League tables: use for patients

For too long health professionals in the United Kingdom have enjoyed a world largely free from scrutiny other than that of navel gazing. Unlike the patients they treat, doctors, nurses, and others have always been aware of colleagues who perform below standard and of departments that persist in using outdated techniques or perform too few procedures for optimum results. The professionals may know the system – patients on the whole do not. When a senior doctor recently admitted that he would use his inside knowledge to secure the best treatment for his own family relations he did no more than provide an honest statement of the obvious and a blameless one at that. Yet to many patients brought up on the medical myth of near infallibility and the reassuring presence of a unified and seemingly uniform NHS, the idea of wide variations in clinical standards still comes as a shock.

The case for greater openness and accountability then is so overwhelming that the presumption must be to publish anything that might lead to greater understanding. The onus is on those who oppose disclosure to show how such information will be detrimental to patients. Thus far in the case of so called “death league tables” a range of arguments has been used by such opponents. The first may be summed up as “a little knowledge is a dangerous thing,” the suggestion being that the public is either so innumerate or so stupid that crude data will be misinterpreted, causing panic and dismay all round. Yet the early signs from Scotland, which has embarked on disclosure, suggest that this argument is wrong. The clinical outcome measures, including death rates, released by the Scottish Office towards the end of last year do not seem to have prompted irrational patient behaviour or indeed any great gnashing of teeth – those people who have bothered to think about the matter at all seem capable of understanding the caveats and warnings that accompanied publication. Even the media behaved itself, up to a point.

Exercising caution

Yet in this issue McKee and Hunter (p 5) make a powerful case at least for exercising caution, and they highlight the very real difficulty of producing data that have any meaning. They point to the small sample sizes from one year’s hospital figures and the problems that could arise using data over three years, when conclusions would have to be drawn about practices and events that may long since have passed. (Although this does not seem to have been a problem in Scotland it is perhaps too early to say whether useful changes will follow publication there.) More importantly, they draw attention to the limitations of devices for adjusting case mix for severity and the dangers of transposing American models which may not be appropriate in the United Kingdom. And they also highlight the undoubted scope for distortion in data collection, either because the quality of coding remains poor or because there will be fresh incentives for hospitals and their staff to make sure that whatever is coded will cast their unit in the best possible light. It would be foolish to deny too that publication of any performance measurement is likely to alter professional and managerial behaviour and that that change will not always be for the better – the temptation to divert resources towards what is measured rather than what matters is a legitimate concern.

Nevertheless, McKee and Hunter concede that they found differences in death rates between hospitals, “that cannot be explained by known factors that can be ascertained from routine data.” They add that some other differences have identifiable explanations such as the fact that some hospitals perform more operations and thereby seem to achieve better results.

Justifying publication

And that is, surely, where the justification for publication rests; the purpose of producing such figures should never be to create crude league tables (and to be fair the NHS has never attempted to create league tables – so far only performance tables without rank orders have been produced). As the chief medical officer for Scotland was at pains to emphasise when launching the clinical outcome indicators the idea should be to raise questions not provide answers. In many instances differences between hospitals may be entirely justified, in some others they will not be. Differences should be explored and explained.

McKee and Hunter acknowledge that publication of mortality rates is probably inevitable, and they call for a series of reforms to tackle the damage they otherwise believe would follow. The authorities would do well to consider these carefully. But it should not be beyond the wit of the research community to produce data which for all their imperfections allow the public and health purchasers to ask why it should be that twice as many patients die from heart attacks in one hospital compared with another. And it should not be beyond the intelligence of the rest of us to understand the limitations of this information.

NIALL DICKSON

Chief Social Affairs Correspondent, British Broadcasting Corporation, Broadcasting House, Portland Place, London W1A 1AA

The British Thoracic Society (BTS) has developed a database as a tool to support audit of hospital management of acute severe asthma. Based on the findings of the national audit of management of acute asthma in adults (March issue, p 24), the database consists of eight items relating to assessment, hospital management, and discharge planning. Important criteria in choosing each item were the likely availability of data in hospital case notes and the clinical relevance of items. They all relate to specific recommendations in the BTS guidelines for acute asthma management.

The BTS invites local hospitals to send in data on their current practice in managing acute severe asthma. A single A4 data collection sheet is accompanied by specific instructions to ensure uniformity of the data collected, and a short form seeking background information on the sampling method and hospital.

Participating hospitals will receive their own results in comparison with current data in the database, using box and whisker plots to show the middle 50% and range of responses throughout the country. There is a pledge to provide such feedback within a month of receipt of data so that an audit cycle could be completed before junior and middle grade staff rotate onwards. Ultimately the data in the database will complement the guidelines review process. The data will also inform the review of guidelines with the aim of improving standards of care.

Copies of the tool and further information are available from Ms Ida Ryland, Asthma Audit Office, Aintree Chest Centre, Fazakerley Hospital, Lower Lane, Liverpool L9 7AL. The database is funded from Department of Health Central Audit Funds.

The organisers of the Golden Helix Award are calling for applications for 1995–6 (see Diary section and loose insert).

This is the fourth year the award scheme has operated across Europe, and the top teams’ work is impressive (limited numbers of copies of selected summaries from the top projects for the past three years, with contact details, are available in local language and English). The judges are constantly looking for more “cutting edge” projects. About 80 healthcare organisations serve on the boards of the award across nine countries, and a director, president, or chairman sits on the management board and judging panel, thus ensuring a high level of support for the award and of visibility for the teams who apply. National judging takes place in the local language. The nine boards are UK/Ireland, Germany, France, Italy, Netherlands, Iberia, Belgium, Switzerland, and the Nordic countries (literature is available in the local language). The national winners compete for the overall European prize, when judging is in English.

The judges are looking for quality improvement projects in any aspect of health care, including public and private sectors, specifically projects that show initiative and innovation and significantly improve a process in the team’s work. Claims of improvement must be substantiated with actual data (taken at the start of the project and again at completion) and be focused on “customers.” Further factors taken into account are whether the project has made a significant impact on its own department/organisation and whether it has the potential to be applied elsewhere in Europe and make a notable impact.

Those with a project for submission or who are thinking of starting a project now should contact the appropriate award manager for an application pack and guide which gives details on how to apply (see diary).

DIARY

27 November
London: Royal College of Physicians of London. Hospitals without beds? Innovations in outpatient and ambulatory care. North Thames Regional Health Authority one day conference to review current understanding of outpatient services, explore examples of innovation, and highlight the implications for the Department of Health; NHS; royal colleges and faculties; and nurses, patients, and carers. (£100.) Application forms and further details from Ms Vicki Greenway, NTRHA, 40 Eastbourne Terrace, London W2 3QR (fax 0171 725 5532).

30 November
The Golden Helix Award for Quality in European Healthcare. Deadline for applications (see also entry in Notes and loose insert in this issue). For more information, application pack, and guide, please contact (UK): The Golden Helix Award Manager, Healthcare Group, Hewlett-Packard Limited, Cain Road, Bracknell, Berkshire RG12 1HN (tel +44(0)1344) 36 92 69; fax +44(0)1344) 36 10 51) (continental Europe): The Golden Helix Award Manager, Medical Products Group, Hewlett-Packard GmbH, Schickardstrasse 3, 71034 Böblingen, Germany (tel +49(0)7031) 14 45 39; fax +49(0)7031) 14 23 46).

30 November

1–2 December

7–9 March 1996
London: Queen Elizabeth Conference Centre. Bringing quality improvement to the heart of European health care. First European Forum on Quality Improvement in Health Care. Comprising plenary lectures, seminars and workshops, and short courses, the forum is aimed at doctors, nurses, other health professionals, hospital leaders, and policy workers, researchers, and patients’ representatives and will explore in a very practical way methods of improving patient care. Main themes: continual quality improvement, patient orientation, leadership and managing organisational change, improving quality and reducing cost, measurement, professional education for quality. Further information from Clare Moloney, Conference Unit, BMA, BMA House, Tavistock Square, London WC1H 9JF (tel +44(0)171 383 6478; fax +44(0)171 383 6663; email 100632.1404@compuserve.com).

First European Forum on Quality Improvement in Health Care Exhibition

7–9 March 1995
To complement this important forum there will be a major exhibition. There are also numerous openings for sponsorship partnerships and promotional packages, which can be negotiated to suit both large and small scale budgets. Analysis of over 260 delegate inquiries to date disclose a high level of interest from directors, senior managers, and researchers from the United Kingdom, Europe and the United States.

Further information from Carol Gill, Marketing Executive, Conference Unit, British Medical Association, BMA House, Tavistock Square, London WC1H 9JP (tel +44(0)171 383 6381; fax +44(0)171 383 6663).

Correction
An error occurred in the first editorial (March, p 1). Reference 1 should have been given as: Clinical Resources and Audit Group and Scottish Office. Clinical outcome indicators. Edinburgh: CRAG 1994. The editor apologises for this editorial error.