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Performance outcomes

The NHS in England and Wales, the world's biggest healthcare provider, is facing one of its biggest challenges over the next few months with significant changes to the way that funding is managed within the UK. The move can be summarised as a change from a macro to micro economy with GPs (family doctors) playing a central role in commissioning services from healthcare providers for their patients. Much has been made of the potential changes, in terms of opening up a free market health care economy, the potential efficiency savings associated and the risks of moving from a top down to bottom up healthcare model.

What has gone almost unnoticed is the continued move at the same time towards greater accountability. Surgeons in the UK will be ranked, and their results (from a range of performance indicators) available on the internet for all and sundry to see. Potentially a great thing as transparency and openness provide not only faith in healthcare providers, but also flag up best (and worst) practice. It seems though that perhaps some of the most important lessons from history have not been learned. Surgical outcomes and registers became central to UK practice in the wake of the Bristol heart scandal[1] and within orthopaedics as part of the Capitol hip scandal. On the face of it, regulation and use of 'Key Performance Indicators' seems to be one method of pushing up the quality of care. The difficulties of course being that picking out just one or two measures on which to base an assessment of a complex intervention can not only give a misleading impression, but can result in skewed care where trust boards place too much emphasis on particular aspects of care they know they are to be measured on. One of the key findings of the Mid Staffordshire report (a small hospital in middle England where upwards of 1000 patients died due to poor care over a four-year period) was that "[The Management] chose to rely on apparently favourable performance reports by outside bodies, such as the Healthcare Commission, rather than effective internal assessment and feedback from staff and patients". While we must all strive to improve patient outcomes, the most effective methods have been through implementation of comprehensive care pathways (such as in fractured neck of femur patients) where the whole pathway, not a key performance indicator, is used to assess quality. Orthopaedic surgeons and the wider community must ensure that public accountability does not result in skewed clinical priorities or Mid Staffs may not become an isolated case.

This month in *360* we publish two extremely interesting features concerning innovation and intellectual property. Professor Angus Wallace has shared his experiences as a surgeon inventor and while not only a riveting and sometimes amusing read, it contains a wealth of useful information for any surgeon looking to widen their experience in the field and when taken with an equally enlightening article from Kate McNamara on the basics of patenting, *360* should arm any budding inventor with some of the tools necessary to establish themselves in what is a veritable minefield.

Among one of the most interesting (and surprising) articles to ever have crossed the journal desks must be a report on treatment of scaphoid non-union with an Ilizarov method,[2] one of very few reports describing the fate of infected revision total elbow arthroplasties[3] and a superb little article describing the use of matched allografts for that ever difficult problem of ankle arthritis in the young.[4]

I hope you will enjoy reading this issue of *360* as much as I have enjoyed editing it. My very best wishes to you all.

REFERENCES

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3. **Wee AT, Morrey BF, Sanchez-Sotelo J.** The fate of elbows with unexpected positive intraoperative cultures during revision elbow arthroplasty. *J Bone Joint Surg [Am]* 2013;95-A:109-16.
4. **Bugbee WD, Khanna G, Cavallo M, et al.** Fresh Osteochondral Allografting of the Tibiotalar Joint. *J Bone Joint Surg [Am]* 2013;95-A:426-432.