HQIP
Healthcare Quality Improvement Partnership

Cardiovascular Domain Operational Group feedback on outputs of a joint CQC and HQIP dashboard project

July 2016

QUESTION 1: Is this data new to you or were you aware of it and using it already

Ref	Comment
1	We were aware of our own data but less so of the other organisations. There is potential real power to drive improvement in comparative data. Although this data is in the public domain it is not that readily accessible. Finding a format to compare GM trusts in a non-judgemental way would be very useful to providers and I assume commissioners
2	The Trust has a process in place for receiving and reviewing national audit reports, these are received and reviewed at Executive level prior to distribution to the divisional teams, although as you will already be aware for some audits, the detail goes directly to the clinician responsible for the audit. The data contained within the received dashboard is not new to us..

QUESTION 2: Is the PDF format understandable?

Ref	Comment
1	The pdf format is very user friendly and easy to interpret
2	Yes, I think it is helpful to have the information distilled in this way. It is helpful to know what the 5 important measures are and a clear picture of our position. The content is quite straightforward. It compares with the previous year, national aggregate, national aspirational standard and a comparison with other hospitals. The latter uses a rag rated chart and a clear statement about whether we are in the expected range. The RAG rating system is used within the Trust for the current clinical audit reports to division and specialty and is well received and understood by the clinical teams.
3	Thanks for sharing the dashboard. The data is familiar of course, my only real comment would be that inclusion of oesophago-gastric cancer in hospitals not offering oesophago-gastric cancer surgery is probably of limited use, unless the included metrics are chosen differently. The PDF format is fine, and the presentation of the data easy to understand.

QUESTION 3: How could we improve on the PDF format (bearing in mind that we hope in years' time to have access to the real data)

Ref	Comment
1	Finding a way to identify the really key indicators and compare the GM trusts as real time as Possible
2	The advantage of the current format is that it is succinct. I would try not to add any/much more information.

QUESTION 4: Are there obvious omissions in the data displayed in any of these individual audits?

Ref	Comment
1	None obvious though some could be lost without detriment
2	None that are immediately apparent.

GENERAL COMMENTS:

Ref	Comment
5	We discussed the proposed pilot at the GM AHSN SMT this morning and there was strong support. We felt it was a powerful way to engage clinicians, managers and service users and develop a shared agenda for quality improvement to support delivery of reliable standards based care. We also commented on the synergy with Right care looking at population variance which is a 5YFV priority and high on our CCGs and STP work plans . A note of caution was struck pointing out improvement often needs specific focus and resource in addition to the data for change and measurement systems but of course you are aware of that. We didn't address the questions you raised at the close of the presentation but did want to flag some potential combinatorial opportunities where we may be able to support the program; 1 the potential that datawell will enable more efficient and more frequent data flow – data for change / improvement needing to be available in a timely fashion and repeated measures being needed in the improvement cycle to maintain clinician enthusiasm . Datawell will also facilitate measurement across setting of care. 2 possibility of linkage with our resource management capability which is a well-established system supporting our trusts currently used mainly for urgent care but the same skills and capability could of course be applied to benefit throughout the pathway of care. 3 Alignment with our SCN and Health + Implementation teams programs to support front line staff and organisations to achieve the goals they may set after reflection on the audit data and action planning. We will be interested in the comments you receive and are happy to support the proposal. We can discuss the above suggestions and other synergies at a mutually convenient time.
4	I'm not sure which colleagues you're looking for feedback from. Is this something you'd want me to take to the GM Medical Directors meeting? A few comments from me: I think it is helpful. In the numbers column on the left hand side, it would be helpful to understand which year the (or years) the data refers to. Eg NBOCAP is I think for year to March 2014; NOGCA numbers relate to 3 years data (2012 – 2015 inc). Seeing the data in a GM comparator mode would also make it much easier, though I accept that the number of slides would have to increase. It would also be helpful to understand why some Trusts have data and not others – not relevant since don't do procedures, or chose not to participate. Eg NOGCA – only SRFT, CMFT and UHSM undertake procedures, but others have case ascertainment (correctly) but no operative data. If you had cardiac arrest data in there, I understand that one Trust doesn't participate rather than have no arrests, so again, would need to made clear.
6	I think the slides are excellent and are, in a way, similar to what we are aiming to do with our Dashboard but aiming at a different audience. I've answered your specific queries below. The questions I would like answered are: 1. Is this data new to you or were you aware of it and using it already – For the # NOF data I've seen this some time ago, but the other data (outside my domain) is new. 2. Is the pdf format understandable? Yes but the slides are a bit busy. Have a look at the presentation for the NJR data at: http://www.njrsurgeonhospitalprofile.org.uk/<https://urldefense.proofpoint.com/v2/url?u=http-3A www.njrsurgeonhospitalprofile.org.uk &d=BQMFAw&c=bMxCA1upgdsx4J2OmDkk2Eep4PyO1BA6pjHrrW-ii0&r=gLCwdgW-

Ref	Comment
	1d0JwWksIVp4JeuFvN0sJLR9_pMIG7zm5pk&m=WBliONSfzklnwifi60R674Muf2sGtBRu_T0Z4Arxkp4&s=-5LYycn8G9853G0lrBBa_Bk_z1_FvKyjKMQB-QI189Y&e=> (with screen shot below). 3. How could we improve on the pdf format (bearing in mind that we hope in a years' time to have access to the real data). I'd keep the .pdf format. It is easy to send round by e-mail and anyone can see it, also it can't be altered! 4. Are there obvious omissions in the data displayed in any of these individual audits. For the # NOF data there is much more in the reports. You don't need to put all the info but I would add BPT achievement which acts as a surrogate for most of the other measures, it also allows some assessment of loss of income based on £1300 per case missed – perhaps the right button to press in management circles. I think that you've hit the nail on the head regarding getting the message across and getting change to occur, which is something I've realised is far more of a problem than collecting / collating / presenting the information. This is something we are wrangling with in the GMOA and is part of what we are aiming to do at our launch event in November. If you want, I'd be happy to meet up, possibly with Phil if free, as I'd be keen to explore ways of getting change to occur. I'll also happily send you a copy of our next Dashboard, which I'm designing at present.
7	This is a great format and I think will work really well. We have been working on a renal specific dashboard and would like to develop on this template. There may be some tweaks required for a medical speciality practice but the generic structure will work i think. We can work wth you if this is of further interest.
1	We now have a recently established GM Medical Directors group. That would be a very useful forum to help take this forward. If you would be interested in attending please let me know
1	***Additional comments for the development team:*** • Minor anomalies in the reported results figures in the table provided when reviewed against received reports • The 30 day mortality is beneficial as the Trust Mortality Steering Group reviews 30 day mortality • Comparative Performance graphs – expected range would be useful -and perhaps Trust status in National report as there are differences, this will need to be interpreted. Also for some of the reporting data e.g. NOGCA the Trust provides diagnostics, the data is shared with the Tertiary Centre – will this be reflected? • Some of data is now historic due to publication of new reports, understand that the dashboard is currently in development, but will future reports contain the most up to date information?
8	I agree that audits need to be fed back in a very timely manner to ensure they are of value to clinicians and managers. Our stroke audits used to do the same, and by the time we published the results people inevitably said that obviously they'd improved since then.. The brevity of the HQIP presentations means that while they provide a useful dashboard (are we better or worse than the national average) they don't allow people to see some of the detail. Issues such as case ascertainment and case mix adjustment are not described at all which are vital to understanding the context. The SSNAP audit does feedback data (it was 3 monthly but unfortunately due to lack of funding we are going to 4 monthly reports). Reports are forwarded to trusts and commissioners as well as networks, and there's a A-E classification for a number of key indicators which makes it easy for people to see where they are; a simple colour key to show if you are improving on that key indicator or not; and a slide deck for each Trust showing their own results, somewhat more detailed than these, which are very useful for Board meetings, CG etc. More detail is available at www.strokeaudit.org But we produce data at a CCG level and a CCG dashboard (attached); a single stroke marker for all teams

Ref	Comment
	(attached) , a variety of infographics, heat maps: http://www.strokeaudit.org/results/Clinical-audit/MapsJanMar2016/Key-Indicator-Map-Routinely-Admitting.aspx and case mix adjusted mortality data (attached) and an annual report for the public. All data is in the public domain. It might be that developing other NCAs in line with SSNAP might mean that clinicians, managers and commissioners are used to the format, and could get used to the idea of a 4 monthly return on all their national audits to contribute to a whole health economy dash board across a variety of disease areas. I am sure the SSNAP team at RCP would be happy to discuss this further. *The embedded documents have been removed to keep the file small, at an acceptable size*
9	The data is very well presented. My main thought is that it does not audit secondary prevention opportunities which can make as much difference to health as the acute management. Examples in regard to the audit data: Hip fractures: proportion assessed for future risk of fragility fracture and given recommendations for bisphosphonates/ calcium and vitamin D Abdominal aortic aneurysm: proportion with family contact tracing to enable cascade screening All patients: Stop smoking advice given before discharge. I appreciate that one has been done so far is only a selection but getting the appropriate balance of indicators is important.