ESSENTIAL READING FOR SMART SPENDING

DR FOSTER HOSPITAL GUIDE 2013
This year’s Hospital Guide looks at four areas:

1. How financial austerity is affecting the way we spend money on hospital treatment.
2. The impact of drug and alcohol problems on patients and hospitals.
3. The quality of care at weekends.

We have also worked with Doctors.net.uk to survey hospital doctors in England.

There are three components to the 2013 Hospital Guide. First, this booklet, which explains everything we have measured and our main findings.

Second, and most importantly, we have distilled all our data into a series of posters that explain what the analysis shows. We encourage everyone who reads the Hospital Guide to display these posters, celebrate the good care highlighted and use it as a catalyst in the areas where either care needs to be improved or a review of how money is being spent needs to take place. Please email us at hospitalguide@drfoster.co.uk if you would like extra copies of these posters.

Third, information about each individual NHS hospital trust and Clinical Commissioning Group, all the data, and the methodologies explaining how we made our calculations can be found on our website myhospitalguide.com
Dr Foster exists to help healthcare organisations improve their performance through better use of data. We are the leading provider of healthcare information and benchmarking solutions in England and, increasingly, worldwide (we now work with more than 40 leading academic hospitals in nine countries). We work with providers, commissioners, clinicians and managers to benchmark and monitor performance against key indicators of quality and efficiency, drawing on multiple datasets in innovative and pioneering ways.

We work closely with the Dr Foster Unit at Imperial College London and all our methodologies are published in full.

We adhere to a code of conduct that prohibits political bias and requires us 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.
Why posters? In the era of electronic media, using one of the oldest forms of communication known to man may seem perverse. But there are good reasons why sticking information up on walls has remained popular, from ancient royal proclamations to modern marketing campaigns.

One of the most obvious features of posters is that they are, by their nature, public and transparent. Books and websites are made to be read individually and digested in private. Posters are about sharing information and messages.

Another reason is that they are concise. More than ever, in healthcare, we need to learn to boil information down into clear conclusions. We need to work hard to see the wood for the trees.

When Dr Foster first started publishing this guide more than a decade ago, we were addressing the lack of information about quality of healthcare. It was not just that the public had little or no information. Nobody inside or outside the NHS had the information they needed to tell good care from bad.

Today, for much of the NHS the problem is no longer a lack of information; it is a surfeit.

NHS hospitals are awash with data. Along with the information that Dr Foster provides, there are national reporting systems; national clinical audits; feedback from NHS Choices, from national patient surveys and from staff surveys; reports from patient safety monitoring programmes and from infection control monitoring... to name just some of the most obvious sources. Within the hospital there is an ever-increasing pool of information drawn from internal information systems and electronic records. Each source is capable
of providing information about different diagnoses, different patient groups as well as trends over time.

Put it all together and those running hospitals or commissioning NHS services have available to them tens of thousands of data points which relate to the cost and the quality of the service they provide. How does the board of a hospital make any decision comfortable in the knowledge that it has adequately assessed the available information?

The complexity leads some people to despair of the process. Observing that the data is of variable reliability, sometimes contradictory and never simple to interpret, they conclude that nothing can be proven beyond doubt and wash their hands of the whole exercise.

That is a cop out. Decisions about spending and care will be made one way or the other. We have seen too often the consequence of bad decisions – decisions made in the face of strong clues in the data that the actions being taken were causing harm to patients and wasting resources. The problem may be hard but it cannot be ignored or avoided.

Doctors understand this dilemma. The art and science of diagnosis requires the assessment of complex, sometimes contradictory clues to reach a view on the best way to treat the patient. Sometimes it is simple. Sometimes the only option is to proceed with treatment on the basis of uncertain conclusions on the grounds that doing nothing is likely to be worse.

The management and administration of our health services has yet to achieve an equivalent degree of skill in the way it uses information to diagnose the problems of our health system and identify the most appropriate remedies.

This may explain one of the most troubling findings in this year’s guide. On p26 we set out the findings of a survey of NHS hospital doctors carried out by Doctors.net.uk. Most doctors responding to the survey did not agree that their hospital always acted on concerns raised by staff. One in four expressed no confidence in the management of their hospital.

Less surprising was the finding from the survey that most doctors believe patients get a worse standard of care if they come
into hospital at a weekend. This year we have returned to the subject of hospital care at weekends and looked at a wide range of measures – mortality rates, readmission rates, access to diagnostic tests and the length of time that urgent patients wait for surgery. On every measure we looked at, the position for patients admitted at weekends was worse than for patients admitted during the week.

Each data point on its own is open to interpretation. Every number we publish is affected by confounding factors and surrounded with statistical uncertainty. No single metric could ever safely lead to a firm conclusion.

But when all the data points in one direction – when every piece of information is repeating a consistent message – it is important to draw that conclusion out clearly and share it.

That is why we have used posters.

Whether it is the impact of drugs and alcohol on our health and on the NHS, the variation in mortality rates between hospitals or the way in which financial constraints are affecting services, our aim has been to draw out the important messages and provide a mechanism to communicate them.

This guide is sent to every hospital and commissioning chief executive in England. We hope that within it you will find at least one poster that you would like to put up in your office or in the corridors of your hospital.

This does not mean, of course, that we are giving up on digital media. Go to myhospitalguide.com and you can interrogate all the data in detail and link to the many examples of excellent practice highlighted in the guide.

Roger Taylor
Co-founder, Dr Foster Intelligence
Elective procedures: how has NHS money been spent?

less effective procedures have fallen more than effective procedures

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Less effective procedures have fallen more than effective procedures.

Elective procedures: how has NHS money been spent?

- Hip and knee replacement and cataract operations (effective procedures)
- Less effective operations (e.g. injections for back pain)

Read more statistical data in the Put Care into Spending & Spending into Care poster within the Hospital Guide wallet.
Clinical Commissioning Groups (or CCGs) have only been in existence since April 2013. It is these new organisations’ responsibility to decide how a large proportion of NHS money is spent. To make sure the most appropriate care is in place in the future for patients, they have to understand what has happened in the past.

We have mapped resident patient activity for the past ten years as if CCGs had existed, in order to examine decisions made in the past on behalf of their patients. We looked at the following issues:

- **Planned operations** We have looked at whether financial constraints had an impact on the number of planned (elective) operations taking place and compared changes in the number of more effective operations (such as hip replacements, knee replacements or cataract removal operations) to the change in the number of less effective operations (such as injections for back pain).

  We looked at the following:
  
  > Less effective planned operations. The Audit Commission has identified eight operations commonly performed where the evidence suggests that, in the main, these procedures are ineffective. Although some individual patients may have benefitted, in general, the benefit is small and the evidence is that, on average, patients who do not have the operation recover as well as those who do. (See http://goo.gl/FqZ9gH for more information on this.)
More effective operations. We looked at several operations where evidence says they are effective but there is still a degree of discretion over when or how often they are performed. The Audit Commission has defined two groups of procedures of this sort: one where, although the operation is known to be effective, possible alternative treatments may be preferable (such as carpal tunnel surgery or elective cardiac ablation); and another, where the risks of the operation may outweigh the benefits. We focused in particular on three of the most common operations from this last group: hip replacements, knee replacements and cataract removal operations.

- **Emergency hospital treatment** Sometimes nothing could have been done to prevent the need for emergency treatment in hospital. But often there is. People with long-term conditions, such as diabetes, will need emergency treatment if their condition deteriorates. But if well-managed, it is possible to avoid it. Similarly, conditions such as urinary tract infections (UTI) often do require treatment in hospital. But if caught early enough and treated out of hospital, this can be avoided. One way in which the NHS is trying to cope with the financial squeeze is by better managing conditions that lead to ‘avoidable’ hospital admission. It will never be possible to completely avoid this but it is possible to avoid some and to reduce the number overall. We have looked at this and compared the number of potentially avoidable admissions with the number of emergency admissions overall as well as with changes in the population.

Since 2009, spending on the NHS has slowed and as a result the increase in activity has slowed, in some cases going into reverse. To try to ensure that this does not affect quality of care, efforts have been made to try to make savings by limiting the availability of operations that are known to be less effective and by reducing the number of emergency admissions for conditions that should be manageable outside hospital by GPs and other professionals.

**Conclusions**

Our evidence shows that spending on less effective operations has fallen whereas spending on more effective operations has been maintained, with a 0.1% increase in the number of operations. However, in some areas of the country this is not the case.

Our evidence also shows that there has been no reduction in
WHAT ARE OUR FINDINGS?

- **Three per cent** rise in overall emergency visits to hospital between 2009/10 and 2012/13.
- **Eight per cent** rise of avoidable emergency admissions between 2009/10 and 2012/13.
- **Nine per cent** drop in less effective procedures carried out between 2009/10 and 2012/13.
- **0.1 per cent** increase in hip replacements, knee replacements and cataract removal surgery.
- **24 per cent** of people live in areas where the number of hip, knee and eye operations has been cut while the number of avoidable emergency admissions to hospital has risen.
- **Three per cent** of people live in areas where the number of less effective operations has risen but the number of hip, knee and eye operations has not.
- **15 per cent** of people live in areas where the number of avoidable emergency admissions to hospital has been cut but not the number of hip, knee and eye operations.
- **Seven per cent** of people live in areas where both avoidable emergency admissions and less effective procedures have been reduced while hip, knee and eye operations have been maintained or increased.

Avoidable emergency admissions and, indeed, these admissions have risen faster than overall emergency admissions. Some parts of the country have been more successful in reducing spending on these unnecessary admissions to hospital.

The new CCGs’ management teams should review this information to determine if they are using funds in the best possible ways.

THE SMALL PRINT

The procedures we have defined as effective planned procedures are hip replacements, knee replacements and cataract removal surgery.

The procedures we have defined as less effective planned procedures are operations where the benefit is small and the evidence is that, on average, patients who do not have the operation recover as well as those who do. These include tonsillectomies, knee wash-outs and injections for back pain.

Avoidable emergency admissions: these are admissions to hospital for conditions where treatment in the community can prevent the need for an emergency admission (e.g. diabetes) and for conditions that can be prevented by vaccination or by timely intervention in the community (e.g. a urinary tract infection). While it is inevitable that some patients will require admission for these conditions, the overall number could be reduced.
Drug and Alcohol-related Emergency Admissions

Read more statistical data in the Get Help for Your 44-Year-Old Drink & Drug Issue Poster within the Hospital Guide Wallet.
Dr Foster has investigated the impact on hospitals of people with a known drug or alcohol problem. This was originally drawn to our attention by one of the hospital trusts we work with, which had noticed an increasing number of patients with such problems arriving in their emergency department and subsequently being admitted. Often these patients were seen multiple times. They tended to be older patients with a longer-term dependency, not binge-drinking teenagers coming to A&E after experimenting with drugs and alcohol and falling ill.

Our analysis has focused on patients admitted to hospital in the past three years (2010/11–2012/13) with drug or alcohol problems. We have looked at two groups of patients: one group who each had a single admission for less serious alcohol-related issues and a second group who had more serious problems.

Our findings have confirmed that this second group, while it includes people from all ages, is most concentrated among people in their forties.
• Drug and alcohol dependency is one of the biggest contributors to hospitalisation among middle-aged people.

• More than 500,000 people have been hospitalised for this reason at least once in the past three years.

• The peak age for such admissions has increased over recent years, suggesting a generational problem among people in their forties.

• In 2012/13, 19 per cent of emergency admissions for people aged 40–44 were for those with a known drug or alcohol issue. This means that around one-fifth of emergency hospital care for middle-aged people is linked to drug and alcohol abuse.

• The average (median) age of this group of patients is increasing: in 2002/3 it was 41 but by 2012/13 it had risen to 43.

• While this problem affects people from all sections of society – 8.6% are from the wealthiest fifth of the population – it particularly affects patients from poorer groups: 36 per cent of patients were from the most deprived areas of the country.

• 22 per cent of emergency drug and alcohol admissions in 2012/13 had no GP practice recorded.

• While some areas in the north have particularly high admission rates this is a national problem and every area needs to take action.

WHAT ARE OUR FINDINGS?
These figures remind us that drug and alcohol misuse is a major health challenge and that binge drinking does not only affect younger people. They point to the need for changes within the wider health and care system to meet the challenge this growing trend presents.

The increase in hospital admissions of middle-aged people points to a growing trend among this age group of substance misuse issues. The reasons for this could be linked to a number of factors, including people living longer with complex needs (particularly people over 65) or the effect of the economic downturn. Whatever the reason, the results of this work call for an integrated response, taking into consideration the wider social impact of addiction, for example on families, employment and housing status. We know that people with complex needs often fall through the gaps in provision. This will only cease if the NHS, social care and public health services work together in individual cases to ensure this does not happen. Challenges such as separate budgets need to be addressed.

Early intervention is critical if we are to stop intergenerational problems escalating. This is why Turning Point has developed a service where alcohol-trained workers based in A&E help to identify early people who have alcohol-related issues or who are at risk of repeated hospital admissions because of their alcohol misuse.

One example of this is Turning Point’s project in Sunderland, where we work in partnership with the Sunderland Royal Hospital to operate a service that identifies and helps people attending hospital with alcohol-related conditions. Since this began there has been a decline in the overall alcohol-related attendances within the hospital. An evaluation from 2012 showed that 57 per cent of people who engaged with a ‘brief intervention’ did not attend A&E during the following six months.

The fact that no GP was recorded for 22 per cent of all emergency drug and alcohol admissions (many of which are due to people who are not registered with a GP) highlights the need for primary care to improve the way it supports people with complex needs, some of which may be hidden, who often feel stigmatised and unable to ask for help.

The challenge for the health service now is to take these figures and consider the costs associated with substance misuse and how investment in existing programmes, services and initiatives in certain areas of the country can be implemented to benefit everyone.

Lord Victor Adebowale CBE, Chief Executive of Turning Point
THE SMALL PRINT

The codes used to identify patients are taken from the Health and Social Care Information Centre’s annual reports on drug and alcohol use. From the alcohol report, only those that are 100 per cent alcohol attributable are used. These codes can be in the primary or secondary setting. Current smokers and those with only one admission for acute alcohol intoxication are not included. Overall, we believe that the numbers will be an underestimate because:

• Coding is known to be poor in some areas.
• We do not include those admissions which are due to alcohol but not explicitly known to be (i.e. those diagnoses where the alcohol attributable fraction is less than 100 per cent).

CASE STUDIES

Some of these admissions will be intentional. For example, Royal Liverpool and Broadgreen University Hospitals NHS Trust has a fast-track system for admitting patients with these problems so they can get help quickly.

At Nottingham University Hospitals NHS Trust, nurses provide intensive case management. This leads to better coordination and, in turn, better care. Initial results are showing that this leads to increased patient and carer satisfaction, a decrease in inappropriate use of health services and an increase in planned care.

St George’s Healthcare NHS Trust in London has a programme run by an assertive case management team for those who are repeat attendees at the hospital and who live in Wandsworth. They provide social support as well as practical help to get to appointments at appropriate services.
MORTALITY AT THE WEEKEND

Adjusted mortality rate

MON TUE WED THU FRI

SAT SUN

7.0%

8.4%

READ MORE STATISTICAL DATA IN THE STRENGTHEN YOUR WEEKEND POSTER WITHIN THE HOSPITAL GUIDE WALLET
Strengthen your weekend

ANALYSING WEEKEND CARE IN THE NHS

WHAT ARE WE MEASURING?

Dr Foster has been publishing information about the standard of care at weekends for two years through the Hospital Guide. We have focused in the past on mortality rates, but this year we also include a number of new analyses, including evidence of longer waits for tests and scans at weekends and a higher chance of patients discharged at weekends having to return to hospital.

Care provided by hospitals outside normal working hours is poorer on a number of measures than care provided on weekdays. Patients admitted as emergencies at weekends are less likely to survive their treatment; less likely to get diagnostic tests on the day of admission; and less likely to have emergency operations within a day or two of being admitted. They are also more likely to have to return to hospital shortly after discharge.

There are very few planned (elective) admissions to hospital on Saturdays and Sundays but patients who have planned operations on weekdays are more likely to survive if their operation is earlier in the week than later, when their immediate post-operative period will take place over the weekend.

While some hospital trusts have improved their care, there is still a big discrepancy between the best and the worst. The NHS is not addressing this quickly enough. Although some progress has been made in the past year, the evidence suggests there is still much to be done. We hope hospital trusts themselves as well as those responsible for measuring quality of care will act upon these findings to ensure patients receive safe care no matter which day they are admitted to hospital.
• **68 per cent** of doctors surveyed by Doctors.net.uk and Dr Foster believe that, at the hospital they work in, patients admitted at weekends receive poorer quality of care than patients admitted on weekdays (see page 26 for more information about this survey). Perception of care quality at weekends is also associated with seniority: a greater proportion of junior (74 per cent) and middle-grade (76 per cent) doctors think that patients admitted at the weekend receive poorer quality of care than those admitted on weekdays compared with their consultant colleagues (66 per cent).

• Emergency overall mortality is **20 per cent** higher when admitted at the weekend.

• Mortality for patients who had routine surgery is **24 per cent** higher if the operation is performed just before the weekend.

• The number of patients returning to hospital after first being admitted at the weekend is **3.9 per cent** higher at the weekend.

• Repairing fractures on the day of admission is **10 per cent** lower at the weekend.

• Waiting more than two days for a broken hip replacement is **24 per cent** higher on weekends.

• Emergency imaging (MRI scans) on the day of admission is **42 per cent** lower on a weekend.

• Emergency endoscopies on the day of admission are **40 per cent** lower on a weekend.

• Eight hospital trusts have low mortality rates for patients admitted on weekends and weekdays.

• Eight hospital trusts have improved their mortality rate for patients admitted on a weekend since 2011/12.

• However, eight hospital trusts still have higher mortality among patients admitted on a weekend than a weekday.
WHAT IS BEING DONE?

“The performance of the majority of the trusts [we inspected] was much worse than expected for their emergency patients, with admissions at the weekend and at night particularly problematic. General medicine, critical care and geriatric medicine were treatment areas with higher than expected mortality rates.”

Sir Bruce Keogh, Medical Director, NHS England. Review into the quality of care and treatment provided by 14 hospital trusts in England; July 2013.

Sir Bruce Keogh has made the improvement of NHS care at weekends one of the priorities for NHS England. The Sunday Times and others have campaigned effectively to keep this issue at the forefront of the public debate about standards in the NHS. In October 2013, the organisation that represents doctors, The British Medical Association, agreed to senior doctors working routinely on Saturdays and Sundays. Much is happening and our data highlights many trusts that have made significant improvements in the care provided at weekends. But as our findings continue to show, there are some hospital trusts that need to urgently review care arrangements.

THE SMALL PRINT

Our mortality indicator is based on the Hospital Standardised Mortality Ratio (see page 25) but considers emergency admissions only, given the limited amount of elective activity scheduled for a weekend. It addresses the question of whether patients are more likely to die if they are admitted during the weekend compared to weekday emergency admissions. We have looked at emergency readmissions within 30 days of discharge for patients admitted at weekends and for patients discharged at weekends.

Our broken hip measure is a rate of patients non-electively admitted to hospital with fractured neck of femur who had a related procedure in the two days following admission compared to those who did not. We compare those patients admitted on a Friday or Saturday, who need their operation over a weekend, to those admitted on a Sunday to Thursday.

Our MRI and endoscopy indicators compare the proportion of patients admitted on weekdays who have a test done on the day of admission to the proportion of patients admitted on weekends who have a test done on the day of admission.

National rates for weekday and weekend mortality and readmissions are adjusted for patient mix using the national standardised ratios for patients admitted on weekends and weekdays. Trusts which are highlighted as having improved patient care on a weekend compared with 2011/12 are those where the outcome for patients admitted on the weekend has improved, the outcome for patients admitted on a weekday has remained stable and the outcome for all patients is not above the expected level in 2012/13.
2012/13 in Numbers

237,100 patients died in hospital in 2012/13

4,400 more than 2011/12

5,300 fewer than 2010/11

The second lowest number for ten years

Read more statistical data in the Your Mortality Rate is Your Pulse poster within the Hospital Guide wallet
Your mortality rate is your pulse
(keep your finger on it)

MEASURING MORTALITY IN THE NHS

WHAT ARE WE MEASURING?

Measuring mortality rates – comparing the number of deaths that occur in a hospital with the number that occur to similar patients being treated anywhere else in the NHS – is a good way of checking how well our hospitals are caring for patients. This is why we have been publishing mortality rates for more than ten years. These rates alert hospital trusts when things might be going wrong and they are used across the NHS. We share our information with all NHS hospitals, the people who buy services (known as commissioners) and the Care Quality Commission, which is responsible for inspecting hospitals.

SO WHAT DO WE DO?

First, we count all the patients who died in hospital within a given time period.
Second, we know that each hospital treats different patients. Some have older patients and some have patients more likely to have a serious condition. We take this into account. In 2012/13 we included 12 different factors in our main way of measuring deaths in hospital.
Third, we compare the number of patients who died with the ‘expected’ number, taking into account the factors in point two. This is the Hospital Standardised Mortality Ratio, or HSMR.
Fourth, we group the hospitals into bands. This highlights those organisations where the difference between the observed
mortality rate and the expected mortality rate is statistically significant, and therefore less likely to be the result of chance.

But there is not only one way to measure mortality, so we also look at:

- How many patients died who had a diagnosis with a low immediate risk of death?
- How many patients died after an operation potentially went wrong?
- How many patients died in each hospital site and what happens if we remove patients treated by hospital trusts but for longer-term (community) care?
- What happens if we include patients who died soon after leaving hospital (within 30 days)?

![WHAT ARE OUR FINDINGS?](image)

- In 2012/13 **237,100** patients died in hospital. This is 4,400 more than 2011/12 but 5,300 fewer than 2010/11 and the second lowest number for ten years.
- The most important factors to take into account – once we know the patient’s diagnosis – are the age of the patient, whether they had any underlying health conditions (known as comorbidities) and whether the admission was planned or unplanned.
- **16 hospital trusts** have higher than expected rates and **28** have lower than expected rates on our overall measure, the Hospital Standardised Mortality Ratio (HSMR). In last year’s analysis, 20 trusts were high and 25 low.
- **Three hospital trusts** have higher than expected rates and **four** have lower than expected rates when we examine how many patients died who had a condition with a low immediate risk of death.
- **Five hospital trusts** have higher than expected rates and **five** have lower than expected when we focus on operations which potentially went wrong.
- When we look at individual hospital sites within a hospital trust, **ten trusts** have one or more hospitals with a rate higher than the trust’s overall rate. **14 trusts** have one or more hospitals with a lower rate than the overall trust.
- **13 hospital trusts** are high on at least two of our four (and not low on any) of our most important measures. They need to carefully check the reasons behind this.
- **20 trusts** are low on at least two of our four (and not high on any) of our most important measures.
WHAT SHOULD BE DONE?

“The NHS should use mortality rate indicators such as the Hospital Standardised Mortality Ratio or suitable alternatives as one of its ways to detect potentially severe performance defects that are worth investigating further.”

A promise to learn – a commitment to act (The Berwick Review), August 2013.

Hospitals should pay close attention to the way they record what has happened to patients (known as ‘coding’). These results can only be accurate if information is recorded properly. If hospitals have not noted what happened to the patient, what their treatment was and anything that might have gone wrong – such as infections – no one can accurately measure their mortality rate.

THE SMALL PRINT

The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths multiplied by 100 for a collection of 56 diagnosis groups which represent approximately 80 per cent of in-hospital deaths.

The HSMR was designed to look at patients treated in acute hospitals, not in community care. However, some NHS acute trusts also manage community hospitals. To understand the impact of this, we have looked at the site of admission for each patient. In some trusts this is not coded, but in most it is. Where possible, we have identified patients who were only treated in community sites and excluded them and then recalculated the HSMR to see how it affects the calculations.

In some cases, where the hospital trust runs more than one acute site, we have then also looked at the acute sites separately to see if they have different mortality rates.

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio of observed deaths to expected deaths for all deaths within hospitals and those within 30 days of discharge. Integrated hospital trusts that combine both acute and community beds may record a higher mortality rate on this indicator because of the way in which their services are structured.

The Deaths in Low-risk Conditions indicator provides information about deaths following admissions for conditions where there is a low immediate risk of death. These are the conditions where the mortality rate has been shown to be consistently below 0.5 per cent in adult populations. Admissions for cancer, trauma or disorders of the immune system are excluded. The indicator has been developed to help monitor and investigate particularly unexpected deaths.

The Deaths after Surgery indicator provides information about surgical patients who have died from a possible complication of surgery. It has been developed to indicate problems with surgery such as patients developing complications after surgery. On some occasions, this may also raise questions about whether some operations should have taken place.
THE OPINIONS OF DOCTORS

Each year, Dr Foster includes a quantitative survey to complement the analysis we carry out using routine hospital data. This year we partnered with Doctors.net.uk to survey doctors about some of the themes in this year’s Hospital Guide. It is important for the views of all NHS staff to be heard. We have chosen topics that fit into our overall Hospital Guide themes.

Doctors.net.uk surveyed its membership of GMC-registered secondary care doctors. The 110,915 UK secondary care doctors who were eligible to participate were invited by a combination of letter, email and invitation from the Doctors.net.uk website. Of these, 5,669 completed the survey (a five per cent completion rate); 4,638 of these worked in England. Eligibility for completion was not randomised and doctors were not incentivised for their participation. The survey was live from 24 September to 16 October 2013.
Doctors are telling us that organisations do not always act on concerns raised by staff

- **5.3%** Don't know
- **18.7%** Disagree/strongly disagree
- **23.7%** Neither agree nor disagree
- **52.3%** Agree/strongly agree

Only half of respondents agree that 'my organisation acts on concerns raised by staff.'

Not all doctors have confidence in the board and management team in the trust in which they work

- **4.1%** Don't know
- **26.1%** Disagree/strongly disagree
- **31%** Neither agree nor disagree
- **38.8%** Agree/strongly agree

About a quarter disagree that 'I have confidence in the board and management team in the trust in which I work.'

Doctors would recommend their organisation as a place to work

- **0.9%** Don't know
- **14.1%** Disagree/strongly disagree
- **19.6%** Neither agree nor disagree
- **65.4%** Agree/strongly agree

65 per cent agree that 'I would recommend my organisation as a place to work.'
Only six out of ten doctors have access to sufficient information to be able to evaluate the outcomes of their clinical practice

Almost 40% told us they did not have access to sufficient information.

A majority of doctors do not agree that patients admitted at weekends to the hospitals they work in receive care that is as good as the care of patients admitted on weekdays

32 per cent agree that care at weekends is as good as care on weekdays. Perception of care quality at weekends is also associated with seniority: consultants (34 per cent), career grades (33 per cent) and training grade doctors (34 per cent) are more likely to think that patients admitted at the weekend receive care that is as good as those admitted on weekdays than their junior (26 per cent) or middle-grade colleagues (24 per cent).
More nurses, more inpatient beds and better integration with social care would have the most positive impact on the quality of care delivered by the hospital in which they work

More nurses, more inpatient beds and better integration with social care would have the most positive impact on the quality of care delivered by the hospital in which they work.

More nursing staff More inpatient beds Better integration with social care Better management More A&E staff Fewer targets More consultants in the hospital out of hours More outpatient/day case capacity Better diagnostic services

Number who put this in their top three

WHAT DOES THIS ALL MEAN?

WHAT DO DOCTORS THINK ABOUT THE NHS?

Knowing what doctors think about the NHS and where they would choose to be treated for emergency or elective care is surely one of the best indicators of how good our healthcare system is. To address this, Doctors.net.uk collected data from 5,669 doctors working in secondary care across the UK, of whom 4,638 work in England (October 2013).

WOULD DOCTORS CHOOSE TO BE TREATED IN THE NHS?

Reassuringly, when it comes to emergency care, 95 per cent of doctors say they would choose to be treated in an appropriate NHS centre. For all the concerns voiced in the media, doctors understand the quality of emergency care delivered in NHS hospitals in England to the extent that they would choose it for themselves over private or independent providers. As one doctor put it: “I believe that the NHS is still staffed by highly trained and committed health professionals who strive to provide the best care they can in extremely difficult times.”
For non-urgent care, the majority of doctors practising in England (66 per cent) would still choose to be treated at an NHS-run hospital, with only 18 per cent preferring privately run hospitals. More junior doctors (that is, junior and middle grades) are also more likely to choose the NHS over private hospitals (70 versus 17 per cent).

When it comes to weekend care, it is of considerable concern that 68 per cent of doctors believe their organisations do not provide the same level of care at the weekend as they do during the week. This figure increases to 75 per cent for junior doctors and middle-grade doctors combined – the very group of doctors who are covering the wards out of hours and at weekends.

THE NHS AS A WORKPLACE

A substantial minority of doctors (34 per cent) did not agree that they would recommend their organisation as a place to work. Perhaps two reasons for this are that only 39 per cent agreed that they have trust in their organisation’s board and management and only 52 per cent agreed that their organisation acts on concerns raised by staff. If the events of Mid Staffordshire are not to be repeated it must be a top priority for NHS leaders to ensure that concerns of NHS staff are acted on.

DO DOCTORS RECOMMEND THEIR LOCAL HOSPITAL TO THEIR FRIENDS AND FAMILY?

When asked ‘If a friend or family member asked you to recommend a hospital, how likely is it that you would recommend the hospital you work in?’, one in three doctors surveyed who practise in England (32 per cent) said they would be extremely likely to recommend the hospital they work in. This compares with one in four (25 per cent) who would not recommend their centre (net promoter score of +7%). Nearly three in four doctors (72 per cent) are likely to recommend their organisation.

Taking the findings as a whole, then, we can be reassured that the majority of doctors in England would choose the NHS for themselves and for their friends and family for both emergency and elective care. But it is clear that NHS organisations still need to dramatically improve their response to concerns raised by staff. It is also evident that leaders in the NHS need to build trust with their workforce if they are to retain and motivate them.

FOR THE FULL RESULTS AND METHODOLOGY PLEASE VISIT myhospitalguide.com
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EDITOR
Alex Kafetz, ZPB Associates

CONTRIBUTORS
Dr David Ashby
Julie Coope
Liz Little
Humphrey Pring
Vincent Sorel
Alice Inch

DATA AND ANALYSIS
Dr Jenny Lewis
Bethan Jones
Maria Bogdanovskaya
Dr Mark Stevenson
Nisha Rajendran
Dr Neil Casey
Ellie Bragan Turner
Clare Aitken
Rachel Alsop
Dr Jess Collins

PROJECT MANAGEMENT
Robert Douce
Diane Gould
Tara Rowe

COPYWRITERS
Robin Smith, HOST Universal
Bis Turnor, HOST Universal

DESIGN
Design to Communicate

PROOFREADING
Jacqui Gibbons

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