Project Board Meeting 8: MINUTES

Wednesday 18th January 2017, 10.30am-12.30pm
6th Floor, Council Chamber at the Royal College of Anaesthetists

Members:	
Mr John Moorehead	Chair, ASGBI
Ms Tasneem Hoosain	HQIP
Mr Jose Lourtie	Project Administrator
Dr Dave Murray	National Clinical Lead
Mr Tim Russell	ICNARC
Ms Lynn Smith	Patient Representative
Miss Gillian Tierney	ASGBI
Apologies:	
Mr John Abercrombie	Royal College of Surgeons
Dr David Cromwell	Project Team Methodologist/RCS
Ms Sharon Drake	Direction of Clinical Quality and Research, RCoA
Prof Mike Grocott	Project Team Chair
Dr Jeremy Langton	RCoA
Ms Yvonne Silove	HQIP
In Attendance:	
Mr James Goodwin	Research Manager, RCoA
Ms Susan Warren	Audit and Research Team Administrator

NELA PB/ 01.17/ 1 INTRODUCTIONS AND APOLOGIES

The Chair welcomed all members and apologies from Board members were noted.

NELA PB/ 01.17/ 2 DECLARATION OF INTERESTS

There were no conflicts of interests that were declared.

NELA PB/ 01.17/ 3 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 26/08/16 were accepted with no amendments.

NELA PB/ 01.17/ 4 HIGHLIGHT REPORT

Mr Lourtie provided an overview of the project covering the five months since the last Project Board meeting. The main highlights included updating HES data during Year 3 of data collection to be more contemporaneous, the start of Year 4 on 1st December 2016, with changes in the Proforma based on local feedback and guidance from the CRG, the 2016 Organisational Audit, an updated outlier report, the launch of QI videos and the planning of regional QI workshops, the changes to P-POSSUM score to be more NELA specific, the launch of the NELA app, data linkage via NHS Digital to HES and ONS and an update on our Section 251 application. For Section 251, whilst we continue to have coverage which is accepted by both NHS Digital and CAG, our application has needed to be amended slightly and has since been submitted to CAG for further evaluation. It is expected that this amendment should not delay receiving coverage in the future.

The highlight report continued to discuss the engagement with other studies, specifically looking at the PROMS feasibility study. In the past, the PT has struggled to include lay involvement with emergency laparotomies being a difficult cohort to capture as it often doesn't include an ongoing diagnoses. The Team has made progress however by including a number of different stakeholders

and will be putting together a more concrete piece of work that will look at different points along the patient pathway, particularly on the care received on the ward after.

Mr Lourtie continued the highlight report by updating the Board on HQIP retender process. In December 2016, the NELA Project Team met with HQIP to discuss the future of NELA during a Specification Development meeting. We have been updated by HQIP that NELA will be out for retender for 3+2 years (for a total of 5 years).

Ms Hoosain updated the Board that from HQIP standpoint, the retender is on time for procurement which will be in February or March. There will be six weeks for the papers to be completed then following that if further clarifications are needed, there will be a clarifications meeting. Then it will go into contract. The future contract should be done within the three months before the end of the current contract, which is in November. The major change is that HQIP is on an e-procurement system meaning that the Royal College of Anaesthetists will apply using this method with Mr Lourtie as the main contact.

Mr Lourtie continued his report by updating the Board on the collaboration with the CQC. We are waiting final confirmation of when our data will go live on the CQC dashboard.

ACTION: Ms Hoosain will follow up with the CQC to find out their timeframes of releasing NELA data on the CQC dashboard.

Mr Lourtie discussed the current risk scores, with case ascertainment being downgraded from amber to green as we have moved away from historical HES to contemporaneous data. We have also targeted July for when the Year 3 report will be published.

Dr Murray also discussed the annual variation at hospital level, looking at case ascertainment on a monthly schedule with the final report looking at contemporaneous data, job-planned time dedicated to NELA, and using case ascertainment as a marker of care. Dr Tierney suggested contacting Angus Wallace, director of professional affairs at RCS, to discuss potential opportunities to increase profile of NELA

NELA PB/ 01.17/ 5 PATIENT AUDIT

5.1 Patient Report

Dr Murray led this discussion by saying that the Patient Report this year will combine the Patient Audit with the Organisational Audit. We will be trying to relate structure to process to outcome and look at clinical behaviours, using the Organisational Audit to back it up. Ultimately the plan is to integrate the two reports instead of separate reports, balancing giving people something that is readable but also focused on the appropriate audience. An annual outcome report is acceptable, but publishing shorter regular reports would also be useful, particularly if the publications can be automated. We will continue to produce additional Individual Hospital Level Reports, whilst also looking at ways to increase the reporting frequency, focusing more on Quality Improvement. By doing this we are also working on publication timing and the practicality of an increase of frequency. We are also looking into having a dedicated data analyst within the team. This combined with a stable dataset, with less free text, will make data cleaning and overall analysis easier and quicker.

Looking at the changes within Year 4 dataset, we are asking less questions but include more questions related to admission pathways and sepsis. Currently there is no extraneous data, with all of the questions being there to help tell us what's happening. Dr Murray discussed potential frameworks to lessen the burden of data entry, with potentially using a mandatory and discretionary dataset, with the concept of not having to collect all of the data all of the time. Focusing on hospitals that have good ascertainment levels and good outcomes, they could be targeted for mandatory data collection only, with the discretionary dataset to be used for local quality improvement. This could potentially separate the quality assurance role versus using the data for quality improvement.

NELA PB/ 01.17/ 6 2ND ORGANISATIONAL AUDIT

This has been previous discussed during the highlight report.

NELA PB/ 01.17/ 7 CQC COLLABORATION

This has been previous discussed.

NELA PB/ 01.17/ 8 QUALITY IMPROVEMENT

We have regional workshops going forward and are focusing on a collaborative process between surgeons and anaesthetists. By also focusing on the demarcation between quality assurance and quality improvement role, we will get a greater understanding of how that data is being used. This ties in to what the annual report looks like and is more in line with HQIP's changing priorities from having an annual report to running quality improvement initiatives.

NELA PB/ 01.17/9 RESEARCH COLLABORATION

The publication of EPOCH results have been delayed because of issues with ONS data, with EPOCH deciding to put in a separate NHS Digital data linkage application.

Emergency Laparotomy Collaborative (ELC) is a scaling up project which is run by Niall Quiney and is based in Guildford. It is a Health Foundation funded initiative which is collaboration between AHSN's, using a variety of leads, both surgeons and anaesthetist. It is similar to EPOCH in a way with local collaboration on how they are using the data. They suggested that mortality decreases by delivering a bundle of care with quality improvement initiatives to back it up. Collaboration with them may help us with the quality assurance and quality improvement implementation structure.

Collaborating with PROMS and NASBO allows us to look at the datasets side by side. NASBO also covers patients who don't have surgery, particularly with bowel obstruction.

Dr Murray continued by looking at the study by Andy Klein, who looked at the determinants of outcomes for cardiac surgery on patient with emergency laparotomies. This study looking at the impact that hospital outcomes versus surgical teams had on patient outcomes. Dr Murray felt that this will give us more information on the role individual hospitals have on outcome and can also rationalise what data we need to collect.

ACTION: Dr Murray will email Dr Tierney the article by Andy Klein

Dr Murray concluded this section by briefly discussing the collaboration with surgical sub-specialities societies within NELA, specifically looking at Small Bowel Obstruction, Hartmann's, Colitis, all in various stages of progress of analysis. Iain Anderson's intention is to have as much of this data analysed as possible in order to be presented to the ASGBI conference in May. He continued by discussing the challenges around delivering this is was not insignificant. A more in depth analysis of the data is important but the time and funding to doing this analysis, including providing data access, has also presented barriers.

NELA PB/ 01.17/ 10 FUTURE DIRECTION OF AUDIT

Dr Murray updated the Board that we are currently restructuring the Clinical Roles within the Project Team. Specifically, Professor Grocott will be stepping down as Chair, with Dr Murray assuming the position, Sonia Lockwood is our new Surgical Lead, and we will be posting for a QI Lead. The Project Team is also looking into having a Research Lead, which Matt Oliver, who was a NELA fellow and who has just finished his PhD looking at NELA data, targeted for the position. The Team will continue to have NELA fellows, predominantly in anaesthesia, but with the potential to also having a surgical fellow, specifically from private hospitals. This would give us an opportunity to have a surgical fellows attached to NELA. The role would include undertaking a higher degree, with a proper research proposal, which would need supervising.

ACTION: Dr Murray will continue the discussion of RMO/Surgical Fellows with Dr Tierney.

Dr Murray stated that there has been initial discussions with NHS England and HQIP about the potential to implementing Best Practice Tariffs within NELA. This has been agreed by NHS England that emergency laparotomy care is suitable for Best Practice Tariffs. There is a meeting in February to begin those discussions. Best Practice Tariffs are currently commissioned on a 2 year cycle, with this being introduced in 2019.

NELA also has a role to play within professional bodies to advise on standards and engage with them on the refinement of standards of deliverable care.

NELA PB/ 01.17/ 11 HQIP

This has been previously discussed.

NELA PB/ 01.17/ 12 COMMUNICATIONS STRATEGY AND PLAN

Dr Murray put this on the Agenda as a reminder that NELA is a multidisciplinary audit and we depend on being able to communicate to all aspects of the pathway and would like to enlist the Boards help to doing so.

NELA PB/ 01.17/ 13 AOB

There was no Additional Other Business.

The meeting was adjourned with thanks at 12.15

Date and Time of next meeting – **September 2017**

Agenda Item	Action	Responsible
4	Ms Hoosain will follow up with the CQC to find out their timeframes of releasing NELA data on the CQC dashboard	TH
9	Dr Murray will email Dr Tierney the article by Andy Klein	DM
10	Dr Murray will continue the discussion of RMO/Surgical Fellows with Dr Tierney	DM