



The Association of Coloproctology
of Great Britain and Ireland

Press Release

Surgeon Specific Outcome Reporting For Colorectal Cancer Surgery

The Association of Coloproctology of Great Britain and Ireland (ACPGBI) welcomes the intention of the NHS Commissioning Board to see publication of surgical outcome data as set out in Offer 2 of the publication Everyone Counts: Planning for Patients 2013/4 and recognises that open reporting of surgical outcomes is associated with improvements in surgical performance.

ACPGBI intends to publish post operative death rates for colorectal surgeons working in English NHS Trusts who perform planned (elective) surgery to remove large bowel cancer. The outcome measure assessed for this publication is the 90 day mortality rate following planned removal of a bowel cancer – that is the proportion of patients who undergo surgery who die from whatever cause within 90 days of their operation. It is based on data submitted to the National Bowel Cancer Audit (NBOCA) on patients diagnosed between April 2010 and March 2012. This is the first time such an exercise has been undertaken for colorectal cancer surgery in the UK. This has been a challenging project and release of outcome data is being delayed until the autumn because the complexity of the data base used to calculate surgical outcomes has led to a number of problems which mean that for some surgeons the calculated survival is inaccurate. ACPGBI realises that confidence in this initiative from patients and surgeons requires that the data be inclusive and accurate.

Graham Williams, President ACPGBI has made the following statement;

“Colorectal Surgeons are committed to measurement and critical analysis of surgical outcomes and open reporting of their results is a logical extension of this. Although the Association of Coloproctology welcomes surgeon specific outcome reporting we have delayed release of this data until surgeons are happy with the accuracy of the data. The ACPGBI has always been consistent in driving forward support for the improvement of standards in colorectal surgery and has been at the fore-front of training surgeons in techniques in cancer surgery. We will continue to work with clinical teams and key stakeholders including the Royal Colleges, DH and the public in this regard”

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Background information

The Association of Coloproctology of Great Britain and Ireland:

The Association of Coloproctology of Great Britain and Ireland represent the 1300 medical and nursing professionals in the UK who treat patients with Bowel Cancer; Crohn's Disease, Ulcerative Colitis, Diverticular Disease, Faecal Incontinence and Anal disease – including haemorrhoids, perianal abscess and fissure. In England there are 560 consultant members, most of whom are involved in the treatment of patients with colorectal cancer.

Colorectal Cancer Treatment:

Treatment of colorectal cancer involves complex pathways because patients suffering this condition present in a variety of ways and will require different treatments depending on the site of the cancer within their bowel and the stage of the tumour at presentation. Treatment of colorectal cancer involves a large team of medical, nursing and other health care professionals. Whilst the surgeon is a key part of this team, performance and outcome are also influenced by other factors, including the quality of anaesthetic care and availability of critical care facilities. In addition, consultant surgeons are increasingly operating in pairs, particularly on more complex cases. Thus focussing on an individual surgeon's outcome in colorectal cancer treatment is analogous to awarding the FA cup to the striker, rather than the whole team. A patient seeking information on outcome in colorectal cancer should be advised to look at the outcome for the whole unit, rather than an individual surgeon.

The patient and their cancer:

Patients suffering with colorectal cancer tend to be elderly and as well as having the cancer to contend with, they often suffer a number of other medical conditions such as heart and lung disease that put them at a high risk of developing non-surgical complications following major abdominal surgery. Indeed it has been estimated that 2/3rd of patients who die in the postoperative period following bowel cancer resection succumb from medical complications of their associated medical conditions, rather than as a result of surgical complications. Colorectal cancer can affect different parts of the large intestine; tumours in the lower part (rectum) are more difficult to remove and surgery takes longer because of the relative inaccessibility of this part of the bowel. Complications are more common for rectal cancer surgery than for surgery to remove tumours in the colon. Some surgeons may have developed a special interest and skill in dealing with particular types of bowel cancer and therefore treat higher risk patients than other colleagues. Thus the case mix is likely to vary from surgeon to surgeon and with it the outcome of the surgery.

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The Audit:

This data was extracted from the National Bowel Cancer Audit (NBOCA). This audit has been in place for a number of years and has collected data related to bowel cancer treatment from Trusts around the UK. It collates cancer administrative data, primarily designed to monitor waiting times. There are real and widely acknowledged problems in how routine NHS administrative data collection reflects actual patient outcomes. A recent analysis of nationally submitted health care data (NHS England First National Data Quality Review: Executive Summary Quality Information Committee www.england.nhs.uk/wp-content/uploads/2013/04/1ndqr-exec-sum.pdf) highlighted these shortcomings. Data accrual has increased year on year, but the Audit was designed to look at cancer management and outcomes of Trusts and Cancer Networks, not at individual surgeons, mainly because the treatment of colorectal cancer involves a large team of health care professionals working together. For this reason it has proved difficult to allocate correctly each patient to an individual surgeon and ensure that all that surgeon's cases are included in the analysis (hence the delay in publication). The accuracy of this process was patchy and for many surgeons data are being re-analysed to improve the reliability of the outcome data. We have established that for some surgeons, not all operations to remove a colorectal cancer have been included in the outcome calculations, making their survival figures inaccurate. Using the Audit in this way is seen as a start and this will improve in future years as the audit is modified to perform this role reliably.

The Data:

Most colorectal surgeons will perform between 20 and 40 planned operations to remove a colorectal cancer per year. They will also operate on a number of patients who present for the first time as an emergency with the complications of bowel cancer. In addition they operate on many other patients with non-cancerous conditions of their bowel. Thus the 20-40 patients included in the analysis are only a proportion of the bowel operations that colorectal surgeons perform. By comparison, Cardiac Surgeons have a more limited range of operations they perform and consequently operate on a much larger number of patients, making outcome calculations more robust. For this reason it is unlikely that an individual colorectal surgeon will perform enough cases to make any comparison of outcome statistically valid. It has been calculated that a colorectal surgeon would need outcome data on over 150 patients before there is an 8 out of 10 chance of spotting genuine poor performance. With low numbers, a surgeon could have a high death rate simply by chance and be wrongly labelled as performing poorly. Similarly, low numbers could mask a poorly performing surgeon and engender complacency.

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National Bowel Cancer Audit:

The National Bowel Cancer Audit (NBCA), commissioned by the Healthcare Quality Improvement Partnership (HQIP), has been developed by the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and is managed by the Clinical Audit Support Unit within the Health and Social Care Information Centre. The analyses for this report were carried out by the Clinical Effectiveness Unit (CEU) of the Royal College of Surgeons of England (with support from the Health and Social Care Information Centre

Audit of Colorectal Cancer has been a core ACPGBI activity for nearly 20 years. In this time data submission has advanced from 8000 “enthusiast” cases to 30,000 cases, representing the national colorectal cancer practice. An obvious strength of the Audit is both completeness of case ascertainment and NHS database linkage that describes the patient experience.

The National Bowel Cancer Audit (NBOCA) for 2013 will be released on the 3rd of July and describes:

- 90 day surgical mortality by Trust, Network and nationally
- emergency admission rates and outcomes by Trust, Network and nationally
- laparoscopic surgery rates by Trust, Network and nationally
- stoma rates after rectal cancer surgery by Trust, Network and nationally
- 2 year survival rate for patients that do and do not undergo surgical resection by Trust, Network and nationally

The Future:

This exercise has been difficult, but a lot will have been learnt in the short time available to produce this data. In future years more robust methods of ensuring the correct data is entered in the correct fields to allow individual outcomes to be reported. Furthermore, accumulating more cases each year will increase the statistical validity of the outcomes reported. On this first round we have tried to extract information from a source that was not designed for this purpose. It is analogous to using the National Weather Summary to forecast whether it will rain in your garden today.

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