| | |
|---|---|
| Medical Leader | |
| Medical Expert | |
| Communicator | • |
| Advocate | • |
| Scholar | |
| Professional | |
| Collaborator | • |
| Manager | ☐ |

# Benchmarking with the NHS

2013 Q2

As a dedicated medical administrator, you read widely particularly around issues of quality and safety in hospitals. One of your favourite sources of information comes from the NHS in the United Kingdom – the Hospital episode statistics (HES) published on the Dr Foster Health website. This is the data source for a wide range of healthcare analysis for the NHS, government and other organisations and individuals. Each year HES publishes tables of data relating to admitted patient care in NHS hospitals in England.

One day you come across the HES statistics on mortality rates on weekends compared with weekdays in NHS hospitals, and find the extract shown in Appendix A.

This is of special interest to you because your hospital is responsible for emergency and elective vascular surgical care and your Executive Director of Surgery is a vascular surgeon. Your CEO and Board see this data and wonder whether the same thing could be happening in your hospital.

How would you investigate this matter?

If you find similar results, what do you think are the factors that may be causing the observed difference and what actions could be taken to manage the situation.

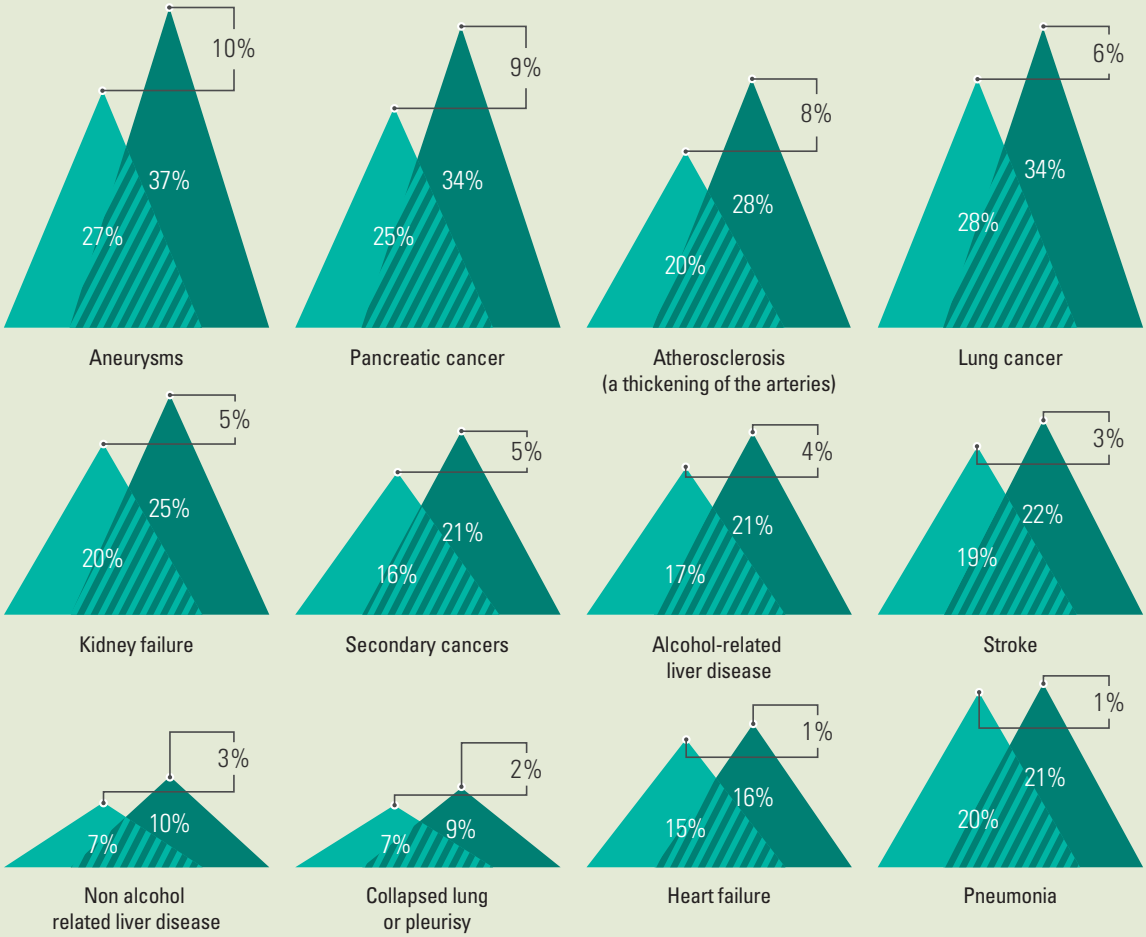
# DEATHS ON WEEKENDS SIGNIFICANTLY HIGHER FOR VASCULAR CONDITIONS

**THE DEATH RATE FOR** NHS patients undergoing unplanned treatment for certain vascular conditions is up to 10 percentage points higher for those admitted at weekends, according to figures released today.

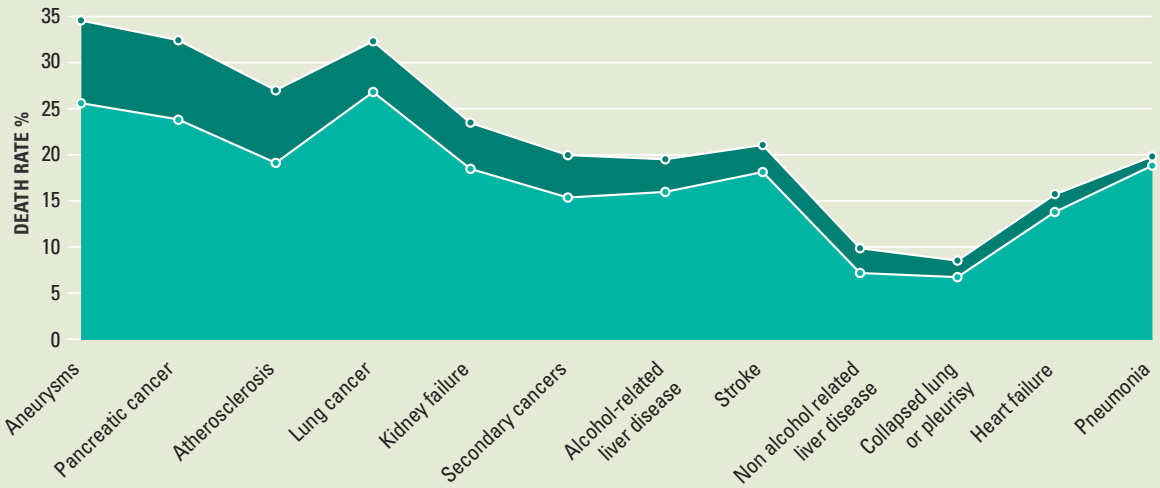
In a new breakdown of hospital data, we reveal a sharp jump in weekend mortality, including aneurysms (10 percentage points higher) and atherosclerosis (a thickening of the arteries – 8 percentage points higher).

**KEY**

- Weekday death rate
- Weekend death rate




**OVERVIEW**



# Benchmarking with the NHS

2013 Q2

Three (3) core requirements for this question

1. Interpretation of health data, in this case, death rate comparisons between weekdays and weekends.
2. Managing a quality improvement project.
3. Clinical engagement in managing quality

Question writer's notes (these are not meant to be an exhaustive check-list but as prompts for Censors)

The candidate should be able to identify a number of factors (staffing levels, access to support services, clinician fatigue) that might contribute to a higher mortality incidence at weekends and the strategies for identifying those factors.
Is the importance of death rate for immediate care modified at all if the underlying disease has a high short term mortality rate even with hospital care? (In other words, is this a real problem with the particular diagnosis or are these statistics more valuable for the implications across a range of clinical conditions?)

Emphasis on strategies for ensuring care standards, and support for especially junior staff are maximised out of hours. Who they can call? Is there any reason to believe that the pathology may be more severe in weekend presentations?

Part of the approach might need to involve primary care access out of hours, particularly for the more disadvantaged communities if they prove to be over represented in the weekend peaks. National or state health help lines.

NZ:
After hours primary care is vastly more expensive in NZ, and the already disadvantaged show sound fiscal judgment to defer until Monday if they can - but sometimes that strategy backfires. NZ has "Healthline" a free calling nurse led telephone advice service, which is being promoted in this context.