Victorian Regional Office
250-290 Spring St
East Melbourne 3002
Telephone: +61 3 9249 1254
Email: Katherine.walsh@surgeons.org

Mr Pat Henry
Health Data Standards and Systems
System Intelligence and Analytics Branch
Department of Health and Human Services
50 Lonsdale Street
Melbourne Vic 3000

Pat.henry@dhhs.vic.gov.au

27 October 2016

Dear Mr Henry,

ESIS Proposals for 1 July 2017

I write in response to the ESIS Proposals for 2017-2018 as circulated to Victorian hospitals.

As the leading advocate for surgical standards, professionalism in surgery and surgical education in Australia and New Zealand, the Royal Australasian College of Surgeons (RACS) is committed to taking informed and principled positions on issues of public health at both state and federal levels. RACS represents more than 7000 surgeons and 1300 Surgical Trainees and International Medical Graduates (IMGs) across Australia and New Zealand.

The Victorian Regional Committee (VRC) would like to provide some feedback on

"Proposal 1: Add Treating Surgeon Identifier".

- *For monitoring quality and safety outcomes*
- *Utilising the last 7 digits of the Medical Board of Australia registration number to individually identify each surgeon responsible for the treatment of each waiting list episode*
- *A common identifier across all health services*
- *A particular specialty within a hospital may appear unremarkable, but it may be that several good surgeons are masking the fact that one is not treating patients in a timely manner or miss-classifying patients or leaving patients with poor outcomes*
- *Can be updated as clinician responsible for treatment at the start of the episode and throughout as surgeon performing treatment may change*

Improved data collection is important to improving patient outcomes and better identification of health practitioners involved in a patient's treatment is a necessary step. In settings where a surgeon has low-volume appointments at multiple hospitals this is particularly important as hospital-level data may not appropriately capture information on such surgeons.

A key concern with the implementation of Proposal 1 is the quality of data collection in hospitals. It is common for admission episodes to be assigned to the wrong surgeon, an issue often identified when the Victorian Audit of Surgical Mortality (VASM) forms are sent out.

Patient care and outcomes are reliant on a team of health professionals and the facilities available at the hospital, not solely on an individual surgeon. It is not uncommon for patients to be under the care of, or operated on by, multiple surgeons or teams throughout their patient journey.

RACS considers that the purpose of collecting and publishing performance outcomes data is to improve the quality of medical care and increase public trust and confidence in the delivery of that care. However, the public release of

surgical data may have unintended consequences that could impact on the delivery of quality and safe care. It is therefore important that appropriate quality assurance and evaluation mechanisms are in place for any data collected.

Additionally RACS also considers that data collection and data public reporting of outcomes data should include all sectors of healthcare deliver and not be confined to the surgical specialities.

RACS' position on the collection and reporting of surgical outcomes data is further detailed in the attached Position Paper *Public Reports on Surgical Outcomes and Performance.*

Given the complexity involved in the treatment of patients the VRC recommends that:

- The Department of Health and Human Services (the department) consults with the relevant speciality surgical groups prior to progressing Proposal 1.
- If Proposal 1 is progressed the department provides assurances on the quality, security and confidentiality of the data collected.
- If Proposal 1 is progressed the department provides assurances that data collected under this proposal will not be used to build a publicly accessible ranking or performance table of individual surgeons.

If you would like to discuss this further please contact the RACS Victorian Regional Office.

Yours sincerely

Mr David Love, FRACS
Chair, Victorian Regional Committee
Royal Australasian College of Surgeons

Attachment: Royal Australasian College of Surgeons Position Paper *Public Reports on Surgical Outcomes and Performance*

Subject:	Public Reports on Surgical Outcomes and Performance	Ref. No.	FES-PST-056

INTRODUCTION

The Royal Australasian College of Surgeons (RACS) supports the release of surgical reports to the public that are valid, reliable and transparent. Healthcare providers and their patients should be able to have confidence that reports accurately reflect health care outcomes and surgical performance. RACS supports the public release of outcomes based data on surgical performance at a team, institutional or national level but does not support the release of reports on individual surgeon performance. RACS does not support the concept of league tables but does accept that outliers be reliably identified and managed.

The following are recommended principles for the public reporting of surgical outcomes and performance.

METHODOLOGY FOR DATA REPORTING

Rigorous statistical analysis is required to avoid the misrepresentation of the quality performance of institutions, teams and surgeons in public reports. Reports should include a common set of clinically relevant measures that have been properly evaluated for fairness and accuracy so data can be compared across broad populations for meaningful analysis. The methodology for collection of data should be publicly available and include a detailed description of any data that is used to estimate performance, the use of statistical risk adjustment techniques, the selection of performance measures and how surgical performance was categorised. It must be possible to audit the report results.

RELIABILITY AND VALIDITY OF REPORTS

Reports should be subject to independent analysis to ensure their validity and reliability. Details of volume should be included to ensure that reported data are statistically robust. Where reports contain risk-adjusted data, minimum volume levels should be reported to ensure that the data is excessively representative of the surgical group. Reports on institutions with too few procedures to accurately characterise performance should not be included in public reporting. Such reports should include a statement that an inadequate number of procedures does not allow a meaningful analysis, and in no way reflects upon the performance of the institution.

TRANSPARENCY OF REPORTS

Reports must be transparent about the observation period and information in quality measures, including an explanation of the observation period, clearly differentiating between long-term follow-up and short-term outcomes. Focus on short-term outcomes may be inappropriate for some procedures and may not help to meet patient expectations. For example, 30-day mortality may be appropriate for some cardiovascular procedures but not for Otolaryngology Head and Neck procedures that would normally carry a low 30-day mortality. Results from these two groups may therefore not be comparable. Similarly the short term follow-up of major joint replacements may not reflect the long-term outcome.

STATUTE OF LIMITATIONS

Data within reports should be timely and reflective of current performance of standards of care. Out-dated material may not reflect current performance because of changes in technique or technology. Some measurements can become irrelevant after new evidence and research is published. There should be a statute of limitations within a public report and out-dated reports must be removed from circulation. As a minimum all public reports should clearly indicate the following information in this statute of limitations: Date of creation; date of the most recent update; date of expiry; inclusive dates for the data used in the report and what data has been included or excluded from the report.

RISK ADJUSTMENT

Reports should use recognised risk adjustment methodology, as determined by the appropriate specialty society, to ensure ongoing accuracy for patients who are at higher risk of complications and poor outcomes. Conditions that increase the complexity of surgery are difficult to convey accurately in performance reports and there can be significant differences in the course of disease or outcome between groups of patients with the same diagnosis. Factors that influence the outcome not only include patient comorbidities but also socio-economic status, health system structures and health resources available in that community. Considering the health system's balance of resources the most urgent cases and those in most need are usually dealt with in the public hospital sector. These patients may not be comparable with the population group operated on in the private sector and this may be reflected in the outcome data.

INPUT FROM SPECIALIST SOCIETIES

Surgeons are the most familiar with the scope of practice, clinical management and published research associated with their craft group. Specialty societies should have the opportunity to provide input regarding institutional or team measures chosen for public reporting. To ensure that measurement outcomes and data accurately reflect surgical care it would be appropriate for the various surgical groups to review the measures to be reported. Each subspecialty can decide and rank the importance of which quality measures best reflect their care.

STANDARDISED REPORTING

Report format and content should be standardised in order to provide clear and comprehensible presentation of data. In the absence of standardised formatting patients will not be able to make comparisons for well-informed decisions about their care.

REVIEW AND FEEDBACK ON REPORTS

Adequate time frames should be allowed for institutions or teams to review reports prior to publication. Mechanisms should be in place to allow institutions or teams to verify the content of reports, submit feedback and to allow reports to be amended prior to publication. In addition to reviewing data contained within the report, an explanation of the methodology should also be provided. If individual physicians or surgeons are reviewing reports the individual's data should be made available to that individual so that their data can be validated appropriately.

PILOT TESTING OF REPORTS

Pilot tests to determine usefulness and effectiveness of reports should be conducted. Reports should be highlighted to test the effectiveness of the report on the intended audience. Highlighting of reports will allow provision of confidential feedback to providers to build provider trust. It is likely that clinicians will be more likely to release data if they have trust and confidence in the methodology and results.

EVALUATION OF REPORTS

Reports should be evaluated to ensure that its stated purpose has been achieved and to identify any unintended consequences. Importantly results must not identify individual practitioners as evidence suggests that the publication of individual performance data may lead to risk-averse behaviour. The best clinicians may be those who manage the most complex and difficult patients and this may be reflected in the performance outcome measures.

STANDARDS AND DUTY OF CARE

Public reporting should not be used to establish the standard of care or the duty of care of a healthcare provider. The standard of care should be clearly defined prior to the release of any public reports. While it is expected that in most cases the quality of care will exceed that, the defined standard and the identification and management of outliers will generally increase the general

standard of care across all groups. It is recognised that not every individual, team or institution can be the best performer so their performance should not be the benchmark for all other providers.

CONCLUSION

RACS considers that the purpose of publication of performance outcomes data is to improve the quality of medical care and to improve the public trust and confidence in the delivery of medical care. Importantly public reporting of outcome data should include all sectors of health care delivery and not be confined to the surgical specialties. RACS recognises that the public release of surgical data may have unintended consequences that may impact on the delivery of quality and safe healthcare and affirms the importance of thorough evaluation of reports to minimise this risk. RACS encourages all organisations and individuals involved in the production of reports on surgical outcomes and performance to utilise these principles to guide their analysis and presentation of data.

RESOURCES

Medicare's Physician Value-Based Payment Modifier – Will the Tectonic Shift Create Waves? Chien AT & Rosenthal MB. N Engl J Med 369;22, November 28, 2013 p 2076-8

Grading a Physician's Value – The Misapplication of Performance Management. Berensen RA & Kaye DR. New Engl J Med 369;22 November 28, 2013 p 2079-81

The Professional Attributes of Surgeons. Clare Marx Ann R Coll Surg Engl (Suppl) 2014;96:220-222 Individualised surgical outcomes: please look the other way. S R Moonesinghe. Postgraduate medical Journal December 2013 volume 89 number 1058 page 677 – 678.

Developing Observational Measures of Performance in Surgical Teams. A N Healy, S Undre, C A Vincent. Qual Saf Health Care 2004 13 (suppl) i33-i40

Publishing individual surgeons' death rates prompts risk adverse behaviour. S Westaby BMJ 2014;349:g5026 doi: 10.1136/bmj.g5-26 (published 12 August 2014)

Analyzing :failure to rescue" Is this an opportunity for outcome improvement in cardiac surgery .Reddy HG, Shih t, Englesbe MJ, Shannon FL, Theurer PF, Herbert MA. Et al. Ann Thorac Surge. 2013;95:1976-81

Berwick DM A Primer on leading the improvement of systems. BMJ 1996;312:619-22 Agency for Healthcare Research and Quality. US Department of Health & Human Services. www.qualitymeasures.ahrq.gov/content.aspz?id=47545

Complications, failure to rescue, and mortality with major inpatient surgery in medicare patients. Ghaferi AA(1), Birkmeyer JD, Dimick JB. Ann Surg. 2009 Dec;250(6):1029-34.

Uses and Abuses of Performance Data in Healthcare. Shaw J, Taylor R, Dix K, Dr Foster Intelligence in Healthcare. April 2015

ASSOCIATED DOCUMENTS

No documents associated with this position paper.

Approver Professional Development and Standards Board
Authoriser Council