National Respiratory Audit Programme

Case Ascertainment Strategy 2026-28

Version 1.0 July 2026

1. Introduction

This strategy will outline the current level of case ascertainment in the National Respiratory Audit Programme, discuss key factors affecting case ascertainment, and set out the steps NRAP will take around case ascertainment for 2026-28. This strategy builds on learnings from the previous case ascertainment strategy 2023-26 published in September 2023.

Case ascertainment means the proportion of eligible patient records entered by a service into each audit. This is a measure which is used to determine the representativeness and generalisability of the audit results. Ideally, all services would enter all eligible patients to the audit, obtaining a case ascertainment value of 100%.

Case ascertainment has fluctuated over the years (see *figure 1*) but remains short of 100% in each audit. NRAP has agreed targets with our commissioners HQIP to improve case ascertainment from 2023-24 levels by 20%, by May 2028. This strategy will outline the steps we will take to better understand our case ascertainment and where possible, progress towards this goal.

2. NRAP case ascertainment

Case ascertainment is tracked annually and calculated retrospectively based on number of records entered to the audits compared to national hospital asthma and COPD exacerbation data obtained from Hospital Episode Statistics (HES) and Patient Episode Database for Wales (PEDW). For pulmonary rehabilitation (PR) services, a separate online survey is conducted by NRAP to determine case ascertainment rates as there is no central dataset that can be used for comparison. Neither of these mechanisms for calculating case ascertainment is wholly reliable, and the challenges are outlined below.

Case ascertainment since 2023 is presented here, broken down by audit and nation.

Year	COPD	Adult asthma	CYP asthma	PR
2024-25	**52.2%**	**49.4%**	**74.5%**	**74.9%**
England only	*51.7%*	*48.6%*	*72.7%*	*74.8%*
Wales only	*65.5%*	*77.5%*	*115.3%*	*78.1%*
2023-24	**50.8%**	**43.5%**	**70.3%**	**66.6%**

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England only	*50.2%*	*43.0%*	*69.9%*	*65.4%*
Wales only	*65.8%*	*62.8%*	*77.7%*	*128.5%*
2022-23	**54.4%**	**45.1%**	**67.5%**	**76.1%**
England only	*53.6%*	*44.3%*	*66.6%*	*74.3%*
Wales only	*73.4%*	*69.2%*	*93.6%*	*77.7%*

Figure 1: NRAP case ascertainment between 2022-23 to 2024-25.

Targets agreed with HQIP are to improve on case ascertainment as reported in 2023-24 by 20%, by May 2028:

- COPD audit target: 61%
- Adult asthma audit target: 52%
- Pulmonary rehabilitation audit target: 80%
- Children and young people asthma audit target: 84%.

3. Barriers for case ascertainment

The barriers to improving case ascertainment in NRAP are complex and varied. The main barriers include:

- **Resource and capacity of eligible services to enter data**, as reported by the NRAP case ascertainment survey from 2023. Over 60% of respondents reported that time and staffing were main barriers to entering all patients into the audit. As the NHS landscape continues to shift, we hear anecdotally that a number of trusts are losing audit support staff, affecting their ability to engage comprehensively with NRAP.
- **Local system coding issues** cause some data inputters to struggle to identify eligible patients using their local patient record system. This means that patients are missed and not entered into the audit. For an exacerbation of COPD or asthma, the original admission diagnosis may often be changed post-discharge, changing their audit eligibility after the decision to include or exclude them from the audit has already taken place. Interpretation of patients notes and discharge summaries as part of the coding process can be challenging; any inaccurate coding affects not only local audit results, but has wider implications around visibility of who is being treated within hospital and how activity is reimbursed. It is considered that coding issues similarly affect the accuracy of eligibility as reported through HES and PEDW, therefore skewing ascertainment figures and potentially creating an unreachable target for services.
- **Eligibility to the CYP asthma audit** is commonly misunderstood, meaning that many services enter too many - meaning ineligible - patients into the audit. This creates additional strain on limited resource and skews local ascertainment values to the extent that numerous hospitals will report a value of over 100%. In 2024-25, 26 CYPA services reported a case ascertainment value of over 100%.
- **Lack of technical capability for data automation.** Automatically flowing data from electronic patient record systems into NRAP would greatly reduce burden on staff required to enter data, but the

capability to do this through the numerous electronic patient record systems used by hospitals is not currently in place.

- **PR case ascertainment is self-reported** by services through an online survey each year, as there is no equivalent national dataset that reports the number of patients being assessed for PR. This means that caution must be given when interpreting PR case ascertainment values.
- **Case ascertainment will always be retrospective** because it requires linking audit data with HES data. We therefore do not know during any given year what case ascertainment value a service is achieving. This limits the amount of targeted case ascertainment communications that can be done during the time where a service can enter more data and improve that year's case ascertainment.

4. Previous approaches to improving NRAP case ascertainment

The previous 2023-26 case ascertainment strategy was underpinned by a survey and dedicated task and finish group, delivered in 2023. The survey received 116 responses and identified key barriers to achieving full case ascertainment.

We have addressed a number of barriers highlighted in the survey over the past three years. For example, the previous requirement for PR services to gain individual patient-level consent, which was reported as an additional step and burden for both clinicians and data-inputters, has been removed as NRAP secured approval from the Confidential Advisory Group to instead use the National Data Opt Out (NDOO) approach to replace individual consent. The overall case ascertainment levels for the PR audit have steadily increased since April 2024.

The outlier policy was developed and implemented for the first time in 2024. A key motivator for implementing this was to communicate a clear definition of participation and non-participation with services, improving participation in the audits and therefore improving case ascertainment. Following the first round of outliers:

- 18 COPD services were identified as outliers; 15 re-engaged
- 6 PR services were identified as outliers; 4 re-engaged
- 25 adult asthma services were identified as outliers; 23 re-engaged
- 6 children and young people asthma services were identified as outliers; 6 re-engaged.

Due to its effectiveness, maintaining the delivery of our outlier policy, and potentially expanding it to similarly identify services with very low case ascertainment, is therefore a central element for our case ascertainment work in the future.

There were elements of the previous strategy which have not been taken forward. Representative sampling was considered as a potential option as a way to reduce data burden. However, it is not felt that this is an appropriate methodology for NRAP when a core function of the audits is to deliver healthcare improvement which requires complete data.

5. Improving case ascertainment in 2026-28

Our strategic focus for improving case ascertainment in the next two years will focus on the following key priorities:

I. Improving our understanding of case ascertainment:

We currently only link records which are entered into the NRAP webtool with data in HES and PEDW for case ascertainment and outcomes. Within the extension period, our top priority will be to update our data access agreements to access the HES and PEDW datasets for all patients eligible to be entered into NRAP. This is to inform our understanding of which cases are being entered into the audit and which cases are being excluded, in order to better understand how representative NRAP data is and whether there are trends in which cases are not entered into the audit by services. We hope to publish our findings by the end of 2028.

As part of this updated data agreement, we also aim to get case ascertainment data more quickly through NHS Data Access Request Service (DARS) and the Welsh Government. This should allow us to report data more quickly and meaningfully to services and systems.

II. Groundwork for audit data automation:

A priority for 2026-28 will be scoping the potential for automated data entry to the NRAP audits, as a means to reduce data burden and improve case ascertainment. Key initial surveying all services in England and Wales to understand availability and functions of electronic patient record (EPR) systems, which builds upon our findings in our organisational audit. We aim to share insights and learning back with services by the end of 2026, and showcase local solutions and examples.

We also intend to work with HQIP to understand any cross-NCAPOP learnings around data automation, and will explore opportunities to work with EPR system providers to understand which templates or NRAP metrics are already within their systems and therefore open for automatic extraction. Collectively these actions will ensure we utilising opportunities for data automation in national audit.

III. Focus on children and young people (CYP) asthma case ascertainment:

Over the next two years we will work to better understand specific nuances around case ascertainment for the children and young people asthma audit, and the reasons behind the misinterpretation of the inclusion and exclusion criteria, particularly around the inclusion criteria for wheeze. We will aim to share insights and if any updates are required to the inclusion/exclusion criteria, these will be ready to go live for April 2028.

IV. Service-level case ascertainment targets:

We are in regular communication with services through implementation of the NRAP service participation strategy. This strategy identifies services who are not achieving the low submission threshold (see below). Please note that services reporting fewer than 60 cases in the previous year through HES or PEDW are not deemed to be eligible for the secondary care audits.

NRAP workstream	Low submission threshold
COPD	20 cases in the previous 3 months
Adult asthma	20 cases in the previous 3 months
CYP	10 cases in the previous 3 months
PR	15 cases in the previous 3 months

Over the next two years, we will use our learnings from the areas above to explore whether we can create realistic and achievable tailored case ascertainment targets for services.

6. Relevant strategies and policies

The case ascertainment strategy is supported operationally and strategically by the following additional policies and strategies. It may be helpful to read these in conjunction with this strategy.

- **Service participation strategy:** *This defines the meaning of participation in the National Respiratory Audit Programme, and outlines the ongoing process NRAP follows for communicating with registered services about their participation.*
- **Outlier policy:** *This outlines the formal process by which NRAP identifies, manages and escalates non-participation outliers across the programme, to improve participation.*
- **Data burden reduction strategy:** *This outlines how NRAP reduces the impact of data burden for eligible providers, and outlines how NRAP datasets, webtool and processes are optimised to reduce effort required to input data.*
- **Healthcare improvement strategy:** *This identifies key healthcare improvement goals which NRAP will support services to achieve, and outlines a sustainable framework for how NRAP will support healthcare improvement within respiratory settings in England and Wales.*