Thoracic Audit Update:
Board of Representatives Meeting
18\textsuperscript{th} December 2015 London

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Contents

- LCCOP 2015
  - Timeline
  - Analysis
  - Outliers support
  - 2016 plans

- SCTS database and the third blue book
- Non-cancer surgery audit
NLCA recommissioning

• 2015-18 contract won by RCP London team
  – Analysis: Respiratory Epidemiology, Nottingham
  – Commissioning; yearly audit report and LCCOP report

• Data ownership changed
  – COSD

• Data flows
  – From cancer registry data at Trusts
  – Previously annual LUCADA upload, soon quarterly COSD uploads
LCCOP 2015

- 2013 data
- Cases: all resection of primary NSCLC
- Outcomes: unit level
  - 30 day
  - 90 day
- MDT resection rates
- Alert and alarm levels

Mid-Dec 2015
Complete analysis, begin drafting press release

Late December 2015
Notify

Late January
Data to NHS choices

8th March report released / upload to websites
LCCOP outcomes 2016

• Posted on NHSciences and SCTS.org
• Background narrative from Trust on SCTS.org
• Parallel SCTS returns “signposting” data on SCTS.org on pectus and mesothelioma surgery
• Data expected to show continuing fall in perioperative mortality despite increased activity.
  – 30 day ≈ 98% survival
  – 90 day ≈ 96% survival
Outliers

- Remember...
  - 3 outcomes not one
  - “balanced” outcomes reporting: resection rates and peri-operative mortality
  - Higher resection rates correlate with improved population-level survival AND higher perioperative mortality
  - Not risk adjusted
Outliers: suggested response and support

Alert and alarm levels
- highly different false discovery risks
Joint letter from
SCTS/NLCA to
  unit audit lead
  unit clinical lead
  medical director
Internal review mandated
In its advice to Trusts, the Society has established five principles;

The mechanisms for support to individuals and the investigation of outlying results are separate

Divergence is a cause for looking at the data in more detail, and is not sufficient reason in itself for restricting a surgeon's practice unless there are clear concerns about the safety of patients

The mechanism is reasonable and proportionate

Divergence is classified according to its level and frequency

Explanation proceeds in four stages;

- Analysis of the data for accuracy
- Analysis of the caseload. This is particularly important in the LCCOP, which reports unadjusted data
- Analysis of institutional factors that may contribute to the divergence in clinical outcomes
- Analysis of individual surgeon’s performance within a unit
Result of internal inquiry

- Should establish cause of divergence
  - Data issues
  - Chance
  - Organisation / resource issues
- Circulated to stakeholders
- Copy sent to SCTS/LCCOP
- Outline and link can be posted on SCTS.org
Society support to members in LCCOP

• Email, phone or letter request for support to President / Hon Secretary
• Offer of choice of senior SCTS office holder to act as a “friend” throughout the outlier process
Future Development of LCCOP: principles

• Patients/public, profession and stakeholders must derive audit criteria and standards

• Should support high quality services
  – Avoid risk aversion
  – Promote high standards of professionalism and team working

• Facilitate quality improvement
  – Highlight areas of suboptimal care
  – Disseminate best practice
LCCOP outcomes: development

• Risk adjustment 2017
• Future options
  – 1 year survival or later
  – ?process of care outcomes
    • Pneumonectomy rate
    • Node dissection rates
    • Length of stay / readmission
    • R0 rate
    • ?QoL / PROMS
• Patient input- Roy Castle
• Plan to survey membership pre SCTS
Dendrite database

• In third year of GMC funding
• Decision to end at end of 2015/6 FY. Why
  – High burden on units
  – Competing with LCCOP
  – Can’t link to NHS data
  – Poor accrual of cases
• Forward plan
  – Third blue book Q4 2016/Q1 2017
  – Registry 1980-present, database 2013-16
Data Quality in NLCA/COSD

- NLCA- not designed to quality assure surgery
- 10-20% error rates
- Mitigation
  - Permissive validation to continue
  - Validation earlier in 2016
- Suggestion: surgical units enter data directly to Somerset/Infoflex etc
Options for non-lung cancer surgery

Ideally, low data burden on units, cheap, linked to NHS data
SCTS thoracic audit group

- Mo Asif, Scotland
- Joel Dunning
- Ira Goldsmith, Wales
- David Healy, Eire
- Juliet King, SCTS executive
- Eric Lim
- Kieran McManus, Northern Ireland
- Doug West
Quality- past and future

George VI
Lung resection 23rd September 1951
Surgeon: Clement Price-Thomas
Quality- past and future

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Operation: left pneumonectomy

Comorbidity: severe PVD, current smoker

Centre: Buckingham Palace.

Centre volume n=1

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Outcome Died PoD #136