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TRANSCRIPT OF "FILE ON 4" – "DEADLY HOSPITALS?"

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READER IN STUDIO: More hospitals face probes over patient deaths.

READER 2 IN STUDIO: We reveal true toll of deadly NHS errors.

NORTHAM: They are the headlines hospital managers dread.

READER IN STUDIO: Doomed to die by the NHS.

READER 3 IN STUDIO: Revealed: NHS trusts with high death rates.

NORTHAM: These reports are triggered by a range of mortality statistics published for each of the 145 NHS hospital trusts in England. The commercial company which publishes them in the Hospital Guide invites readers to 'find out if your hospital is fit for the future'. It argues that the data helps spot hospitals which are failing national standards.

TAYLOR: What they do is they identify those areas where there's a greater risk of poor quality care.

NORTHAM: But this week File on 4 reports on cases where mortality statistics don't tell the whole story. And an expert reviewing the data for the NHS tells us that the public and the official watchdog should simply ignore them.

SIGNATURE TUNE

ACTUALITY IN BIRMINGHAM

NORTHAM: The largest hospital site in the country is the University Hospitals Trust here in Birmingham. It's a massive modernist set of curved buildings, which treats well over 120,000 inpatients a year. It's a foundation trust with an international reputation as a teaching hospital, linked to a top-class university. So it might seem strange that just before last Christmas, Birmingham was one of thirteen trusts named in the press as having death rates 'significantly higher' than the national average.

EXTRACT FROM NEWS PROGRAMME

NEWSREADER: A quarter of the worst hospitals in England and Wales are in the West Midlands, according to an official report. Both the Heart of England Trust and the University Hospitals Birmingham have higher than expected death rates.

ACTUALITY IN HOSPITAL

NORTHAM: Managers at the Birmingham hospital say these reports are unfair and misleading. And they point to an elaborate computerised control system they've developed, to ensure that quality of care is maintained at a high level throughout.

RAY: This is used by our nursing staff and managers to look at the quality of care that's being given on our wards.

NORTHAM: The Head of Informatics, Daniel Ray, runs a monitoring programme called HED - Healthcare Evaluation Data - which Birmingham uses and sells to a number of other hospitals.
So you call it a dashboard, because it looks like a car dashboard you've got. The different, as it were, speedometers here with green shading on the left …

RAY: That's right, yes.

NORTHAM: …. curved round to amber, yellow and then finally red, and that's presumably when you start to worry, if the needle reaches there?

RAY: Yes.

NORTHAM: This one here, on the other hand, is at zero – no problem at all, and that's MRSA.

RAY: That's right, yes.

NORTHAM: You're on top of that, then?

RAY: Yes.

NORTHAM: The Medical Director at University Hospitals Birmingham, Dr Dave Rosser, is a believer in the power of daily statistical analysis of the hospital's clinical teams. He argues that it helps keep standards high – and that patients recognise this.

ROSSER: The fact that people are literally flocking here, sometimes driving past other hospitals in order to get here, to receive care here, I think is a pretty strong indication. We've actually opened up over 250 additional beds in order to accommodate demand, which is mainly fuelled by individual patients making choice to come here.

NORTHAM: You're in a list which looks to the public like the most dangerous hospitals in the country. Did that worry you?

ROSSER: Well, certainly it has no bearing on the number of patients who wish to come and get their treatment here, because we're extremely busy.

NORTHAM: If I were to use the word 'cavalier' about your reaction, would that be fair?

ROSSER: No, it wouldn't. I understand these figures in enormous detail. They are supremely irrelevant in terms of assessing how well a hospital is run and how good the care is. I think it's a random number generator. I mean, we have been visited by CQC, other regulators, commissioners, CCGs, the local GPs have come and looked at our quality management systems and they all go away very reassured because we can demonstrate to them we know exactly what's going on in our hospital. I know exactly which patients are getting their drugs and which patients have missed doses of their drugs, why, which nurses are not giving the drugs, which doctors' prescribing is not up to scratch – and we can deal with all that.

NORTHAM: Birmingham's statistical model is a direct commercial competitor to Dr Foster, the company producing The Hospital Guide. So Dr Rosser might be thought partisan. We've discovered, however, that he is not alone in questioning the reliability of hospital-wide death statistics as indicators of quality of care. How, then, are these influential figures produced? Every year, an English national average death rate is calculated for each medical condition. For some illnesses, it's almost negligibly small. For others, close to 100%. Dr Foster then compares the number of patients who actually die of each condition in each hospital with these national averages. There are adjustments for age, sex and other factors before a final number is produced - the hospital's overall score. It's called the HSMR - Hospital Standardised Mortality Ratio. But how useful is it?

ACTUALITY WITH BLACKBOARD

SPIEGELHALTER: If I can draw it on the board here, you can see a sort of distribution of performances of hospital, perhaps. Some up at the top and some down at the bottom and most of them vaguely around the middle.

NORTHAM: At Cambridge University's Centre for Mathematical Sciences, one of Britain's most distinguished statisticians, Professor David Spiegelhalter, has his doubts.

SPIEGELHALTER: I get very uncomfortable with these numbers. I don't think you can just summarise a hospital by one number. There are so many reasons why there may be more deaths one year in a hospital than you might expect. My preference very strongly

SPIEGELHALTER cont: is for systems that monitor mortality at a much finer level and look at it within each unit - within strokes or within heart attacks or whatever.

NORTHAM: But for individual hospitals?

SPIEGELHALTER: Oh yes, still individual. I'm a statistician, I think they should collect the data. I love … I think these stats are great, it's just what you do with them and whether you handle them, I think, in an appropriate and responsible way.

NORTHAM: So getting down to that, as you say, fine grain of what's going on in a hospital in each particular kind of disease, you're quite happy with that?

SPIEGELHALTER: I like that …

NORTHAM: But one number for a whole hospital?

SPIEGELHALTER: It's too easy to misinterpret - people have said it's a smoke alarm. I don't think it's even as strong as a smoke alarm. It's a very weak signal. I don't think you can judge the quality of care by any of these single numbers; you have to go in and look at it in more detail of what's going on.

ACTUALITY IN BLACKFRIARS

NORTHAM: The company at the centre of this dispute is based here, on a quiet street in Blackfriars, to the west of the City of London. The ground floor of an elegant granite building is occupied by the wryly named Dr Foster - as in 'went to Gloucester' - Dr Foster Intelligence. It produces reams of data on individual hospitals. And, in contrast to the reservations of Dr Rosser and Professor Spiegelhalter, Dr Foster's Director of Research, Roger Taylor, argues that mortality ratios are measures which have proved valuable to the NHS and the public.

TAYLOR: We can point to the fact that they helped to identify issues at Mid Staffordshire Hospital and at Basildon Hospital. We can point to the fact that the number of hospitals that used them actively as part of their quality assurance and quality

TAYLOR cont: improvement programmes. In many countries around the world they're now using HSMRs, which again I think is evidence of their value.

NORTHAM: Do you think they give any indication of the quality of a hospital's clinical practice?

TAYLOR: Yes I think they do. What they do is they identify those areas where there's a greater risk of poor quality care.

NORTHAM: Professor David Spiegelhalter says that when you try to give one number to summarise a hospital's mortality, he says he's very uncomfortable with that. Do you understand why?

TAYLOR: One of the issues may be the following, which is that inside a hospital often there are many different practices going on. Some may be being done excellently and some may be being done poorly, and so if you average across those, you might get a picture that says, well this looks just very average, whereas in fact it's disguising the fact that there's a lot of difference within that, and so I would fully agree with him in saying it's really important to look not just at high level figures, but to look beyond them.

NORTHAM: But the single hospital-wide figure he thinks is, well he calls it a very weak signal.

TAYLOR: Yes, and he's quite right, that it's one number amongst many numbers that need to be looked at in order to properly understand the quality of care in the hospital.

NORTHAM: One of the reasons for some statisticians' caution over HSMRs is that they can be influenced up or down by a range of factors which have nothing to do with a hospital's clinical standards - and everything to do with the way it collects statistics.

ACTUALITY IN HOSPITAL

NURSE: Hi Abigail, how are you feeling?

ABIGAIL: I'm feeling fine.

NURSE: You feel fine, yeah? Once this has finished, I'll put a small bag of saline over ten minutes and then we'll disconnect you from your canula, remove that.

NORTHAM: In Birmingham's Young Persons Cancer Unit, Abigail is lying on her bed, hooked up to a drip of chemotherapy.

NURSE: In the meantime, we'll prepare your discharge paperwork and you'll be able to go home.

ABIGAIL: Oh, lovely.

NORTHAM: For her, as for every other patient, the hospital keeps detailed notes of clinical treatment and progress. But it's the record of diagnosis which is particularly important in working out mortality comparisons.

ACTUALITY IN CODING DEPARTMENT

NORTHAM: In a large office inside one of the old buildings at University Hospitals Birmingham, a team of twenty clerical staff sit at computers, recording the details of each patient's illness and treatment. They're called coders. And, as one of them, Elaine Madden, explains, categorising individuals can be a complex task.

MADDEN: This is my pro-forma. I've got this information by going to the ward and reading the patient's notes.

NORTHAM: And what can you tell me about this patient?

MADDEN: Well, this patient is an elderly patient who's been admitted because she has pneumonia.

NORTHAM: How old is she?

MADDEN: 79, and she also has various other conditions that I've had to list. She has epilepsy and she has hypertension and osteoarthritis.

NORTHAM: How many conditions in all have you found in her medical notes?

MADDEN: For this particular patient, I've been able to extract eleven conditions.

NORTHAM: Eleven?

MADDEN: Eleven.

NORTHAM: Is that an uncommonly large number?

MADDEN: No, it isn't. What I do now is I use my books to translate the medical terminology into a specific code. I would get the best code I can to assign to that particular condition.

NORTHAM: How many different codes are there for different kinds of pneumonia?

MADDEN: Possibly about three pages.

NORTHAM: We're talking about more than a hundred different codes for pneumonia?

MADDEN: Yes we are, yes. And then I go onto our system and I add the code onto the system.

NORTHAM: Do you ever get it wrong?

MADDEN: I'd like to say no to that question. We do generally get it right.

NORTHAM: Coding like this has grown under the NHS payment by results process. A hospital gets paid different amounts for each illness, so recording diagnoses correctly is the key to getting paid properly. The HSMR takes as its starting point these records kept for administrative purposes and uses them to indicate the risk of something going wrong clinically. But, as the Head of Informatics, Daniel Ray, explains, a change in coding can alter a hospital's mortality ratio.

RAY: If you have a hospital that is purely an eye hospital, that just does cataracts, your expected mortality there is pretty much going to be zero. If you've got another organisation that do heart/lung transplantation, that organisation's expected amount of deaths is going to be higher per patient that they treat. And so the codes that are assigned to the patient is the petrol, if you like, going into the engine that drives the expected amount of deaths that are allowed. The more codes that you assign and the sicker the patient appears, through the codes that they're assigned, the higher the amount of expected deaths that you are allowed. And obviously you would then end up with a better performance in the death statistic.

NORTHAM: Daniel Ray points to an instance of this statistical effect. It is the change Birmingham has recently introduced - coding more patients as needing palliative care. Since many of them will therefore be expected to end their lives in the hospital, the number who do die looks less unusual. And so the HSMR comes down, closer to the national average of 100. The hospital's Medical Director, Dr Dave Rosser, argues that this is entirely foreseeable.

ROSSER: In line with the national guidelines, we've changed the palliative care coding and that's reduced our HSMRs, as we would have predicted, but it doesn't demonstrate a step change in the care they were offering the patients in the hospital. I mean, obviously we're working all the time to improve and we believe we are continuing to improve, but there's been no step change over a month, which is what has happened when we used to change the palliative care coding.

NORTHAM: So your HSMR, published next December, will be a lot lower, will it?

ROSSER: It's currently 102 and it's averaging around 100 since we changed the coding practice.

NORTHAM: And it was what? 120 or something?

ROSSER: It's been up to 112, 114 at one stage, yes.

NORTHAM: But you're not saying that's because you're suddenly taking better care of patients? It's because you're taking different approaches to the statistics?

ROSSER: Yes, it wasn't high because we were offering poor care and it hasn't improved because we're offering better care.

NORTHAM: Dr Foster says that every trust should be coding in line with national guidance. It points out that rates of palliative care vary widely and that Dr Foster provides context by routinely looking at palliative care coding rates alongside HSMR. You don't have to travel far from Birmingham to find another example of a sudden drop in a hospital's mortality ratio.

ACTUALITY IN WALSALL

NORTHAM: This is the 50-foot high atrium in the reception area of nearby Manor Hospital in Walsall. It too has a long record of high HSMRs which here has turned around in the past two years. Manor Hospital went from having one of the highest mortality ratios in England to one of the lowest - an apparently remarkable achievement. But look more deeply into this transformation and it can seem very different.

KHAN: At the first instance, if you look at it as a lay person, that is an indicator which shows that more people are dying in this hospital than they should.

NORTHAM: At the Walsall hospital, managers did what Dr Foster suggests they should do. The Medical Director, Amir Khan, took the high HSMRs as a trigger for action. Dr Foster also offers a commercial consultancy service, which Manor Hospital employed. Mr Khan set about a programme of changes at the hospital, designed to improve clinical practice and learn from any mistakes.

KHAN: The first thing which I did was we got the data and we reviewed the notes. Two senior clinicians from my organisation who had recently retired, I invited them in and I said, would you go through all those deaths.

NORTHAM: Did you find any deaths which you thought could have been prevented or avoided?

KHAN: Most of those patients who actually died, probably their outcome would not have changed.

NORTHAM: So it wasn't that you discovered a lot of deaths which could have been avoided?

KHAN: No, because this was, by the reviews at that time, made categorical to me that most of those, the outcome, like a death, would not have changed, but the process they went through should have been improved.

NORTHAM: The hospital extended consultant cover from five days to six or seven each week. It tightened up policy on drug administration and appointed two consultants in palliative care. Before long, the hospital's coverage in the news took a turn for the better. The local Primary Care Trust - the then paymaster of the hospital - got its consultant in Public Health, Dr David Pitches, to investigate mortality at Manor Hospital. Dr Pitches welcomes all the improvements made to standards of clinical care. But he found that they weren't the reason for the drop in Walsall's historically high mortality ratio.

PITCHES: We found that around about the same time that the hospital mortality ratio began to drop and began to drop quite precipitously.

NORTHAM: When was that?

PITCHES: Early 2012.

NORTHAM: So after this peak here in August/September 2011 …

PITCHES: That winter, yes.

NORTHAM: In 2012 it dropped, oh, and it goes way below 100 …

PITCHES: And it stays …

NORTHAM: Goes way below the national average.

PITCHES: And stays at around 90 for the rest of the year.

NORTHAM: And the explanation for that drop was what?

PITCHES: Well that coincided with the hospice in Walsall - which had been twenty years in the planning - getting up to full capacity and all of a sudden, patients who historically might have died in the hospital had a new option available to them - they were dying in a hospice.

NORTHAM: And therefore not counting in the hospital's figures?

PITCHES: Correct.

NORTHAM: And was the number of patients dying in the hospice sufficient to explain this drop in the mortality ratio of the hospital?

PITCHES: I believe so.

NORTHAM: So it was a purely statistical change?

PITCHES: Yes. I believe that the reason for the huge drop in HSMR was primarily a result of a statistical artefact. The statistical effect of that hospice opening alone could potentially account for all of the change in hospital mortality ratios.

NORTHAM: We put this conclusion to Roger Taylor of Dr Foster Intelligence, who accepts that an apparent risk signalled by high HSMRs can have a quite different explanation.

TAYLOR: One of the things we did was we looked at the mortality ratios, including everybody in the hospital, and then we looked at what would happen if we excluded hospices from these calculations. And we could see that in most hospitals it didn't make a big difference at all. But there were some that it did. So you are absolutely right, this is an important issue and we can start to capture it in the data. It's not very well recorded, we don't have all the data we would like to fully capture that, but we can see some instances where it's making a difference.

NORTHAM: We looked at a particular example of a hospital in Walsall, which had a high HSMR, which suddenly dropped dramatically. And the explanation, according to the public health consultant who reviewed this for the local NHS, was that the drop was explained principally by the opening of a hospice, not by any change that had been made at the hospital.

TAYLOR: You're absolutely right, it can be an issue, and that's why we know that mortality ratios are a signal of higher risk, but there may be another explanation. But just to be clear, the mortality ratios are still a very useful way of understanding risk, but it's absolutely right that it's a risk that there's an issue with care, but it may be explained by other issues.

NORTHAM: If the hospital in Walsall saw its reputation rise following a drop in mortality statistics, last year another trust further north experienced the unwarranted damage that can be done by misunderstanding data.

EXTRACT FROM NEWS REPORT

NEWSREADER: The number of deaths at the Royal Bolton Hospital may have been wrongly recorded, according to an independent investigation. It raises the possibility that there've been more deaths than the official figures show.

NORTHAM: The Royal Bolton Hospital had high mortality statistics for most of the past decade. It was used to being criticised in the national press on the basis of Dr Foster's data. Then in 2011-2012, there was suddenly a dramatic rise in the number of patients Bolton recorded as having sepsis - a life-threatening condition. The Clinical

NORTHAM cont: Commissioning Group commissioned an audit from Dr Foster, which examined 150 spells in hospital and concluded that in more than half of them, records were out of line with accepted standards. Dr Foster's report said:

READER IN STUDIO: The Auditor found that of the 150 spells audited, 76 were not systemic septicaemia cases. The Auditor found that all of the 76 incorrect spells had contravened national coding standards. The trust's data quality process for the recording of sepsis patients is extremely poor.

NORTHAM: This was followed by widespread suggestions in the media that the hospital had been caught fiddling its sepsis figures in order to make its mortality statistics look less bad. The trust announced that the Acting Chief Executive had stepped aside from her post while a full clinical investigation was launched. At the UK Sepsis Trust, a charity which followed the details of the case, Dr Ron Daniels recognised the seriousness of these allegations.

DANIELS: Dr Foster, understandably, would have naturally compared the incidents – or the numbers of patients with sepsis at Bolton Hospital – with their existing data for similar sized hospitals, and that flagged up that Bolton were finding significantly more numbers of patients with sepsis.

NORTHAM: And the word 'fiddling' appeared in the press.

DANIELS: Yes, absolutely, and 'fiddling' is an incredibly powerful word when we relate it to the healthcare service. That, I'm sure, for many members of the press, was a natural assumption from the Dr Foster report.

NORTHAM: Is it fair to say that during that period, the Royal Bolton Hospital was under a cloud of suspicion?

DANIELS: Yes, absolutely, and personally, because I had been involved nationally in some of the work, I was receiving phone calls on a daily basis from members of the press, trying to find out what was really happening.

NORTHAM: And the tone of those questions from the press was what?

DANIELS: Baying for blood, essentially. Members of the press were, as is usually the case, keen to see the allegation being founded and substantiated.

NORTHAM: And the suspicion was, here was a hospital which had fiddled its statistics in order to make it appear that it had better mortality statistics than it had, and the way they had done that was by coding more patients for sepsis?

DANIELS: That was absolutely the allegation and that was what I was being asked to say.

NORTHAM: The effect on some patients in Bolton was also serious.

VOX POPS WITH PATIENTS

MAN: There's people been going, rumours that you come out worse than what you go in with.

NORTHAM: And did that affect the way you think about the hospital or was it just rumours?

MAN: Yeah, it affects the way you think about it, yeah, yeah, course it does.

NORTHAM: In what way?

MAN: Well, you think, well, is it worth going to hospital? Is it worth …? Like I say, you could come out worse than going in with. You might go in with a broken leg, you might come out dead. Well, you'd probably never come out.

MAN 2: It does put a different kind of mind set on top of it, as in you don't really want to go there, if you know what I mean. Even if you need to, you'd rather go to Salford Royal or you'd rather go to the Bury Hospital or something like that.

NORTHAM: Choose a different hospital if you had to go to hospital?

MAN 2: If I had to go to hospital, yeah.

NORTHAM: But patients need not have worried. The story was more complicated than the journalists were reporting. When the independent clinical review of the case was concluded last April, it found that the hospital was not guilty of fiddling. The clinical expert on this review was the Medical Director of the Royal Liverpool Hospital, Dr Peter Williams.

WILLIAMS: We looked at quite a significant number of cases that had been coded as sepsis at the Royal Bolton Hospital and I asked two of my colleagues, both senior consultants in infectious diseases, to look at the case notes and to give me an opinion about whether these patients had sepsis or not. And I also looked at around fifty cases myself.

NORTHAM: And what did you find?

WILLIAMS: We found broadly that there was evidence of sepsis in the overwhelming majority of cases.

NORTHAM: And your conclusion from that, therefore, was what?

WILLIAMS: Our opinion was that the trust was aware that its mortality rates appeared to be high. They had decided on an improvement programme and there's clear evidence in the trust board minutes and elsewhere that one of the areas they wished to improve on was the treatment of sepsis. It's important that it's not the coding of sepsis that they wanted to improve on; it was the treatment of sepsis.

NORTHAM: In other words, they wanted to fix the hospital rather than to fix the statistics?

WILLIAMS: Yes, sure.

NORTHAM: So they were benign?

WILLIAMS: Oh, I believe so, yes.

NORTHAM: Royal Bolton's Acting Chief Executive was reinstated and has now been confirmed in her post. She wasn't available for interview by File on 4. The paradox in this case is that her hospital did the right thing for patients, improved its care and suffered accusations of deceit as a result. So where did this leave Dr Foster and its audit, which somehow set off the initial reports about fiddling the figures? Dr Ron Daniels thinks that the audit didn't manage to see the whole picture.

DANIELS: I can understand the way that Dr Foster approached the case. Dr Foster do collect data on severe sepsis and occasionally fail to identify and appreciate that actually they're only collecting the tip of the iceberg. This is a condition that is not actively sought and coded for in most hospitals and so the majority of the hospitals reporting to them will not identify a majority of cases, and certainly won't code for those cases.

NORTHAM: Cases go unrecognised?

DANIELS: They certainly do. Now I believe that there was a certain arrogance in the original Dr Foster report in believing that their own data was entirely robust rather than questioning why this had been in an open manner.

NORTHAM: Arrogance?

DANIELS: I believe so, yes.

NORTHAM: Because?

DANIELS: Because of the almost blind assumption that their own data were correct and therefore that anyone who is identifying patients over and above those numbers were erroneous.

NORTHAM: Roger Taylor, Dr Foster's Director of Research, rejects the charge of arrogance in the company's use of data.

TAYLOR: I don't think that's fair, but I think I understand why he says that. And I think the issue is that when we publish information or we produce information or we share information with a hospital that shows that data is being mis-recorded or that it has a high mortality ratio, often people feel that we are calling into question their integrity or their professionalism and it's understandable why people make that leap. But what I would say, and I'd make a plea for, is that it's really important that we are able to discuss these data openly, recognising the limitations, and that doing that does not call into question people's integrity or their professionalism.

NORTHAM: How do you think it was, then, that in the press your report on the Royal Bolton, led to the reputation of the hospital being dragged through the mud? There was talk about them fiddling the figures, that this was another Mid Staffs disaster being concealed by the hospital management. And the hospital Acting Chief Executive was made to stand aside while a further investigation was undertaken.

TAYLOR: Just to be clear about this, Dr Foster didn't publish anything about this. We produced a report for the commissioners. We certainly did not publish any information about this.

NORTHAM: And if this appeared in the press as a hospital fiddling the figures, you say that's nothing to do with you?

TAYLOR: Well in this particular instance we didn't publish any of that information or talk to the media so it wasn't anything to do with us, no.

NORTHAM: An even more damaging conclusion often drawn from mortality statistics is that hospitals above the national average are dangerous places – responsible for avoidable deaths, even for killing some patients. Dr Foster doesn't publish the figures that way, but journalists sometimes miss the subtleties. At NHS England, the Medical Director, Sir Bruce Keogh, has commissioned a review of what can be read into mortality statistics – a review being carried out by two experts in the field. One of them is Professor Nick Black of the London School of Hygiene and Tropical Medicine. He's extending research on the subject which he conducted three years ago.

BLACK: The study we've already completed found no association between the HSMR a hospital had and the proportion of avoidable deaths. And in this regard, it was consistent with four or five other studies from North America and from the Netherlands, which also failed to find any connection between the two.

NORTHAM: Is there any study pointing the other way that you're aware of?

BLACK: There's one study that in one particular disease - I believe it was pneumonia - found some positive association, but otherwise all the evidence points the other way, that there's absolutely no association at all.

NORTHAM: No association between the overall mortality ratio for a hospital and its number of avoidable deaths?

BLACK: That's correct.

NORTHAM: That does seem a slightly surprising result, doesn't it? I mean, if the mortality statistics mean anything, a high ratio ought to mean there are more avoidable deaths?

BLACK: Well, that's what we set out to find out and we expected the same - that is what one would expect.

NORTHAM: Is there any value in the publication of HSMRs?

BLACK: I don't think there's any value in the publication of HSMR and I'd go further. I think it's actually a distraction, because it gives the high risk of it giving a misleading idea of the quality of care of a hospital, and that's why I think we should be focusing on measures of the quality of care and not on a spurious measure of mortality ratios, which can be altered relatively easily.

NORTHAM: How then does Roger Taylor of Dr Foster Intelligence, which publishes HSMRs, respond to these doubts from Professor Black?
Professor Black concludes, as he said to us, that HSMRs are dubious and spurious.

TAYLOR: No I wouldn't … I would not agree with that, no.

NORTHAM: If you disagree with Professor Nick Black, you've got a problem, haven't you, because he's currently looking into this for the NHS Medical Director, Sir Bruce Keogh?

TAYLOR: Well, he's been tasked with finding is there a better way of measuring mortality and obviously that's very welcome.

NORTHAM: But if he thinks that what you do in HSMRs is dubious or spurious, that doesn't bode well for you, does it?

TAYLOR: Well if he … No, but I'd be absolutely delighted if he comes up with a better method of measuring mortality - that would be wonderful.

NORTHAM: Better than HSMRs?

TAYLOR: Yes, absolutely.

NORTHAM: It's certainly the case that Dr Foster is extremely influential in senior health circles. The company itself is half-owned by the Department of Health. Its two founders, originally journalists, have been taken to the heart of the Health Service. One of them is now the National Director for Patients and Information in NHS England, having previously been recruited by the Cabinet Office. The other founder, Roger Taylor, is now seconded two days a week to the Care Quality Commission. There, the Chief Inspector of Hospitals, Professor Sir Mike Richards, takes a positive view of the company and its mortality ratio.

RICHARDS: It's a powerful measure, but it is only one of several powerful measures. So I would always look at mortality data alongside looking at patient experience data, data on safety indicators as well.

NORTHAM: Isn't one of the problems with hospital-wide mortality ratios that they can be used to trash the reputation of a hospital on the basis of a statistic which, statisticians tell us, is unreliable?

RICHARDS: I would certainly never use a single metric to trash a hospital's reputation.

NORTHAM: But you know it happens.

RICHARDS: Well, what I do know is when fourteen hospitals were identified just over a year ago as having high mortality, and when we did inspections of those through the Keogh Review, we did actually find that there were problems in all fourteen of those hospitals. And eleven of the fourteen, it was sufficiently severe that the decision was made to put them into Special Measures.

NORTHAM: Professor Nick Black, who's looking into these matters for the NHS Medical Director, Sir Bruce Keogh, has told us that he thinks you at the Care Quality Commission, he says should stop using them.

RICHARDS: I know Professor Black well, I have a high regard for him. I don't agree with him on this point, because we're finding it a very valuable indicator - taken alongside all the other indicators that we use.

NORTHAM: And you're not going to stop using it?

RICHARDS: What we are finding is that as an indicator, it is one that is quite valuable. If we can develop better indicators in the future, I'm more than happy that we should go down that line.

NORTHAM: By the end of this year, the NHS Medical Director will be presented with the report on mortality statistics and what, if any, use should be made of them in the Health Service. At the same time, Dr Foster is expected to publish its 2014 Hospital Guide, with accompanying lists in the press of the highest and lowest performers on the mortality scale. Professor Nick Black, the co-author of the review Sir Bruce Keogh has commissioned, advises the public not to make too much of these numbers.

BLACK: Personally, I would suggest that the public ignore them. I'm not that interested in a dubious overall measure of deaths in hospital. There is a desire on the part of ministers, which I can quite understand, to have a single simple measure of the

BLACK cont: quality of a hospital. Any Secretary of State would love to have on a Monday morning a simple chart on their desk telling them about the quality of each hospital in the country, so that they're reassured that everything is okay. And as the great American commentator, H L Mencken said many years ago and oft quoted - 'for every complex problem, there is a simple solution - and its wrong' and this is a good example of that.

NORTHAM: File on 4 would have liked to discuss mortality ratios and their use by the NHS with the Secretary of State for Health, Jeremy Hunt, but he was not available for interview.

SIGNATURE TUNE