

REGIONAL REVIEW OF GENERAL SURGERY

QUALITY AND PERFORMANCE WORKSTREAM

REPORT

DATE: 15 April 2022
VERSION: 2

CONTENTS

1. Introduction and Context
2. Approach to the work
3. Patient Experience
4. Quality and Safety
5. Activity and Access
6. Integrated Dashboard
7. Summary of Recommendations

Acknowledgements

Appendices

Appendix 1 - Terms of Reference - Quality and Performance Workstream

Appendix 2 - Patient Experience – Report and Recommendations from PHA

Appendix 3 – CHKS Report

Appendix 4 – Activity Report

1. Introduction and Context

The regional review of General Surgery was approved by RMB early in 2021, and a project board was convened and started its work in summer 2021. A series of workstreams were established to support the work, many of these are to inform a consultation process on the options for strategic reform of general surgery in NI. There were also several enabling workstreams which were helpfully included in the work, and these included the Quality and Performance Workstream (QPW).

The membership and ToR for the QPW is included in Appendix 1.

2. Methodology and approach

The ToR sought to bring forward measures and benchmarks which would point to the need for service change from a range of angles. In reviewing the ToR and making an early assessment of the deliverables, the QPW viewed that the main thrust of the requirement was to seek out or recommend of the development of a core set of metrics, which would be used to inform the Review team, and the wider HSC system, as the Review progressed to implementation.

The QPW therefore agreed that the key deliverable of its work would be to:

- offer up to the Regional Review an appropriate mechanism and associated indicators which would objectively measure a baseline of delivery and outcomes for the current model of General Surgery delivery across NI hospitals, and
- propose a methodology for measuring the impacts of changes which may/will come as a result of the outworking's of the Regional Review.

The QPW agreed at an early point that an integrated approach should be taken, where 3 domains would be brought forward as the primary elements of the integrated dashboard. These were:

- Safety and Quality
- Activity and Access
- Patient Experience

A clinical panel was also constituted, to support the work, and 3 surgeons agreed to assist the review as the clinical panel.

Recommendation:

- 1. An integrated dashboard should be developed to provide a baseline of high level indicators at a regional level, which can be monitored over time as/if the service model changes, and can be analysed to Trust/hospital level if required.**

3. Proposed Patient Experience Indicators

3.1 Developing the approach

The Q&P workstream agreed at an early point in its work that patient experience should form part of the suite of indicators which would be developed.

To develop thinking on this area, the Workstream engaged with expert Linda Craig, Regional Lead for Patient Client Experience from PHA, and a meeting of the workstream was dedicated to a presentation by Linda on options, and possible approaches were debated by QPW members with her advice. It was accepted that any approach would need to be further tested with the Engagement and Communications workstream in the Review.

This report and the general approach was shared with the chair of the Engagement and Communications Workstream for that purpose.

It was also acknowledged that there was a short period available to complete the work for the regional group, and it was preferred that both qualitative and quantitative information would be accessed through a systematic approach to enable change in the general surgery model of provision over time to be viewed objectively from a patient experience perspective.

Equally, Workstream members viewed the inclusion of patient stories, even on a periodic basis, as this would be essential in order to gather a rich narrative on the impact of any change.

Taking all these factors into account, the Workstream agreed to harness the primary Online User feedback system used by HSC **Care Opinion** as the primary approach to providing indicators of patient experience.

3.2 Initial assessment and baseline

A stocktake of the current position as a baseline was then prepared by PHA which showed in total, that there were **285** stories shared on the system which relate to General Surgery and these included the experiences from pre assessment, ward, theatre and discharge. This provided a **quantitative** baseline, and condensed suite of indicators for future use.

Figure 1: The top 5 “Tags” to describe experience on Care Opinion relating to General Surgery:

Most common tags added by authors to these stories					
<i>What's good?</i>		<i>What could be improved?</i>		<i>Feelings</i>	
staff	178	communication	16	thank you	68
Care	69	waiting times	10	good	54
communication	59	food	9	safe	49
nurses	53	not being listened to	8	excellent	38
cleanliness	51	a&e waiting times	7	great	36

A qualitative approach was also proposed, using patient stories submitted to Care Opinion, which were framed with the lens of **“What matters to you”**, which can be themed as follows:

- Compassionate Care
- Person centred care
- Professional Team/teamwork
- System approach
- Listening to the patient
- Supporting families

The approach recommended by PHA has the ability to analyse patient experiences submitted to Care Opinion, identifiable by Trust (this can be further broken down to ward areas), and by treatment category (for example theatre/recovery).

An initial report provided to the QPW contained relevant stories from across the five NIHSC Trusts and there were also a number of stories reflecting upon NIAS which relate to admission to surgical ward through Emergency Departments.

The full report from PHA is included at Appendix 2.

3.3. Testing the proposed approach

Finally, contact was made with Roisin Kelly, the chair of the Engagement and Communications workstream to test the approach to be recommended.

Correspondence from Roisin Kelly (08/04/2022) – “The approach is comprehensive and will be an excellent way to include service user and carer feedback as part of the outcomes and monitoring process for general surgery. As this will be part of a wider performance management/monitoring framework it would also be useful to see how the quarterly reports will be factored in/weighted in terms of accountability”.

The QPW were therefore satisfied that a sufficiently robust approach had been taken and that PHA could secure the relevant patient experience input to the work going forward, if commissioned to do so.

3.4 Other Considerations

A QPW member also raised the possibility that IAD might be able to supplement the Care Opinion data set with information from discrete surveys. This was raised with IAD who advised that funding was made available for IAD to carry out a number of Patient Experience surveys in order to develop a robust PfG indicator for healthcare experience.

However, as these surveys will no longer be required for the upcoming Programme for Government, it is unlikely that IAD will be taking forward any similar surveys in the near future. DoH could explore other avenues to obtain direct patient feedback from core/mainstreamed government surveys.

Recommendations:

- 2. DoH should adopt Care Opinion as an Online source of patient experience feedback, in support of the General Surgery Review.**
- 3. DoH should commission PHA to provide a monthly (if required) quantitative dashboard which can be included in an overarching dashboard for General Surgery, accompanied by a “word cloud” of patient experiences.**
- 4. DoH should consider commissioning a detailed patient experience report on a 6 monthly basis, or after a major service change, to assess and track the impact of the change on patient experience.**
- 5. DoH should seek out opportunities to bring forward additional information from government surveys as IAD Patient Experience surveys have not been commissioned at this time.**

4. Proposed Quality and Safety Indicators

4.1 Developing the approach

The challenging timescales for the review meant that a pragmatic approach was sought to developing the Quality and Safety aspects of the proposed integrated dashboard. It was acknowledged that extensive work would be required to develop a new baseline tool and that HSC currently contracted with an established UK Benchmarking service – CHKS – which is used by all HSC Trusts and the HSCB (DoH SPPG).

The annual investment in the CHKS contract is costing £250k per annum, and CHKS have wide reaching access to clinically coded and validated HSC data through established and robust data sharing arrangements with HSC NI, and with NHS Trusts across the UK. CHKS currently provides a reporting service to all Trusts which include a suite of indicators which can be analysed down to consultant level.

It was therefore proposed by the QPW at an early point, and accepted by the regional General Surgery Project Board, that CHKS would be the source/provider who would capture, validate and analyse the primary Quality and Safety indicators which would be proposed.

Having obtained the acceptance of the Regional Project Board to the broad approach, the QPW then met with the CHKS User Group, which manages the contract with CHKS on behalf of HSC. The development of the CHKS suite of indicators was discussed in the context of the requirements of the Regional Review of General Surgery. CHKS were then commissioned to propose a “fit for purpose” approach and associated proposal.

A dedicated workshop was arranged with the QPW members where CHKS presented their proposal and it was debated and shaped by comments from members.

4.1.1 The CHKS proposal

CHKS proposed the use of their suite of benchmarking analysis platforms, principally the iCompare benchmarking and Data Analysis Toolkit systems, using Trust extracts of data provided by local information teams across HSC NI. CHKS asserted that their Data Analysis Toolkit would provide the ability to extract data across services and at patient level to support further detailed analysis and to help establish relative performance.

CHKS proposed benchmarking solutions with a suite of key performance indicators, to enable analysis within NI and to provide comparisons with NHS peers at a UK level. The CHKS GIRFT scorecard was proposed as the basis of the general surgery work for QPW.

Figure 2: iCompare GIRFT Scorecard

Description	Local Numerator	Apr 20 - Mar 21	Apr 19 - Mar 20	Change	Peer Value	Performance	25th Percentile	75th Percentile
Day Case Rate	25872	90.03%	89.11%	↑ 1.0338%	85.37%		84.61%	90.22%
Outpatient New to follow-up ratio	186096	1 : 1.77	1 : 1.81	↓ -2.48%	1 : 2.19		1 : 1.87	1 : 2.71
Readmissions within 30 days	4991	7.226%	6.943%	↑ 4.073%	9.777%		8.449%	10.827%
Total Spells	89174	89174	111045	-19.7%	105612		62473	136001
Average Length of Stay (Spell)	217112	3.14	3.2	↓ -2.07%	2.51		2.24	2.78
Total FCEs (Finished Consultant Episodes)	118383	118383	140179	-15.5%	132812		77277	173952
Complication rate - attributed	391	0.4385%	0.3647%	↑ 20.222%	0.9882%		0.7030%	1.0013%
Misadventure rate	14	0.015700%	0.025215%	↓ -37.74%	0.13202%		0.08385%	0.15311%
Post operative wound infection	19	0.3477%	0.5728%	↓ -39.30%	1.1085%		0.8052%	1.2531%
RAMI (Risk adjusted mortality index) 2019	1043	90.69	90.50	↑ 0.19983%	97.53		88.89	104.31
Average Pre-Op Length of Stay	11807	0.63	0.53	↑ 20.4%	0.65		0.53	0.74
Total Attendances (Outpatient)	291462	291462	314802	-7.4%	549103		322153	686331
% Uncoded FCEs (Finished Consultant Episodes) - Blank Primary Diagnosis	2	0.0016894%	0.7333%	↓ -99.77%	0.9470%		0.05327%	0.4848%

CHKS advised that their GIRFT Scorecard analysis could be split at several levels including Trust, hospital and speciality. Further drill down analysis by procedure / procedure groups (Figure 4) could be provided. Performance for each metric is then presented at the chosen level to enable comparison and to establish variation to UK or local 'peers'.

It was also agreed with CHKS that **index procedures** would be utilised and would be an important way to track change. These index procedures were agreed via a member of the group, Dr Rachel Coyle, and reflected key BADS procedures where there was known variation in Day Case rate across NI.

On the basis of this workshop, members were content to proceed with CHKS as the primary provider of the Quality and Safety Indicators for the Review. The CHKS User Group was asked to take forward detailed meetings to test the robustness of the approach, to review concerns about coding and data quality, and to shape the presentation of the dashboard metrics.

4.1.3 Recommended Indicators

On the basis of the workshop and follow up discussions, CHKS recommend that reporting for the General surgery review on Quality and Safety metrics should focus on the 3 domains of **Mortality, Flow and Efficiency, and Safety and Quality**. There will also be several data quality indicators to support efficacy of the reporting.

They have recommended that we utilise the specific indicators listed below, which are widely recognised and generally robust when used in peer analysis and can also be further refined at lower levels.

Figure 3: CHKS recommended indicators – summary

Mortality	Flow & Efficiency	Safety & Quality	Data Quality
Crude Mortality	Length of stay Pre-OP LoS / Adm on day of surgery	Complications –wound Infections	Diagnostic/procedural coding Completion
Risk Adjusted Mortality	Risk Adjusted LoS	Misadventure/Accidental lacerations	Depth of Coding
Index Condition	Daycase rates-Specialty & Procedure(BADS)		Accuracy Indicators e.g. Non- specific diagnosis
	Readmission rates-7 or 28 days		
	Delayed discharges		

It was agreed that the CHKS reporting would have the ability to profile these indicators over a **five year period** if required, and they should be able to be re-presented in reports at the following levels of granularity:

- NI HSC
- Trust and Site
- Specialty/Sub-specialty
- Elective/Non elective categories
- Specific diagnoses and procedures

4.1.4 Specialty Reporting and benchmarking

Benchmarking analysis requires a comparable case profile with peers. However no administrative sub- specialty coding is available in PAS data to distinguish sub-specialty activity within ‘General Surgery’. It is therefore proposed that two approaches to provide the most meaningful comparative analysis for the purposes of the General Surgery Review.

Sub-Specialty

This approach reporting will be based on aggregation of specific diagnostic/procedural categories to provide a derived sub-specialty group. These are provided at the following level:

Colorectal Endocrine	Hepato-biliary Upper Gastrointestinal	General
-------------------------	--	---------

Index Procedures

A basket of procedures within the wider ‘General Surgery’ group will be examined to balance the sub-specialty approach above.

Reporting would initially include a range of index conditions which are specific enough to be attributed and useful at a sub-specialty level:

Figure 4: Recommended Index procedures to be used by CHKS

Index Condition Description	
Thyroidectomy	Subtotal colectomy
Parathyroidectomy	
Adrenalaectomy	Oesophagogastrectomy
Appendicectomy	Gastrectomy
Hemi-Colectomy	Closure perforation in Dudodenum
APER/Resection Rectum	Laparotomy – Exploratory/Emergency
Anal Fistula Inc/Seton	Freeing Adhesions – Peritoneal
Drainage Perianal Abscess	Inguinal Hernia Repair – Primary
Pilonidal Sinus Drainage/Laying Open	Umbilical Hernia Repair
Destruction of a haemorrhoid	Cholecystectomy- Open/Laparoscopic
Total Colectomy	Excision of a skin lesion

The CHKS User Group have advised that when commissioned, CHKS can bring forward information on these index procedures in their reporting.

4.1.5 Peer Groups

CHKS propose that several peer groups should be used for reporting to optimise comparability and to provide a broad range of comparators. Crude comparison between hospitals/Trusts does not account for differences in underlying case mix. For example, length of stay would be expected to be longer where the patients having treatment had more complicated clinical conditions or a higher frequency of other medical conditions. Selection of appropriate peers for comparison and, where required, additional risk adjustment, can be used to facilitate more nuanced comparisons.

Mitigation can also be provided through the use of appropriate statistical reporting so that there is clarity regarding expected versus unexpected levels of variation in relation to a specific metric and the presentation of information, though funnel plots will be used for this reason (see section 4.1.5 below).

CHKS have recommended that for the purposes of fulfilling the request from the Regional Review of General Surgery, and with the intent of being able to monitor and track the impact of changes to the model of general surgery in NI. Peers recommended by CHKS will include:

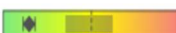
- NI HSC Peer
- Acute Teaching Hospitals - England
- All Acute Hospitals - England

4.1.6 Reporting and Presentation

The QPW have requested that in their reporting CHKS should use measures which have the capability to be produced, and profiled/trended over time to assess the impact of changes to the model of provision, and also against peers. However, as natural variation is present in all measures and together with data quality and issues with peer selection. It has been stressed by CHKS, the CHKS User group and QPW members that in practical terms it is critical to be able to present measures as within acceptable levels of variation.

For that reason, CHKS suggest the use of funnel plots, and many clinical and management teams will be accustomed to this approach to identify unwarranted variation in service provision and clinical outcomes. The use of funnel plots would illustrate data on each Trust with peers but also against an average and is especially relevant in safety metrics.

Statistical spread with additional graphics will assist in the understanding of material impact of indicators and percentile performance can also be included in the reporting (see below).

Description	Local Numerator	Jan 19 - Dec 19	Jan 18 - Dec 18	Change	Peer Value	Performance	Alert
Complication rate - attributed	519	0.7802%	0.6637%	17.553%	2.6597%		-

4.1.7 Other relevant issues

Definitions of measures/indicators within patient safety metrics (e.g. complications) will require explanation as these will not always have direct translation into clinical measures. All of the information used in the analysis is sourced from PAS and the practical use of some indicators may vary.

Time Periods available include previous five years data. A stable baseline period for comparison will be difficult to construct due to the COVID-19-related case mix and activity changes. For that reason, the financial year 2019/20 is proposed as the baseline year, with an amendment to exclude the month of March 2020, which is judged to be the first month when the pandemic had a material impact on delivery of HSC services.

4.2 Request to Feedback on CHKS approach by the clinical panel

The Clinical panel were asked for views on the approach. Responses indicated that, they were supportive of the approach taken, and that it was useful, and a reasonable way to track key measures. There was a comment on its limitations, and that some of the metrics are not in themselves measures of safety.

It will therefore be important to supplement the CHKS indicators with both the information on index procedures, and with information from National Audits (see below).

4.3 Initial assessment and Baseline report

The CHKS User Group have confirmed that the timeframe is likely to be mid to late May 22 for an initial baseline report.

4.4 Overarching indicators for integrated dashboard

Views on the most important indicators were sought from clinical representatives and members of the Workstream, via a “survey monkey”.

There was broad consensus from this survey that the most important indicators which should be drawn for the CHKS detailed reports for a High level integrated dashboard were:

Most important:

- Risk adjusted Mortality
- Readmission rates
- Complications compared with peer

A collective approach to reach a broader consensus on the primary indicators for use in an integrated dashboard should be taken forward as follow-on work, if the recommendation to provide an integrated dashboard is taken forward. This could be done through a “survey monkey” of clinical teams

Recommendations:

- 6. DoH should accept CHKS as the provider of information for the Safety and Quality metric/indicators (and associated analysis) for the General Surgery Review.**
- 7. DoH should commission the HSC CHKS User Group to secure regular reporting under the terms of the current regional contract in order to provide regular**

reports and a monthly (if required) iCompare dashboard, based on GiRFT indicators proposed in this report.

- 8. Detailed CHKS reports should be produced on a 6 monthly basis (alongside the patient experience reports) or after a major service change to assess and track the impact on Safety and Quality indicators against the baseline data provided.**

5. Proposed Access and Activity indicators

5.1 Developing the approach

In support of the Regional Review of General Surgery, (DoH SPPG)HSCB Performance Management and Service Improvement (PMSI) have prepared an extensive, interactive data covering inpatient and outpatient data 2017/18 – 2021/22. This data set is updated on a monthly basis and has been made available to all members of the Project Board. The indicators included within the data set include aspects of demand, activity and performance.

A key feature of the data set is the ability to filter and view the data at regional, Trust and hospital level. The data set also captured the patient's Trust of Residence (ToR). This allows visualisation of the number and proportion of patients who have travelled across Trust geographic boundaries to access emergency and elective general surgical care.

These capabilities mean that the live data set has been used to inform the work of a number of the Workstreams in the Regional Review, including the Demand and Capacity Workstream, the Paediatric Workstream and the Adult Emergency Surgery Workstream. For example, through identifying the volume of activity currently undertaken in a given Trust or site, including the proportion of 'non-resident' patients treated within a Trust/hospital, it is possible to estimate the impact of service redesign.

The data primarily focuses on demand and activity, however there are aspects of access and performance which can be derived from the dataset, while not duplicating those available within the CHKS proposed data set. Going forward the data set can be used to facilitate monitoring of activity and performance at a regional level and allow comparison between Trusts and hospitals as required.

5.2 Suggested use of the data set in Quality and Performance monitoring

(DoH SPPG) HSCB PMSI have agreed to maintain this data set to support ongoing monitoring of access and activity. The QPW propose that the data set is used to monitor selected indicators of access and activity. Examples of proposed indicators are outlined at section 5.3 below.

The data is currently accessible to selected users via a Sharepoint site. Data extracted from the Sharepoint site has been used to demonstrate the proposed indicators. Going forward,

it is recommended that, in addition to the sharepoint data, a **Power BI Dashboard** would be developed which would select the key regional high-level activity and performance metrics on a monthly basis for ease of access/user consumption.

In addition,(DoH SPPG) HSCB PMSI have agreed to prepare specific waiting times information for patients waiting over 5 years for outpatient and inpatient services. It is recommended by QPW that this data be monitored over time to track the improved access to care for longest waiting patients, and how the profile of patients waiting changes over time, as the outworkings of the General Surgery Review are implemented.

5.3 Suggested indicators

Suggested indicators are outlined below. As outlined above, the data set can be filtered to allow focus on the indicators below at a regional, hospital and Trust level and can be presented accordingly as required. Example visualisations are given in Appendix 5.

Demand

- New Referrals to Consultant-led Outpatient Services.

Activity

- Outpatient Attendances at Consultant-led Outpatient Services.
- Elective Inpatient and Day Case Activity.
- Non-Elective Inpatient Activity.

Performance

- The number of patients waiting each month for a first Outpatient Appointment at Consultant-led Outpatient Services.
- The number of patients waiting each month for an Outpatient Review Appointment at Consultant-led Outpatient Services.
- Proportion of Emergency Adult General Surgical Admissions associated with no operation or procedure during admission.

Waits can be stratified by urgency (routine, urgent, red flag) and by length of wait (e.g. less than 9 weeks, 9-26 weeks etc).

5.4 Overarching Indicators for an Integrated Dashboard

Views on the most important Activity and Access to Care indicators were sought via a “survey monkey” however insufficient responses were available to be included in time for the submission of the report.

A collective approach to reach consensus on the primary indicators for use in an integrated dashboard should be taken forward as follow-on work, if that recommendation is accepted by the Regional Project Board.

Recommendations:

9. DoH should utilise the existing General Surgery Review data set to visualise and monitor selected indicators of demand, activity and performance at hospital, Trust and regional level, and should seek to select a set of indicators for use in an integrated dashboard through consensus.
10. DoH should commission the development of a Power BI dashboard, drawing data from the existing data set, to support regular monitoring of demand, activity and access performance.

6. Development of an Integrated General Surgery Dashboard for HSCNI

Recommendation 1 of this report asks that an **integrated dashboard** for **General Surgery HSCNI** be used to track the impact of the changes that would emerge from this Review. That dashboard can be used to provide a balanced but high level view across 3 critical domains of care:

Patient Experience Quality and Safety of Care Activity and Access to Care

The Patient Experience metrics are well developed, and a range of baseline data is available. In the domains of Quality and Safety and Activity and Access to Care more work is needed to agree a set of preferred metrics suitable for use in an integrated dashboard.

In the short term, this information could be sourced through a wider “poll” of the regional project board membership (for example) and be brought forward to enable visualisation of an “at a glance” dashboard for General surgery for HSC NI. In a wider context, the Project Board may wish to include questions on “***What Measures Matter to you?***” in a public or targeted consultation process.

It is recommended that this integrated dashboard be developed either by DoH SPPG (PMSID) or by DoH IAD, to support ongoing monitoring at a high level, and to enable engagement with stakeholders on the baseline and impact of the Regional Review of General Surgery.

7. Other considerations

7.1 Utilisation of National audits

Clinical audit is a tool which can be used to assess the delivery of care against an agreed standard and can be used both to understand and benchmark current practice as well as assessing the impact of quality improvement interventions to support delivery of high quality patient care.

There are various national audits, examples as below, relevant to General Surgery and which local trusts currently participate in. For example, the National Emergency Laparotomy Audit, and the National Hiatal Surgery database. Data returns to national audits should also be made accessible to the DoH SPPG monitoring at a regional level to facilitate understanding of performance in relation to specific clinical conditions against the nationally agreed standards.

Recommendation:

11. Relevant clinical audits should be identified and agreed by General Surgery clinical leaders. These should be included in the Quality and Safety monitoring approach adopted by DoH SPPG and HSC NI.

7.2 CHKS Contract

It should also be noted that the contract with CHKS is due to be tendered in 2022, however it is expected that any tendering exercise will require that the provider will be capable of supplying the dataset which is being proposed for this review. If accepted for future utilisation as a central dataset to enable monitoring and improvement, this could be specified in the tendering documentation. This will need to occur at the earliest possible point, as tender preparations have commenced with BSO PaLS.

The Service specification of the contract be such that if CHKS are not successful, the selected supplier will be required to have the same system functionality and reporting capabilities as the current CHKS service.

7.3 Performance oversight and monitoring

It is expected that, going forward, a networked approach to the changes in General Surgery in NI, involving all Trusts, PHA and DoH will be proposed. In addition, DoH SPPG is expected to set planning expectations, and new delivery targets for HSC NI at a regional and Trust level. Appropriate monitoring frameworks will require oversight by DoH SPPG within the existing accountability and performance framework for HSC NI.

The establishment of an integrated dashboard and the utilisation of the baseline and continuing analysis from this work should form part of the resources for DoH SPPG and any collaborative Network which is established.

Recommendation:

12. DoH should agree the oversight and monitoring arrangements for General Surgery in NI, including a clinical network and regional monitoring and performance management processes through DoH SPPG.

8. Summary of Recommendations

1. **An integrated dashboard should be developed to provide a baseline of high level indicators at a regional level, which can be monitored over time as/if the service model changes, and can be analysed to Trust/hospital level if required.**
2. **DoH should adopt Care Opinion as an Online source of patient experience feedback, in support of the General Surgery Review.**
3. **DoH should commission PHA to provide a monthly (if required) quantitative dashboard which can be included in an overarching dashboard for General Surgery, accompanied by a “word cloud” of patient experiences.**
4. **DoH should consider commissioning a detailed patient experience report on a 6 monthly basis, or after a major service change, to assess and track the impact of the change on patient experience.**
5. **DoH should seek out opportunities to bring forward additional information from government surveys as IAD Patient Experience surveys have not been commissioned at this time.**
6. **Accept CHKS as the provider of information for the Safety and Quality metric/indicators (and associated analysis) for the General Surgery Review**
7. **DoH should commission the HSC CHKS User Group to secure regular reporting under the terms of the current regional contract in order to provide regular reports and a monthly (if required) iCompare dashboard, based on GiRFT indicators proposed in this report.**
8. **Detailed CHKS reports should be produced on a 6 monthly basis (alongside the patient experience reports) or after a major service change to assess and track the impact on Safety and Quality indicators against the baseline data provided**
9. **DoH should utilise the existing General Surgery Review data set to visualise and monitor selected indicators of demand, activity and performance at hospital, Trust and regional level, and should seek to select a set of indicators for use in an integrated dashboard through consensus.**
10. **DoH should commission the development of a Power BI dashboard of activity and access indicators, drawing data from the existing PMSI data set, to support regular monitoring of demand, activity and access performance.**
11. **Relevant clinical audits should be identified and agreed by General Surgery clinical leaders. These should be included in the Quality and Safety monitoring approach adopted by DoH SPPG and HSC NI.**

- 12. DoH should agree the oversight and monitoring arrangements for General Surgery in NI, including a clinical network and regional monitoring and performance management processes through DoH SPPG.**

Acknowledgements

I want to thank all the members of the Quality and Performance Workstream for their support and energy in developing this report, and the clinical panel for the advice and input they provided.

It was challenging to commit time, particularly during such a pressured period for HSC NI, and to balance this work with the responsibilities members held in their daily roles. While all the work was done via “zoom”, I am very grateful that they could find time to support the efforts needed to bring forward this report.

I also want to thank the chair of the CHKS User Group Danny McWilliams, and Ms Linda Craig, Patient Experience Lead in the PHA, for their support and expert advice to our Workstream.

Teresa Molloy

Director of Performance & Service Improvement – Western Trust

Chair of the Quality and Performance Workstream

Appendices

- Appendix 1 - Terms of Reference - Quality and Performance Workstream
- Appendix 2 - Patient Experience – Report and Recommendations from PHA
- Appendix 3 – CHKS Report
- Appendix 4 – Activity Report

Appendix 1 – Terms of Reference

Membership

Teresa Molloy (Chair)	Western Trust	Director of Performance & Service Improvement
Kevin McMahon	Northern Trust	Interim Director of Surgery and Clinical Services
Dr Diane Corrigan	PHA	Consultant in Public Health Medicine
DR Rachel Coyle	PHA	Consultant in Public Health Medicine
Ronan Carroll	Southern Trust	Assistant Director SEC & ATICs, Acute Directorate
Maggie Parks	South Eastern Trust	Assistant Director of Surgery
Siobhan Morgan	DoH	Information & Analysis Directorate
Stephen McDowell	HSCB	PMSI
Dr Chris Hagan	Belfast Trust	Medical Director
<i>In attendance</i>		
Joanne Elliott	DoH	Hospital Services Reform Directorate

Clinical Panel Members

Mr Michael Whiteside	NHSCT	Consultant General Surgeon
Ms Claire Jones	BHSCT	Consultant General Surgeon
Mr Richard Thompson	SHSCT	Consultant General Surgeon

Priority Focus

Benchmark elective performance in Northern Ireland against best practice in other parts of the UK, including an assessment of delivery of procedures as daycase in line with BADS guidance;

Appendix 2 - Patient Experience – Report and Recommendations from PHA

GENERAL SURGERY FEEDBACK ON CARE OPINION PLATFORM

BRIEFING PAPER

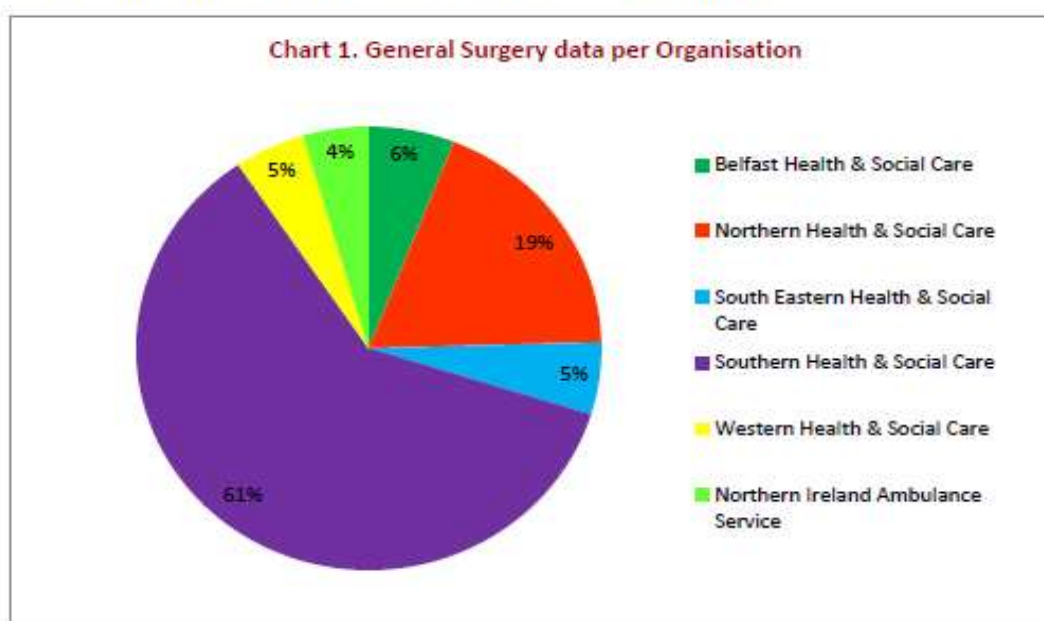
The purpose of this briefing paper is to demonstrate how the current database in Care Opinion can be used to inform the HSC system on the experiences of General Surgery. The following information reflects the stories published on Care Opinion up to and including 25th November 2021 and the data generated through a service search using the keyword “General Surgery”. It is important to note this can be further refined to be in line with a specific project or strategic approach as outlined in Section 4.0 “Next Steps”.

1.0 CONTEXT

Care Opinion launched in NI on 3rd August 2020 as a new opportunity for service users, relatives and carers to share feedback on their experiences of HSCNI. It is an online user feedback system which allows for feedback loop between the service and the author of the story. The purpose is to effect change at a local level and also ensure the voice of staff/service user experience influences and impacts upon strategic direction and decisions.

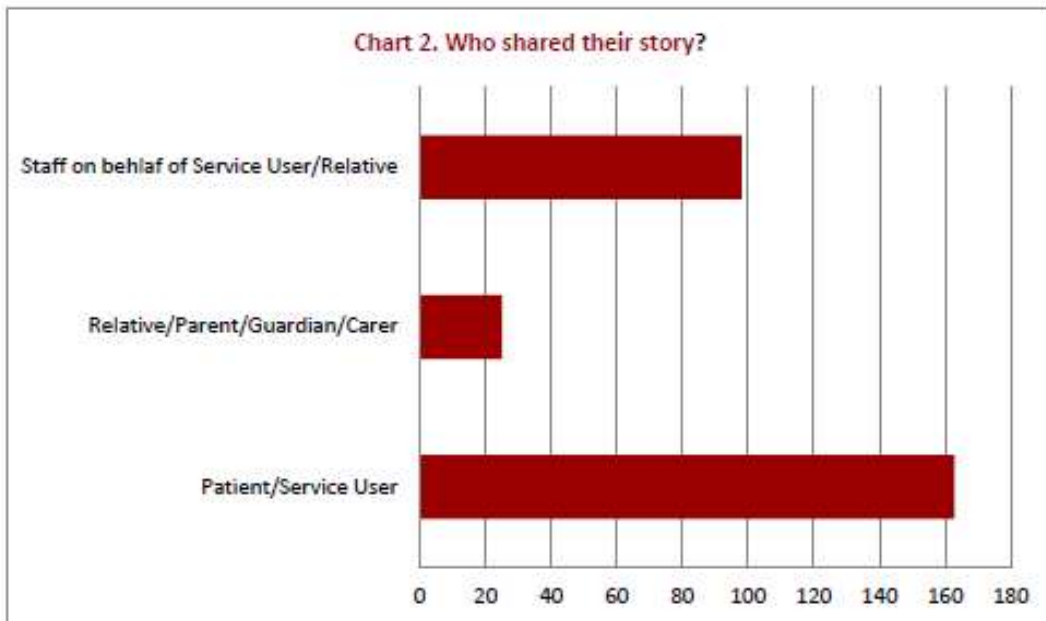
2.0 OVERVIEW

In total there are 285 stories shared on the system which relate to General Surgery and includes the experiences from pre assessment, ward, theatre and discharge. The following charts provide a high level overview, however analysis can be refined by Trust, by ward, by treatment category (for example theatre/recovery). There are stories submitted for the five acute HSC Trusts as detailed in Chart 1. There are also a number of stories reflecting upon NIAS which relate to admission to surgical ward through Emergency Departments.



It is significant to note the high number of stories for SHSCT relate to a campaign which was rolled out in July 2021 in relation to the acute setting. This demonstrates the importance of designing a campaign specific to any project in support of the project outcomes. This campaign is also reflected in Chart 2 when considering “Who” shares the story. From this chart it can be seen there are a large number of stories shared on behalf of the patient. This is due

to the approach in SHSCT whereby medical students (independent of care) gathered the feedback through discussion with the patient.



As part of the analysis through Care Opinion, each story is assigned a criticality score by a moderator to highlight the level of critique included in story. Chart 3 illustrates the scores for the 285 stories submitted. Table 1 outlines the definition of each score.

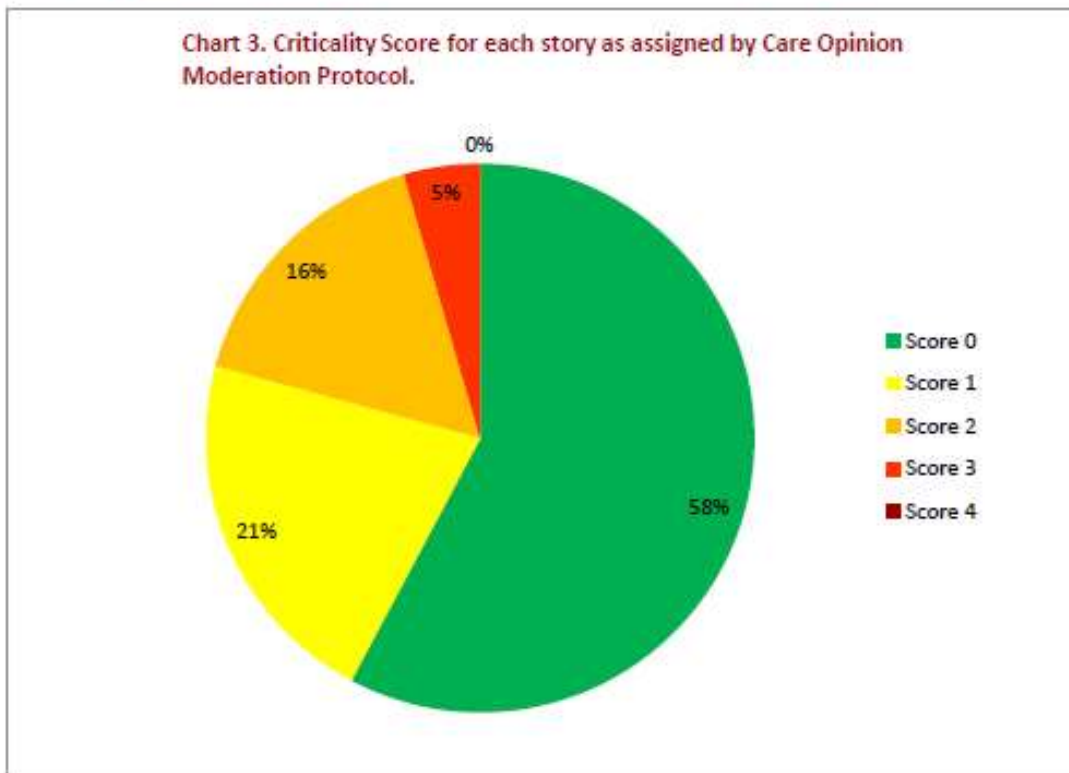


Table 1. Definition of Criticality scores as assigned by Care Opinion moderators

Score	Definition
0	No Critical Content: Entirely positive or neutral postings with no hint of criticality.
1	Minimally Critical: Mention of dissatisfaction with non-clinical non-personal aspects of care, typically "facilities" issues such as food, parking, or waiting.
2	Mildly Critical: More specific but still mild criticism, which may also include non-clinical but interpersonal issues such as attitude of staff, compassion, politeness. This might include the timely nature of the service whether in hospital or in the community where it has caused distress, e.g. carers not turning up on time
3	Moderately Critical: Criticism which may include alleged shortcomings in clinical or non-clinical aspects of care, the author may not say what the effect of these are. Also includes serious comments about facilities: 'never cleaned'; and where people's essential basic care needs are not being met, e.g. inadequate nutrition and hydration, development of bedsores
4	Strongly Critical: Serious criticisms of specific unnamed staff or groups of staff, or of clinical or other care or facilities. This might have had very serious consequences for physical or emotional health. These will be described by the author. There might also have been social consequences that have increased the risk or vulnerability of an individual
5	Severely Critical: Posting alleges or describes actions or events which may be illegal, grossly negligent, or allege serious misconduct by named members of staff or organisations.

It is important to highlight criticality scores in the selected data applies to the whole story, not just the term General Surgery. For example 10 stories reflect a positive experience on the surgical ward but a difficult experience through Emergency Department and delays in accessing surgery. The whole patient journey is significant to patient experience, however for clarity of the data this reinforces the importance of a campaign specific to a project.

3.0 THEMATIC ANALYSIS OF NARRATIVE

Care Opinion is built upon the concept of "What's your story" and supports the author to highlight what matters to them in their experience ; however there are three closing questions included on the platform exploring what went well, what needs to improve and the feeling and emotion related to the experience. These are listed in Table 2 and further illustrated in the word clouds in Appendix 1.

Table 2. Top 5 Tags to describe experience on Care Opinion relating to General Surgery

Most common tags added by authors to these stories					
<i>What's good?</i>		<i>What could be improved?</i>		<i>Feelings</i>	
staff	178	communication	16	thank you	68
Care	69	waiting times	10	good	54
communication	59	food	9	safe	49
nurses	53	not being listened to	8	excellent	38
cleanliness	51	also waiting times	7	great	36

Framing each story with the lens of "What matters to you" the following themes have been identified in the narrative. The values of HSC and standards for Patient Client Experience are also echoed in the themes. The purpose of this section is to give insight into the rich information available using the words of the service user/relative/carer. Each theme is illustrated using quotes directly from the story and referring to the experience of surgery to ensure

the voices of the stories are heard. Names have been included in the quotes of positive experiences, however consideration should be given to anonymising the quotes if included in a public facing document. The analysis encompasses the positive concepts which were part of the experience (highlighted in red & purple) and also the negative impact when the concept was not part of the experience (highlighted in blue). Through analysis of Experience data it is also an opportunity to highlight areas for improvement through the perspective of the service user. The following reflects areas highlighted by authors of stories. Through the Care Opinion process change and improvements are managed at organisational level however this is also an opportunity to consider the areas as a region or to influence strategic approaches). It is also important to highlight that the themes are not mutually exclusive and a number of themes can be identified within the quotes.

3.1 Compassionate care

"...The staff in all areas have been amazing. The medical intervention saved my life and thanks doesn't seem to be enough. The human kindness by nurses, doctors and everyone has been amazing. I will never be able to thank you all. Fantastic hospital with fantastic staff. Thank-you from the bottom of my heart. You are all in my prayers and I will be forever grateful..."

"...Recent stay in surgical 2 causeway hospital and all I can say is exceptional care from all staff on the ward, theatre, recovery ward, Tommy the porter. Friendly compassionate caring staff who turned what was a very negative experience to a positive one..."

"...So to every single person in the Ulster Hospital Dundonald, from the biggest part to the smallest part, made my experience less frightening and as pleasant as they did. Thank you all from the bottom of my heart, may you all be blessed in your lives..."

"...The nurses on ward 4 South; Krystina, Paula, Isabella and Blaithin were amazing- they took great care of me and were always so kind when doing so. Particularly Blaithin chatted with me when I was feeling pretty low after surgery and made a huge effort to chase up paperwork so that I could be discharged, I really appreciated that. I'm incredibly grateful to Dr Finnegan... She took great care of me when I found myself in a lot of shock after learning I needed to go to Craigavon for surgery and I really appreciated the time she took to explain what was happening and help me feel safe in a very overwhelming situation. The aftercare I had from Dr Finnegan and the rest of Craigavon staff was incredible; I felt they were really thorough and very accessible for any concerns I had. Any time I called they were fantastic at getting back to me and I was never made to feel like an annoyance, I really felt they were always there for me which helped so much in my recovery. Mostly I just appreciated their kindness and felt they really understood how difficult everything had been, it was nice to feel that was always acknowledged. I really can't thank the team enough or think more highly of the people working there, they really helped me through such a difficult time..."

3.2 Person-centred care

"...Yesterday I accompanied the same service user to a similar day procedure on the Elective day surgery ward on level 4 in Daisy Hill Hospital. Having given details of this particular gentleman's needs and anxiety levels through a pre op questionnaire our staff were concerned their comments would not be taken on board. We were pleasantly surprised by the support and forethought of the staff from Dr's, nurses and the Anaesthetist. We had previously discussed our service user's anxieties and Autism and the staff had taken on board what had been said and worked with us. They demonstrated understanding and respect at all times to the service user and made every effort to reduce triggers to his anxieties. Once his pre-med had taken effect he was immediately taken to theatre before the effect wore off. I think this shows how important it is to listen to information shared and knowledge of staff working daily with people with a learning disability. Much appreciation to the staff at Daisy Hill for the support they gave..."

"...My mum had emergency surgery and was in HDU for a week and then moved to female surgical. Over the past year she was in and out for weeks at the time so I got to know staff very well. They were amazing. My mum has Alzheimer's and is profoundly deaf. The care she received was above and beyond. They cared for her personally and with such love. They mean so much that a year later I still be praying for those staff members, from surgeons, nurses and support staff. I can tell you them all by name. When I tell people that the staff know mum they laugh at me. But

one of the surgeons who did mums drain 6 months later when she was admitted said he knew mum, this was such a comfort as we stood for the 2nd time in HDU, mum had septicaemia and they need to do the drain again..."

It is clear in stories with negative emotional tone of the importance of a person centred approach as when this is not apparent a patient is left feeling disengaged with the care.

".. I was far from happy with my stay on the ward. When in hospital, your emotions are heightened and I was made to feel sick, vulnerable and very much not at ease. At some points during my stay I was even managed to feel intimidated. I felt as if I was being treated as an illness not as a person. Even when it came to getting a scan, it was delayed and I had to wait a lengthy period of time for feedback afterwards, with only a junior doctor available. My main piece of advice would be to always treat and view a patient as somebody's loved one and not to disregard their feelings..."

3.3 Communication – Information sharing

"...My 15yr old son complained of stomach pains and it got progressively worse and when he vomited we took him to our local A&E. He was admitted quickly and tests showed it was likely his appendix... The surgical team leader Mr Hashim spoke at length with us as he explained that our son was at high risk of arrest under anaesthetic [Cardiac condition] and how they were working with my son's cardiac consultant to ensure the risks were mitigated as much as possible. The surgery went ahead with an anaesthetist's team, a cardiac team and the surgical team all in the theatre with our son. My wife was invited into the theatre and Mr Hasim introduced the teams and explained to her very unambiguously the risks of going ahead with the operation but also assured her that the teams were ready to deal with all possible scenarios. The surgery went ahead and there were no complications. During the surgery the anaesthetist called up to the ward where we were waiting and the nurse delivered messages on how our son was reacting to the anaesthetic and how his heart was reacting to the pressures of surgery. We know So much of our experience is not normal procedure, it showed how the medical personnel took our sons issues very seriously. This was an extremely high risk hospital experience added to by the COVID 19 risks that was managed by everyone we came in contact with with complete Calm professionalism. Thank you to everyone involved..."

"..The nurse Maria was fantastic, even though we had never met and I wasn't sure if she would be Deaf aware, she knew how to work with an interpreter, which felt good. She prepared me for what to expect from the procedure. I wasn't expecting her to provide me, unprompted, with a number I could text if I had any queries because she was aware, as a Deaf person, telephoning the service isn't accessible. I'm really grateful to Maria and HSC for understanding the difficulties Deaf people face when people are not aware of our needs, especially during the pandemic. I also want to say how impressed I was with the instructions before procedure leaflet explaining fasting and when to take the medication in preparation for the procedure. It was fantastically clear and the use of diagrams instead of reams of text was invaluable. It's great to see the service is Deaf-friendly and that the leaflet we worked on has had the desired effect..."

Considering stories with more negative emotional tone highlighted the importance of the approach to communication, with particular reference to difficult conversations.

"...I have been waiting years on surgery which has been cancelled multiple times this year. Having had to call my surgeons secretary at Musgrave Park to ask questions regarding medication and other problems I have been having, this person has made me feel even more ignored and as if I am a major inconvenience to their life. To have such a patient centred role this was the most unhelpful and rude interaction I have ever had with a person on the phone within the NHS. Quite frankly patients who are being denied treatment deserve better. Since writing the above, I am so reassured to know that not all staff are that rude. I was speaking with Julieann (Mr Connelly's secretary in the RVH) and she was amazing. She went above and beyond to find out the information I needed. She was so nice and patient. She went to a lot of effort to gather the information and double check and took my phone number to call back if anything was wrong. Her attitude and helpfulness was top notch, very reassuring..."

"...Yesterday I woke from a nap and was surrounded by 9 members of the medical team, I was both frightened and confused and this was all before they even said what they had come for. After a short conversation between

themselves they disclosed some very shocking information to me about my potential diagnosis, I was confused and anxious and after having just woke from a nap I was in no mind to ask any questions or what this meant for me, then just like that they were gone and I was left to take it all in. I would have loved an extra few minutes with the team just to have a chance to take it in and think of any questions at that time"... I felt so worried and frightened and once the blue curtains opened I became aware that other patients around me had also heard my news. Although they tried to comfort me I didn't feel like they should have heard this news in the exact way I had been told and I felt this extremely difficult conversation although behind a blue curtain lacked privacy which I was very disappointed about. I think a more private approach needs to be put into place with regards to disclosing information as such, sometimes the blue curtain isn't enough!"

3.4 Professional Team/Teamwork

I'd like to thank all of the staff at Craigavon, for looking after my mum. She came into a&e very out of it and in septic shock. Thank you to all those a&e staff and Rebecca the surgeon for saving her life, as she's still here today because of you guys and for that we cannot thank you enough. Mum spent around 5 weeks up on 4 northTo Sean (physio) who gave mum a reason to get up and out of bed every day, even on the days she really didn't feel like. Thank you for persevering with her and giving her a laugh every time she saw you! Mum couldn't get over how clean the ward was and how great the nurses were, she still says to this day she takes her hat off to you all! ...Mums making amazing recovery, her wound is nearly healed and she's now walking unaided, still needs a little help on the stairs but we're getting there. We never thought once we heard sepsis, that we would ever have our mum back, but thanks to the amazing staff we do. So from the bottom of our hearts thank you for all you do!..."

"...I was admitted to Causeway Hospital on New Years Eve suffering from gallbladder problems...The condition was diagnosed as Mirizzi Syndrome . I was admitted to Surgical 2 where I was treated with great care and respect and kept informed at all times as to the progression of my treatment. My consultant surgeon was exceptional in that he got a specialist surgeon to do the procedure, the nursing throughout has been exemplary from the trainer nurses to the Ward Sister. Always available always ready to listen and totally professional. As this is my third time in hospital in sixty seven years I can only say the standards are way above that which anyone might expect.. Thank you surgeons and thank you Surgical 2..."

"...In January I underwent major surgery in the Ulster Hospital Dundonald. Beforehand the team of surgeons knowing that it was going to be a long complicated surgery pulled out all the stops. During the op (roughly 14 hours) the team worked long and hard. At one time I had 5 surgeons/anaesthetists in theatre with me. I can't thank that team enough. There are not enough words to express my gratitude to them. The job they done was amazing, before and after care second to none. Every member of staff connected to my treatment were brilliant. My stay in ward 5 afterwards was made much easier by the staff. Everyone who entered the room was friendly and helpful. I noticed how well all staff worked together. Helping each other and making sure my needs were catered for. Would love to mention them all by name but there are too many to remember..."

Also reflected in stories with negative emotional tone was lack of confidence when the resourcing of the team is stretched and challenge in the delivery of care.

"...The effects of under resourcing and working through a pandemic was obvious and I am sure staff are exhausted. I appreciated the care and concern shown by those nurses who clearly 'knew the ropes'. Being offered human connection, conversation and concern when in a lot of pain, means so much particularly when visitors are not permitted...My experience was not all reassuring, with many staff new to the ward or appearing inexperienced requiring supervision, maybe due to staffing shortages? In 5 days, 7 different surgeons spoke briefly to me and while I understand the enormous pressures they are under, continuity and taking time to explain would have really helped to give clarity and reduce anxiety...Thank you to the staff who keep on going, when patients return home still you go on..."

3.5 System Approach

"...After a week of isolation for my family, covid tests for my son who was having surgery and myself as I was coming in to the ward with him, we arrived at hospital to receive excellent care and attention. The whole system ran smoothly and the staff couldn't have been better. It is such a relief to have this urgent surgery behind us and just wish that whoever makes decisions re. hospital admissions would allow more people to have their surgery. The process was simple and safe for all involved and it would be great to see admissions for surgery running at full capacity..."

Stories with negative emotional tone give insight into the delays experienced due to waiting lists and the impact upon the patient quality of life

"...it's been 5 years now waiting for this operation I am 68 years of age and was told 2 years ago that I am on the waiting list as my doctor contacted hospital to say this is urgent my condition has got worse as I am passing blood and am now waiting to see a consultant still waiting 2 weeks later. Because of my condition I have had to urinate into a plastic measuring jug for the past 3 years this has become very difficult I am retired and worked all my life and I have no quality of life what so ever I wish someone would help when I contact hospital they say your still on list but no day procedures are being done..."

"...I've been suffering for over 15 months now with multiple gallstones. This came to a head in November 2020 when the pain became unbearable and I was admitted to hospital. 4 days spent in hospital and during that time I was informed that my gallbladder needs to be removed as I had so many gallstones along with an infection. From November I've had 5 or 6 (can't remember exactly) more visits to hospital due to the pain. I'm on the urgent waiting list but I'm not being updated or nothing. Well the only thing I'm constantly told is that they aren't doing gallbladder surgery due to the pandemic. While I respect this decision, I don't understand how someone else I know who had the same thing but 'NON URGENT' was able to get their surgery and I'm constantly left in the dark. I'm in constant pain everyday without fail. I'm hardly eating due to everything I basically eat is causing severe pain. I am suffering greatly mentally as I suffer from panic attacks and anxiety and all this pain has increased that dramatically. All I'm looking/asking for is clarity and to be given some hope that this surgery will be done ASAP!!"

Concerns were raised regarding referral to surgical teams from Primary Care and the importance of a timely interventions. This gives insight into the importance of the journey up the point of surgery.

"...I had been on a waiting list for Hernia Surgery, but had to be rushed to A/E at Ulster Hosp. for emergency surgery for a strangulated Hernia. The result was not satisfactory and I had further emergency surgery in the same week from which my family was told I may not survive; however I made it and I had excellent aftercare. ..."

"...In my annual blood test results my GP noted an elevated PSA level and he referred me to the Ulster Hospital. It took 3 months to get an appointment with the Surgical Consultant who instructed a biopsy to be carried out. In the following months several PSA tests were carried out as well as the biopsy but it was 1 year from the GP referral that the consultant confirmed that there was Stage 1 Prostate cancer. They declined treatment (other than for better urine flow) and said they would do 'active surveillance'. My GP also referred to this approach as 'watchful waiting'. I refer to this approach and both these statements as doing nothing until matters get worse. So much for early treatment of cancer !!At various reviews thereafter the Consultant (and a colleague whom I dismissed) were left in no doubt that I was not happy with my lack of treatment. A TRUS biopsy confirmed that the cancer was now at Stage 2....From the initial GP referral to having hospital treatment took 3 years 4 months during which time the cancer moved from Stage 1 to Stage 2.(Note this is all pre Covid 19)..."

3.6 Listening to the patient

"...I felt rushed out, the doctors didn't have enough time to find the correct diagnosis and it felt I was only there for 2 minutes. I didn't feel listened to by both nurses and doctors, it felt as if I was frauding them. So I was discharged, went home and still felt sick. I ended up coming back to A&E where I was told I was misdischarged and the staff seemed quite annoyed about this. My experience in 4 the second ward has been totally different, I feel listened to and I can ask questions, they have great communication skills, the staff here have been amazing..."

"...My hospital experience hasn't been one bit positive. I don't feel I get the treatment that I need. I have talked to the doctors and the nurses and I feel they just don't listen...On numerous occasions I feel staff have tried to blag me off. I don't feel listened to at all and I feel my opinion is not valued.."

"...In terms of operation recovery I have went between many wards, immediately after my operations I was taken back to ward 4 north where 2 days into recovery I was given impossible tasks to complete by the physio. I knew their goal was right in getting me up and moving, but I felt this approach didn't facilitate my needs and had no aid in my recovery. I deemed this as quite insensitive as not only was I recovering from the operation but I am also an amputee and this meant I was battling many of my conditions which I felt the physio just wasn't accounting for. After a discussion with a few members of the team, I felt listened to and my opinion was valued as I was able to verbalize how I didn't find this element of my recovery very appropriate which led to the necessary changes being made..."

3.7 Supporting Families

Stories also reflected upon the importance of support for the family at a time of surgery. This includes receiving updates on progress, the facilities for families and the important role of the team during COVID restrictions on visiting. The following quote gives insight into the important feedback from families.

"... to Donna and the team of specialist palliative nurses, words can't express! Your expert care and support to both dad and us as a family during our journey, keeping us informed every step of the way will never be forgotten - thank you... To Kate and the head and neck nursing team for their care and attention to dad, and for providing such expert training to us in an attempt to get dad home - thank you... For being his family when we were not with him, during highs and the very dark days, laughing with him, and wiping his tears. For your genuine care, empathy and support you gave him - thank you...For the warmth, care and support you showed in all communications with us as a family - thank you...For the spiritual support you provided to dad, knowing this was so important to him - thank you. For playing and even singing hymns and worship songs with him during dark and distressing days, and to him in his last few days when he was no longer able to sing, some even staying behind after hours after a long shift to do this - thank you so so much..."

"...Sandra [senior nurse], who didn't only have to deal with me and my gurning but the phone calls of my worried overprotective husband, and trying to calm him. Sandra looked out for me at all times and helped me in so many ways even my first shower. No job is too big or too small for anyone in surgical 2 everyone cares..."

It is also evident the negative impact on the experience when families are not supported in the process.

"...My partner has had to undergo a 4 hour operation to remove part of his bowel and infection caused by a perforated duodenum...The point that has shocked me is the staff's attitude to my frequent presence. I have been told by one ward sister that my presence was 'not needed' because I wanted to arrange to come 15 minutes earlier than the usual visiting hours as my partner was on the road to recovery and when I mentioned his ongoing agony she flippantly remarked that he 'couldn't possibly be in pain'. Also, I was told that if visiting hours did not suit me then I should have to arrange for someone else to visit.... I was extremely concerned that staff had no empathy, concern for fairness or flexibility with someone who has done the utmost to ensure her relative has been adequately cared for as much as I can possibly do without their assistance..."

5.0 NEXT STEPS

Care Opinion is currently available across the system of HSCNI and will continue to support feedback on the experience of General Surgery. This briefing paper reflects the current feedback available to inform and influence strategic work; however going forward consideration should be given to the benefits of specific campaigning in relation to the specific outcomes for the Quality & Performance Workstream for General Surgery. To support a campaign it would be important to work in partnership with the PCE team in the following steps to ensure the data is accurately aligned to the work (for example to avoid stories which relate to medical outliers or stories which relate to speciality surgery areas)

- 1- Define services which relate to the work within Quality & Performance Workstream. Care Opinion link and service trees will reflect this list.
- 2- Develop promotional material to promote the campaign with patients and families specific to the defined services.
- 3- Agree reporting required to demonstrate Patient Experience in relation to the work of the Quality & Performance Workstreams. Proposed outcome statements which could be considered are:-
 - Patients and families will provide feedback through service promotion of Online User Feedback System
 - Patients and families will report on an experience which is patient centred
 - Patients and families will report on a positive experience of their care
 - Improvements will be informed by patient and family experience
- 4- Identify areas for Care Opinion Training. It is recognised that a large number of staff are already trained in Care Opinion across Surgical Directorates as reflected in the number of stories to date

It is recognised for reporting purposes the group may consider the frequency and criticality of stories on a monthly basis; however as detailed in this report the richness of the patient experience is best reflected through thematic analysis of the returns and through the words of the story authors.

For further information and support contact:-

Regional Lead for Patient Client Experience:- Linda Craig.

[✉ linda.craig3@hscni.net](mailto:linda.craig3@hscni.net)

☎ 028 9536 2869

Care Opinion Project Lead:- Thelma Swann

[✉ Thelma.swann@hscni.net](mailto:Thelma.swann@hscni.net)

☎ 028 9536 2761



CHKS Benchmarking

Regional Review of General Surgery,
Health and Social Care
Quality and Performance Workstream

January 2022

Commercial in Confidence ©CHKS 2022

www.chks.co.uk

Who we are

A leading provider of healthcare intelligence and quality improvement products and services.

Over the last 32 years our CHKS team of NHS data experts, clinicians and quality managers has worked with more than 400 healthcare organisations around the world to improve population health.

What we do

We enable providers and commissioners to make better decisions at patient, service, organisation and population level in order to deliver sustainable improvements in care quality, patient outcomes and service efficiency along the entire patient pathway.



Benchmarking Service, Health and Social Care

- As part of the regional benchmarking contract, CHKS work with trusts and the HSCB to identify areas of good performance, where improvement is required and support the ability to share good practice within their peer benchmarking platform, iCompare.

CHKS iCompare

iCompare

- CHKS's iCompare suite of products is an online healthcare comparative benchmarking and analytics system that facilitates peer comparison against a library of 600+ performance indicators;
- Web-based tool accessible across a range of different devices;
- 5 years of data available for target site and peers from across the UK;
- The system brings actionable benchmarking insight by combining data from different sources and organisations and allowing the creation of individual indicators and scorecards;
- Themed scorecard approach with appropriate statistical analysis to identify if performance is within acceptable levels of variation.

Data submissions

- Data sources:
 - Client submissions – directly from NI HSCs and the regional HSCB;
 - NHS England Acute Hospital Trusts via NHS Digital (Hospital Episode Statistics [HES] dataset).
 - IPDC and OP
- Routine validation and data quality monitoring processes for all data.
- Hospital administrative (PAS) data – particular focus on clinical coding (ICD10 diagnosis codes, OPCS procedure codes) to construct many of our indicators / metrics.

Clinical Coding

- Informs many of our benchmarking indicators providing the necessary information with which to monitor trust performance against other trusts, thereby ensuring equality for patients, implementation of best practice and addressing bad practice.
- Accurate, comprehensive and timely coding is therefore critical in supporting a clear understanding of trust performance. Data quality indicators (coding completeness, depth, invalid use of codes) included in the system and it is recommended that contextual analysis is always run to provide assurance.

Benchmarking – Interpreting Performance

- The best analytical approach is to consider the data you wish to benchmark (local recording practices, casemix) and always to choose your own peer group carefully.
- iCompare includes a range of information and metrics to monitor performance, quality and outcomes for regional surgical re-organisation.

General Surgery Activity Analysis

General Surgery Activity Analysis

- Recorded administratively as specialty code 100.
- Wide ranging variety of sub-specialties:
 - Breast
 - Colorectal
 - Endocrine
 - General
 - HPB
 - Upper Gastrointestinal
 - Vascular
- Benchmarking analysis require similar / comparable case profile. However, no administrative subspecialty coding available in PAS data to distinguish sub-specialty activity.

General Surgery Activity

- Two proposed approaches to identifying subspecialty analysis and ensuring comparative data with peer:
 - Diagnosis / procedure groups to identify sub-specialty activity.
 - General Surgery only
 - General Surgery with HPB, Colorectal, Endocrine, Upper GI
 - Separate analysis of other sub-specialties – Vascular, Breast.
 - Specific index conditions – sub-specialty index procedure data cut on availability of significant volumes.
- In addition, not all spells will include detailed clinical recording (procedure coding) and therefore General Surgery specialty 100 can be used to provide an overview of performance at specialty level.

General Surgery Activity

- Five year dataset available for analysis;
- Stable baseline period for comparison will be difficult to construct due to Covid related casemix and activity changes.
- Suggested that the 2019/20 period is used with some amendment e.g. exclusion of the month of March 2020.

Demonstration

Sub-Specialty Summary Analysis

Scorecard Key

- **Description** – indicator name;
- **Local numerator** – the number of records for that indicator, e.g. for the misadventures indicator, this would be the number of misadventures;
- **Local denominator** – usually the number of spells / attendances;
- **Current period** – the indicator value for the current period chosen, e.g. for the misadventures indicator, this would be the percentage of misadventures;
- **Performance** – the coloured spectrum that displays a range of information concerning the indicator. The spectrum can run from green to red (good to bad), red to green (bad to good), all green or red (for never events) or all grey (where high or low does not signify good or bad). The black diamond is the client organisation position when compared to the selected peer. The line running to the left and right of the black diamond depicts the confidence limits. The middle vertical line shows the peer average. The grey bar shows the range of peer organisation values from the chosen percentile values (e.g. 25th to 75th percentile);
- **Peer value** – the peer value of the indicator;
- **25th Percentile** – the lower quartile of the selected peer;
- **75th Percentile** – the upper quartile of the selected peer;
- **Alert** – Negative alerts show at two levels: red indicates performance was in the ‘worst’ quartile and this was statistically significant - that is, the lower or upper confidence limit (whichever is relevant) was also in the ‘worst’ quartile; light red indicates performance was in the ‘worst’ quartile, but this wasn’t statistically significant - that is the lower or upper confidence limit (whichever is relevant) wasn’t also in the ‘worst’ quartile. Positive alerts show at two levels; green alert indicates performance was in the ‘best’ quartile and this was statistically significant - that is, the lower or upper confidence limit (whichever is relevant) was also in the ‘best’ quartile; light green indicates performance was in the ‘best’ quartile, but this wasn’t statistically significant.



CHKS
Insight for better healthcare

General Surgery Sub-Specialty Summary

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Total Spells	8924	1	8924		1996	1362	2412	-
Average Length of Stay (Spell)	26851	8924	3.01		2.47	2.05	2.79	Red
RALI (Risk Adjusted Length of Stay Index) 2019	26587	23321	114		94.21	83.08	101.39	Red
Mortality Rate	98	8924	1.0982%		0.8852%	0.6608%	1.0821%	Amber
RAMI (Risk adjusted mortality index) 2019	98	98	99.95		84.78	71.72	99.28	Amber
Day Case Rate	3623	4691	77.23%		71.31%	67.68%	78.22%	-

Peer: HES Acute Peer

Colorectal Sub-Specialty Summary

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Total Spells	15811	1	15811		3562	1876	4674	-
Average Length of Stay (Spell)	25948	15810	1.64		1.33	0.88	2.43	-
RALI (Risk Adjusted Length of Stay Index) 2019	25800	24701	104.45		90.71	82.45	97.21	Red
Mortality Rate	28	15811	0.17709%		0.23029%	0.15230%	0.3630%	-
RAMI (Risk adjusted mortality index) 2019	28	52	53.85		75.76	59.70	90.60	Light Green
Day Case Rate	11254	12842	87.63%		86.38%	76.44%	92.26%	-

Peer: HES Acute Peer



Endocrine Sub-Specialty Summary

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Total Spells	267	1	267		51	16	100	-
Average Length of Stay (Spell)	428	267	1.60		1.48	1	1.91	-
RALI (Risk Adjusted Length of Stay Index) 2019	427	463	92.15		90.40	72.50	116.42	-
Mortality Rate	0	267	0%		0.04806%	0.3559%	0.7246%	Light Green
RAMI (Risk adjusted mortality index) 2019	0	0.153	0		142.71	835.8	2087	Light Green
Day Case Rate	11	262	4.198%		11.613%	4.167%	31.82%	-

Peer: HES Acute Peer

HPB Sub-Specialty Summary

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Total Spells	555	1	555		154	47	214	-
Average Length of Stay (Spell)	6484	555	11.7		8.1	6.1	9.6	Red
RALI (Risk Adjusted Length of Stay Index) 2019	6408	5562	115.21		94.74	79.72	102.93	Red
Mortality Rate	12	555	2.1622%		1.6264%	1.1905%	2.9654%	-
RAMI (Risk adjusted mortality index) 2019	12	15.1	79.33		61.50	43.88	94.70	-
Day Case Rate	39	214	18.224%		34.58%	25%	77.08%	Amber

Peer: HES Acute Peer



Upper GI Sub-Specialty Summary

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Total Spells	3778	1	3778		710	183	930	-
Average Length of Stay (Spell)	4819	3778	1.28		1.23	0.54	3.3	-
RALI (Risk Adjusted Length of Stay Index) 2019	4770	4668	102.19		97.71	77.35	104.57	-
Mortality Rate	5	3778	0.13235%		0.30936%	0.22075%	0.9950%	Light Green
RAMI (Risk adjusted mortality index) 2019	5	15.3	32.73		81.90	61.37	137.98	Light Green
Day Case Rate	3143	3384	92.88%		89.48%	79.45%	97.32%	-

Peer: HES Acute Peer

Vascular Sub-Specialty Summary

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Total Spells	1256	1	1256		298	11	600	-
Average Length of Stay (Spell)	8294	1256	6.6		8.1	1.18	9	-
RALI (Risk Adjusted Length of Stay Index) 2019	8205	10446	78.54		84.59	58.42	96.78	-
Mortality Rate	18	1256	1.4331%		2.1929%	1.7058%	2.9155%	Light Green
RAMI (Risk adjusted mortality index) 2019	18	34	52.79		61.15	47	85.79	-
Day Case Rate	442	884	50%		24.062%	12.721%	85.71%	-

Peer: HES Acute Peer

Demonstration

Proposed Scorecards

Data Quality Scorecard, General Surgery Sub-Specialty

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Data Quality Index	8855	9150	96.78		95.27	96.91	98.01	Amber
% Uncoded FCEs (Finished Consultant Episodes) - Blank Primary Diagnosis	0	9150	0%	No data to display	0%	-%	-%	-
FCE (Finished Consultant Episode) HRG U Groups	7	9150	0.07650%		0.0008052%	0.018132%	0.06321%	Amber
Sign or symptom as a primary diagnosis	1432	9150	15.650%		17.477%	13.998%	20.334%	-
Sign and Symptoms as Primary Diagnosis (Episode 2)	95	394	24.112%		21.921%	14.474%	25.926%	-
Admitting Diagnosis Emergency for Elective Admission	61	4679	1.3037%		1.6204%	0.3731%	1.3233%	-
Average Diagnoses per FCE (Finished Consultant Episode)	37318	9150	4.1		5.5	4.7	6.1	Red
Unacceptable Primary Diagnosis	0	9150	0%	No data to display	0%	-%	-%	-
Diagnosis Non-Specific	347	9150	3.792%		2.6693%	2.1182%	3.0809%	Red
Diagnosis: Potential conflict with age or sex	0	9150	0%		0.20131%	0.08074%	0.31546%	Light Green
Procedure code invalid	0	9150	0%		0.0020131%	0.028019%	0.06086%	Light Green
Procedure: Potential conflict with age or sex	0	9150	0%		0.0024157%	0.04184%	0.07599%	Light Green
Date conflicts	0	9150	0%		2.2389%	0.04909%	0.4024%	Light Green

Peer: HES Acute Peer



Patient Flow and Efficiency Scorecard, General Surgery Sub-Specialty

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
% Elective in-patients admitted on day of procedure	437	555	78.74%		84.12%	94.34%	98.88%	Red
Average Length of Stay (Spell)	26851	8924	3.01		2.47	2.05	2.77	Red
RALI (Risk Adjusted Length of Stay Index) 2019	26587	23321	114		94.14	83.08	101.39	Red
Average Pre-Op Length of Stay	2151	4869	0.44		0.43	0.262	0.49	-
Average Post-Op Length of Stay	6358	4869	1.31		1.61	1.21	1.87	-
Delayed discharge (excess days above HRG spell trim points)	4109	26801	15.332%		8.202%	5.528%	9.075%	Red
Weekend discharge rate for emergencies as percentage of weekdays	426	660	64.51%		67.08%	50.05%	72.55%	-
Readmissions within 7 days	296	8924	3.317%		5.465%	4.109%	5.752%	Green
Readmissions within 14 days	448	8924	5.020%		7.711%	6.110%	8.177%	Green
Readmissions within 28 days	608	8924	6.813%		10.091%	7.963%	10.911%	Green
RARI (Risk adjusted readmissions index) 2019	628	749	83.87		102.37	84.98	110.02	Light Green
Elective Inpatient - procedure not carried out - other than patient reason	2	566	0.3534%		0.21730%	0.5747%	1.4925%	Light Green
Day Case Overstays	346	3969	8.718%		12.962%	9.354%	16.741%	Light Green
Day Case Overstays - Average length of stay	683	346	1.97		1.74	1.39	2	-
Day Case Rate	3623	4691	77.23%		71.30%	67.06%	78.22%	-
% Potential reduction in beddays	204	1375	14.836%		13.344%	10.117%	14.844%	-
% Zero Length of Stay, Non-Elective excl. deaths	280	4133	6.775%		25.981%	17.225%	31.062%	Green



CHKS Peer: HES Acute Peer
Insight for better healthcare

Patient Safety and Quality Scorecard, General Surgery Sub-Specialty

Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Complication rate - attributed	104	8924	1.1654%		3.890%	3.0120%	4.604%	Green
Complication rate - treated	520	8924	5.827%		6.181%	4.630%	7.221%	-
Complications of anaesthesia	1	4814	0.020773%		0.05472%	0.08606%	0.20866%	Light Green
Misadventure rate	11	8924	0.12326%		0.27458%	0.16940%	0.3873%	Light Green
Accidental puncture or laceration	0	4112	0%		0.20405%	0.10607%	0.4274%	Light Green
Foreign body left in during procedure	3	8806	0.03407%		0.012160%	0.029461%	0.05599%	-
Retained instrument post-operation	0	-	0	Never event	0	*	*	Green
Administration of mis-selected concentrated potassium chloride	0	-	0	Never event	0	-	-	Green
Post operative acute respiratory failure	0	4011	0%		0.03640%	0.08651%	0.22321%	Light Green
Post operative pulmonary embolism or deep vein thrombosis	1	4823	0.020734%		0.03837%	0.08130%	0.15576%	Light Green
Post operative sepsis	1	117	0.8547%		0.0603%	2.1277%	4.762%	Light Green
Post operative wound infection	35	819	4.274%		6.211%	4.545%	7.653%	Light Green
Potential in hospital fall	2	8924	0.022411%		0.14002%	0.08065%	0.22650%	Light Green
Potential in-hospital hip fracture (fall)	0	8907	0%		0.0008304%	0.021263%	0.04160%	Light Green
Potential in hospital fall (dementia patients)	0	105	0%		0.9502%	2.3810%	5%	Light Green
Decubitus ulcer	3	1535	0.19544%		2.7662%	1.4852%	3.704%	Green

Peer: HES Acute Peer



Mortality Scorecard, General Surgery Sub-Specialty

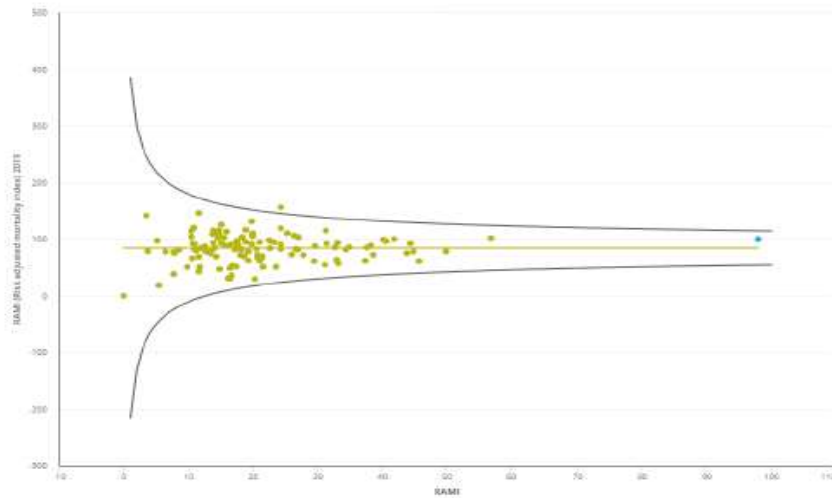
Description	Local Numerator	Local Denominator	Mar 19 - Feb 20	Performance	Peer Value	25th Percentile	75th Percentile	Alert
Mortality Rate	98	8924	1.0982%		0.8809%	0.6608%	1.0479%	Amber
RAMI (Risk adjusted mortality index) 2019	98	98	99.95		84.39	71.72	97.77	Amber
Deaths in Low Mortality CCS Groups	11	2324	0.4733%		0.28178%	0.21505%	0.5587%	-
Rate of Mortality in hospital within 30 days of elective surgery	0	828	0%		0.05760%	0.3497%	0.9174%	Light Green
Rate of Mortality in hospital within 30 days of Non elective surgery	19	665	2.8571%		1.4296%	0.9259%	2.0460%	Amber

Peer: HES Acute Peer

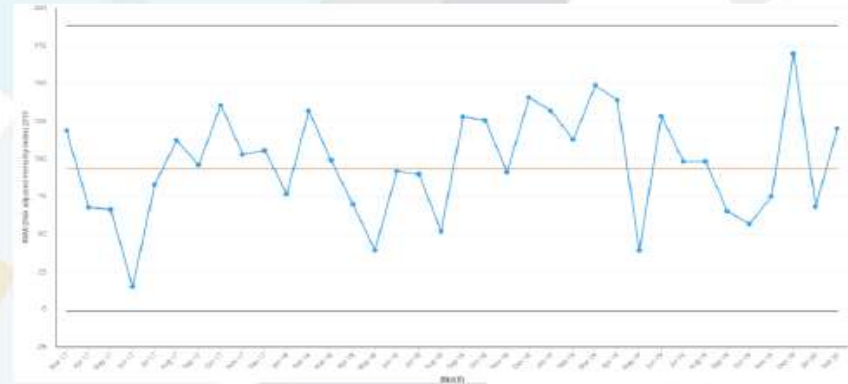
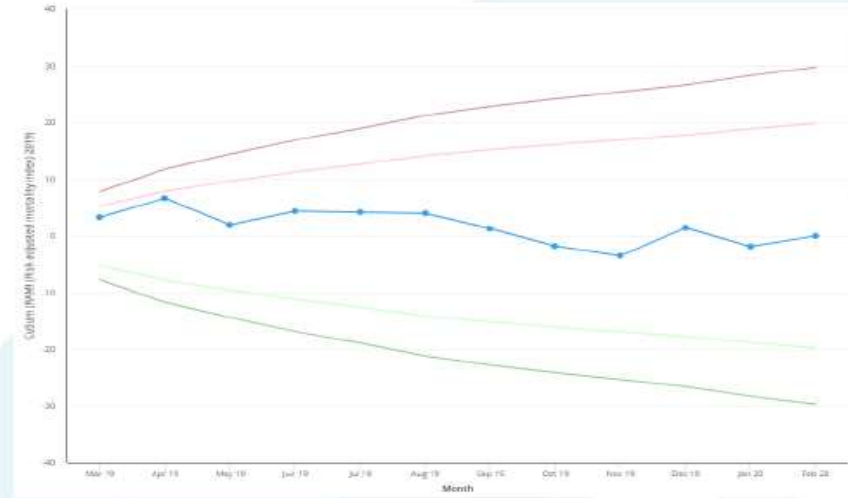


Mortality SPC & Funnel Plot Analysis, General Surgery Sub-Specialty

Performance can be presented within acceptable levels of variation.



Peer: HES Acute Peer



Demonstration

British Association of Day Surgery – Analysis
Outputs

Target View: Performance measured against BADs targets, Summary Data

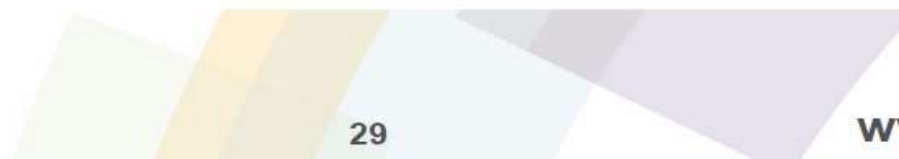
Description	Total Procedures	Zero LoS Target	OP Target	OP Count	OP Rate	Zero LoS Count	Zero LoS Rate	One Day Count	One Day Rate	Two Day Count	Two Day Rate	Greater Than Two Day Count	Greater Than Two Day Rate	Potential Bed Day Saving (vs Target)	Potential Admissions Savings
BADS: All Procedures	20689	-	-	0	0%	17147	82.88%	1887	9.121%	686	3.316%	969	4.684%	8042.78	5032.33
BADS: Breast Surgery	426	-	-	0	0%	189	44.37%	98	23.005%	56	13.146%	83	19.484%	592.32	0.00
BADS: ENT	1132	-	-	0	0%	973	85.95%	138	12.191%	9	0.7951%	12	1.0601%	240.57	53.20
BADS: General Surgery	1120	-	-	0	0%	712	63.57%	205	18.304%	86	7.679%	117	10.446%	1098.35	32.60
BADS: Gynaecology	1514	-	-	0	0%	1151	76.02%	94	6.209%	133	8.785%	136	8.983%	775.48	853.10
BADS: Head and Neck	368	-	-	0	0%	116	31.522%	134	36.41%	71	19.293%	47	12.772%	316.00	0.00
BADS: Ophthalmology	4751	-	-	0	0%	4511	94.95%	197	4.146%	29	0.6104%	14	0.29467%	329.46	1111.73
BADS: Orthopaedic Surgery	3040	-	-	0	0%	2338	76.91%	334	10.987%	153	5.033%	215	7.072%	1851.92	61.60
BADS: Paediatric Surgery	1751	-	-	0	0%	1620	92.52%	117	6.682%	10	0.5711%	4	0.22844%	79.60	0.00
BADS: Urology	4456	-	-	0	0%	3890	87.30%	319	7.159%	100	2.2442%	147	3.299%	1046.26	2892.10
BADS: Vascular Surgery	651	-	-	0	0%	464	71.27%	49	7.527%	12	1.8433%	126	19.355%	756.35	28.00
BADS: Medical	1480	-	-	0	0%	1183	79.93%	202	13.649%	27	1.8243%	68	4.595%	956.47	0.00

Example data

Target View: Performance measured against BADs targets, General Surgery Data

Description	Total Procedures	Zero LoS Target	OP Target	OP Count	OP Rate	Zero LoS Count	Zero LoS Rate	One Day Count	One Day Rate	Two Day Count	Two Day Rate	Greater Than Two Day Count	Greater Than Two Day Rate	Potential Bed Day Saving (vs Target)	Potential Admissions Savings
BADS: General Surgery	1120	-	-	0	0%	712	63.57%	205	18.304%	86	7.679%	117	10.446%	1098.35	32.60
BADS: Laparoscopic repair of hiatal hernia with anti-reflux procedure (eg fundoplication)	1	20%	0%	0	0%	0	0%	0	0%	0	0%	1	100%	5.1	0
BADS: Laparoscopic gastric banding	0	50%	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
BADS: Transanal excision of lesion of anus	34	35%	40%	0	0%	15	44.12%	8	23.529%	4	11.765%	7	20.588%	29.5	13.6
BADS: Repair of rectal mucosal prolapse	2	70%	0%	0	0%	0	0%	2	100%	0	0%	0	0%	1.40	0
BADS: Excision/destruction of lesion of anus	41	100%	0%	0	0%	32	78.05%	5	12.195%	3	7.317%	1	2.4390%	14	0
BADS: Haemorrhoidectomy including staples	17	100%	0%	0	0%	13	76.47%	2	11.765%	0	0%	2	11.765%	8	0

Example data



29



www.chks.co.uk

Day Case Rate View: Performance measured against BADs targets, Summary Data

Description	Total Procedures	Elective IP Spells	Day Case	Day Case Overstay	Day Case Rate (Site)	Day Case Overstay Rate (Site)	IP ALoS (Site)	Elective Bed Days (Site)	Day Case Opportu	Excess Overstay	Day Case Overstay Rate (Peer)
BADS: All Procedures	20689	3256	16491	942	79.71%	5.404%	2.60	8459	728.16	374.86	7.341%
BADS: Breast Surgery	426	343	66	17	15.493%	20.482%	1.80	618	161.62	2.77	17.324%
BADS: ENT	1132	125	934	73	82.51%	7.249%	1.40	175	36.13	16.97	9.247%
BADS: General Surgery	1120	251	660	209	58.93%	24.051%	3.6	916	77.82	1.60	15.803%
BADS: Gynaecology	1514	389	1108	17	73.18%	1.5111%	2.41	939	18.68	62.55	9.878%
BADS: Head and Neck	368	214	110	44	29.891%	28.571%	2.17	465	17.63	1.12	4.440%
BADS: Ophthalmology	4751	171	4486	94	94.42%	2.0524%	1.30	222	92.52	10.94	1.0249%
BADS: Orthopaedic Surgery	3040	713	2292	35	75.39%	1.5041%	2.92	2080	114.05	102.79	5.929%
BADS: Paediatric Surgery	1751	34	1606	111	91.72%	6.465%	1.09	37	3.02	16.66	4.966%
BADS: Urology	4456	606	3721	129	83.51%	3.351%	1.83	1108	54.46	128.78	12.548%
BADS: Vascular Surgery	651	159	446	46	68.51%	9.350%	5.7	900	0.42	22.79	6.461%
BADS: Medical	1480	251	1062	167	71.76%	13.588%	4	999	151.81	7.89	8.161%

Example data



30

www.chks.co.uk

Day Case Rate View: Performance measured against BADs targets, General Surgery Data

Description	Total Procedures	Elective IP Spells	Day Case	Day Case Overstay	Day Case Rate (Site)	Day Case Overstay Rate (Site)	IP ALoS (Site)	Elective Bed Days (Site)	Day Case Opportu	Excess Overstay	Day Case Overstay Rate (Peer)
BADS: General Surgery	1120	251	660	209	58.93%	24.051%	3.6	916	77.82	1.60	15.803%
BADS: Laparoscopic repair of hiatus hernia with anti-reflux procedure (eg fundoplication)	1	1	0	0	0%	0%	6	6	0.111	0	55.35%
BADS: Laparoscopic gastric banding	0	0	0	0	0%	0%	0	0	0	0	22.951%
BADS: Transanal excision of lesion of anus	34	12	13	9	38.24%	40.91%	1.56	19	3.6	-6.9	16.081%
BADS: Repair of rectal mucosal prolapse	2	1	0	1	0%	0%	1	1	0.84	-1	17.421%
BADS: Excision/destruction of lesion of anus	41	1	32	8	78.05%	20%	3	3	3.7	-6.5	4.744%
BADS: Haemorrhoidectomy including staples	17	5	10	2	58.82%	16.667%	0.80	4	4.1	-1.07	9.291%
BADS: Injection or banding of haemorrhoids	19	0	19	0	100%	0%	0	0	-0.81	0.284	1.4965%
BADS: Treatment of anal fistula with seton suture	41	4	35	2	85.37%	5.405%	0.50	2	0.33	-0.247	5.010%
BADS: Excision/treatment of anal fissure	0	0	0	0	0%	0%	0	0	0	0	6.024%
BADS: Pilonidal sinus surgery -laying open or suture/skin graft	24	3	14	7	58.33%	33.33%	2.33	7	4.5	-5.9	8.104%
BADS: Diagnostic laparoscopy	121	43	68	10	56.20%	12.821%	1	43	20.9	-2.21	11.456%
BADS: Laparoscopic cholecystectomy	369	36	230	103	62.33%	30.931%	2.19	79	-17.2	-35	29.369%

Example data



BADs Procedures – General Surgery

Description	Include										Exclude				Age > 16	
Laparoscopic repair of hiatus hernia with anti-reflux procedure (eg fundoplication)	G24.3															
	+Y75.2															
Laparoscopic gastric banding	G30.3															
	+Y75.2															
Transanal excision of lesion of anus	H40.1	H40.2	H40.3	H41.2	H41.3											
Repair of rectal mucosal prolapse	H42.1	H42.5	H42.6	H42.7	H42.8	H42.9										
Excision/destruction of lesion of anus	H48	H49	H56.1													
Haemorrhoidectomy including staples	H51.1	H51.3														
Injection or banding of haemorrhoids	H52.3	H52.4							H52.1	H52.2	H52.8	H52.9				
Treatment of anal fistula with seton suture	H55.4	H55.1	H55.2	H55.3					H55.5							
Excision/treatment of anal fissure	H56.4								H50							
Pilonidal sinus surgery -laying open or suture/ skin graft	H59	H60							H60.4							
Diagnostic laparoscopy	J09	T43	J73.8	J73.9	J51.8	J51.9		J73.1	J53.1							
Laparoscopic cholecystectomy	J18.1	J18.3						J18.2								
	+Y75.2	+Y75.2														
Primary repair of inguinal hernia	T20															
Repair of recurrent inguinal hernia	T21															
Primary repair of femoral hernia	T22															
Repair of umbilical hernia	T24							T24.4								Y
Laparoscopic repair of incisional hernia	T25	+Y75.2														
Excision/biopsy/sampling of lymph node for diagnosis (cervical, inguinal, axillary)	T87	T86.1	T86.2	T86.7				T87.4	T87.5	T87.6	T86.2 with O14.2	T87.3 with O14.2				
Closure ilostomy	G75.3	H15.4														
Incision and drainage of perianal abscess	H58.2															
Appendectomy (including laparoscopic)	H01.2	H01.3														
Incision and drainage of skin abscess	S47.1	S47.2	S47.3	S47.4	S06.1	S06.2										

Appendix 4

Demand/Activity/Performance – Monitoring and Reporting

As part of the review of Regional General Surgical Services, and as part of the Quality and Performance workstream, the following indicators and reports have been developed to be used for regular monitoring and analysis. Example visualisations are included below.

Demand

The number of New Referrals to Consultant-led Outpatient Services from 2017/18. This can be filtered by:

- Trust/Hospital
- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)
- Clinical Priority
- Age category
- Area of Patient Residence

This will facilitate the monitoring of long-term Referral trends and patterns both pre and post the Covid Pandemic.

Activity

The number of Outpatient Attendances at Consultant-led Outpatient Services from 2017/18. This can be filtered by:

- Attendance Type i.e. New or Review
- Activity Type i.e. F2F or Virtual, In-House or Independent Sector
- Trust/Hospital
- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)
- Clinical Priority
- Age category
- Area of Patient Residence

This will facilitate the monitoring of long-term trends and patterns of OP activity both pre and post the Covid Pandemic.

The number of Elective Admissions from 2017/18. This can be analysed by:

- Admission Type i.e. Daycase/Inpatient
- Activity Type i.e. In-House or Independent Sector
- Trust/Hospital
- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)
- Clinical Priority
- Age category
- Area of Patient Residence
- By Procedure carried out
- By Diagnosis

This will facilitate the monitoring of long-term trends and patterns of Elective Treatment activity both pre and post the Covid Pandemic.

The number of Non-Elective Inpatient Admissions from 2017/18. This can be analysed by:

- Trust/Hospital- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)
- Admission Pathway i.e. via ED or Other
- Age category
- Area of Patient Resident
- By Procedure carried out
- By Diagnosis

This will facilitate the monitoring of long-term trends and patterns of Non-Elective Surgical activity both pre and post the Covid Pandemic.

Performance

The number of patients waiting since 2018 for a first Outpatient Appointment at Consultant-led Outpatient Services. This can be analysed by:

- Length of Wait i.e. > 9/13/26/52 weeks
- Trust- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)
- Clinical Priority
- Age category
- Area of Patient Residence

The number of patients waiting each month for an Outpatient Review Appointment at Consultant-led Outpatient Services. This can be analysed by:

- Length of Wait i.e. > 6/12/24 months
- Trust
- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)

The number of patients waiting since 2018 for Hospital Admission for Elective Treatment. This can be analysed by:

- Admission Type i.e. Daycase/Inpatient
- Length of Wait i.e. > 13/26/52 weeks
- Trust
- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)
- Intended Procedure
- Clinical Priority
- Age category
- Postcode of Patient Residence

The number of Beddays used/Average Length of Stay for Surgical patients admitted Electively since 2018. This can be analysed by:

- Activity Type i.e. In-House or IS
- Trust/Hospital

- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)
- Clinical Priority
- Age category
- Area of Patient Residence

The number of Beddays used/Average Length of Stay for Surgical patients admitted Non-Electively since 2018. This can be analysed by:

- Trust/Hospital
- Sub-specialty (i.e. General Surgery, Breast, Paediatric, Vascular can all be monitored or excluded individually)
- Admission Pathway i.e. via ED or Other
- Age category
- Area of Patient Residence

These key performance indicators will facilitate the monitoring of long-term trends and patterns in performance across a range of Outpatient, Elective and Non-Elective Surgical services and can help assess the impact of interventions as they are implemented.

Method of Monitoring/Reporting

Currently, detailed reports covering all the indicators/metrics listed above are updated monthly and placed on a Sharepoint site for users to access.

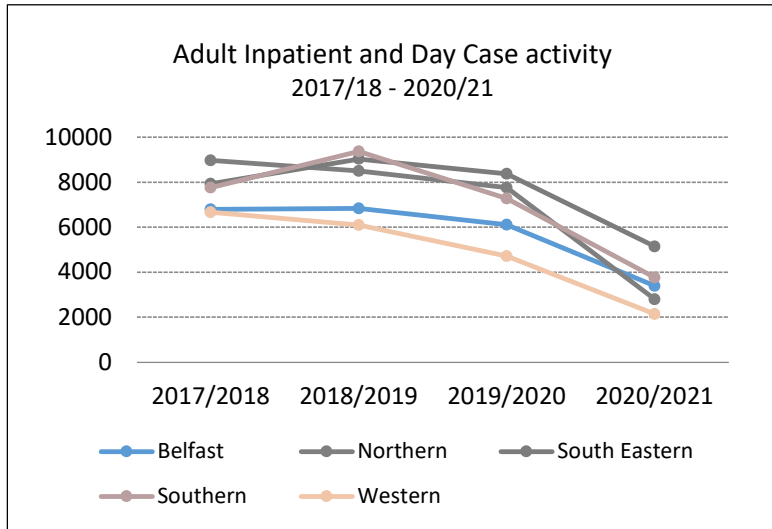


Figure 1 Adult inpatient and day case activity, by trust, 2017/18 - 2020/21

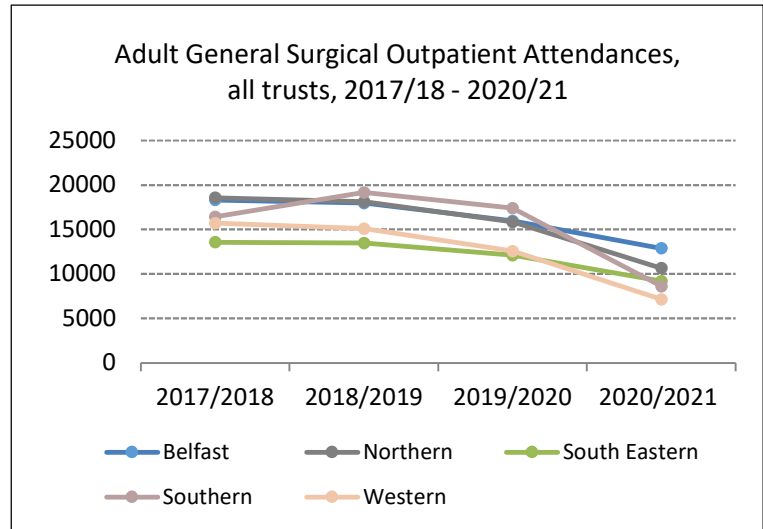


Figure 2 Adult outpatient attendances, by trust, 2017/18 - 2020/21

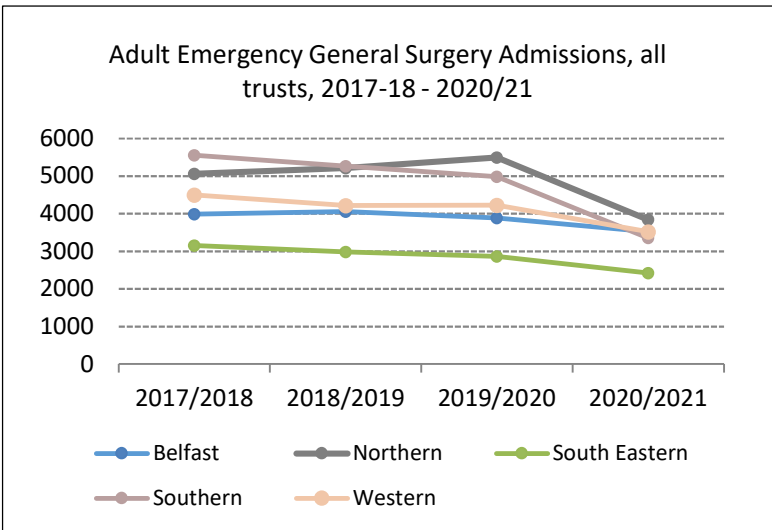


Figure 3 Adult emergency general surgery admissions, by trust, 2017/18 - 2020/21

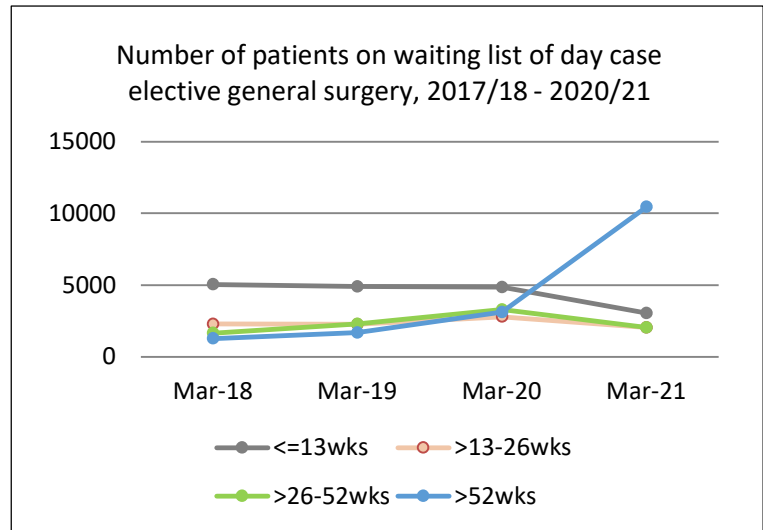


Figure 4 Number of patients on waiting list for day case general surgery procedures, by trust, 2017/18 - 2020/21