

South and East London Clinical Audit and Improvement Network

27th February 2015, University Hospital Lewisham

Present:

Anne Jones (Chair)	AJ	Kingston Hospital NHSFT
Kate Hutt (Deputy Chair)	KH	St George's University Hospitals NHSFT (minutes)
Sarah Goreham	SG	Lewisham + Greenwich NHS Trust
Jason Wells	JW	Lewisham + Greenwich NHS Trust
Janet Kingdom	JK	Epsom and St Helier NHS Trust
Sylvia Tan	ST	The Royal Marsden NHSFT
Andrew Swain	AS	Kingston Hospital NHSFT
Mallisa Edward	ME	East London NHSFT
Tetyana Byford	TB	Lewisham + Greenwich NHS Trust
Rupinder Chana	RC	Hounslow + Richmond Community Trust
Deborah McBrien	DM	Barts Health NHS Trust
Nathalie Celestin	NS	Lewisham + Greenwich NHS Trust
Natasha Antoine	NA	Lewisham + Greenwich NHS Trust

Attending

David Harvey	DH	Manager, Acute Intelligence Monitoring, CQC
Sanjay Krishnamoorthy	SJ	Clinical Fellow, CQC
Laura Spratling	LS	Senior programme manager, Health Innovation Network
Andrea Carter	AC	Senior programme manager, Health Innovation Network

1. Welcome, apologies and minutes of the previous meeting

AJ welcomed everyone to the meeting. Apologies were noted from Kerry Tauxe and Veronica Kemp (SLAM).

The minutes of the meeting held on 24th November 2014 were agreed as an accurate record, subject to the following amendment:

- Correction of SG's name to Sarah Goreham

Matters arising and discussion

- It was agreed that the minutes would be taken on a rota basis. KH/AJ to ask for a volunteer for the June meeting.
- AJ will send SELCAN minutes from 24th November 2014 to NQICAN for inclusion on their website. **ACTION AJ**
- AJ has spoken to Kate Godfrey at HQIP and they are currently considering whether to reappoint to the post held by Liz Smith prior to her retirement.
- Terms of Reference which were agreed at the last meeting will be circulated with the minutes. **ACTION AJ**

2. CQC Intelligent Monitoring

AJ welcomed David Harvey and Sanjay Krishnamoorthy. DH mentioned that he would be happy for his presentation to be circulated. **Action: AJ/KH to circulate with minutes.**

DH briefed the group on the changes to the CQC's strategy which resulted in a move from the Quality + Risk Profile (QRP) reports to Intelligent Monitoring (IM) reports.

The IM is a simpler model than the QRP with fewer indicators. There are approximately 150 measures, but not all will be relevant to every organisation. There is less statistical modelling and a move towards simplified assessment of whether there is evidence of any risk. A priority score is calculated for each organisation which takes into account the presence and level of risk for each relevant indicator. This priority score is then translated into a banding, and those with the highest risk are prioritised for inspection.

The IM report is also more widely published than the QRP, supporting the NHS agenda of increasing openness and transparency. DH informed the group that the message to the public and press was not always easily understood as the priority score and banding does not equate to a definitive judgement about the quality of an organisation.

The IM team try to organise the measures around the CQC's 5 key questions (i.e. is the service safe, effective, caring, responsive and well-led?). There are 3 tiers of indicators:

- Tier 1 – included in IM report;
- Tier 2 – used to form a wider view of an organisation and are looked at in more detail at inspection. These indicators are included in inspection data packs;
- Tier 3 – in development.

DH reported that the CQC see patient experience as an increasingly important driver for monitoring and inspection.

DH reported that the CQC have identified learning from experience of the IM to date:

- Communication with the press is a challenge;
- Longer time for trusts to review draft prior to publication (but this must be balanced with ensuring timeliness of publication);
- Evaluating comparison between indication from IM report and outcome of inspection. Early work suggests that there is some correlation but this work is not yet complete.

The IM team work with a Provider Reference Group to help guide development and implementation of IM.

Next steps identified:

- Refinement of IM for mental health trusts. Only one report published to date;
- Developing IM for other sectors that the CQC regulates (for example General practice);
- Meet intended quarterly publication schedule;
- Ongoing indicator development.

DH clarified the Tier 1 audit indicators currently included in IM:

- SSNAP (stroke);
- NHFD (hip fracture);
- MINAP (ischaemia and heart attacks)

It was noted that MINAP data did not appear in the December 2014 IM as the data was considered too old; however DH confirmed that it would be included in the next IM report. SSNAP was identified as the 'gold standard' audit indicator as timely data is published regularly with clear judgement on standards that allows benchmarking of organisations.

SK briefed the group on development of Tier 2 indicators drawn from national audits. The list presented was not definitive but gave a useful indication of the breadth of indicators being considered, with the intention that the 8 key services are covered. It was noted that not all audits are NCAPOP.

Some network members highlighted that the quality of audits is variable. SK provided assurance that when deciding on those to be included they would identify the key metrics the audit provides and ensure that the data flow and presentation are of sufficient quality. Network members were hopeful that this work would further help to drive the quality and usefulness of national audits. SK informed the group that HQIP will be hiring a clinical fellow to work with him in taking this forward. DH explained that there is a 'control gateway' for Tier 1 indicators, so that if the metric is not of sufficient quality it will not be included in the IM report.

AJ asked how non-participation is evaluated. DH reported that there was no definitive answer but that this may be identified as a risk, but stressed that the CQC should not be seen as the 'stick' to force participation in audit. SK informed the group that the approach at inspection is reasonably flexible and if a trust can provide assurance that local audit and action is in place then that would be accepted. However, participation in mandatory NCAPOP audits is expected.

Questions were asked about the scheduling of inspections and DH explained that the IM is a key driver in prioritisation, however there is no rule to say inspection of trusts with the highest priority score must be carried out within a set timeframe. However, trusts in Band 1 or 2 are likely to be included in the next scheduling round.

ST asked how mortality data was derived and DH informed the group that this was a direct feed from Dr Foster Intelligence. Some explanation of composite indicators is included on the website, however the IM team can be contacted for assistance if necessary. DH clarified that the IM team has 9 members and therefore same day responses could not be guaranteed.

ME asked if there was particular focus on any mental health audits. RC suggested that it may be helpful to look at the National Schizophrenia audit and the Prescribing Observatory for Mental Health.

3. Health Innovation Network

AJ welcomed Andrea Carter and Laura Spratling from the Health Innovation Network.

AC and LS attended to provide the network with an overview of the work of the HIN, with detail about the programmes that they manage (musculoskeletal and diabetes). **Action: AJ/KH to circulate slides with the minutes.**

AC explained that the HIN is in its second year of operation and is one of 15 academic health science networks. There are two other AHSNs in London. The HIN is also hosting the SW London Patient Safety Collaborative programme.

The HIN is a membership organisation (with cross sector and industry members), funded by NHS England. There are strong links with Health Education South London (HESL). HIN's agenda is to capitalise on teaching and research strengths and to generate wealth to benefit local areas. Exchange between networks is encouraged.

The clinical themes prioritised by HIN represent large scale population health challenges; specifically diabetes, dementia, musculoskeletal (MSK), alcohol and cancer. All of these projects have cross cutting themes relating to patient safety, wealth creation, engagement and education. It was noted that variation and poor access to treatments and pathways are common across the themes or programmes.

Each programme has a 'plan on a page' which summarises the priorities to be addressed. These are identified through a process with varied stakeholders and must be things that the network can add value to. These priorities are translated into a number of projects. For example in diabetes key strands of work are around technologies, self-management and integration of care. For MSK projects are underway to address early identification and self-management.

Each programme team has a Senior responsible officer, Clinical director, Programme manager and Project managers. The inclusion of Darzi fellows is particularly valuable in bridging the boundaries between academic and clinical work.

The HIN works to identify best practice and information on what works well and provide access to member organisation of models that have been tested and shown to work well. The network also aims to share approaches that have worked well and could transfer to another programme. Examples include:

- Dementia: 'Barbara's story' produced by GSTT to raise awareness of dementia.
- MSK: The 'escape pain' programme which has spread to a number of areas.
- Diabetes: Work with LAS to implement pathways that result in higher quality follow up and prevention of recurrence may also have applicability for other areas such as alcohol and falls.

AC explained that none of the projects have yet been completed so sustainability has not been tested, however some are now receiving less support as they are working well, for example 'escape pain'.

AC explained that the HIN encourage people to share their innovative approaches and that some grants are available through HESL to organisations that want to spread innovations.

General discussion showed that the presentation increased members knowledge of this work and all were thankful for the valuable overview.

4. Round table

There was discussion around the table about current issues in each trust:

- Lewisham & Greenwich – SG asked what approaches members had for registration of audits as they wish to move away from paper forms. Members shared information on their systems including Keypoint, RaTE, SNAP and CRT viewpoint, however many of these were used for collecting audit data rather than for automating registration. Kingston previously used a form designed in Access and currently use an Adobe product but are considering using Formstack as the Adobe product is being discontinued. TB reported that there have been progress with the teams work around NICE, PROMs, benchmarking and Training and education.
- Kingston Hospital – AS informed the group that the team recently had an away day to evaluate progress over the last year. Issues that were discussed included the impact of

implementing Cerner clinical documentation which has slowed down the audit process. The London Quality Standards work also had an impact on resource. Cost savings and the need to do more with less resource was also highlighted. An action plan has been developed from this review.

- St Georges – KH advised that the trust was authorised as a Foundation Trust in February 2015. The team continue to engage in learning how to extract data to be used in audit directly from the Cerner system, but this is proving to be time consuming and complex.
- East London Foundation Trust – ME asked members to share their approaches for reporting audit results and actions to service users in a timely and engaging way. The trust is currently looking at a company called Pictograph. It was suggested that there may be HQIP guidance, particularly from Kim Rezel (PPI lead).
- Epsom & St Helier – JK reported that they are also looking at revising their registration process. Current issues include a reluctance from juniors to get involved in re-audit and the team are working to drive this forward. Mapping the BAF to the audit programme is also underway.

5. Sharing and learning session

AJ suggested that each meeting should include a sharing and learning session where organisations share their approach to a particular issue so that we may all learn from one another. This was approved as a regular standing item and it was agreed that the management of national audits and confidential enquiries should be the focus in the June meeting. **Action: AJ/KH to liaise with colleagues about involvement in and specific content of session.**

6. AOB

Feedback on leaflet for junior doctors from HQIP/NICE: Some members reported that they had not received the leaflet and therefore this will be discussed in June. **Action: AJ/KH to resend leaflet.**

ME kindly offered to host a future meeting. Action: KH to liaise with ME regarding a date for September.

7. Date of next meeting

Monday 1st June 2015, 13:15- 16:30

Hosted by Barts Health at 9 Prescott Street, Aldgate, London E1 8PR

Guest presentation from Marisa Mason, Chief Executive of NCEPOD.

Sharing and Learning Session: National audits and confidential enquiries.

Minutes to be taken by: ACTION: volunteer needed please!