off. Sign off is required before submission of the report to commissioners/HQIP.

| **7.4 Recommendations** |
| --- |
| *Note:*<br>*The programme, in making specific recommendations about how to improve the quality or safety of healthcare services should provide a web URL to any documents making recommendations to participants*<br><br>*As a general principal, recommendations should:*<br>• *be specific, action oriented, and tailored to the intended audience*<br>• *agreed and signed off through an agreed process*<br>• *reviewed (e.g. annually)*<br>• *be underpinned by evidence and be supported by data collected by the programme*<br>• *be designed to have impact* |
| A full list of recommendations can be found:<br>General hospitals: on pages 47-49 of the Round 4 report.<br>For current audit activity, national data collection completion, reporting and related recommendations are yet to take place.<br>Memory Services spotlight audit: on page 4 of the National Report |

## 7.5 Comparators and benchmarking

*Note:*
*A description or list of if/how performance is compared between healthcare providers or areas, and the benchmark against which performance is measured.*

*This should provide a high level overview of how comparisons are made using the programme data, not a detailed list of all indicators and how they are individually used to benchmark or compare performance.*

*Examples of benchmarks include:*

- *National*
- *International*
- *Regional*
- *Organisational*
- *Clinical team*
- *Individual clinician*
- *Audit/registry standards*
- *Relative benchmarks (e.g. top 10%)*
- *Temporal (e.g. changes over time)*
- *Results from randomised controlled trials*

The audit will compare performance for each individual item and for each hospital/ service against:

- Full data set (derived from all participating hospitals/services in England and Wales)
- Regional data set
- Previous rounds of audit (if applicable/ comparable)

All local reports for R4 can be seen here.

### 7.6 Motivating and planning quality improvement

*Note:*
*A short description of the approaches the programme uses to motivate and support quality improvement.*

*Programmes are not expected to provide a bespoke service to support trusts to interpret the findings or recommendations. The programme should, however, provide information in a format that is easy to digest and ready to use for the intended audience.*

*Examples of approaches include:*

- *Recommendations for action*
- *Action plans*
- *Education and training*
- *Supporting peer learning*
- *Providing positive feedback*
- *Workshops*
- *Including motivating statements as part of feedback*

The audit provides action planning templates and publishes collated information from action plans together with examples of good practice that hospitals are asked to provide.
Action planning webinar workshops were held following the conclusion of the spotlight audit. For the audit in general hospitals, these will begin to take place towards the end of data collection, to encourage hospitals to begin the process of diagnosing any problems and action planning as early as possible.

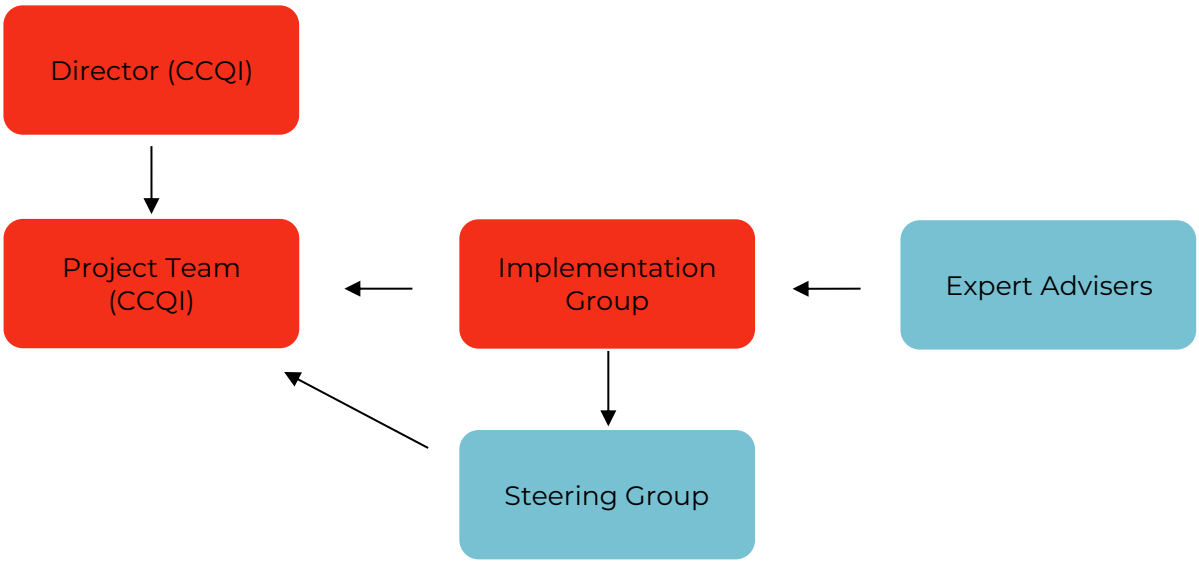
# National Audit of Dementia: Organogram 2022 (September)

**Key:**

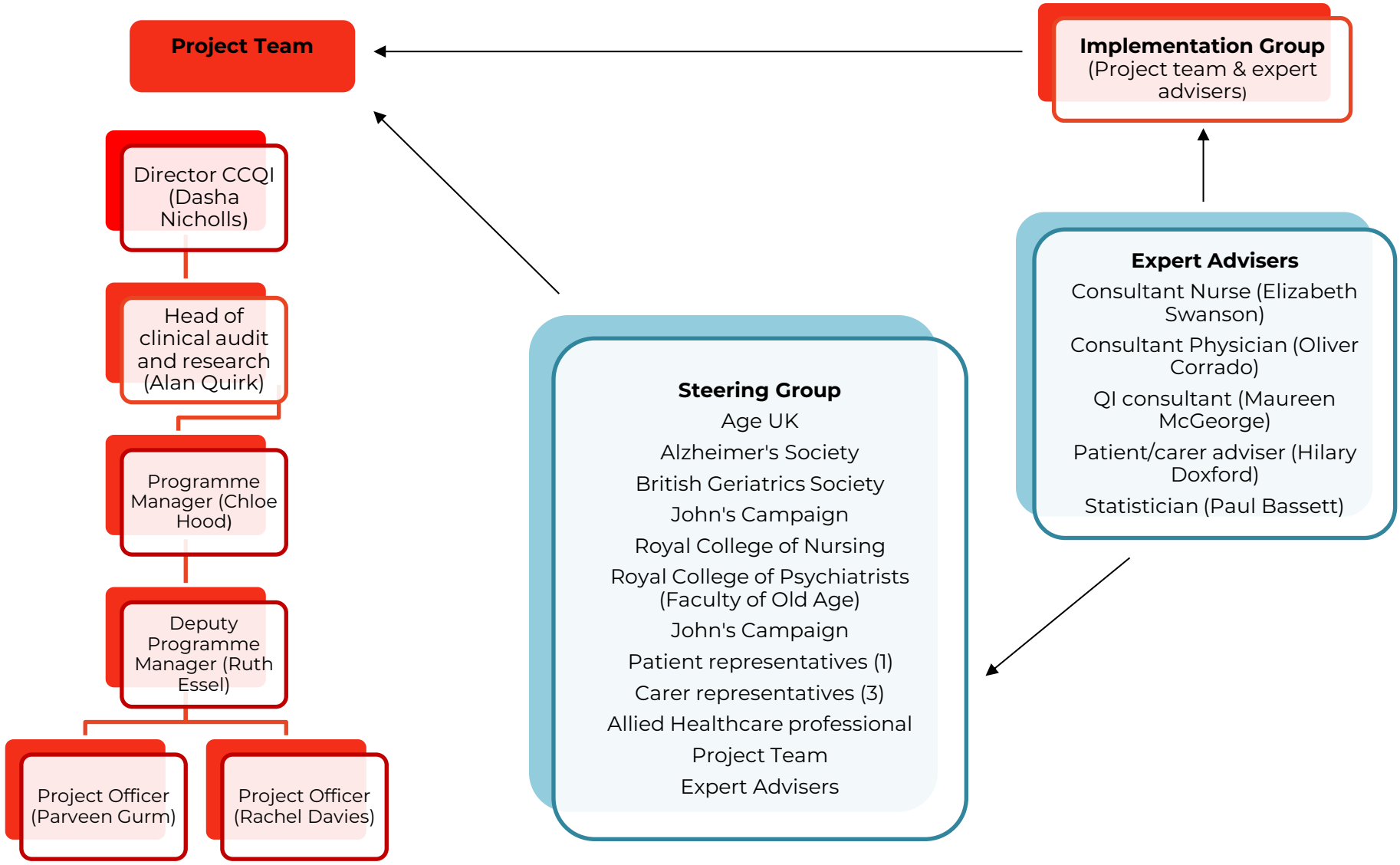
Decision making input

Advisory input

**Summary of input**



## Organogram




*See Page 3 for further explanation of roles/input*

## Audit Management and Governance

### *Decision making input*

| | |
|---|---|
| Professor Mike Crawford **Director, CCQI** | • Directs and has overall responsibility for delivery of all CCQI projects<br>• Sits on Steering Group and Implementation Group<br>• Attends Contract Review meetings |
| Dr Alan Quirk **Head of clinical Audit and research** | • Directs and supervises the work of all audits in CCQI<br>• Sits on Steering Group and Implementation Group<br>• Attends Contract Review meetings |
| **Implementation Group** Expert advisers and CCQI managers | • Coordinates expert input into audit development and operation<br>• Meets monthly during development and bimonthly otherwise |
| **Project Team** Programme Manager Deputy Programme Manager Project Officers | • Responsible for implementing the project, engagement with participants and day to day decision making<br>• Meet weekly with Dr Quirk to coordinate tasks, report on progress and anticipate and report on feasibility<br>• Provide regular updates to Implementation and Steering Groups and take forward decisions |

### *Advisory input*

| | |
|---|---|
| **Steering Group** Representation from supporting organisations representing clinicians, service users and other stakeholders, plus expert advisers and CCQI managers | • Provides advice and guidance on all aspects of the audit including recruitment and engagement, content development, communications, and reporting<br>• Meets two-four times a year throughout |
| CCQI Audit **Programme Managers** | Provide peer support and advice to audit Programme Manager and team |

### *Other*

| | |
|---|---|
| CCQI Governance Board | Chaired by Royal College of Psychiatrists President, membership includes RCPsych CEO, Dean and Clinical Lead for Accreditation<br>Provides oversight to all CCQI projects in matters of practice, ethics and methodology, e.g. approves general CCQI guidance on involvement of service users. Not involved in decision making relating to project content and delivery |