

Standardized mortality ratios not reliable indicator of quality of hospital care

A new study by researchers from the University of Birmingham suggests that standardized mortality ratios, the system used by the government to inform key decisions about the performance of NHS hospitals, are not a reliable indicator of the quality of hospital care (Girling et al, 2012).

The study concluded that an observed lack of agreement between different methods for calculating hospital-wide mortality rates may result from 'fundamental flaws in the hypothesised association between hospital-wide mortality and quality of care.' Such a flaw would arise if preventable deaths were low in relation to inevitable deaths.

The team modelled the correlation between overall risk-adjusted deaths and deaths resulting from poor care. They developed a model to estimate the proportionate variation in standardized mortality ratios accounted for by fluctuations in preventable deaths.

Professor Richard Lilford, Professor of Clinical Epidemiology, University of Birmingham, Birmingham



'The relationship between overall mortality and deaths preventable by better care is not linear,' explains Professor Richard Lilford, Professor of Clinical Epidemiology at Birmingham and lead author of the study. 'The signal (preventable deaths) gets lost in the noise (inevitable deaths) unless more than a quarter of all deaths are preventable. The appalling idea that one in four of all NHS hospital deaths are preventable is not backed up by current evidence.'

Girling AJ, Hofer TP, Wu J, Chilton PJ, Nicholl JP, Mohammed MA, Lilford RJ (2012) Case-mix adjusted hospital mortality is a poor proxy for preventable mortality: a modelling study. *BMJ Qual Saf* doi:10.1136/bmjqs-2012-001202

Fewer than 1 in 100 patients with chronic hepatitis C get triple therapy

Analysis of data from the Health Protection Agency and the IMS Health Hospital Pharmacy Audit Index, looking at the prescribing of protease inhibitors against chronic hepatitis C (genotype 1) in the UK, shows that fewer than 1 in 100 (0.9%) eligible patients are receiving the drugs.

This is despite these treatments having had accelerated assessments by the European Medicines Agency because of their public health benefit, and recommendations for NHS use from both the National Institute for Health and Clinical Excellence and Scottish Medicines Consortium.

Protease inhibitors include boceprevir and telaprevir, and are given in combination with dual therapy (peginterferon and ribavirin), to form triple therapy. Out of the 47 520 patients diagnosed with G1 hepatitis C in the UK, and therefore eligible for treatment, only around 450 are currently receiving triple therapy.

By treating hepatitis C, there is a potential to clear the virus – referred to as sustained virologic response. Clinical trials have shown that triple therapy can significantly improve the number of patients clearing the virus compared to dual therapy.

Age should not restrict access to surgery

As people are living longer and healthier lives, using someone's age as a shortcut to assessing their suitability for treatment should be redundant. Instead a person's overall health – or 'biological age' – must be the main consideration, says a report by the Royal College of Surgeons of England (2012).

It shows that while a patient's health needs – including conditions that could be treated by surgery – increase with age, elective surgery rates decline steadily for people as they grow older. Thus the gap between the increasing health need and access to surgery means many older people are missing out on potentially life-saving treatment.

Access all Ages looks at the potential causes of these trends and makes recommendations as to how the NHS can ensure

that all patients can access the best possible surgical treatment, irrespective of their age.

The study also warns that the £20 billion NHS efficiency drive heightens the danger of older people being disproportionately impacted, as restrictions may be imposed because of the perceived reduction in the cost effectiveness of providing treatment when relative life expectancy is shorter.

It highlights that a new ban on age discrimination in the NHS came into effect at the beginning of October, providing a legal framework to go alongside moral and professional imperatives to ensure that older patients receive the most appropriate treatment for their individual needs whatever their date of birth.

Among others, the report found that the incidence of

breast cancer peaks in the 85-year+ age group, while the surgery rate peaks for patients in their mid-60s and then declines sharply from the age of 70 years.

It also highlighted that the majority of recipients of joint replacement surgery are people over the age of 65 years. However, the rate of elective knee replacement and hip replacement surgery for patients in their late 70s and over has dropped sharply and consistently over the 3 years examined.

The report concludes that there should be no informal 'cut-offs' and that older patients and their families must be supported to challenge this where it is suspected.

Royal College of Surgeons of England (2012) *Access all ages. Assessing the impact of age on access to surgical treatment*. Royal College of Surgeons of England, London