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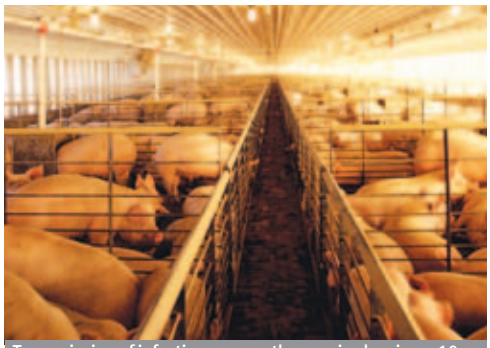
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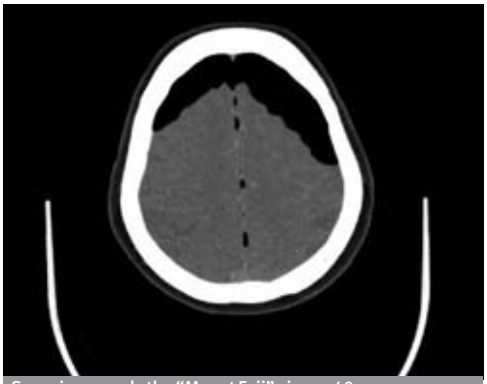

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PA

PICTURE OF THE WEEK

A protester displays a car sticker during a demonstration last week against the proposed closure of the accident and emergency unit at Lewisham Hospital in southeast London. Under the proposal the unit would be turned into an urgent care centre (*BMJ* 2013;346:f189). Critics of the closure argue that the hospital has performed well and has been unfairly targeted. The NHS's medical director, Bruce Keogh, has warned that opposing changes to hospital services in England risked "perpetuating mediocrity."

NEWS, p 5

RESPONSE OF THE WEEK

Hospitals are still organised around the care of younger, fit adults presenting with a single acute medical problem. Yet this is no longer the population requiring care . . . The problem is not with our patients, the problem is with our health systems. Let's fix our healthcare system to make it responsive to the needs of the patients who require it. Let's change training and education to ensure that staff possess the skills to manage people with multimorbidity, including older people. Let's enable prompt diagnosis and invest more in downstream systems designed to allow older people to leave hospital when ready to do so. Let's have equity of access for all patients who require it and begin the overhaul of the NHS to make it fit for the 21st century.

Marion E T McMurdo, professor of ageing and health, Dundee, UK, in response to "Alternatives to hospital for older people must be found" (*BMJ* 2013;346:f453)

BMJ.COM POLL

Last week's poll asked: "Are acute hospitals the right place for the frail and older people?"

84% voted no (total 829 votes cast)

BMJ 2012;346:f453

This week's poll asks:

"Would you encourage your patients to have prostate specific antigen testing"

Clinical review *BMJ* 2013;346:f325

Observations *BMJ* 2013;346:f548

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MOST SHARED

Drug-grapefruit juice interactions

How science is going sour on sugar

Science souring on sugar

Benefits of cancer screening take years to appreciate

Indian doctors decry decision to move raped woman to Singapore

EDITOR'S CHOICE

Mid Staffs and mortality data

This has been a bitter episode in the NHS's history which, like the Bristol heart surgery scandal in 1998, is likely to echo down the years

Stafford Hospital in England's West Midlands was just one of many medium sized hospitals treating a wide range of medical and surgical conditions within the NHS. But then, in 2007, the health analytics company Dr Foster reported higher than expected death rates among its patients. Few could have predicted the long and murky chain of events that would follow, culminating in a public inquiry chaired by Robert Francis (see our timeline at http://tw.gs/YxS0gV). The inquiry's findings will be published next week.

This has been a bitter episode in the NHS's history which, like the Bristol heart surgery scandal in 1998, is likely to echo down the years. Evidence given to the inquiry over the past 18 months speaks of problems well before 2007, including target driven managers, poor standards of nursing care and cleanliness, a culture of bullying and intimidation, serious complaints from patients and relatives being ignored, and doctors continuing to refer and treat patients rather than speaking out. Patients and their relatives will be right to feel betrayed.

But what of that first public signal suggesting that something was wrong? Is the hospital standardised mortality rate (HSMR) a reliable indicator of poor standards of care? The methodology has its critics, chief among them Richard Lilford and colleagues at Birmingham University. And it was these critics to whom the beleaguered Mid Staffs strategic health authority turned for an opinion on the trust's unflattering mortality data. The resulting report, highly critical of the HSMR's ability to reflect differences in quality of care, was published in the *BMJ* (2009;338:b780). At the authors' request, it was published on the same day as a Healthcare Commission report into Mid Staffs. Was the *BMJ* used as part of a concerted effort to discredit the HSMR?

We asked Nigel Hawkes to investigate. After talking to all parties he finds no clear evidence to support this claim, nor the claim that Mid Staffs orchestrated efforts to manipulate mortality data (p 16). What he does find is a "tangled tale" of coding changes and false reassurances, which almost certainly delayed the necessary action to tackle what we now know were fatal failures of care.

As Hawkes reports, the NHS is now using a new version of the HSMR: summary hospital level mortality indicators (SHMIs), and five English hospitals have just been named as having higher rates than expected (*BMJ* 2013;346:f554). But we are being urged not to see these as a definitive judgment but more as an early warning.

What does all this mean for future attempts to track the quality of hospital care? While acknowledging concerns about existing methods, Harlan Krumholz and colleagues seem optimistic (p 9). The science of healthcare measurement is advancing rapidly, they say, as is the availability of higher quality data. Both promise a more accurate picture of how our systems of care are performing. But on their own they won't be enough. Scrutiny, scepticism, listening, and courage are needed if we are to promote effective clinical strategies, give patients the information they need, and reward excellence, not just reputation. The Bristol scandal woke us up to the need to share data on clinical outcomes and to speak out when we witness poor quality or unsafe care. But that was 15 years ago. How much has really changed?

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