The Association of Coloproctology of Great Britain and Ireland

Clinical Outcomes Publication
Update for ACPGBI Membership
July 2016

Consultant Outcomes Publication 2015

The ACPGBI published Consultant Outcomes for bowel surgery for the third time in 2015. Case numbers and risk-adjusted 90-day mortality for elective colorectal cancer surgery in patients diagnosed during the four-year audit period of April 2010 to March 2014 were published on the ACPGBI website on 18 November 2015 and then on NHS Choices on 9 February 2016.

The National Bowel Cancer Audit (NBOCA) provided data on just under 60 000 patients who were treated in England during this period. 784 surgeons and 146 NHS Trusts were included in the 2015 outcome data. 90-day mortality rate has fallen every year with an average elective mortality across all English Trusts of just 2.8% in 2015. No individual surgeon was an outlier. One Trust was a negative outlier with a higher mortality rate than expected and one Trust was a positive outlier.

Policy Changes in Clinical Outcome Publication

In May 2016, HQIP announced that Consultant Outcome Publication would be re-branded as *Clinical Outcome Publication*.

NBOCA has secured written confirmation from Dr Kieran Mullan, Clinical Director of COP, that future outcomes may be reported at "team" (Trust/hospital) level rather than a requirement to report further outcomes at individual surgeon level. *Elective resection 90-day mortality and case number will still be reported each year at individual level.*

There is an HQIP requirement to report on additional outcomes each year for 5 years. An ACPGBI focus group has worked with NBOCA and the Clinical Effectiveness Unit to determine robust clinical outcomes that could be reported at Trust level over the next few years.

Publication of Future Metrics

COP 2016 will again report case number and 90-day mortality for elective colorectal cancer resections at surgeon and Trust/hospital level for patients diagnosed during the 5 year period between April 2010 and March 2015.

In addition, the following Trust/hospital level outcomes will be reported for all patients with colorectal cancer (emergency and elective) treated in the corresponding Audit period:

COP Reporting Year	**Additional Trust Outcomes**	**Notes**
2016	Rate of major resection*	Crude rates with no outlier reporting
	Case ascertainment*	Including patients who do not undergo surgery
2017	30 day unplanned readmission	Outlier reporting; risk-adjusted
	Percentage length of stay >5 days	Outlier reporting; risk-adjusted
2018	Positive circumferential rectal resection margin rates	
	Proportion of colonic resections with >12 lymph nodes reported	
2019	Unplanned rates of return to theatre	Outlier reporting; risk-adjusted

* equivalent respectively to the 4th column in Table 7.1 and to the 4th column in Table 7.2 of the 2015 Annual Report http://www.hscic.gov.uk/catalogue/PUB19500/nati-clin-audi-bowe-canc-2015.pdf

It is anticipated that any outcome included in the NBOCA Annual Report may eventually be published under COP. Reporting periods (usually one year) for each new metric in COP will be based on the reporting period for that metric in the Annual Report. The new outcomes will be reported in addition to all previous outcomes each year.

These outcomes have been selected as they reflect quality of care and may be reliably reported based on current levels of data completeness.

Timelines for COP 2016

The contact address at HSCIC for NBOCA is bowelcancer@hscic.gov.uk and we are grateful to Julie Michalowski who has been looking after our Audit at HSCIC pending a permanent replacement.

The final data for inclusion in COP 2016 will be returned to Trusts on 22 July 2016 and final changes will need to be submitted through the Clinical Audit Platform by 12 August 2016. No new cases may be added at this late stage but completion of all other items in the data set is still possible during this period. Recording of all risk adjustment variables (age, sex, TNM stage, ASA grade, tumour site) on every patient in the data set (not just those who have died) is essential if notified of potential outlier status.

Formal notification of outlier status will be sent to Consultants and Trusts on 12th September 2016 with a 21 day period for final data verification. Outlier consultation will close on 12th October 2016. COP will be published on the ACPGBI website on 10 November 2016 and subsequently on NHS Choices.

Surgeons will have data published alongside the Trust where they were working on 31 March 2015. Where data has accumulated from more than one Trust, there will be a comment to this effect.

If there were no cases registered against a surgeon's GMC number for the two year period April 2013 to March 2015, the surgeon's outcomes will not be published.

If there were no cases registered against a surgeon's GMC number for the one year period April 2014 to March 2015, the surgeon's outcomes will be published on the ACPGBI website with a comment that no cases have been recorded for this period, but will not be submitted for publication to NHS Choices.

Clinical Audit Platform

Access to the Clinical Audit Platform for verification of data is available to all surgeons. Access requires creation of Single Sign On (SSO) at https://clinicalaudit.hscic.gov.uk and approval from the Trust Caldicott Guardian.

Type 2 Objections to NHS Data Storage

Any patient who has lodged a Type 2 objection to their data being collected or stored will no longer be included in the NBOCA as HSCIC may not legally share their data. Just under 3 000 patients have been removed from the Audit data set over the past 5 years. The consequence is that individual surgeon and Trust outcome statistics may not coincide precisely with the surgeon's own data.

Further information about Type 2 objections can be found on the HSCIC website http://www.hscic.gov.uk/careinfochoices

Minimising Risk Averse Behaviour

Within colorectal surgery, there are a number of areas where risk aversion behaviours may have an impact on patient care:

- Not offering surgery to high risk patients
- Offering less invasive procedures e.g. TEMS, radiotherapy for rectal cancer
- Avoiding anastomoses
- Re-classification of patients as "urgent" or "emergency"

The Society of Cardiothoracic Surgeons has introduced a "Star Chamber" policy to allow high risk patients to have cardiac surgery after case review by a central multidisciplinary team and selection of a pair of surgeons to carry out the case together with one designated as lead. Star Chamber patients are subject to all normal audit processes but not included in single surgeon reporting.

The option of a similar central mechanism in elective colorectal cancer surgery is unlikely to succeed given case numbers and need to meet cancer targets but other options are under consideration. We are currently exploring a model of prospective local MDT agreement that a patient was high risk based on P-POSSUM scoring or the procedure-specific American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) Surgical Risk Calculator, with surgery offered in the setting of dual Consultant operating and appropriate level of perioperative care, typically a minimum of level 2 high dependency. These patients would then be included in Trust data but excluded from individual surgeon data. Any protocol of this type will require approval from HQIP before implementation.

New Executive Lead for COP

Charles Maxwell-Armstrong will take over responsibility for ACPGBI Executive Lead for COP within the role of elected Assistant Honorary Secretary for ACPGBI. I would like to take this opportunity to wish Charles well in the role and to thank all ACPGBI members for their help and support with COP over the past three years.

Nicola Fearnhead
ACPGBI Executive Lead for COP
14 July 2016