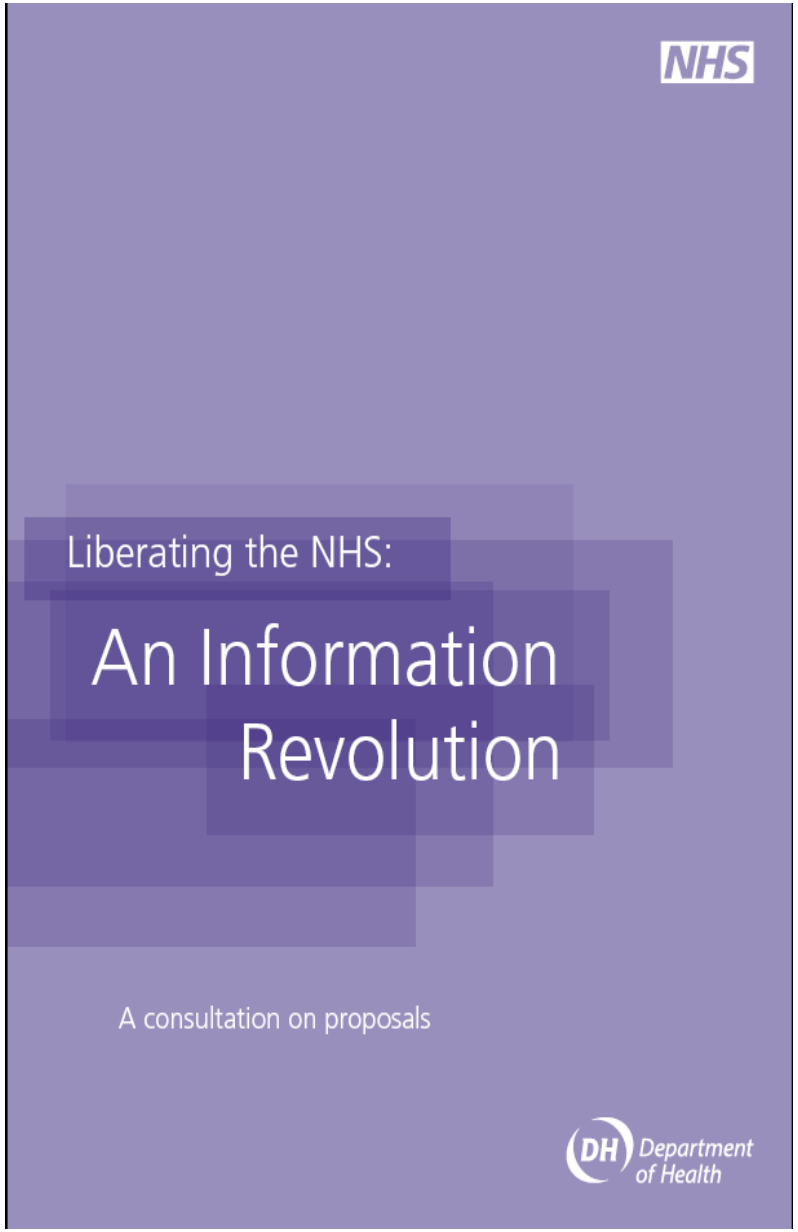
Information and Quality: Letting the Public Know

Dr A Mitchell

Medical Director

NHS London



Information for professionals

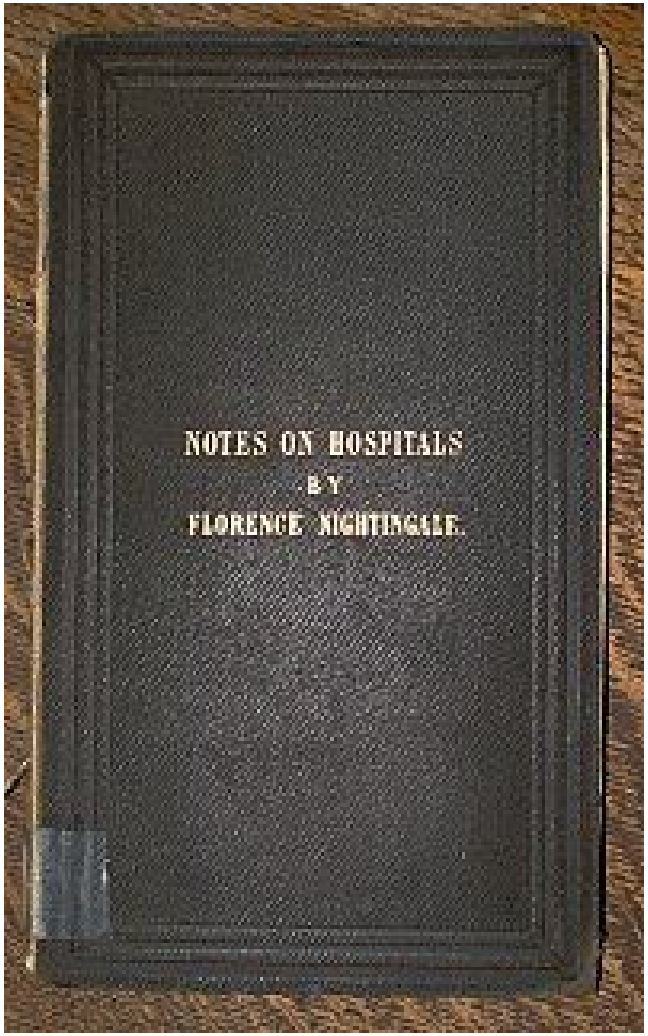
Information for improved outcomes

Information for patients

Autonomy, accountability and democratic legitimacy

Challenges for the Future
‘The Information Revolution’

How do we make comparative data more effective in achieving quality and performance improvement?



The Past...

William Guy 1867

On the MORTALITY *of* LONDON HOSPITALS: *and* INCIDENTALLY *on the* DEATHS *in the* PRISONS *and* PUBLIC INSTITUTIONS *of the* METROPOLIS. *By* WILLIAM A. GUY, M.B., F.R.S., F.R.C.P., *Professor of Forensic Medicine, King's College, London; Physician to King's College Hospital, &c.*

[Read before the Statistical Society, Tuesday, 16th April, 1867.]

AT a meeting of the *Congrès de Bienfaisance*, held in London in the year 1862, I read a short paper "On the Rate of Mortality prevailing in the General Hospitals of London," based upon the returns made to the Council of this Society in the previous year.* The returns for five years are now published in the pages of our *Journal*; and I hope to be able to deduce from them some results which may prove instructive to medical men, and not uninteresting to the members of other professions.

The returns in question have supplied the materials for the following summary:—

1.—*Results of all the Returns from Thirteen General Hospitals for any, or all, of the Five Years* 1861-65.

	Admissions.	Deaths.	Deaths per 1,000.
Medical cases	52,819	7,657	145
Surgical "	78,142	5,074	65
All "	143,245	13,898	97
Males	57,696	6,074	105
Females	40,524	3,480	86
Males, medical cases	18,586	3,231	174
Females, "	17,747	2,003	113
Males, surgical cases	35,230	2,489	71
Females, "	19,536	1,198	61
Special wards	9,165	135	15
Medical cases, highest mortality in any hospital in any year			196
" lowest " " "			104
Surgical cases, highest mortality in any hospital in any year			102
" lowest " " "			53
All cases, highest mortality in any hospital in any year			151
" lowest " " "			76
			Days.
Mean residence, medical cases (36 returns)			28
" surgical " { " }			32
" all " {48 " }			30

* For an account of the circumstances under which these returns were set on foot, see *Journal of the Statistical Society*, vol. xxv (1862), p. 384.

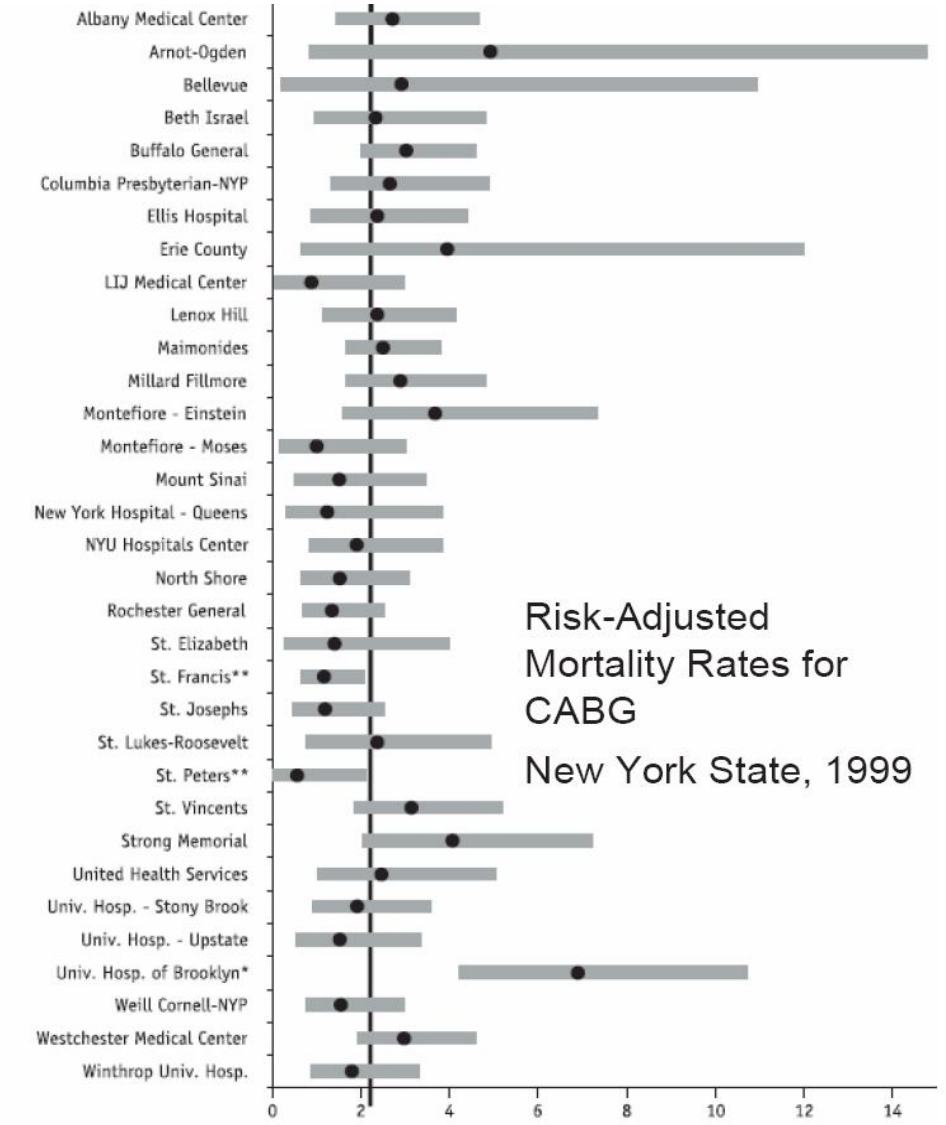
- ..we are dealing with institutions which in all probability have carried their sanitary arrangements to a point of excellence
- ..it would be unjust to attribute the differing death rates to any difference in the aggregate skill and ability of the professional staff..
- ..within the limits of the same capital city the mortality of hospitals is mainly due to the nature and severity of cases admitted...

Whose information is it anyway?

CORONARY ARTERY BYPASS SURGERY

in New York State

1997-1999



http://www.health.state.ny.us/nysdoh/heart/heart_disease.htm

The Public Release of Performance Data

What Do We Expect to Gain? A Review of the Evidence

Martin N. Marshall, MSc, MD, FRCGP
Paul G. Shekelle, MD, PhD
Sheila Leatherman, MSW
Robert H. Brook, MD, ScD

Context Information about the performance of hospitals, health professionals, and health care organizations has been made public in the United States for more than a decade. The expected gains of public disclosure have not been made clear, and both the benefits and potential risks have received minimal empirical investigation.

Objective To summarize the empirical evidence concerning public disclosure of performance data, relate the results to the potential gains, and identify areas requiring further research.

Data Sources A literature search was conducted on MEDLINE and EMBASE databases for articles published between January 1986 and October 1999 in peer-reviewed journals. Review of citations, public documents, and expert advice was conducted to identify studies not found in the electronic databases.

Study Selection Descriptive, observational, or experimental evaluations of US reporting systems were selected for inclusion.

Data Extraction Included studies were organized based on use of public data by consumers, purchasers, physicians, and hospitals; impact on quality of care outcomes; and costs.

Data Synthesis Seven US reporting systems have been the subject of published empirical evaluations. Descriptive and observational methods predominate. Consumers and purchasers rarely search out the information and do not understand or trust it; it has a small, although increasing, impact on their decision making. Physicians are skeptical about such data and only a small proportion makes use of it. Hospitals appear to be most responsive to the data. In a limited number of studies, the publication of performance data has been associated with an improvement in health outcomes.

Conclusions There are several potential gains from the public disclosure of performance data, but use of the information by provider organizations for quality improvement may be the most productive area for further research.

JAMA. 2000;283:1866-1874 www.jama.com

INFORMATION ABOUT THE PERFORmance of hospitals, health professionals, and health care organizations is increasingly being released into the public domain.[1] The data, often produced in the form of "report cards," "provider profiles," or "consumer reports," necessitates the development and dissemination of standardized reports on quality of care and facilitates comparisons of performance over time, among providers, and against defined standards of good practice. Health care performance data have been made public in the United States for more than a decade,[2] and the production and dissemination of report cards is now a multimillion-dollar industry. However, evaluation of the impact of report cards has not kept pace with the development of reporting systems.[3-7] In addition, there has been minimal agreement among the vari-

QQUIP Quest for Quality and Improved Performance

Does public release of performance results improve quality of care?

A systematic review

Paul G Shekelle, Yee-Wei Lim, Soeren Mattke, Cheryl Damberg

Southern California Evidence-based Practice Centre

RAND Corporation

The Health Foundation

TheSundayTimes
MAY 29, 2000

BLAIR'S DEATH LIST

ARE YOU ON IT?

Hidden in the government's own figures is an A-Z of life and death in Britain. Today, The Sunday Times Magazine reveals the extent of

NHS

HOW THE GRIM REAPER PLOTS HIS COURSE

Everybody has to die sometime. The problem is that some die sooner than others, and that your chance of a long and healthy life may depend as much on your postcode as on your genes. What all these figures show, with dreadful clarity, is the unshakable hold that poverty has on ill health and early death

Best areas Worst areas

Source: NHS Executive, high-level performance indicators

The death map

The figures here are ratios, showing how death rates vary between areas, and how they are changing over time. The figures are for 1995-97, as a percentage of the 1993 national average. They include deaths from all causes, for people between 15 and 64. Some areas are much worse than the national average.

1	Oxfordshire	66
2	E Norfolk	71
3	=N Hertfordshire	71
4	Bromley	72
5	=Buckinghamshire	72
6	Cambridge & Huntingdon	73
7	E Surrey	73
8	=N & E Devon	73
9	Kingston & Richmond	75
10	=N Essex	75
11	Wiltshire	75
12	W Surrey	76
13	=W Sussex	76
14	E & N Hertfordshire	77
15	=N Yorkshire	77
16	Berkshire	78
17	=S Essex	78
18	Solihull	79
19	=Suffolk	79
20	Avon	80
21	=Barnet	80
22	=Herefordshire	80
23	=N & Mid Hampshire	80
24	=S'thampton & SW Hants	80
25	=S Staffordshire	80
26	Somerset	81
27	=Dorset	81
28	=Gloucestershire	81
29	=Leicestershire	81
30	NW Anglia	82
31	Croydon	83
32	=S & W Devon	83
33	=Warwickshire	83
34	=W Kent	83
35	Worcestershire	84
36	Redbridge & W'ham Forest	85
37	=S Cheshire	85
38	Bedfordshire	86
39	=Brent & Harrow	86
40	=Shropshire	86
41	Dudley	87
42	=Lincolnshire	87
43	Portsmouth & SE Hants	88
44	Cornwall & Isles of Scilly	89
45	=E Kent	89
46	=Isle of Wight	89
47	=Ken, Chelsea, W'minster	89
48	=Northamptonshire	89
49	Barking & Havering	90
50	=Hillingdon	90
51	=Merton, Sutton & W'worth	90
52	=N Nottinghamshire	90
53	=Stockport	90
54	Calderdale & Kirklees	91
55	=E Riding	91
56	=N Cumbria	91
57	=S Derbyshire	91
58	E Sussex, Brighton & Hove	93
59	=Leeds	93
60	=Rotherham	93
61	=Walsall	93
62	N Derbyshire	94
63	=S Lancashire	94
64	Enfield & Haringey	95
65	=Nottingham	95

Heart disease and stroke

Circulatory diseases cause a third of all deaths in men under 65, and a fifth of all female deaths. They can often be prevented, so deaths are key measures of both community health and primary and emergency care. Here are deaths per 100,000 (aged under 75) in 1995-97. The national average was 133.

1	Bromley	90
2	Oxfordshire	94
3	Ken, Chelsea & W'minster	97
4	=N Hertfordshire	99
5	=W Surrey	99
6	Dorset	99
7	Cambridge & Huntingdon	100
8	E Surrey	103
9	=Somerset	103
10	E Norfolk	104
11	=Kingston & Richmond	104
12	=W Sussex	104
13	Buckinghamshire	108
14	=N & E Devon	108
15	E Sussex, Brighton & Hove	109
16	N Essex	110
17	Barnet	111
18	=E & N Hertfordshire	111
19	=Suffolk	111
20	=Wiltshire	111
21	Berkshire	112
22	Avon	113
23	Cornwall & Isles of Scilly	114
24	=S'thampton & SW Hants	114
25	Gloucestershire	115
26	N & Mid Hampshire	116
27	=S & W Devon	116
28	Herefordshire	117
29	NW Anglia	118
30	=N Yorkshire	118
31	Croydon	119
32	=Solihull	119
33	E Kent	120
34	Brent & Harrow	123
35	=Merton, Sutton & W'worth	123
36	=W Kent	123
37	=Worcestershire	123
38	S Cheshire	124
39	Bedfordshire	125
40	=Northamptonshire	125
41	=S Essex	125
42	S Staffordshire	126
43	Stockport	127
44	Barking & Havering	129
45	=Warwickshire	129
46	Leicestershire	131
47	=Lincolnshire	131
48	=Hillingdon	131
49	=Morecambe Bay	131
50	Isle of Wight	132
51	=Leeds	132
52	=Shropshire	132
53	=S Derbyshire	132
54	E Riding	133
55	Portsmouth & SE Hants	135
56	Bexley & Greenwich	138
57	=Ealing, H'smith & H'slow	138
58	=N Nottinghamshire	138
59	=Sefton	138
60	Dudley	139
61	=Enfield & Haringey	139
62	=N Cumbria	139
63	Redbridge & W'ham Forest	141
64	=Wirral	141
65	Nottingham	142

How many commit suicide?

Suicide rates are a useful measure of care standards for mental illness, which affects some 20% of women and 14% of men. The figures show numbers of suicides per 100,000 population for 1995-97, when the national average was nine.

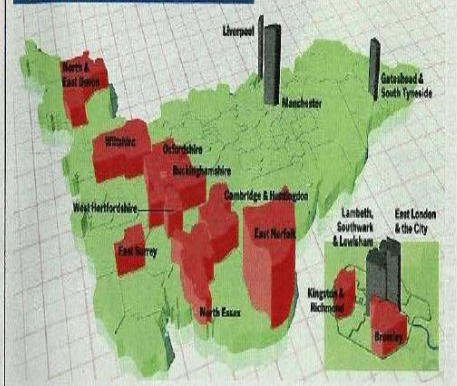
1	Barking & Havering	5
2	=Berkshire	5
3	=Bromley	5
4	=Solihull	5
5	Wakefield	5
6	=Walsall	5
7	=Wiltshire	5
8	Avon	6
9	=Cambridge & Huntingdon	6
10	=E Riding	6
11	=Kingston & Richmond	6
12	Sandwell	6
13	=Sefton	6
14	=S Humber	6
15	=Warwickshire	6
16	Barnet	7
17	=Croydon	7
18	=E & N Hertfordshire	7
19	=Hillingdon	7
20	=Lincolnshire	7
21	=N Cheshire	7
22	=N Essex	7
23	=N Staffordshire	7
24	=Nottingham	7
25	=Rbridge & W'ham Forest	7
26	=Shropshire	7
27	=S Essex	7
28	=S Derbyshire	7
29	=S Staffordshire	7
30	=Suffolk	7
31	=W Hertfordshire	7
32	=W Kent	7
33	Bedfordshire	8
34	=Buckinghamshire	8
35	=Coventry	8
36	=Ealing, H'smith & H'slow	8
37	=E Norfolk	8
38	=Enfield & Haringey	8
39	=Leicestershire	8
40	=N & Mid Hampshire	8
41	=Oxfordshire	8
42	=Portsmouth & SE Hants	8
43	=Rotherham	8
44	=St Helens & Knowsley	8
45	=Somerset	8
46	=S'thampton & SW Hants	8
47	=Stockport	8
48	=Wolverhampton	8
49	Bradford	9
50	=Brent & Harrow	9
51	=County Durham	9
52	=Dorset	9
53	=Dudley	9
54	=E Kent	9
55	=Gloucestershire	9
56	=E London & the City	9
57	=Northamptonshire	9
58	=N Derbyshire	9
59	=N & E Devon	9
60	=N Nottinghamshire	9
61	=Northumberland	9
62	=Sheffield	9
63	=W Surrey	9
64	=Wigan & Bolton	9
65	=Worcestershire	9

How many babies die?

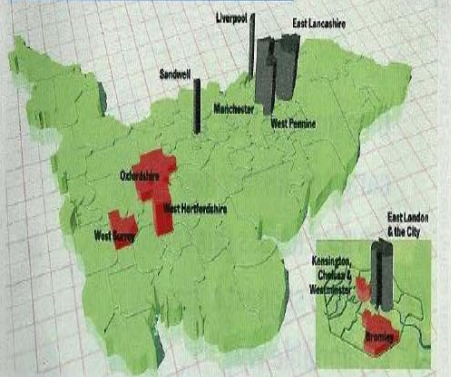
Deaths in the first year of life, including stillbirths, reflect the quality of care given to mothers and infants, and the level of health education on smoking, drinking and nutrition. The figures, which are for 1995-97, show percentage variations above and below the national average (which rates zero).

1	W Surrey	-56
2	Bromley	-47
3	N Yorkshire	-46
4	Somerset	-44
5	Kingston & Richmond	-42
6	=Suffolk	-42
7	N Essex	-41
8	=S Essex	-41
9	Berkshire	-39
10	Cambridge & Huntingdon	-38
11	E Norfolk	-36
12	=E Surrey	-36
13	=N & Mid Hampshire	-36
14	Herefordshire	-35
15	=Oxfordshire	-35
16	W Hertfordshire	-32
17	S Lancashire	-27
18	Northamptonshire	-24
19	=Sefton	-24
20	=Solihull	-24
21	=W Kent	-24
22	=W Sussex	-24
23	=Wiltshire	-24
24	Morecambe Bay	-22
25	N Derbyshire	-21
26	Avon	-20
27	=N & E Devon	-20
28	=S'thampton & SW Hants	-20
29	S Staffordshire	-19
30	E Sussex, Brighton & Hove	-18
31	=S Derbyshire	-18
32	Ealing, H'smith & H'slow	-17
33	=Isle of Wight	-17
34	Camden & Islington	-14
35	=Dorset	-14
36	Bexley & Greenwich	-13
37	=N & E Hertfordshire	-13
38	=S Humber	-13
39	Nottingham	-12
40	Barnet	-11
41	=E Riding	-11
42	=S Cheshire	-11
43	=S & W Devon	-11
44	N Cumbria	-10
45	=Shropshire	-10
46	Warwickshire	-9
47	Newcastle & N Tyneside	-7
48	Buckinghamshire	-5
49	=Gloucestershire	-5
50	E Kent	-4
51	=Leeds	-4
52	Croydon	-2
53	N Cheshire	-1
54	=N'bridge & W'ham Forest	-1
55	=Wirral	-1
56	Hillingdon	0
57	Barking & Havering	1
58	=Salford & Trafford	1
59	N Nottinghamshire	3
60	Worcestershire	3
61	Merton, Sutton & W'worth	4
62	=W Pennine	5
63	N Staffordshire	5
64	=Stockport	8

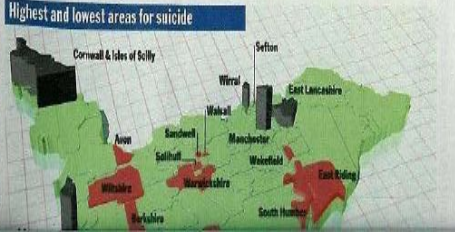
Highest and lowest areas for death



Highest and lowest areas for heart disease and stroke



Highest and lowest areas for suicide



UNIVERSITY OF BIRMINGHAM

Health Services Management Centre

Research that makes a real difference

May 2009 **HSMC policy paper 4**

Supporting patients to make informed choices in primary care: what works?

Jo Ellins and Shirley McIver, in association with NHS West Midlands

Public Information in Primary Care
The Evidence

Quality in Health Care 2001;**10**:152–158

Systematic review of studies of quality of clinical care in general practice in the UK, Australia and New Zealand

M E Seddon, M N Marshall, S M Campbell, M O Roland

doi: 10.1111/j.1369-7625.2006.00394.x

Development of an information source for patients and the public about general practice services: an action research study

Martin Marshall BSc MBBS MSc MD FRCGP FRCP,* Jenny Noble BA MSc PGCE,† Helen Davies MSc RN,‡ Heather Waterman BSc PhD Dip N RGN OND,§ Kieran Walshe BSc PhD DipHSM,¶ Rod Sheaff BA DPhil MHSM** and Glyn Elwyn BA BM BCh PhD FRCGP††

‘Tacit’ Knowledge

Journal of Evaluation in Clinical Practice, **8**, 2, 215–228

Reporting health care performance: learning from the past, prospects for the future

Russell Mannion PhD[1] and Huw T. O. Davies PhD, HonMFPHM[2]
[1]Senior Research Fellow, Centre for Health Economics, University of York, York, UK
[2]Professor of Health Care Policy and Management, University of St Andrews, St Andrews, UK

The Patient Perspective?

What are we doing in London?