The Surgical Forum of Great Britain and Ireland

'Surgical Audit"

Foreword

The Surgical Forum of Great Britain and Ireland, formerly known as the Senate of Surgery, is comprised of the Presidents and Vice Presidents of the four Royal Colleges and the Presidents of the 10 SAC-defined and GMC-recognised surgical specialties. The Surgical Forum is therefore a truly representative voice of surgery across the entirety of Great Britain and Ireland.

In recent years, the Surgical Forum meetings have all followed a similar format: a topic is selected that is important across both the specialty spectrum as well as having relevance to all geographic parts of the UK and Ireland and, as such, is relevant to all four Colleges. Each meeting is for a full day, is prefaced by invited guest speakers to lay the groundwork to the subject and then all members of the Forum are invited to contribute to the discussions. The proceedings of the meetings are described in a discussion paper which is agreed by all participants prior to being posted on SSA and College web sites and being made available to the media.

The topic of the most recent Forum meeting was '*Surgical Audit; who owns the data*". This meeting was held at the Royal College of Surgeons of Ireland, Dublin on the 18th July 2016. An attendance list and programme showing names of invited speakers and their representative organisations are attached as Appendix 1. In addition to the Presidents, or their representatives, of the four Royal Colleges and 10 Specialty Associations, BOTA and ASIT were represented.

This document aims to provide a consensus view. It is based upon the opinions expressed throughout the meeting. Preliminary drafts were distributed to all participants as well as to other interested parties in surgery. This document is therefore a representation of the opinion of the surgical profession throughout the UK and Ireland.

Summary

The NHS will soon be 70 years old. It is only in the latter part of the 20th-century that the profession has begun to take an interest in the collection of data aimed at improving outcomes, informing progress in research and providing evidence for the efficacy of what we do.

Now that society and government are keen to publish individual surgeons' outcomes, there is increasing concern on the part of surgeons about the accuracy of the data that is used to make these judgements. On the other hand, there are multiple specialty and individual audits for whom the same concerns are expressed.

There is no doubt that the public are justified in seeking to ensure that individual clinicians that treat them are competent and up-to-date. It is equally certain that the profession has a desire to move increasingly towards evidence-based treatment so the interests of all parties agree that data collection and analysis should be carried out. The questions arise over who collects the data, how reliable is the data and who owns the data?

This document explores some of the issues that were discussed at a meeting of the Surgical Forum in Dublin on 18 July 2016.

1. Background

The NHS is an enormous institution. It provides care for a population of 65 million in the United Kingdom. The vast majority of this care is in the community and by general practitioners in primary care. However, the more technical the care gets, the more expensive it is and the greater the need for scrutiny to ensure effectiveness. Surgery in particular requires justification of the procedures carried out in order to ensure high quality care for patients.

The need for scrutiny is amply demonstrated by a number of scandals in the health service over recent years. These extend from the Bristol enquiry 20 years ago
http://webarchive.nationalarchives.gov.uk/20090811143745/http:/www.bristol-inquiry.org.uk/final_report/the_report.pdf
through to the Mid Staffs enquiry
https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
and onto more recent enquiries across the United Kingdom. Furthermore, it is now a requirement that surgeon-specific outcomes are published annually in certain specialties and for certain procedures. This must be seen as part of a response to increasingly knowledgeable patients, carers and the public in general who increasingly question what has in the past been a paternalistic approach by medical practitioners to patients.

Surgeons are interested in the results of the procedures that they perform. This is demonstrated by the number of surgical audits that have been carried out over the years by individual surgeons and specialist associations. It is clear that surgeons care about what they do and about the results of their procedures. There is a desire on the part of surgeons to ensure that the data collected is accurate and that analysis of that data can inform progress in surgical specialties. Patients and carers also have a personal interest in knowing that surgery is safe and effective.

Health service managers, and by extension the government and public who ultimately pay for the National Health Service, are clearly concerned that any surgical procedure carried out is good value for money.

Transparency is also an important perspective for the government and public. The stated aim is to reduce variations in patient care. In order to achieve this, the government wishes to publish meaningful and comparable information for all major pathways of care for every provider. The aim is to do this by 2020. Against this background, it is clearly the case that managers also will have an interest in what the information says about the institutions that they manage.

Clinical audit is now regarded by clinicians and managers alike as a pre requisite to successful surgical activity. It is now a normal part of day to day surgical life. This discussion paper seeks to provide an overview of the subject of clinical audit. This will include a review of the various types of audit, an appraisal of the accuracy and potential failings of audit, implications of data collection, a consideration as to who should pay for audit and finally a comment on who should own audit data.

2. Reasons for conducting Clinical Audit

2.1 *Learning outcomes*

Learning outcomes were probably the catalyst to most surgeons embarking upon their first audits often in the context of morbidity and mortality meetings. The collection of data in these circumstances is often directed at learning immediately after a death or an adverse event. Such information can inform longer term data collection which has benefits in informing the effectiveness of healthcare.

For clinicians, the importance of data collection cannot be overestimated. It allows them to critically examine what they do and helps to inform progress in effective healthcare delivery.

Historically, many audit projects have been undertaken as a result of local clinical interests. This may reflect interest in a particular procedure by an individual or a group, or may reflect concern about specific outcomes for a particular operation.

2.2 Clinical incident reporting

Most UK health care organizations should have sophisticated systems in place to report and learn from adverse incidents and near misses. Integral to the system should be regular morbidity and mortality meetings which should facilitate early learning from the incident. Reporting is usually voluntary and investigated according to a "fair and just culture" but it is unlikely that all incidents that occur are reported. If an adverse incident is recorded, this identifies that it has occurred, but gives no indication of how often it has happened previously, and only limited indication of the likelihood of recurrence. A mature organization should have clear links between incident reporting and audit, and choose topics for the latter based on data from the former.

2.3 *To comply with regional or national initiatives*

Increasingly, audits have been driven by organizations that exist outside a hospital. These may include audit led by professional societies, regulatory bodies, or regional/ national quality improvement initiatives. To inform patients about surgical results across the world, health care is becoming more patient focussed. Recent surveys from the United Kingdom suggests that patients are interested in outcomes of surgery by their doctors [9]. The modern health care consumer will sometimes look to choose their health care provider on the basis of that hospital or surgeon's outcomes. Patients' views should inform decisions about what to audit, and they may be interested in many areas which will be dependent on the planned operation but may include information on mortality, success rates, length of stay, and the incidence of postoperative infection and other complications.

2.4 *To drive continuous quality improvement*

It is clear from the experience of cardiac surgery that structured data collection, analysis, and feedback to clinicians improves the quality of outcomes. This has been detected when surgical results are anonymous [2.3] and where named surgeon and hospital outcomes have been published [1.4]. The magnitude of this effect can be large. In the

United Kingdom, a system of national reporting for cardiac surgical outcomes was introduced in 2001 and has led to a 40% reduction in risk-adjusted mortality [4]. Simply collecting and reviewing data seems to drive improvement, but it is likely that the magnitude of the benefits derived and the speed at which improvements are seen can be maximized by developing a clear understanding of what data to collect and using it to deliver better care by refining systems and processes. There is a caution that some of this improvement may be due to risk averse case selection induced by the presence of the audit.

2.5 Health Care Regulation commissioning

There are many purposes to data collection from the perspective of the commissioner (payer). Data supports the efficient conduct of a business which includes such things as financial resource allocation, service delivery, the benefits or otherwise of commissioning and also the monitoring of trends and patterns in hospital activity. Data collection will also support local service planning and provide the basis for national indicators of clinical quality. Data will reveal health trends over time. From a patient's perspective, the collection of data will provide information so that patient choice can be more informed. It also helps them to identify and make a choice over their care providers.

From a governmental point of view, the collection of data supports NHS and parliamentary accountability and assists in the development of monitoring and evaluation of government policy.

2.6 Revalidation

Whatever the perceived idealistic reasons, it is fact that most consultants participate in audit to fulfil the requirements of revalidation and appraisal, which are necessary for continued professional practice. A recent E-survey of over 1000 consultants in 2012 confirmed this (Spencer, BMJ Open 2012,2,6).

3.0 Accuracy and Reliability

3.1 The publication of information on surgeon specific outcomes reflects directly on the activity of the surgeon. Surgeons have concerns about this. Principally, is the data used to derive the information accurate? There are many debates about whether the data collected by the health service is accurate and indeed many surgeons believe that it isn't. The reasons for this include distrust of data collected by others for non-clinical reasons and poor communication between surgeons and data coders.

3.2 Hospital Episode Statistics (HES) data. There is widespread concern about the accuracy of HES data. Despite these misgivings, the evidence from a variety of sources:
http://jpubhealth.oxfordjournals.org/content/early/2011/07/27/pubmed.fdr054.full
http://bmcmedresmethodol.biomedcentral.com/articles/10.1186/1471-2288-12-161
https://www.ncbi.nlm.nih.gov/m/pubmed/27130167/, http://www.ejves.com/article/S1078-5884(14)00689-3/abstract
indicates that the HES data is remarkably accurate. However, it is not collected for clinical reasons. Its main function is to provide data for payment, monitoring trends and patterns in NHS hospital activity. This is important for

management because it ensures that they are accurately resourced for the activity that the institution delivers. It is noteworthy that non medically qualified personnel are responsible for creating the sources for HES data, this should be an important motivator for surgeons to communicate with clinical coders to ensure that accurate data is entered.

3.3 Because of concerns about the accuracy of data collected by the institution, surgeons tend to favour personal audits of their own activity. However there are concerns over the accuracy of personally collected data. External validation of the completeness of the data set can be difficult to obtain and hence there may be bias in favour of collecting good outcomes.

3.4 Many specialist societies conduct national audits the accuracy of which are usually independently verified. Participation in these audits is rapidly becoming a pre requisite to perform certain procedures. This is a form of credentialing.

4.0 HES (Hospital Episode Statistics)

4.1 *HES is a data warehouse*

It contains details of all admissions, outpatient appointments and A & E attendances at NHS hospitals in England. The data is collected during a patient's time in hospital and is designed to enable secondary use, that is use for non-clinical purposes. HES data is stored as a large collection of separate records, one for each period of care, in a secure data warehouse.

4.2 Who is HES for?

HES data supports a wide range of healthcare analysis for the NHS, government and others including:

- national bodies and regulators
- local commissioning organisations
- provider organisations
- researchers and commercial healthcare bodies
- patients, service users and carers

4.3 What are the benefits of HES?

The collection of data on all English NHS hospitals allows NHS management to:

- monitor trends and patterns in NHS hospital activity
- assess effective delivery of care
- support local service planning
- provide the basis for national indicators of clinical quality
- reveal health trends over time
- inform patient choice
- determine fair access to health care

- develop, monitor and evaluate government policy
- support NHS and parliamentary accountability

4.4 Why was HES developed?

HES was originally conceived in 1987 following a report on collection and use of hospital activity information published by a steering group chaired by Dame Edith Körner (1921-2000).

Before 1987, only a 10 per cent sample of admitted patient records were collected nationally. By comparison HES is designed to collect a detailed record for each 'episode' of admitted patient care delivered in England, either by NHS hospitals or delivered in the independent sector but commissioned by the NHS.

Admitted patient care data is available for every financial year from 1989-90 onwards. During this period, the mechanisms for collecting the data have changed considerably, often in response to changes in the organisation of the NHS. For example, HES was once initially collated sub-nationally by regional health authorities. In 1996 these bodies were abolished and the NHS-Wide Clearing Service (NWCS) was set up to provide a means of transmitting the records. In 2006 this work was taken over by the Secondary Uses Service, which is run NHS Digital (formally, Health and Social Care Information Centre) and the National Programme for IT.

Initially, data for HES publications was collected annually from provider submissions. After a number of years the frequency of collections increased to quarterly to allow analysis and investigation (these were not published) and a final annual publication was released at the end of the year. HES data is now collected monthly.

4.5 Other applications of HES data

HES data are widely available and there is a mature governance process through which access is managed and usage controlled. Public sector bodies such as the Care Quality Commission, researchers and commercial organisations have used these data for years.

There are numerous examples of HES data being used by the medical Royal Colleges and specialist associations. One example of an audit system based on HES data is "SWORD", originally developed by AUGIS and ALS. The SWORD database identifies operations performed in England and is organised by surgical pathway. It contains counts and procedure specific metrics, uses definitions developed with surgeons and coders and has been validated against local data. It is only accessible by surgeons in active practice.

4.6 Accuracy of HES data

There have been numerous publications about the accuracy of HES data, often making conflicting claims. In recent years the evidence suggests that HES data are accurate and reliable. Most large audits do comprehensive testing against HES. Most show that less is reported to the audit than is available in HES:

- Only 29.5% to 45.7% of mortality reported in HES is reported in the National Vascular Database
- National Joint Registry – 96% case ascertainment
- National Vascular Database varies by procedure from 15% (Lower Limb endodovascular procedures) to 90% (Abdominal Aortic Aneurysm)
- Central Cardiac Audit Database – variability at a unit level
- Myocardial Ischaemia National Audit Programme – 96.6% linkage
- National Bowel Cancer Audit Programme – 90.5%
- National Emergency Laparotomy Audit – 83%

The accuracy of HES data is dependent upon the clerks and clinical coders who create the data. However, a recent survey found that:

- Only 3.4% consultants used HES outputs regularly and few are actively involved with data entry
- Only 6.2% consultants met coding staff at least monthly
- Only 21% were 'regularly' involved in clinical coding
- Over 90% said they would code diagnosis in the Outpatient department

It seems obvious that time spent by surgeons communicating with clinical coders would address the concerns expressed about accuracy and for uniform collection of accurate data across the whole health service. This presents the possibility of a large and accurate store of information which would inform healthcare decision-making and promote high quality research.

4.7 Summary

- HES and SUS are largely management hospital data sets. Their disadvantage is that there is little clinical data. Hence at the moment, specific audits are justified for more focussed clinical questions.
- HES is comprehensive. It contains what the NHS 'knows' about you, and is used for payment, planning, monitoring, managing and regulation.
- HES is less likely to be subject to bias because it is independent of the surgeon.
- We should use HES more and do fewer local audits.
- HES data is considerably cheaper than other options.
- HES accuracy is good and with use will continue to improve.
- It is in the gift of surgeons to improve it. Surgeons should engage with clinical coders to ensure data accuracy and to enhance the role of HES in the collection of clinical data.

5.0 Transparency

5.1 An increased need for scrutiny

The media frenzies that have surrounded well known and highly publicised medical misdemeanours have rightly resulted in a public perception of the need for greater scrutiny of the actions of the medical profession. This applies particularly to surgeons where outcomes are easily measured. This has led to a series of initiatives over recent years all designed to reassure the public under the label of transparency.

5.2 MyNHS website

This web site illustrates the Governments' commitment to transparency. MyNHS site was created for the public, professionals and organisations. It is designed to compare publicly, the quality and performance of NHS and care services, providers and commissioners, including public health.

MyNHS is designed to stimulate improvements in quality, safety, and efficiency, to provide public accountability and to complement other public-facing and publically available sites (eg NHS Choices, National Cancer Intelligence Network).

MyNHS selects key measures from existing data which demonstrate overall quality and it uses language and presentation for non-specialists and presents facts rather than judgements.

5.3 Feedback

There is little evidence that these NHS led government initiatives for transparency have had any major impact on the public. Between November 2014 and February 2015, there were only 133,000 consultant searches on the MyNHS website representing less than 200 hits per day from a population of >60 million.

Anecdotally, it appears that in the United Kingdom, few patients look at the information that is currently available on MyNHS.

5.4 Patient information

The importance of the accurate and sympathetic provision of information to the patient by the individual surgeon was agreed by all who attended the Forum. Such information might be influenced by both local and national clinical audit. What is crucial is that patients are allowed time to make an informed choice, are provided with information that is relevant to them, and are able to decline surgery without risk of criticism. This forms an important part of the process of confirming consent for surgical procedures. The recent ruling from the Supreme Court in the case of *Montgomery v. Lanarkshire*[1] affirms the idea of mutual respect between patient and surgeon in which the transparent sharing of data is an integral part of the process.

[1] 11 Mar 2015, **Neutral citation number** [2015] UKSC 11; **Case ID** UKSC 2013/0136

6.0 Data Protection (from Information Commissioners Office)

There are 8 principles that must be adhered to in any data collection exercise. These apply to collection of personal information and are that it must:

- be fairly and lawfully processed
- be processed for limited purposes
- be adequate relevant and not excessive
- be accurate and up to date
- not be kept for longer than is necessary
- be processed in line with the data subjects rights
- be secure
- not be transferred to other countries without adequate protection

7.0 Benefits of Audit

7.1 There is good evidence to confirm that collecting data on surgical procedures over time, properly examined and reflected upon, is associated with reduced postoperative mortality. This demonstrates the clear responsibility felt by individual surgeons to continuously improve their practice.

7.2 Careful scrutiny of surgical outcomes and other measures supports quality improvement at an individual and unit level – there is evidence for this across the specialty spectrum. The cardiac surgeons have been in the forefront of these initiatives. http://www.bluebook.scts.org

7.3 Publication of reliable information gives patients confidence in the service to which they have been referred. It supports transparency which, for patients who are vulnerable and concerned, is invaluable. It also provides an evidence base for other clinicians when considering their own practice.

7.4 When the data provides evidence of good outcomes, it restores confidence and pride in a specialty and profession and provides a role model for others.

7.5 All reliable data is essential for learning. If it can be collected across the NHS, it will support research on a large scale.

8.0 Potential effects of Audit

8.1 Risk averse behavior

A recent survey of cardiac surgeons reported that a third of all cardiac surgeons will not perform difficult operations to avoid poor mortality ratings. Stephen Westaby has argued that much morbidity and mortality in surgery can be attributed to team dynamics and processes rather than surgical error (S Westaby). Publishing individual surgeon's death rates, he argues, encourages risk averse behavior. However, such an argument is hardly an argument for not examining data about outcomes. Risk averse behaviour is a complex topic. It may be an indication of an individual who is practicing in some degree of isolation and without the benefit and support of a team of colleagues. The main argument against identifying an individual surgeon's outcomes is that there is seldom an associated commentary about the unique circumstances of that surgeon which might explain the statistics.

8.2 Risk averse behaviour may result in senior surgeons being less willing to supervise trainees for fear of poor outcomes. In other words, it may have an adverse effect on training. This raises the question of whether surgeons were complacent before outcomes were published, about the effects of trainees operating on patients. It also calls into question how good training is, because patients should never be exposed to harm while trainees are being supervised. This emphasizes the importance of mentorship as well as recommending that at least for complex procedures, surgeons should operate as teams.

8.3 Publication of information based on inaccurate or incomplete data can be misinterpreted by the media and by NHS Trust personnel resulting in unfair reputational damage to individual surgeons. This problem is compounded by failure to recognize importance of the team in supporting the individual.

8.4 Publication of surgeons' outcome data can result in divisions within the profession and upset team dynamics. This all results in loss of confidence which can adversely impact on patient care.

8.5 Data can be misused to encourage uniformity. This risks suppressing innovation and research. Having said that, there is no doubt that uniform processes in a hospital will enhance safety and reduce mortality[2].

8.6 While acknowledging all these concerns, they are not a reason to work against transparency in healthcare. Rather the objective should be to recognise the problems, develop a strategy and address any deficiencies in healthcare processes or in individual surgeon's practice that contribute to poor results.

[2] Haynes AB, Weiser TG et al; A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population: N Engl J Med 2009; 360:491-499January 29, 2009

9.0 Who pays for audit ?

9.1 The Health and Social Care Information Centre (HSCIC)

The Health and Social Care Information Centre (now called NHS digital) is commissioned to collect HES data, run clinical audits and registries by a number of organisations including Dept of Health and Colleges of Surgeons. Examples of audits relevant to surgery include the national audit of cardiac rehabilitation, funded by HQIP. The national bowel cancer audit and the national oesophagogastric cancer audit are run by RCSEngland with some aspects subcontracted to NHS Digital. Operating expenditure for 2015/16 was £224.8 million. A list of expenditures is available on line.

9.2 HQIP

The main "customer" to HSCIC is HQIP (healthcare quality improvement partnership). The extent and nature of future funding of HQIP remains unclear. It is of the order of £20m per annum.

HQIP is an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices. It was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality improvement. HQIP commissions, manages, supports and promotes national and local programmes of quality improvement
(Ref http://www.hqip.org.uk/media/Accounts/HQIP-signed-Accounts-to-31-March-2014.pdf)

9.3 Surgical Specialty Associations (SSAs)

Some SSAs (e.g. BAUS, SBNS, BOA) expend considerable resources on audit. This money comes from their membership. For some Associations, this can amount to £150,000/year. In contrast, the clinical audits involving members from some Associations are those commissioned by HQIP.

This inconsistent approach is clearly unsatisfactory. Furthermore, there may be questions over the reliability of the data when it comes from a variety of sources without a common set of principles for the purpose of the data collection. These are powerful arguments for encouraging the use of routine hospital data like HES for monitoring surgical activity and outcomes, as discussed above.

9.4 Local coordinators

At a trust level, some hospitals have appointed local coordinators who collate data from morbidity meetings and also feed data into national databases. This is a development to be actively encouraged. Local M&M meetings promote real-time learning as well as contributing reliable data into the system.

9.5 The future

We would recommend that there should be organizational support for clinical audit in all NHS Trusts. This would include an allowance of time for senior medical staff and infrastructure support from administrative personnel.

HES is an established system wide system which could be used by surgeons to address many of the concerns about the completeness of audit data but which requires that surgeons allocate time and effort in engaging with the system and with local coders.

10.0 Who owns the audit data?

10.1 Fundamental to the collection of any clinical data is the need to maintain patient confidentiality. In this regard, therefore, it is worthy of note that each patient owns his/her data and may select to opt out from secondary use. Currently, at a national level, between 2% and 2.8% of activity is likely to be suppressed under this.
(REF http://content.digital.nhs.uk/article/7092/Information-on-type-2-opt-outs).

10.2 In reality, the importance of audit data usually relates to how it is interpreted, and those individuals or units drawing conclusions from audit data will maintain they own the intellectual property of whatever they publish. This inevitably leads to a consideration of copyright legislation.

However, in the case of HQIP funded audits, the intellectual property is owned by HQIP and is often free for use with approval.

10.3 HES data is owned by NHS digital (formerly HSCIC) which is an executive non-departmental public body of the Department of Health. However, there is other nationally collected data managed by Public Health England and similar data sets exist in the devolved Nations

10.4 Arguably, it does not matter who owns the data. What matters is what we learn from it.

Conclusions

There is universal agreement that the collection of data on surgical practice and outcomes is important.

In clinical practice, it is essential for quality improvement and quality assurance and in the management environment for accounting for the use of resources. Standardising processes of care as happens in care pathways and multidisciplinary team meetings will enhance patient safety and similarly, standardising audit processes will also contribute towards efficiency and patient safety overall.

At the start of the clinical audit process is a recognition that never events, mortality and morbidity should be discussed at an early stage to maximise learning and for patient safety. This should be seen as the start of data collection for the audit process. Up to now, it has been relatively easy to focus on mortality as a hard endpoint. There should now be an increasing focus on morbidity as well.

Recognition of the importance of Morbidity and Mortality meetings should result in an appropriate allocation of time and resource for this process.

While it is recognised that audit is important, the concerns that clinicians have about how data is collected, its reliability and how it is used have to be addressed to ensure that data collection is fair and unbiased and provides results that have the confidence of the medical community, as well as patients and management.

Patient care is paramount but the profession has a duty of care for surgeons. The use of data to attack surgeons is to be deplored but at the same time surgeons should be working as part of teams who will be mutually supportive and have their own mechanisms for dealing with performance issues. The ideal is to prevent performance issues developing.

A potential effect of data collection is to produce an environment in which trainers are reluctant to allow trainees to carry out surgical procedures. At the moment, this is an anecdotal effect. ISCP is one way of identifying whether there is an effect on training. The introduction of accreditation for trainers by the GMC is another mechanism for addressing this potentially difficult issue.

Data collection is expensive in both time and resource. HES data is a useful tool which is already in place. It would be sensible to use this system in order to help encourage its development so that it is used not only for collecting management data but also for clinical data. One way of dealing with this immediately is for clinicians to engage with the local coders to ensure that the quality of the data being entered is high.

There is a need for public education. Although the public generally are increasingly knowledgeable, the presentation of data on surgeons outcomes requires interpretation and the profession should engage in the process of dialogue with the public in order to manage expectations.

The Surgical Forum of Great Britain and Ireland

ATTENDANCE LIST, MONDAY 18 JULY 2016, COLLEGE HALL, RCSI

NAME	
Professor Derek Alderson	Vice President, Royal College of Surgeons of England
Mr William Allum	Consultant Surgeon Chair, Joint Committee on Surgical Training
Mr Kevin Baird	Vice President Royal College of Physicians and Surgeons of Glasgow
Dr John Carlisle	Consultant Anaesthetist
Mr Graham Cooper	President, Society for Cardiothoracic Surgery
Dr David Cromwell	Director of Clinical Effectiveness Unit Royal College of Surgeons of England
Mr Michael Davidson	Chair of Council, British Association of Oral and Maxillofacial Surgeons
Professor John Duncan	Vice President, Royal College of Surgeons of Edinburgh
Ms Nicola Fearnhead	Consultant Colorectal Surgeon
Mr Eunan Friel	Managing Director of Surgical Affairs Royal College of Surgeons in Ireland
Professor David Galloway	President, Royal College of Physicians and Surgeons of Glasgow
Mr Tim Graham	Consultant Cardiothoracic Surgeon Chair, Joint Surgical Colleges Fellowship Examination
Ms Cathy Hassall	Head of Clinical Programmes & Team Support Clinical Policy and Professional Standards
Professor John Hyland	President, Royal College of Surgeons in Ireland
Professor Cathal Kelly	Chief Executive & Registrar, Royal College of Surgeons in Ireland
Mr Richard Kerr	President, Society of British Neurological Surgeons
Mr Manoj Kumar	Consultant Surgeon
Mr Mike Lavelle-Jones	President, Royal College of Surgeons of Edinburgh
Professor Graham Layer	Vice President, Royal College of Surgeons of Edinburgh
Professor John MacFie	President, Federation of Surgical Specialty Associations
Miss Clare Marx	President, Royal College of Surgeons of England
Mr Kenneth Mealy	Vice President, Royal College of Surgeons in Ireland
Mr Nigel Mercer	President British Association of Plastic, Reconstructive and Aesthetic Surgery

The Surgical Forum of Great Britain and Ireland

ATTENDANCE LIST, MONDAY 18 JULY 2016, COLLEGE HALL, RCSI

NAME	
Mr John Moorehead	President, Association of Surgeons of Great Britain and Ireland
Professor Tony Narula	President, ENT-UK
Mr Kieran O'Flynn	President, British Association of Urological Surgeons
Mr Mustafa Rashid	President, British Orthopaedic Trainees Association
Professor David Richens	Consultant Cardiothoracic Surgeon Chair, Joint Committee on Intercollegiate Examinations
Mr Ian Ritchie	Chair of Surgical Forum Immediate Past President, Royal College of Surgeons of Edinburgh
Ms Alison Rooney	Chief Executive, Royal College of Surgeons of Edinburgh
Ms Piriyah Sinclair	Director for Mentoring & LTFT
Mr Simon Swift	Co-founder of SWORD database
Ms Collette Tully	Royal College of Surgeons in Ireland
Dr Mary Walsh	Royal College of Surgeons in Ireland
Mr Ian Winson	President Elect, British Orthopaedic Association
Mr Mike Wyatt	President, Vascular Society of Great Britain and Ireland

The Surgical Forum of Great Britain and Ireland

Monday 18 July 2016, 10.30am, Royal College of Surgeons in Ireland

"Who owns the audit data?"

Time		*Chair(s)*
1030am	**Welcome to the Royal College of Surgeons in Ireland** **Opening remarks: setting the scene**	Professor John Hyland, President, RCSI Mr Ian Ritchie, Chair, Surgical Forum
Session 1	***Data collection and other problems***	Mr Kenneth Mealy, Vice President, RCSI Mr Richard Kerr, President, SBNS
1040-1100	**SASM – evolution and lessons learned** - *Mr Manoj Kumar, Consultant Surgeon*	
1100-1120	**How accurate is HES data?** - *Mr Simon Swift, Co-founder of SWORD*	
1120-1140	**Data interpretation and perioperative risk** - *Dr John Carlisle, Consultant Anaesthetist*	
1140-1230	**Discussion**	
1230-1315	***Lunch***	
Session 2	***Users of the data***	Professor Cathal Kelly, CEO & Registrar, RCSI Professor Tony Narula, President, BAO-HNS
1315-1335	**What can data tell us about the effectiveness of surgery?** - *Dr David Cromwell,* *Director of Clinical Effectiveness Unit, RCSEng*	
1335-1355	**Managing Outliers** - *Mr Tim Graham, Consultant Cardiothoracic Surgeon*	
1355-1415	**The paradox of good audit data: improved outcomes versus risk aversion** - *Miss Nicola Fearnhead, Consultant Colorectal Surgeon*	
1415-1430	***Coffee/tea***	
Session 3	***Who owns the data?***	Mr Kevin Baird, Vice President, RCPSG Mr Nigel Mercer, President, BAPRAS
1430-1500	**The ambition for data transparency in the NHS** - Ms Cathy Hassell, *Head of Clinical Programmes & Team Support, NHS England*	
1500-1530	**Data and risk, and what do we do with it?** - Ms Shauna Dunlop, *Regional Manager, Information Commissioner's Office, Northern Ireland*	
1530-1630	**Forum Discussion** (to which all attendees will be invited to speak)	Mr Ian Ritchie, Chair, Surgical Forum
1630-1700	***Summing up***	Professor John Hyland, President, RCSI Mr Ian Ritchie, Chair, Surgical Forum