

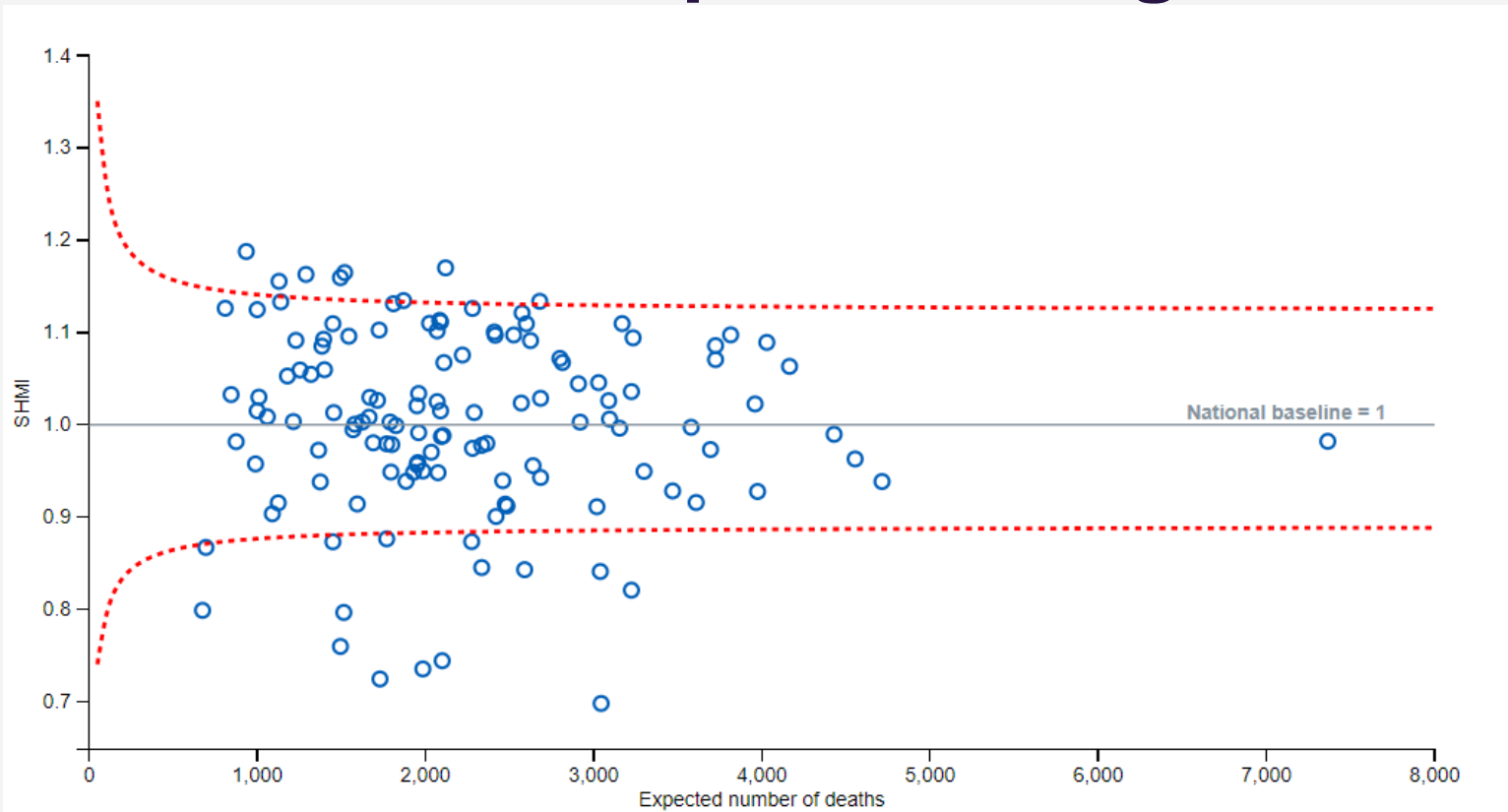


Variation in Secondary Care

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SHMI Acute Hospitals in England 18/19



Is this really useful?

The Impact of a National Clinician-led Audit Initiative on Care and Mortality after Hip Fracture in England

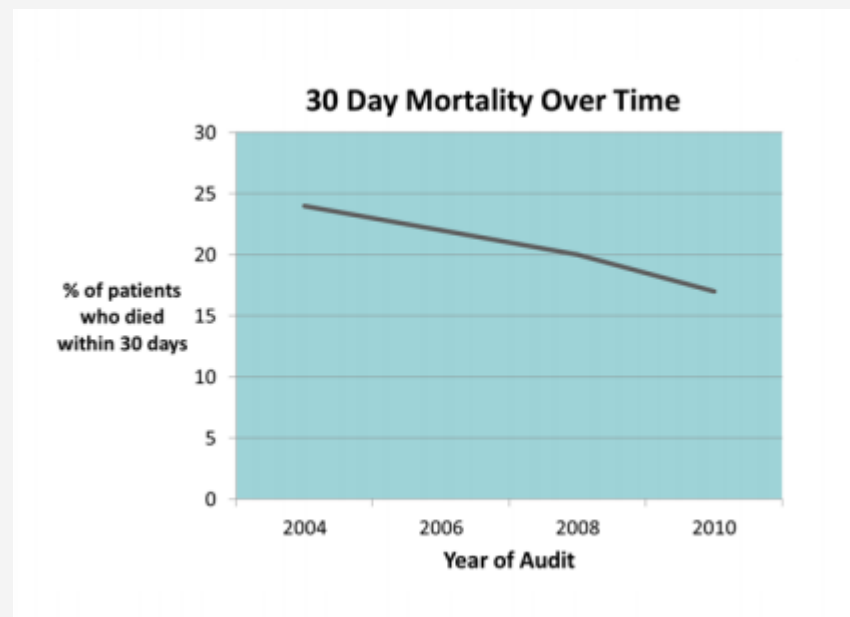
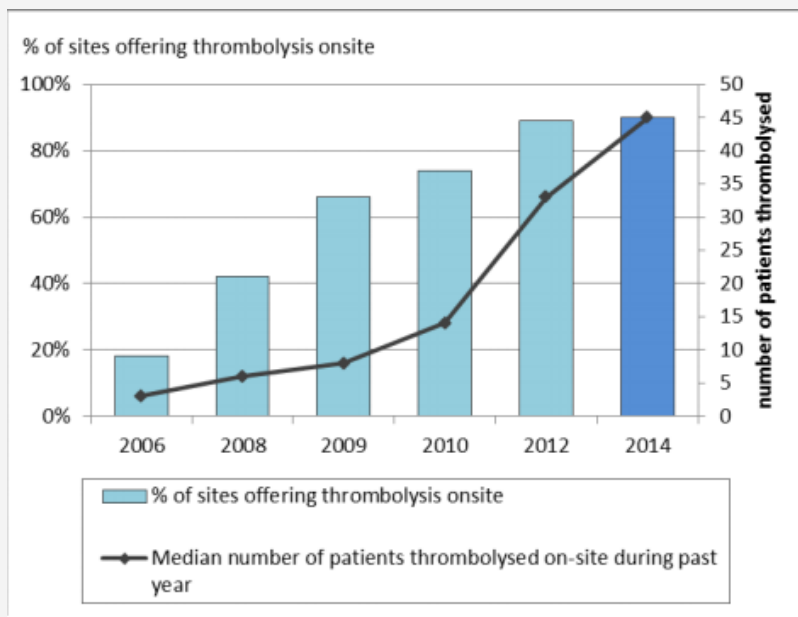
An External Evaluation using Time Trends in Non-audit Data

Jenny Neuburger, PhD,† Colin Currie, FRCPE,‡ Robert Wakeman, FRCS,§
Carmen Tsang, PhD,*† Fay Plant, BSc,|| Bianca De Stavola, PhD,¶
David A. Cromwell, PhD,*† and Jan van der Meulen, PhD*†*

Findings: The number of hospitals participating in the NHFD increased from 11 in 2007 to 175 in 2011. From 2007 to 2011, the rate of early surgery increased from 54.5% to 71.3%, whereas the rate had remained stable over the period 2003–2007. Thirty-day mortality fell from 10.9% to 8.5%, compared with a small reduction from 11.5% to 10.9% previously. The annual relative reduction in adjusted 30-day mortality was 1.8% per year in the period 2003–2007, compared with 7.6% per year over 2007–2011 ($P < 0.001$ for the difference).

SSNAP

Sentinel Stroke National Audit Programme



Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis



OPEN ACCESS

Results In London there was a significant decline in risk adjusted mortality at 3, 30, and 90 days after admission. At 90 days the absolute reduction was -1.1% (95% confidence interval -2.1 to -0.1 ; relative reduction 5%), indicating 168 fewer deaths (95% confidence interval 19 to 316) during the 21 month period after reconfiguration in London. In both areas there was a significant decline in risk adjusted length of hospital stay: -2.0 days in Greater Manchester (95% confidence interval -2.8 to -1.2 ; 9%) and -1.4 days in London (-2.3 to -0.5 ; 7%). Reductions in mortality and length of hospital stay were largely seen among patients with ischaemic stroke.

Evaluation of reconfigurations of acute stroke services in different regions of England and lessons for implementation: a mixed-methods study

Naomi J Fulop, Angus IG Ramsay, Rachael M Hunter, Christopher McKeivitt, Catherine Perry, Simon J Turner, Ruth Boaden, Iliatha Papachristou, Anthony G Rudd, Pippa J Tyrrell, Charles DA Wolfe and Stephen Morris

Conclusions: Centralising acute stroke services can improve clinical outcomes and care provision. Factors related to the service model implemented, **how change is implemented and the context in which it is implemented are influential** in improvement. We recommend further analysis of how different types of leadership contribute to MSC, patient and carer experience during the implementation of change, the impact of change on further clinical outcomes (disability and QoL) and influence of severity of stroke on clinical outcomes. Finally, our findings should be assessed in relation to MSC implemented in other health-care specialties.

NHS England and NHS Improvement

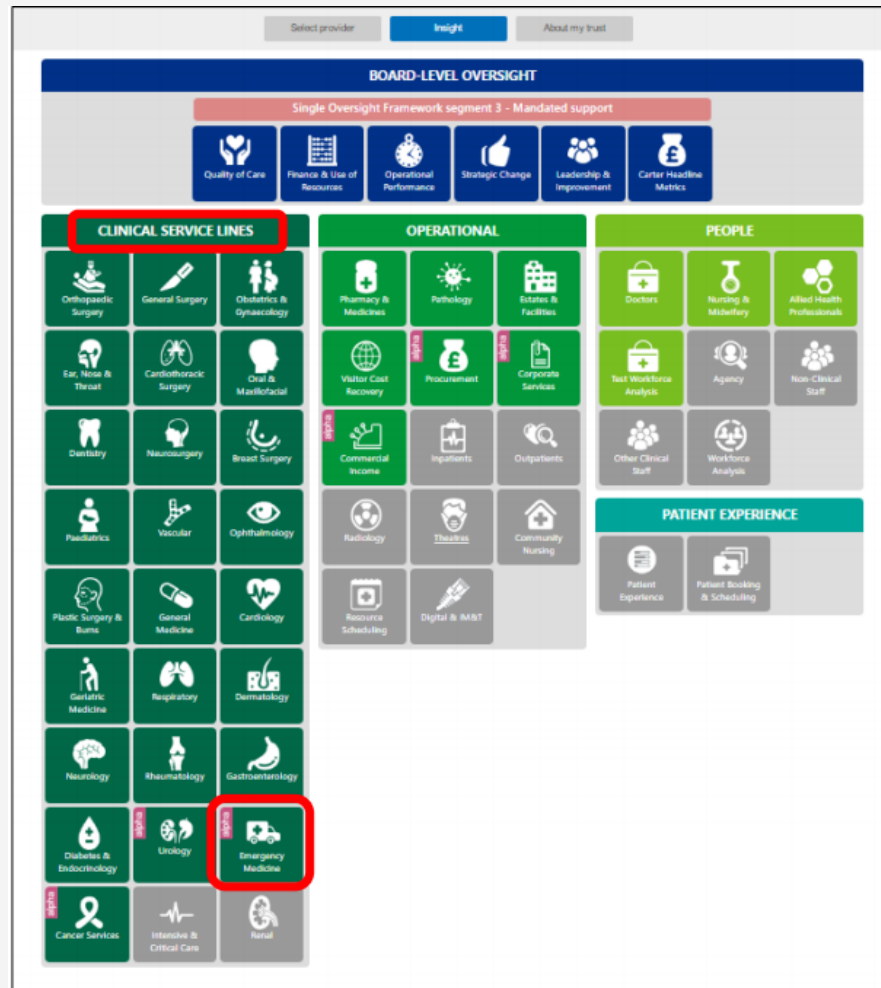


Same day emergency care national programme

The same day emergency care (SDEC) programme is part of the NHS England and NHS Improvement urgent and emergency care (UEC) transformation team.

Types of SDEC treatment include:

- acute medical SDEC
- surgical SDEC
- acute frailty



What is the evidence base for ambulatory care for acute medical illness?

DS Lasserson, C Harris, TNE Elias, JST Bowen & S Clare

Key points

- Observational studies that describe processes of care and prognosis can support discharge decisions for acute medical illness.
- There is no consensus on the level of risk that is appropriate for home-based care as opposed to hospital admission for acute medical illness
- Although policy and guidance have developed without a large evidence base of randomised trials, there is a role for research to optimise the design and delivery of ambulatory care

[Intervention Review]

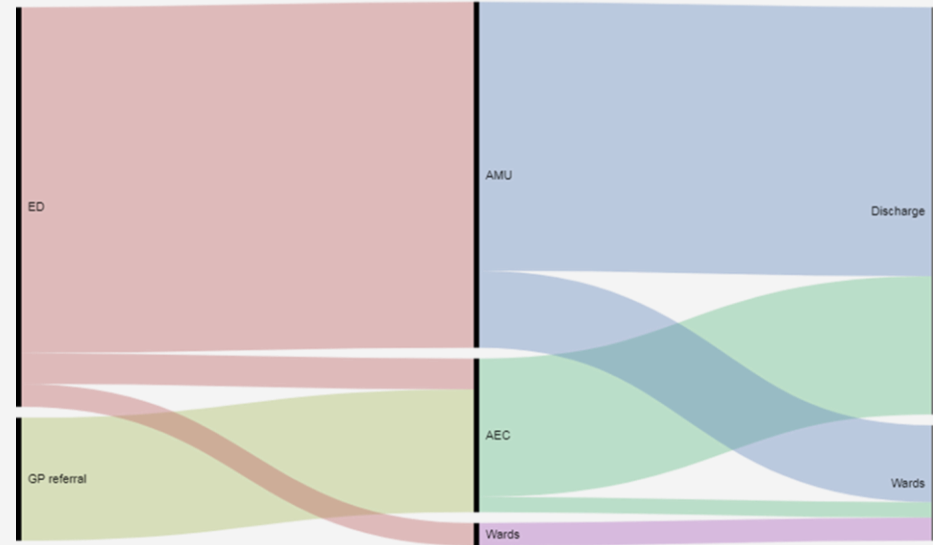
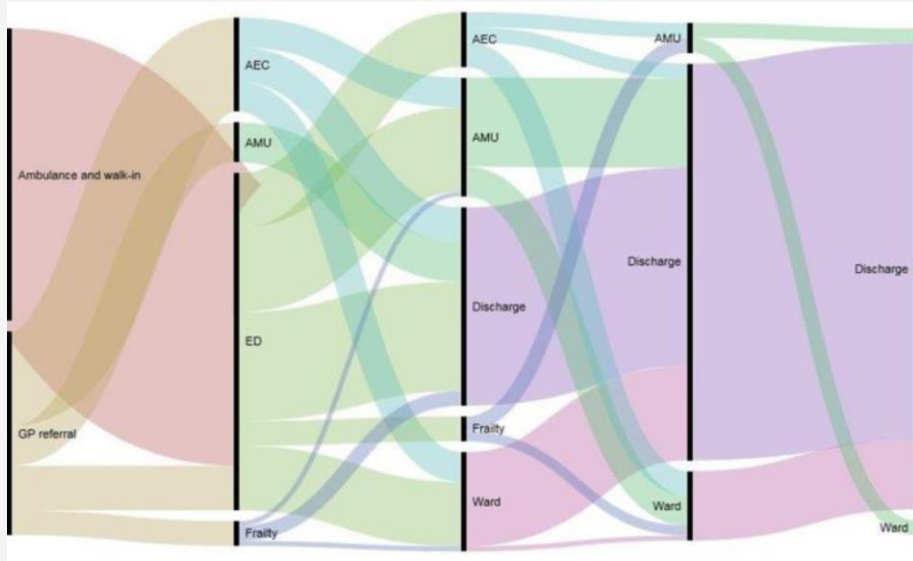
Comprehensive geriatric assessment for older adults admitted to hospital

Graham Ellis^{1a}, Mike Gardner^{2b}, Apostolos Tsiachristas², Peter Langhorne³, Orlaith Burke², Rowan H Harwood⁴, Simon P Conroy⁵, Tilo Kircher⁶, Dominique Somme⁷, Ingvild Saltvedt⁸, Heidi Wald⁹, Desmond O'Neill¹⁰, David Robinson¹¹, Sasha Shepperd^{2c}

Authors' conclusions

Older patients are more likely to be alive and in their own homes at follow-up if they received CGA on admission to hospital. We are uncertain whether data show a difference in effect between wards and teams, as this analysis was underpowered. CGA may lead to a small increase in costs, and evidence for cost-effectiveness is of low-certainty due to imprecision and inconsistency among studies. Further research that reports cost estimates that are setting-specific across different sectors of care are required.

Models of Care and Flow



Flows through 2 rural hospitals, each with ~350 beds

How Good is the Evidence?



Factory Floor vs 'Bespoke'



Variation or Innovation?



To get to there, I
wouldn't start from
here!

(Dave Allen)



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