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FIT FOR THE FUTURE?

DR FOSTER HOSPITAL GUIDE 2012

IS YOUR HOSPITAL FIT FOR THE FUTURE?

DR FOSTER HOSPITAL GUIDE 2012

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THE DR FOSTER TEAM

About Dr Foster

Dr Foster exists to help healthcare organisations improve their quality and efficiency through the use of data. We work with clinicians, healthcare managers and leading academic centres in England and internationally to develop clinically-focused performance metrics, and facilitate positive change through the use of meaningful, accessible and robust analytical insight.

We believe in the value of publishing information on healthcare performance and the contribution this can make to improving care. We are committed to responsible sharing and have made a public promise to collaborate with hospitals before we share findings with

the media. All our methodologies are published in full so that everyone can review and understand our approach.

The Dr Foster Unit at Imperial College London has developed pioneering methodologies that enable fast, accurate identification of potential problems in clinical performance, as well as 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 Dr Andrew Vallance-Owen.



ALL DATA AND METHODOLOGIES CAN BE ACCESSED VIA OUR WEBSITE AT [DRFOSTERHEALTH.CO.UK](https://drfosterhealth.co.uk)



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2012: WHAT HAVE WE LEARNT?

Hospitals are under pressure from

the rising numbers of emergency admissions, particularly among frail elderly patients. For 48 weeks a year most trusts are more than 90% occupied. High levels of occupancy make it harder to provide a safe, effective service.

Wide variations in hospital

mortality rates persist. Twelve trusts did poorly on two of our four measures of mortality. Five did well on three of our four measures.

Mortality rates for patients

admitted at weekends are higher than for those admitted on weekdays. Higher levels of senior medical staffing at weekends are associated with lower mortality rates and we have seen a slight increase in weekend staffing since last year. Five trusts have high mortality rates only at the weekend.

29% of hospital bed days are taken

by patients whose admission might have been avoided if their care was better managed. This includes patients who could have been seen as day cases, patients with conditions that could have been treated in the community and patients who have been readmitted within a week of discharge. While there will always be a need to admit patients in all of these categories, better community and primary care could reduce the numbers.

Trusts that provide cost effective

care by reducing the length of stay in hospital, avoiding emergency readmissions and using resources effectively can also achieve good outcomes. At a time when budgets are under pressure, efficient care must be delivered but not at the expense of quality.

The level of treatment provided to

patients declines as they get older and intervention is less appropriate. Variation in the degree to which it declines may indicate differing clinical views as to which treatments should be available for older patients.

Cambridge University Hospital

NHS Foundation Trust is our trust of the year for providing care that has great outcomes while also being efficient in its use of resources.

Frimley Park Hospital NHS Foundation Trust and **Airedale NHS Foundation Trust** were our two runners-up, also doing well on both aspects of care.

Introduction



The Dr Foster Hospital Guide has, for many years, called for safer medicine and hospital care that consistently delivers

good outcomes. The evidence of wide variations in hospital mortality rates indicates that there is still some way to go to achieve this.

Providing safe, effective care — and treating patients with the compassion they deserve — becomes much harder when there are no free beds left in the hospital. That can happen in the NHS today. As our research this year shows, many acute hospitals are often working at between 95 and 100% capacity. When that happens patients are put in whatever bed can be found, orderly management of admission and discharge can become strained, infections are harder to control and mistakes are more likely to happen.

The answer is not in more hospital beds, but in the fact that many of the people currently in hospital beds would be better off somewhere else. Of particular concern is the number of frail elderly people who are finding themselves admitted to hospital because of lack of access to more appropriate treatment. Last year, 54,915 people were admitted as an emergency to an acute hospital with a diagnosis of nothing more than dementia. Another

151,449 had urinary tract infections which landed them in a hospital bed. Our hospitals are becoming refuges for those who have been let down by the wider health system.

The number of days in hospital spent by people over 75 with multiple underlying illnesses has grown by 15% over the past five years. That is the equivalent of adding two new hospitals to the NHS. Much of what needs to be done to fix this rests with GPs, community services and social care. But there is also much that hospitals can do to improve the efficient use of resources. Better use of day case surgery, avoiding unnecessary admissions and reducing the number of patients who have their operations cancelled after admission would all help. In this year's guide, for the first time, we are comparing hospitals' efficient use of clinical resources alongside indicators of quality of care.

Making better use of hospitals at weekends is another area where the NHS could be more efficient. We have looked at the extent to which scans are available at weekends and the amount of elective surgery performed outside the normal working week. Increasing activity and staffing levels in hospitals at weekends is an efficient use of expensive assets and a way of improving the safety of services.

It is good news that we have seen some increase in hospital staffing at weekends since we looked at the issue last year. However, the issue of poor outcomes at weekends persists.

Finally, in this year's guide we have looked at the issue of varying rates of access to care as people become older. Determining the right level of care for each patient is a difficult decision that involves weighing up the risks of invasive treatments for frail patients against the danger of failing to offer patients' care they would benefit from. The key influence on these decisions should be the views of patients. Variation in levels of treatment suggest that they may at times be driven by the availability of resources and the views of clinicians.

This year, we have given the online guide a revamp. Our website drfosterhealth.co.uk contains information from the guide to help the public find out about their local hospital. In addition, we have created *My Hospital Guide*, where healthcare professionals and consumers can interrogate the data and share their views. Throughout this report, an * indicates that a hospital has posted a comment online. Whether you agree or disagree with our conclusions, I invite you to go online and join the conversation.



ROGER TAYLOR

Co-founder, Dr Foster

HOSPITALS UNDER PRESSURE

KEY FINDINGS

FULL TO BURSTING

The peak occupancy rate for NHS beds is 92%. For 48 weeks a year most trusts are more than 90% occupied.

SUPPORT IN THE COMMUNITY

A lack of integration with social care and community services is contributing to the pressure on NHS hospitals.

A WORSENING PROBLEM

Rising numbers of emergency admissions of frail elderly patients have required an additional 10,000 bed days over the past five years. That is equivalent to two new hospitals.

DECREASED AVAILABILITY

The number of acute and general beds in the NHS has decreased by a third in the past 25 years.¹

TECHNICAL BRIEFING

The number of hospital beds has decreased by a third in the past 25 years¹, as hospital stays have become shorter. However, admissions are rising, especially for groups such as the frail elderly (see page 11). This is one of the main causes for the growing pressure on hospital beds.

The NHS publishes figures for NHS trusts giving the average percentage of hospital beds that are occupied. These figures disguise the highs and lows in occupancy that occur week by week and season by season. According to these figures, the NHS has an average occupancy rate of just over 85%².

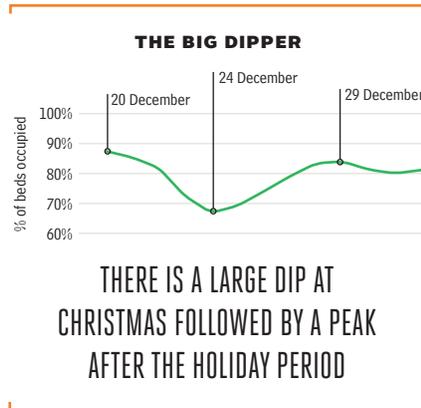
When occupancy rates rise above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.³

Our analysis calculates the number of patients in hospital each day and compares it to the number of beds the hospital says it has available.

Our figures reveal the extent to which occupancy varies from the low points at weekends and during bank holidays to the high points, when occupancy rates at some hospitals can reach 100%. This analysis shows that the average mid-week occupancy in the NHS is 88%, and that for most of the year most NHS hospitals are experiencing occupancy rates above 90%.

When is the NHS closest to breaking point?

Holidays create a dip in bed usage, such as the large dip at Christmas time. Occupancy is highest mid-week (Tuesday or Wednesday) and falls during weekends. Occupancy also varies during the day. We are looking at midnight occupancy but the highest point during the day is at midday.



AVERAGE MID-WEEK BED OCCUPANCY

88%

2011/12

INDIVIDUAL TRUST OCCUPANCY

90%

FOR 48 WEEKS A YEAR, MOST TRUSTS ARE MORE THAN 90% OCCUPIED

HIGHEST BED OCCUPANCY NATIONALLY

92%

FEB 27



TECHNICAL BRIEFING

Nearly one-third of hospital beds are

taken by patients who might not have needed them if their care were better managed. More than 10% of beds are occupied by people with a condition that should not require emergency hospitalisation; conditions which, if well managed, are treatable in the community. A further 6% of beds are occupied by people who have been readmitted as an emergency within a week of being discharged.

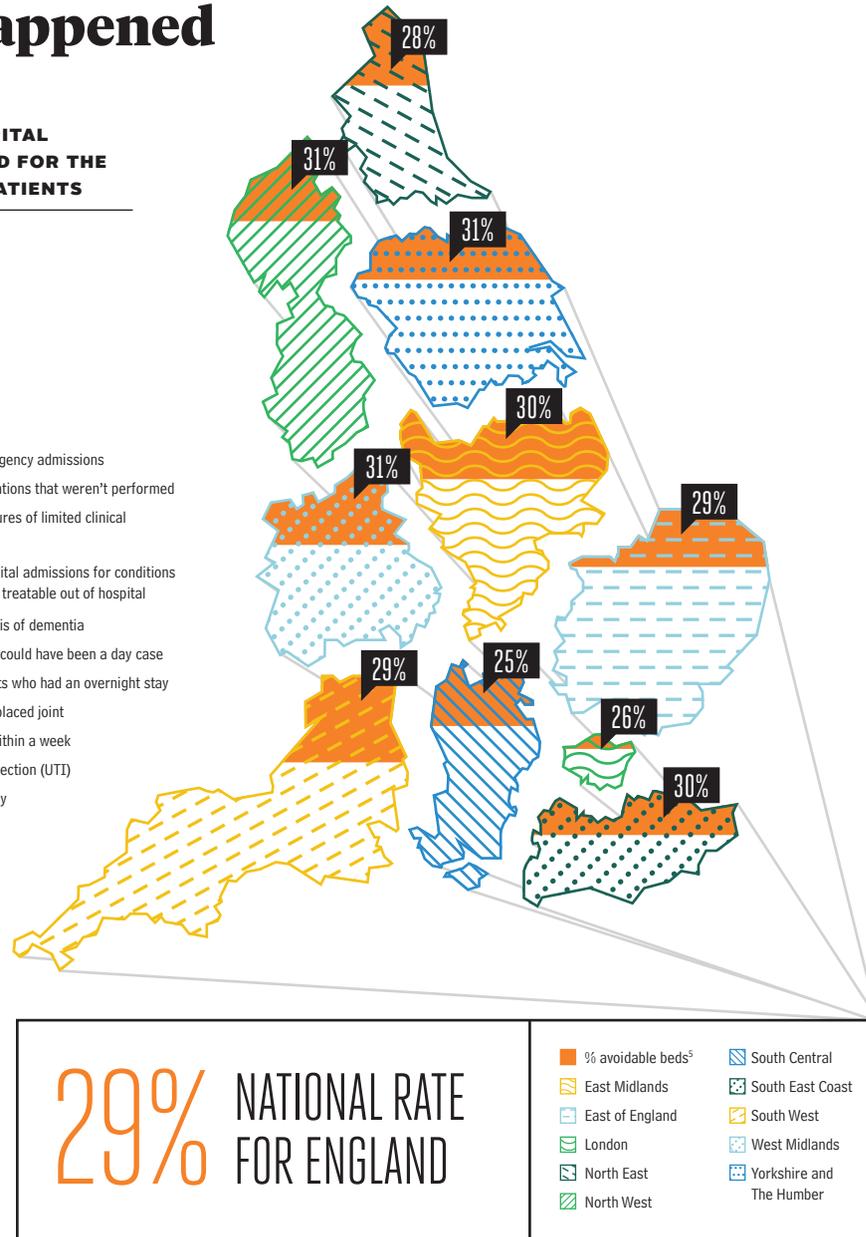
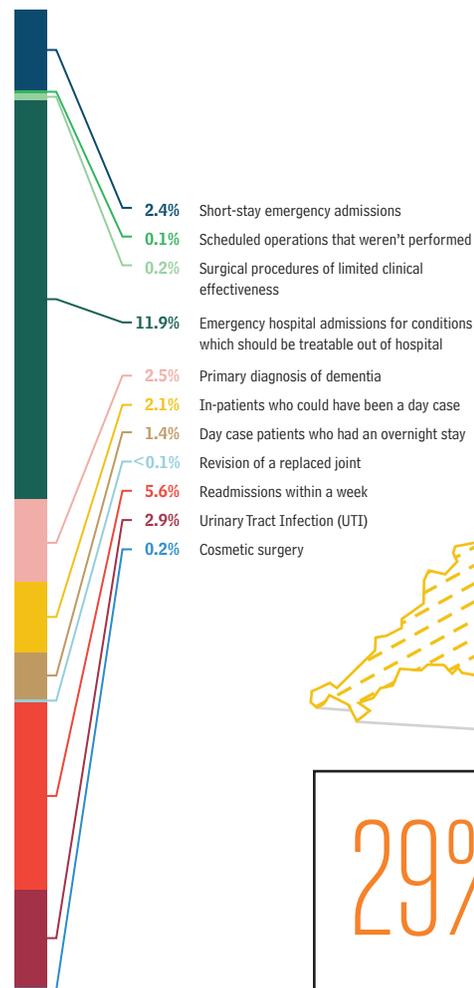
Our list includes several other unfortunate situations, from patients admitted for an operation that was then cancelled, to those who were admitted as emergencies and then discharged home the next day. A quarter of these were discharged without even being given a diagnosis.

More than 2% of beds in the NHS are taken by someone admitted for dementia. This is not the right place for these patients. When we asked acute hospitals if they had a pathway for the management of patients with dementia, only 57% said yes⁴.

Failure to maximise day case surgery accounts for another 2% of bed days, and a further 1.4% of patients were planned as day cases but ended up staying overnight. This is bound to happen for some, but with more than 4% of day case patients experiencing this, there may be room to improve.

Hospital stays that should not have happened

PERCENTAGE OF ALL HOSPITAL BED DAYS THAT WERE USED FOR THE FOLLOWING GROUPS OF PATIENTS



29% NATIONAL RATE FOR ENGLAND

- % avoidable beds⁵
- South Central
- South East Coast
- East of England
- South West
- West Midlands
- London
- North East
- Yorkshire and The Humber
- North West

A system that works against the elderly

ELDERLY PATIENTS OCCUPY BEDS FOR LONGER

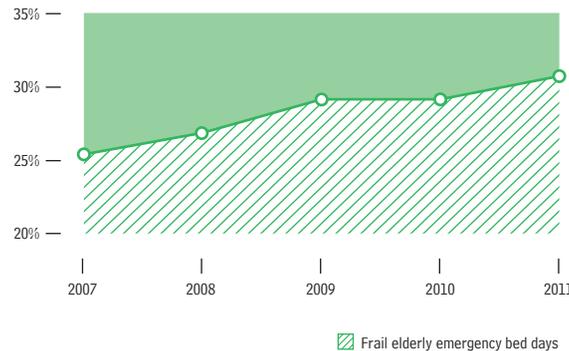
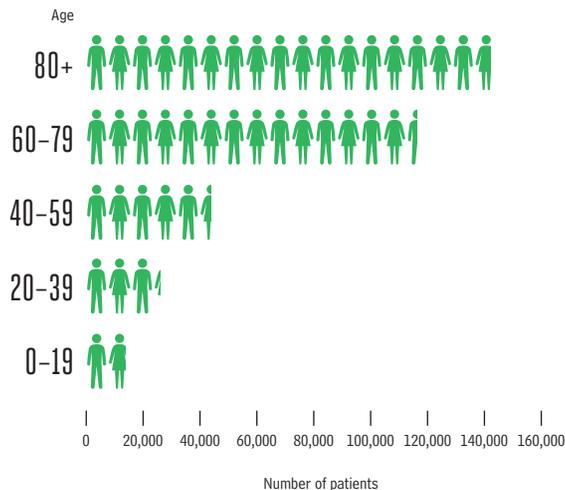
50%

OF AVOIDABLE BED DAYS ARE OCCUPIED BY PATIENTS OVER 75

15%

INCREASE IN BEDS USED BY THE FRAIL ELDERLY IN THE PAST FIVE YEARS⁶. EQUIVALENT TO MORE THAN 10,000 BEDS

PATIENTS SPENDING MORE THAN 30 DAYS IN HOSPITAL IN A YEAR



VIEW FROM THE EXPERT



Michelle Mitchell

Charity Director General, Age UK

Despite being the largest users of NHS services, the chances of older people receiving high quality care are often stacked against them. They stay longer in hospital and are more likely to arrive with complex needs and co-morbidities. Of people over 70 who are admitted to an acute hospital, for example, 27% have previously diagnosed dementia; 24% have possible major depression; 27% have two or more long-term conditions.

Bed occupancy is a major demonstration of this issue. The total number of beds has decreased, but the NHS has failed to fully provide an alternative. Missed opportunities to reduce the need for hospital beds, such as prevention of falls and malnutrition, have combined with fragmented management of long-term conditions and poor provision of effective community services. Left with nowhere else to go, older people frequently arrive at hospital, not necessarily inappropriately, but often avoidably.

Once there, the system further works against them. Older people are more likely to be moved multiple times during their stay and not given comprehensive assessments. The result is a greater chance of readmission and their clinical needs ignored. This is all before the issues identified, showing spikes in bed use and five-day-a-week services, which can mean discharges needlessly delayed and older people admitted at the weekend being at greater risk of dying. Hospitals are a vital part of older people's care. They must work better for their largest users.

KEY FINDINGS

HIGH MORTALITY RATES PERSIST

STAFF INFLUENCE

Low levels of senior doctors continue to be linked to higher mortality rates at weekends

DOING BADLY

Twelve trusts do badly on at least two of our four key measures

DOING WELL

Five trusts do well on three of our four key measures

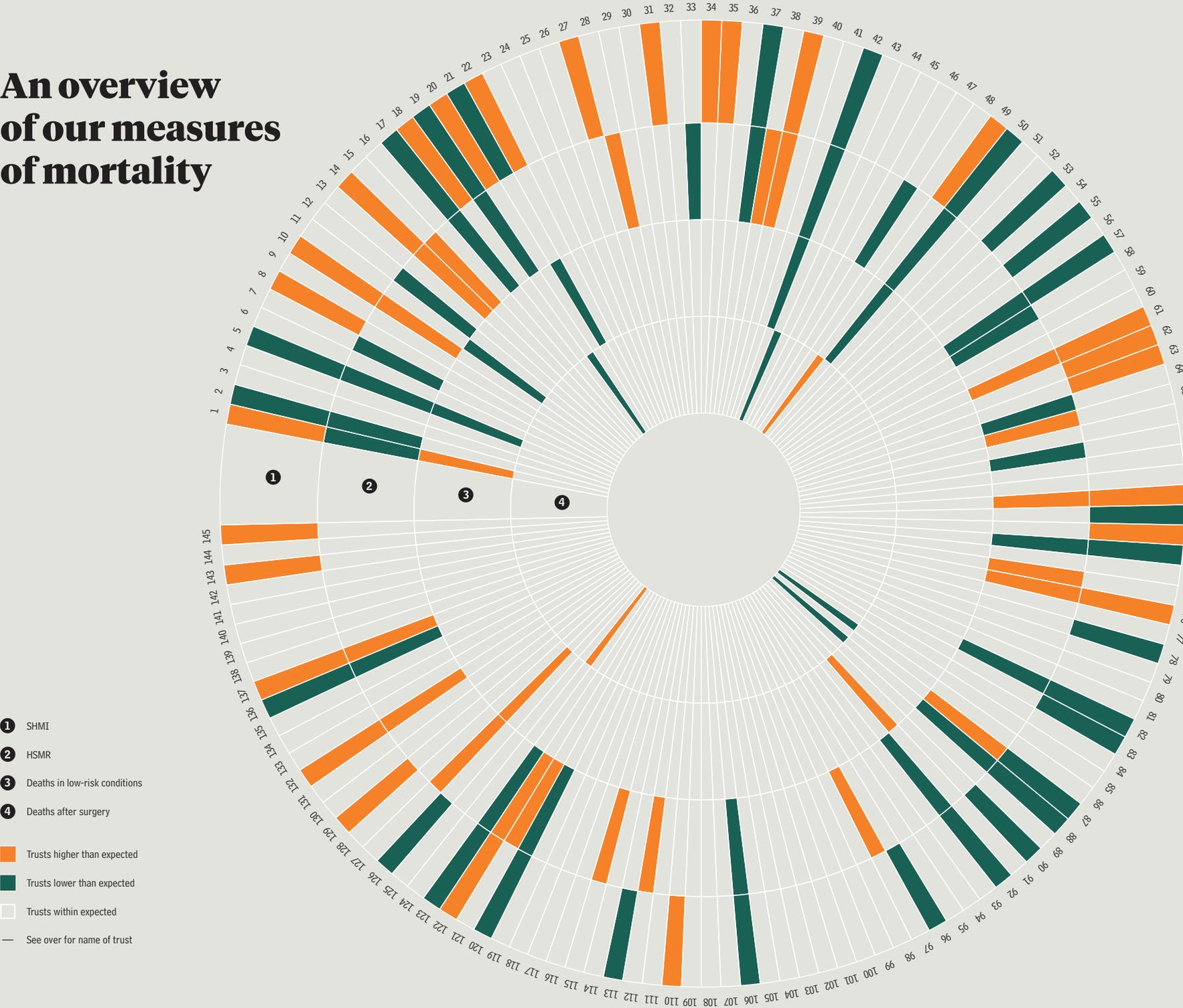
Four measures of mortality are included in this year's Hospital Guide. These measures are to be used as a warning sign of a risk that poor quality care may be leading to a higher than expected mortality.

They are not measures that definitively state that poor quality care is happening. Rather, they are a signal that further investigation should be carried out.

The inquiry at Mid Staffordshire NHS Foundation Trust will examine what went wrong at the trust between January 2005 and March 2009¹. The scale of the failings identified, coupled with the slow pace at which regulators identified those failings, yet again reiterates the compelling case for change. Patients must be assured that they will receive high quality care in every circumstance, no matter where they are.

Since the commissioning of the inquiry in 2010, the NHS has undergone massive structural changes while being charged with achieving unprecedented financial savings. With the rising demand for care and falling revenues, there are concerns that trusts will focus more (or exclusively) on cost of care rather than quality of care. Because of this, there is a fear that there could be another 'Mid Staffs'. Hospital managers must ensure that they do not sacrifice one for the other.

An overview of our measures of mortality



- ❶ SHMI
- ❷ HSMR
- ❸ Deaths in low-risk conditions
- ❹ Deaths after surgery
- Trusts higher than expected
- Trusts lower than expected
- Trusts within expected
- See over for name of trust

HOSPITAL MORTALITY MEASURES

HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

A measure of deaths while in hospital care, based on 56 conditions that account for 80% of deaths. Deaths only take place in hospital. **Uses:** a check on the quality of care in hospitals. High ratios suggest potential underlying problems.

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)

Deaths following hospital treatment. Based on all conditions, deaths are measured that take place in hospital or in the 30 days following discharge. Dr Foster has used the bandings published by The NHS Information Centre for health and social care, which does not adjust for over-dispersion². **Uses:** a check on the quality of care in hospitals and immediately after discharge.

DEATHS AFTER SURGERY

Surgical patients who have died from a possible complication. **Uses:** may indicate problems with surgery, either patients developing complications during surgery or raising questions about whether some operations should have taken place.

DEATHS IN LOW-RISK CONDITIONS

Deaths from conditions where patients would normally survive. **Uses:** to monitor and investigate particularly unexpected deaths.

Trusts that were higher than expected on two out of four measures:

- › Aintree University Hospital NHS Foundation Trust
- › Blackpool Teaching Hospitals NHS Foundation Trust
- › Buckinghamshire Healthcare NHS Trust*
- › George Eliot Hospital NHS Trust
- › Hull and East Yorkshire Hospitals NHS Trust*
- › Medway NHS Foundation Trust
- › North Cumbria University Hospitals NHS Trust
- › Northern Lincolnshire and Goole Hospitals NHS Foundation Trust*
- › United Lincolnshire Hospitals NHS Trust
- › University Hospitals Birmingham NHS Foundation Trust
- › Walsall Healthcare NHS Trust*
- › Western Sussex Hospitals NHS Trust

NHS acute trust [†]	SHMI	HSMR	Deaths in low-risk conditions [†]	Deaths after surgery
1 Aintree University Hospital NHS Foundation Trust	113	89	1.53	81
2 Airedale NHS Foundation Trust	89	78	0.64	71
3 Ashford and St Peter's Hospitals NHS Foundation Trust	100	103	0.54	95
4 Barking, Havering and Redbridge University Hospitals NHS Trust	98	104	0.71	101
5 Barnet and Chase Farm Hospitals NHS Trust	87	91	0.29	94
6 Barnsley Hospital NHS Foundation Trust	108	110	0.73	96
7 Barts and the London NHS Trust	-	86	0.94	97
8 Basildon and Thurrock University Hospitals NHS Foundation Trust	112	102	0.95	97
9 Bedford Hospital NHS Trust	105	91	0.61	129
10 Blackpool Teaching Hospitals NHS Foundation Trust	125	114	0.95	124
11 Bolton NHS Foundation Trust	106	104	0.22	103
12 Bradford Teaching Hospitals NHS Foundation Trust	94	89	0.40	104
13 Brighton and Sussex University Hospitals NHS Trust	95	94	0.96	99
14 Buckinghamshire Healthcare NHS Trust*	112	110	0.55	103
15 Burton Hospitals NHS Foundation Trust	101	112	0.48	60
16 Calderdale and Huddersfield NHS Foundation Trust	103	101	0.36	94
17 Cambridge University Hospitals NHS Foundation Trust	83	81	0.47	89
18 Central Manchester University Hospitals NHS Foundation Trust	111	109	0.46	105
19 Chelsea and Westminster Hospital NHS Foundation Trust	76	80	0.36	7
20 Chesterfield Royal Hospital NHS Foundation Trust	110	105	0.74	106
21 City Hospitals Sunderland NHS Foundation Trust	92	93	0.33	91
22 Colchester Hospital University NHS Foundation Trust	118	102	0.74	109
23 Countess Of Chester Hospital NHS Foundation Trust	106	108	0.82	95
24 County Durham and Darlington NHS Foundation Trust	101	100	0.52	114
25 Croydon Health Services NHS Trust	100	103	0.75	95
26 Darford and Gravesham NHS Trust	103	93	0.45	102
27 Derby Hospitals NHS Foundation Trust	109	103	0.54	88
28 Doncaster and Bassetlaw Hospitals NHS Foundation Trust*	104	109	0.67	101
29 Dorset County Hospital NHS Foundation Trust	106	107	0.70	127
30 Ealing Hospital NHS Trust	91	95	0.73	63
31 East and North Hertfordshire NHS Trust	114	98	0.81	121
32 East Cheshire NHS Trust	100	98	0.40	81
33 East Kent Hospitals University NHS Foundation Trust	100	84	0.87	102
34 East Lancashire Hospitals NHS Trust	113	103	0.55	100
35 East Sussex Healthcare NHS Trust	107	101	1.09	88
36 Epsom and St Helier University Hospitals NHS Trust	96	92	0.77	96
37 Frimley Park Hospital NHS Foundation Trust	88	78	0.50	102

Trusts that were lower than expected on three out of four measures:

- › Barnet and Chase Farm Hospitals NHS Trust
- › Chelsea and Westminster Hospital NHS Foundation Trust
- › Guy's and St Thomas' NHS Foundation Trust
- › Imperial College Healthcare NHS Trust
- › Royal Free London NHS Foundation Trust

38	Gateshead Health NHS Foundation Trust	103	111	1.32	73
39	George Eliot Hospital NHS Trust	116	120	0.80	125
40	Gloucestershire Hospitals NHS Foundation Trust	96	98	1.02	89
41	Great Western Hospitals NHS Foundation Trust	104	106	0.72	113
42	Guy's and St Thomas' NHS Foundation Trust	89	74	0.32	134
43	Hampshire Hospitals NHS Foundation Trust	103	102	0.62	59
44	Harrrogate and District NHS Foundation Trust	99	106	0.20	63
45	Heart Of England NHS Foundation Trust	103	98	0.61	102
46	Heathrow and Wexham Park Hospitals NHS Foundation Trust	102	98	0.62	102
47	Hinchingbrooke Health Care NHS Trust	94	86	0.40	103
48	Homerton University Hospital NHS Foundation Trust	98	104	0.60	65
49	Hull and East Yorkshire Hospitals NHS Trust*	110	105	0.90	155
50	Imperial College Healthcare NHS Trust	76	70	0.17	92
51	Ipswich Hospital NHS Trust	105	101	0.57	59
52	NHS Isle Of Wight	107	106	1.52	112
53	James Paget University Hospitals NHS Foundation Trust	87	93	0.75	80
54	Keitnering General Hospital NHS Foundation Trust	106	102	0.51	110
55	Kingston Hospital NHS Trust	84	93	0.59	90
56	Lancashire Teaching Hospitals NHS Foundation Trust	102	104	0.74	108
57	Leeds Teaching Hospitals NHS Trust*	92	92	0.66	123
58	Lewisham Healthcare NHS Trust	96	86	0.96	55
59	Luton and Dunstable Hospital NHS Foundation Trust	105	103	0.57	68
60	Maldstone and Tunbridge Wells NHS Trust	99	101	0.56	93
61	Medway NHS Foundation Trust	114	112	1.21	124
62	Mid Cheshire Hospitals NHS Foundation Trust	112	110	0.44	85
63	Mid Essex Hospital Services NHS Trust	109	98	0.82	58
64	Mid Staffordshire NHS Foundation Trust	93	84	0.29	77
65	Mid Yorkshire Hospitals NHS Trust	103	108	0.73	119
66	Milton Keynes Hospital NHS Foundation Trust	99	95	0.82	98
67	Newham University Hospital NHS Trust	-	80	0.59	122
68	Norfolk and Norwich University Hospitals NHS Foundation Trust	103	105	0.53	74
69	North Bristol NHS Trust	98	93	0.74	108
70	North Cumbria University Hospitals NHS Trust	112	118	0.94	96
71	North Middlesex University Hospital NHS Trust	82	94	0.30	50
72	North Tees and Hartlepool NHS Foundation Trust*	110	99	0.61	106
73	North West London Hospitals NHS Trust	82	87	0.54	86
74	Northampton General Hospital NHS Trust	105	102	0.49	145
75	Northern Devon Healthcare NHS Trust*	98	118	1.03	64
76	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust*	117	118	0.77	98
77	Northumbria Healthcare NHS Foundation Trust*	102	106	0.85	71
78	Nottingham University Hospitals NHS Trust	93	103	0.76	101
79	Oxford University Hospitals NHS Trust	98	107	0.67	100
80	Pennine Acute Hospitals NHS Trust	105	102	0.63	100
81	Peterborough and Stamford Hospitals NHS Foundation Trust	101	95	0.76	91
82	Plymouth Hospitals NHS Trust	93	90	0.75	78
83	Poole Hospital NHS Foundation Trust	90	95	0.65	167
84	Portsmouth Hospitals NHS Trust	98	99	0.65	81
85	Royal Berkshire NHS Foundation Trust	106	102	0.49	96
86	Royal Cornwall Hospitals NHS Trust	102	103	0.71	61
87	Royal Devon and Exeter NHS Foundation Trust	88	110	0.73	84
88	Royal Free London NHS Foundation Trust	74	73	0.31	70
89	Royal Liverpool and Broadgreen University Hospitals NHS Trust	107	99	0.69	143
90	Royal Surrey County Hospital NHS Foundation Trust	91	112	0.42	102
91	Royal United Hospital Bath NHS Trust	97	104	1.44	109
92	Salford Royal NHS Foundation Trust	86	78	0.77	89
93	Salisbury NHS Foundation Trust	105	104	0.35	85
94	Sandwell and West Birmingham Hospitals NHS Trust	97	99	0.69	89
95	Scarborough and North East Yorkshire Health Care NHS Trust	-	109	1.02	147
96	Sheffield Teaching Hospitals NHS Foundation Trust	92	98	0.85	101
97	Sherwood Forest Hospitals NHS Foundation Trust	103	113	0.74	112

Trusts that have had a consistently high HSMR for the past three years

- › Buckinghamshire Healthcare NHS Trust*
- › The Dudley Group NHS Foundation Trust
- › George Eliot Hospital NHS Trust

98	Shrewsbury and Telford Hospital NHS Trust	107	100	0.76	107
99	South Devon Healthcare NHS Foundation Trust	94	94	1.10	90
100	South London Healthcare NHS Trust	99	96	0.70	93
101	South Tees Hospitals NHS Foundation Trust	97	102	0.98	124
102	South Tyneside NHS Foundation Trust	108	107	1.06	69
103	South Warwickshire NHS Foundation Trust	108	107	0.77	95
104	Southeast University Hospital NHS Foundation Trust	102	95	1.19	84
105	Southport and Ormskirk Hospital NHS Trust	103	93	0.94	93
106	St George's Healthcare NHS Trust	79	83	0.70	124
107	St Helens and Knowsley Hospitals NHS Trust	103	102	0.82	83
108	Stockport NHS Foundation Trust	96	109	1.03	57
109	Surrey and Sussex Healthcare NHS Trust	94	100	0.97	92
110	Tameside Hospital NHS Foundation Trust	118	102	0.99	120
111	Taunton and Somerset NHS Foundation Trust	95	94	0.66	110
112	The Dudley Group NHS Foundation Trust	107	111	0.37	88
113	The Hillingdon Hospitals NHS Foundation Trust	89	107	0.45	74
114	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	95	97	0.51	100
115	The Princess Alexandra Hospital NHS Trust	106	113	1.23	111
116	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	99	104	0.44	72
117	The Rotherham NHS Foundation Trust	105	103	0.65	101
118	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*	100	108	0.48	61
119	The Royal Wolverhampton Hospitals NHS Trust	103	100	0.47	94
120	The Whittington Hospital NHS Trust	71	79	0.55	79
121	Trafford Healthcare NHS Trust	-	121	0.79	104
122	United Lincolnshire Hospitals NHS Trust	109	111	0.88	102
123	University College London Hospitals NHS Foundation Trust	72	76	0.46	109
124	University Hospital Of North Staffordshire NHS Trust	106	104	1.05	155
125	University Hospital Of South Manchester NHS Foundation Trust	97	100	0.62	142
126	University Hospital Southampton NHS Foundation Trust	92	100	0.80	88
127	University Hospitals Birmingham NHS Foundation Trust	105	112	1.57	137
128	University Hospitals Bristol NHS Foundation Trust	95	93	0.68	136
129	University Hospitals Coventry and Warwickshire NHS Trust	107	103	0.71	95
130	University Hospitals Of Leicester NHS Trust	105	102	0.83	101
131	University Hospitals Of Morecambe Bay NHS Foundation Trust	107	107	0.90	108
132	Walsall Healthcare NHS Trust*	113	117	0.62	99
133	Warrington and Halton Hospitals NHS Foundation Trust	107	107	0.57	78
134	West Hertfordshire Hospitals NHS Trust	104	102	0.63	106
135	West Middlesex University Hospital NHS Trust	98	103	0.89	114
136	West Suffolk NHS Foundation Trust	90	86	0.66	89
137	Western Sussex Hospitals NHS Trust	108	108	1.02	93
138	Weston Area Health NHS Trust	105	94	1.11	95
139	Whipps Cross University Hospital NHS Trust	-	105	0.79	58
140	Wirral University Teaching Hospital NHS Foundation Trust	105	108	0.58	99
141	Worcestershire Acute Hospitals NHS Trust	103	107	0.58	103
142	Wrightington, Wigan and Leigh NHS Foundation Trust	106	95	0.59	101
143	Wye Valley NHS Trust*	117	109	0.81	118
144	Yeovil District Hospital NHS Foundation Trust	105	104	0.79	127
145	York Teaching Hospital NHS Foundation Trust	112	104	0.70	92

Hospitals are still understaffed at weekends

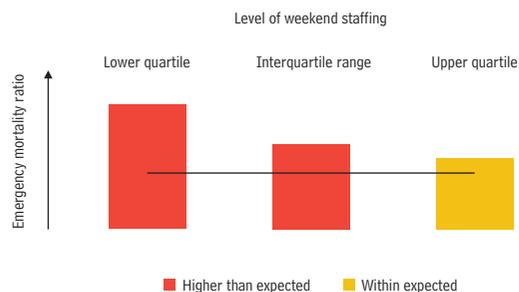
In the 2011 Hospital Guide we drew attention to the relationship between emergency mortality (HSMR) at the weekend and staffing. We found that emergency mortality dropped when trusts had more senior doctors on site. Using data collected through the Hospital Guide Questionnaire we have re-run this for 2012.

We were able to examine the situation in 105 of the 142 trusts. Using the same criteria (senior staff scheduled to be on site⁴), we have calculated the number of staff per 100 beds. This shows a slight increase when compared with 2010/11.

SENIOR STAFF PER 100 BEDS⁵

	2010/11	2011/12
Lower quartile	0.8	0.8
Interquartile range	2.0	2.1
Upper quartile	4.1	4.4

WEEKEND MORTALITY RATIO COMPARED TO SENIOR STAFF/BED RATIO



Hospitals with lower numbers of senior staff have higher mortality rates than those who have more senior staff on site.

The following trusts have had a notable increase in staff numbers since 2010/11, telling us they now have at least two additional members of senior staff per bed.

- > Croydon Health Services NHS Trust
- > Dartford and Gravesham NHS Trust
- > Great Western Hospitals NHS Foundation Trust
- > Imperial College Healthcare NHS Trust
- > NHS Isle Of Wight
- > Sandwell and West Birmingham Hospitals NHS Trust
- > The Rotherham NHS Foundation Trust
- > West Middlesex University Hospital NHS Trust
- > Wirral University Teaching Hospital NHS Foundation Trust

MORTALITY AT THE WEEKEND

The following trusts have an emergency HSMR that is either lower than or within the expected range during the week, and higher than expected at the weekend.

The reason for this could be inadequate staffing levels but, equally, a lack of out-of-hours primary, community or social care services, which means patients are inappropriately admitted to hospital. It could also be because access to tests and scans are not always readily available at weekends.

- > Buckinghamshire Hospitals NHS Trust
- > Mid Yorkshire Hospitals NHS Trust
- > Oxford University Hospitals NHS Trust
- > Royal Cornwall Hospitals NHS Trust
- > The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust*

EMERGENCY HSMR 2011/12: WEEKEND VS WEEKDAY



FIND MORE INFORMATION ABOUT WEEKEND MORTALITY AT DRFOSTERHEALTH.CO.UK

CAN EFFICIENT HOSPITALS DELIVER GOOD QUALITY CARE

KEY FINDINGS



LACK OF CONSISTENCY
between our measures of
quality and efficiency



VERY FEW
hospitals stand out as
delivering efficient and
high quality care



FOUR TRUSTS
score well in both
our measures



TWO TRUSTS
score badly in both
our measures

TECHNICAL BRIEFING

Are the hospitals that are delivering the best quality care also delivering efficient care? And are hospitals who are struggling to cut costs also compromising on standards?

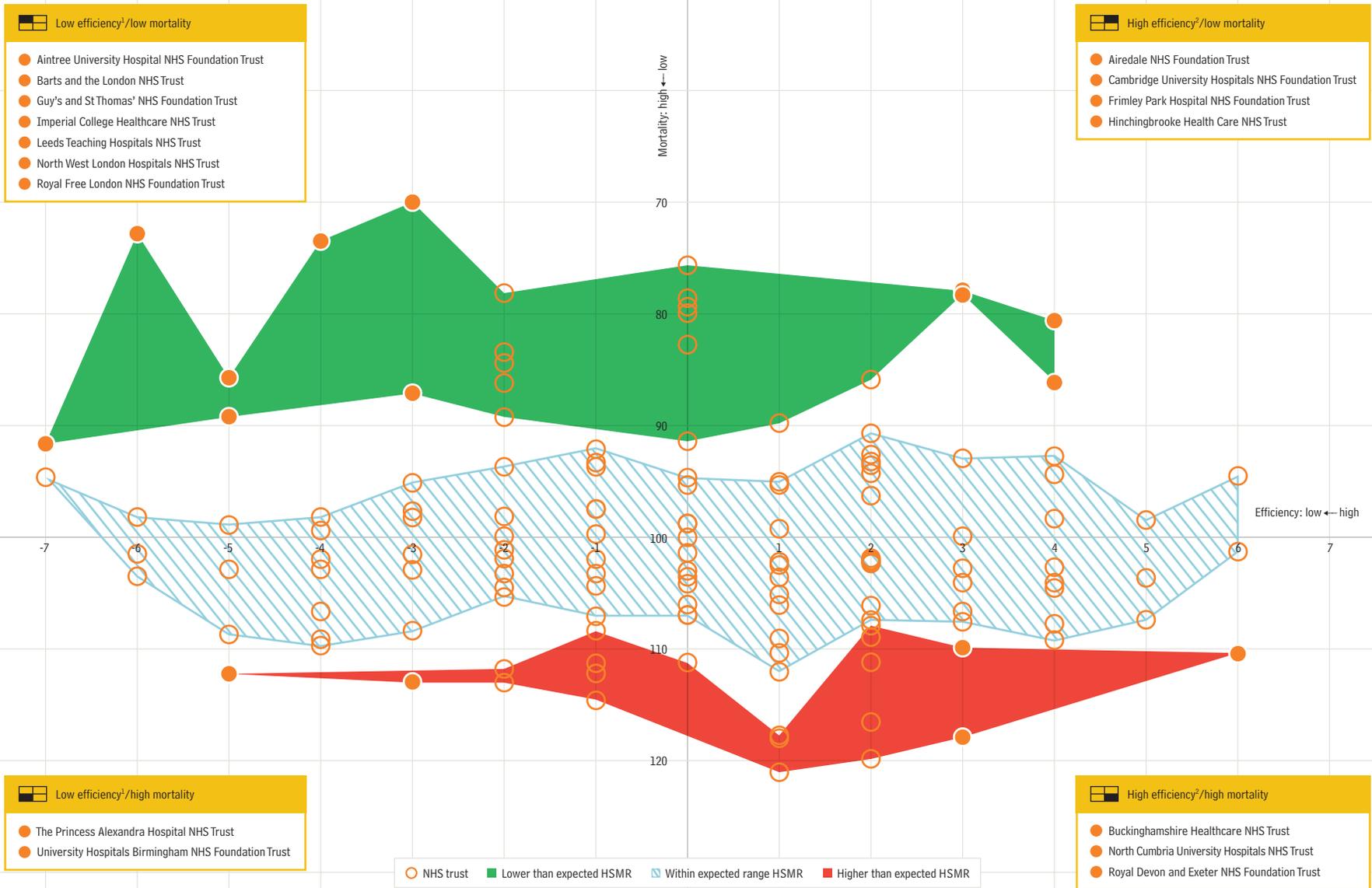
Dr Foster has looked at the relationship between clinical efficiency and quality by comparing mortality ratios with an index of 13 indicators of inefficient practice. These include emergency readmissions, long lengths of stay, discharges without a diagnosis, patients not attending and ineffective procedures.

Although there is no strong relationship between our measures of outcome and clinical efficiency, some hospitals with the best mortality ratios in the country also perform well on measures of efficient use of resources. We have identified hospitals with significantly high and low mortality ratios that also score well (3 or more net positive scores) or less well (-3 or less) on our metrics of efficiency.



**FIND MORE INFORMATION
ABOUT EFFICIENCY AT
DRFOSTERHEALTH.CO.UK**

Comparing clinical efficiency with mortality



OPPORTUNITIES FOR EFFICIENCY

KEY FINDINGS

FINANCIAL CRISIS

NHS trusts are currently facing a financial environment that is forcing them to become more efficient in the services they provide. Some are better than others in this regard.

ROOM FOR IMPROVEMENT

No trust has a highly efficient result in every indicator, meaning every trust has areas in which it can improve.

QUALITY OF CARE

This drive to be efficient and address the financial deficit that exists for many hospital trusts should not be at the expense of quality. The drive should be for improvements in quality and consistency of care between trusts at the same time.

TECHNICAL BRIEFING

We looked at 13 aspects of clinical efficiency. Some of these are within the control of the hospital, such as increasing rates of day case surgery. Some depend on working with the wider health economy, such as reducing readmission rates or making use of operating theatres at weekends. Clinical efficiency is only one aspect of running an efficient hospital. But the wide variations we found reveal scope for reducing costs.

AREAS OF INEFFICIENCY

READMISSIONS

UNNECESSARY ADMISSIONS

SPENDING TOO LONG IN HOSPITAL

OUTPATIENT APPOINTMENTS

WEEKEND WORKING

The best and worst performers¹



NHS trusts with serious financial concerns

However good a hospital is at delivering clinically efficient care, and however effectively it uses its resources, it does not mean that hospitals will be either cost effective or financially viable. Effective use of estates and workforce, PFI costs and simply the scale of the organisation will have a big impact on whether hospital trusts can keep their finances in balance.

Some trusts that do well on our measures of clinical efficiency are nonetheless struggling to cope with the financial pressures currently affecting the NHS. The number of trusts currently reporting financial difficulties is rising², culminating in South London Healthcare NHS Trust being placed into administration in summer 2012³.

The Audit Commission has reported the following organisations as being in deficit in 2011/12⁴:

- > Barking, Havering and Redbridge University Hospitals NHS Trust
- > Epsom and St Helier University Hospitals NHS Trust
- > Imperial College Healthcare NHS Trust
- > Mid Essex Hospital Services NHS Trust
- > Mid Yorkshire Hospitals NHS Trust
- > Newham University Hospital NHS Trust
- > North West London Hospitals NHS Trust
- > South London Healthcare NHS Trust
- > Surrey and Sussex Healthcare NHS Trust
- > Whipps Cross University Hospital NHS Trust

Monitor has concerns about the current financial position at the following⁵:

- > Bolton NHS Foundation Trust
- > Burton Hospitals NHS Foundation Trust
- > Derby Hospitals NHS Foundation Trust
- > Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- > Medway NHS Foundation Trust
- > Mid Staffordshire NHS Foundation Trust
- > Milton Keynes Hospital NHS Foundation Trust
- > Peterborough and Stamford Hospitals NHS Foundation Trust
- > Sherwood Forest Hospitals NHS Foundation Trust
- > Tameside Hospital NHS Foundation Trust
- > The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust
- > University Hospitals Of Morecambe Bay NHS Foundation Trust

READMISSIONS: £1.8BN COSTS

Emergency readmissions within

seven days of discharge from hospital cost £778.6 million in 2011/12. This is 43% of the cost of all emergency readmissions within 28 days of discharge. Emergency readmissions within seven days include many that are avoidable. They indicate areas where hospitals could better manage the pathways of patients.

Nearly a third (31%) of readmissions within 28 days of a hospital discharge are for patients over 75 years old. The costs associated with these emergency readmissions are 42% higher than those for younger patients⁶. This highlights the crucial importance of effectively managed discharges and care within the community.

LOWEST SEVEN-DAY READMISSION RATES

Weston Area Health NHS Trust	2.2%
Wye Valley NHS Trust*	2.2%
Hinchingbrooke Health Care NHS Trust	2.2%
Bedford Hospital NHS Trust	2.2%
University College London Hospitals NHS Foundation Trust	2.2%

HIGHEST SEVEN-DAY READMISSION RATES

Lewisham Healthcare NHS Trust	4.5%
Northumbria Healthcare NHS Foundation Trust	4.1%
Milton Keynes Hospital NHS Foundation Trust	4.0%
Heart Of England NHS Foundation Trust	4.0%
Warrington and Halton Hospitals NHS Foundation Trust	3.9%

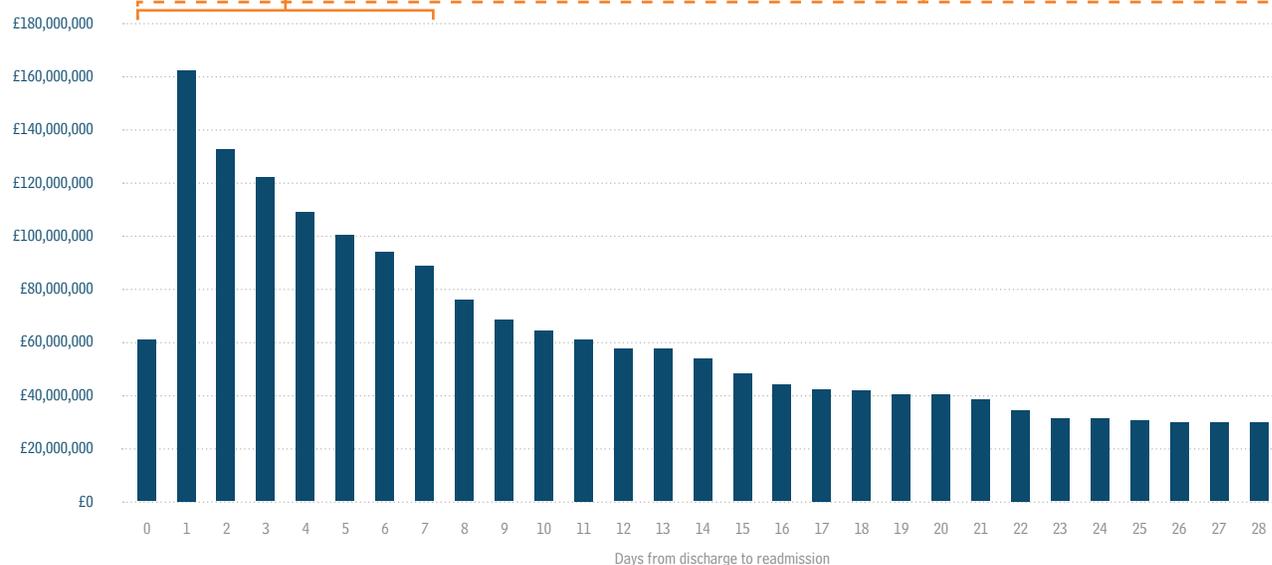
READMISSIONS COST BY DAY

£778,642,487

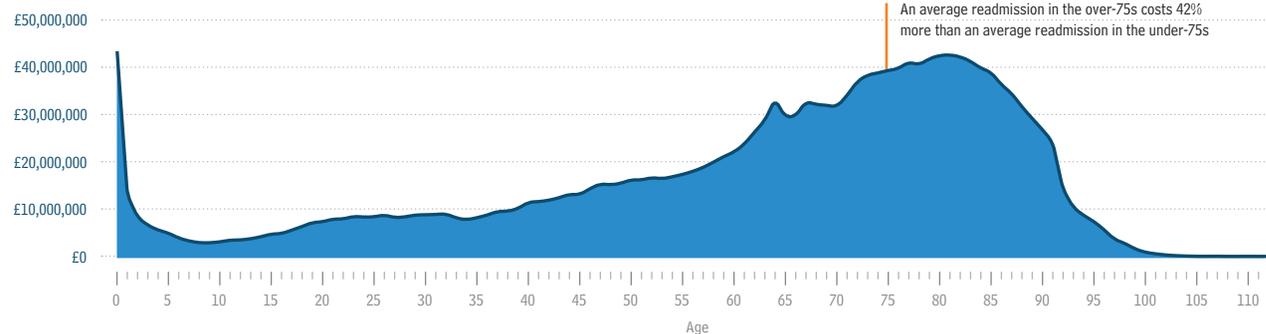
TOTAL COST FOR READMISSIONS WITHIN SEVEN DAYS

£1,812,130,272

TOTAL COST FOR READMISSIONS WITHIN 28 DAYS



READMISSIONS COST BY AGE



UNNECESSARY ADMISSIONS: ONE MILLION HOSPITAL STAYS OF LITTLE OR NO BENEFIT TO THE PATIENT

Being admitted to hospital to have an operation that is then cancelled wastes NHS resources and the patient's time. While the rate at which operations have been cancelled after admission has been falling in recent years, it still happened to more than 200,000 patients last year.

Clinical judgement is needed to decide when to admit patients to hospital who have arrived at A&E with symptoms that may indicate a serious illness but might be nothing at all. We looked at how often patients are admitted with vague symptoms, spend a brief time in hospital (no more than one night) and then leave without being assigned a diagnosis.

It happened more than half a million times last year. Hospitals with high rates should consider whether their processes in A&E are working as well as they could do.

Evidence that certain operations such as tonsillectomies or knee wash operations are of little or no benefit to patients has been available for some time⁷. There have been calls to reduce the number of these procedures, which has resulted in a fall of 15% over the past four years. However, more than 175,000 such operations took place in the NHS last year.

SCHEDULED OPERATIONS THAT WERE NOT PERFORMED: BY YEAR



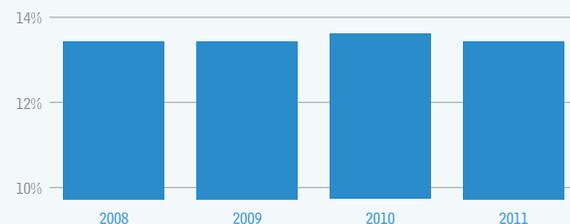
SCHEDULED OPERATIONS THAT WERE NOT PERFORMED: LOWEST RATES

University College London Hospitals NHS Foundation Trust	1.3%
Heart of England NHS Foundation Trust	1.7%
Sheffield Teaching Hospitals NHS Foundation Trust	1.7%
Gloucestershire Hospitals NHS Foundation Trust	1.9%
Buckinghamshire Healthcare NHS Trust	1.9%

SCHEDULED OPERATIONS THAT WERE NOT PERFORMED: HIGHEST RATES

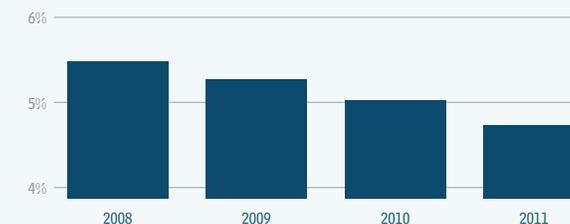
Harrogate and District NHS Foundation Trust	5.7%
Newham University Hospital NHS Trust	5.0%
North West London Hospitals NHS Trust	4.4%
Northampton General Hospital NHS Trust	4.3%
NHS Isle Of Wight	4.3%

SHORT-STAY ADMISSION WITHOUT A DIAGNOSIS



	HIGHEST	NATIONAL RATE	LOWEST
	21.6%	13.2%	6.5%
Total number of short-stay emergency admissions with a vague diagnosis:	669,319		
Total cost of short-stay emergency admissions with a vague diagnosis:	£409,754,802		

PROCEDURES OF LIMITED CLINICAL EFFECTIVENESS



	HIGHEST	NATIONAL RATE	LOWEST
	13.0%	4.7%	1.7%
Total number of procedures of limited clinical effectiveness:	175,106		
Total cost of procedures of limited clinical effectiveness:	£260,757,480		

SPENDING TOO LONG IN HOSPITAL: 490,808 EXCESS BED DAYS

A longer length of stay in hospital

than necessary is undesirable for both the patient and the hospital. Hospitals working at high levels of efficiency will not keep patients in hospital longer than is necessary, allowing the beds to be used by additional patients.

Excess bed days looks at the number of patients who stayed in hospital longer than a predicted number of days (or 'trim point'). The percentage of bed days taken by patients staying longer than the trim point varies from 4% to 23% from the best to worst trusts.

Similarly, trusts should do all they can to discharge patients as early as possible following planned surgery. However, only 57% of trusts confirmed in our survey that they had an enhanced recovery programme (which helps them discharge patients early) following hip and knee replacements.

Day surgery has grown rapidly in recent years. It has reduced demand for hospital beds and improved the experience of care. We have looked at operations where it is estimated that more than 90% of patients could be treated as day cases⁸. In some hospitals, almost 96% of these patients were treated as day cases. In others it was only 78%. The variation is even greater among operations where day case surgery is a newer innovation, such as laparoscopic gallbladder operations.

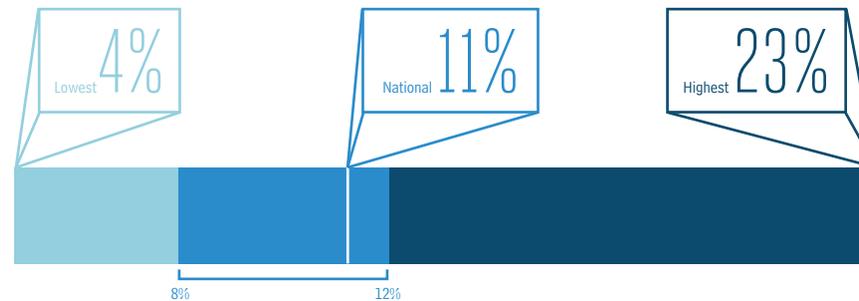
LOWEST EXCESS BED DAY RATES

▼ Epsom and St Helier University Hospitals NHS Trust	4.1%
▼ George Eliot Hospital NHS Trust	4.5%
▼ Weston Area Health NHS Trust	4.5%
▼ Southport and Ormskirk Hospital NHS Trust	5.1%
▼ East Cheshire NHS Trust	5.2%

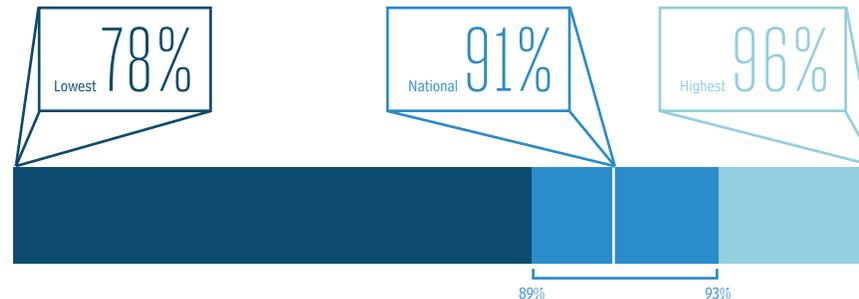
HIGHEST EXCESS BED DAY RATES

▲ University College London Hospitals NHS Foundation Trust	23.0%
▲ East Sussex Healthcare NHS Trust	21.6%
▲ Royal Free London NHS Foundation Trust	19.7%
▲ Brighton and Sussex University Hospitals NHS Trust	18.7%
▲ Northampton General Hospital NHS Trust	18.5%

EXCESS BED DAYS: TRUST RATES

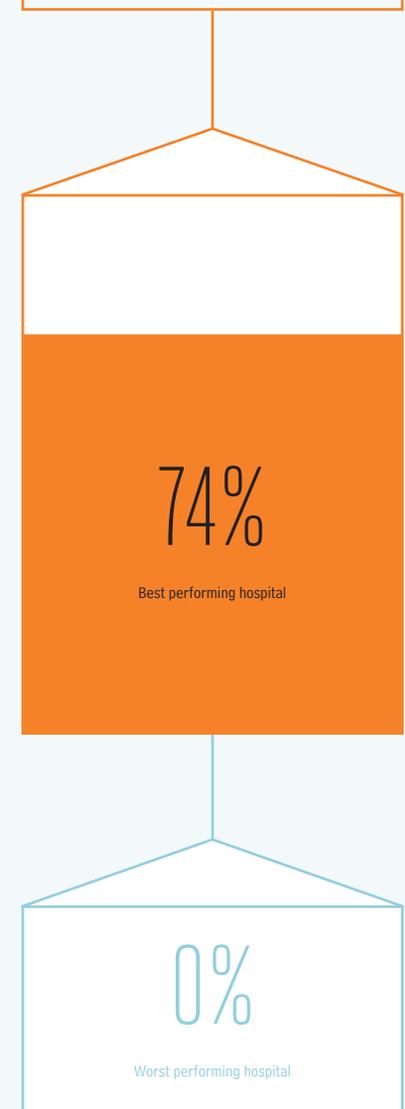


USE OF DAY CASE SURGERY: TRUST RATES



— Interquartile range

LAPAROSCOPIC GALLBLADDER SURGERY CAN NOW BE DONE AS A DAY CASE:



WASTED OUTPATIENT APPOINTMENTS: 5.8M NOT ATTENDED

Efficient outpatient departments

should have high attendance rates and minimise the number of follow-up appointments that patients need.

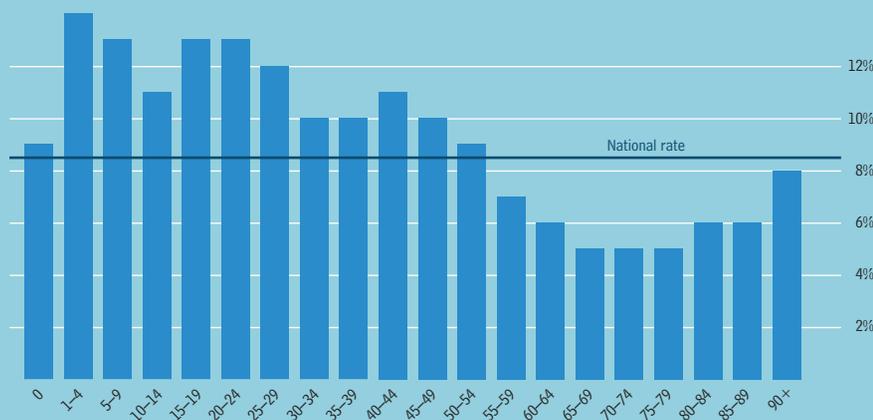
Last year, 5.8 million outpatient appointments were missed by patients, representing a lost potential revenue to the NHS of £585 million. Younger patients have a higher rate of non-attendance than the elderly. Also, people in more deprived areas are significantly more likely not to attend (see graph below). As a result, hospitals in inner cities face a difficult challenge to reduce levels of missed appointments.

Both primary and secondary care providers can take measures to improve the proportion of patients who attend hospital outpatient appointments.

Where hospitals have high rates of follow-up appointments, many of the hospital visits may be unnecessary. Phone calls and visits to the GP to check the patient is OK are often enough.

Nationally, for each initial outpatient appointment, there were 2.2 follow-up appointments. At some trusts there are 3.4 follow-up appointments for every first appointment.

OUTPATIENT APPOINTMENTS NOT KEPT, BY AGE RANGE



Appointments for patients under 30 have a high rate of non-attendance

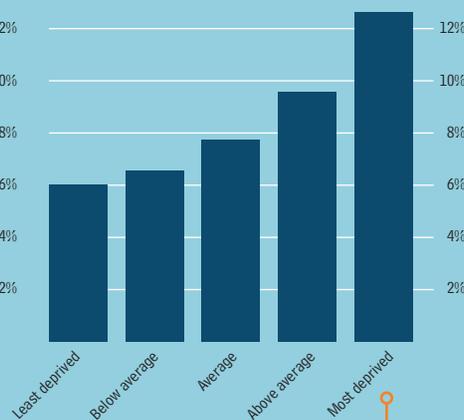
OUTPATIENT NON-ATTENDANCE: LOWEST RATES

▼ Hinchingbrooke Health Care NHS Trust	4.5%
▼ Harrogate and District NHS Foundation Trust*	5.0%
▼ Salisbury NHS Foundation Trust	5.2%
▼ The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	5.2%
▼ Shrewsbury and Telford Hospital NHS Trust	5.3%

OUTPATIENT NON-ATTENDANCE: HIGHEST RATES

▲ Middlesex University Hospital NHS Trust	15.6%
▲ Ealing Hospital NHS Trust	13.8%
▲ Homerton University Hospital NHS Foundation Trust	13.7%
▲ Aintree University Hospital NHS Foundation Trust	13.7%
▲ Central Manchester University Hospitals NHS Foundation Trust	13.5%

OUTPATIENT APPOINTMENTS NOT KEPT, BY DEPRIVATION GROUP



There is a high rate of non-attendance in highly deprived areas

HOW MANY OUTPATIENT FOLLOW-UP APPOINTMENTS DO YOU GET?

NATIONAL RATE

1:2



First appointment



Follow-up appointments

MAXIMUM RATE

1:3



First appointment



Follow-up appointments

THAT EXTRA APPOINTMENT COST THE NHS £295 MILLION IN 2011/12

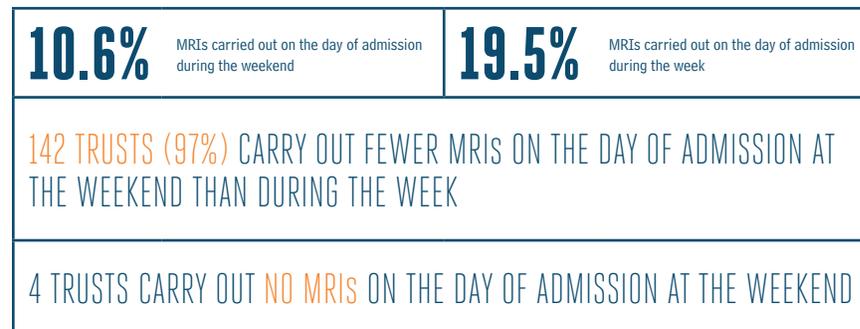
WEEKEND WORKING: 4% OF OPERATIONS PERFORMED AT WEEKENDS

Moving to seven-day working can bring efficiencies if it means operating theatres and scanners are used more frequently. Currently, much of the expensive equipment that the NHS has invested in lies unused at the weekend.

Few hospitals offer many elective services at weekends currently and many of those that do are doing so in order to clear waiting lists. These short-term initiatives are often costly. However, planned activity at weekends can, if properly organised, save money.

The proportion of a basket of common elective operations performed in hospital at weekends⁹ varies from close to zero to 16%. We also looked at how frequently emergency patients who needed an MRI scan had it on their day of admission. In some hospitals, this was more likely to happen at weekends than on weekdays. But in some hospitals, no patients received scans over the weekend.

FEWER SCANS AT THE WEEKEND



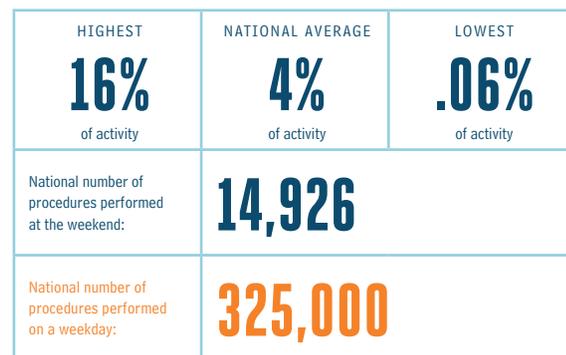
HIGHEST WEEKEND MRI RATES

- ▲ Barking, Havering and Redbridge University Hospitals NHS Trust
- ▲ Barts and the London NHS Trust
- ▲ Buckinghamshire Healthcare NHS Trust
- ▲ Royal Surrey County Hospital NHS Foundation Trust
- ▲ Salford Royal NHS Foundation Trust
- ▲ St George's Healthcare NHS Trust
- ▲ University Hospital Southampton NHS Foundation Trust
- ▲ University Hospitals Of Leicester NHS Trust

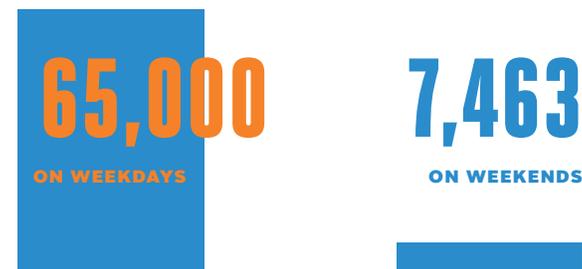
LOWEST WEEKEND MRI RATES

- ▼ Chesterfield Royal Hospital NHS Foundation Trust
- ▼ County Durham and Darlington NHS Foundation Trust
- ▼ Homerton University Hospital NHS Foundation Trust
- ▼ Mid Staffordshire NHS Foundation Trust
- ▼ Tameside Hospital NHS Foundation Trust
- ▼ West Hertfordshire Hospitals NHS Trust

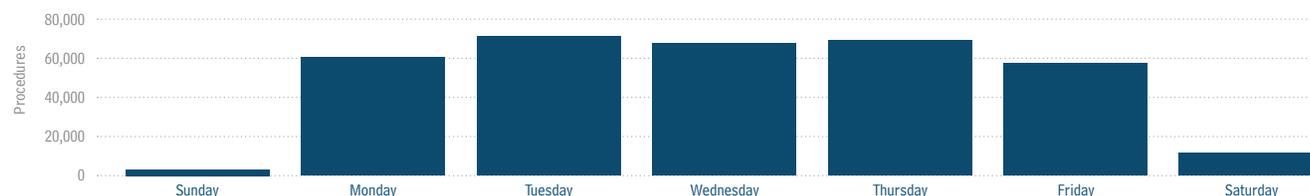
10 COMMON PROCEDURES: HOW MANY ARE PERFORMED AT THE WEEKEND?



WHEN DO PLANNED OPERATIONS HAPPEN?



WHEN ARE OPERATIONS LIKELY TO BE PERFORMED?



VIEW FROM THE EXPERT



Hannah Farrar

Director of Strategy
and Commissioning
Development, NHS London

The conclusions in the Hospital Guide, that almost all trusts can improve the relationship between cost and quality, aligns with work undertaken at NHS London. In the SaFE programme¹⁰, we examined the sustainability of 18 NHS trusts in London and, as part of this, we explored the relative productivity of each trust compared to its peers in England.

We found that the variation in cost is great and that this does not relate to the quality of services provided. High cost and high quality don't correlate because, first, quality can be achieved by excellent lean processes, and second, you can spend money unproductively without any quality benefit accruing.

We need to develop the evidence base on value such that we better understand the minimum costs necessary to deliver high quality; the capability required to optimise cost and quality; and what incremental investments in cost add which quality benefit.

Trust of the year



This year we have awarded our trust of the year award to Cambridge University Hospitals NHS Foundation Trust. It scored well on our efficiency index (see page 19), and has lower than expected rates on two of our four mortality measures, and no concerns on the other two measures (see page 14).

'PATIENTS COME FIRST AND THE QUALITY OF CARE WE PROVIDE IS PARAMOUNT'

"At our two hospitals, Addenbrooke's and The Rosie, we are dedicated to ensuring patients get the best care possible and that they are treated with respect and dignity in a clean, safe and friendly environment. Patients come first and the quality of care we provide is paramount. We listen to what our patients say, learn from their experiences and make improvements.

"We are pleased that the majority of patients continue to say that we meet or exceed their expectations. The hospitals have grown immensely over the past 50 years and today we have more than 1,000 beds and 8,000 staff. Our combined strengths in specialist care, teaching and research offer the local community the benefits of

international care on their doorstep as we translate research from the laboratory directly into new drugs and therapies to improve treatment and patient care.

"Our role as a partner in Cambridge University Health Partners, one of only five academic health science partnerships in the UK, has given us new opportunities to move forward. The backbone of our success is our staff and our values (kind, safe and excellent), which define the way we work and behave towards patients, partners and each other. All staff are committed to putting the patient at the heart of everything we do.

"Through our programme of change, *Transforming Care for the Future*, we are building a sustainable future to serve a growing local population, improve the way we care for our patients, expand our areas of clinical excellence and harness new technologies and research."

DR KAREN CASTILLE, OBE, INTERIM CHIEF EXECUTIVE

We also made awards to Frimley Park Hospital NHS Foundation Trust and Airedale NHS Foundation Trust, which both performed particularly well on our measures.

FAIR ACCESS TO TREATMENT?

KEY FINDINGS

TREATING OLDER PATIENTS

Medical intervention will become less appropriate as patients become older and more frail, and rates of treatment for many conditions decline with age. However, the extent to which this happens varies and may reflect lack of access to services for older people or differing views among clinicians about the best way to treat patients.

THE RIGHT LEVEL OF CARE

Over-treatment of older patients can be as much a problem as under-treatment. In many areas of health-care, there is limited agreement on appropriate levels of care.

CONSISTENT ACCESS

The level of disability for patients receiving hip replacement surgery varies greatly by hospital. Women more frequently have severe needs when they receive surgery than men.

SHARING BEST PRACTICE

Looking at clinical variation can provide a way to identify best practice and understand why some trusts appear to be providing higher or lower levels of treatment to older patients.

THREE EXAMPLES OF WHY IT MATTERS WHERE YOU ARE TREATED

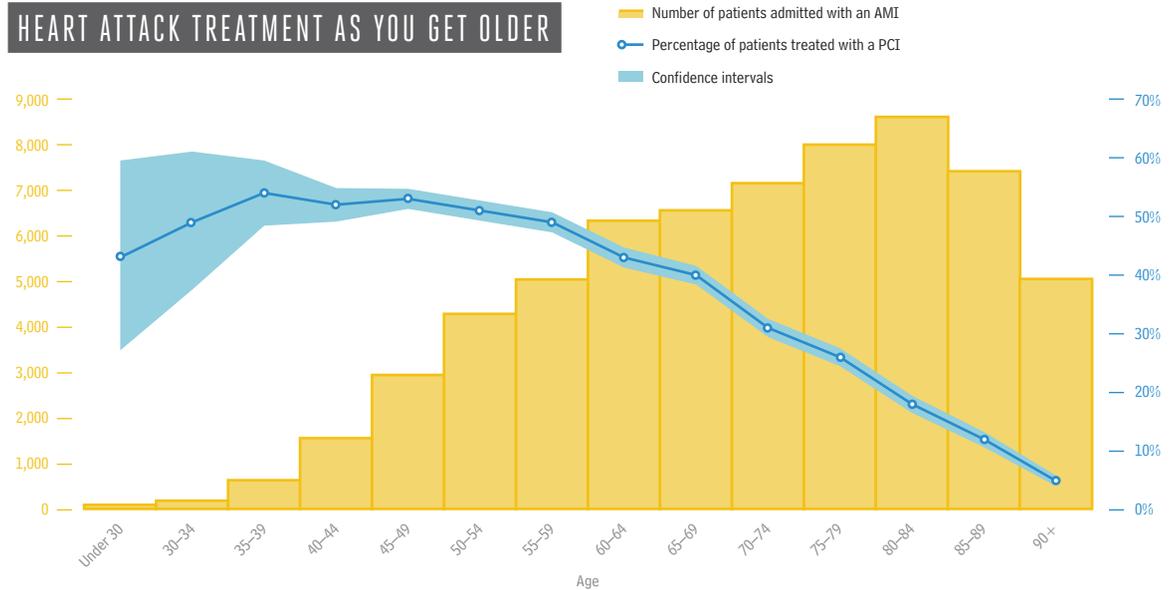
1 VARIATION IN TREATMENT LEVELS WITHIN TRUSTS ACCORDING TO AGE: HEART ATTACK

2 VARIATION IN TREATMENT LEVELS WITHIN TRUSTS ACCORDING TO AGE: BREAST RECONSTRUCTION AFTER A MASTECTOMY

3 OXFORD HIP SCORE (OHS) THRESHOLD FOR HIP SURGERY

Older people don't always get the best treatment

HEART ATTACK TREATMENT AS YOU GET OLDER



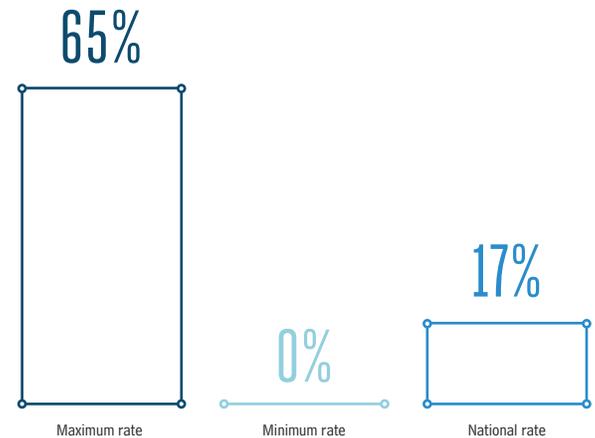
Percutaneous Coronary Intervention (PCI) is

an emergency treatment given to patients who have suffered a heart attack (acute myocardial infarction, or AMI). Although not suitable for all patients, it has been found to have better outcomes than alternative treatments.

There is clear variation between trusts, with a smaller proportion of older patients receiving this treatment at some hospitals than at others.

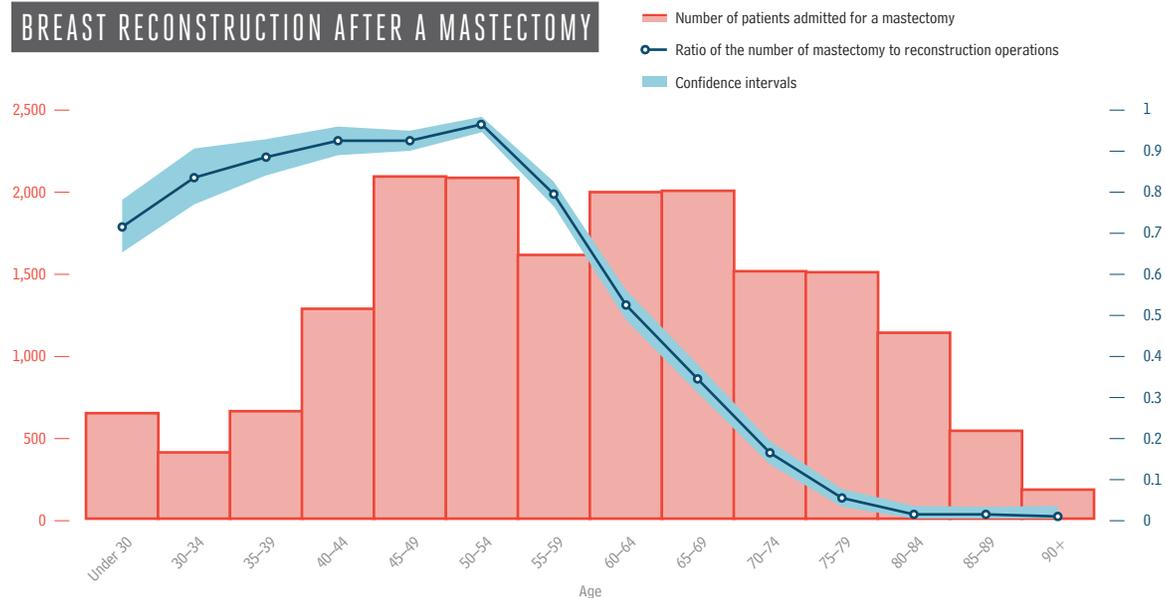
Older patients with underlying health conditions (co-morbidities) may not all be suitable for this treatment. However, in some hospitals the fact that very few elderly patients or none at all are offered the treatment is a concern. The highest rates of PCI for over 75s is 65%; the lowest rate is zero.

RATE OF PCI TREATMENT FOR AGE 75 AND OLDER



Older women don't always have all the options

BREAST RECONSTRUCTION AFTER A MASTECTOMY



NICE guidelines¹ say that all women should be offered breast reconstruction if they have a mastectomy, unless there are clinical reasons why they would not be suitable for this.

There is a variation within trusts as age increases. Nationally, only one in 34 women aged over 75 has a breast reconstruction following a mastectomy compared with two out of three women aged under 75. Some of this variation could be explained by patient preference, but it could be due to a lack of opportunity to take up breast reconstruction².

The decision by a patient to have breast reconstruction is more complicated than in the PCI example, and this drop-off is much more likely to be influenced by patient preferences. However, the sharp decline in procedures again raises a possibility of age discrimination within the NHS. It may be that older patients are not being consistently offered breast reconstruction when advised to undergo a mastectomy.

1 IN 34 FOR OVER 75

COMPARED WITH

2 IN 3 FOR UNDER 75

VIEW FROM THE EXPERT



Dr Rachel Greig

Senior Policy Officer,
Breakthrough Breast
Cancer

The risk of breast cancer increases with age and four out of five cases of the disease occur in women over 50. With our ageing population, the number of older women diagnosed with breast cancer will increase, so it has never been more important for healthcare professionals to base their decisions on clinical need rather than age.

The large variations in reconstruction rates by age reported here are worrying. It is important that we understand the reasons behind them. Some variation is likely to be due to patient preference or differences in the clinical characteristics of patients. But we need to ensure that inaccurate assumptions are not being made about these patients solely due to their age.

There are many factors that healthcare professionals and patients must take into account when considering certain medical procedures and it is important that all appropriate treatment options are discussed so that patients can make informed choices about what they want from their own treatment and care.

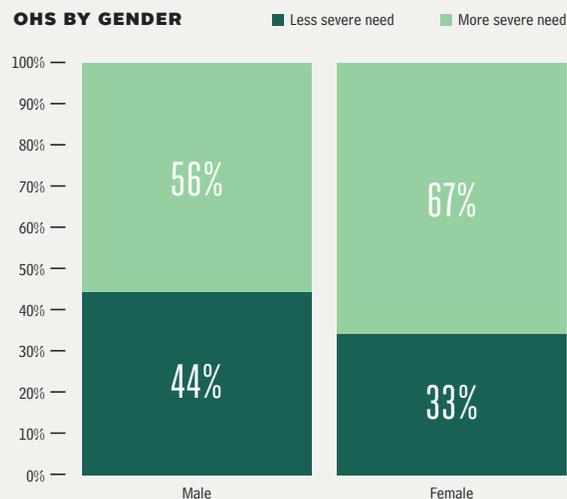
Equal access to hip replacements

The Oxford Hip Score (OHS) is a measure of disability in patients being assessed for total hip replacements. We have generated this from Patient Reported Outcome Measures (PROMS) survey data for 2010/11. It is measured both pre- and post-operatively and is most commonly used as a measure of the effectiveness of the procedure.

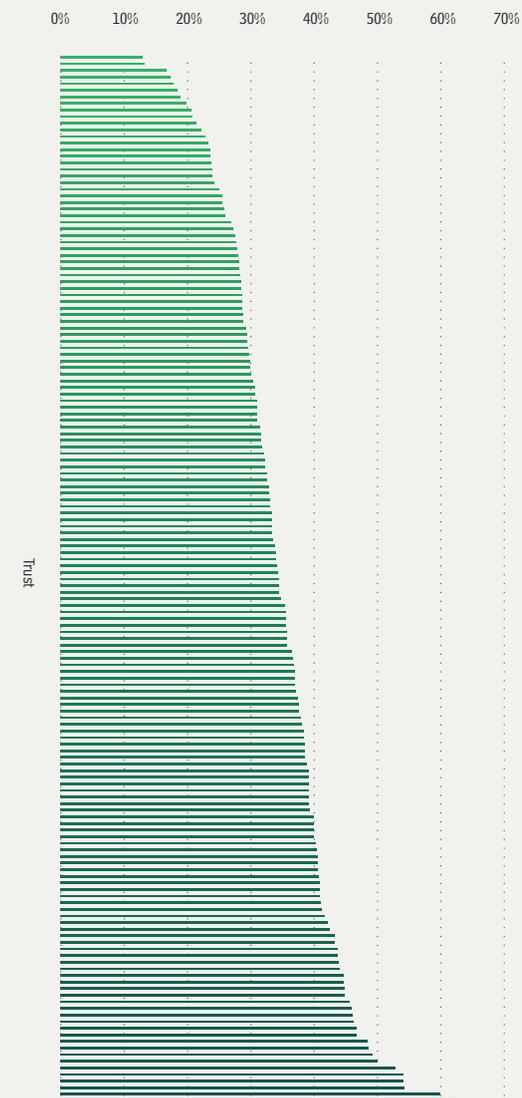
A number of commissioners use the OHS as a way of prioritising patients for referral for a hip replacement. A score of 20 is often used as a threshold to divide patients with more severe needs (less than 20) from those with less severe needs. Nationally, some hospitals have more than 60% of patients in the less severe need category, compared to less than 15% in others.

In some hospitals, many patients with less severe needs are operated on. In others, very few. We compared rates for men and women. Men who had operations were more likely than women to have less severe needs.

OHS BY GENDER



PERCENTAGE OF PATIENTS WHO HAVE LESS SEVERE NEEDS YET ARE RECEIVING SURGERY



TECHNICAL BRIEFING

VARIATION IN TREATMENT LEVELS ACCORDING TO AGE: DEFINITIONS

PCI for AMI

The number of emergency admissions with an acute myocardial infarction (AMI) and the proportion of percutaneous coronary intervention (PCI) for these patients across a range of age bands.

Breast reconstruction after a mastectomy

The ratio of the number of mastectomy operations to the number of breast reconstruction operations within a range of age bands.

OXFORD HIP SCORE (OHS) THRESHOLD FOR HIP SURGERY

The proportion of patients who had a hip replacement procedure and had an OHS of 20 or less, and the proportion of patients who had a hip replacement procedure and had an OHS greater than 20. A score below 20 may indicate that the patient had a more severe clinical need prior to the operation.



FIND OUT HOW YOUR LOCAL TRUST IS PERFORMING AT DRFOSTERHEALTH.CO.UK

END NOTES

For full methodologies, please visit

www.drfoosterhealth.co.uk

* Visit www.drfoosterhealth.co.uk to see what the trust has said about this indicator

Hospitals under pressure

1. Imison C, Poteliakhoff E, Thompson J. Older people and emergency bed use: Exploring variation. The King's Fund (2012) www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/older-people-and-emergency-bed-use-aug-2012.pdf

2. Based on KHO3 data transparency dh.gov.uk/2012/07/05/bed-availability-and-occupancy/

3. Bagust (1999). Dynamics of bed use in accommodating emergency admissions: stochastic simulation model www.bmj.com/content/319/7203/155

Department of Health (2001). Shaping the future NHS: Long-term planning for hospitals and related services response to the consultation exercise on the Findings of The National Beds Inquiry www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009394

4. All NHS acute trusts responded to our questionnaire except University

Hospitals Birmingham NHS Foundation Trust

5. The cumulative number of bed days taken up by patients for whom the reason for admission may have been avoidable through changes in the healthcare system, either inside or outside of hospital care. For the purposes of this analysis 11 categories of admission have been used. For each of these, a substantial proportion of the admissions are potentially avoidable. There will, however, always be some patients for whom admission is a necessity, particularly in the categories for short-stay emergency admissions, admissions for dementia and UTI, readmissions within a week and ACS conditions. It is also recognised that in a hospital at the forefront of day case surgery there will inevitably be a population of patients who rightly convert to an in-patient stay.

6. For the financial years 2005–2010 we examined the demand on the NHS due to emergency admissions of patients aged 75 years or above with more than one co-morbidity. We measured demand by the average number of beds required quarterly. This is calculated by multiplying the number of admissions in a quarter by the average length of stay, then dividing by the number of days in a quarter. This reveals that there has been a growth in demand due to this group of around 10,000 quarterly beds.

The rate of growth is possibly inflated by an increase in reported co-morbidities in HES data for all in-patients. Nevertheless, when we make a comparison with those younger than 75 years of age with multi-co-morbidities we see growth in the relative size of the elder multi-co-morbidity cohort to the younger multi-group cohort of about 15% over these five years.

High mortality rates persist

1. The Mid Staffordshire NHS Foundation Trust public inquiry www.midstaffspublicinquiry.com

2. Further information on the NHS Information Centre for Health and Social Care's approach to banding the SHMI is at <https://indicators.ic.nhs.uk/webview/>

3. We were unable to include King's College Hospitals NHS Foundation Trust in our analyses due to discrepancies in its submission of Secondary Uses Service (SUS) data

4. Trusts also told us numbers of staff who were on call but actually on site for another reason. This information can be found on www.drfoosterhealth.co.uk

5. The following trusts were either unable to supply complete staffing data or this was received too late to be included in the analysis, or information about bed numbers was incomplete.

- > Aintree University Hospitals NHS Foundation Trust
- > Ashford and St. Peter's Hospitals NHS Foundation Trust
- > Barts & The London NHS Trust
- > Bradford Teaching Hospitals NHS Foundation Trust
- > Burton Hospitals NHS Foundation Trust
- > Chesterfield Royal Hospital NHS Foundation Trust
- > Countess of Chester Hospital NHS Foundation Trust
- > Doncaster and Bassetlaw Hospitals NHS Foundation Trust
- > Dorset County Hospital NHS Foundation Trust
- > East Cheshire NHS Trust
- > Frimley Park Hospital NHS Foundation Trust
- > Guy's and St Thomas' NHS Foundation Trust
- > Hampshire Hospitals NHS Foundation Trust
- > Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- > James Paget University Hospitals NHS Foundation Trust
- > Leeds Teaching Hospitals NHS Trust
- > Mid Cheshire Hospitals NHS Foundation Trust

- › Mid Essex Hospital Services NHS Trust
- › Newham University Hospital NHS Trust
- › Norfolk & Norwich University Hospitals NHS Foundation Trust
- › North Middlesex University Hospital NHS Trust
- › Royal United Hospital Bath NHS Trust
- › South Tees Hospitals NHS Foundation Trust
- › South Tyneside NHS Foundation Trust
- › Southport and Ormskirk Hospital NHS Trust
- › St George's Healthcare NHS Trust
- › Surrey and Sussex Healthcare NHS Trust
- › The Hillingdon Hospitals NHS Foundation Trust
- › The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust
- › The Royal Wolverhampton Hospitals NHS Trust
- › The Shrewsbury and Telford Hospital NHS Trust
- › University Hospital of North Staffordshire NHS Trust
- › University Hospital Southampton NHS Foundation Trust
- › University Hospitals Bristol NHS Foundation Trust
- › Warrington and Halton Hospitals NHS Foundation Trust

- › Whittington Hospital NHS Trust
- › Wrightington, Wigan and Leigh NHS Foundation Trust

Efficient hospitals can deliver good quality care

1. Threshold of -3
2. Threshold of +3

Methodology

Each individual indicator has been banded using either control limits (for crude rate or adjusted rate indicators) or quartiles (for over-dispersed crude rates). Where a trust performs outside these ranges, their efficiency score is altered accordingly.

For every case where the trust performed more efficiently than expected or in the upper quartile of efficiency, the efficiency score increases by 1. And for every case where the trust performed less efficiently than expected or in the lower quartile of efficiency, the efficiency score decreases by 1.

All trusts are outliers at one end of the spectrum at least once. The result is a composite score of efficiency ranging between 13 and -13, with 13 being most efficient and -13 being least efficient. Individual scores for trusts range from 6 to -7.

Opportunities for efficiency

1. Each individual indicator has been banded using either control limits (for crude rate or adjusted rate indicators) or quartiles (for over-dispersed crude rates). Where a trust performs outside these ranges, its efficiency score is altered accordingly.

For every case where the trust performed more efficiently than expected or in the upper quartile of efficiency, the efficiency score increases by 1. For every case where the trust performed less efficiently than expected or in the lower quartile of efficiency, the efficiency score decreases by 1.

All trusts are outliers at one end of the spectrum at least once. The result is a composite score of efficiency ranging between 13 and -13, with 13 being most efficient and -13 being least. Individual scores for trusts range from 6 to -7.

2. 2011/12 saw biggest number of trust deficits for half-decade www.hsj.co.uk/news/finance/2011-12-saw-biggest-number-of-trust-deficits-for-half-decade/5046225.article

3. South London Healthcare NHS Trust put into administration www.bbc.co.uk/news/uk-england-london-18812193

4. Data published by the Audit Commission <http://www.audit-commission.gov.uk/SiteCollectionDocuments/Downloads/NHS-financial-year-11-12.pdf>

5. Information supplied to Dr Foster by Monitor www.monitor-nhsft.gov.uk

6. An average readmission in the over-75s costs 42% more than an average readmission in the under-75s

7. Audit Commission (2011). Reducing Spending on Low Clinical Value Treatments, Health Briefing www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/lowclinicalvalue/Pages/Default.aspx

8. We looked at procedures that The British Association of Day Surgery says hospitals should be able to perform at least 90% of as day cases

9. We have used an indicative basket of the following operations:

- › Hip replacement
- › Knee replacement
- › Repair of abdominal aortic aneurysm (AAA)
- › Excision of colon and/or rectum
- › Vaginal excision of uterus (without repair of prolapse)
- › Vaginal prolapse repair +/- hysterectomy
- › Excision of thyroid gland

- › Other excision of gall bladder
- › Excision of ovary and/or fallopian tube (without hysterectomy)
- › Excision of breast
- › Tonsillectomy
- › Laparoscopic cholecystectomy

10. NHS London (2012). Acute Hospitals in London: Sustainable and Financially Effective www.nhshistory.net/safe-report-february-2012.pdf

Fair access to treatment?

1. NICE Guidelines (2009). CG80 — Early and locally advanced breast cancer: Diagnosis and treatment publications.nice.org.uk/early-and-locally-advanced-breast-cancer-cg80

2. Walton L, Ommen K, Audisio RA. (2011). Breast reconstruction in elderly women breast cancer: a review www.ncbi.nlm.nih.gov/pubmed/21371824

ACKNOWLEDGEMENTS

Dr Paul Aylin

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With special thanks to Dr Andrew Goddard, Director of Medical Workforce, Royal College of Physicians for his insight and guidance.

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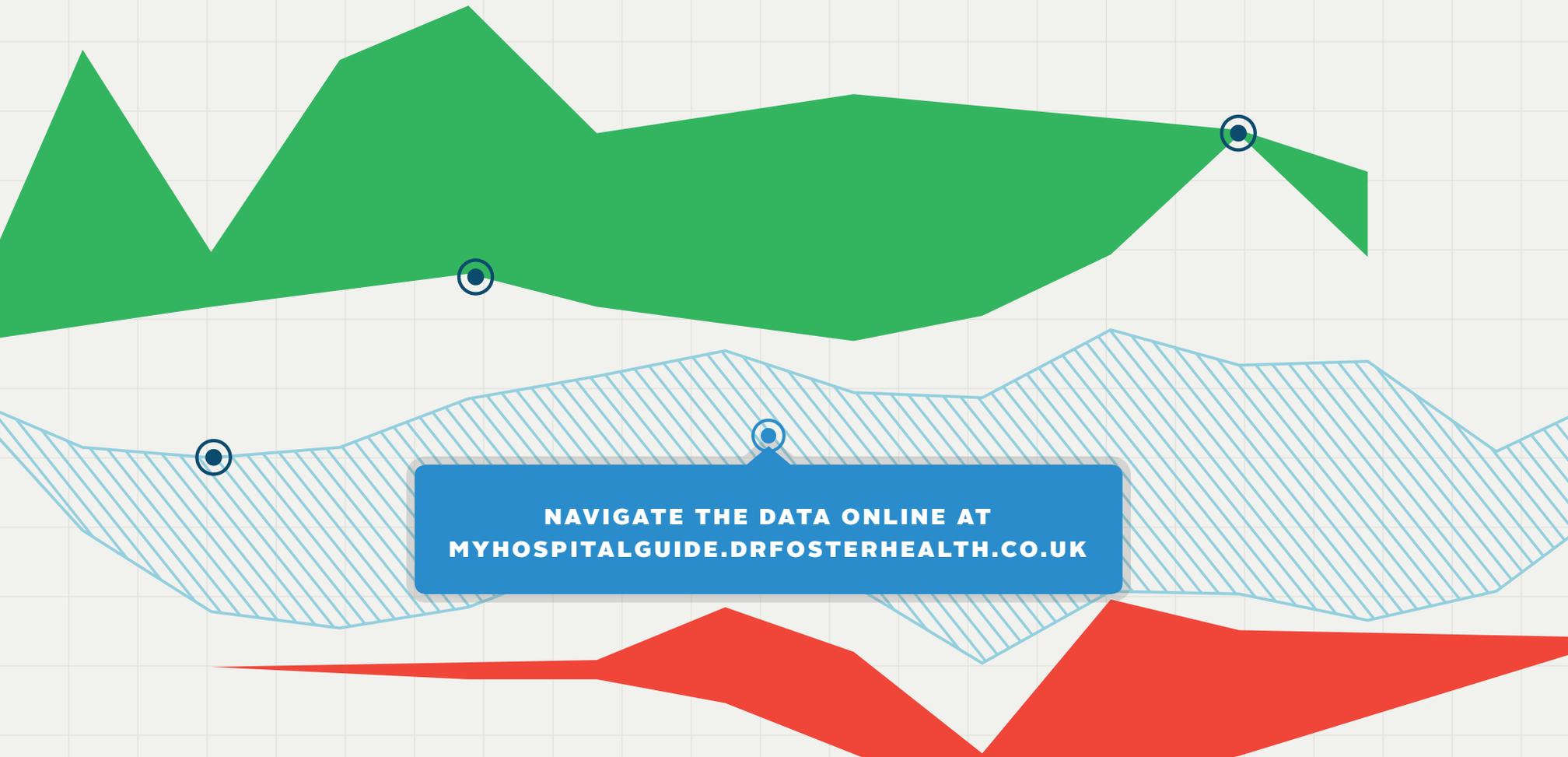
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