# The United Kingdom National Bariatric Surgery Registry

## POLICY FOR MANAGING NON-CONTRIBUTION OF PATIENT DATA

### Introduction

The data used for the 2012/13 Consultant Outcomes Publication for bariatric surgery for NHS England were submitted voluntarily to the NBSR by individual surgeons and units. As part of the process it was necessary to formulate a policy on how to manage potential statistical outliers that might be found during analysis. The NBSR Committee published its Policy for Identification of Potential Outliers in June 2013. The Policy can be found here:

http://www.bomss.org.uk/wp-content/uploads/2014/04/NBSR-Policy-for-identification-of-potential-outliers-June-2013.pdf .

Not every patient was entered into the NBSR for the first round of publication but data entry become mandatory as part of NHS England contracting in 2013/14. During the process of data analysis for the second round of reporting in July 2014 it became apparent that there was variation between hospitals in case ascertainment, that is, the number of patients entered into the database as a proportion of those operated on, identified through Hospital Episode Statistics (HES) data.

The published Outliers Policy deals with potentially outlying data in the submitted records, but by definition this does not cover potential outliers among surgeons not submitting data. So as to be as complete as possible in the recording of adverse events, in particular mortality, it becomes logical to have a policy on how to deal with hospitals under-reporting overall patient numbers and how to deal with hospitals that were known by other sources to have mortality that was not entered.

The NBSR Committee notes that it has no mandatory brief or the wherewithal to oversee the entering of all patient records onto the database. This is the remit solely of local commissioners responsible for funding the service and is a matter between them and the local hospital provider. However, the rise in case ascertainment from 83% in 2012/13 to 94% in 2013/14 shows the commitment of bariatric surgeons operating on NHS patients in England to be open and transparent with their data on caseload and survival. The lack of a mandatory brief of the NBSR Committee for oversight of the process of data submission and quality is not withstanding of the funding by the Healthcare Quality Improvement Partnership for the actual production of the 2013/14 report, which entailed analysis time for the software provider and detailed HES analysis as well as designated meetings of the NBSR Committee.

## Actions after identification of non-contribution of individual patient records

In the 2013/14 round of the Consultant Outcomes Publication the Committee identified hospitals whose number of patients entered into the NBSR was more than 10% lower than the number identified according to HES, including some hospitals that failed to submit any data. At a designated meeting the Committee decided a letter would be sent to the Chief Executive Officer and Medical Director of each of the hospitals identified as deficient in this A 'soft' letter was to be sent to the hospitals with more than 10% fewer than expected entries, and a 'hard' letter to those hospitals who failed to submit any data.

For the 2014/15 round the Committee will undertake case ascertainment via a HES provider unit as before, and the policy of writing letters will continue as above. The letter will be followed up by a phone call a month later if there is no response. In addition the Committee will consider publishing the names of these hospitals in the Consultant Outcomes Publication report on the BOMSS website.

## Actions after identification of non-contribution of mortality data

As part of the process of analysing the 2013/14 data for the Consultant Outcomes Publication the Committee reviewed each NBSR mortality to provide a 'sense check' that the mortality was correctly recorded. If the Committee becomes aware through another source that mortality has occurred but has not been recorded an email or letter will be sent to the consultant surgeon concerned inviting an explanation and reminding them that submission of the data is mandatory, according to NHS England commissioning policy. This will also provide the hospital the opportunity to check the data submitted and clarify the situation if an error is found.

The Committee will check via the software provider but if a response is not received within a a month a further email or letter will be sent to the Chief Executive and Medical Director, copying in the consultant contributors, advising them of the situation and inviting a formal reply. If the suspected death is confirmed the hospital will be given a specific time period in which to correct the data.

## In-hospital mortality, 30-day mortality, and mortality occurring after readmission where bariatric surgery is not recorded as the primary diagnosis

The Committee recognises that the definition of mortality occurring as a result of bariatric surgery (where bariatric surgery is the primary diagnosis) is open to definition. Broadly there are 3 areas:

1 A death occurring during the index admission before discharge; this would normally be recorded in HES

2 A death occurring after the index admission where the patient has gone home but has died within 30 days of the surgery either with or without readmission; if the patient is readmitted the death might not be linked to the index bariatric surgery in HES if the readmission diagnosis is different

3 A death occurring after discharge from the index admission more than 30 days after the surgery either with or without readmission

It is recognised that when a patient is readmitted after the index admission and subsequently dies, the diagnosis code for the readmission may be different from bariatric surgery (eg peritonitis) and therefore the records might not be linked. It is also recognised that a patient who dies more than after 30 days after surgery would not be included as a death in the 30-day mortality figures. Since the NBSR does not include NHS numbers it is impossible to track mortality automatically that occurs outside the primary hospital. Also, since attendance in clinic for follow-up is necessary to record 30-day complications, by definition absence of recorded follow-up may mask 30-day mortality. If in the future NHS numbers are added to the NBSR records it would be possible to ascertain patient outcomes more accurately by HES linkage.

The mortality reporting for the Consultant Outcomes Publication for 2012/14 was in-hospital. The Committee would ideally like to report 30-day mortality but due to the limitations above this may never entirely reliable. It is the intention however that a death that would be considered by an independent observer to be clearly the sequela of the initial bariatric surgery should be recorded. The Committee accepts that the exact definition is open to discussion but encourages all known deaths that a responsible opinion would indicate are related to the initial surgery to be recorded, so as to reassure the public that bariatric surgeons are being open and transparent with their data.

NBSR Committee
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