

SURGICAL OUTCOMES & RECERTIFICATION CONFERENCE OF THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH (RCSEd) ON 30 JANUARY 2009 @ RCSEd QUINCENTENARY HALL COMPLEX, EDINBURGH

Trip Funded by:	College of Surgeons Travelling Fellowship Fund
Attended by:	A/Prof Anette S Jacobsen
Reported by:	A/Prof Anette S Jacobsen

Trip Report

INTRODUCTION

This course was circulated on email to all RCS(Ed) Fellows. As such we thought it very appropriate for us to attend representing the Academy / College of Surgeons / Chapters.

COURSE CONTENTS

The one-day course on Surgical Outcomes and Re-certification brought speakers from the various official bodies in the UK, the GMC, the NHS as well as all the surgical specialties. Clearly the main thrust was on clinical outcomes and Quality of care and secondarily on CPD and re-certification process. Some of the discussion was not applicable in Singapore – for example as concerns NHS issues.

The programme, participants and speaker details are attached. The speakers' main slides are also available as per Teresa's mail.

EVALUATION AND LESSONS LEARNED

The system of audit and ensuring standards must be practical, easy to implement and more importantly supportive rather than censorious of the individual practitioner.

Levels of 'monitoring' needs to be found on national organisational and individual basis.

On a national level in UK Scotland individuals and their outcomes, e.g. of surgery for breast cancer, will be plotted in terms of reported surgical outcomes on a 'trumpet chart'. Thus the individual surgeon (and everybody else with access) can see how they measure up.

The monitoring and charting is maintained at various levels, and as above is maintained at Cancer Registry level. Thus some are maintained at National level and some at Registry/organisational level. Variance is measured and interpreted on an individual basis. As all mortalities are required to be reported there is a current plan to publish individual surgeons' death rates.

National Reporting standards are similar to ours, and measure mortality, HAI, MRSI, C Diff and surgical site infections. The above is fairly standard practise and relates to quality and outcomes.

A new way to get data and feedback is to consider having patient reported outcomes. This was discussed as a possibility in various areas, but collection and maintenance of database, funding and validity of data are some of the issues that require more thought.

Many of the specialties have in practise or are planning in the near future a Surgeon E-logbook which requires entry following each surgical operation. Some of the specialties will track in their chapter equivalent or national association:

- 1) low volume high risk cases outcome – on a national basis,
- 2) high volume cases – from hospital data, and
- 3) long term outcomes based on Patient reported outcome.

Most specialties consider using e-logbook as part of a CPD/re-certification process. And many specialties track individual surgeons' outcomes for specific index cases – or specialty specific cases. For example in British Association of Paediatric Surgeons, they will track 3yr redo/intervention rate following hypospadias surgery and for Vascular surgery, a national database is maintained on carotid endarterectomies / AAA / inguinal bypass surgery and amputation.

Annual Surgeon appraisals are conducted in all NHS institutions with one within / one without own specialty. Finally, validity of data input needs serious consideration – it should not be by the surgeon, and presumably for audit purposes, nurses reporting has a much better compliance.

Usefulness of Event to Self & College of Surgeons

IN SUMMARY

- The surgical outcomes and re-certification conference was very useful and informative
- Reporting should be at the national/hospital/individual level
- Validity of data needs to be considered
- Individual surgeon funnel or trumpet plots are used to assess individuals against national norm
- Many specialties have or are implementing compulsory e-logbooks
- Patient reported outcomes are seen as potentially very useful especially for long term outcomes
- Re-certification must be supportive rather than censorious and on a continuing basis.

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Trip Funded by:	College of Surgeons Travelling Fellowship Fund
Attended by:	Dr Swaminathan Ikshuvanam
Reported by:	Dr Swaminathan Ikshuvanam

Trip Report

Introduction

Prof Jacobsen and myself have attended the above course, as representatives of the College, to learn more about the re-certification process as well as measuring of surgical outcomes. Our SMC is planning to introduce the same processes locally, so it was timely that we learn from them and transfer knowledge to our administrators.

Course Content

The course was well-structured, covering general issues in the morning, (such as Devising the System, Counting the Numbers and Measuring the Output) and specialty-specific issues in the afternoon.

The speakers represented a wide spectrum of bodies, including the General Medical Council, the Academy of Medical Royal Colleges, the NHS, SASM (Scottish Audit and Surgical Mortality) and the Leapfrog Foundation, a body that audits surgical outcomes. The local equivalents would be the SMC and the various Colleges.

Important issues, such as the purpose of regulation, the purpose of revalidation, the role of the Medical Council and Royal Colleges – The GMC is in charge of Re-licensing while the College takes care of Re-certification- were addressed. The roles may overlap a bit, but are generally well-defined. Re-licensing is a biennial process, whereas re-certification is an ongoing, five-year cycle of audit of outcomes.

As Prof Jacobsen mentions, some matters are specific to the U.K, but we can still learn from their experience, such as E-logbook and Patient-reported outcomes. The latter is a new concept, and it has been tried out, with mixed reviews.

Monitoring individual surgeons has been described well, but when it comes to multi-disciplinary teams, it gets harder. Many factors affect the outcome in such cases, so it is in practice very difficult to monitor or regulate.

The afternoon sessions were useful in highlighting the issues unique to each specialty – for example, Plastic/Aesthetic Surgery is cross-covered by General Surgery, Orthopaedics, Hand Surgery, Burns and Dermatology, so how to monitor and how to compare?

Another example is in fields like Urology and ENT, where much of the work is outpatient or clinic-based. These data are often not captured, and therefore the true morbidity and complication rates may be heavily skewed.

Tracking and self-reporting of outcomes seems to be an accepted culture and we should encourage this locally, so as to be transparent. E-logbooks are part of the re-certification process and all surgeons fill them in right after the operation. Also Funnel and Trumpet plots are used, and the individual surgeon can measure his performance against his peers and improve himself by re-training, if he falls outside acceptable limits.

As Prof Jacobsen mentions, the whole idea of monitoring outcomes is to improve service standards and not to be censorious or find fault.

Usefulness of Event to Self & College of Surgeons

To self- I learnt a lot and I would say I have neglected an important aspect of my practice.

To College – If SMC decides to go ahead and monitor outcomes, in order to revalidate (Re-license and Re-certify) Surgeons, then the College must be prepared to play its part.

We are the ones who have to specify what we want to monitor and how we propose to do it. Both Prof Jacobsen and I would naturally be involved, as attendees, but the different chapters of the College will of course have to contribute in a big way.