Project Board Meeting 14

Wednesday 13th May 2020, 14:00-16:00pm
(Teleconference) at the Royal College of Anaesthetists

Members:

Dr Paul Clyburn	Project Board Chair, AAGBI
Ms Sonia Lockwood	NELA Surgical Lead/ Research Lead
Dr Carolyn Johnston	NELA QI Lead
Ms Lynn Smith	Patient Representative
Mr John Abercrombie	Royal College of Surgeons
Dr Sarah Hare	National Clinical Lead
Mr James Goodwin	Head of Research, RCoA
Mr Jose Lourtie	NELA Project Manager
Ms Karen Williams	Audit & Research Administrator, RCoA

Apologies:

Prof David Cromwell	Project Team Methodologist/RCS
Ms Tasneem Hoosain	HQIP
Ms Sharon Drake	Director of Clinical Quality and Research, RCoA
Dr William Harrop-Griffiths	RCoA
Dr Gillian Tierney	ASGBI
Trevor Corrithers	Audit and Research Team Administrator
Dr Dave Murray	Project Team Chair
Dr Yvonne Silove	HQIP

NELA PB/ 13.05/ 1 Introductions and apologies

Introductions were made around the table and apologies as noted above.

NELA PB/ 13.05/ 2 Declaration of interests

There were no conflicts of interests declared.

NELA PB/ 13.05/ 3 Minutes of previous meeting

The minutes of the previous meeting held on 26/11/19 accepted with no amendments.

- Actions will be discussed during the meeting

NELA PB/ 13.05/ 4a Project Report

Highlight Report

Jose Lourtie went through the highlight report outlining developments that have taken place since the last Project Board Meeting. Overall, the project continues to progress well and these were the main points covered:

- NELA continues to carry out Quality Improvement activities including publication of individual hospital and AHSN level quarterly reports.
- NHS England are not currently reviewing any reports due to COVID-19, may be further delays down the line.
- 7th Year dataset has been updated. This dataset comes into use at the start of the 7th year of data collection on 1st December 2019. Number of cases have declined over the March April period.
- Infographic poster generator will allow sites to pull data into graphic and share locally and push forward QI agenda.
- Additional rolling mortality chart which is currently going through testing.
- QI webinars, delayed until further notice.

- Excellence and exception report was updated a few months ago and available for sites to download.
- Isle of Man now participating and now collecting data since December.
- Conversation happening on how COVID-19 is effecting NELA data.
- Contract extension process changed with shorter submission form and longer timescale.

NELA PB/ 13.05/ 5 Patient Audit

a. COVID-19

Sarah Hare presented to the group some ideas NELA can do to assess the impact of COVID-19 on patients requiring emergency Laparotomies. Sarah Hare explained that there is a good basis to look at historical comparatives with what is happening now and what has happened to patients since shutdown. Sarah Hare noted that NELA data could become powerful as it looks into change in risk profile/ results of the potentially missed cases

There were only 364 cases entered in April as teams are thinking about other things in this time, and nurses have been redeployed. Sarah explained the questions we could ask around this data, and potentially produce a COVID-19 themed report later down the line. Sarah also noted that we do not understand the denominator just yet and get some clear messages out within the next few months. Sonia Lockwood noted that people stop contributing to national reports during COVID-19, and with NELA data is completed mostly by clinicians the lack of numbers could mean that we may miss some important cases.

Sarah Hare noted that Appendix presentations have decreased, however the presentations that do come in are in severe cases. Whilst we can see that cases are being started, some of the datasets are not being completed. Carolyn Johnston suggested that some clinicians have been setup with home access to patient data.

b. Year 6 Patient Audit

SH and SL and CS presented to the group an overview of the analysis to date of the draft year six report.
Key analysis points include:

- SH and SL and noted that time to Intensive care has improved. Some presence of theatre not bad. Direct admission to critical care.
- CJ noted that the suspicion of Sepsis dashboard is with Netsolving they are sharing some drafts ready for the final bits of testing. Almost ready to go within the next month.
- Frailty and care of older patients - The proportion of patients seen by geriatrician remain unchanged. Overall, things are still improving - linked to best practice tariff.
- SL note that mortality is higher if patient is admitted under geriatrician. SL noted that the recommendation here would be to involve the surgeon early.
- Radiology key process measures have not changed much. The proportion of patients that have outsourced reporting has increased and the Discrepancy rate is higher.
- Consultant input, there is no variation for time of day or day of week. Driven by concepts of what is a risk.
- Peritonitis- look at sepsis and signs of sepsis no difference. In the High-risk group, there is no change.
- Pre-op risk assessment- 84% patients having risk assessment before operation. Lines in graph starting to meet. Both normal and high risk are having a pre-assessment 77% the year before.

- Indications for surgery – group together last year and kept this for year. Remain unchanged laparoscopic rate remains unchanged. Commonly performed remains unchanged.
- Surgeon presence in theatre- Surgeons have outperformed anaesthetists – impact of the best practice tariff – process measures have improved.
- Care of the older patients. Process measures have changed slightly. Need to work out the proportion of over 65's who have had a frailty assessment.
- 30-day mortality- Recommendations need to be discussed.

SH explained that the previous report had a direct question about a frailty assessment directly which is now removed in the year 6 report and now we just ask for the score. SH explained how the frailty score is documented noting that patients scoring 1-9 are not frail and 3-9 as frail. CJ noted that those patients who are documented as frail are automatically high risk. Patients who have had had a frailty assessment and classed as frail however have been judged to be low risk, the judgement is inaccurate. DC noted that it is not clear what formal screening tool is being used to determine frailty assessment. If Frailty is assessed from a point before admission this suggests that people are measuring correctly because people who are frail are having worse outcomes.

SH noted that patients who are over 65 who do not have frailty assessed behave more like a frail patient than a patient who is not. DH queried the relationship with frailty and age and noted that the frailty scale published by HES can be applied to the NELA data to give an accurate frailty scoring. DC queried whether there is capacity to do this for this report. SH noted that this would be helpful so that we can report some concrete analysis on the results. SH also queried how quickly this could be done.

SH noted that time to theatre is important, there is a systemic problem everywhere. SH noted that 1 in 7 patients are not getting to theatre on time. LS noted that from a layperson perspective, 1 in 7 not getting to theatre is a good way of displaying the data within the report and is impactful at quick glance. LS also noted that having a simple methodology of describing the stats is good way of driving some change.

SH noted that COVID-19 has been referenced in the report to state that the data was published before. DH and JL proposed that something could be looked at post COVID-19 to understand how much the risk there were to patients post-operatively.

c. Year 7 Patient Audit

Ongoing - Nothing to report

d. Outlier discussion

Nothing to report

NELA PB/ 13.05/ 6 Future Development of NELA

a. NELA Tender Extension

Nothing to report - DM to discuss extension process for a further 2 years. Extended submission timeline.

b. NELA Future Reports

The Project Team are at the stage of pulling together the outcome chapter, Quarterly reports and reporting through COVID-19. Qi activity, patient engagement & best practice.

C & d. QI & QA Activity

Sarah Hare outlined how the application has now gone through the HQIP process.

e. Patient Engagement

Nothing to update

f. Best Practice Tariff

Nothing to update

NELA PB/ 13.05/ 9 AOB

Nothing to update

NELA PB/ 13.05/ 10

The next Project Board Meeting will be held 3rd November 2020.

Agenda Item	Action	Responsible	Due
4	Update risk register to include National Data Opt-outs	JL	As soon as possible
9	Pick up conversations around HQIP delay and revision of dates	JL	As soon as possible