South and East London Clinical Audit and Improvement Network

15th November 2016, King's College Hospital

Present:

Anne Jones (Chair)	AJ	Kingston Hospital NHSFT
Kate Hutt (Vice-Chair)	KH	St George's University Hospitals NHSFT (minutes)
Sylvia Tan	ST	The Royal Marsden NHSFT
Claire Palmer	CP	King's College Hospital NHSFT
Emma-Kate Chawishly	EKC	NHS Blood & Transplant
Aysha Ahmad	AA	King's College Hospital NHSFT
Liane Greenwood	LG	King's College Hospital NHSFT
Neville Butler	NB	Your Healthcare CIC
Sam Eaton	SE	Kingston Hospital NHSFT
Philip Thompson	PT	East London NHSFT
Adisha Perera-Pitumpe	AP	Lewisham & Greenwich NHS Trust
Kathryn Chapman	KC	Lewisham & Greenwich NHS Trust
Sonia Anwar	SA	King's College Hospital NHSFT

Attending:

Kirsty MacLean Steel	KMS	NCEPOD
Nick Mahoney	NM	NCEPOD
Aysha Butt	AB	NCEPOD
Kathryn Kelly	KK	NCEPOD

Apologies:

Carol Kibble	Moorfields Eye Hospital
Emily Cannon	London Ambulance Service
Imogen Lyons	Kingston Hospital NHSFT
Karamjeet Chana	East London NHSFT
Lee Cummins	Lewisham & Greenwich NHS Trust
Matthew Picken	Epsom & St Helier University Hospitals NHS Trust
Roberta Cole	Your Healthcare CIC
Sarah Goreham	Lewisham & Greenwich NHS Trust
Amanda Allen	South East Coast Ambulance Service NHS Foundation Trust

1. Welcome, apologies and minutes of the previous meeting

AJ welcomed everyone to the meeting. The minutes of the meeting held on 15th April 2016 were agreed as an accurate record. It was noted that our most recent meeting, held on 19th September was a training session looking at data presentation and communication. AJ confirmed that materials from the session have been circulated to attendees. EKC requested a copy and AJ agreed to send on. **ACTION AJ**

Matters arising and discussion

- AJ confirmed that a summary of SELCAIN progress over the last year has been submitted to NQICAN and is available on the website
- AJ will liaise with NELCAN regarding access for all trusts in London. **ACTION AJ**
- Members reminded to place a generic clinical audit contact on websites. **ACTION All**

- AJ provided an update on the HQIP & CQC project to improve the accessibility and value of national clinical audit data. The CQC tested this approach recently in Greater Manchester and CP informed all that tranche 2 will be piloted at King's. HQIP anticipate that identification of the 5 key metrics will have been completed for all NCAPOP audits by the end of 2016/17; however, at first this will only be used for trust's undergoing CQC inspection. The intention is to have this available for all trusts, but the timescale is dependent on resources in the CQC analytics team as it is planned that the process will be automated.

2. Feedback from NQICAN

AJ gave an overview of the most recent meeting held in September, as previously circulated. The following were highlighted:

- Changes to subscription funding for NCAPOP audits, to a flat rate of £10k per trust;
- NAGCAE has been disbanded;
- NQICAN will be participating in the Patient First conference in November (some free places may still be available);
- No major changes to the Quality Account for 2017/18 are anticipated and guidance will be issued in January;
- COPD national audit will be moving to continuous collection;
- The long awaited Information Governance guide for clinical audit is due to be issued shortly;
- Feedback was provided to the authors of 'QI – training for better outcomes';
- CA Awareness Week begins on 22nd November;
- Funding for networks will continue to be available, but will not increase;
- Achievement highlighted in the SELCAIN annual report was the use of sharing and learning sessions. Improved planning of the network's programme was identified as a potential area for improvement;
- The retirement of Mandy Smith was noted and it is not clear whether HQIP will have a role dedicated to supporting local clinical audit teams.

3. Outcomes Based Healthcare

CP introduced the need to consider measurement of outcomes and explained that the team at King's has made this the focus of their work. As part of the redesign of their service King's have linked with Outcomes Based Healthcare. CP introduced Dr Rupert Dunbar-Rees.

RD-R provided a presentation which will be circulated to members and facilitated discussion around the need to measure outcomes. One of the key developments is to link the drive to measure outcomes to the cost of healthcare, i.e. is it possible to design a framework that pays for poor outcomes that do not happen. This would incentivise improvement and reward those where poor outcomes are not observed. This would require payment to be based on complete pathways, with multiple organisations sharing responsibility for overall care. The US is moving towards this system of payment.

Clarification of inputs (staff, training, budgets), processes (BP check, blood sugar test, x-ray), outputs (blood results, scan results, weight measurement) and outcomes (good quality of life, return to work, able to self-manage, less pain, prevention of complications) was provided, using the example of making a cake. This aided the understanding that an

improved output (e.g. lower blood pressure) may not be perceived an improved outcome by the patient.

Development of population based PROMs, rather than procedure specific PROMs was discussed (e.g. all frail patients, rather than just hip replacement). Members reflected that national audits focus more on processes than outcomes.

The importance of asking the right question and the balance of measuring positive and negative elements was discussed and RD-R agreed that selection of the correct PROMs tool is key. It was acknowledged that there is a trade off between length of tool and number of outcomes you can measure. It was mentioned that some commissioners are combining questions from a number of tools to fit the outcomes they are trying to measure, but that it is important that these are tested properly.

RD-R explained that his organisation, Outcomes Based Healthcare (OBH), link datasets across sectors to measure whole patient outcomes. This is very complex. RD-R was encouraged that the question has shifted from why measure outcomes to how to measure outcomes. He is keen to support colleagues through making resources available on OBH website (www.outcomesbasedhealthcare.com)

CP explained the development of the team at Kings and how it had evolved since the 1990s, to encompass clinical audit, guidelines, NICE, NCEPOD, NHSLA and mortality. However, recently with a decrease in staff numbers and a changing external environment the team re-evaluated their roles and remit. They now focus on essential activity (NICE, NCAPOP, NCEPOD), have reduced or ceased what they have assessed to be non-essential (database, minutes, reports, local clinical audits and guidelines work, follow-up and chasing) and have made patient outcomes their core purpose. They have rebranded themselves as the Patient Outcomes Team and have rewritten their job descriptions. The strapline "*What matters most: patient outcomes are defined as 'the results people care about most when seeking treatment, including longer life, symptom relief, quicker recovery and the ability to live normal, productive lives."* defines their work.

The team produce specialty and organisation level patient outcome reports, which look at risk adjusted mortality and readmissions, outcomes indicators from national audit reports and registries, national PROMS and other local sources. Also included are a few key process indicators and governance indicators.

Evolution of the department continues with Patient Outcome Lead posts of 1PA in place for each specialty, there is increased separation between outcome and safety and governance. The team want to move away from looking at specialties to pathways and to focus on value based healthcare, with increased collaboration with finance.

4. NCEPOD

AJ welcomed colleagues from NCEPOD. KMS introduced the team and all participated in delivery of a presentation providing an update on current and forthcoming studies. Hand-outs were provided.

The team acknowledged a number of frustrations over the year, including the length of the questionnaires, the more complex methodology for children's health projects and the use of SurveyMonkey.

It was clarified that child health reviews are building on work previously done and NCEPOD did not design the methodology used. NCEPOD's remit in child health is limited to the studies currently underway and they would have to bid again to manage projects in the future.

There are two new projects in the pipeline: heart failure and diabetes – peri-operative care. Members queried the selection of heart failure as a topic as there is already a national audit. KMS offered to get further detail to feedback.

5. Round table

Time did not allow for a round table session and no urgent issues were raised.

6. AOB

Having served an extra year in addition to the initial 2 year term, AJ and KH confirmed their intention to stand down as SELCAIN chair and vice-chair respectively. AJ and KH are happy to facilitate the meeting planned for February, and will include the election of a new chair and vice-chair on the agenda. Both would be happy to discuss the roles with any interested members.

7. Date of next meeting

The next meeting will be held on 2nd February 2017, 13:30 – 16:30 at Guy's Hospital (Burfoot Court Room, Counting House). NICE will be delivering a session to provide an update on their work and to engage with local teams.

Minutes to be taken by: volunteer needed please. **ACTION All**