Response to HQIP Consultant Outcomes Publication Manual for National Clinical Audits

A statement from

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Written On behalf of the ASiT Executive and Council

About ASiT

The Association of Surgeons in Training (ASiT) is a professional body and registered charity working to promote excellence in surgical training for the benefit of junior doctors and patients alike. With a membership of over 2700 surgical trainees from all 10 surgical specialties, the Association provides support at both regional and national levels throughout the United Kingdom and Republic of Ireland. Originally founded in 1976, ASiT is independent of the National Health Service (NHS), Surgical Royal Colleges, and specialty associations. Governed by an elected Executive and Council, the Association is run by trainees for trainees.

Background

NHS England reports that publication of surgeon-specific outcomes is to "spread best practice and identify any issues that need investigating". [1] This was introduced in England in 2013-2014 partly in response to Mid-Staffordshire Inquiry, in an effort to improve transparency and promote quality improvement. [2-3] Prior to this, surgeon-specific outcome reporting was first introduced in Cardiothoracic Surgery in 2005; this was as a direct result of the Bristol Public Inquiry led by Sir Ian Kennedy in 2001. [4] Patient safety is ASiT's main priority. ASiT readily accepts the importance of trust in the profession, and the need for efforts to improve transparency. The effects of publication of consultant-specific outcomes, however, are potentially far reaching. ASiT has significant concerns regarding its impact on surgical training.

Specifically, ASiT is concerned about:

- The potential to reduce trainee operative experience under appropriate supervision, including independent operating.
- The risk of "cherrypicking", reducing complexity of case mix required for senior trainees.
- The erosion of teamwork/team responsibility and the risk of not truly identifying contributors to adverse events (e.g. staffing levels and resources) by focusing on consultant-specific rather than hospital/unit outcomes.
- Attractiveness of surgery as a career- the impact of "naming and shaming" on attracting top caliber candidates into surgery and retention of surgical trainees and consultants.

The publication of surgeon-specific data has the potential to have a huge impact on a surgeon's career and reputation. Consultant Outcomes Publication (COP) may

promote risk averse practice, with consultant surgeons choosing not to allow trainees to gain necessary experience as the primary operator. Surgical training is an essential component of providing quality healthcare to both current and future generations. Teaching hospitals have been shown to have equivalent outcomes to non-teaching hospitals. [5] Involvement of surgical trainees in operations with appropriate supervision has been shown in numerous studies to be safe, with no detrimental effect on patient outcomes. [6-11] Reduction in surgical operative experience during training may however result in serious harm in the future. Khan *et al* have shown a significant decrease in trainee operating experience following introduction of surgeon-specific outcome reporting in cardiothoracic surgery. [12] Training has already suffered in the past decade with the reduction in working hours since the European Working Time Directive (EWTD), resulting in erosion of operative experience. [13] Already, worrying numbers of consultants have been shown to feel inadequately trained to manage complex operative cases. [14] The potential for COP to further reduce surgical trainee operative experience by promoting defensive practice by consultants is therefore of huge concern. COP may also lead surgeons to engage in "cherry-picking", avoiding difficult and complex cases [15] This is not in patients best interests, and furthermore will reduce exposure of surgical trainees to an adequately complex case mix to be competent consultant surgeons.

There has been little evidence to show that publication of surgeon-specific data improves outcomes. [16-17] Instead, a more complex analysis of unit outcomes may be more appropriate. Timely identification of a patient with a complication is crucial in avoiding post-operative mortality. Failure to rescue (FTR) in these patients is a key outcome in many surgical specialties. FTR is influenced by numerous factors that may be outside the individual surgeon's direct control, including medical and nursing staffing levels and availability of critical care support. [17-18] Therefore, unit related data might be a more accurate reflection of the care processes and a more powerful

catalyst for positive change. Indeed, Ozdemir *et al* have recently shown that outcome after ruptured abdominal aortic aneurysm is associated with modifiable hospital resources. [19] Publication of surgeon-specific rather than unit-specific data undervalues the role of the multidisciplinary team, including anaesthetics, critical care, peri-operative medical input, nursing staff and allied healthcare professionals. This also undermines the critical emphasis on teamwork in surgical training. We feel publication of unit-specific data would be associated with less risk averse practice, with less detriment to surgical training.

Finally, surgery needs to attract and retain high calibre candidates to the specialty to ensure that patients get the best possible outcomes. Surgeons often suffer from severe psychological stress when complications arise, which may in fact negatively impact patient outcomes. COP may accentuate this, to the detriment of patients and surgical training. [16] Publication of surgeon-specific outcomes in their current form have thus far promoted annual "naming and shaming" of surgeons. There is potential for a negative impact on the attraction and retention of doctors, and medical students, from pursuing a career in surgery, as they may opt for a less adversarial specialty. Already, there has been a significant decline in UK graduates pursuing a career in cardiothoracic surgery in the NHS over a ten-year period since the introduction of surgeon-specific outcome reporting (68% UK graduates in 2000, 18% in 2013). [20] Newly qualified surgeons may be encouraged to seek work outside the UK or NHS, where they are less likely to be unfairly targeted by negative publicity. Reporting unit outcomes may be more meaningful in changing patient outcomes and more acceptable to the surgical community. [21]

Response to Recommendations

ASiT welcomes the opportunity to be involved in the consultation process on Consultant Outcomes Publication (COP), to represent the concerns of trainees

regarding its impact on surgical training.

ASiT has reached the following conclusions:

- Patient safety is paramount and ASiT is keen to engage in efforts to improve transparency. However, ASiT has serious concerns about the outcomes data in their current form.
- In the era of multidisciplinary care comprehensive institutional outcome publication may increasingly help to improve health outcomes, and be more helpful to patients on a day-to-day basis. This demonstrates a more true-to-life metric of the patient journey within a hospital, allowing for real sources of potential error to be identified and corrected. Publication of unit or hospital-specific data, using adequately designed tools, would have a positive effect on surgical training.
- A regular public meeting of stakeholders, (including but not limited to employers, surgeons, trainees, trainers, and patients), where benefits and challenges of the system employed are discussed, should be available.

Despite ASiT's concerns, if surgeon-specific outcomes are to represent the surgical patient journey:

- We welcome the proposal that consultants have the right to check data prior to publication and re-submit data for further analysis, with adequate explanation. The data collection process must be robust, with accurate and reliable data collected. Poor quality, incomplete and unadjusted data misinform the public and unfairly damage both the profession and individual surgeons. Independent systems for submitting data, which are designed specifically for this purpose, must be invested in. This will facilitate accurate and meaningful data collection.
- We welcome the acknowledgment that risk adjustment be conducted. The precise mechanisms for adjustment are not specified in the document, as this will be

an evolving process, directed by the individual specialty associations. Unless properly risk adjusted, surgeons may select cases of lower complexity; with implications both for current patients and for surgical trainees who may not be exposed to an adequately complex case mix. This may therefore also negatively affect future surgical patient populations.

- We are concerned that there is no reference to the effect of COP on surgical training in this document. There is a need to include data on surgical training to ensure there is not a deleterious effect on surgical training. Proper surgical training does not compromise patient safety. With appropriate consultant supervision, trainees have been shown to be safe at performing procedures. [6-10]
- Identification of "trainer-specific outcomes" may be necessary if surgeon-specific outcomes are published, to reduce the adverse impact on training. A mechanism must be provided to monitor the number of cases performed by trainees before and after the introduction of COP. Trainees should have access to this data to guide their selection of training post. Trainees should only be allocated to trainers who can demonstrate that the number of procedures that trainees are performing under consultant supervision is adequate and has not been eroded following COP.
- Publication of COP may place an additional necessary administrative burden on consultant trainers, which may dilute time available to provide training. We ask that all NHS consultants be supported in this process with adequate administrative support and a realistic timeframe to complete these important audit tools.
- The document acknowledges that on occasion Trust resources and infrastructure, rather than the performance of individual clinicians are deleterious to patient outcome. In an era of austerity, this could be of more importance than individual consultants. This we feel should be given more credence to both in the document and the COP process. COP may miss the root cause of poor outcomes, and misinform the public, both damaging a surgeon's reputation and completely failing

to improve patient care. Blame-free mechanisms for staff and patients to report concerns about Trust resources and infrastructure must complement COP.

- Defining validated outcome measures is important; particularly as many outcomes such as length of stay are affected more by hospital systems than by individual surgeons.
- Data collected must be acted upon appropriately. We agree with this sentiment on the document. As detailed in this document, however, blaming individual surgeons is an easy option, when patients have numerous interactions that influence the course of their journey. Systems failures, which arguable affect more patients than individual surgeons, should be thoroughly investigated and remedied by the CQC. The threat of the GMC has the potential to cause alarm among surgeons and promote risk-averse practice. Risk-averse practice may include a tendency by surgeons to become the primary operator on all audited cases, with a resultant detrimental effect on surgical training. Improving systems within hospitals has a far wider reaching, longer lasting benefit.
- In each specialty, certain procedures have been chosen e.g. elective abdominal aortic aneurysm repair in vascular surgery. This may limit trainees' exposure to these index operations that are subject to COP in particular. There should be a mechanism built into the process to ensure that the numbers of these index cases performed by trainees under consultant supervision does not decline following the introduction of COP.
- We note that surgical trainees are not listed among the Stakeholders; we feel surgical trainees are important stakeholders in this process for two reasons. Firstly, COP may adversely affect their training. Secondly, they are the surgical consultants of the future. Any negative impact on surgical training is of grave concern, however ASiT is keen to engage in the process in order to make the necessary improvements for both patient safety and surgical training. The ability of the NHS to continue to deliver

excellence in surgical care is based on tomorrow's consultant surgeons receiving excellent training today.

References

1. NHS choices. Consultant Treatment Outcomes. http://www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx [accessed 12th April 2015]
2. Report of The Mid Staffordshire Foundation Trust Public Enquiry. Chaired by Robert Francis QC. http://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry [accessed 12th April 2015]
3. HQIP Consultant Outcomes Publication. https://www.hqip.org.uk/consultant-outcomes-publication [accessed 12th April 2015]
4. The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol. Chaired by Ian Kennedy. http://www.bristol-inquiry.org.uk/final_report/report/index.htm [accessed 12th April 2015]
5. Zafar SN1, Shah AA, Hashmi ZG, Efron DT, Haut ER, Schneider EB Schwartz D, Velopulos CG, Cornwell EE 3rd, Haider AH. Outcomes after emergency general surgery at teaching versus nonteaching hospitals. J Trauma Acute Care Surg, 2015; 78(1): 69-76.
6. Singh P, Turner EJ, Cornish J, Bhangu A; National Surgical Research Collaborative. Safety assessment of resident grade and supervision level during emergency appendectomy: analysis of a multicenter, prospective study. Surgery, 2014; 156(1): 28-38.
7. Oo AY, Grayson AD, Rashid A. Effect of training on outcomes following coronary artery bypass graft surgery. Eur J Cardiothorac Surg, 2004; 25 (4): 591-6.
8. Kanakala V, Bawa V, Gallagher P, Woodcock S, Attwood SE, Horgan LF, Seymour K. Outcome of patients in laparoscopic training courses compared to standard patients.

Surgeon, 2010; 8 (3): 132-5.

9. Kelly M, Bhangu A, Singh P, Fitzgerald JE, Tekkis PP. Systematic review and meta-analysis of trainee-versus expert surgeon-performed colorectal resection. Br J Surg, 2014; 101 (7): 750-9.
10. Handagala SE, Addae-Boateng E, Beggs D, Duffy JP, Martin-Ucar AE. Early outcomes of surgery for oesophageal cancer in a thoracic regional unit. Can we maintain training without compromising results? Eur J Cardiothorac Surg, 2012; 41 (1): 31-4.
11. Baron R, Sujendran V, Maynard N. Should oesophagectomies be performed by trainees? The experience from a single teaching center under the supervision of one surgeon. Ann R Coll Surg Engl, 2008; 90 (4): 305-9.
12. Khan OA, Iyengar S, Pontefract DE, Rogers V, Ohri SK, Livesey SA. Impact of surgeon-specific data reporting on surgical training. Ann R Coll Surg Engl, 2007; 89 (8): 796-8.
13. The Association of Surgeons in Training (2009). Optimising Working Hours to Provide Quality in Training and Patient Safety http://www.asit.org/assets/document/ASiT_EWTD_Position_Statement.pdf [accessed 12th April 2015]
14. Brooks A1, Butcher W, Walsh M, Lambert A, Browne J, Ryan J. The experience and training of British general surgeons in trauma surgery for the abdomen, thorax and major vessels. Ann R Coll Surg Engl, 2002; 84 (6): 409- 13.
15. Using Surgeons Outcome Data for Quality Control. http://www.hsj.co.uk/home/innovation-and-efficiency/using-surgeons-outcome-data-for-quality-control/5059613.article#.VSu0XlqRhUQ [accessed 12th April 2015]
16. Westaby S, Baig K, Pepper J. Publishing SSMD: The Risks Outweigh the Benefits. Bulletin of The Royal College of Surgeons of England, 2015; 97 (4), 155-159.
17. Radford PD, Derbyshire LF, Shalhoub J, Fitzgerald JE; Council of the Association of Surgeons in Training. Publication of surgeon specific outcome data: a review of

implementation, controversies and the potential impact on surgical training. Int J Surg, 2015; 13: 211-6.

18. Johnston MJ, Arora S, King D, Bouras G, Almoudaris AM, Davis R, Darzi A. A systematic review to identify the factors that affect failure to rescue and escalation of care in surgery. Surgery, 2015; 157(4): 752-63.
19. Ozdemir BA1, Karthikesalingam A, Sinha S, Poloniecki JD, Vidal-Diez A, Hinchliffe RJ, Thompson MM, Holt PJ. Association of hospital structures with mortality from ruptured abdominal aortic aneurysm. Br J Surg, 2015; 102 (5): 516-24.
20. Westaby S, Baig K, De Silva R, Unsworth-White J, Pepper J. Recruitment to UK cardiothoracic surgery in the era of public outcome reporting. Eur J Cardiothorac Surg, 2015; 47 (4): 679-683.
21. Sherman KL, Gordon EJ, Mahvi DM, Chung J, Bentrem DJ, Holl JL, Bilimoria KY. Surgeons' perceptions of public reporting of hospital and individual surgeon quality. Med Care, 2013; 51 (12): 1069-75.

Further reading

ASiT has published a number of statements that are available at http://www.asit.org/resources/articles