# National Emergency Laparotomy Audit

**Project Board Meeting 6**

**Minutes of the meeting held on Tuesday 8 September 2015, 11:00-13.00**

**at the Royal College of Anaesthetists**

**In attendance:**

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| Mr John Moorehead | Chair, ASGBI |
| Dr Dave Murray | National Clinical Lead |
| Dr Yvonne SiloveMs Tasneem HoosainMs Gillian TierneyMr Charlie Evans | HQIPHQIPASGBIICNARC |
| Professor Mike Grocott | Project Team Chair |
| Ms Sharon DrakeMr James Goodwin | Director, RCoAProject Manager – Education & Research |
| Mr Jose LourtieMr Dimitri Papadimitriou | Project AdministratorResearch Team Administrator |

**Apologies:**

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| Mr John AbercrombieMs Lauren OsborneDr William Harrop-GriffithsMr Tim RussellDr Liam BrennanDr David Cromwell | RCSPatient RepresentativeOutgoing Chair, AAGBIICNARCRCoAProject Team Methodologist/RCS |

1. **Introductions and apologies**

The Chair introduced himself to the group in his first meeting and welcomed everyone to the 6th Project Board Meeting and other introductions were made.

1. **Declaration of interests**

None of the members had any declarations of interest.

1. **Minutes of previous meeting.**

It was agreed that the minutes were an accurate record of the previous Project Board meeting.

1. **Project Manager’s Report**

Mr Lourtie went through the highlight report that had been prepared in consultation with the NELA Project Team. This covered an overview of the project achievements and actions over the previous 6 months:

**Highlight Report -**

* Patient Audit:
	+ The numbers for year 1 of the patient audit was outlined and the process leading up to publication of the first patient audit report was described.
	+ The response to publication including patient feedback, press attention and website activity were set out.
	+ The current status of year 2 audit data collection was explained.
	+ Mr Lourtie gave a demonstration of the current functionality of the web tool dashboard which allows users to view their Patient Demographics figures, as well as the QI aspects of the dashboard which are currently being finalised and will be made available to audit participants in the coming weeks.
	+ Other dissemination being made available to audit participants was described including the Patient audit slideset and patient audit action plan.
* **Other work**
	+ An update was given on the Burden Advice and Assessment Service process that NELA has been undergoing. The BAAS summary report is currently being reviewed by HQIP and the NELA Project Team.
	+ The HQIP 2 year extension process was completed within the timeframe and new deliverables were signed off. The extension contract will run from 1st December 2015 to 30th November 2017.
	+ Information governance – Section 251 was successful for the current year and renewal is ongoing for next year. Information Governance Toolkit has also been updated.
* **Data Linkage:**
	+ HES / ONS Data linkage – The delays to obtaining this data linkage were explained and the current state of the submission was described. It is hoped by the project team that Data linkage will take place in October 2015 but this is still dependent on HSCIC.
	+ ICNARC data linkage process has been approved by the ICNARC DAAG committee.
	+ Ms Tierney explained that the Bowel Cancer Audit reporting outcomes on a surgeon-specific level has had some incredibly negative consequences on the way individual surgeons’ work is assessed and there is a concern in the surgical community that NELA publishing its outcome data will have the same affect.

Prof Grocott understood the concern and explained that as HQIP own the NELA data he can’t promise that the Health Service won’t at some point ask that outcomes be published alongside surgeon GMC numbers. He assured the Board however that the Project Team have absolutely no intention of publishing results on this level, with the Team planning releasing outcome data on a hospital-level only. He went on to ask Dr Murray to add a slide in the slide-set currently being developed for local NELA leads explicitly stating that the audit does not plan on reporting outcomes on an individual basis.

* **Project Management:**
	+ The project deliverables achieved in the last 6 months were shown to the Board. All current deliverables have been met on time or are currently being worked through. The only deliverable to show any delay is the issues surrounding Data Linkage as discussed previously.
	+ Risk Score – The failure to link data is the only score highlighted as ‘High risk’.
	+ Finance – The project finances are currently within targets.
	+ Communications – The NELA team continue to attend a large number of meetings around the country, a list was presented to the Board.
1. **Patient Audit**

Dr Murray explained that following a very successful first year in terms of case ascertainment for the Patient Audit, the Project Team still requires to improve on the Year 1 case numbers. Case ascertainment will most likely never reach 100%, however this is mostly down to the way in which HES codes are entered and reported on locally at participating hospitals. The number of cases being completed and locked is likely to increase towards the end of the year as the Year 2 case deadline approaches, and the Project Team are also expecting the publication of the First Patient Report and the release of the QI dashboard to further improve case ascertainment.

He asked the Board if there were any meetings they could recommend for NELA to target so as to advertise the audit and push for data entry. Mr Moorehead and Ms Tierney recommended the Project Team look into attending ASGBI and colorectal-specific surgical events.

There are a number of Scottish hospitals currently taking place in the EPOCH study who have expressed an interested in keeping their access to the NELA web tool once the study has ended so as to continue examining how well they are performing.

Dr Silove explained that discussions continually take place so that the Scottish government and Welsh governments can participate in all HQIP audits. Scotland has already begun to contribute towards certain HQIP audits on a case-by-case basis, but the overall commissioning structure has yet to be changed. She recommended that the sites hoping to continue using the NELA web tool lobby to the Scottish government in order to convince them to begin contributing towards the funding of the audit.

Mr Moorehead asked about the involvement of Northern Ireland in HQIP audits, with Dr Silove explaining that the main deterrent for Northern Ireland joining HQIP audits thus far has been issues with allowing patient identifiable data to leave the country.

Mr Evans added that sites from Northern Ireland are included in the ICNARC Casemix Programme, with Mr Moorehead recommending that the NELA Project Team look into contacting someone within the Northern Irish government in order to discuss the matter further.

Dr Murray explained that as part of a HQIP/CQC joint project all HQIP audits have been asked to submit five quality improvement metrics to the CQC which will eventually fit into their inspection process. The metrics that the Project Team are currently considering are; timeliness to theatre within NCEPOD guidelines, consultant presence in theatre, preoperative risk assessment and direct admission to critical care postoperatively.

Ms Tierney recommended that case ascertainment be added to the list as it determines how robust the rest of the data being analysed is.

Dr Murray suggested that a metric be held in place for when outcome data is available. Dr Silove explained that the metrics can be changed at a later date, so place-holding outcomes would most likely not be necessary.

Prof Grocott asked if consultant anaesthetist present and consultant surgeon present should be combined into one metric, i.e. cases in which both consultants were present in theatre. Ms Tierney expressed a worry with this idea however, fearing that poor number could incorrectly be misinterpreted as surgeons not being present.

Dr Silove concluded the discussion by advising the Project Team that even though the CQC has asked for just five metrics, more can be submitted and discussed.

1. **Patient Involvement with NELA**

Dr Murray explained that following the publication of the Patient Report the Project Team received correspondence from patients who had undergone emergency laparotomy or their family members. As the standards of care have already been highlighted in the Report the Project Team feels that further correspondence needs to take place.

Dr Silove highlighted that other audits have created patient leaflets explaining what ‘Good Patient Care Looks Like’ to respond to patient queries.

Ms Tierney warned of the potential legal repercussions of telling patients that their care may not have met the set standards, with Mr Moorehead pointing out that once information on standards is available to the public, as it is in the Patient Report, it’s impossible to control how people will interpret it.

The Board agreed that the best solution for dealing with patient queries is to direct them back to the hospital at which they received care along with the information included in the Report.

1. **Research Collaboration**
	1. EPOCH/ELPQuiC – Prof Grocott provided the Board with an update of the EPOCH study, with which he is involved, as well as a brief overview of ELPQuiC, which is a similar Quality Improvement initiative.
	2. Other collaboration requests – Prof Grocott also outlined a potential new study post-EPOCH which will examine process measures on an individual patient-level basis. He explained that from his point of view it looks like a worthwhile project which will feed back directly to the QI side of NELA.
2. **HQIP Contract Renewal**

Dr Murray presented the Board with an updated list of deliverables for Years 4 & 5 of the audit, now that NELA has been extended for an additional two years. Some of the main points to mention are a second Organisational Audit which will take place to see what improvements hospitals have made since the first Organisational Report was published. It also means that an Organisational and Patient Audit will be taking place simultaneously which will allow the Project Team to draw comparisons between the two. Years 4 & 5 will also see a much larger QI push and the Project Team working on driving multidisciplinary QI forward.

Mr Moorehead asked the members of the Project Team where exactly they see the audit going in several years’ time. Will it eventually tie into NHS commissioning or possibly be used to set targets?

Dr Murray explained that the Project Team currently see it as an ongoing QI project, with perhaps a move towards making participating in NELA less of a data burden for participants in the coming years. It could also potentially be used towards achieving CQUIN targets and best practice tariffs.

Dr Silove added that as it’s currently a time of transition and change for HQIP they are in the process of setting up a longer term vision for the organisation and its audits. When NELA is up for retendering in two years’ time it will have to set clear goals and targets for the future; a decision will then be made as to whether funding will continue and where exactly that funding will come from.

1. **Communications Strategy and Plan**

Mr Lourtie explained that this is a standing agenda item and the latest version of the communications plan is available to Project Board members on the ‘protected area’ section of the NELA website. He asked the Board that should there ever be an organisation or specific meeting that they feel the Project Team should be targeting to please let him know.

1. **AOB**

Mr Lourtie distributed a copy of the latest Board terms of reference and asked its members if they felt the terms needed to be updated; specifically if a length of term needs to be introduced. Dr Silove asked that the wording be changed so that HQIP are identified as commissioners, not funders of the audit.

Ms Drake announced that Dr Brennan will be stepping down as the RCoA representative as he has now been elected president and one of the new vice-presidents will most likely be taking his place.

Dr Silove stressed the importance of patient representation on the Board and suggested a second representative possibly join the Board. She also added that most other audits do have fixed terms of length of stay.

Mr Moorehead recommended that the Chair of the Board alternate between an anaesthetist and surgeon and explained that he was happy for lengths of stay to be added to the terms of reference.

Prof Grocott recommended a three year term which all other members agreed was reasonable. Dr Silove also recommended that a six month overlap between chairs be introduced so as to allow for a handover.

Mr Lourtie agreed to incorporate these changed into the terms of reference and circulate to the rest of the Project Board.

1. **Next Meeting**

*Date and time of next meeting are yet to be confirmed*