clinical audit
SUPPORT CENTRE
RAISING STANDARDS IN CLINICAL AUDIT

NCAPOP Funding Survey 2016

Background

On 30 August 2016, NHS Medical Director, Sir Bruce Keogh sent a letter to Medical Directors and Finance Directors of all NHS Trusts. The letter details significant changes to the funding arrangements for the National Clinical Audit and Patient Outcomes Programme (NCAPOP). Subsequently the Clinical Audit Support Centre (CASC) were contacted by many clinical audit staff asking for our views. As a result, we decided to set up a short anonymous and confidential online survey to gauge opinion and this ran from 26 September to 17 October 2016. This paper provides full details of the survey and all data is included for completeness. Note: CASC have no conflict of interest: we do not participate in the NCAPOP in any capacity.

Details of the survey

The survey was sent to over 1,000 members on the CASC distribution, promoted via Twitter, on the CASC website, etc. Participation in the survey was entirely optional and respondents were asked to complete the following questions:

- Your job title (optional)
- The Trust that you work for (optional)
- The type of Trust that you work for
- The letter from Sir Bruce Keogh announcing the new funding terms was sent to Trust Medical Directors and Finance Directors on 30th August. Please advise how long it took you to find out about the new proposals
- Please state how you were made aware of the new NCAPOP funding arrangements, (e.g. internal correspondence in Trust, heard from other audit colleagues, etc.)
- What is your view of the new NCAPOP funding arrangements?
- Do you have any additional comments on the new NCAPOP funding plans, for example, in terms of how they will impact on local clinical audit delivery?

Respondents

Question: Your job title

50 respondents specified their job title and 16 were Managers with 15 Heads of Department (see Appendix 1 for all job titles).

A total of 66 responses were received. 31 respondents classified themselves as ‘acute’, with 27 classifying themselves as ‘community’ [8], ‘mental health’ [8] or ‘community and mental health’ [11]. There were 8 ‘other’ responses.

Question: The type of Trust that you work for:

	Response Count	Percentage
Acute	31	47.0%
Community	8	12.1%
Community and Mental Health	11	16.7%
Mental Health	8	12.1%
Other	8	12.1%

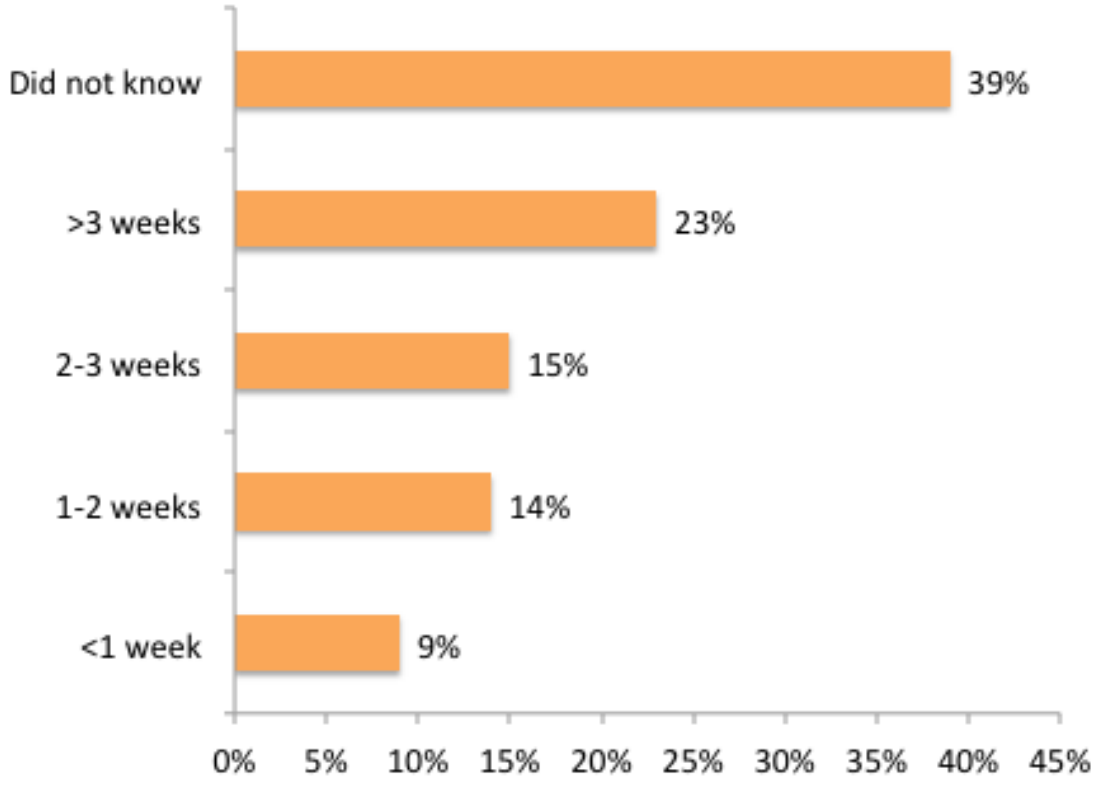
Results

Question: Please state how you were made aware of the new NCAPOP funding arrangements, (e.g. internal correspondence in Trust, heard from other audit colleagues, etc.)

Before looking at the responses to this question, it is important to supply background information. The letter from Sir Bruce Keogh was sent on 30 August and details of the survey were circulated from 26 September, i.e. 27 days after the Keogh letter.

	Response Count	Percentage
Less than 1 week	6	9.1%
1 to 2 weeks	9	13.6%
2 to 3 weeks	10	15.2%
Over 3 weeks	15	22.7%
Didn't know prior to receiving CASC survey	26	39.4%

As the results indicate, the most popular response was 'Didn't know prior to receiving the CASC survey' (39.4%). A further 22.7% were not aware of the letter within 3 weeks of its publication which means 60.1% of respondents did not know of the new NCAPOP funding arrangements within three weeks of the NHS Medical Director's initial correspondence.



Question: Please state how you were made aware of the new NCAPOP funding arrangements, (e.g. internal correspondence in Trust, heard from other audit colleagues, etc.)

60 respondents gave an answer to this question and all answers are located in Appendix 2. The most popular responses identified the following as pivotal to alerting respondents to the change in NCAPOP funding: CASC 16, 'colleagues' 8, National Quality Improvement and Clinical Audit Network 5, Healthcare Quality Improvement Partnership 4.

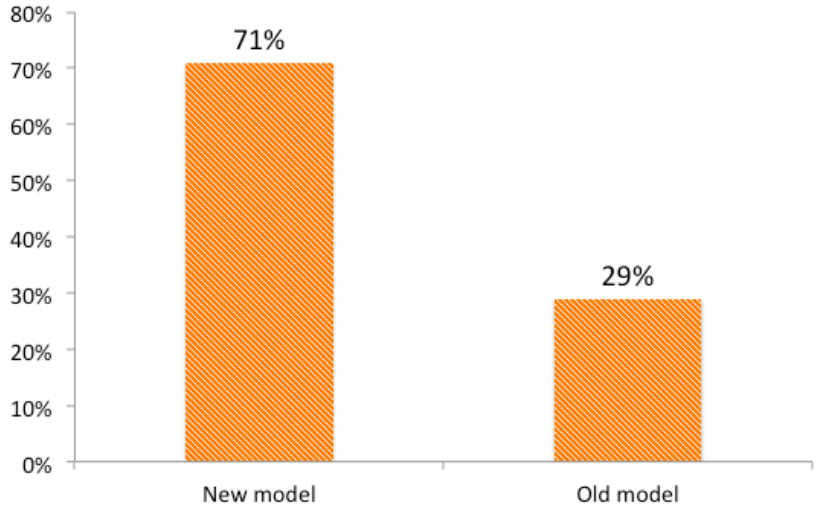
Question: What is your view of the new NCAPOP funding arrangements? N.B. Two answers were available: 'I support the new model, i.e. All Trusts pay £10,000 + VAT per year' or 'I prefer the old model, i.e. Trust charges linked to participation'.

Results are provided in the table below:

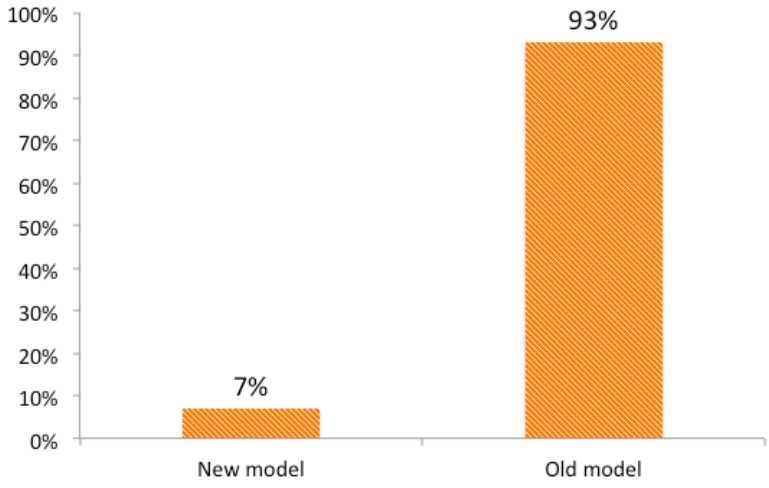
New Model [£10K + VAT fixed fee]	**Respondents [by group]**	**Old Model** [pro rata]
41%	ALL (n=66)	59%
71%	ACUTE (n=31)	29%
7%	COMMUNITY/MH (n=27)	93%

Results show that across all 66 respondents, 59% prefer the old model, compared to 41% in favour of the new model. However, when respondent results are grouped by type of Trust the results are significantly different.

The graph below shows the result for Acute Trust respondents (n=31)



The graph below shows the result for those respondents working in Community and Mental Health Trusts (n=27)



Question: Do you have any additional comments on the new NCAPOP funding plans, for example, in terms of how they will impact on local clinical audit delivery? Answers, are given by sector:

In the following section of the report we have supplied all comments in relation to the above questions. None of the comments have been altered in any way and it is clear that there is a significant difference in how respondents working in different NHS Trusts view the change to NCAPOP funding arrangements.

Acute:

- Sorry but it don't know how it will impact on the delivery of clinical audit
- It is fair that all organisations pay a standard fee. The previous model penalised large acute Trusts who were required to participate in many NCAPOP audits, rather than reward their efforts. The difference in cost can be diverted into local support for national audits which, with so many audits applicable to the Trust, can be onerous
- Do very little NCAPOP audits as specialised organisation. Will be a big hit if paying standard charge with no outcome
- If trusts further specialise under the STPs, there will need to be consideration in a varied module so those trusts with few services that are nationally audited can pay a smaller rate
- As a small trust we receive a small income - proportionate to the care provided - this new methodology for funding disadvantages us in that a much higher proportion of our overall income is then set towards this. Also our internal model is that the specialty that the audit relates to funds that audit - this new model will put us in the position of asking services to pay for something they don't get!!
- Unfair to charge all Trusts the same irrespective of how many audits they participate in!
- I think the new arrangements are much better and will help encourage Trusts to participate in audits. Previously the charging system made almost seemed to penalise those that were more involved in audit as they would be charged more for the more audits they were involved in
- No - most National Audits are a waste of time
- Don't understand what is happening well enough to comment at this stage
- For us, this change represents a reduction in costs so is, of course, extremely welcome
- Why are providers paying for this in the first place? They do all the work and the DoH get all the benefit. Very unfair charging mental health Trusts the same as acute if they only have one or two national audits in return
- The change will be positive for us as a small acute trust
- Any changes in funding has an impact on the budget available for resource
- The previous model didn't take in to account the patient population for each audit, as a large acute Trust with service level agreements with other organisations even if 2 or 3 patients attended and were referred to other

organisations we were deemed to participate so were required to pay the same as other organisations with a much larger patient population. We queried this with HQIP at the time and there wasn't any room for negotiation

- No, but I would like to say that Clinical Audit Teams not being copied in to information circulated to senior people within organisations is not a new issue

- Consultation on reasons for this change and doing it at year end would make more sense the funding plans will save me money but put a lot of burden on small trusts, non acute trusts and non NHS providers

- It is better than last year as the cost is reduced from £23.5K in 15/16 to £10K + VAT in 16/17 to take part in as many audits as we like. This will be guided by the NCAPOP list of audits that go into the quality account. In our Trust the Clinical Audit Department budget did not fund the cost of it. Money came from central reserves

- As a large Trust participating in most of the National Audits previous cost was over £23,000, therefore we will now pay less. Specialties are finding it increasingly difficult to find the resources to collect the huge amount of data required without having to find the money for the privilege of participating

- As yet unknown

- My opinion has always been that charging already stretched NHS Trusts, seems wrong when we also have to find the resource to carry out the audits. The standard charge is presumably to encourage Trusts to participate in more/all NCAs, however this does not then encourage the sponsoring organisations managing the audit projects to produce higher quality reports on outcomes.

- I'm assuming that, for our Trust, this will mean a reduction in the fee, but I don't think this will have any impact on the resources available for clinical audit

- Re: Q4. Of course, paying substantially less than previous years is a bonus, as this is a cost saving for us, which is why I have favoured my response in that way. However, I am very mindful that for my colleagues in our region they have found this inequitable. So it should be by participation, but it should provide 'value for money' and I do not think that all the national audits are of equal quality. There still continues to be more work done to improve the quality of these national audits, in my opinion

- This is a cost saving for our Trust. The audits were undertaken previous and the same level of participation will continue as it is part of Service Line annual planning

- The new funding method favours larger acute Trusts who will pay less. Community and Mental Health Trusts will be paying for projects that they do not benefit from

- Confused as to why we paid for DANHO last year when there was no service provided. Especially as this is the most expensive one

- As a large acute Trust these finding arrangements represent a significant saving for our Trust so very much in favour.

Community and Mental Health Trusts:

- From a Mental Health and Community Trust perspective many of the NCAPOP audits are not applicable and therefore are we getting value for money?

- Lucky that our Trust supports payment of this mid-year imposition from the contracts budget rather than clinical audit budget. I support this as a fair way for all Trusts to pay, but a % levy may be fairer across both small and large trust budgets. If taken at source, would save transaction costs across the NHS, and negate politics too

- We do not have the funding / capacity in the team. It could result in staff cuts as we have not had to pay before as most projects do not cover our care and services.

- Although the letter stated new funding method this was not clear until the further letter was received 6/9/16 with the subscription charge. The Trust does not have the funding available for this charge and given the significant increase from what was previously paid £0 this should of been notified before the start of the financial year rather than half way through. The Trust is disputing these charges and I will be writing informing that we will not be paying the amount

- This will have no direct impact on delivery, but will impact on the finances of the Trust. It is fundamentally unfair to any NHS organisations that are not Acute trusts, because the majority of NCAPOP audits are not applicable to those outside the acute sector. Furthermore, most Mental Health Trusts pay to participate in POMH-UK audits, which are not part of the NCAPOP programme (so not included in £10,000 standard charge), but are included in the Quality Accounts list of national audits in which all Trusts are expected to participate

- We are a small Trust, and have few national audits that are relevant. Our main NCA's are with Mental Health via POMH-UK, which we subscribe to at the rate of £5000 each year. The only national audit we paid to participate in was the Intermediate Care at £1000 per year, but as it fell outside NCAPOP this year we did not participate in that. So our "bill" for NCA will increase by £10,000, which we can ill-afford, which many larger Trusts will benefit as their bill will reduce quite considerable for those who take part in many of these NCAs. However, a number of NCA's and Clinical Outcome Review Programmes that were not previously part of the NCAPOP have now been added. I hope this will not necessarily impact on local clinical audit delivery, but it may result in challenge as to our future participation in NCA's and what level of risk this poses to the organisation

- NB: I only ticked the, "I prefer the old model" option for question 4, because there was no option labelled: "I entirely despise both models." I only "prefer" the old model in the sense that I'd, "prefer" to eat only one mouldy big-mac with blue fur growing out of it, than say, ten of them. Neither option is remotely palatable. First they made NCAPOPs mandatory, and then had the gall to charge everyone through the nose for the privilege of participating in these most atrociously conceived, badly organised, and terrible value for money exercises, that do not meet standards of best practice in clinical audit, and do not deserve to be referred to as such. It will impact on local clinical audit delivery in precisely the way you'd expect. We won't be able to do as much of it, because we've just had £10k + VAT mugged out of our budgets because we're over a CQC-shaped barrel. Great!

- It's a big chunk of our budget and penalizes us as we only participate in one or two audits a year. They are already taking resources away from useful audits by forcing us to participate in audits of topics that may not be our top priority of areas that need improving

- As the Trust will have to pay for participation then this may encourage and improve data collection and submission. At a time when Trusts are required to make significant cost improvements is it timely and appropriate to be asking them to pay for national clinical audits.

Community Trusts:

- We don't participate in most of the NCAPOP audits but we are now paying towards them, this is very unfair. We have bank staff to help with our annual programme and these people are having their hours reduced to enable the trust to make this payment. In turn this creates more pressure on the existing team with no benefit to our patient/client group

- This is a huge increase in cost to our Trust and is completely unfair as we only participate in a handful of audits (compared to the Acute Trusts)

- NHSE pandering to Acute Trusts in my opinion. Totally unfair and certainly badly planned. Why wasn't letter sent 1 April to help with inevitably budgetary impact this will have?

- No problem with the principle although it is unfair that a community trust who may only be eligible to participate in 4 or 5 national audits pays the same as an acute trust who may have to participate in 50. Can understand the rationale though and the ease things brings to collecting payment

- As a community based Trust we do not take part in that many national audits and so do not feel this new approach is fair

- As a community provider very few national audits are applicable to us - however, we pay the same amount as organisations doing 20-30 audits. Not sure this is equitable

- Our Trust is already struggling regarding staff shortages due to lack of funding. Paying this amount every year, which might not seem a lot to some people, takes away money that might have allowed us to employ part time/bank staff to assist in undertaking some of our tasks. They need to re-consider

- Sharing costs equally is fair for acute trusts but very few NCAPOP audits are for community and MH, so they could be paying £10k for 3 or 4 audits of minimal quality/usefulness.

Mental Health Trusts:

- We as a mental health Trust this will have a huge impact. We also have to pay subscription fees for POMH audits!

- New model for payment should be reconsidered. NHSE and HQIP silence on providing any further explanation is scandalous and identifies they clearly want to disassociate themselves from the decision that they presumably have made in partnership

- It is not my responsibility to comment for this Trust on this or other financial issues, but I am happy to answer these questions and share my personal experience

- Clearly this is grossly unfair to those Trusts who access only a small part of the NCAPOP. Why must we pay for NCAs that are irrelevant to our patients?

- There seemed to be no clear answer to the question of whether we would no longer be required to pay the subscription to the POMH-UK audit programme or whether the £10,000 subscription would be in addition to the money paid to the Royal College of Psychiatrists

- My fear is that this will either lead to Trusts reducing the amount of clinical audit they do or reducing the amount of staff they employ to cover the cost.

Others:

- Will reduce the funding available to conduct local clinical audit

- Seems slightly unfair for set prices for large vs small scale trusts. or trusts where not many audits are applicable vs where all audits are applicable

- I don't think this will have any impact on our delivery, the concerning element to me will be the costs of NCAs not on NCAPOP list, E.G. TARN & RCEM audits, will these grow in number? Overall the current cost of the 'mandatory' projects will be reduced but to this we will have to add the non-NCAPOP projects to our spend so the saving is not as great as it first looks if we continue to do the projects on the QA list that are not NCAPOP

- I would guess if they have paid the one off fee, participation might reduce as funding remote from participation

- It seems to favour larger acute Trusts which have more NCAPOP audits relevant to them and other Trusts will be paying more for less.

Conclusion

This survey and report were conducted to provide feedback on the changes to NCAPOP funding arrangements as expressed in Sir Bruce Keogh's letter at the end of August 2016. It is not for CASC to interpret the results and the views expressed in this report are not those of the CASC team. All responses have been displayed as they appear in the survey.

Disclaimer

All comments made by respondents to this survey represent the personal viewpoint of the responder and not those of the Clinical Audit Support Centre Ltd.

Appendix 1: Your job title:

- Acting Clinical Audit Manager
- Clinical Audit Facilitator (x4)
- Clinical Effectiveness Officer
- Head of Clinical Governance
- Head of Patient Safety and Quality
- Head of Registration and Compliance
- Clinical Audit and Compliance Lead
- Clinical Audit & Outcome Specialist
- Clinical Audit & Effectiveness Manager (x2)
- Clinical Effectiveness & NICE Manager
- Clinical Audit and Quality Coordinator
- Audit Lead
- Clinical Audit Manager (x5)
- Clinical Effectiveness Manager (x2)
- Clinical Effectiveness and Audit Manager
- Head of Clinical Audit and Effectiveness (x2)
- Head of Clinical Audit & NICE Guidance Lead
- Head of Patient Outcomes
- Clinical Audit and Improvement Facilitator
- Research, Innovation & Clinical Effectiveness Manager
- Clinical Audit Adviser
- Head of Clinical Effectiveness (x2)
- Head of Clinical Audit & Research
- Director of Finance and Business Development
- Head of Research and Clinical Effectiveness
- Clinical Audit Team Leader
- Head of Department Clinical Audit and Effectiveness
- Clinical Audit Officer (x2)
- Audit Manager
- Senior Clinical Audit Facilitator (x2)
- Clinical Auditor
- Clinical Audit Lead
- Compliance and Audit Manager
- Deputy Audit, Assurance and Effectiveness Manager
- Head of Quality and Clinical Governance - Corporate Services
- Head of Registration and Compliance
- Head of Governance & Improvement.

Appendix 2: Please state how you were made aware of the new NCAPOP funding arrangements. Answers, are given by sector:

Acute:

- Healthcare Conferences Clinical Audit on 5th October
- Internal correspondence in Trust - invoice was forwarded to me for sign off
- Heard from colleagues
- Via audit team from SECEN
- Email from Medical Director
- Via HQIP website I think!
- The letter received from NHS England
- Email from CASC
- Via CASC
- I heard it here (CASC survey) first
- Via the NQICAN agenda
- At NQICAN national network meeting

- When the invoice arrived
- From audit colleagues external to the organisation
- Internal correspondence (letter forwarded via Medical Director)
- From a colleague in another Trust circulation a question through an audit network
- Heard through NQICAN local audit and colleagues in other Trusts, nothing yet from my own!
- Wasn't aware until got newsletter from CASC
- By Sir Bruce Keogh's letter making its way to me and from the clinical audit network at the same time
- Other Audit colleagues (SCAN)
- Came across letter whilst on HQIP website and forwarded to my executive lead
- CASC newsletter
- Didn't know prior to this email from CASC
- Internal correspondence
- This (CASC) survey alerted me to the letter sent to all Medical Directors and I have now been able to follow this up to ensure all
- I received an email from CASC on 28th September 2016 notifying me of the new funding
- Subscription charge request letter dated 6th Sept forwarded from finance department
- By HQIP - I had previously asked for this information so they sent me the letter by e-mail as an update
- Email correspondence from other audit colleagues across the region initially, latterly an email from our finance director
- CASC website.

Community and Mental Health Trusts:

- CASC email
- Link on a health care circular
- Via query from medical and finance directors
- Through a clinical audit network email
- Communication from line manager
- Internal email
- Business Development querying the size of the bill
- Email detailing feedback from a CASNET meeting
- Email cascaded down the hierarchy.

Community Trusts:

- A colleague in our finance directorate happened to mention it to me one day
- Clinical audit network chairs
- My manager told me when I returned from holiday in September
- E-mail from Medical Director
- Email forwarded by Medical Director who was the recipient
- From colleague.

Mental Health Trusts:

- From a recent Clinical Audit Conference
- CASC website
- Found out by visiting the HQIP website
- I heard from other audit colleagues
- Via CASC

- Heard about this from regional colleagues via an e-mail exchange and at a regional audit managers meeting
- I received an email on 13th September from our Director of Finance and
- Via the CASC newsletter.

Others:

- Regular CASC news email
- Just found out via this (CASC) survey (although a colleague at another Trust had mentioned that they had received a larger invoice
- My manager forwarded the CASC email
- Picked up via a colleague's link with NQICAN
- The (CASC) email this survey was linked in
- Informed by clinical audit colleague in another NHS Trust
- Colleague
- Via NQICAN meeting (audit colleagues).