



NACSA Project Board Meeting

8th January 2013 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
Joel Dunning	JD	Consultant Cardiothoracic Surgeon	James Cook Uni. Hosp.
Mike Fisher	MF	Patient Representative	SCTS
Zoë Fearnley	ZF	Chief Operating Officer	NICOR
Stuart Grant	SG	Core Surgical Trainee & Honorary Research Fellow in cardiovascular surgery	Uni. Hosp S. Manc
Graeme Hickey	GH	Biostatistician	NIBHI
Emmanuel Lazaridis	EL	Senior Information Analyst	NICOR
Tracy Smailes	TS	Database Manager	James Cook Uni. Hosp.
Lynne Walker	LW	Programme Manager	NICOR

Action

1. Welcome and Introductions

RC welcomed TS to the group as the new database manager representative.

2. Apologies

Apologies were received from Nadeem Fazal, Simon Kendall and Sue Manuel.

3. Minutes of the last meeting

The minutes were agreed to be an accurate record of the meeting.

Matters arising

4. HES Data

BB reported that the HES project has regained analytical capacity but that comparison between HES and national audit data has revealed significant discrepancies. It is difficult to tell whether the error lies with the HES or audit data, but there are likely coding and classification issues with HES. Resolving and explaining these discrepancies would be a major piece of work that would require funding, and NACSA has other priorities for the time being.

ZF stated that David Cunningham is currently working to link audit and HES data for NICOR.

Action: RC to seek update from David Cunningham on this work for the next meeting

RC

5. The E-lab

EL reported that the NCAS project team requires more information about the E-lab to establish whether it can be incorporated into the new system, or NCAS development can

be informed by E-lab.

BB stated that data cleaning and flag attribution should be incorporated into NCAS, but that E-lab development shouldn't be held up by NCAS.

EL stated that GH's code should be able to be incorporated into NCAS, but that issues might lie in incorporating the web interface.

Action: RC to set up meeting between Rob Harper, GH, EL, BB and an interface developer from NCAS. **RC**

6. Public portal

MF raised a query about the contention around publishing funnel plots.

BB explained that this was down to the various ways of presenting funnel plot data as either:

- a) One dot per surgeon/hospital with control limits
- b) All surgeons/hospitals displayed greyed out with unit under consideration in bold, along with control limits

The profession in general seems to favour a), but both BB and MF agreed that they preferred b), as it is easier for patients to understand and for units to compare their performance to others'.

MF asked whether indecision was holding up the process of publishing funnel plots. BB stated that a decision needs to be made this week prior to the plots being sent for upload next week.

GH reported that some surgeons would not appear in analysis as they have carried out <30 operations in the three year analysis period. Their data will still contribute to the overall model.

MF queried whether low volume surgeons should be monitored more closely. BB explained that these surgeons had probably only just started operating toward the end of the analysis period, rather than being genuinely low volume surgeons.

7. NACSA Annual Report Schedule

Action: ZF to chase the allocation of honorary contracts to GH and SG, and report back week starting 14th January. **ZF**

8. Dataset revision

Action: RC to send draft user guide to BB and SG for clinical input **RC**

9. SCTS database manager's meeting

Action: RC to send BB a drafted email to mail out asking clinical leads for provision to be made for database managers to attend this meeting, along with distribution list. **RC/BB**

RC reported that the attendance fee and standard class travel will be funded by NICOR. TS stated that this is a positive development, as attendance last year dropped due to lack of funding.

11. Private hospital data submissions/recruitment

RC reports that only one NHS hospital has reported itself as submitting private hospital data. The private healthcare provider concerned was approached and has stated that the issue would be looked into.

Action: RC to chase private healthcare provider to sign up to submit data independently.

RC

12. Any other business

RC drew the group's attention to the new NACSA project plan.

BB commented that an ambitious work schedule was being kept well to time.

4. Database Manager Representation

RC stated that TS has suggested that database managers should be representatives on the NACSA project board on a rotational basis. This would allow for wider representation and lessen the burden of participation.

JD remarked that consistency is important, and TS agreed that a 6 monthly rotation might be too frequent, but that equal representation is important as database managers come from diverse backgrounds and employ different methods to collect and submit data.

LW suggested that it might be advisable to have two database managers on the project board.

Action: RC to put this issue on the agenda for the database manager's meeting in March

RC

5. Project development updates

a) SCTS governance

BB reported that this process is complete; letters have been sent out by James Roxburgh and units are acting upon them where necessary.

In order to carry out the governance procedure, a series of choices about how to conduct out the analysis were made, according to what was thought to be accurate and fair. However, should someone else have made these choices the outliers may have differed.

For the sake of transparency, and in response to the NHS commissioning board's announcement that ten other specialities will soon be required to publish individual team results, the project team have described the governance process in detail in a paper that will be sent to the BMJ tomorrow. This work has been carried out in collaboration with Roger Boyle and John Deanfield.

LW requested that this paper be sent to Peter Ludman and Simon Redwood.

Action: BB to send BMJ governance paper to PL and SR

BB

BB reported that the governance procedure has confirmed that internal regulation and monitoring has been effective.

b) SCTS Public Portal

It has been agreed that the public portal will be hosted on the SCTS website. James Roxburgh and Bruce Keogh have negotiated for this to be funded by HQIP, and the cost is minimal. We are now awaiting confirmation of opt outs, finalisation of the look and format, and testing of the portal prior to launch at the end of January 2013.

LW requested that HQIP are informed of the launch date.

Action: RC to inform HQIP of the SCTS public portal launch date.

RC

The deadline for opting out of publication of hospital and/or surgeon level data passed on 4th January 2013. Read receipts and/or responses have been received for all but five

hospitals, which RC will chase this week. Three units have opted out of the publication of individual surgeon data.

c) Blue Book

BB stated that the project team has taken the decision to concentrate on the patient friendly version of the Blue Book, as E-lab will largely satisfy the requirements of professionals. All of the analysis is ready and the writing is largely complete, with contributions from MF and Donald Irving. The Blue Book also contains information on Patient Reported Experience Measures (PREMS) via a picker questionnaire.

BB is to complete the writing on Thursday, send to RC for proofing/editing, after which stage Dendrite will convert the file into a working document to be published in PDF format when finalised.

The Blue Book will be published soon after the Francis mid-staffs report is released, along with an SCTS press release.

MF queried whether BB wishes to link the Blue Book to mid-staffs?

BB stated that the mid-staffs report will likely be highly critical. The Blue Book will act as a good example of how things can be done, in addition to informing patients.

MF stated that the cardiac experience will be fundamental and a great piece of learning to be rolled out.

LW queried whether hard copies will be available.

BB stated that the report will be available online only as a PDF. MF stated that this is the best way to distribute it to patients.

d) E-lab

BB reported on the developmental progress for the three modules planned for the E-lab, described in project board minutes dated 5th October 2012.

Blue Book online – almost ready for launch

Governance tool – we will receive an update on the development of this at the next meeting with NWeH, scheduled for 23rd January 2013. It should be less work to complete than the Blue Book online

SCTS look-up table – BB explained that since the original conception of the SCTS look-up table, technology has moved on and a more effective method for making this information available has been devised by SG and GH.

SG explained that the SCTS look-up table will take the form of an offline application, which can be launched from both web based and smart phone platforms. The application will use a formula based on the data that will be regularly updated and contain no patient identifiable information.

The setup of servers from which to run the E-lab is ongoing within UCL, and the web address is still to be finalised. BB has notified John Deanfield, Roger Boyle, and ZF of E-lab development, and the tool will be officially launched with a press release at the SCTS annual meeting in March 2013. PM David Cameron has been invited to attend the meeting.

TS praised the development of the E-lab, and queried whether hospitals are submitting data frequently enough to support the quarterly updates.

RC reported that units are getting better at submitting data according to the quarterly deadlines, after a long period of being used to annual upload in some cases.

BB stated that generally data is chased according to specific project deadlines, such as governance analysis, but that quarterly upload should be sufficient to support the needs of NACSA.

LW queried whether monthly upload might be more suitable

BB and TS explained that some cases take over a month to resolve, so a three month lag is required.

6. Annual report 2013: schedule and content

RC reported that she has circulated the draft content to the Project board, and that the analytical material will mirror that included in the Blue Book, so that it can be generated rapidly by GH.

RC voiced concern that the Annual report is not yet being drafted, and would need to be submitted to HQIP by the end of January if it were to be published in March 2013.

BB queried the need for an annual report given that the data contained within it will be freely available via the E-lab and SCTS portal.

LW and ZF suggested that a meeting should be set up with Helen Laing at HQIP to discuss the Annual Report contractual deliverable.

It was suggested that an annual report could point to the data available online, and focus more on case studies and the project development plan.

Action: RC to bring forward NACSA contract review meeting with HQIP to discuss the Annual report

RC

7. Project board terms of reference

RC explained the requirement for TOR for the project board, and that the document had been disseminated to members prior to the meeting.

LW suggested that the TOR might serve as a template for other audits and RC stated that a best practice sharing workshop between the other Project Managers is scheduled for January, after which point the terms of reference may be altered slightly.

ZF suggested that the TOR should explain the relationship of the project board with the NACSA research group.

LW suggested that a commissioner of care should be invited to join the group. BB agreed in principle but stated that at the moment the changing NHS infrastructure makes it unclear who would be best to invite. On hold.

The group approved the TOR in principle, on the understanding that ZF's suggestion is incorporated and that the document may evolve in the future in consultation with the project board.

Action: RC to incorporate the relationship between the research group into the TOR and report back to the group on any changes made to them in future.

RC

8. Date of death

RC explained that NICOR are still unable to provide date of death to anyone external to NICOR, and that only select individuals within NICOR are able to view them according to the data sharing agreement with MRIS.

BB queried why the issue was taking so long to resolve and ZF explained that discussions are ongoing, and that it will be chased with David Cunningham, John Deanfield and Roger Boyle ASAP.

BB stated that data protection shouldn't apply post mortem and that clarity on what is/isn't allowed and why is needed. BB queried whether GH could be added to the list of people allowed to view DOD on NICOR's data sharing agreement via an honorary contract. ZF agreed to explore this option.

EL explained that he doesn't need to see date of death for analysis of the other audits as the cleaning code runs within the server and produces aggregate, non-identifiable analysis to be viewed.

GH stated that in order to clean the NACSA data he must be able to see the data to check that the code is working correctly.

SG added that the cleaning is a dynamic process, and new data coming in can break the code. Therefore the data needs continued monitoring to ensure the effectiveness of the cleaning, including resolving date of death conflicts.

The group concluded that there is no way around the issue, and that GH and SG require access to date of death. Intervals to death are insufficient. This is a very important issue that requires urgent resolution.

Action: ZF to chase discussions to resolve the data sharing issue, and also explore the possibility of adding GH and SG to the data sharing agreement.

ZF

9. NACSA Inclusion criteria: Age and Congenital

RC explained to the group that currently inclusion criteria for the Congenital Heart Disease Audit is:

"All cardiac or intrathoracic great vessel procedures carried out in patients under the age of 16 years, and all adult congenital cardiac procedures performed for a cardiac defect present from birth."

As NACSA only includes patients aged 18 or over, this means that there is a two year gap where non-congenital patients receiving heart surgery may be being missed. A lack of clarity on the age criterion and where adult congenital patients should be entered has led to there being duplication of data and, presumably, patients missing from both databases.

RC has contacted the Clinical Lead for Congenital, John Gibbs, who argued that patients who aren't congenital and are 16 or over should be entered onto NACSA, and all heart surgery for <16year olds and all congenital surgery (irrespective of age) should go to the congenital database.

BB disagreed, stating that congenital surgery on adults should be entered onto NACSA. Adult operations are carried out in adult units that are not configured to enter data onto the congenital database. It would not be practical to set up adult units to contribute to the congenital audit as the number of relevant operations would be minimal.

GH reported that 448 patients out of a total >450,000 on the database have been entered onto NACSA that are <18 years old.

The group agreed that the congenital audit should close the age gap (i.e. include all

patients aged 16 and 17), and that all patients, including congenital, aged 18 and over, should be entered onto NACSA.

BB reassured the group those non-congenital cases for <18 year olds would likely be trauma, which are picked up by the national trauma audit (TARN).

Action: RC to relay the group's views to the Congenital audit team and report back to the project board at the next meeting.

RC

10. National Clinical Audit System Schedule

RC reported that the new NICOR IT platform, replacing lotus notes, is currently under development. The audits will be migrated to the new system one at a time, with NACSA scheduled to go live in August 2013. Consultation with the NACSA team on development of the system is scheduled to begin in mid-May 2013.

ZF added that Heart Failure is currently being developed, and that the timetable may alter as work progresses. For the time being NICOR hopes to adhere to the ambitious schedule laid out by the IT platform project team.

11. Dataset revision

The minutes of the last meeting stated that dataset revision should be scheduled for the project board meeting in April, but RC explained that they have been added to this agenda in case revision needed to be considered earlier with the new national clinical audit system schedule in mind.

Further, NICE guideline IPG343: Endoscopic Vein Harvest states that endoscopic saphenous vein harvests for CABG should be entered onto NACSA. However, there is currently no field in the dataset to detect endoscopic vein harvests specifically.

BB explained that a separate piece of work has been carried out by SG in conjunction with NICE, whereby individual units carrying out Endoscopic vein harvest were contacted and asked to identify relevant patients within the database. The paper resulting from this work was published in Heart. Ideally a field would capture this information but it is not worth revising the dataset especially for this.

ZF stated that one of the design specifications for NCAS is that database revision is made more straightforward.

LW queried how useful it would be at local level for the IPG343 data to be collected. TS said that it would be very helpful, but that a database revision at this stage would not be well received by database managers.

BB suggested that database revision should be put on the agenda for every meeting to ensure that adequate planning can go into a database revision when it is deemed necessary. For the last dataset change local software developers needed 18 month's warning to make any changes.

LW stated that 3 months has been set by NICOR as the timeframe for software developers amending the dataset, and that the window of time required could be negotiated once a change requirement was identified.

JD suggested that a 'wish list' of changes/additions to the dataset should be compiled. Whilst individually they may not warrant a revision, the group can thereby easily keep track of when they collectively indicate that a dataset change is required.

Action: RC to keep this item live on future agendas, and compile a dataset 'wish list', with input from the project board.

RC

12. Private patient data

BB explained that the SCTS governance procedure was run on private patient data in two ways:

- 1) Private practice within NHS hospitals was analysed together with NHS practice
- 2) Private practice within private hospitals was looked at independently, using mean NHS mortality rates as a standard.

In this way all data that is contained within the database has been screened via the governance procedure.

JD queried whether all private hospitals should be required to enter data onto NACSA, as they are not all currently participating.

BB stated that low operative numbers in private practice means that participation would not be practical in all cases, and that all private hospitals have already been contacted by NACSA stating that we would like them to participate. Beyond that it would be the responsibility of the CQC to mandate/enforce contribution.

ZF reported that the CQC are looking into doing this at the moment.

MF added that patients will want data on the performance of private hospitals as well as NHS ones.

13. Database manager's meeting agenda

RC stated that the Database Manager's meeting agenda needs to be finalised so that it can be uploaded to the SCTS annual meeting website.

BB reported that he has sent a draft agenda to Ian Wilson, which he will forward to RC.

RC queried whether MF, SG, GH and BB will be available to present at the meeting. They confirmed that they are, but that ideally presentations from the 'UK activity and practice' section of the meeting shouldn't be repeated.

Action: RC to query with Ian Wilson whether the Database Managers can attend the 'UK activity and practice' section of the general meeting, and finalise the agenda in collaboration with BB.

RC

14. Any other business

BB reported that a review of registries has been submitted to the European Journal of Cardiothoracic Surgery (EJCTS). It outlines the philosophy, uses and infrastructure of a national registry and should assist others in setting them up. The EJCTS editors were impressed with the paper and it has been accepted.

Date of next meeting

RC to circulate dates for the next meeting, scheduled for early April 2013