The Surgical Profiles Project Evaluation

Questionnaire Survey of NHS Board Medical Directors, Chairs of Clinical Governance Committees and Clinical Governance Leads

Summary Report

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Summary of free text responses
1. INTRODUCTION

The surgical profiles project was set up by NHS Quality Improvement Scotland (NHS QIS) and the Information Services Division (ISD) in an attempt to lead to better and more widespread use being made of existing Scotland-wide data sources for supporting improvements in clinical care.

For this project, each NHS Board is given its own surgical profile, comprising of a suite of clinical indicators about the surgical care provided by the NHS Board and its hospitals. The profile is a tool designed to be interpreted/used locally by those providing surgical care in order to stimulate reflection on surgical services – and in doing so to identify opportunities for improving patient care. Each NHS Board is asked to provide NHS QIS with a formal response to its profile, approved by its Clinical Governance Committee, describing how the data are being used locally. A clinically led panel then reviews these responses, providing feedback to each NHS Board about how the data are being used.

Having undertaken two cycles of the surgical profiles project, in 2006-7 and 2008-9, we are now formally evaluating this work to gain a better understanding of the perceived usefulness of this approach and whether the project is meeting its objectives. The results of this evaluation will be used to inform the work we carry out in the future, in particular the current development of a medical profile.

As part of this evaluation, the Medical Director (MD), Clinical Governance Lead (CG Lead) and the Chair of the Clinical Governance Committee (CG Chair) in each NHS Board area were asked to complete short questionnaires which were designed to elicit their individual views about the overall approach used for the surgical profiles project.

2. METHODS

The survey questionnaires and a covering letter co-signed by the NHS QIS Medical Director and the Head of the Health Services Research & Effectiveness Unit were distributed to recipients (n=45) by post and by e-mail during August 2009. Respondents were asked to base their responses on their views about the 2009 surgical profile report, the second issue, which was sent out to NHS Boards in December 2008. Two different versions of the questionnaire were distributed, Type A to Chairs of NHS Board clinical governance committees and Type B to medical directors and clinical governance leads. Although many of the questions were the same, the two versions had questions specifically tailored to their particular audiences.
3. RESULTS

3.1 Response Rate

A total of 23 responses were received; 17 from NHS Board medical directors (MDs) and clinical governance leads (CG leads) and 6 from Chairs of clinical governance committees (CG Chairs), giving an overall response rate of 51%. The response rate among MDs and CG leads was 57% (16/30) and amongst the Chairs of clinical governance committees was 40% (6/15).

All responses were anonymous but respondents were asked to identify whether surgery in their NHS Board area is undertaken in a teaching hospital or a district general hospital. Of the 6 CG Chairs who responded, a third (n=2) were from NHS Boards with a teaching hospital and two-thirds (n=4) were from NHS Boards with a district general hospital. Among the 17 MDs and CG leads who responded, 18% (n=3) were from NHS Boards with a teaching hospital, 65% (n=11) from NHS Boards with a district general hospital, 2(12%) from NHS Boards with both and one from a special health board (6%).

3.2 Data

Respondents were asked for their overall view on the validity of the information provided in their surgical profile report and although the responses were mixed, the overall response was positive with 70% (n=16) either ‘very confident’ or ‘quite confident’ in the validity of the information provided. The level of confidence was higher among the CG Chairs (83.3%, n=5, ‘very’ or ‘quite’ confident) than among the MDs and CG leads (64.7%, n=11, ‘very’ or ‘quite’ confident). However, this means that a third (37.3%, n=6) of MDs and CG leads were either ‘not very confident’ or ‘not at all confident’ in the validity of the information provided.

The surgical profile data were made available to NHS Boards via a secure website and the majority (82.3%, n=14) of MDs and CG leads reported that they found the website easy to navigate. Among the 6 CG Chairs who responded, 67% (n=4) accessed the information using the website and 75% (n=3) of these found the website easy to navigate.

Six respondents made suggestions for changes or improvements in the way the data are presented and these are show in Appendix A.

Seventy percent (n=15) of respondents stated that the data identified potential issues that they were previously unaware of (80%, n=5, CG Chairs; 64.7%, n=11, MDs and CG leads) and respondents were asked to specify what potential issues were identified. The responses are shown in Table 1 (respondents could give more than one answer).
### Table 1 - Potential issues identified by the data

<table>
<thead>
<tr>
<th>Issue</th>
<th>CG Chairs</th>
<th>MDs &amp; CG Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance/outcomes were better than expected</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Performance/outcomes were worse than expected</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Types of surgery being undertaken about which I was unaware</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Number of cases more or less than expected</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>No response</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong>*</td>
<td><strong>7</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

*Total is greater than 23 as respondents could give more than one answer*

The most common response was that the data suggested that performance/outcomes were worse than expected with more than half of CG chairs and MDs/CG leads (52.2%) stating that this was the case. Other potential issues respondents identified included problems with data accuracy, statistical issues concerning small numbers, and the fact that the data did not reflect the current situation.

More than two-thirds of respondents (83%, n=5, CG Chairs; 64.7%, n=11, MDs/CG leads) reported that they had service level concerns after viewing the surgical profile data. Among the MDs/CG leads, 47% (n=8) reported that they were able to access further data to easily support or refute these concerns, 17.6% said they weren’t able to access further data and over a third (35.3%, n=6) did not answer the question. All 5 CG leads who had concerns said that these had also been identified by other key personnel within their organisation and all were reassured by the course of action that was agreed upon.

#### 3.3 Process

The overall aim of the surgical profile work is to provide NHS Boards with data that allow them to gain a better understanding of their surgical services and to embed these data in a process designed to support the practical use of these data. When respondents were asked how useful they felt the approach taken to date had been in supporting the achievement of this overall aim the overall response was positive, with 30% (n=7) stating that the approach was ‘very useful’ and 60.9% (n=14) stating that it was ‘quite useful’ (Table 2).
Table 2 – Usefulness of approach taken to date

<table>
<thead>
<tr>
<th></th>
<th>CG Chairs</th>
<th>MDs &amp; CG Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very useful</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Quite useful</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Not very useful</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Not at all useful</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

As a result of reviewing their surgical profile, 70.6% (n=12) of MDs/CG leads said that they had ‘live’ action plans embedded within robust systems of governance.

All NHS Boards were asked to provide a written response on their surgical profile to NHS QIS and they then received feedback from NHS QIS on this response. Among the 16 MDs and CG leads who responded to this question, 12.5% (n=2) said that they found this feedback from NHS QIS ‘very useful’ and 62.5% (n=10) found it ‘quite useful’.

The Chairs of Clinical Governance Committees were asked a series of questions about the support and tools provided by NHS QIS to help them understand the data, and responses to these questions were mixed.

Only 2 of the 6 CG Chairs felt that NHS QIS had provided the appropriate support and tools to help them adequately understand the data. All 3 respondents who felt that the support and tools provided were inappropriate made comments relating to how understandable the data were to non-executive members of the clinical governance committee or to Chairs with no background in statistics (actual comments are shown in Appendix A). These 3 respondents also felt that the approach adopted by NHS QIS did not provide them with appropriate tools and support to assist them in gaining assurance about the robustness of their local governance system. However, 67% (4/6) of CG Chairs felt that the approach adopted by NHS QIS provided appropriate support and tools to assist other key personnel (eg, medical director) to consider and/or act on the data.

3.4 Impact

All but one of the respondents felt, to some extent, that the surgical profile data had allowed them to gain a better understanding of surgical service provision in their NHS Board with half of CG Chairs and 47% of MDs and CG leads saying it had helped ‘a lot’ or ‘quite a lot’. However, almost half of all respondents (47.8%, n=11), reported that the data had helped only ‘a little’.
Among the MDs and CG leads, there were mixed views about the extent to which the surgical profile data had allowed them to identify where further investigation/action was required (64.7%, n=11, said ‘a lot’ or ‘quite a lot’; 35.3%, n=6, said ‘a little’) or to be assured about the quality of surgical care in their NHS Board (58.8%, n=10, said ‘a lot’ or ‘quite a lot’; 41.2%, n=7, said ‘a little’) although again all respondents felt that the data had helped them to some extent.

Among the 6 CG Chairs who responded, two-thirds (n=4) said the surgical profiles initiative had helped them ‘quite a lot’ in gaining a better understanding of the arrangements for governance in relation to surgery in their NHS Board, and a third said it had helped them ‘a little’.

Over half (58.8%, n=10) of MDs/CG leads reported that, in their opinion, there had been changes in practice or approach to practice in their NHS Board as a consequence of the surgical profiles initiative and 70.6% (n=12) of them said it had provided a catalyst to review and develop greater robustness around the governance systems relating to surgery that were already in place. Among the remaining 5 respondents, 2 felt it had had no effect because robust governance systems were already in place, 2 felt it had provided a catalyst to develop and embed robust systems where few previously existed, and one was unsure of the effect.

MDs/CG leads were also asked to what extent the issues identified within the last two surgical profile data releases had been thoroughly explored and appropriate action taken forward. The answers were mixed. Almost a quarter (23.5%, n=4) said the issues had been dealt with totally and that they were comfortable with the position; over half (58.8%, n=10) said that the issues had been dealt with partially and that they were comfortable with the position that was developing; and 17.6% (n=3) said the issues had been dealt with to some extent but that they had concerns about their local position.

Among the CG Chairs, half (n=3) stated that the surgical profiles initiative had changed the governance arrangements in relation to surgery in their NHS Board by providing a catalyst to review and develop greater robustness around the governance systems that were already in place. Among the remaining 3 respondents, one felt it had provided a catalyst to develop and embed robust systems where few previously existed, one felt it had had no effect, and one was unsure of the effect. Two-thirds (67%, n=4) of CG Chairs felt assured that robust governance arrangements in relation to surgery were in place in their NHS Board.

All respondents were asked if they were aware of any unintended or undesirable consequences of this work and the majority said ‘No’ (76.5%, n=13; 67%, n=4, of MDs/CG leads and CG Chairs, respectively).

A number of respondents stated what the unintended or undesirable consequences were and these included delays in reporting to the CG committee, inclusion of some inappropriate indicators, a large additional administrative workload, errors recording mortality, confusion caused by release of HSMR data at the same time (a full list is given in Appendix A).
MDs and CG leads were asked to rate how useful they thought the surgical profiles work to be and although responses were largely positive there was no consensus (35.3%, n=5, said ‘very useful’; ’41.2%, n=7, said ‘quite useful’; 17.6%, n=3 said ‘somewhat useful’; and 5.9%, n=1, said ‘not at all useful’).

3.5 The Future

Respondents were overwhelmingly in favour of the surgical profiles work continuing in the future with 83% (n=5) of CG Chairs and 70.1% (n=12) of MDs and CG leads expressing this view. Of the remainder, all but one reported that they were unsure if it should continue.

There was no consensus regarding how frequently respondents thought the surgical profile data should be produced with responses ranging from quarterly to biennially. However, when respondents were asked how frequently NHS Boards should to asked to provide a formal response to NHS QIS describing how the data are being used locally the responses were more polarised, with 60% (12/20) saying ‘annually’ and a quarter (5/20) saying ‘biennially’.

Respondents were asked whether they would welcome a similar initiative focussing on medicine and MDs and CG leads were mostly in favour of this (82.3%, n=14, saying ‘Yes’) whereas only half of the CG Chairs were in favour.

Finally, respondents were asked if there was anything about the surgical profile as a whole and the process surrounding it that could have worked better or anything that worked particularly well. Overall, 54% (n=23/23) of respondents thought that there was something that could have worked better, and 30.4% (n=7/18) said there were aspects that worked particularly well.

Most respondents provided comments on what they thought could have worked better or what they thought worked particularly well and these ranged from comments on the (lack of) timeliness of the data and the speed of responses to queries about the data to suggestions for a newsletter for surgeons and ‘buy-in’ from senior management. A full list of the comments received is included in Appendix A.
4. SUMMARY

In general the surgical profiles project has been well received among its target audience within NHS Boards with the majority of respondents reporting that it highlighted issues they had previously been unaware of and many stating that it had led to changes in approaches and/or processes relating to surgical data and related clinical governance arrangements. Respondents had mixed views on the extent to which the surgical profile had helped them to better understand surgical service provision in their area and any issues there might be, but many also stated that things had changed locally as a direct result of receiving and responding to the data presented in the profile with the majority saying it had led to improvements in governance arrangements that already existed. Respondents were overwhelmingly in favour of the initiative continuing and indeed, almost three-quarters said they would welcome a similar initiative focussing on medicine.
5. APPENDIX A

SUMMARY OF FREE TEXT RESPONSES BY QUESTION NUMBER

Q4a – Suggestions for changes or improvements in the way the data are presented

Comments from Medical Directors and Clinical Governance Leads

“Felt report for previous year was more useful”.

“For distribution of the data to colleagues it would be useful to have one ‘button’ to press to print the lot”

“Frequently the presentation of data implies that a particular outcome is desirable or otherwise. In fact it is not always clear what represents a desirable outcome.”

“On the whole the graphs were ok but more working around what the graphs were telling clinical staff may have been useful for example NHS XX is better or worse than the National…It is very time consuming for myself speaking and explaining the graphs to clinical staff especially when they often felt the data criteria was not relevant eg urology cautery.”

Comments from Chairs of Clinical Governance Committees

“Clearer comparisons between profiles for individual board areas/Scotland in order to highlight areas for improvement.”

“It’s now months since I looked at the data but I seem to remember that referencing wasn’t clear and links from summary to individual graphs.”

Q8a – What other support or tools do you think NHS QIS could provide to help you consider the data?

Question asked of Chairs of Clinical Governance Committees only

“As a statistician I understand the figures, I suspect other Chairs do not, but they should need to know the level of detail. Also in some cases it’s unclear what’s good performance or bad, as 2-sided control limits are presented.”

“Written guidance in “lay” terms which could be issued to non-executive members of the CG committee to enable informed debate and challenge.”

“Last year I asked for confirmation that the use of funnel charts provided better information than a conventional SPC – type chart, ie plot the data in the two ways to see if there was significant difference on outlier population. The reason for the request was
that some non-execs have expressed ‘graph blindness’ so I wanted to make it as easy as possible for them……I received no response.”

Q16a – What type of unintended or undesirable consequences arose?

Comments from Medical Directors and Clinical Governance Leads

“The data, when reviewed, showed that 2 of the patients were still alive, and thus there must have been an error in the data, which reduces the usefulness of the report.”
“A large extra administrative workload

“Only that it has been confusing getting Surgical Profiles and HSMR data at the same time and in the same format which has led to some of the Surgical Profiles investigations not progressing as quickly as I would have liked. It was useful for me to use as a tool to speak to clinicians and explain the governance structure we have reviewed and are currently implementing new revised structures.”

“Initial …from general….relating to …presentation of mortality following elective admission in general surgery. I think this has now …following input from Clinical Director.” (Unable to read hand writing.)

Comments from Chairs of Clinical Governance Committees

“Some inappropriate indicators were included in this round – they were eventually withdrawn. Coding issues were identified.”

“Delay in reporting to CG committee (now rectified).”

Q20a/21a – What aspects of the process worked particularly well and/or could have been better?

a) What worked well?

Comments from Medical Directors and Clinical Governance Leads

“Was a successful prompt to evaluate services and benchmark. Some …of weakness (?) were identified and have been ….” (Unable to read handwriting.)

“Amy and Sam were very helpful with any queries I had.”

“The concept of being to provide data like this (sic).”

“Info on demographics, SIMD’s and coding is very useful context.”

“Data was well presented and areas needing addressed were quite clear.”

“Letting Boards explore data to improve services with a more gentle review process.”
Comments from Chairs of Clinical Governance Committees

“Buy-in from Senior Management Team to process for producing report. Buy-in from CGC and Extraordinary Meeting to discuss Board response. QIS suggestions and support – in particular questions for non-executive members to ask executives.”

b) What could have worked better?

Comments from Medical Directors and Clinical Governance Leads

“I think that a questionnaire should be sent to all Surgeons in Scotland asking them which data you should be collecting next time. Then when common themes have occurred you should send out the list of criteria for approval and information, this may encourage staff to be more involved and stop negative responses I had on occasions. Also clinical staff would know that the profile data would be coming and would not cause the defensive attitudes.
Perhaps a news letter to all surgeons explaining the purpose of the Surgical Profiles and inviting them to contact the team for more information may have been useful.
Length of hospital stay should be removed for emergency cholecystectomy cases, it is not an indicator of good (sic) practice, in our area we do same index surgery and we were an outlier because people were recovering from surgery and being acutely unwell. This practice is better for patients because they don’t have to return to hospital for surgery at a later date.
When printing off the report summary (blue and yellow boxes pages) some of the information did not print.”

“Selection of appropriate data to provide.”

“The data is relatively old by the time the feedback is received. Fresher data would make the response more relevant.”

“Access to patient identifiable data to assist local analysis is a slow process. It would be helpful to have access to more “real time” data locally.”

“A better briefing beforehand on how the data and process worked would have been helpful not just for medical directors but clinical and surgical directors.”

“Clarity on what you wanted for a report back – some confusion – a template would have been helpful.”

“Need to hold(?) additional data sets. To individual consultant level?”

Comments from Chairs of Clinical Governance Committees

“I think the patient safety approach works much better than this top down approach, or alternatively it needs to be integrated with performance management systems.”
“Data categorisation/agreement so as to ensure data is correct. This will avoid post publication concerns when local data is an outlier.”

“Faster response by ISD to clarifications in data sought at outset. Delay resulted in Board response missing normal cycle of CGC and necessity for Extraordinary Meeting.”