Confirmed

Project Board Meeting 7: MINUTES

Tuesday 23rd August 2016, 10.30am-12.30pm
8th Floor Meeting Room at the Royal College of Anaesthetists

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

1. INTRODUCTIONS AND APOLOGIES

The Chair welcomed all members and a round table introduction was completed. Apologies from Board members noted.

2. DECLARATION OF INTERESTS

There were no Interests that were declared.

3. MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 24/02/16 were accepted with no amendments.

4. HIGHLIGHT REPORT:

Mr Lourtie provided an overview of the project covering the 6 months since the last Project Board meeting and future developments. These included: Year 2 report publication, quality improvement initiatives, audit participant dissemination and engagement with other studies.

4.1. Audit update

The 2nd Patient Audit Report was published on 5th July reporting on data captured from December 2014 to November 2015. It was written by the Project Team and received contributions from the project team, project board, clinical reference group and other stakeholders. The media response was limited, but the report did receive a generally positive response from local sites and participants. Twitter proved a fruitful forum for communicating about the audit and the website received the most hits on a single day since the project started. The report has been disseminated via stakeholder organisations websites, blogs and an article was published in the HSJ. A presentation by Dr Murray was given at the EBPOM Congress on the day of publication.

We are currently in the 3rd Year of data collection and in the extension period of the contract, which will end on 30th November 2016. Currently Year 3 has similar numbers in terms of actual cases

entered and locked to Year 2, but we now have a higher bar for case ascertainment, which may prove complicated to achieve but is something that NELA Project Team aims for. We continue to ask sites to enter as many cases as possible and we are assisting them to do that.

We are currently finalising the updated dataset for the 4th Year of data collection, which will go live in December 2016. Plans are in place for the re-tender towards the end of this year.

4.2. Quality Improvement and Audit Engagement

Individual Hospital Level Report – The project team are finalising an individual hospital level report to disseminate to participating sites. This is in response to the feedback we have received from participants in that they need something they can pass on locally to try to encourage others to enter more data and ultimately improve quality of care. The Individual Hospital Report will be an A4 sheet and will provide graph highlights of the hospitals key measures. It will be easy to see, interpret and will allow them to disseminate the results of the Audit to their local trusts. Once finalised, the Leads and Local Administrators will be notified that this document will be available on the web tool. Ms Silove suggested that it also be published within the HQIP E-Bulletin. This will ensure that it will be passed up through the trust governance structure.

ACTION: An announcement that the Individual Hospital Report is available should be included within the HQIP E-Bulletin

Mr Abercrombie brought forward that the National Bowel Cancer Audit makes similar reports publically available and asked if the NELA Project Team will be doing the same? Mr Lourtie responded by saying that plans are at an early stage but there was no reason why they can't be. Historically we have used the web tool to get information back to hospitals. Ms Silove suggested that a statement be made on the main NELA website, under the Reports section, that the Individual Hospital Reports are available upon request. Chris Boulton at RCP may have information on how the Falls Audit has disseminated this sort of information, as well as Nicola Fearnhead at the National Bowel Cancer Audit.

ACTION: A statement should be made on the "Report" section of the website that the Individual Hospital Reports are available upon request

ACTION: Follow-up with Chris Boulton at the Royal College of Physicians

There was a question from the Board and discussion on if the Individual Hospital Reports will include case ascertainment. Mr Lourtie responded by stating that we RAG rated hospital case ascertainment and the report will include different bullet plots, demonstrating the various RAG ratings. Mr Moorehead had concerns on how the report will be used locally, that the good news might overshadow the trusts with poor case ascertainment and there was no way to regulate which aspects hospitals will concentrate on. Mr Lourtie stated that there will be text to contextualise the information.

Other quality improvement initiatives being carried out by the project team include providing sites with Action Plans, having a Results Slide Set, running QI poster competitions, adding QI videos on the website, launching a NELA App and further developing the online NELA dashboard. Work is ongoing alongside the CQC to finalise their dashboard of key measures.

The conversation relating to the NELA App brought about discussion relating to risk tools. A question was raised regarding using CEPOD risk tool instead of POSSUM within the NELA App. Dr Murray responded by stating it is on the horizon but that it would take work to clarify how it would integrate into data analysis. Prof Grocott added that we still don't understand performance characteristics within this patient group making it difficult to use different risk tools. It has also always been the intention to see how well POSSUM performs and has only been possible to do so with the release of ONS data in Year 2. Equally, the development of a bespoke risk tool for emergency laparotomy patients, that involving far less data points, is also being considered. The discussion continued by looking at different risk tools with the consensus that it is better to use something that at least determines risk, despite having imperfections, rather than not calculating risk at all.

Dr Murray spoke later on the effectiveness of POSSUM as a risk prediction tool. He stated that up to about 10% POSSUM performs accurately, which is useful from our point of view as the standard says between 0-10% you should make a decisions around consultative or admitting into critical care,

preoperatively. Values over 15-20%, POSSUM overestimates by a factor of 2. He gave the example that if is used to deny care because the risk is too high, POSSUM is not appropriate use. Being able to put that out there for clinicians is useful and has allowed us to comment on how well POSSUM performs.

There was further discussion on case ascertainment and the uncertainty within it and how the HES algorithm isn't reporting as well as the Project Team would like. There have been a small number of Trusts who queried their case ascertainment within the hospital and the PT is looking to modify the algorithm alongside the NELA inclusion/exclusion criteria.

4.3. Overall Project Management

The project is currently in the extension period of the HQIP Contract and a timeline is in place to assist in meeting all the contract deliverables. The future of the audit after its current contract is discussed later in the meeting. Mr Lourtie updated that although monthly IT costs have increased the finances continue within targets. Since the last meeting one risk score has been downgraded (Poor Quality Data Collection) and deliverables are on target to being met.

5. PATIENT AUDIT

5.1. Patient Report

Dr Murray presented the highlights of the patient report (presentation available alongside the minutes). He stated that when you look at it as a whole, things look pretty good. When looking at the hospital level, things look different. A lot of the hospitals are sitting around 60-70% mark, so we are hopeful that as it won't take long/much to tip them over the 80% bar for which their performance is rated green.

He went on to look at the hospitals that are rated green from Year 1 to Year 2, and demonstrated there are more hospitals rated green compared to Year 1. This equates to about 10% more hospitals that have >80% metric within those patients.

He explained that the audit shows improvement of individual clinician/clinical team performance. Where the improvement requires structural/hospital level change however has proved more challenging.

A question came from Mr Moorehead related to elderly medicine and whether improvement can ever be achievable without a dedicated medical-surgical geriatrician, as seen in orthopaedics. Dr Murray replied that until there is a financial incentive to have an Ortho-Geriatrician within medical-surgical wards, it won't change. We also have only started discussing elderly medicine from the 1st Report so it is very early dates to see movement on it, but we will need professional drivers to make changes. Ms Silove suggested that Dr David Oliver, Clinical VP at the RCP, could be a professional leader and could provide suggestions to how geriatrics might be engaged. Prof Grocott mentioned that NELA could also look at the characteristics within NELA, examples being length of stay in older patients, and drive the interest forward that way. Dr Murray stated that by collaborating with subspecialty units, predominately surgical at the moment, discussion with Jugdeep Dhesi, with BGS collaboration on the delivery of elderly care and emergency laparotomy to get a greater understanding of what patterns of care might look like.

ACTION: Connect with Dr David Oliver at the RCP to determine how geriatric care could be improved on medical-surgical wards and the role that NELA could play within that

Dr Murray continued by looking at the metrics over time, covering several of the key measures from the report. This included the review of patients within 14 hrs of admission by consultant surgeons. There were issues in the reporting of this metric in that the PT were hoping the HES data could give a good handle on admitting speciality, but it didn't, so we weren't able to report it on a hospital level. Going forward there will be additional questions added to the Patient Audit dataset, asking about admitting specialty, so the PT can disentangle patients admitted under acute surgery rather than medicine and then referred. About ¼ of patients in some hospitals were admitted under non-surgical specialities which lend to questions about how the hospital front of house is setup and how is it different from other hospitals. This question will also be included on the Organisational Audit, and will provide more data of the relationship of the structure of on-call and admitting specialty.

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Dr Murray continued by looking at patients arriving in theatre within a time appropriate for the urgency of surgery. The need to improve this has been flagged within the Report's recommendations aimed at Commissioners.

Mr Moorehead suggested that by looking at some of the information behind the information, we can look at why and when these delays are occurring. Mr Abercrombie brought forward that few hospitals don't statistically measure the emergency capacity that they require. He gave the example in Nottingham, mathematical models have been applied and have made a huge difference, and shows that it is more predictable than you think. Ms Silove suggested Ben Bray's article in the Lancet be used as an example of a model in continual data collection which showed a more detailed analysis on timing. Dr Murray suggested that the biggest gaps in data completion within the current dataset are around timings, stating that it is not well recorded.

ACTION: Review Ben Bray's article in the Lancet on the weekly variation in healthcare quality by day and time of admission:

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30443-3/abstract

Dr Murray continued his report by discussing sepsis and peritonitis. The Audit currently only asks for the date and time of the first dose of antibiotics following the patient's admission. The Year 2 Report shows improvement of time of antibiotics and decision to surgery, and we are likely to be changing the questions further in subsequent years.

He furthered by looking at post-operative critical care admissions and stated more clarity is needed on how the standards are worded.

Looking at overall mortality, NELA has been able to calculate 30-day and 90-day mortality trend lines. Within the 30-day, there was no statistical difference between Year 1 and Year 2. However looking at 90-day mortality there is improvement. He also stated that when looking at Risk-Adjusted Mortality, there were no outliers within three standard deviations.

The Report also published hospital level performance in terms of LOS, Return to Theatre (RTT) and unplanned admission into critical care. There was variability in terms of resource and quality marker at a patient level. There was however a 2-day improvement level in LOS between Year 1 and Year 2, which we calculated as a result of £20 million in saving across England and Wales. The argument is improving care results in a decreased LOS is a useful one to make if you are talking about the resource implications.

Mr Abercrombie had a question about mortality and the rate of RTT. Dr Murray responded by staying the figures within NELA have been too small with not enough information to start to talk about RTT as an adverse marker in terms of outcome. RTT has been a critical determinant in colorectal surgery rate and was similar regardless of which hospital you went to. RTT in emergency laparotomy's may be a good thing or a bad thing, and difficult to determine. It was decided then it was important to specify that it was an unplanned returned to theatre, instead of a simple return.

ACTION: Amend the Patient Audit to include "unplanned return to theatre" instead of "has the patient return to theatre following their initial emergency laparotomy"

Dr Murray continued his presentation and discussed the 12 high-level recommendations published within the Year 2 Report. He mentioned that these recommendations were more specific in Year 2 versus in Year 1 and focussed on commissioners and hospital boards. The discussion continued to regarding the variability within M&M meetings across hospitals. Mr Abercrombie also mentioned that the RCS has published guidance on how to run a M&M meeting, but delivery is very difficult. Another project by HQIP is a national program helping Trusts to standardise how mortality is reviewed with a new national mortality review programme being run by the RCP; "National Mortality Case Record Review Programme." Dr Murray indicated that because of the variability, the delivery and structure of M & M meetings with the Trust is one of the questions in the Organisational Audit.

5.2. Audit Update:

Dr Murray reported that the Year 4 dataset is currently being refined and that we have the opportunity to analyse existing data within ONS. An example of one of the refinements is how we look at sepsis.

At the moment, Case Ascertainment is measured by historical HES figures. We are doing work to get a better understanding of what Case Ascertainment looks like, which is proving challenging. An idea is to produce a 'basket' of cases that we can be certain of and base case ascertainment on this.

6. 2ND ORGANISATIONAL AUDIT

An Organisational Audit took place within the first year of NELA. This autumn we plan to run another one. Content is currently being signed off and is based on the original audit but refined to address areas that had ambiguity.

7. CQC COLLABORATION

Prof Grocott stated that we have collaborated with the CQC and have provided them with seven metrics, one case ascertainment, five process measures and now risk-adjusted mortality. They are now on the draft CQC Dashboard. There is a small bit of refining on the wording, and we need to finalise aspirational targets, before final submission. Currently the national target is at 80%. We anticipate that bar moving and are currently determining how high and how far in advance to set it. The PT recognises that we need to do it gradually.

There was a question on how the CQC Dashboard will be linked to the NELA data, with the point being made that we need to be very clear on how the audit and the CQC work together.

There was a second point on how the CQC Metrics will be aligned with NELA Report, and that there needs to be consistency across both the CQC and the Report.

8. QUALITY IMPROVEMENT

Dr Murray stated that the project continues to develop, taking more of a QI approach vs traditional audit approach. This means that data is more available and local collaboration is encouraged. The NELA dashboard allows for hospitals to look at real-time data and compare their local data to the national average. That dashboard facility has been there for a while, and we are now backing this up with more directed work on showing how to use it. The project team will also be starting to produce a measure of the month, encourage hospitals to have targeted work on a particular measure.

9. RESEARCH COLLABORATION

NELA has collaborated with a number of different trials, specifically:

- EPOCH: This has recently finished and is in write up phase. It has been slightly delayed as they trying to get their data from the HSCIC.
- ELC: This developed from the ELQIP collaboration. This 4-academic health sciences network, is working together to provide a QI package. It is similar to EPOCH but uses a different approach. More streamline. This is due to be completed in 2017.
- FLO-ELA: This is an individual patient randomised control fluid therapy, involving 100 hospitals, 7000 patients.

ACTION: Develop overall statistics within the NELA program to demonstrate how data is being directly used by other QI programs

10. FUTURE DIRECTION OF AUDIT

Dr Murray stated that he has touched on this through his previous presentation. Currently we are refining the data set, getting greater clarity on metrics, start to raise the bar on case ascertainment, and working on ways to have continuously QI with the facilitation of delivery of QI rather than just data collection.

11. HQIP

The NELA Specification Development meeting will be taking place in December with the Tender launch in February 2017. The new contract targeted at being launched in September 2017. This would be three months prior to the current contract finishing. The project team has an away day

planned in October, to allow for broad brush thinking of the program and to prepare for the Spec Development day in December.

12. COMMUNICATIONS STRATEGY AND PLAN

There is a Communications Plan in place and there has been general discussion on how our Stakeholders take audit results and disseminate within their own organisation. There was discussion within the Board on how we reach the MDT versus one defined subspecialty. Prof Grocott requested suggestions on creating a wider profile. Ms Silove suggested using Best Practice Tariffs and for the project team to connect with Helen Laing, Quality Governance Associate at Monitor. She suggested that it could be something that could be put on the agenda for the Spec Development meeting, or could discuss with the project team to get a better understanding of the process.

ACTION: Put Best Practice Tariff on Spec Development meeting

ACTION: Send 1-2 paragraphs to Ms Silove about what the Audit is measuring, what it is finding, and what a best practice tariff would be helpful, we so she can facilitate a conversation with Helen Lang at Monitor.

13. AOB

Prof Grocott mentioned that there may be future collaboration with Nick Black at the London School of Hygiene and Tropical Medicine, evaluating 500 patients and their recollection of PROM. This will be discussed further at the project team meetings. Mr Abercrombie mentioned that patient recollection and PROM is extremely difficult because the memory of patients is often poor because they are so ill, so methodically it is very difficult, but there was consensus that it was important to try.

The meeting was adjourned with thanks at 12.30

Date and Time of next meeting – **January 18th 2017 from 10.30-12.30**

Agenda Item	Action	Responsible	Due
4.2	An announcement that the Individual Hospital Report is available should be included within the HQIP E-Bulletin	SW	ASAP
4.2	A statement should be made on the "Report" section of the website that the Individual Hospital Reports are available upon request	SW	ASAP
4.2	Follow-up with Chris Boulton at the Royal College of Physicians	JL	ASAP
5.1	Connect with Dr David Oliver at the RCP to determine how geriatric care could be improved on medical-surgical wards and the role that NELA could play within that	MG/DM	ASAP
5.1	Review Ben Bray's article in the Lancet on the weekly variation in healthcare quality by day and time of admission:	ALL	ASAP
5.1	Amend the Patient Audit to include "unplanned return to theatre" instead of "has the patient return to theatre following their initial emergency laparotomy"	DM	ASAP
9	Develop overall statistics within the NELA program to demonstrate how data is being directly used by other QI programs	JL	ASAP
12	Put Best Practice Tariff on Spec Development meeting	SW	ASAP
12	Send 1-2 paragraphs to Ms Silove about what the Audit is measuring, what it is finding, and what a best practice tariff would be helpful, we so she can facilitate a conversation with Helen Lang at Monitor.	MG	ASAP