



NACSA Project Board Meeting

5th October 2012 11:00 – 13:00

Minutes

Present:

| | | | |
|----------------------------|----|-----------------------------------|----------------------|
| Ben Bridgewater (Chair) | BB | Consultant Cardiothoracic Surgeon | Uni. Hosp S. Manc |
| Rebecca Cosgriff (Minutes) | RC | NACSA Project Manager | NICOR |
| Nadeem Fazal | NF | Services Manager | NICOR |
| Mike Fisher | MF | Patient Representative | SCTS |
| Stuart Grant | SG | Surgical Trainee | Uni. Hosp S. Manc |
| Graeme Hickey | GH | Biostatistician | NIBHI |
| Simon Kendall (via Skype) | SK | Consultant Cardiothoracic Surgeon | James Cook Uni. Hosp |
| Lynne Walker | LW | Programme Manager | NICOR |

Action

1. Welcome and Introductions

RC welcomed everyone to the first meeting of the National Adult Cardiac Surgery Audit (NACSA) project board and all attendees introduced themselves to the group.

2. Apologies

Apologies were received from Zoë Fearnley, Emmanuel Lazaridis and Sue Manuel.

3. The Blue Book

BB explained to the group that all NACSA participating units are currently validating their data from April 2008 to March 2011 using analysis provided by GH. The deadline for resubmission of any amended data is 08/10/2012. A fresh export will be taken on 09/10/2012 by NF's team at NICOR so that GH can re-do analysis for units to sign off for inclusion in the next edition of the Blue Book. The Blue Book will update analysis from previous editions and provide in depth commentary on National Commissioning. It will contain minimal hospital level data and nothing surgeon specific. The core team for writing of the Blue Book will be BB, GH, SG and RC, in consultation with MF and the SCTS editorial group. The Blue Book should be ready for publication by the end of 2012.

Hospital/Surgeon specific data and analysis will be sent to the SCTS for governance checks, and will be published by the SCTS in due course in consultation with NICOR. Graham Cooper and James Roxburgh want a time window between identification of outliers and the publication of this data to allow time for the SCTS governance processes to take effect (see agenda item 6).

SK queried the possible risks associated with this project and BB described potential incompatibility of the export from NICOR, the dependence on a small number of individuals and units unable to validate their data.

RC stated that she has received acknowledgement of the receipt of the analysis files from

all units, and that herself and GH have received follow up queries about the data from approximately half of hospitals.

LW queried the timescale for publication and BB stated that John Deanfield, James Roxburgh and the SCTS need to decide a publication date. The group agreed that publication should be as soon as possible as the 2008 Blue Book data is now out of date. Dendrite has agreed to produce digital copies of the Blue Book. Funding will need to be secured for printing if it is deemed necessary.

MF queried how idiosyncrasies in the data are followed up on and BB explained that this is done through unit's validation of their own data and the SCTS procedure for identifying outliers.

LW asked why the Blue Book will only include analysis of data up to 2010/11. RC explained that many units have only just submitted 2011/12 data in accordance with the extended September 2012 deadline. Analysis of this data will be included in the next NACSA annual report, to be published early next year (see Agenda item 7). Deadlines can be more actively enforced and publication dates brought forward now that a full time project manager is in post.

Action: Blue Book Project team to report back to group on progress at the next meeting.

BB, GH,
SG, RC

4. HES Data

BB explained that there has been a historic misconception that HES data should be considered the 'gold standard', whereas in reality HES and National Audit data are different ways of collecting similar information, with neither being overtly superior to the other. Work is currently on-going in partnership with Domenico Pagano's team in Birmingham to compare HES data to NACSA audit data in order to understand variance. The project has been held up by lack of analytical capacity in Birmingham but things are moving forward now. The project will be used to inform a discussion of HES data in the commissioning section of the Blue Book.

Ultimately there is a goal to link HES data with National Clinical Audit Data at patient level. LW reported that David Cunningham is working on this at the moment.

Action: BB to update the group on the progress of this project at the next meeting

BB

5. The E-Lab

BB provided the group with an outline of the E-Lab project. It is designed as a move away from static books/reports to a more accessible and contemporaneous window into cleaned NACSA data. The E-Lab will be co-branded between SCTS, NICOR and University of Manchester, and will have three modules:

1. Hospital and Surgeon level customisable analysis, accessible only to relevant hospitals/surgeons and downloadable for use in Revalidation.
2. Free access 'Blue Book Online', replicating analysis that will be provided in the next Blue Book, which can be tailored by time frame and operative group and will be updated on a quarterly basis.
3. SCTS look-up table, which will provide surgeons and the public with the ability to enter patient characteristics and bring up actual outcomes (mortality and LOS) of similar patients entered whose details are held on the NACSA database. This will assist clinical decision making and provision of comprehensive patient

information.

Funding has been sourced for the first two modules, and it is hoped that the E-Lab will be up and running by the end of 2012. It will create a scientific network that is open to all.

NF queried how data will be fed into the E-Lab, and GH stated that it will be via export as with the Blue Book initially, with a view to establishing a direct link between E-Health and NICOR, with data cleaning built in, at a later stage.

MF queried how data security will be ensured. BB stated that no patient identifiable information will be transferred within the export from NICOR, and that RC will manage the access rights for individuals and groups, such as hospitals, surgeons and cardiac networks. E-Health's E-Lab platform is secure and the SCST platform will undergo further penetration testing.

GH added that the web front end of the E-Lab will be accessible only with a login name and password, and that E-Health's security ensures that the data stored on the server cannot be accessed by any other means.

SK asked whether the E-Lab would replace future editions of the Blue Book. BB said that it will replace the majority of the analytic content, but that publications will still be produced similar to *Maintaining Patient's Trust* and section two of the edition currently being drafted.

RC relayed a query from Emmanuel Lazaridis regarding the degree to which E-Lab coding will be transferable to the new National Clinical Audit System, which is in development at NICOR and would possibly benefit from the analytical functions within E-Lab. GH stated that it will predominantly be written in C-Sharp, with some JAVA and a small amount of R. A compatible system may not be easy to achieve, as the SCTS E-Lab is designed to lie on the pre-existing E-Health online 'Lab' platform.

Action: RC is to relay this information to Emmanuel Lazaridis and the NCAS project manager, Emma Raine.

RC

Action: BB to update the group on the progress of this project at the next meeting

BB

6. Public Portal

It is yet to be decided whether the public portal, replacing the webpages on the CQC website, will take the form of a downloadable PDF or web-pages. James Roxburgh is keen to incorporate the portal into the SCTS website and discussion is on-going within the professional society regarding this.

Action: SK to report back on these discussions at the next meeting

SK

NF queried what will happen to the old CQC webpages. BB stated that they will be closed down once the new portal is up and running.

SK raised the contention surrounding publication of surgeon specific data. BB recognised that this is a political discussion not under the jurisdiction of the NACSA project board, but relayed that current feeling at the SCTS may be to move away from Surgeon specific data.

MF stated that, from a patient point of view, it is the hospital level data that is of interest, and that hospitals should be responsible for individual consultant figures within that.

BB acknowledged this but stated that at the moment hospitals need to earn the right to be solely responsible for managing their own outliers. SK agreed that for the time being external scrutiny is required to assist units to deal with any problems in this area.

GH added that surgeon specific data is required for statistical reasons. Individual surgeons might be outliers, but be hidden amongst better performing surgeons at hospital level. Also, several borderline surgeons may not individually appear as outliers, but cumulatively result in an outlying hospital.

BB relayed that the SCTS have asked for a response about potential risk adverse behaviours as a result of surgeon specific data publication. A lot of work has been done to counter/avoid this, such as excluding emergency and salvage cases from current risk adjusted analysis. A paper is under review for publication regarding this.

7. NACSA Annual Report Schedule

The group are keen to bring the publication dates for annual reports closer to the analysis periods. BB stated that, once the current validation period is over and units have been given a bit of respite, they will be asked to validate their 2011/12 data for the annual report (mid-November). This should be less laborious as all data from 2008/09 – 2010/11 will have already been checked. Also, much of the coding for the analysis will already have been written for the Blue Book. Once validation has occurred, content will be finalised and commentary written with a target publication date of end of Feb/March 2013.

BB stated that the majority of the work for the previous report was done by the team in Manchester (BB, GH and SG) as NICOR lacks analytical capacity. BB requested that this work be formally recognised through honorary contracts for all those involved. This would also potentially help with data sharing agreements between the two groups.

GH clarified that his current contract is solely with the University of Manchester and that SG's contribution to NACSA is entirely voluntary.

The group were in support of this arrangement being established as soon as possible.

RC reported that Zoë Fearnley is working on BB's contract and that GH has sent his CV to begin the process.

Action: SG to send his CV to ZF

Action: RC to speak to ZF about formal recognition of 'NICOR in the North'

SG
RC

In the meantime, BB, GH and SG are happy to begin work on the next NACSA annual report in due course.

Action: RC is to draft a proposal of the basic structure and content of the annual report in consultation with GH for approval by the Board.

RC

BB asked MF whether he would be willing to write a 'patient perspective' for the report.

MF agreed but requested guidance when doing so, which will be provided by members of the board.

A project plan is to be included in the next annual report to outline the developments discussed at this meeting.

8. Dataset revision

RC explained that the NACSA dataset version 4.1.2 is due to be considered for revision in accordance with NACSA project plan v2.0.

RC and GH explained that there are a number of relatively minor issues with the dataset, such as repetition of the pre, intra and post-operative support devices sections and 'other cardiac procedures' that are not actually cardiac (e.g. Carotid Endarterectomy). Although these issues can be countered by cleaning the data for analysis purposes, they lead to confusion with the users and affect data quality.

BB explained that changing the dataset is an enormous undertaking and that it should be avoided unless absolutely necessary to incorporate new clinical practices/guidelines. RC stated that some users are only now updating their commercial systems to accommodate the 'new' 2011 dataset.

RC suggested that a comprehensive 'user guide' explaining all of the fields in detail, including any idiosyncrasies, would help to maintain data quality. RC is happy to write the bulk of the document, but will need clinical input for some fields.

Action: RC to draft a user guide, engaging BB and SG as necessary, for approval by the board.

RC

The group agreed that, in light of the problems identified in dataset version 4.1.2, and the time it takes to implement changes, the dataset should be considered for revision in six months (March 2013) rather than the usual two years outlined in the project management plan.

Action: Dataset revision to be put on the Project Board's agenda in 6 months' time.

RC

SK queried whether the dataset should start tracking hemi sternotomies for AVR. BB stated that this is a research question rather than something to be included in the dataset at the moment. However, unconventional sternotomies could be considered for inclusion in 6 months.

SK queried whether the Birmingham Training fields are in use. SG reported that they are not, and BB stated that adding these extra fields, which are collected via other means, would overburden units unnecessarily.

9. SCTS Database Manager's meeting

BB explained that the SCTS conference includes a session for NACSA database managers. GH and SG presented at it last time, when it was funded by Dendrite.

SK pointed out that often database managers don't have study leave or funding to attend meetings, but are key to the success of NACSA. LW stated that NICOR may be able to subsidise travel expenses for attendees.

Action: RC to draft communication to clinical leads asking for provision to be made for database managers attending this meeting, to be sent out by/on behalf of BB and SK.

RC

Action: LW and RC to discuss funding with ZF

LW/RC

RC pointed out that this meeting replaces the HQIP contractual deliverable for user 'workshops' so it needs to be structured to incorporate networking opportunities and best practice sharing.

Action: RC to draft agenda for approval by the Board. It is to include presentations on EuroSCORE/Risk modelling

RC

Action: BB to provide RC with conference secretary Ian Wilson's contact details

BB

10. LOS data for NHS choices

RC reported that NHS choices have requested LOS data in addition to the mortality data already provided by NACSA.

BB stated that this information is not readily available as it was not included in the annual report. LW said that we are not required to provide analysis that hasn't already been carried out.

Action: RC to report to NHS choice that LOS data will be provided if/when it is available

RC

11. Private Hospital Data Submissions/Recruitment

RC reported that she has been canvassing private hospitals to increase participation (currently three hospitals from HCA international are the only private participants in NACSA). BUPA has expressed a desire to encourage the healthcare providers it commissions with to participate, and recruitment material has been sent to them to pass on. St Anthony's and Manor Hospital have both respond and are being set up with access at the moment.

Incidentally RC has been informed that some private hospitals may be submitting their data under a separate NHS hospital's three digit code. This would affect data quality as it would be impossible to tell which 'private' patients were genuinely treated within the NHS hospital, and which were operated on in a separate private unit.

SK reported that this may be due to lack of resource in small private units, and that in his opinion it is better to capture the data under the wrong hospital than not at all.

RC pointed out that Lotus Notes licences are provided free of charge to hospitals that want to submit data.

GH queried whether hospitals could simply select a different hospital identifier if they were entering records on behalf of another unit. BB reported that some commercial software companies have refused to support this function in the past.

BB said that this was shocking news, which is not in the spirit of what NACSA is trying to achieve and interferes with governance arrangements. This problem needs to be rectified going forward and we need to explore how feasible it is to amend affected

records retrospectively.

Action: RC to send out an email to database managers to assess the scale of the issue so that an appropriate plan of action can be formulated.

RC

BB queried whether the group felt that we should feed back to NHS hospitals about their surgeon's private practice at other hospitals, or whether hospitals are only concerned with practice within their own procedures.

SK suggested that it is beneficial to have all the information about a surgeon for safety, and to ensure that NHS and private practice doesn't significantly differ.

GH stated this it's difficult to provide analysis on all of a surgeon's practice due to missing GMC codes. RC stated that all GMC codes are now complete for 08/09 – 10/11.

The group agreed that analysis should look at the totality of practice but review these both separately and together for the purposes of governance.

12. Any Other Business

MF suggested that it would be useful to have a timeline for all current and planned projects for the board to consult and track. The group were in agreement.

Action: RC is to write a NACSA timeline for circulation ahead of the next meeting

RC

Date of the next meeting

RC is to send out a doodle poll ASAP for suggested meeting dates in January 2013, to be held on the same day as the Research Group meeting.

RC