

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 5 October 2011

6.30 pm

Ground Floor Meeting Room G01B - 160 Tooley Street, London SE1
2QH

Supplemental Agenda

List of Contents

Item No.	Title	Page No.
6.	Presentation by Southwark's three acute hospital trusts.	1 - 62
	This will be a coordinated presentation by Southwark's three hospital trusts:	
	<ul style="list-style-type: none">• King's College Hospital NHS Foundation Trust (KCH)• Guy's and St Thomas' NHS Foundation Trust (GSTT)• South London and Maudsley NHS Foundation Trust (SLaM)	
	1. Brief overview of Kings Health Partners (KHP) and strategic objectives. John Moxham	
	2. Integrated Care Pilot - impact across KHP & Lambeth & Southwark communities. Maggie Kemmner or Jim Lusby	
	3. Impact of community service integration within Guy's and St Thomas' Health Trust on behalf of KHP. Angela Dawe or Heather Blake	
	4. South London and Maudsley (SLaM) Mental Health. Zoe Reed, Director of Strategy and Business Development	
	Dr Foster's hospital report 2010, as well as a summary of publically available information is also enclosed.	

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Date: 30 September 2011

List of Contents

Item No.	Title	Page No.
10.	Contract information	63 - 69

Kings Health Partners – An Overview

Southwark Health & Adult Social Care Scrutiny Sub -Committee

5th October 2011

Professor John Moxham – Director of Clinical Strategy

Why create an AHSC?

- UK Health care system underperforming.
- Severe inequalities, poor outcomes.
- Not well placed to meet new challenges (Ageing populations, obesity, diabetes).
- Development of new treatments slow and costly.
- Adoption of best practice patchy.
- Imbalance between basic and translational research.
- Others do better.
- Internationally some AHSCs (combining a critical mass of academic and clinical activity) perform strongly.

South East London Heat Map

Health Indicator	Lambeth	Southwark	Lewisham	Greenwich	Croydon	Bromley	Bexley
Binge drinking adults	Worse	Worse	In line	In line	Better	Better	Better
Deaths from smoking	Worse	Worse	Worse	Worse	Better	Better	Better
Drug Misuse	Worse	Worse	Worse	In line	Better	Better	Better
Early deaths: Cancer	Worse	Worse	Worse	Worse	Better	Better	In line
Early deaths: Heart disease & stroke	Worse	Worse	Worse	Worse	In line	Better	Better
Healthy eating adults	Better	In line	Worse	Worse	In line	Better	Worse
Hospital stays due to alcohol	Worse	Worse	Worse	In line	In line	Better	Better
Infant Mortality	Worse	Worse	In line	In line	Worse	Better	In line
Life expectancy	Worse	Worse	Worse	Worse	In line	Better	Better
Mental Illness	Worse	Worse	Worse	Worse	In line	Better	Better
Obese Adults	In line	Worse	Worse	Worse	Worse	Better	Worse
Obese Children	Worse	Worse	In line	Better	In line	Better	Better
Physically active adults	Better	In line	In line	Worse	Worse	Worse	Worse
Teenage Pregnancy	Worse	Worse	Worse	Worse	Worse	Better	Better
Tuberculosis	Worse	Worse	Better	In line	Better	Better	Better
Violent Crime	Worse	Worse	Worse	Worse	Better	Better	Better

Key

- Worse than London average
- In line with London average
- Better than London average

Source : Department of Health Community Health Profiles 2009

Our Mission

King's Health Partners will become the UK's leading AHSC. We will:

- **Drive the integration** of research, education and training and clinical care, for the benefit of patients, through our new Clinical Academic Groups (CAGs).
- **Consider all aspects of the health needs** of our patients when they come to us for help.
- **Improve health and well-being** across our ethnically and socially diverse communities and work to reduce inequalities.
- **Develop an AHSC that draws upon all academic expertise** in medical science and also in basic science, social science, law and humanities.
- **Deliver a radical shift in healthcare** by identifying 'at risk' groups, based on genotype and lifestyle, and helping them to avoid illness.
- **Work innovatively with stakeholders** in the redesign of care pathways, including the delivery of care closer to home.

Our Strategic Objectives

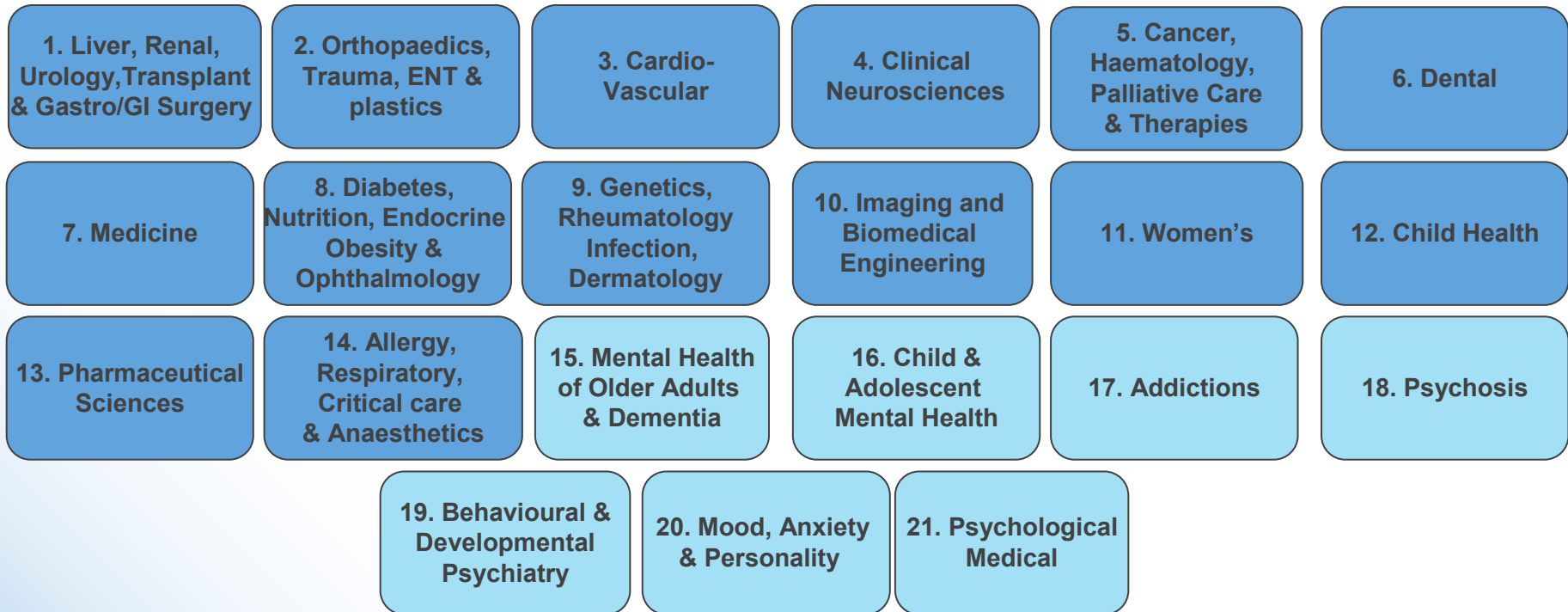
- We will be in the top 10 globally, both clinically and academically, in the fields of:
 - Cardiovascular disease
 - Transplantation, immunity and inflammation linked to disease
 - Mental health and neurosciences
- We will build our capacity to address diseases that have a particularly large impact on our **local community**, but also are important on a global scale, in the areas of:
 - Childhood diseases
 - Diabetes and obesity
 - Cancer
- Ensure our academic expertise is applied to all our clinical services to pursue our tripartite mission.

Our Strategic Objectives cont...

- Mental health services and physical health services work collaboratively to treat the entire individual.
- Constantly seek to reduce costs and improve quality for the benefit of patient care across the partnership and the wider health and social care system.
- Underpin all these objectives by working with our stakeholders to build information technology and resources to support our efforts.
- Establish, in collaboration with our stakeholders, an 'Academy of Apprentices' to offer training opportunities to our local population in a range of health related skills.
- Develop education programmes for staff and share with wider healthcare community of south London and beyond

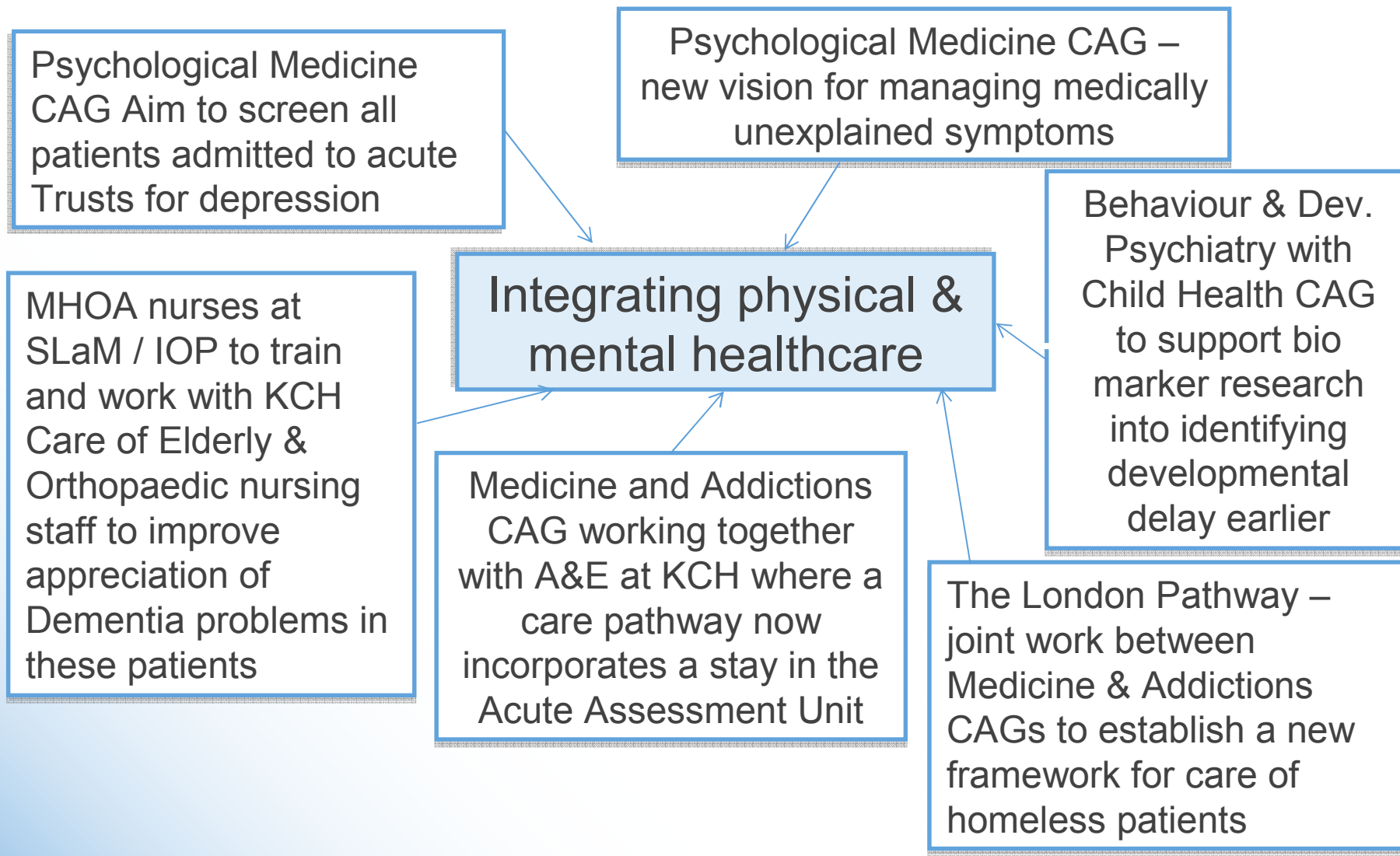
CAG and Research Group Structure

Basic Science Institute



Health Policy and Evaluation Institute

Integrating physical and mental healthcare



∞

The whole patient pathway

Available evidence suggests that healthcare systems must cover, in an integrated way, the whole patient pathway if we are to achieve:

- Optimal clinical care pathway design and implementation
- Engagement/commitment from all healthcare/social care professionals involved in an individuals care
- A shift in the mindset of staff – to focus on the performance of the system, rather than an institution
- Public health goals
- Control of costs
- Effective commissioning

King's Health Partners wishes to work with commissioners and partner providers to achieve an integrated high quality cost-effective sustainable healthcare system for south London.

Academic Health Sciences Centre to an Academic Health Sciences System – the journey

To achieve our Vision, King's Health Partners should become the hub of an Academic Health Sciences System (AHSS).

In the AHSS, there should be integration of clinical and academic activity, along the whole length of all disease pathways, from the bench to the bedside and from the bedside to the population.

The AHSS must involve patients, primary care, local authorities, community services and hospital care.



Integrated Care Pilot

Southwark Scrutiny Committee

Integrated Care and King's Health Partners

The pilot is a significant strategic objective for King's Health Partners and provides exciting opportunities for innovation, improvement and efficiency on a number of fronts.

The development of new approaches to integration reinforces KHP's commitment to the health and health outcomes of its local population in Lambeth and Southwark. At the same time and with sufficient investment KHP will be able to make a leading contribution to the national policy agenda on integrated care.

Good progress has been made though the challenges associated with integration are not to be underestimated. The process of changing well-established cultures, behaviours and ways of working across a system of the complexity of the one within which KHP operates will require ongoing focus and attention.

The Integrated Care Pilot in SE London will address a number of challenges, while aiming to improve outcomes and efficiency

CURRENT CONTEXT

- **Healthcare challenge** – aging population, increased incidence of LTCs
- **Fragmented care, complex pathways, duplication** – poor patient experience and a lack of shared knowledge about patients
- **Incentives** that encourage admission, discourage investment in services outside hospital
- **Financial challenge:** ~ £500m shortfall in SE London within 3-4 years

AIMS

- Better health outcomes
- Prevention, lower numbers of 'crises' requiring admission
- Pathways that are easier to navigate for patients
- Sustainable costs
- **Increased value**

The Pilot aims to improve the integration of care by focusing on clinical change and change to systems or supporting infrastructure

- Primary care (L&S)
- Social care (L&S)
- KHP:
 - Mental health (SLaM)
 - Community services
 - Acute trusts (KCH and GSTT)

Clinical priority:
Frail older people

Clinical priority:
Urgent care

Clinical priority:
Long term
conditions

Funding

Information systems

Governance

Workforce development

What do older people think? (Local interviews & reference group)

The pilot's aims are 'excellent' – but there is scepticism about whether it will happen

People don't want to go to hospital or into a care home

- Older people are concerned and sometimes frightened about being admitted to hospital as they feel vulnerable and are worried about cleanliness, infections and dignity (eg requests for bedpans)

They want better support when they're discharged from hospital

- Want more communication and support after discharge – a single named contact, better GP access, temporary social or nursing care at home

They want better access to specialist health advice and more time to talk

- They find it hard to get an appointment at the GP, and not enough time to talk about eg side-effects or concerns; want 6-monthly check-up on medicines, 6-monthly healthcheck
- Want to have access to an older person's specialist (specialist nurse or geriatrician). They like the older age-specific environments as the staff understand and sort out their problems

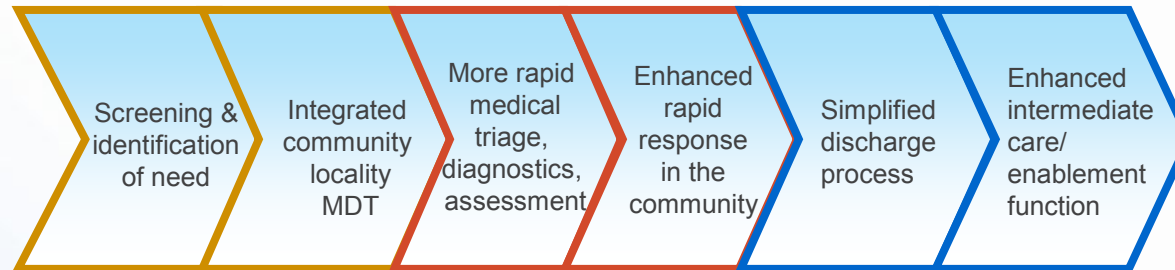
People want support for psychological, not just physical, wellbeing and to be helped to have an active, fulfilling life

They value continuity of care with the same professionals, people who know them (so they don't have to keep repeating themselves), and people they trust

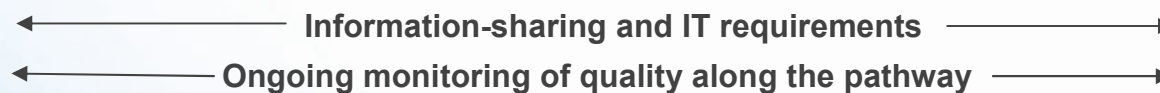
Older carers often don't know their entitlements, and need more support e.g. respite

The whole system design group for older people has prioritised *generic functions*...combined with an across-function focus on certain *conditions*

Generic functions to promote the health and independence of older people:



Supported by:



With a specific focus on preventing and managing:



What will be different for older people?

People will be able to stay in their own homes longer because they are helped to stay healthy and independent

They'll have support for psychological and physical wellbeing, health and social care which feels part of a whole package

They will be less likely to have to go to hospital in a crisis, and should be less likely to need to move to a care home

They will have someone who knows them and their various care needs well, to whom they can turn for support and advice

Professionals who support them will understand their whole needs, because professionals are supported by better IT that shares information across providers – so people won't have to keep repeating themselves

They'll get more support after a spell in hospital

Update on integration of community health services

Angela Dawe – Director Operations Community Services



Key organisational achievements – first 6 months

Page 1

- Integrated 1st April 2011
- One community management team across Lambeth and Southwark – 2 clinical directorates
- Building the new teams
- Performance framework implemented
- Bedding down within GSTFT – systems, processes, ways of working
- Working on culture and values

- **Adult community services**

 - Community nursing and inpatient units

 - Rehabilitation and therapies

 - Health inclusion teams

 - Health promotion and sexual health

- **Children's community services**

 - Universal (health visiting & school nursing)

 - Specialist services (children with disabilities and special needs)

- **Admission avoidance – a “virtual hospital” for KHP**
- **Improving discharge arrangements – adults and children**
- **Delivering new model of health visiting**
- **Opportunities for service integration – musculoskeletal triage, stop smoking, sexual health, leg ulcers**

Longer term (3 – 5 years)

- **Bring community services into KHP partnership**
- **Integrate and embed into the CAGs**
- **Use as a platform for KHP to lead an integrated local health system and to further diversify**

Publically available performance data for Southwark's three acute trusts

Dr Foster Intelligence

This is a joint venture with the Department of Health. This had a significant had a role in alerting to problems at Mid Staffordshire NHS Foundation Trust. It also reported problems at Basildon and Thurrock University Hospitals NHS Foundation Trust which later inspections confirmed.

The 2010 report is circulated and the website has more detailed information.

<http://www.drfoosterhealth.co.uk/hospital-guide/>



hospital-guide-2010
.pdf (2 MB)...

Care Quality Commission

The Care Quality Commission is the new health and social care regulator for England. They look at the joined up picture of health and social care and their aim is to ensure better care for everyone in hospital, in a care home and at home.

They regulate:

- Providers of medical and clinical treatment and care given to people of all ages, including treatment given in hospitals, ambulance services, and mental health services. They will eventually include primary care such as GP and dental practices.
- Providers of care services for adults in residential homes, in the community and in people's own homes. They focus on people who find themselves in vulnerable circumstances, including those with mental health problems, learning disabilities, physical disabilities or long-term health conditions and older people.
- Providers of services for people whose rights are restricted under the Mental Health Act.

Quality Account

A Quality Account is a report about the quality of services provided by an NHS healthcare service. The report is published annually by each NHS healthcare provider and available to the public. Quality Accounts aim to enhance

accountability to the public and engage the leaders of an organisation in their quality improvement agenda. The first statutory Quality Accounts were published in June 2010 covering activity for 2009/10. All healthcare providers or sub-contractors of NHS services are required to produce a Quality Account but for its first year only not in relation to the provision of any primary care or community health services. The regulations state that Quality Accounts must be published by June 30 each year following the end of the reporting period.

Collated hospital data links

King's College Hospital NHS Foundation Trust (KCH)

Care Quality Commission

http://caredirectory.cqc.org.uk//caredirectory/searchthecaredirectory.cfm?widCall1=customWidgets.content_view_1&cit_id=590313

Quality Accounts

<http://www.nhs.uk/Services/UserControls/UploadHandlers/MediaServerHandler.ashx?id=229&t=634475427459744279>

Guy's and St Thomas' NHS Foundation Trust (GSTT)

Care Quality Commission

http://caredirectory.cqc.org.uk//caredirectory/searchthecaredirectory.cfm?cit_id=RJ1&widCall1=customWidgets.content_view_1

Quality Accounts

<http://www.nhs.uk/Services/UserControls/UploadHandlers/MediaServerHandler.ashx?id=332&t=634475424174795414>

South London and Maudsley NHS Foundation Trust (SLaM)

Care Quality Commission

http://caredirectory.cqc.org.uk//caredirectory/searchthecaredirectory.cfm?cit_id=RV5&widCall1=customWidgets.content_view_1

Quality Accounts

<http://www.slam.nhs.uk/media/258026/slam%20quality%20report%2010-11.pdf>

HOSPITAL GUIDE 2010
WHAT MAKES A GOOD HOSPITAL?

TEST RESULTS

NAME

FIRST

MIDDLE

LAST

dr foster®
intelligence



Contents: **TEST RESULTS**



PATIENT: NHS Hospitals
BIRTH DATE: 2010
DOCTOR: FOSTER

NAME:

HOSPITAL GUIDE 2010

Contents

4	Editor's letter
5	How good is my hospital?
6	Introductory message
7	Trusts of the year
10	Measuring mortality - a key step to ensuring quality
18	Stroke - excellence across a care pathway
22	Orthopaedics - excellence among care teams
24	Urology - excellence in operations
26	Patient safety - the foundation for quality
32	Efficiency - how quality saves money
34	Patient experience - not just a medical matter
36	References
37	Acknowledgements
38	About Dr Foster
38	Our methodology

Editor's letter



It is 10 years since the first Dr Foster Hospital Guide was published. In some ways much has changed in 10 years, but in other ways not enough has changed. A decade ago we had data on all hospital admissions, from which we compared mortality ratios and other measures. That data is still our main source of information. We have no primary and community care data, no private sector data and no data that shows what happens to patients over the whole course of their illness. Excitingly, the Coalition Government seems committed to finally addressing this issue, and the 2010 guide is in part a case for more and better information. More on this from Roger Taylor on page 6.

The Hospital Guide has also changed over the past 10 years, although some constants remain. We continue to publish Hospital Standardised Mortality Ratios (HSMRs) but, in addition to this, have now introduced two other ways of looking at mortality. You can find the results on pages 16-17.

For the 2010 guide we have teamed up with leading clinicians and analysts to shine the spotlight on three areas important to many patients: stroke, orthopaedics and urology (see pages 18-25). And we have returned to the thorny subject of safety. The publicity around last year's safety index took some by surprise, but raised awareness of the risks facing patients. This year we look back to see where there has been improvement and where problems remain. The 2009 guide prompted some changes, including a Department of Health task force on measuring mortality and new rules around the reporting of safety incidents. However, we still have some way to go to get reliable data about 'adverse events'.

We are also trying out some new ways of presenting information on our website. Visitors to www.drfoosterhealth.co.uk can now specify which aspects of patient experience matter most to them and then find out which hospital trusts perform best on the relevant criteria.

As ever, thanks must go to all those who have helped make this year's guide come to life, especially the experts whose commentaries and opinions you will find throughout the report. Thank you also to those individuals in each NHS trust who coordinated activity around the Hospital Guide, not least in responding to our annual survey, to which 99 per cent of trusts returned data.

The challenge we set ourselves is to produce a report which is accessible for patients and the public and valid for clinicians and managers. This guide has been 10 years in the making and we hope you find it stimulating and informative.

How good is my hospital?

What we can tell you: the good news

1. Deaths in hospital continue to fall, dropping 7 per cent between 2008/09 and 2009/10 in crude terms. See page 11.
2. The gap between the highest and lowest Hospital Standardised Mortality Ratios (HSMRs) has narrowed, with eight fewer trusts' HSMRs above the expected range. See page 10.
3. Safety standards have improved, with higher rates of compliance with safety alerts and better reporting of errors. See page 27.
4. Airedale is our small trust of the year for a remarkable fourth time, with very good performance in clinical outcomes, safety and patient experience. See page 9.
5. Royal Free Hampstead and Ipswich Hospital have won large and medium trust of the year, while East Kent Hospitals is recognised for the first time as foundation trust of the year with excellent outcomes in a range of clinical areas. See pages 7-9.

What we can tell you: areas of concern

1. Variations in mortality ratios persist, with 19 trusts having high HSMRs. See page 10.
2. Four trusts have high ratios for the 'deaths after surgery' indicator. Two of these trusts also have high HSMRs. See pages 12-13.
3. Rates of emergency readmissions vary widely, as do revisions and manipulations following common operations, where three trusts have high rates. See pages 22-23.
4. In 2009/10 over 27,000 potential 'adverse events' were recorded in hospital data. This is almost certainly an undercount due to inconsistent recording. See page 30.
5. Standards in the treatment of life-threatening conditions such as stroke and broken hips vary widely. Many trusts fall short of best practice. See pages 18-23.

What we cannot tell you but would like to know

1. How many people suffer potentially life-threatening blood clots following treatment? Despite being a Department of Health priority, this information is not being recorded properly. See page 30.
2. The quality of care for patients after leaving hospital. Information about community and primary care services for people with long-term conditions is not available for analysis in the way that hospital data is. See page 19.
3. The level of medical errors taking place. Recording is inconsistent and trusts with high rates of 'adverse events' can often be best at keeping accurate records. See pages 30-31.
4. How NHS care for common procedures in private hospitals compares with the care given in NHS trusts. See pages 22-23.
5. More detailed information about how individual clinical teams treat patients (held on databases such as the National Joint Registry or Cancer Registry). See page 23.

Introductory message



Roger Taylor
Co-founder of Dr Foster

The aims of the first Dr Foster Hospital Guide were simple. We wanted to put more information – and more power – into the hands of patients and the public by giving them an independent view on where healthcare was working and where it was not. We wanted to end the official monopoly on data about NHS performance. We wanted to see a public debate about what it looks like to have quality in healthcare.

In the decade since the first guide, Dr Foster has grown from a small publishing company into a business that works with most hospitals in England. The debate has also shifted: everyone now accepts that delivering good healthcare means measuring performance and being transparent about that measurement. There is much more information today about clinical outcomes and about what patients think about their services than there was 10 years ago.

We have seen improvements as a result. The wide variations in hospital mortality ratios have narrowed since we first published the data, and there is greater focus on improving clinical outcomes and safety. In this guide you will find many examples of where improvements in quality have been driven by better information. But how have we done on our original aims of giving greater power to patients and having a more open debate about quality? The fact is, there is still a long way to go.

A third of patients still say they are not sufficiently involved in decisions about their care. As a patient, it is still too difficult to find out about the treatment options available to you, the standards of care you should expect and whether or not the service you are receiving meets these. Try finding out what to expect from your GP and other local services following a diagnosis of depression. Try finding out how that compares with best practice. Try finding out what other patients think about these services. You will not get far. The NHS collects vast amounts of data but too little of it is turned into useful information. Where information is available, it is rarely provided to patients or the public in ways that help them make decisions.

In this guide we have tried to answer a few questions about hospital care: where does it appear that stroke care is delivered well? Which hospitals would we recommend for treatment of pelvic cancers? Where do high mortality ratios raise questions about care? But there are many more questions where we would like to give answers but cannot.

The Coalition Government has recognised that the NHS cannot be managed from Whitehall. It is committed to greater transparency and giving patients more say over what happens to them. We welcome these ambitions and hope that, before another 10 years are up, we will be able to address some of the unanswered questions in this guide.

Trusts

of the year

Each year Dr Foster celebrates the achievements and successes of the NHS by naming our foundation, small, medium and large trusts of the year, as well as one overall winner. This year we have related the awards to the Coalition Government's Outcomes Framework.¹



East Kent Hospitals University NHS Foundation Trust

On the next pages

See the best performing trusts
in each category

East Kent Hospitals University NHS Foundation Trust

Preventing premature death		Result	Trust score	National average
These are four mortality ratios, comparing the actual numbers of deaths with our estimates. 100 is the national average. Lower scores are desirable. See pages 10-17.	Hospital Standardised Mortality Ratio (HSMR)	●	79	100
	Basket of five standardised mortality ratios	●	81	100
	Deaths after surgery	▲	89	100
	Deaths in 'low-risk' conditions	▲	77	100
Quality of life despite long-term conditions		Result	Trust score	National average
In focusing on stroke we have selected six indicators following patients along a hospital pathway. See pages 18-21.	Stroke patients scanned on the same or next day	●	54%	47%
	Thrombolytic treatment when appropriate	●	6%	3%
	Pneumonia due to swallowing problems	●	3%	5%
	Discharge home within 56 days	▲	78%	73%
	Readmissions within 28 days	▲	114	100
	In-hospital mortality	●	71	100
Helping recovery from ill health or injury		Result	Trust score	National average
We have measured trusts across orthopaedics and urology, looking at readmissions and operations which need to be done again. See pages 22-25.	Re-do rates for transurethral resection of the prostate	▲	6%	5%
	Knee revisions and manipulations within one year	▲	0.04%	1%
	Hip revisions and manipulations within one year	▲	1%	5%
	Hip replacement readmissions	▲	118	100
	Knee replacement readmissions	▲	124	100
	Hip fracture operations within two days	●	71%	67%
	Hip fracture standardised mortality ratio	▲	89	100
Positive experiences of care		Result	Trust score	National average
All trusts are focusing on these five questions from the national patient survey and they can receive financial rewards for performing well. See pages 34-35.	Sufficiently involved in care decisions?	▲	68%	70%
	Staff available to talk to about worries?	▲	57%	59%
	Enough privacy when discussing care?	▲	80%	81%
	Medication side-effects explained pre-discharge?	▲	49%	45%
	Given a contact for post-discharge concerns?	▲	74%	74%
Safe environment and avoiding harm		Result	<div style="border: 1px solid black; padding: 5px;"> <p>Key</p> <p>● Exceeds expectation</p> <p>▲ Meets expectation</p> <p>✓ Yes</p> </div>	
We have revisited a number of measures of patient safety that were highlighted in last year's Hospital Guide. Most of the information is from our survey. See pages 26-31.	Trust has a board lead for patient safety?	✓		
	Patient safety is on board's monthly agenda?	✓		
	Inpatients with 'track and trigger' systems in place?	100%		
	Trust complies with selected safety alerts?	✓		
	All surgical patients given clot-prevention devices?	✓		
	Patients risk-assessed for blood clots on admission?	31-60%		
	Reported rate of safety events?	▲		

Scorecards for all trusts are available at www.drfoosterhealth.co.uk/hospital-guide

Our 2010 overall trust of the year is East Kent Hospitals University NHS Foundation Trust, which has shown dedication to putting the patient first. In fact, across all the winners there is a common theme of delivering services closer to the people who need them. This type of reorganisation has been proven to benefit patients and, in these tough economic times, save money.

On the previous page, the scorecard for East Kent gives an overview of the categories and data that we used to determine our top trusts. These measures are explored in more detail throughout the guide. Scorecards for all English acute trusts can be found on our website.

Foundation trust of the year and overall winner

East Kent Hospitals University NHS Foundation Trust

As demonstrated by its scorecard, East Kent Hospitals University NHS Foundation Trust has become our winning trust this year by performing consistently well across our chosen criteria. In doing so, it has succeeded in meeting the particular challenges of being one of the largest trusts in the country – a network of three district general hospitals, two community hospitals and several satellite sites serving a population of 750,000 people.

Its motto of 'Putting patients first' has been a driving force behind recent changes to make key specialist services available locally and in a timely manner. New technology is also helping to improve care, not least in the hyper-stroke service where the innovative, award-winning use of telemedicine has enabled the development of a 24/7 service. The trust offers a routine radiology service seven days a week, ensuring that all patients receive the scans at the time they need them, and recently became the lead trust for delivering primary angioplasty for heart attack patients across the whole of Kent.

In commenting on the award, chief executive Stuart Bain explained that "the success of the trust can be put down to a combination of very high ambition by the board, good planning, and the dedication of the 7,000 staff who always go the extra mile for their patients". He added,

"Safety and effectiveness have been the key drivers in directing our investment in service change and this is reflected in our exceptionally low HSMR and good infection prevention rates."

Large trust of the year

Royal Free Hampstead NHS Trust

Royal Free Hampstead NHS Trust is known for its pioneering surgery, being the first in Europe to offer keyhole mastectomy and one of the few centres offering keyhole surgery for pancreatic cancer. It even has ethical approval to perform what would be the country's first face transplant. But despite the complexity of its caseload, its mortality ratios have been among the lowest in the country for many years, and this high-quality performance is recognised in becoming Dr Foster's large trust of the year.

"This achievement is down to the efforts of our workforce who aim to offer the best clinical care, the best patient experience and who pioneer new and effective healthcare approaches," said David Sloman, the trust's chief executive.

Reflecting its efforts to put patients at the centre of everything it does, the trust is participating in a programme to improve staff-to-patient interactions, as well as providing care closer to patients' homes through its network of Royal Free clinics. In another innovative move, it has been the first acute trust to appoint a public health lead.

Medium trust of the year

Ipswich Hospital NHS Trust

Ipswich Hospital NHS Trust is a vibrant general hospital that provides a range of services on site, many of them specialised. These include vascular surgery, spinal surgery, radiotherapy and gynaecological cancer surgery, which are capable of being provided to a population of more than 500,000. It also offers midwifery in the community, and indeed is working closely with local GPs to further increase the range of community services.

In addition to being one of 10 hospitals in the UK leading a national programme of improvements

for orthopaedic patients, the trust prides itself on having low rates of healthcare-acquired infections and has been rapidly reducing rates of avoidable harm such as from patient falls and pressure sores.

Chief executive Andrew Reed said, "I am very proud that Ipswich Hospital has been named medium-sized trust of the year. Everyone at the hospital plays a part in the quality of care we provide, but it is a particular accolade to our doctors, nurses and all clinical professionals who have maintained an unrelenting focus on the safety and experience of our patients."

Small trust of the year

Airedale NHS Trust

Supporting more than 200,000 people across Yorkshire and Lancashire, Airedale NHS Trust has been our best performing small trust on several previous occasions.

"We are extremely pleased to win the Dr Foster award again for the fourth time in five years, especially as it is in the same year that we achieved foundation trust status," explained Bridget Fletcher, former director of nursing and now chief executive.²

"It is not only a fantastic achievement for our staff but also recognition for the hard work they do every day to make sure we provide high-quality, safe, compassionate, personal care for all our patients."

The trust provides services from the main hospital site and also from community hospitals and health centres, as well as to a number of prisons throughout England through its pioneering telemedicine service. Over the next 12 months it is planning to install telemedicine equipment into some patients' homes, nursing homes, GP practices and other remote locations. The aim is to provide integrated healthcare to patients in their own homes or as close to home as possible.

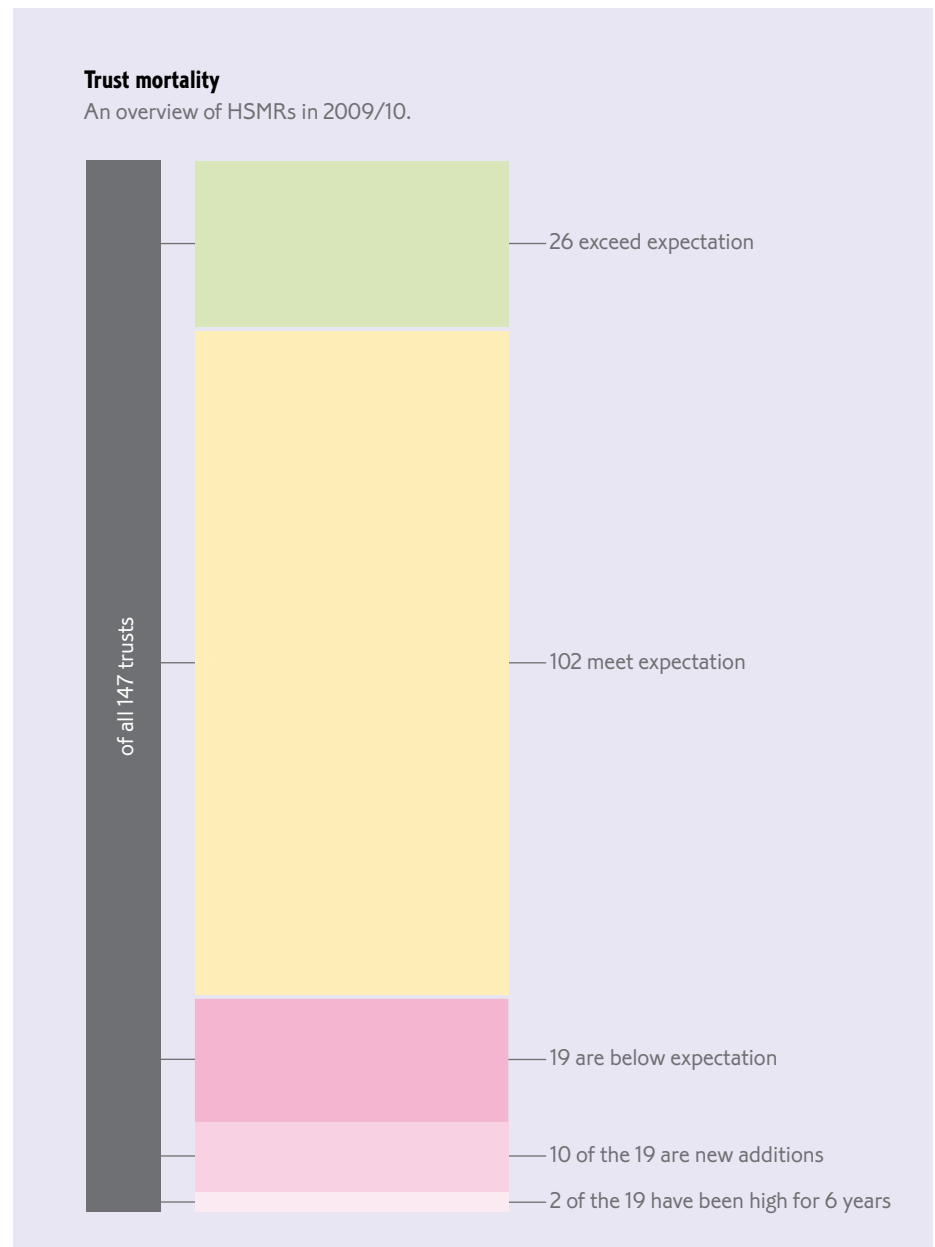
To categorise trusts, we used the Healthcare Commission's definitions (based on the number of beds per hospital). Foundation trusts are automatically in that category.

Measuring mortality

a key step to ensuring quality

HSMRs are decreasing across the NHS. Only 19 of the 147 hospital trusts now have significantly high HSMRs, compared with 27 last year, whereas 26 trusts have HSMRs that are significantly low, down from 32 a year ago.

The overall improvement suggests greater consistency across trusts, both in terms of data-recording and perhaps in the quality of care.



Preventing people from dying due to illness or injury is, perhaps, the most fundamental aim of healthcare. Sometimes it is not possible. But by always delivering the best care, it is possible to reduce the chances of death. Lower mortality ratios are one marker of good quality care.

This guide compares the mortality ratios at English trusts after taking into consideration the differences in the patients treated. We do this to see if the number of patients who survive following treatment is in line with the number we would expect, given their condition.

In this section we look at three measures, comparing the number of deaths at the trust with the number we estimate would happen if mortality ratios were in line with the national average. This takes into account a patient's diagnosis, age, admission method and other characteristics. If a trust has the same number of deaths as estimated, we give a score of 100. If it has 10 per cent more deaths, we give a score of 110, or for 10 per cent fewer deaths a score of 90.

I Hospital Standardised Mortality Ratios (HSMRs)

The HSMR is one of the most commonly used measures of overall mortality for trusts. It looks at those conditions which account for the vast majority of deaths in hospital (80 per cent).

This year there continues to be a variation in mortality ratios, ranging from 18 per cent higher than expected to 28 per cent lower than expected. Just by chance there is bound to be some disparity. We identify trusts as having high or low HSMRs if the variation is extreme; in other words, the likelihood of it occurring by chance is less than one in a thousand.

Why the HSMR results matter



Prof Sir Brian Jarman

Hospital Standardised Mortality Ratios (HSMRs), or 'death rates' as they have become known in the media, are an important outcome measure for patients. Imperial College London developed HSMRs in the 1990s.

However, it was the 2001 Bristol Inquiry report, which recommended transparency of hospital data for patients, that acted as a catalyst for Dr Foster to first publish them.¹ Dr Foster was responding to the lack of clinical information available to the public during the Bristol Inquiry.

In April 2010 the Department of Health stated, "A high HSMR is a trigger to ask hard questions. Good hospitals monitor their HSMRs actively and seek to understand where performance may be falling short, and action should not stop until the clinical leaders and the board at the hospital are satisfied that the issues have been effectively dealt with."² I strongly support this position and welcome the continued publication of HSMRs by Dr Foster and NHS Choices (www.nhs.uk).

Putting the data into the public domain is an essential way to focus clinicians and managers on investigating outcomes. High HSMRs, together with concerns in other measures of mortality, prompted the Healthcare Commission's investigation at Mid Staffordshire NHS Foundation Trust.³ It is possible that, without the alarm being raised, the problems that were found could have continued unrecognised by the system.⁴

Professor Sir Brian Jarman is emeritus professor at Imperial College London

When a trust has a high mortality ratio, we cannot be sure of the reason why; it may be because of inaccurate data or a result of particularly unusual circumstances at that trust. However, it is a useful screening tool that warrants investigation, and we believe that the

public should be made aware of it. This year's HSMR results can be seen on page 16.

No single measure can tell the whole story, so it is important to look at mortality and the outcomes of treatment in many different ways.

Why look at deaths after surgery?



Prof Peter Griffiths

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Sadly, some deaths in hospital are inevitable. Much of the difference in mortality ratios between hospitals has little to do with differences in the quality of care that people receive. Instead it is related to the sort of people who are treated and how vulnerable they are. Measures like the HSMR try to account for this using statistical techniques, but no statistical adjustment can ever be perfect.

The ratio of avoidable deaths among surgical patients with treatable complications gives another way of exploring how a hospital performs, one which relates to a specific group of people and which offers some advantages. For people undergoing surgery, the chance of developing a complication such as bleeding or pneumonia depends very much on their age, underlying conditions and other factors. But while complications are often a result of patient characteristics, a hospital's ability to successfully treat it is strongly related to the quality of care provided. Staff must be vigilant and act promptly to ensure the right treatment is given.

By looking at the ratio of death only among those people who experience complications, this indicator allows for the fact that some hospitals will treat more people who are at risk of complications than others. The indicator is intended to show how well they perform once the complications occur. Hospitals performing poorly on this indicator should consider whether they have proper systems in place for identifying and responding to patients who deteriorate after their operation.

Professor Peter Griffiths is director of the National Nursing Research Unit at King's College London

You will see a range of these throughout the Hospital Guide. Within this chapter, in addition to HSMRs, we also look at mortality in two other ways: mortality in high-risk conditions and deaths after surgery.

2 Mortality in high-risk conditions

It is important to look at mortality for specific conditions (see also pages 19 and 23), especially those where treatment can have the biggest impact. Here we have selected from the HSMR a basket of five conditions which affect a large number of people and where mortality is accepted as an indicator of the quality of care in hospital. By creating a basket of conditions, we can identify variations in mortality more effectively than if we only look at diagnoses individually. Restricting the basket means we can be more focused in measurement than with the HSMR. The conditions in our basket are heart attack, pneumonia, stroke, congestive heart failure and broken hips.

The results can be seen on page 17. They include some trusts whose overall mortality ratios are low or as expected, but which nonetheless have areas of high mortality. Individual trusts may decide to monitor their performance using different baskets relevant to the care they provide.

3 Deaths after surgery

Conventionally known as 'failure to rescue', this is the first time this indicator has been used in the UK, though it is currently published in the US.⁵ Imperial College London and King's College London have developed it alongside Dr Foster.

DID YOU KNOW? Eight hospital trusts do not have a policy to notify GPs on the death of a patient.

The indicator looks at surgical patients who had a secondary diagnosis such as internal bleeding, pneumonia or a blood clot, and subsequently died. Either the patients had this condition already or they developed it as a consequence of the surgery. In the former case, operating on a patient in these circumstances may have increased the risk of death.

Death among this particular group of patients will sometimes be inevitable. But trusts with high ratios should make sure that appropriate procedures are in place to minimise the risk of death following surgery.

Across the 147 acute hospital trusts in England, four have significantly high ratios for 'deaths after surgery', two are performing significantly better, and the rest are performing within the estimated range. However, there is large variation in performance, with ratios from 26 to 179. As with HSMRs, the results may be affected by the accuracy of the underlying data. Again the results are displayed on page 17.

This measure uses a very different approach from the HSMR, so trusts that have high ratios on both of the measures – University Hospitals Birmingham NHS Foundation Trust and Hull and East Yorkshire Hospitals NHS Trust – will want to understand the possible causes.

4 Is the data accurate?

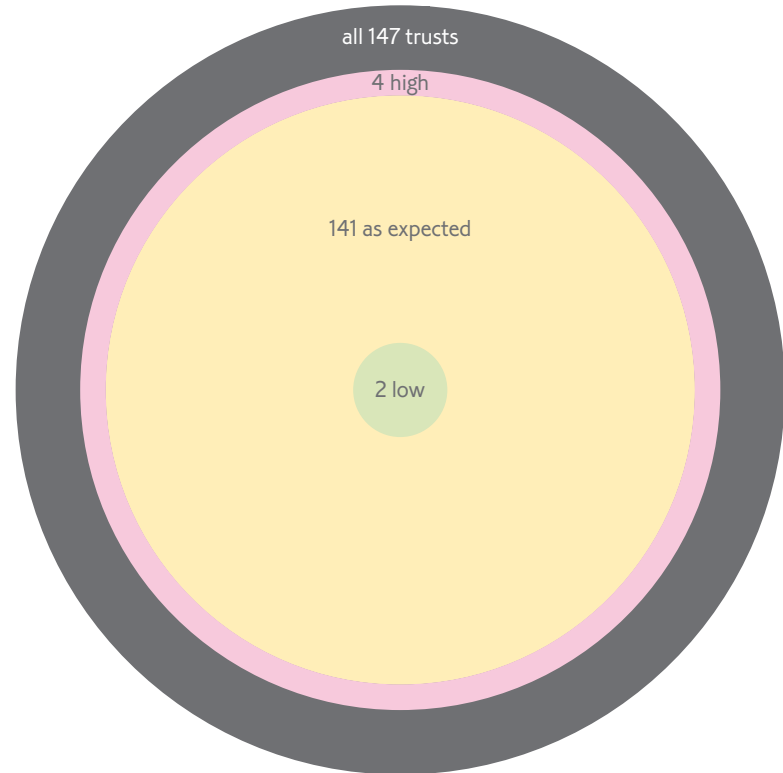
Measurements of hospital mortality ratios are only as good as the data they are based on. Hospital trusts are required to document in detail the care they provide to patients using defined systems of coding. On the whole this coding is robust, but there can be some variation between trusts.

In recent years, because of the continued focus on mortality ratios, some trusts have reviewed the way they code patients and have increased the number identified as being in palliative care. If these patients die, they have relatively little effect on the trust's HSMR, because death is the expected outcome.

A focus on more accurate coding is welcome. However, we have seen greater inconsistency in the way that trusts are coding palliative care

Deaths after surgery

An overview of trusts' results for 2009/10.



A view from the front line by the Royal College of Nursing

The safety of a patient's stay in hospital depends on the level of accuracy invested in the monitoring, recording, measuring and decision-making around crucial changes in their vital signs. Any delay in picking up patient deterioration can have an obvious and tragic human cost. Also, it often means a return to critical care, which incurs costs and prevents trusts from using resources efficiently.

Trusts need to know their standardised mortality ratios so that crucial work can be done to improve them. The predominantly nurse-led critical care outreach teams have been integral to improvements in reducing complications, speeding recovery and enabling a quicker discharge for patients. This must not detract, however, from the need for wards to have correct staffing levels and accurate skill-mixes; we must ensure the best care at all times.

The Royal College of Nursing's training packages and 'nursing practice principles' are giving staff the expert help they need to guide their actions before patients get worse. The obvious key to success is empowering nurses to work closely with other healthcare professionals to get basic care right.

Dr Peter Carter is chief executive and general secretary of the Royal College of Nursing

DID YOU KNOW? All hospital trusts now use the World Health Organisation's Safer Surgery Checklist.

patients in recent years. Some trusts are more likely than others to code particular patients as palliative care and, as a result, their HSMRs are lower than they would be if all data was coded in the same way.

On average this can reduce a trust's HSMR by up to about five points. Therefore, in the interests of transparency, we have started to publish the percentages of deaths at each trust which are coded as palliative care. These range from less than 1 per cent in some trusts

to over 40 per cent in others, with 45.5 per cent at Basingstoke and North Hampshire NHS Foundation Trust and 44.5 per cent at Medway NHS Foundation Trust.

Transparency around outcomes depends on hospitals coding information accurately and consistently. With increasing focus on accurate measurement of outcomes, it is essential that clear guidelines are issued on how patients should be classified, and that high standards of data-recording are maintained.

5 How are trusts responding?

The real value of measuring mortality is in prompting trusts to take practical actions that help deliver better care. Here are some examples.

Forming a successful action plan

Tameside Hospital NHS Foundation Trust

Tameside's HSMR has improved from 'high' to 'as expected' in 2010. According to medical director Tariq Mahmood, this is the result of "the development and systematic application of a detailed mortality action plan with the full support of the trust chief executive, the endorsement of the board and the involvement of clinical and managerial staff".

The trust has been focusing on continuing to improve clinical care, such as by significantly increasing the number of its consultants and nursing staff, and by enhancing the critical care outreach team and intensive therapy unit (ITU). It has also been implementing care bundles for certain high-risk conditions.

Good clinical documentation underpins effective clinical care and appropriate coding, and thereby affects the HSMR. To facilitate this the trust has undertaken a period of education and training for both its clinical and coding staff. In addition, it conducts regular reviews of all 'unexpected' deaths in hospital in order to identify any issues with care management or documentation.

Quality end-of-life care is important for ensuring a dignified death in an appropriate setting, so it is vital to increase awareness of the subject and have an integrated approach across primary and secondary care. This also helps to reduce the

What else don't we know?

by The Patients Association

Patients need meaningful information, delivered in everyday language, so that they can make an informed choice of hospitals and services. However, it is essential that the information is accessible, readable and clear. We hear from patients phoning our helpline about how confused they are by the medical terminology used when delivering information, or that the information is in a format, such as online, that they find hard to access. It is not an informed choice if patients are unable to engage or access the information presented to them.

Although mortality ratios are an important measure for patients when comparing hospital services, they do not tell the whole story of quality of care in a hospital and do not apply to large areas of care. To get to the heart of hospital care, patients need other information: infection rates and the staff-to-patient ratio for a ward or department, and the performance and outcomes for consultants and their teams.

The 'information revolution' is a key part of the proposed changes to the NHS outlined in the White Paper, but it is essential that this data is meaningful and truly representative of the quality of care in hospital wards and departments. The information needs to be easily accessible through a range of media, consistent between hospitals, up to date and explained in plain English, avoiding the need for complex statistics that leave patients confused.

Katherine Murphy is chief executive of The Patients Association

HSMR as more people are supported in dying outside hospital, if that is their choice.

The trust has been visiting other organisations with low HSMRs and is also a member of the North West Reducing Mortality Collaborative (see below), which helps to understand and address the reasons for particularly high HSMRs across the region.

Regional cooperation to improve care

North West Reducing Mortality Collaborative

Nine trusts in the north-west have been working together closely over the past year to bring about improvements in patient mortality ratios. This is all part of a wider strategy to raise standards of care throughout the area.

Facilitated by the Advancing Quality Alliance (AQuA), this 'breakthrough collaborative' is only part way through its first year, but all the trusts have already made improvements. Each one has made a commitment to see a fall in its HSMR of at least 10 points over a 12-month period. Some, such as Tameside Hospital NHS Foundation Trust and Royal Bolton Hospital NHS Foundation Trust, have significantly reduced their ratios from a high starting point.

The collaborative involves a series of learning events, both for front-line teams and hospital executives. In between the events they test out ideas for improvements and measure the impact of the changes they are making. Six sets of interventions are being pursued:

- Reducing harm, such as by tackling healthcare-acquired infections or medication errors.
- Using 'care bundles' to ensure that every patient has the most effective care, every time.
- Improving the care of deteriorating patients by spotting warning signs early and acting quickly.
- Improving end-of-life care to give patients and families more choice and control.
- Ensuring effective leadership and management from boards through to front-line staff.
- Tackling all arising issues to do with coding and data analysis.

AQuA, which is supporting the initiative, is a membership organisation funded by primary care trusts and acute trusts in the north-west to improve quality and spread best practice.

Why measuring mortality is important



Dr Robert Winter

Avoiding unnecessary deaths is an important objective for health services in all countries. People should not die early where medical intervention could make a difference. As far back as 1863, Florence Nightingale recognised that uniform hospital statistics would "enable us to ascertain the relative mortality of different hospitals".

Initial interest in standardised mortality data was muted, but some in the NHS recognised that HSMRs could help trusts to identify where improvements needed to be made. The recent association of persistently high HSMRs with shockingly poor clinical care in a few trusts has focused fresh interest on the use of mortality statistics in local accountability arrangements.

Important caveats need to be made. In particular, there is no 'gold standard' or single indicator which can be deemed as having most power in discerning good or poor quality care. As with most indicators, its use for all audiences is subject to caution. It is not appropriate to use HSMR data for 'league tables' of hospitals. Any inferences drawn from HSMR data should be corroborated (or investigated) by other comparative measures before conclusions are drawn about the quality of care.

Further development and understanding of the use of standardised mortality statistics across the NHS will bring greater quality and consistency in terms of the way we monitor mortality associated with hospitalisation. This will be of benefit to the public at large.

Dr Robert Winter is medical director at NHS East of England

Improving HSMRs through cultural change

South London Healthcare NHS Trust

South London Healthcare NHS Trust was created in April 2009 from the merger of three hospitals. It is currently in the process of major cultural changes: merging departments, reconfiguring services, re-engineering patient pathways and introducing modern working practices.

The trust has recently introduced the following, which it believes will have a positive impact on its HSMR:

- Board-level focus on safety as the trust goes through this period of change.

- The introduction of new models of care, specifically the introduction and development of the 'acute medical unit' model of care.
- Newly developed processes, led by the medical director, for regular analysis of the Dr Foster data, internal investigation of any alerts, and review of all low-risk deaths. These reviews bring front-line clinicians into the process, enhancing partnership with coders.
- Insistence that the coding of deaths is only undertaken by the most senior clinical coders, as well as introducing an internal quality assurance process for the coding of deaths prior to submission. As a result, the proportion of low-risk deaths which on analysis require re-coding has decreased from 45 to 14 per cent on the most recent audit.

Results for the three mortality indicators

Hospital Standardised Mortality Ratios (HSMRs) This is a broad measure across the majority of activity in a hospital where risk of death is significant. Because it covers so much activity, it is an excellent screening tool for identifying where there may be problems with avoidable mortality.

Lower than expected mortality	Ratio	Higher than expected mortality	Ratio
Aintree University Hospitals NHS Foundation Trust	85	Barking, Havering and Redbridge University Hospitals NHS Trust	116
Ashford and St Peter's Hospitals NHS Trust	90	Buckinghamshire Hospitals NHS Trust	118
Barnet and Chase Farm Hospitals NHS Trust	88	City Hospitals Sunderland NHS Foundation Trust*	114
Barts and The London NHS Trust	89	Derby Hospitals NHS Foundation Trust	112
Bradford Teaching Hospitals NHS Foundation Trust	81	East Sussex Hospitals NHS Trust*	110
Cambridge University Hospitals NHS Foundation Trust	81	George Eliot Hospital NHS Trust*	113
East Kent Hospitals University NHS Foundation Trust	79	Hull and East Yorkshire Hospitals NHS Trust	117
Epsom and St Helier University Hospitals NHS Trust	90	Isle of Wight NHS PCT*	115
Frimley Park Hospital NHS Foundation Trust	85	Mid Cheshire Hospitals NHS Foundation Trust	114
Imperial College Healthcare NHS Trust	80	Northampton General Hospital NHS Trust*	112
Leeds Teaching Hospitals NHS Trust	91	Pennine Acute Hospitals NHS Trust ■	110
Maidstone and Tunbridge Wells NHS Trust	92	Royal Bolton Hospital NHS Foundation Trust ■	116
Mid Staffordshire NHS Foundation Trust	87	Shrewsbury and Telford Hospital NHS Trust*	117
North Bristol NHS Trust	90	South London Healthcare NHS Trust*	109
North West London Hospitals NHS Trust	87	Southport and Ormskirk Hospital NHS Trust*	113
Plymouth Hospitals NHS Trust	86	The Dudley Group of Hospitals NHS Foundation Trust	115
Royal Free Hampstead NHS Trust	72	The Royal Wolverhampton Hospitals NHS Trust*	116
Salford Royal NHS Foundation Trust	84	University Hospitals Birmingham NHS Foundation Trust	109
Sheffield Teaching Hospitals NHS Foundation Trust	92	Western Sussex Hospitals NHS Trust*	107
St George's Healthcare NHS Trust	84		
Taunton and Somerset NHS Foundation Trust	89		
The Newcastle upon Tyne Hospitals NHS Foundation Trust	90		
The Whittington Hospital NHS Trust	84		
University College London Hospitals NHS Foundation Trust	72		
University Hospitals Bristol NHS Foundation Trust	86		
West Middlesex University Hospital NHS Trust	86		

*Denotes trusts which did not have high HSMRs last year

■ Denotes trusts with high HSMRs for the past six years

Source: Secondary Uses Service (SUS) data 2009/10

Standardised mortality ratios This basket contains five of the 56 conditions that comprise the HSMR: heart attacks, stroke, pneumonia, congestive heart failure and broken hips.

Lower than expected mortality	Ratio	Higher than expected mortality	Ratio
Ashford and St Peter's Hospitals NHS Trust	83	County Durham and Darlington NHS Foundation Trust	113
Bradford Teaching Hospitals NHS Foundation Trust	87	Derby Hospitals NHS Foundation Trust	115
East Kent Hospitals University NHS Foundation Trust	81	East and North Hertfordshire NHS Trust	118
Frimley Park Hospital NHS Foundation Trust	84	Great Western Hospitals NHS Foundation Trust	117
Imperial College Healthcare NHS Trust	83	Hull and East Yorkshire Hospitals NHS Trust	115
Mid Staffordshire NHS Foundation Trust	74	Royal Bolton Hospital NHS Foundation Trust	118
North West London Hospitals NHS Trust	88	Shrewsbury and Telford Hospital NHS Trust	117
Plymouth Hospitals NHS Trust	87	South London Healthcare NHS Trust	112
Royal Free Hampstead NHS Trust	79	Surrey and Sussex Healthcare NHS Trust	121
St George's Healthcare NHS Trust	87	The Royal Wolverhampton Hospitals NHS Trust	121
University College London Hospitals NHS Foundation Trust	73		
University Hospitals Bristol NHS Foundation Trust	84		
West Middlesex University Hospital NHS Trust	78		

Deaths after surgery This indicator looks at unexpected deaths among surgical patients.

Lower than expected mortality	Ratio	Higher than expected mortality	Ratio
Chelsea and Westminster Hospital NHS Foundation Trust	26	Hull and East Yorkshire Hospitals NHS Trust	166
Winchester and Eastleigh Healthcare NHS Trust	46	The Newcastle upon Tyne Hospitals NHS Foundation Trust	137
		University Hospitals Birmingham NHS Foundation Trust	157
		University Hospital of North Staffordshire NHS Trust	153

Results for all trusts are available at www.drfoosterhealth.co.uk/hospital-guide

Look back at pages 11-13

Why did we choose these indicators?

Stroke

excellence across a care pathway

To understand quality, you need to measure the aspects of care that patients are most concerned about. This often boils down to looking at the detail around individual conditions. Here we focus on the care that patients receive when they have a stroke.

The information we need

by The Stroke Association

The key to providing high-quality stroke care is making sure that everyone who has a stroke is admitted directly to a stroke unit and spends all of their time there. The evidence is strong that these units, staffed with a multi-disciplinary team of stroke specialists, improve outcomes and reduce stroke mortality.

Recent years have seen a dramatic improvement in the number of stroke units, the number of patients treated there and the length of time they stay. Stroke patients and their families will want to assess these different aspects of care, as well as the quality of specific units.

The Sentinel Stroke Audit, which is carried out every two years by the Royal College of Physicians, provides a wealth of data about stroke unit provision. New, real-time measurement of the hyper-acute phase of stroke care is also coming on stream with the introduction of the Stroke Improvement National Audit Programme. Both of these are important measures for clinicians and commissioners, but they are also vital tools for helping patients to assess their care.

Just as vital is data about post-hospital stroke provision, and this is much thinner on the ground. The Care Quality Commission (CQC) is carrying out a one-off review of post-hospital stroke provision to be published later this year, but in future we will need to see more systematic measurement of the quality and quantity of stroke services in the community, building on the baseline provided by the CQC.

Joe Korner is director of communications at The Stroke Association

Stroke is a high national priority but there is a marked variation in standards of care. This was highlighted by the National Audit Office (NAO) in 2005 and recently in 2010.¹

As the UK's third biggest killer, stroke takes the lives of more women than breast cancer. There are 110,000 strokes in England each year, and almost a third of everyone who has one dies from it.² Those who survive often have permanent disabilities. The NAO estimated that the direct cost of caring for people who have a stroke is £3bn a year and the wider economic costs are £8bn.³

Under pressure to improve

The Department of Health's 2007 Stroke Strategy recognised the scale of the problem and set out to make improvements a priority.⁴ But what impact has the strategy had in terms of helping hospitals to adhere to best practice and improve patient outcomes?

In this year's Hospital Guide the Dr Foster team has focused on key indicators of quality and outcomes that stretch across the stroke care pathway, in other words across the many different stages of treatment and care for this particular condition.

Taking action early

Of the six performance indicators, the first two measured interventions that should take place in the critical period of care straight after a stroke:

- The proportion of patients receiving a brain scan on the same or next day.
- The proportion of patients given thrombolytic or 'clot busting' drugs within 24 hours.

Receiving a brain scan promptly is the best way to correctly diagnose the nature of the stroke. Without this information it may not be possible to start appropriate treatment as soon as required. In 2009/10 the highest rate of patients having a brain scan by the next day was 87 per cent at **North Middlesex University Hospital NHS Trust**. Elsewhere the rates were as low as 42 per cent.

Thrombolysis can make a big difference to the patient's recovery but this requires skilled teams on site. Not all trusts are set up to provide this care. In some areas, networks are being set up so that, if a hospital cannot provide treatment, patients are transferred quickly to nearby units which can. Thrombolysis rates varied from 0.2 to 17 per cent. You can see all the scanning and thrombolysis results on our website.

Quality care from start to finish

The following four indicators were chosen to help demonstrate the quality of outcomes:

- The proportion of stroke admissions that lead to pneumonia due to swallowing problems, which should not happen if care teams have carried out a standard check. Rates varied from 2 to 12 per cent.
- The proportion of patients returning to their usual place of residence following hospital treatment within a period of 56 days, which implies successful rehabilitation. Rates varied from 55 to 85 per cent.
- The rate of emergency readmissions to hospital after treatment for a stroke, which highlights return visits that could possibly be avoided. Rates varied from 44 per cent below average to 58 per cent above average.
- The standardised mortality ratio, which can highlight preventable deaths. Rates varied from 34 below average to 66 above average.

What happens to patients after they leave hospital?



Dr Charles Davie

The stroke data in the 2010 Hospital Guide provides an invaluable means of comparing performances across all English acute services for stroke.

Two relevant outcomes for stroke are readmissions and standardised mortality and it is very encouraging that most hospitals perform well on these two measures. A move towards measuring in- and out-of-hospital mortality would be a further advance given that many stroke patients now benefit from early supported discharge, sometimes within 72 hours of admission.

The landscape of acute stroke care is changing dramatically in the UK, and the data presented here is unlikely to reflect this. For instance, this year a new model of care in London has already helped to increase rates of intravenous thrombolysis to 12 per cent for February to July 2010, compared with 3.5 per cent for the same period in 2009.

Of course thrombolysis rates are only a small part of the story. There is also a need to demonstrate improved outcomes of functional recovery following treatment, improvement in the percentage of patients returning to their previous life roles, and patient satisfaction with the care provided. It is to be hoped that the 2011 Hospital Guide looks across the whole stroke pathway, rather than just acute care.

Dr Charles Davie is consultant neurologist at the Royal Free Hampstead NHS Trust, stroke lead for University College London Partners and clinical stroke lead for the North Central London Cardiac and Stroke Network

No room for complacency

To build a picture of overall performance, we have identified trusts that have performed significantly better or worse than expected across all six indicators.





To be in our 'best performers' basket, trusts had to do very well in two or more of our six indicators, and not be below average on any of the others. Likewise our 'worst performers' are below average on at least two indicators, without doing particularly well on any of the rest. You can see the results for these trusts on

pages 20-21, while the full listings for all other trusts are available on our website.

It is clear that there have been measurable improvements in the way the NHS deals with strokes and that the Stroke Strategy is making a difference to the number of deaths. In fact the NAO estimated that, since 2006, stroke patients' chances of dying within 10 years have fallen from 71 to 67 per cent.⁵ But there is still a worrying level of variation in care. Your chance of survival – or your quality of life if you do survive – still varies according to which hospital you are admitted to.

DID YOU KNOW? 97% of trusts have a specialist stroke unit.

Key

 Exceeds expectation
  Meets expectation
  Below expectation
  Not applicable

The care pathway: best and worst performing trusts across six indicators

DIAGNOSIS AND PREVENTION

URGENT TREATMENT

Performing
brain scans the same
or next day

Providing
thrombolytic drugs
within 24 hours

Continued over

Best performers

East Kent Hospitals University NHS Foundation Trust		
Derby Hospitals NHS Foundation Trust		
Northumbria Healthcare NHS Foundation Trust		
Southend University Hospital NHS Foundation Trust		
South Tees Hospitals NHS Foundation Trust		
The Queen Elizabeth Hospital King's Lynn NHS Trust		

Worst performers

Barking, Havering and Redbridge University Hospitals NHS Trust		
Basildon and Thurrock University Hospitals NHS Foundation Trust		
Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust		
George Eliot Hospital NHS Trust		–
Isle of Wight NHS PCT		
Leeds Teaching Hospitals NHS Trust		
Nottingham University Hospitals NHS Trust		
West Middlesex University Hospital NHS Trust		

Source: SUS data 2009/10

ACUTE TREATMENT		HOSPITAL DISCHARGE	SECONDARY PREVENTION
Pneumonia due to swallowing problems	Standardised mortality ratio for stroke	Discharge home within 56 days	Emergency readmissions for stroke
●	●	▲	▲
●	▲	▲	▲
▲	▲	▲	▲
▲	▲	▲	▲
●	▲	▲	▲
▲	●	▲	▲
■	▲	▲	▲
▲	▲	▲	▲
▲	▲	▲	▲
■	▲	▲	▲
▲	■	▲	▲
▲	▲	▲	▲
■	▲	▲	▲
■	▲	▲	▲

Excellence in orthopaedics

a team approach

When measuring clinical effectiveness, it is essential to look at the overall performance of care teams, not just hospitals, so that the results are meaningful to patients. This year we have assessed a basket of six indicators for the quality of orthopaedic care.



With an ageing population, the demand for orthopaedic services has grown steadily over the past 20 years. This is particularly true for hip and knee replacements: 125,000 took place in England in 2009/10. The annual cost for medical and social care in the UK for hip fractures alone is about £2bn, set to rise to £2.2bn by 2020.¹ For these reasons we have focused on orthopaedics as a key specialty.

Avoiding readmissions

First we identified all patients who were readmitted within 28 days after a hip or knee replacement. For both these outcomes, the majority of trusts performed to the expected standard in 2009/10. However, for hips, two trusts had high readmission rates – Leeds Teaching Hospitals NHS Trust (75 per cent above average) and The Newcastle upon Tyne Hospitals NHS Foundation Trust (63 per cent). In contrast, two trusts had low rates – Northern Devon Healthcare NHS Trust (67 per cent below average) and Royal Devon and Exeter NHS Foundation Trust (35 per cent).

Reducing the need for revisions

In 2009/10 more than 2,000 patients had to have their hip or knee replacement revised or manipulated. Wear and tear does mean that replacements will not last for ever. But for most patients they do last for 15 to 20 years.

Hip revision rates varied from 0 to 3.5 per cent, and knee revisions from 0 to 2.1 per cent. Two trusts had high rates for hip revisions – Frimley Park Hospital NHS Foundation Trust and Northumbria Healthcare NHS Foundation

Joining up the data



Robert Middleton

Tom Wainwright

Trust – and one was high for knee revisions – Guy’s and St Thomas’ NHS Foundation Trust. Sixteen trusts have done particularly well on this indicator. Visit www.drfoosterhealth.co.uk to see the full list of results.

Death following a hip fracture

Hip fractures (or ‘fractured neck of femur’) also represent a major expense for the NHS and are the most common reason for admission to an orthopaedic ward. More than 70,000 hip fractures happen each year in the UK, which is likely to increase to 101,000 by 2020.²

Moreover, patients who suffer a hip fracture have a high mortality ratio: about 10 per cent of people with a hip fracture die within one month, and about a third within 12 months. In 2009/10 nearly 6,000 people died in hospital. However, when examining standardised mortality ratios, all trusts performed as well as expected, and Cambridge University Hospitals NHS Foundation Trust had an especially low ratio (46 per cent below average).

Operating straightaway

Patients who fall and break their hips should have them operated on within two days. This is a crucial timeframe, not only as it is accepted best practice from the National Institute for Health and Clinical Excellence (NICE), but also as there is a proven link between a delay in the operation and an increased risk of death.³ Worryingly, in our analysis, 21 per cent of trusts had rates that were significantly low. The percentage operated on within two days varied from 34 to 94 per cent. Again the full results are shown on our website.

For a picture of trusts’ overall performance, we have identified those performing significantly well or poorly across the six indicators (using the same criteria as for stroke, see page 19). These trusts are shown in the box to the right.

Understanding more about the effect of our orthopaedic interventions is imperative, so there is great value in tracking the data we see on these pages.

There have also been recent developments in the way that we can assess the quality of hip and knee replacements. In September 2010, the first data on Patient Reported Outcome Measures (PROMs) was published by The NHS Information Centre for health and social care. PROMs use five different questionnaires to evaluate patients’ health. The initial data is termed ‘experimental’ but shows us that 96 per cent of hip replacement patients and 91 per cent of knee replacement patients recorded a joint-related improvement after their operation.

Benchmarking is a hugely powerful tool in helping hospitals to identify areas where improvements are needed, as well as increasing transparency for the general public so they can make choices about where to be treated.

It should be noted that the variation in outcomes across providers – and therefore the inferred difference in quality – is often greater than we might imagine. For example, case-mix-adjusted average length of stay varies by over seven days across hospitals for knee replacement. We would like to see more sensitive and discriminative data; at present the data we have does not provide patients with enough detail to choose between different hospitals by making meaningful judgements about quality.

A step towards more meaningful data could happen by bringing together the various databases that we already have. While the Dr Foster data is very useful in isolation, it would be strengthened further by aggregation with the other major databases such as PROMs, the National Joint Registry and the national hip fracture audit.

Robert Middleton is consultant orthopaedic surgeon and Tom Wainwright is clinical researcher in orthopaedics, both at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Combining the indicators

Trusts that have performed significantly well or poorly across the six indicators:

- Best performers**
- Airedale NHS Trust
 - Northern Devon Healthcare NHS Trust
 - Royal Devon and Exeter NHS Foundation Trust
 - Royal Surrey County NHS Foundation Trust
 - University Hospitals Coventry and Warwickshire NHS Trust
 - West Suffolk Hospital NHS Trust

- Worst performer**
- Leeds Teaching Hospitals NHS Trust

Urology

excellence in operations



Guidelines recommend that surgery for urological cancer be carried out in specialist centres to improve quality.¹ Simon Carter, consultant urologist at Imperial College Healthcare NHS Trust, shows how the guidelines are being implemented and identifies leading trusts for these types of operation.

Urological cancers, such as those found in the bladder, prostate or kidney, affect more people than breast cancer each year.² It is recommended practice to carry out operations for these conditions in larger organisations where the often complex procedures are performed more frequently. In this section we list some of the leading trusts in the treatment of these illnesses. Operations to treat benign prostate disease are performed in a wider number of units; we have compared how often the procedure needs to be redone within three years.

Surgery for pelvic cancer

There are good reasons to believe that centres which carry out large numbers of surgery for prostate and bladder cancer have consistently

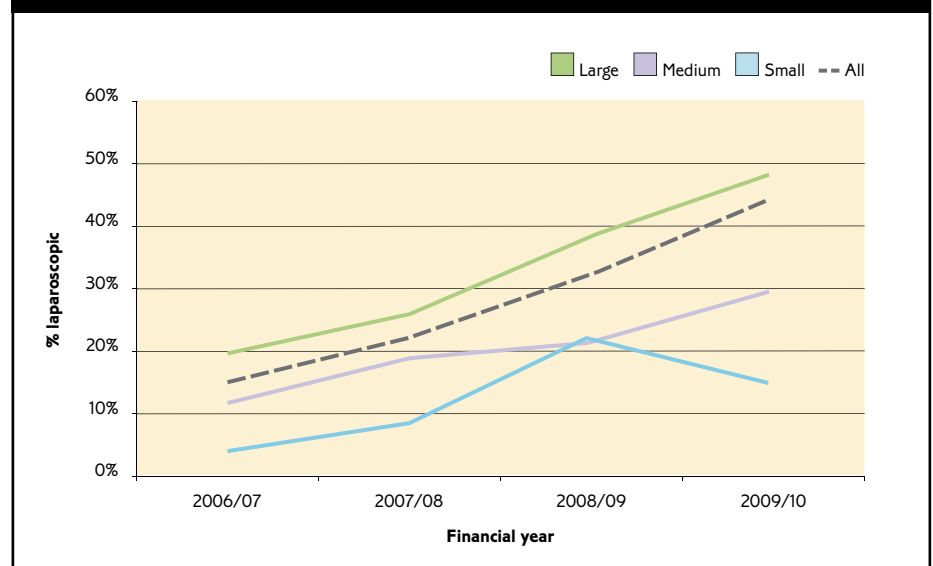
high standards. We have therefore identified the 19 trusts that performed high numbers of operations on people with prostate or bladder cancer from 2007/08 to 2009/10 (see page 25).

In addition, we have identified which of those trusts also performed a significant number of 'laparoscopic' prostatectomy operations during 2009/10. These operations offer considerable benefits to the patient in terms of the speed of operating and the speed of recovery. However, not all trusts have surgeons who are expert in these techniques.

The 2002 guidelines from NICE demanded that pelvic urological cancer surgery should only be undertaken in units where more than 50 procedures are performed every year.

More prostatectomies are now being performed by laparoscopic technique

Source: SUS data 2006/07 to 2009/10.



To a great extent, the guidelines are now being achieved. Over 3,500 prostatectomy operations are being performed in the large trusts each year (defined as trusts doing more than 50 operations a year). Fewer than 1,000 are being performed in small or medium-sized trusts. The use of laparoscopic or keyhole techniques has also increased dramatically, predominantly in the larger centres.

Prostate cancer surgery is on the increase. The total number of operations (both laparoscopic and open) has risen by 33 per cent between 2005/06 and 2009/10. Large trusts have seen a rise of 166 per cent during that time, while medium trusts' activity has fallen by 61 per cent.

In 2006/07 only 15 per cent of prostatectomies were coded as being a laparoscopic procedure; this rate has increased each year and by 2009/10 stood at 44 per cent. The upward trend is true of both large and medium trusts (shown in the graph on page 24).

Removal of the bladder, known as a cystectomy, is another major surgical procedure with many potential complications, and it is probably best performed by surgical teams with great experience. In 2005/06 large trusts (those doing more than 25 operations a year) performed only 21 per cent of cystectomies (304 in total). By contrast, by 2009/10 large trusts accounted for 63 per cent of cystectomies (1,005).

Is it possible to say that the quality of operative urological care has improved? When comparing trusts that perform many procedures with those that only do a modest number, simple measures have shown that their rates of readmissions and length of stay are very similar.

However, the increasing use of sophisticated surgical techniques is concentrated in a small number of trusts, and patients are more likely to get the full range of options in the larger centres.

Surgery for benign conditions

Conventional urological procedures for lower urinary tract symptoms and acute retention of urine – both benign conditions – continue to be undertaken in a wide range of hospitals, with varying quality. One such procedure is transurethral resection of the prostate (TURP). Measuring the need to repeat this operation

Trusts performing high numbers of urological operations on pelvic cancer patients. Source: SUS data 2007/08 to 2009/10.

	Number of cases
North Bristol NHS Trust*	391
Guy's and St Thomas' NHS Foundation Trust*	376
Cambridge University Hospitals NHS Foundation Trust*	330
The Newcastle upon Tyne Hospitals NHS Foundation Trust*	279
Sheffield Teaching Hospitals NHS Foundation Trust*	268
Norfolk and Norwich University Hospitals NHS Foundation Trust	230
Imperial College Healthcare NHS Trust*	225
Leeds Teaching Hospitals NHS Trust	201
Hull and East Yorkshire Hospitals NHS Trust	193
City Hospitals Sunderland NHS Foundation Trust	189
Royal Berkshire NHS Foundation Trust*	182
Nottingham University Hospitals NHS Trust*	179
South Tees Hospitals NHS Foundation Trust	168
Royal Devon and Exeter NHS Foundation Trust	150
University College London Hospitals NHS Foundation Trust	140
Plymouth Hospitals NHS Trust	132
Ashford and St Peter's Hospitals NHS Trust	128
Medway NHS Foundation Trust	125
Central Manchester University Hospitals NHS Foundation Trust	106
*Trusts with more than 40 laparoscopic prostatectomies in 2009/10	

within three years could be a novel way of looking at quality, especially as the data can be used to see when operations are performed in any trust in England.

Trusts with low rates for repeat TURP operations within a three-year period:

- Aintree University Hospitals NHS Foundation Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Derby Hospitals NHS Foundation Trust
- George Eliot Hospital NHS Trust
- Ipswich Hospital NHS Trust
- Luton and Dunstable Hospital NHS Foundation Trust

- Nottingham University Hospitals NHS Trust
- Royal Bolton Hospital NHS Foundation Trust
- Shrewsbury and Telford Hospital NHS Trust
- Southport and Ormskirk Hospital NHS Trust
- University Hospitals of Leicester NHS Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Trusts with high rates for repeat TURP operations within a three-year period:

- Mid Essex Hospital Services NHS Trust
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
- The Queen Elizabeth Hospital King's Lynn NHS Trust

Safety

the foundation for quality



See pages 7-9

Who have we named our trusts of the year?

Wherever medicine is practised in the world, unsafe treatment results in errors and harm to patients. A key part of efforts to improve safety is to accurately measure and monitor the way in which it is being addressed.

99% of all trusts responded to the Hospital Guide survey. Only George Eliot Hospital NHS Trust and University Hospitals Birmingham NHS Foundation Trust failed to submit a response.

1 Is patient safety improving?

A year ago we rated hospital trusts on a range of aspects of patient safety. This year we see if the situation has improved. For all the measures below, full results are available on our website at www.drfoosterhealth.co.uk.

Complying with safety alerts

In our 2009 survey we asked all NHS hospital trusts whether they were meeting basic safety requirements. These are alerts issued by the National Patient Safety Agency (NPSA) which warn hospitals of potentially dangerous practice and advise them what to do to avoid harm to patients. Seven trusts told us that, for one or more of these alerts, it would take them at least six months to become compliant.

This year we asked about alerts that were issued in 2009/10. No trust said it would take longer than six months to become compliant with these alerts. This is a clear improvement on last year.

However, three trusts said they were still not compliant with at least one of the alerts and required a further three months to do this. The alerts included: reducing the risk of overdosing the drug midazolam, and inappropriate use of oral bowel-cleansing solutions prior to surgery. The three trusts were:

- Southend University Hospital NHS Foundation Trust
- St George's Healthcare NHS Trust
- Western Sussex Hospitals NHS Trust

These delays come despite the NPSA clearly stating that its guidance should be acted on immediately. A date for completion is also given.

Track and trigger systems

In last year's Hospital Guide we reported about 'track and trigger' systems. These are regular observations made by nurses, designed to pick up deterioration in a patient's condition.

Last year 64 per cent of trusts said they had this system in place for all acute patients, and this year we are pleased to see this has risen to 79 per cent. But this means that one in five trusts still do not have a track and trigger system in place. To find out the results for your local trust go to www.drfoosterhealth.co.uk.

Commitment by hospital boards

We asked all trusts whether they have a board representative responsible for patient safety, whether they discuss patients' safety at all board meetings, and whether they have clear definitions that enable it to be monitored. This year, as last year, 100 per cent of trusts confirmed that they did.

Infection control

Again we asked all trusts whether they have an antibiotic pharmacist (who has a key role for managing infection risks), whether they have pre-assessment clinics to screen all patients for infections prior to admission, and whether they treat those patients carrying an infection before admitting them (by treatment through a decolonisation routine).

Last year 86 per cent of trusts said that they did all these things. This year it has risen to 97 per cent. However, Walsall Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS Trust told us that they do not employ an antibiotic pharmacist.

Reporting incidents when they happen

Disclosing patient safety incidents through the National Reporting and Learning Service is an important element of managing safety. After last year's guide, this voluntary system now includes some mandatory reporting – a move we welcome. In 2008/09, trusts on average reported five incidents per 100 admissions. This has risen to 5.7 in 2009/10. A higher rate is generally regarded as a positive sign because it shows awareness of errors and near-misses and a culture of freedom to report. The trusts with the lowest rates of reporting are:¹

- Mid Yorkshire Hospitals NHS Trust (2.1 incidents per 100 admissions)
- James Paget University Hospitals NHS Foundation Trust (2.7)
- Winchester and Eastleigh Healthcare NHS Trust (2.7)

2 Measuring patient safety – how big is the problem?

We have looked at how many patient safety incidents were recorded at each hospital trust in 2009/10 using routine data. We know that this underestimates the scale of the problem because the recording of data is still not accurate enough to give a true picture. However, we can say the following:

Pressure sores Approximately 6,000 patients were recorded as having pressure sores while in hospital. Unfortunately we do not know how many patients developed these after arriving, rather than beforehand. But we can say that, in the trusts with the highest rates, more than 3.5 per cent of patients were recorded as having pressure sores.

The information we need

by Lifeblood: The Thrombosis Charity

Deep vein thrombosis is hard to spot. It does not always cause any physical swelling or redness as the textbooks say, so it is often 'clinically silent'. We know from the many calls and stories we receive in the Lifeblood office that many people have their symptoms ignored by health professionals as they do not fit the textbook description.

Knowing how many PEs are actually occurring allows us to monitor how well the condition is being prevented in hospital. We are grateful to Dr Foster for its work in trying to establish the numbers admitted with a diagnosis of PE, and we are just as disappointed that the data is so poor due to the coding system around DVT and PE.

2010 has been a watershed, with the Department of Health setting financial incentives for hospitals in England to assess the VTE risk of all adult admissions. Now, thanks to the Dr Foster team, there is added proof that coding in this area must be improved.

Here is just one of many stories about the serious harm from hospital-acquired clots:

"The risk of a blood clot wasn't even mentioned"

'Amy' was diagnosed with juvenile arthritis aged six, had her first hip replacement at 15 and has now had seven new hips. At her last operation in 2005, aged 32, she did not receive routine thromboprophylaxis pre or post-operatively. Afterwards she was on crutches and not allowed to bear any weight, increasing her risk of developing a blood clot. But this wasn't mentioned and she was sent home without any information.

A month later her leg swelled up. At first she put it down to her arthritis and the strain of hopping about, but it got worse and one day her leg had trebled in size. She called her GP, who lifted her legs, asking if they hurt; she said they did not and he left saying nothing was wrong. But the pain became so severe that her friend took her to hospital.

She was diagnosed with a DVT (a large clot in her thigh), given drugs and kept in bed for two weeks. After being sent home with compression stockings, her leg returned to its normal size in a fortnight. Then she was given three months' warfarin and discharged.

After one DVT, the risk of a second increases. Amy developed a clot two years later after a long-haul flight and is now on life-long warfarin. She has frequent pain and swelling, but her GP only gave her stockings when she showed him a Lifeblood leaflet.

Professor Beverley Hunt is medical director at Lifeblood: The Thrombosis Charity

Pulmonary embolisms (PEs) More than 30,500 admissions were recorded as having PEs while in hospital in 2009/10. This life-threatening condition is a potential complication following a stay in hospital, and there is much that hospitals can do to reduce the risk of it occurring. We found that the rate of recorded PEs varied widely between trusts (see the diagram on page 29), with the highest rates over 3.5 times greater than the lowest.

Obstetric tears Tearing during childbirth can result in incontinence and the need for further treatment. Risks of tearing, however, can be reduced through safe management of patients. More than 13,000 women were recorded as having experienced an obstetric tear in 2009/10 (with a delivery that was not assisted with forceps) and the highest rates were more than six times greater than the lowest. Please visit www.drfoosterhealth.co.uk to find out if your local trust has a high or low rate.

Accidental punctures or lacerations Almost 10,000 hospital patients were recorded as having suffered from an accidental puncture or laceration in 2009/10. This figure is almost certainly an under-recording, and each one of these events could have been avoided.

Post-operative haemorrhages More than 2,000 patients were recorded as having suffered from post-operative intestinal bleeding. This often requires further surgery to treat and can be a life-threatening complication. Again, the levels recorded are likely to be an underestimate.

Post-operative sepsis This is another potentially life-threatening complication. Around 1,300 patients undergoing surgery were recorded as also having sepsis. It must be assumed that in most cases the sepsis was the result of surgery.

3 Preventing blood clots in hospital

A venous thromboembolism (VTE) is a blood clot which develops in a part of the body, usually the leg. Deep vein thrombosis (DVT) is a common type of this condition. Part of a clot may break off and lodge in the arteries that supply the lungs, resulting in a pulmonary embolism (PE). This can often be fatal.

The Department of Health has made sure that the prevention of VTE is a major priority, and it is a key component of the CQUIN scheme (Commissioning for Quality and Innovation). All adult patients admitted to hospital must now be risk-assessed for VTE, and trusts will be required to do a root-cause analysis of all confirmed cases of hospital-acquired VTE.²

The risk of patients developing a blood clot is increased by most surgical and some medical treatments and conditions. In 2001, for example, John Heit from the Mayo Clinic in the US reported that "incidence of VTE is more than 100-fold higher among hospitalised patients compared with community residents".³ In addition, in 2005 the Health Select Committee reported that VTEs could account for 25,000 preventable deaths each year.⁴

We asked trusts in our questionnaire, "What percentage of patients are risk-assessed for VTE on admission?" They told us the following:

Patients assessed for VTE	No. of trusts
100%	6
91-99%	7
61-90%	59
31-60%	36
1-30%	24
0%	1
Did not answer the question	14

The majority of trusts were able to report how many patients were risk-assessed. However, it is a concern that 15 trusts either told us they were not assessing any patients or were unable to provide the information. Also, most trusts need to increase their assessment rates significantly in order to protect patients from risk. See our website for full listings.

Measuring blood clots more accurately



Dr Anita Thomas

Tim Brown

Recognition of the burden of hospital-acquired VTE in England has been consigned to the 'too difficult' box for too many years. In 2005, when we first became involved in the VTE prevention journey in the NHS in England, there was little appetite for exploring routine data in any detail or for considering the data in new ways.

However, under the leadership of Sir Liam Donaldson and now Sir Bruce Keogh, it has become clear that improving coding can provide insight into the number of people each year who develop a hospital-acquired thrombosis.

We have been working with the Dr Foster team to create an evidential basis on which to define hospital-acquired thrombosis. This approach was endorsed recently by the Academy of Medical Royal Colleges through the work of the National Quality Board's VTE sub-group. We are also working with trusts in the south-west to try to improve consistency in coding.

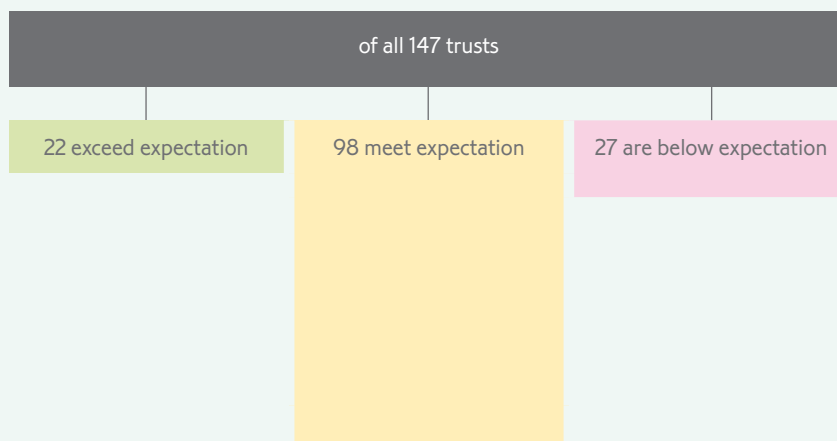
We are still some way from understanding the true incidence of hospital-acquired VTE, and use of discharge coding remains difficult. Post-mortem studies suggest that, in a third of patients where death is caused by a PE, the correct diagnosis is not even suspected beforehand.

Highlighting PEs in this year's Hospital Guide is a welcome contribution to our understanding of the size of the VTE issue. Just as important, though, is the impetus that this published data may provide in stimulating the NHS to locally discuss, publish, use and improve local data on VTE.

Dr Anita Thomas OBE is national clinical director for VTE and Tim Brown is national VTE prevention programme lead, both for the Department of Health

Variation in the rates of pulmonary embolism

Source: SUS data 2009/10, 99.8% control limits.



DID YOU KNOW? Trusts reported 56 incidents of 'wrong site' surgery, as well as 150 'foreign objects' that were left inside patients after an operation.

Why we cannot tell you which trusts are best at preventing blood clots

From the hospital data records, we identified all patients who were recorded as having suffered from a PE. We then took those patients for whom it was recorded as a secondary diagnosis after admission for a different condition or procedure. We also took those patients who were admitted to hospital with a primary diagnosis of PE who had been treated in hospital for a different condition within the previous three months. This is because the risk of developing an embolism following hospital treatment continues for up to 90 days.⁵

Our analysis revealed approximately 30,500 PEs during 2009/10. We know that this is an undercount because many patients with PEs are not coded as such, and instead are recorded as having had unspecified complications caused by their treatment.

As the diagram on page 29 shows, there is wide variation in the number of PEs recorded at each trust. This ranges from 47 per cent below average to 174 per cent above average. However, we do not know the true rate of PEs for each trust. We are also uncertain about the exact number of PEs caused by inappropriate care or inadequate pre-treatment risk assessment. Nevertheless, all hospital trusts must change their coding systems where necessary and ensure that they comply with the mandate to systematically investigate all unexpected PEs.

We are approaching The NHS Information Centre for health and social care, asking it to issue explicit guidance around uniform coding practices. Dr Foster hopes to revisit this topic early next year and be able to identify trusts and their rates.

4 Preventing 'adverse events' in hospitals

For more than a decade, successive reports have attempted to quantify the number of medical mistakes (or 'adverse events') that take place in our hospitals. In 2000 the Department of Health estimated that harm is caused to patients in around 10 per cent of admissions, or at a rate in excess of 850,000 a year.⁶

Ten years later we are still quoting figures based on 'research estimates'. The NHS cannot state categorically how many medical errors take place in its hospitals. Not all hospital chief executives know exactly how many patients are harmed in their units each year, therefore they cannot know exactly how their organisation will prevent harm to all future patients.

Dr Foster has examined routine data to try to gain a picture of the medical mistakes being recorded. In the US, the Agency for Healthcare Research Quality (AHRQ) has been developing ways of measuring these for several years, and in parallel the Dr Foster Unit at Imperial College London has been translating the methods. These have been featured in past Hospital Guides. The AHRQ has also introduced a composite indicator, aggregating this collection of measures into an overall hospital score.⁷ The Unit has reproduced this composite index, using six of the 20 indicators:

- Pressure sores (decubitus ulcer).
- Deaths after surgery (see pages 12-13 for a definition).
- Bleeds or bruises after surgery (post-operative haemorrhage or haematoma).
- Post-operative respiratory failure.
- Post-operative sepsis.
- Accidental puncture or laceration.

Other indicators recommended by the AHRQ were excluded during the research, either as the reported numbers were too small or there was not enough confidence in the coding (ie how well the information was recorded).

In 2009/10, across these six indicators, more than 27,000 potential 'adverse events' were reported. Again, this data does not give us a complete picture because some trusts are better at recording the information than others. In fact we can see that, in general, trusts with high

“It's clear that all trust boards should have the safety of their patients as the number one priority. No matter how dedicated and professional the nursing staff are, things do go wrong and we need to work even harder at tackling avoidable mortality and adverse events.”

Dr Peter Carter, Chief Executive and General Secretary, Royal College of Nursing

rates of incidents are those that tend to have more complete records about their patients. It is not that they have higher rates of medical errors, they are simply better at recording what happens. What is more, trusts that are better at recording information are likely to be better at managing the problems.

On page 31 we list the trusts that are good at recording data, as well as those that are relatively poor at it.

How good are trusts at recording data?

Good data-recording and high 'adverse events'

What this may mean: The coding is more accurate than many other trusts. Those listed below have a high rate of adverse events when compared with the rest of the NHS and this, coupled with the accurate coding, means that there may be potential problems here. The data should be investigated to rule this out.

- Central Manchester University Hospitals NHS Foundation Trust
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Luton and Dunstable Hospital NHS Foundation Trust
- North Bristol NHS Trust
- Nottingham University Hospitals NHS Trust
- Plymouth Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Southend University Hospital NHS Foundation Trust
- St George's Healthcare NHS Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- University Hospitals of Leicester NHS Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- West Hertfordshire Hospitals NHS Trust
- Western Sussex Hospitals NHS Trust

Good data-recording and low 'adverse events'

What this may mean: The coding is more accurate than many other trusts. The low rates are promising because they suggest that fewer medical errors are occurring in these trusts. However, of course, all errors should be investigated.

- Bedford Hospital NHS Trust
- Royal Cornwall Hospitals NHS Trust
- Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- South Devon Healthcare NHS Foundation Trust
- University Hospital of South Manchester NHS Foundation Trust
- Wroughton, Wigan and Leigh NHS Foundation Trust

Poorer data-recording and high 'adverse events'

What this may mean: Coding rates are low compared with other trusts, yet incidents are high. This suggests that the true rate of incidents may be even higher, as not all are being recorded. The recorded incidents should be investigated, and there should also be an assessment to see if more should have been reported.

- Cambridge University Hospitals NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Essex Hospital Services NHS Trust
- North Cumbria University Hospitals NHS Trust
- Oxford Radcliffe Hospitals NHS Trust

Poorer data-recording and low 'adverse events'

What this may mean: Coding rates are low compared with other trusts. This may be the reason for the low rates of incidents. A review may need to take place to ensure that adverse events are being recorded.

- Airedale NHS Trust
- Barking, Havering and Redbridge University Hospitals NHS Trust
- Basingstoke and North Hampshire NHS Foundation Trust
- Buckinghamshire Hospitals NHS Trust
- Calderdale and Huddersfield NHS Foundation Trust
- East and North Hertfordshire NHS Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Heart of England NHS Foundation Trust
- Mid Yorkshire Hospitals NHS Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Shrewsbury and Telford Hospital NHS Trust
- South London Healthcare NHS Trust
- South Warwickshire NHS Foundation Trust
- Southport and Ormskirk Hospital NHS Trust
- The Rotherham NHS Foundation Trust
- The Royal Wolverhampton Hospitals NHS Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Efficiency

how quality saves money

Poor quality care costs the NHS millions of pounds every year. Readmissions are especially in the spotlight due to imminent policy changes, and hospitals should strive to prevent unnecessary extra treatment.

It is easy to see how money can be wasted by poor quality care. For example, patients who get post-operative sepsis spend on average 19 days in hospital (median length of stay), compared with six days for those not infected. Likewise, patients with pressure sores spend an average of 25 days in hospital, as opposed to 10 days for those without. Multiply that by the 6,000 patients who had pressure sores in hospital last year and the cost becomes over £20m a year.¹ All the 'adverse events' listed on page 30 have similar cost implications for the NHS.

Poor performance on patient safety alone could be costing the NHS a minimum of £100m a year in terms of additional hospital care. The fact that safer treatment can cost less is yet another reason for why improving safety is a matter of great urgency.

Operating twice

Revising operations is a wasteful use of NHS resources. In procedures that we have already looked at in this guide, 1 per cent of hip and knee replacement operations require more surgery within a year, and 5 per cent of prostate operations need surgery again within three years. Sometimes this is unavoidable, such as when the patient falls and damages their hip. But the average cost of a hip revision is £7,185.

Returning to hospital

Avoidable emergency readmissions are another way in which poor quality care wastes money. An emergency readmission occurs when a patient returns to hospital soon after a spell of treatment. Last year we reported that more than £1.5bn was spent on emergency readmissions in 2008/09. Our website shows readmission rates for a number of conditions.

Though some readmissions cannot be avoided, a large number of them can be. Often, the cause results from being discharged too early, or from developing a complication or additional health problem that relates closely to the original condition or operation. Being readmitted is of course a poor experience for the patient and, as we have already shown, a costly event for the health service.

Coronary artery bypass graft surgery: the proportion of income for readmissions that were 'avoidable' and the amount of funding that would have been withheld. Source: SUS data 2009/10.

Trusts with the highest percentages of income that would have been withheld	% of readmission income	Amount
Oxford Radcliffe Hospitals NHS Trust	81.8%	£61,462
Nottingham University Hospitals NHS Trust	77.5%	£40,795
Leeds Teaching Hospitals NHS Trust	73.0%	£29,048
Imperial College Healthcare NHS Trust	72.3%	£116,510
Basildon and Thurrock University Hospitals NHS Foundation Trust	71.4%	£87,572
Sheffield Teaching Hospitals NHS Foundation Trust	71.1%	£112,903
Trusts with the lowest percentages of income that would have been withheld	% of readmission income	Amount
University Hospitals of Leicester NHS Trust	42.7%	£27,781
Southampton University Hospitals NHS Trust	44.7%	£64,021
South Tees Hospitals NHS Foundation Trust	45.6%	£83,473
University Hospitals Bristol NHS Foundation Trust	45.8%	£43,590

This issue was recognised by the Coalition Government in June 2010 when it amended the rules around payment in this area. Specifically it said, "There is now an intention to ensure that hospitals are responsible for patients for the 30 days after discharge. If a patient is readmitted within that time, the hospital will not receive any further payment for the additional treatment."²

This policy will come into force in December 2010. Its aim is to bring better coordination between hospitals and community services, and improve post-discharge support. Crucially, in talking about avoidable readmissions, the policy leaves it to the local NHS to decide what 'avoidable' means.

Defining 'avoidable'

Dr Foster has devised a possible definition in one area, coronary artery bypass graft surgery (CABG). We have identified patients who, in the 30 days following a CABG, were readmitted anywhere in the NHS for a set of diagnoses that relate to this procedure and could possibly have been avoided. These include chest pain, a heart attack, a collapsed lung, renal failure and specific complications or bleeds. In each case, wherever the patient was readmitted, we attribute this to the trust where the first operation took place. Details of our methodology can be found on our website.

In 2009/10 there was very wide variation between trusts. At **Oxford Radcliffe Hospitals NHS Trust**, for over 80 per cent of income for emergency readmissions in the month after a heart bypass operation, the causes of those readmissions were potentially avoidable (using our definition).

The table on page 32 shows the trusts with the highest and lowest rates of potentially avoidable readmissions, against the percentage of readmission income that would have been withheld as a result of this new policy coming into force. You can visit the Dr Foster website for the full results.

The long-term cost of poor care

In the six months after being treated in hospital for a stroke, most people need to return to hospital for further care. Overall, seven out of 10 patients will find themselves back in hospital,

How to tackle readmissions



Ben Bridgewater

Dr Foster is continually evolving its methodology by analysing data in more and more detail. By digging deeper, the organisation finds out more about its methods, the strengths and weaknesses of using administrative information for clinical purposes, and individual hospitals' data quality. It is only by appropriate statistical analysis, interpreted alongside clinical understanding, that we will be able to systematically improve the quality of care for patients and make associated cost savings.

The Coalition Government's policy aims to create a strong incentive to minimise the incidence of readmissions, the associated risk and discomfort to patients, and overall costs to the NHS. This does not seem unreasonable. It has been understood for a while that readmission rates following coronary artery surgery are relatively high, and the analysis has found that overall rates are between 10 and 16 per cent across different hospitals. Importantly, Dr Foster has looked at all readmissions, not just those to the hospital providing the surgery.

Coronary artery surgery is a common operation, therefore the associated readmissions have a high overall cost. The methodology used on these pages discriminates between avoidable readmissions (such as wound infections) and unavoidable ones which do not seem to be associated in any way with the recent surgery. This again seems fair, and it is on this basis that Dr Foster has benchmarked hospitals. It will now be up to individual organisations to look at their own results in more detail to understand what lessons can be learned about their data, their quality of care, or Dr Foster's methods.

Ben Bridgewater is consultant cardiac surgeon at University Hospital of South Manchester NHS Foundation Trust

but often this further treatment could have been avoided through better after-care.

Among the most common reasons for ending up back in hospital after a first stroke are: another stroke (one in 10 patients), a urinary tract infection (one in 30) or a broken hip (one in 70). With all these events, the risks of them occurring after a stroke are great, but can be managed. Indeed, in the year after a first stroke, there is double the risk of ending up back in hospital with an infection or a fracture.

These events are costly, and the NHS could save large sums of money if patients are managed better after leaving hospital. When comparing

regions, the rate at which people require further hospital treatment in the six months after a first stroke ranges from 44 to 80 per cent of patients.

Some of this disparity will be due to the types of patients treated, but some of it will be down to variation in after-care. It translates into a difference between £3,400 and £9,500 per patient in the average cost of hospital care within six months of being discharged.

Over the page

Read about our new web-tool for patient experience

Patient experience

not just a medical matter

Good care is not just about treating illness, it is also about treating patients fairly and reasonably. Unfortunately, in striving to address their medical needs, sometimes their human needs can be ignored.



Patient experience is the term used to describe those aspects of healthcare that, though they do not relate directly to the treatment of illness, can make all the difference to whether patients feel that they have been looked after properly. During any stay in hospital, it should be seen as unfair and unreasonable to leave them in pain, accommodate them in dirty wards, fail to attend to their needs, or leave them confused and unsure of what is happening.

Looking after these needs is sometimes seen as less important than delivering safe and effective care. That is a mistake. Of course there are some circumstances when medical needs override all other concerns, such as when a patient is in the grip of a heart attack. But most healthcare is not like that. It is usually about treating an illness and also helping an individual to cope with the impact of that illness and the need for treatment.

Asking the right questions

As a result of the lower priority given to patient experience in the past, we currently have much less information about this aspect of healthcare than we do about clinical standards, outcomes and patient safety.

Every year, Dr Foster conducts a survey of trusts asking about the way that patients are looked after. For instance, trusts are asked whether they are able to let relatives stay with patients overnight (90 per cent do) or whether they have systems in place to support patients dying at home (most do, but in some cases only a small minority of patients who wish to die at home are able to do so).

In addition, all NHS hospitals carry out annual surveys of their patients. These include a range of different questions about whether or not they trusted the staff looking after them, whether they were given enough information about their treatment, and whether they or their relatives were able to speak to doctors and nurses when they needed to.

We have used this information in selecting our trusts of the year. You can download the data from our website at www.drfoosterhealth.co.uk if you wish to do so. In picking this year's top trusts, we have chosen the aspects of patient experience that we feel are most important, then used them to monitor trusts' performance (see the table below). But that is just our opinion; you might have a very different view about which issues matter more than others. For this reason, we have designed a new scoring system on our website.

The Dr Foster Patient Experience Index

Our new index (at www.drfoosterhealth.co.uk/patient-experience) rates all trusts on how well they do at providing a positive experience for patients. However, the score that each trust receives depends on the criteria you select. Here we explain in detail how the index works, or simply go to the website to test it yourself.

As a patient, there are many different aspects to a good experience and not all hospitals do well at all of them.

Some factors relate to the physical aspects of care: is the hospital clean? Are you left waiting

Missing patient notes

In 2009/10, 475 operations were cancelled due to missing notes. These incidents are a waste of time for the patient and usually a waste of money for the NHS. However, 41 per cent of all trusts told us that they had no cancellations. Full results are available on our website.

Trusts with the highest number of cancellations due to missing patient notes:

• Portsmouth Hospitals NHS Trust	38
• North West London Hospitals NHS Trust	23
• University Hospital of North Staffordshire NHS Trust	22

for a long time in uncomfortable waiting rooms? How long do you have to wait for a nurse when you call one? Other factors relate to the human aspects of care: are doctors and nurses able to take the time to talk to you and explain what is happening? Do you feel that you are able to ask questions? Are your fears and concerns being addressed?

Which is better, a hospital where you never have to wait, or one where the nurses always have time to talk to you? That depends on the patient. If you visit the website and tell us what matters most to you, we will tell you which trusts perform best. There are six aspects of a good patient experience that we have listed on the index, as follows:

1. I want my hospital to be clean.

2. I want my stay to be comfortable.

Do the nurses respond quickly when called?

Is pain relief provided promptly?

Are the wards quiet at night?

3. I want to be told what is happening to me.

Do staff have time to talk to you, explain what is happening and involve you in decisions?

4. I do not want to wait for a long time.

How long do patients wait for treatment?

Are operations often cancelled?

5. I want to be treated with respect.

Do some doctors act as if you are not there?

Do you trust the staff looking after you?

6. I want to be treated with compassion.

Do staff talk to you about your worries or fears?

Are relatives able to stay with you overnight?

Of course, patients are entitled to expect that good care entails all of these aspects of patient experience. But it is very useful to know how each trust's strengths and weaknesses compare with patients' priorities. Not only does this help to inform the patients themselves, it also helps trusts to address those areas of care which need the most urgent attention.

Five aspects of patient experience: how well are trusts performing?

Source: Scores from the Care Quality Commission adult inpatient survey 2010.

Key questions we chose	Lowest rate	Average rate	Highest rate
Were you involved as much as you wanted to be in decisions about your care and treatment?	60.0%	70.2%	78.0%
Did you find someone on the hospital staff to talk to about your worries or fears?	47.9%	59.2%	68.2%
Were you given enough privacy when discussing your condition or treatment?	73.7%	80.8%	87.7%
Did a member of staff tell you about medication side-effects to watch for when you went home?	33.8%	45.2%	59.7%
Did hospital staff tell you about who to contact if you were worried about your condition or treatment after you left hospital?	64.3%	74.3%	85.4%

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About Dr Foster

Dr Foster Intelligence aims to improve the quality and efficiency of health and social care through better use of information. We are a joint venture between the Department of Health and Dr Foster Holdings LLP, and provide a unique, innovative public service.

One of Dr Foster's key objectives is to promote the development of an information culture in the NHS by providing appropriate information and analysis to consumers, clinicians, managers and organisations in order to help them deliver the best quality healthcare. Our thought leadership programme seeks to share new thinking, provoke debate and stimulate action in transforming data into knowledge. We are committed to transparency and publish all our methodologies in full.

The Dr Foster Unit at Imperial College London has developed pioneering methodologies that enable fast, accurate identification of potential problems in clinical performance – and areas of high achievement.

Dr Foster works to a code of conduct that prohibits political bias and requires it to act in the public interest. The code is monitored by the Dr Foster Ethics Committee, an independent body chaired by Sir Donald Irvine, chairman of Picker Institute Europe and former president of the General Medical Council.

Our methodology

Most of the indicators in this report are risk-adjusted outcomes. These are where we compare the actual number of events (ie deaths) in an NHS trust against the number of events 'expected' (ie the predicted number of deaths). This latter value accounts for several factors outside the control of a hospital, such as the age and sex of the patient, whether or not they were admitted as an emergency, and certain underlying health conditions. We determine outliers, that is to say 'good' and 'bad' trusts, using 99.8 per cent control limits. This means we are 99.8 per cent certain that the result differs from the expected range and there is a 0.2 per cent risk that it is a 'false positive'. We either calculate adjusted ratios (where performance is compared with a national average of 100) or adjusted rates (which are a percentage).

All our indicators are constructed in partnership with the Dr Foster Unit at Imperial College London and are derived from Secondary Uses Service (SUS) data. The period covered is usually April 2009 to March 2010, although sometimes we have used a longer time period to account for small numbers. We tested out indicators in August 2010 by making them publicly available for comment and by engaging 10 trusts in undertaking case-note comparisons. Our full methodologies are available to see on our website.

Dr Foster also collected data from hospitals using a self-assessment survey approved by The NHS Information Centre for health and social care. Out of all NHS acute trusts, 99 per cent submitted data. Only George Eliot Hospital NHS Trust and University Hospitals Birmingham NHS Foundation Trust failed to submit a response.

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**Commissioned public health services
List of contracts**

Type	Area	Amount	Duration	Renewal date	Lead
SLA	Exercise on referral / cardiac rehab phase 4	£165k	24 months	31/3/12	RDL (3)
SLA	Smoking cessation	£200k	12 months	30/6/12?	JY (3)
SLA	Screening - Breast (KCH) - Cervical (KCH) - Bowel (UHL)	£501,213 £369 K £433K	36 months 36 months 36 months	31/7/14 31/10/11 31/3/12	GH (3)
SLA	Health Promotion Library and leaflets	£104	12 months	31/03/12	PS (2&3)
Community Contract (CC)	Sexual health promotion training	£132k	36 months	31/3/14	JL/AY (2&3)
CC SLA SLA SLA SLA	Sexual health - Chlamydia - Condom Provision - HIV Prevention Programme (local African Programme) - Pan London HIV Prevention Programme - African Health Forum - HIV Testing pilot in Primary Care	£100k £78K £123K £178K £10k £30k	36mths 12mths 12 mths 12 mths 12 mths 12 mths	31/3/14 31/3/12 31/3/12 31/3/12 31/3/12 31/3/12	AY (2)

Notes

(1) held by BSU commissioning

(2) led by Lambeth

(3) led by Southwark

List of contracted Drug and Alcohol Commissioned 'public health' services

Type of contract	Service commissioned	Contract value	Funding stream	Duration	Renewal date	Lead	Category
	Treatment and Outreach						
NHS Standard Contract (NHS SC)	BCDP - Mobile Nx and Health/Outreach Bus	£142,220	SMPTB	Annual	01/04/2012	TL	Drugs
NHSSC	LaSCoT - Running costs of Mobile Bus	£60,000	SMPTB	Annual	01/04/2012	TL	Drugs
	Harm Minimisation						
NHSSC - patr of wider MH contract	SLaM - Needle Exchange Coordination and Materials	£136,305	NHS	Annual	01/04/2012	TL	Drugs
Appendix to Community Pharmacy Contract	Community Pharmacy LES (Needle Exchange) - various Community Pharmacy contractors	£23,000	SMPTB	Annual	01/04/2012	TL	Drugs
NHSSC	GSTT - 3 Borough	£143,191	SMPTB	2 years?	01/04/2013	??	Both
	Criminal Justice Services						
NHSSC	CRi - CJIT (Case	£382,061	DIP	Annual	01/04/2012	TL	Drugs
NHSSC	CRI - Single Point of	£17,939	DIP	Annual	01/04/2012	TL	Drugs
NHSSC	BCDP - Tough Choices	£579,112	DIP	Annual	01/04/2012	TL	Drugs
LA Contract	St Mungos Outreach - DIP	£93,452	DIP	Annual	01/04/2012	SH	Drugs
NHSSC	CRI - DRR Day Programme	£280,564	DIP & SMPTB	Annual	01/04/2012	TL	Drugs
NHSSC	Concateno - DRR Drug	£25,200	SMPTB	Annual	01/04/2012	TL	Drugs
	Direct Access and Tier 3						
NHSSC	F66 E & C Shop front	£370,215	SMPTB	Annual	01/04/2012	TL	Alcohol
NHSSC	BCDP Kappa	£433,565	SMPTB	Annual	01/04/2012	TL	Drugs
NHSSC	BCDP Evolve Crack Service	£365,782	SMPTB	Annual	01/04/2012	TL	Drugs
NHSSC	Multi-agency Access	£8,500	SMPTB	Annual	01/04/2012	TL	Drugs
	Specialist Prescribing and						
NHSSC - patr of wider MH contract	SLAM Southwark CDAT	£3,036,039	NHS & SMPTB		01/04/2012	GK	Both
Appendix to Community Pharmacy Contract	Community Pharmacy LES & LPS (Supvd Dispensing) - various Community Pharmacy contractors	£48,490	SMPTB	Annual	01/04/2012	??	Drugs
	GP Prescribing						
Appendix to General/Personal Medical Services Contract	GP Shared Care - LES1 - various General Practice contractors	£90,000	NHS	Annual	01/04/2012	??	Drugs
Appendix to General/Personal Medical Services Contract	GP Shared Care - LES 2 - various General Practice contractors	£12,000	NHS	Annual	01/04/2012	??	Drugs

Appendix to General/Personal Medical Services Contract	GP Shared Care - LES (Alcohol) - various General Practice contractors	£2,000	NHS	Annual	01/04/2012	??	Alcohol
Appendix to General/Personal Medical Services Contract	Kappa Clinic	£11,500	NHS	Annual	01/04/2012	??	Drugs
NHSSC	BBV Testing (Concateno)	£500	SMPTB	Annual	01/04/2012	TL	Drugs
Appendix to General/Personal Medical Services Contract	GP w Special Interest	£7,296	NHS	Annual	01/04/2012	TL	Both
	Structured Day Care						
NHSSC	BCDP Rise Day Programme	£203,233	SMPTB	Annual	01/04/2012	??	Both
	Inpatient - Crisis Services						
NHSSC	Cranstoun - City Roads	£121,125	NHS & SMPTB	Annual	01/04/2012	??	Both
NHS Standard Contract (NHS SC)	SLaM Inpatients	£150,000	NHS	Annual	01/04/2012	GK	Both
	Inpatient - Detoxification						
NHSSC	Equinox Brook Drive	£290,000	NHS & SMPTB	Annual	01/04/2012	TL	Both
NHSSC	Cranstoun - City Roads (planned)	£416,464	NHS & SMPTB	Annual	01/04/2012	TL	Both
	Residential Rehab						
NHSSC	LBS Adult Social Care - Care Mgmt (Staffing)	£226,049	SMPTB & LA M/stream	Annual	01/04/2012	TL	Both
NHSSC	LBS Adult Social Care - Care Packages (Rehab)	£472,306	SMPTB & LA M/stream	Annual	01/04/2012	TL	Both
Not contracted	LBS Adult Social Care - Care Packages (Long term)	£164,471	LA M/stream				
	Aftercare						
NHSSC	Multi-agency Aftercare @ Users & Carers	£40,000	SMPTB	Annual	01/04/2012	TL	Both
NHSSC	Southwark User Council	£95,412	SMPTB	Annual	01/04/2012	TL	Both
NHSSC	Peer Mentoring	£20,000	SMPTB	Annual	01/04/2012	TL	Both

Key

TL	Tony Lawlor
GK	Gwen Kennedy
JY	Jean Young
NHSSC	NHS Standard Contract
SMPTB	Substance Misuse Pooled
DIP	Drug Interventions Programme
Drugs	Client Group Served - Drugs clients
Alcohol	Client Group Served - Alcohol clients
Both	Client Group Served - Drug & Alcohol clients

Adult Social Care contract details

Contract Description	Supplier Name	Revised End Date
Outreach -Dementia Advocacy and Support	Alzheimers Society Southwark Branch	31/03/2012
Day Care - Mental Health	Blackfriars Settlement	31/03/2012
Mental Capacity Act Advocacy service	Cambridge House Advocacy Service	31/03/2012
Outreach/Support - Neighbourhood Care	Dulwich Helpline	31/03/2012
Outreach/Support - Alone in Hospital Intermediate Care	Dulwich Helpline	31/03/2012
Extra Care Unit - Lime Tree House	In Touch	30/09/2011
Befriending and Home Support	Southwark Churches Care	31/03/2012
Cypriot Day Centre	Southwark Cypriot Day Centre	31/08/2011
Disablement Association	Southwark Disablement Association	31/03/2012
Advocacy/Neighbourhood Scheme	Time and Talents	31/03/2012
Hilltops House Older People	ECHG	30/11/2011
John Perry House Older People	ECHG	31/03/2012
St James Cloister supported housing for older people	ECHG	31/03/2012
Welton Court Older People	ECHG	31/03/2012
Aluna Court teenage parents	EKAYA Housing Association	29/02/2012
Brewster House Older People	Elim Housing Association	31/03/2012
Plowright House Older People	Elim Housing Association	31/03/2012
Long Term Vulnerable Adults	Equinox - Grove Services	31/01/2012
Queens Road - Mental Health	Family Mosaic	31/03/2012
Southwark Sheltered Housing	Hanover Housing Association (HHA)	31/03/2012
Pregnant Teenage/Single Parents	Hexagon	29/02/2012
Helen Peele Memorial Hse - teenage parents	HHA	31/03/2012
Ronald Buckingham court supported housing	Housing 21	31/03/2012
Lime Tree house - older people extra care	Hyde In Touch Support	30/09/2011
Frank Whymark House	Hyde In Touch Support	31/03/2012
Kairos move-on flats for people with alcohol problems	Kairos Community Trust	31/03/2012
Queens Road - learning disability service	Keyring Living Support Networks	30/09/2011
Nunhead Network - learning disability service	Keyring Living Support Networks	30/09/2011
Bush Road mental health supported accommodation	MST (Metropolitan Support Trust)	31/01/2012
Sartor and Borland mental health supported accommodation	MST (Metropolitan Support Trust)	31/01/2012

Lausanne Road mental health supported accommodation	MST (Metropolitan Support Trust)	30/11/2011
DeCrespigny Park mental health supported accommodation	MST (Metropolitan Support Trust)	31/03/2012
Uplands Road mental health supported accommodation	MST (Metropolitan Support Trust)	30/11/2011
SEASONS supported accommodation	MST (Metropolitan Support Trust)	31/12/2012
NACRO Extended hours Housing for Offenders	NACRO Community Enterprises Ltd	31/03/2012
Cerise Road - supported accommodation for young femals	Oasis	31/03/2012
Hindmans Rd supported accommodation	Orbit Housing Association	31/03/2012
Darwin Court supported accommodation	Peabody Trust	31/03/2012
Lomond House supported accommodation	Peabody Trust	31/03/2012
Peabody Court supported accommodation	Peabody Trust	30/11/2011
Southwark domestic violence - Floating Support	Refuge	30/09/2011
Southwark Refuge	Refuge	31/10/2011
Sanctuary Scheme -Floating Support	Refuge	30/09/2011
Arundel Court supported accommodation	SLFHA Ltd	31/03/2012
Barnards House supported accommodation	SLFHA Ltd	31/03/2012
13 Marmora Road supported accommodation	Southside Partnership	30/11/2011
Wren Road Hostel supported accommodation	Southwark Council - Community Housing	31/03/2012
Keyworth Street Hostel supported accommodation	Southwark Council - Community Housing	31/03/2012
SMART	Southwark Council CHS	31/03/2012
Learning Disability Pre-Tenancy Service	Southwark Special Needs	30/09/2011
Older People Hub and Spoke Floating Support Service	Southwark Council CHS	31/03/2012
Elders Assessment	Southwark Council CHS	31/03/2012
Great Guildford Street supported accommodation	St Mungos	31/10/2011
Grange Road supported accommodation	St Mungos	31/10/2011
Supported Lodgings	South London SLYMCA	30/09/2011
Aberdour and Galleywall	Thames Reach	30/09/2011
Tillings Close Permanant supported accommodation for people with mental health problems	Thames Reach	31/01/2012

Roseberry Street supported accommodation for people with mental health problems	Thames Reach	30/09/2011
Tillings Close Short Stay supported accommodation for people with mental health problems	Thames Reach	31/01/2012
TR 3rd Stage supported accommodation for people with drug problems	Thames Reach	30/09/2011
Peckham Rye, 133 - Block Gross supported accommodation for people with mental health problems	Thames Reach	31/03/2012
Thamesreach Permanant Health Focus - Block Gross supported accommodation for people with mental health problems	Thames Reach	31/01/2012
Thomas Milner Hse - Block Gross supported accommodation for people with mental health problems	Thames Reach	31/03/2012
Community Care Advocacy service	Cambridge House Advocacy Service	31/03/2012
Day Services for People with Learning Disabilities	The Camden Society	02/02/2013

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Councillor Eliza Mann	1	Rosemary Watts, Head of Communication & Public Experience
Councillor Emmanuel Oyewole	1	Sarah McClinton, Deputy Director, Adult Social Care
Councillor Poddy Clark [Reserve]	1	
Councillor Neil Coyle [Reserve]	1	
Councillor Mark Glover [Reserve]	1	
Councillor Jonathan Mitchell [Reserve]	1	<u>Southwark Health & Community Services secretariat</u>
Councillor Helen Morrissey [Reserve]	1	Hilary Payne
<u>OTHER MEMBERS</u>		
Councillor Peter John [Leader of the Council]	1	<u>Other Officers</u>
Councillor Ian Wingfield [Deputy Leader]	1	John Bibby, Principal Cabinet Assistant
Councillor Dora Dixon-Fyle [Health & Adult Social Care]	1	Alex Doel, Cabinet Office
Councillor Catherine Bowman [Chair, OSC]	1	Steven Gauge, Opposition Group Office
		Paul Green, Opposition Group Office
		Local Studies Library
		Shelley Burke, Head of Overview & Scrutiny
		Sarah Feasey, Legal Officer
<u>Health Partners</u>		
Stuart Bell, CE, South London & Maudsley NHS Trust	1	
Patrick Gillespie, Service Director, SLaM		
Jo Kent, SLAM, Locality Manager, SLaM	1	
Marian Ridley, Guy's & St Thomas' NHS FT	1	<u>EXTERNAL</u>
Michael Parker, Chair, KCH Hospital NHS Trust	1	Mr C George, Southwark Advocacy Alliance
Phil Boorman, Stakeholder Relations Manager, KCH	1	Rick Henderson, Independent Advocacy Service
Jacob West, Strategy Director KCH	1	Tom White, Southwark Pensioners' Action Group
Julie Gifford, Prog. Manager External Partnerships, GSTT	1	Southwark LINK
Geraldine Malone, chair's PA at Guy's & St Thomas's	1	
		<u>Scrutiny Team [Spares]</u>
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