British Orthopaedic Association

Caring for Patients; Supporting Surgeons

4th February 2015

Mr D Keenan
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By email: Danny.Keenan@hqip.org.uk

Dear Mr Keenan

I am writing in response to your HQIP blog, posted on 29th January and circulated via the HQIP ebulletin.

I would like to highlight that the National Joint Registry has demonstrated improvements in outcomes over the last ten years, and that this is without publication of individual results until 2013. Recent publications from Bristol on total hip replacement and total knee replacement show the adjusted mortality for both almost halved between 2003 and 2011.[1] Whatever the reason for the improvement, it clearly cannot be attributed to the publication of surgeon-specific outcomes. We are deeply uncomfortable with your suggestion that with a similar reduction in mortality in cardiac surgery you "are confident it [publication of surgeon-level data] has made a significant contribution", since this link cannot be proven. We are concerned about this being used as an argument to support the current policy.

We also would like to raise wider concerns about the position portrayed in the blog, particularly in relation to the following statement:

> "Team-based data, in addition to consultant level data, is the model HQIP will be taking forward"

You invite comment. On behalf of the BOA I wish to raise with you our strong belief that publication at unit level is far more appropriate than at individual surgeon level.

There are three principal reasons that lie behind this position.

Firstly, it is suggested that such publication supports patient choice. However, the NHS referral system in place in most of the country does not allow patients to seek out the surgeon of their choosing, and publishing the surgeon-specific data is therefore not useful for patient choice. Rather, patients are more likely to have opportunities for choice over the hospital or unit where they will be treated, and therefore data at this level should be strongly encouraged.

[1] Hunt *et al.* (2013) 90-day mortality after 409 096 total hip replacements for osteoarthritis, from the National Joint Registry for England and Wales: a retrospective analysis *Lancet* **382**, No. 9898, p1097–1104; Hunt *et al.* (2014) 45-day mortality after 467 779 knee replacements for osteoarthritis from the National Joint Registry for England and Wales: an observational study *Lancet* 384, No. 9952, p1429–1436.

Secondly, surgeons do not work in isolation but are always part of a team. The effective working of the whole team is important for good patient outcomes. Unit level data is most appropriate because that it allow units to benchmark against one another, resulting in improvements across the whole team if needed, thereby improving patient care.

Thirdly, we consider that the data available at the unit level is generally more robust, and therefore more reliable and relevant for those who wish to use it. In most cases, the data for the unit will cover more than one consultant and so offers a larger sample for analysis. In addition, case-mix adjustment can be complex, and raises concerns among expert specialist surgeons who work on the more challenging cases. The complexities of case mix adjustment are compounded when looking at the relatively small numbers from an individual surgeon's workload which make publication unhelpful and any actions arising probably legally untenable.

There are two further matters that also require a specific mention:

- Where units specialise in complex cases, it is important that their situation is portrayed appropriately, to reflect the increased risk and complexity of the surgery they perform.
- We would highlight that there are situations, usually for lower volume procedures, in which some units may have only one surgeon performing the procedure, and in these scenarios the unit-level information would in fact be for a single clinician. We believe publication is nevertheless appropriate, but again it will be important to ensure that this situation is portrayed appropriately.

Ultimately, our view is that focusing on unit level is the appropriate level for publication, because:

- It is the most effective and meaningful method of informing patient choice;
- It is informative for commissioning of services;
- It is informative for the public, elected representatives, media and others to allow transparency about performance of services in their area.

Surgeon-level data is enormously valuable, but should be analysed, interpreted and acted upon by the individual surgeons themselves within and with their team as part of monitoring and managing performance. A professionally led audit should identify and manage potential individual outliers. Such mechanisms are a key part of a quality improvement process, and go hand-in-hand with publication of unit level data to support the unit and clinicians in identifying where improvements could be made. However, placing this individual alert process in the public domain is neither warranted nor appropriate and may discourage participation. Failure to take part in the outlier process has been identified by the GMC as the important alarm, and it would be the role of the registries to identify those who do not respond adequately for appropriate escalation.

Finally, we also note that the following quote from the minutes of the National Advisory Group on Clinical Audit and Enquiries:

> "NAGCAE's advice will be sought by NHSE about how the [transparency publication] programme can be expanded for future rounds of publication…,. Members emphasized the need in many areas of health care to consider the outcomes of teams or departments rather than consultants." 2(December 2014)

We would be interested to hear from you whether HQIP's position is aligned with this.

Thank you for providing the opportunity to comment on HQIP's position, and I very much hope that you would reconsider on this particular issue.

Yours sincerely,

Professor Colin Howie
President

2 http://www.england.nhs.uk/wp-content/uploads/2015/01/nagcae-mins-101214.pdf