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<p>Guy's Hospital</p>  <p>Great Maze Pond London SE1 9RT 020 7188 7188 0.45 miles away View map</p>	<p>St Thomas'</p>  <p>Westminster Bridge Road Westminster Bridge Road SE1 7EH 020 7188 7188 1.71 miles away View map</p>	<p>University College Hospital</p>  <p>University College Hospital 235 Euston Road NW1 2BU 020 3456 7890 2.42 miles away View map</p>	<p>King's College Hospital (Denmark Hill)</p>  <p>Denmark Hill London SE5 9RS 020 3299 9000 2.93 miles away View map</p>	<p>The Royal Marsden Hospital (London)</p>  <p>Fulham Road London SW3 6JJ 020 7352 8171 4.02 miles away View map</p>
Data not available	A&E onsite	A&E onsite	A&E onsite	Data not available

Annex Table 10 Health system performance in all Member States, WHO indexes, estimates for 1997

PERFORMANCE ON HEALTH LEVEL (DALE)					OVERALL PERFORMANCE				
Rank	Uncertainty Interval	Member State	Index	Uncertainty interval	Rank	Uncertainty interval	Member State	Index	Uncertainty interval
1	1 – 5	Oman	0.992	0.975 – 1.000	1	1 – 5	France	0.994	0.982 – 1.000
2	1 – 4	Malta	0.989	0.975 – 0.994	2	1 – 5	Italy	0.991	0.978 – 1.000
3	2 – 7	Italy	0.976	0.957 – 0.994	3	1 – 6	San Marino	0.988	0.973 – 1.000
							Andorra	0.982	0.966 – 0.997
							Malta	0.978	0.965 – 0.993
							Singapore	0.973	0.947 – 0.998
							Spain	0.972	0.959 – 0.985
							Oman	0.961	0.938 – 0.985
							Austria	0.959	0.946 – 0.972
							Japan	0.957	0.948 – 0.965
							Norway	0.955	0.947 – 0.964
							Portugal	0.945	0.931 – 0.958
							Monaco	0.943	0.929 – 0.957
							Greece	0.933	0.921 – 0.945
							Iceland	0.932	0.917 – 0.948
							Luxembourg	0.928	0.914 – 0.942
							Netherlands	0.928	0.914 – 0.942
							United Kingdom	0.925	0.913 – 0.937
							Ireland	0.924	0.909 – 0.939
							Switzerland	0.916	0.903 – 0.930

Health (disability-adjusted life expectancy)

Total 50%

Overall or average 25%

Distribution or equality 25%

Responsiveness

Total 25%

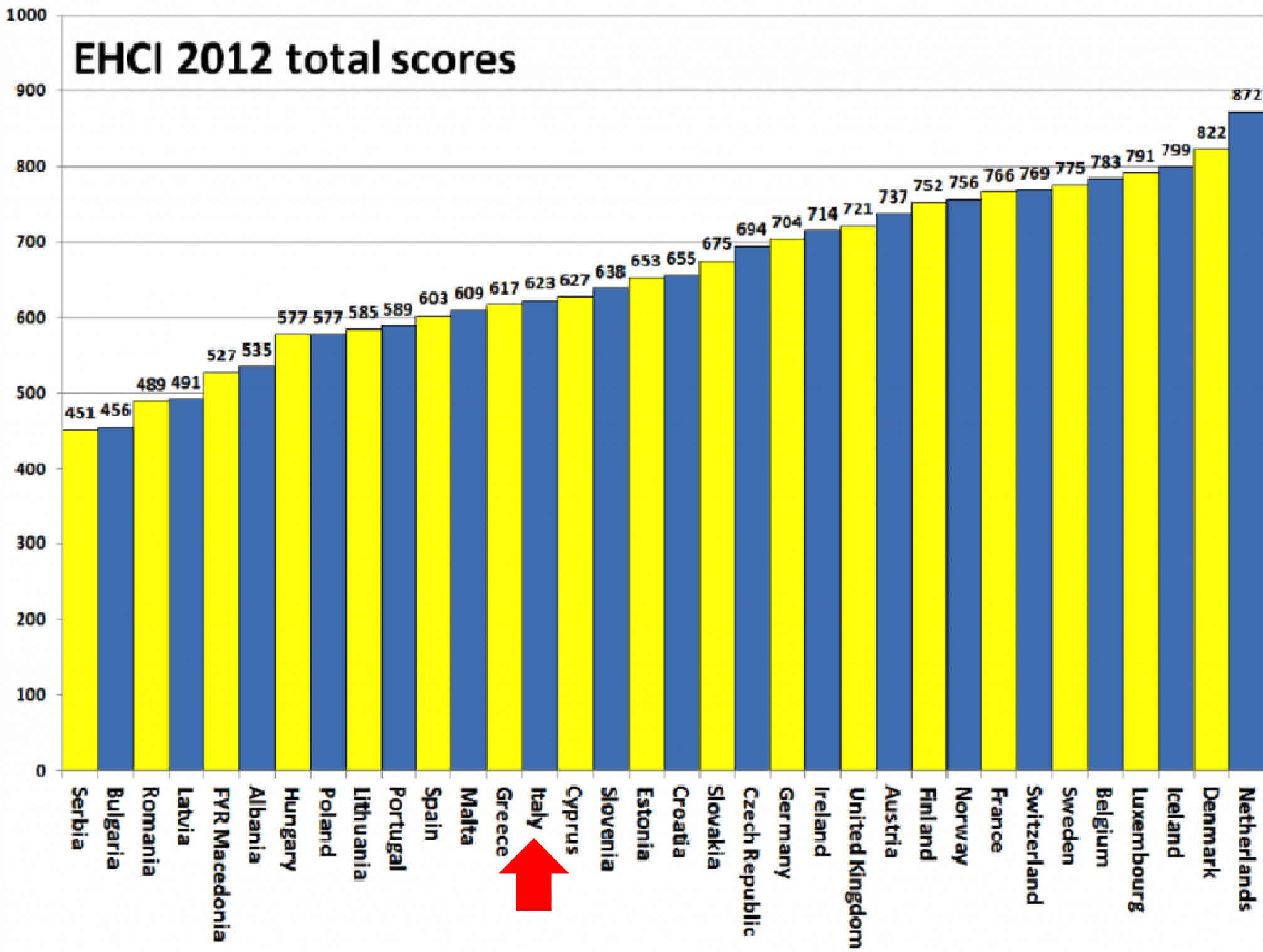
Overall or average 12.5%

Distribution or equality 12.5%

Fair financial contribution

Distribution or equality 25%

EHCI 2012 total scores



Programma Valutazione Esiti (PNE)

Ed. 2012, SDO 2005-2011

Introduzione alla lettura

La valutazione degli esiti degli interventi sanitari, può essere definita come:...

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Metodi statistici

 **D/SP/Lazio**

Nella maggior parte delle applicazioni gli indicatori di valutazione degli esiti degli interventi sanitari sono espressi come ...

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Appendice

Lista degli acronimi e delle definizioni maggiormente usate per la descrizione degli indici e nelle trattazioni epidemiologiche.

[leggi](#)

novità

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indicatori per struttura

struttura con tutti gli indicatori

indicatori di volume

produzione

Analisi per area di residenza

indicatori per area

area con tutti gli indicatori

frequenza per area geografica

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+ -

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GP GPs

H Hospitals

Dentists

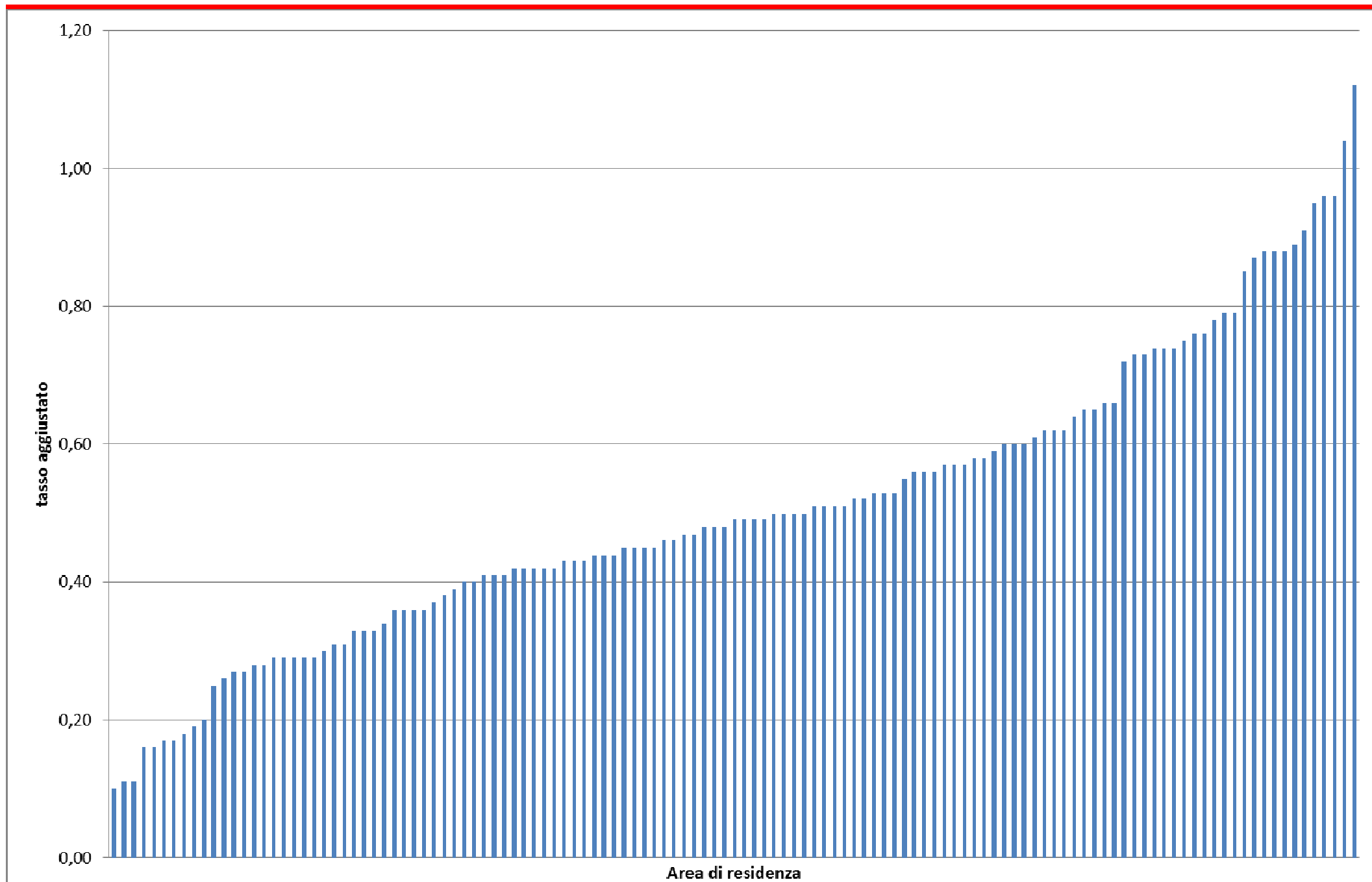
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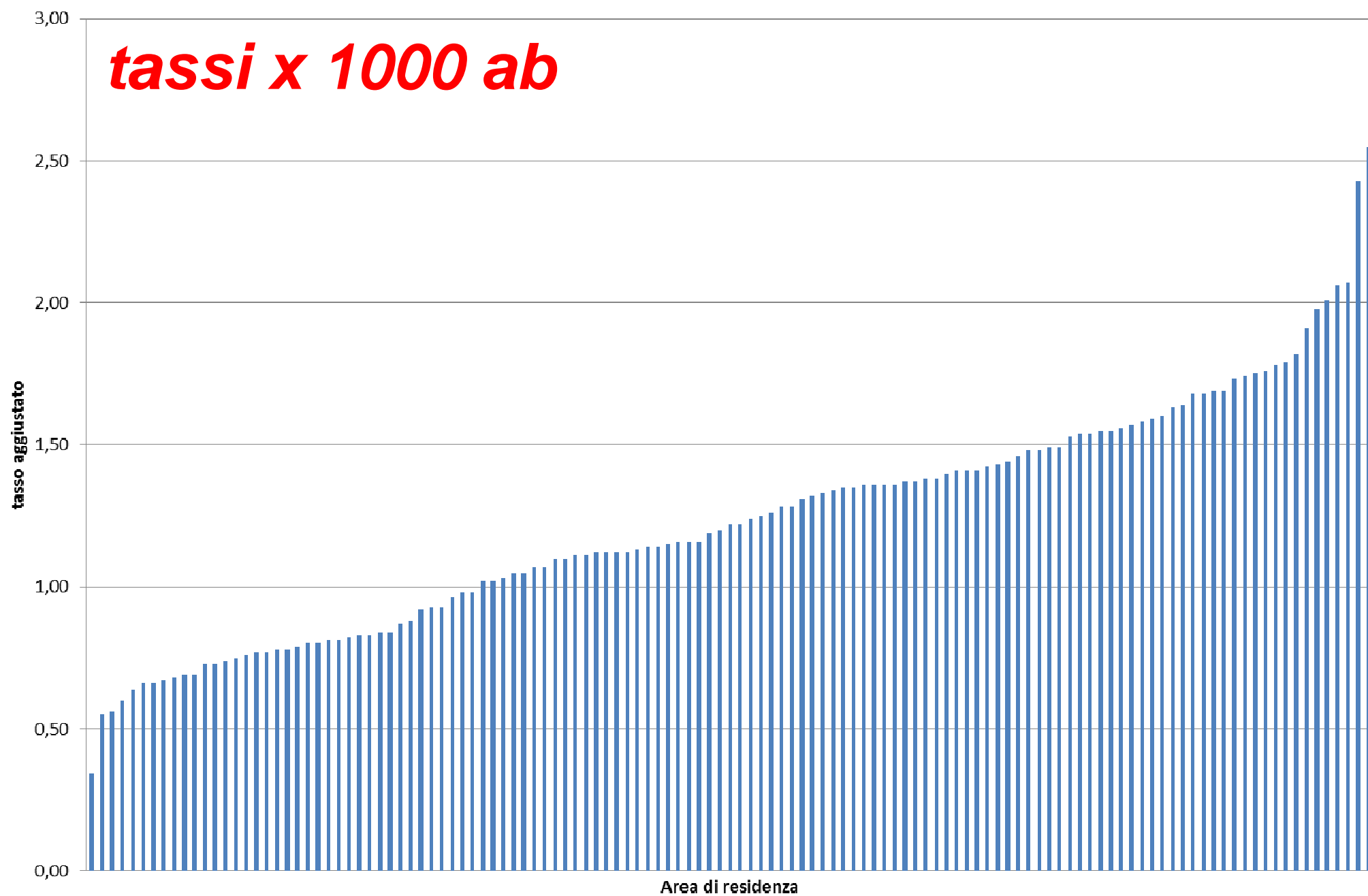
+ -

NHS dental charges explained

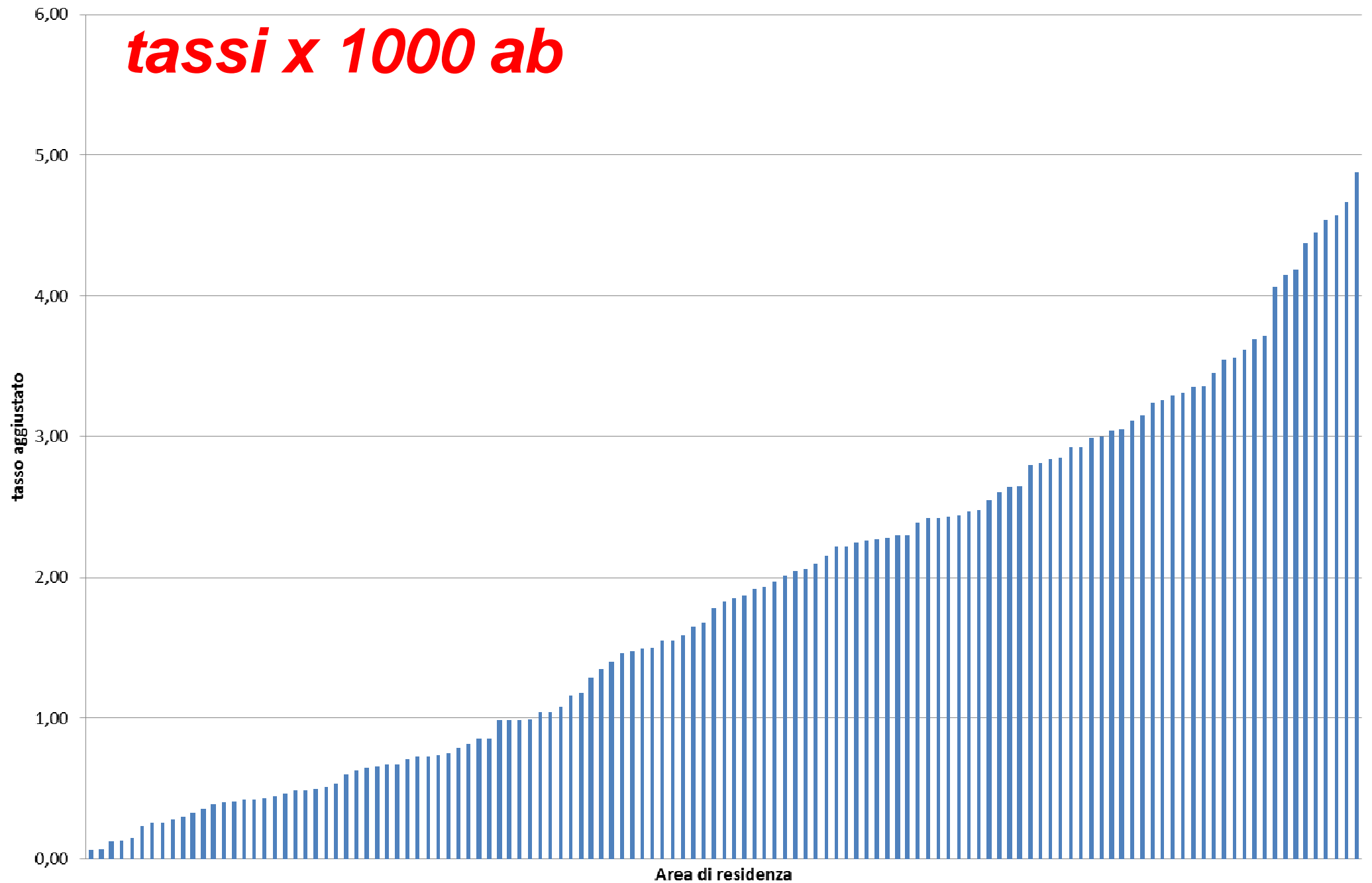
Tasso di Ospedalizzazione per colecistectomia in pazienti con calcolosi semplice senza cc.. Italia 2011



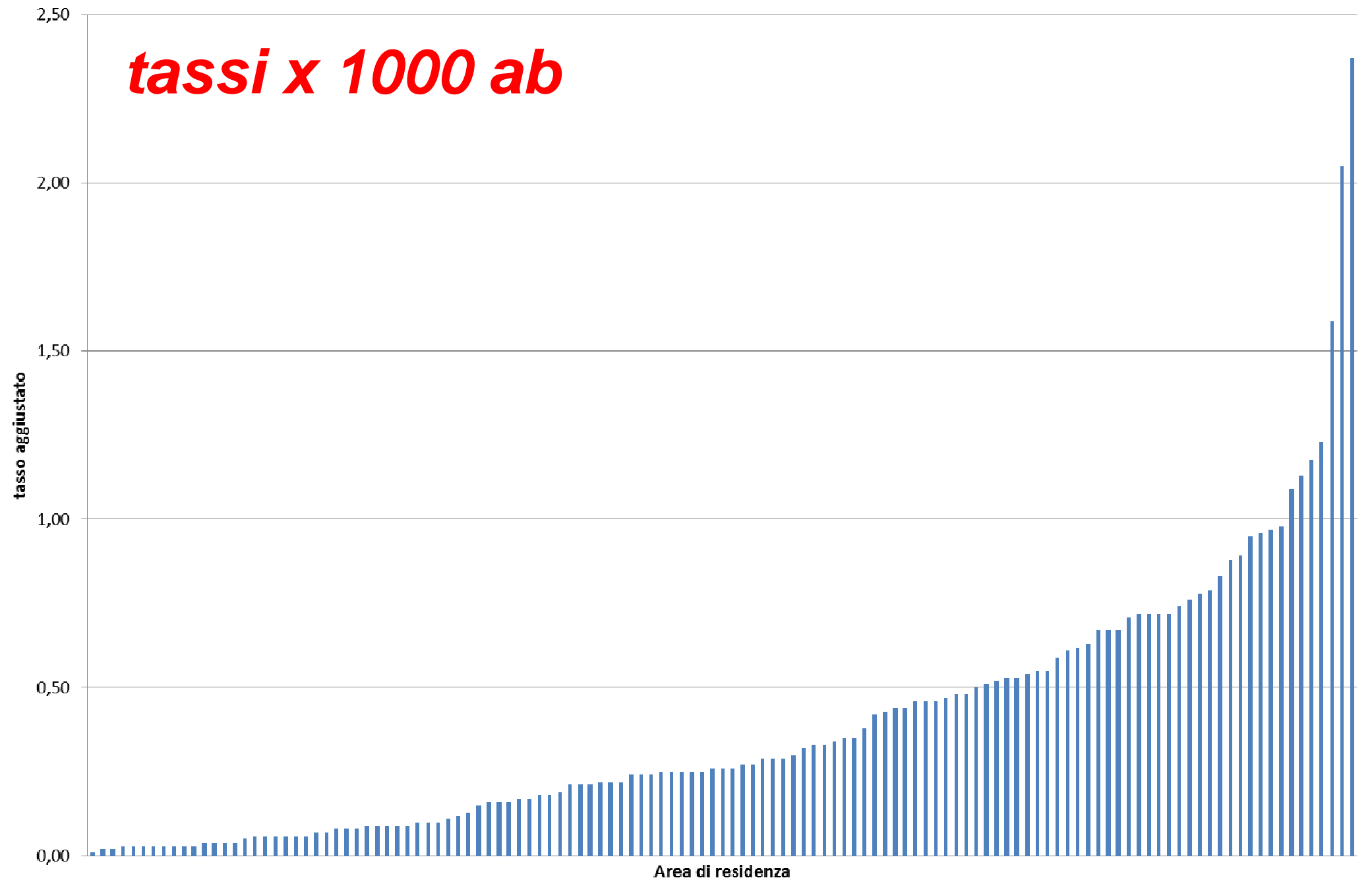
Ospedalizzazione per prostatectomia transuretrale per iperplasia benigna. Italia 2011



Ospedalizzazione per tonsillectomia. Italia 2011

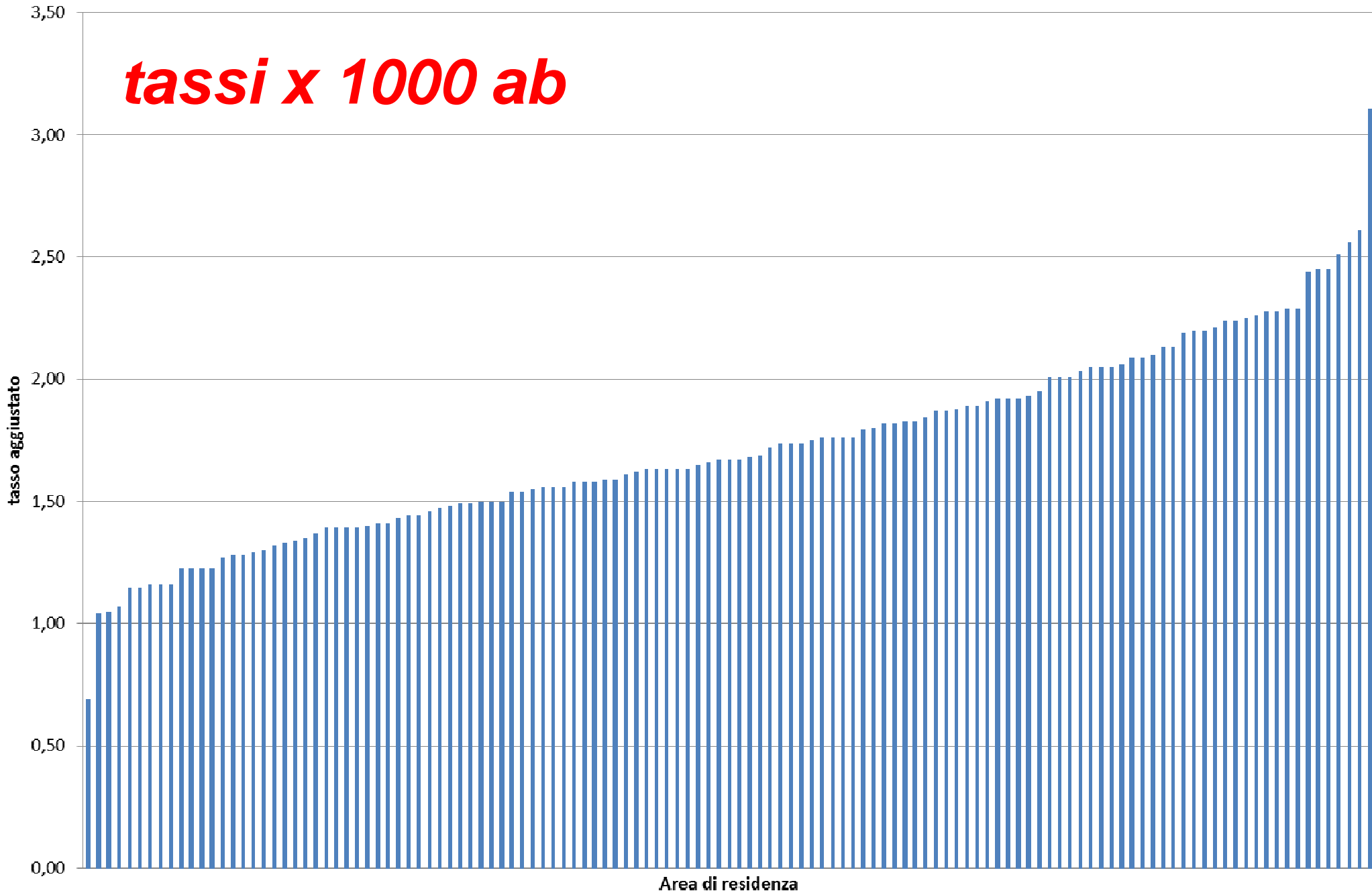


Ospedalizzazione per stripping delle vene. Italia 2011



Ospedalizzazione per isterectomia. Italia 2011

tassi x 1000 ab



Ospedalizzazione per PTCA, Italia 2011

Area	Area	N	tasso_grezzo	tasso_adj	rr_adj
Provincia	Provincia di Napoli	2470	1,49	1,79	2,08
Provincia	Provincia di Matera	292	1,73	1,73	2,02
Provincia	Provincia di Cremona	485	1,59	1,52	1,77
Provincia	Provincia di Ragusa	364	1,41	1,48	1,72
Comune	Comune di Napoli	1037	1,34	1,45	1,68
Provincia					
Provincia	Provincia di Verbano	219	1,57	1,42	1,65
Provincia	Provincia di Bergamo	1209	1,35	1,40	1,63
Provincia	Provincia di Potenza	454	1,41	1,40	1,63
Provincia	Provincia di Avellino	479	1,31	1,34	1,56
Provincia	Provincia di Caltanissetta	282	1,29	1,34	1,55

ACC/AHA 2008 Performance Measures for Adults With ST-Elevation and NonST-Elevation Myocardial Infarction

ACC/AHA Circulation 2008;118;2596-2648

Acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary PCI during the hospital stay with *a time from hospital arrival to PCI of 90 minutes or less*

Median time from hospital arrival to primary PCI	AMI patients whose time from hospital arrival to primary PCI is 90 minutes or less.
Numerator	AMI patients whose time from hospital arrival to primary PCI is 90 minutes or less.
Denominator	AMI patients with ST-segment elevation or LBBB on ECG who received primary PCI.
Period of Assessment	Within 24 hours after hospital arrival.
Sources of Data	Administrative data and medical records.
Rationale	Acute reperfusion therapy for patients with STEMI significantly reduces the risk of death. This benefit is most effective when provided promptly after presentation to the hospital.

- Excluded populations:
- Patients less than 18 years of age
 - Patients received in transfer from the inpatient, outpatient, or emergency department of another facility
 - Patients administered fibrinolytic agent prior to PCI
 - PCI described as non-primary by a physician/advanced practice nurse/physician assistant (physician/APN/PA)
 - Patients who did not receive PCI within 90 minutes and had a reason for delay documented by a physician APN/PA (eg, social, religious, initial concern or refusal, cardiopulmonary arrest, balloon pump insertion, respiratory failure requiring intubation)

Indications for Primary PCI ACC/AHA 2004 STEMI Guidelines (remains in effect)

Class I

If immediately available, primary PCI should **be performed in patients with STEMI** (including true posterior MI) or MI with new or presumably new LBBB who can undergo PCI of the infarct artery within 12 hours of symptom onset, if performed in a timely fashion (balloon inflation **within 90 minutes of presentation**) by **persons skilled in the procedure** (individuals who perform more than 75 PCI procedures per year). The procedure should be supported by experienced personnel in an appropriate laboratory environment (performs **more than 200 PCI procedures per year**, of which at least 36 are primary PCI for STEMI, and has cardiac surgery capability). (Level of Evidence: A)

Data-to-Decision Time

ACC/AHA 2004 STEMI Guidelines (remains in effect)¹⁹

Class I

All STEMI patients should undergo rapid evaluation for reperfusion therapy and have a reperfusion strategy implemented promptly after contact with the medical system.

(Level of Evidence: A)

ACC/AHA 2007 UA/NSTEMI Guidelines²¹

Class I

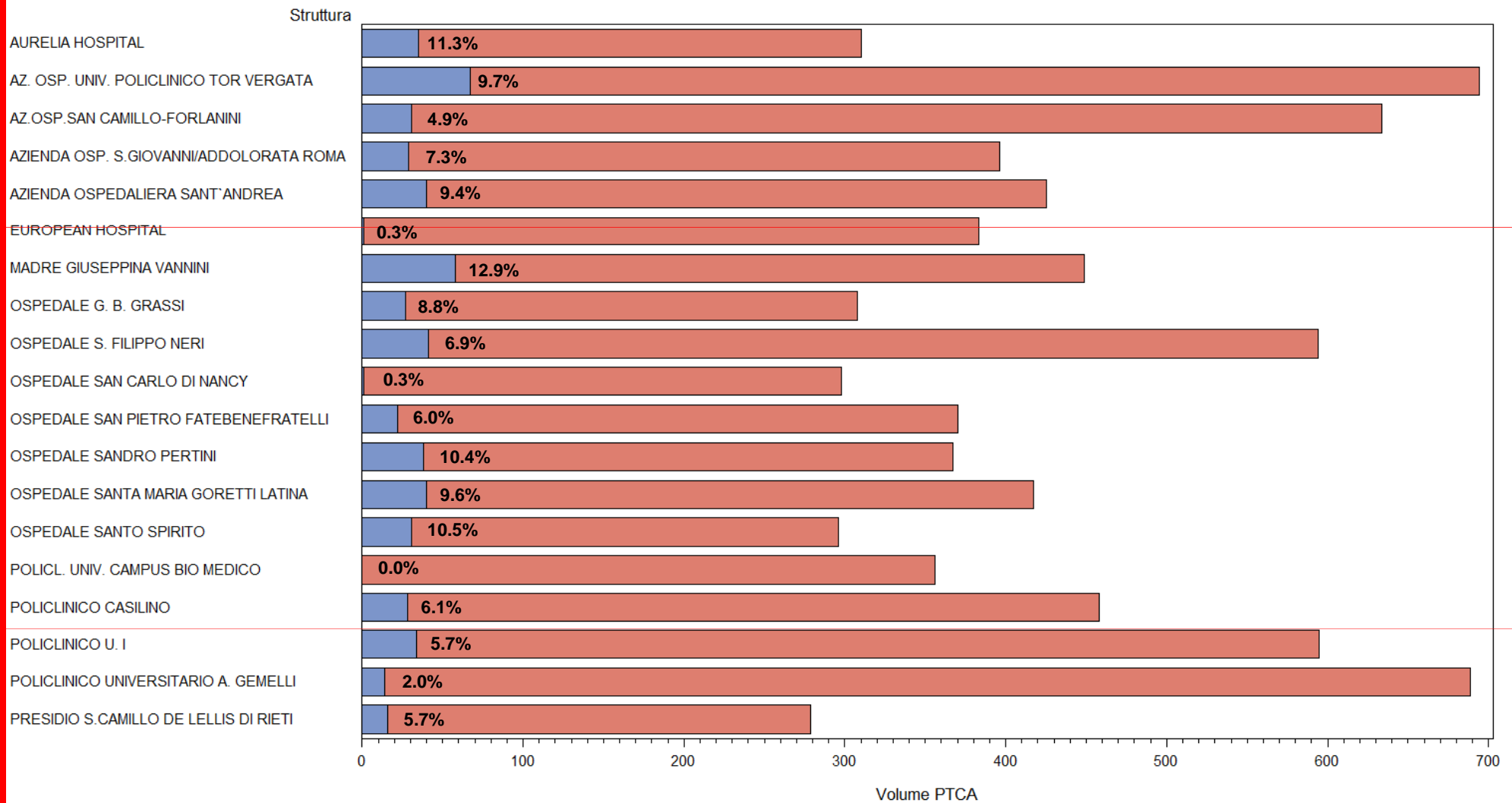
Patients with definite ACS and ST-segment elevation in leads V₁ to V₆ due to left circumflex occlusion should be evaluated for immediate reperfusion therapy. (Level of Evidence: A)

(Level of Evidence: A)

► STEMI: Proporzione di trattati con PTCA entro 90 minuti (struttura di accesso) - analisi con variabili cliniche.

Eta' in anni	-	0.98	0.000
Genere (Donne vs Uomini)	2 242	0.74	0.000
Diabete*	518	0.59	0.005
Malattie ematologiche (ric. ind.)	265	0.44	0.003
Malattie ematologiche	214	0.68	0.211
Altre forme di cardiopatia ischemica*	534	0.61	0.004
Malattie cerebrovascolari * (ric. ind.)	231	0.48	0.007
Malattie cerebrovascolari *	326	0.79	0.277
Nefropatie croniche (ric. ind.)	485	0.68	0.028
Nefropatie croniche	242	0.90	0.709
Pressione>100	5 926	1.00	0.000
Pressione<=100	923	1.25	0.018
Pressione missing	250	1.86	0.000

PTCA Totali. Lazio 2011



■ PTCA entro 90 minuti in STEMI



Volumi di attività ed esiti delle cure: prove scientifiche in letteratura ed evidenze empiriche in Italia

Amato L¹, Colais P², Davoli M¹, Ferroni E², Fusco D², Minozzi S¹, Moirano F³, Sciattella P²,
Vecchi S², Ventura M², Perucci CA³

¹Dipartimento di Epidemiologia del S.S.R. - ASL RME Regione Lazio; Network Italiano Cochrane

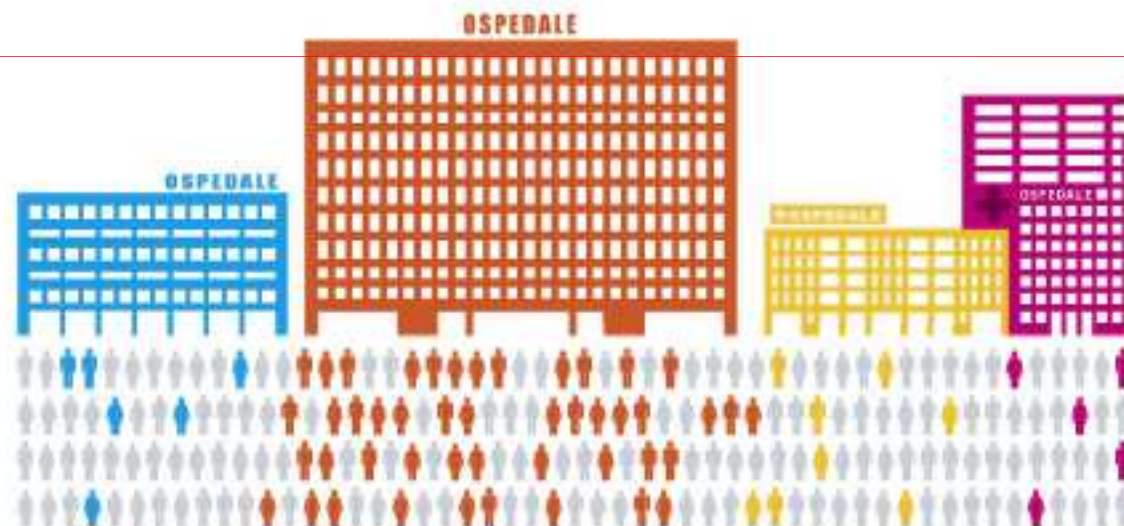
²Dipartimento di Epidemiologia del S.S.R. - ASL RME Regione Lazio

³ Agenzia Nazionale per Servizi Sanitari Regionali (AGENAS)

supplemento 2
numero **2/3**
maggio
giugno
2013

EPIDEMIOLOGIA & PREVENZIONE

Rivista dell'Associazione italiana di epidemiologia



P.N.E.
Piano Nazionale Esiti

agenas
AGENZIA NAZIONALE E PUNTI
REGIONALI SANITARI REGIONALI

D/EP/Lazio
Dipartimento di Epidemiologia del Lazio
Centro Coordinato P.N.E.

In collaborazione con
Network
Baker
Cochrane

**VOLUMI DI ATTIVITÀ ED ESITI DELLE CURE:
PROVE SCIENTIFICHE IN LETTERATURA ED EVIDENZE EMPIRICHE IN ITALIA**

**VOLUME AND HEALTH OUTCOMES:
EVIDENCE FROM SYSTEMATIC REVIEWS AND FROM EVALUATION OF ITALIAN HOSPITAL DATA**

Associazione positiva volume ospedale - mortalità intraospedaliera/30 giorni

1	AIDS	14	Chirurgia CA prostata
2	Aneurisma aorta add. non rotto	15	Chirurgia CA rene
3	Aneurisma aorta addominale rotto	16	Chirurgia CA stomaco
4	Angioplastica coronarica	17	Chirurgia CA vescica
5	Artroplastica ginocchio	18	Chirurgia cardiaca pediatrica
6	Bypass aorto-coronarico	19	Colecistectomia
7	Chirurgia CA colon retto	20	Emorragia sub aracnoidea
8	Chirurgia CA colon	21	Endoarterectomia carotidea
9	Chirurgia CA esofago	22	Frattura femore
10	Chirurgia CA fegato	23	Infarto del miocardio
11	Chirurgia CA mammella	24	Rivasc. arti inferiori
12	Chirurgia CA pancreas	25	Terapia intensiva neonatale
13	Chirurgia CA polmone	26	Aneurisma cerebrale

Programma Valutazione Esiti (PNE)

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La valutazione degli esiti degli interventi sanitari, può essere definita come:...

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Metodi statistici Appendice



Nella maggior parte delle applicazioni gli indicatori di valutazione degli esiti degli interventi sanitari sono espressi come ...

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Lista degli acronimi e delle definizioni maggiormente usate per la descrizione degli indici e nelle trattazioni epidemiologiche.

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Analisi per struttura ospedaliera

indicatori per struttura

struttura con tutti gli indicatori

[indicatori di volume](#)



Analisi per area di residenza

indicatori per area

area con tutti gli indicatori

[frequenza per area geografica](#)



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87**Management of oesophageal
and gastric cancer**

A national clinical guideline

B

Oesophageal and gastric cancer resectional surgery should be carried out in high volume specialist surgical units by frequent operators.

Guidelines for the management of oesophageal and gastric cancer

William H Allum,¹ Jane M Blazeby,² S Michael Griffin,³ David Cunningham,⁴ Janusz A Jankowski,⁵ Rachel Wong,⁴ On behalf of the Association of Upper Gastrointestinal Surgeons of Great Britain and Ireland, the British Society of Gastroenterology and the British Association of Surgical Oncology

¹Department of Surgery, Royal Marsden NHS Foundation Trust, London, UK

²School of Social and Community Medicine, University of Bristol, Bristol, UK

³Northern Oesophago-Gastric Unit, Royal Victoria Infirmary, Newcastle upon Tyne, UK

⁴Gastrointestinal Oncology Unit, Royal Marsden NHS Foundation Trust, London, UK

⁵Department of Oncology, University of Oxford, Oxford, UK

Correspondence to

William H Allum, Royal Marsden NHS Foundation Trust, Fulham Road, London SW3 6JJ, UK; william.allum@rmh.nhs.uk

Revised 11 April 2011

Accepted 17 April 2011

INTRODUCTION

Over the past decade the Improving Outcomes Guidance (IOG) document has led to service re-configuration in the NHS and there are now 41 specialist centres providing oesophageal and gastric cancer care in England and Wales. The National Oesophago-Gastric Cancer Audit, which was supported by the British Society of Gastroenterology, the Association of Upper Gastrointestinal Surgeons (AUGIS) and the Royal College of Surgeons of England Clinical Effectiveness Unit, and sponsored by the Department of Health, has been completed and has established benchmarks for the service as well as identifying areas for future improvements.^{1–3} The past decade has also seen changes in the epidemiology of oesophageal and gastric cancer. The incidence of lower third and oesophago-gastric junctional adenocarcinomas has increased further, and these tumours form the most common oesophago-gastric tumour, probably

earlier version, with some evidence provided in detail to describe areas of development and to support the changes to the recommendations. The editorial group (WHA, JMB, DC, JAJ, SMG and RW) have edited the individual sections, and the final draft was submitted to independent expert review and modified. The strength of the evidence was classified guided by standard guidelines.⁶

Categories of evidence

Ia: Evidence obtained from meta-analysis of randomised controlled trials (RCTs).

Ib: Evidence obtained from at least one randomised trial.

IIa: Evidence obtained from at least one well-designed controlled study without randomisation.

IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study.

III: Evidence obtained from well-designed descriptive studies such as comparative studies, correlative

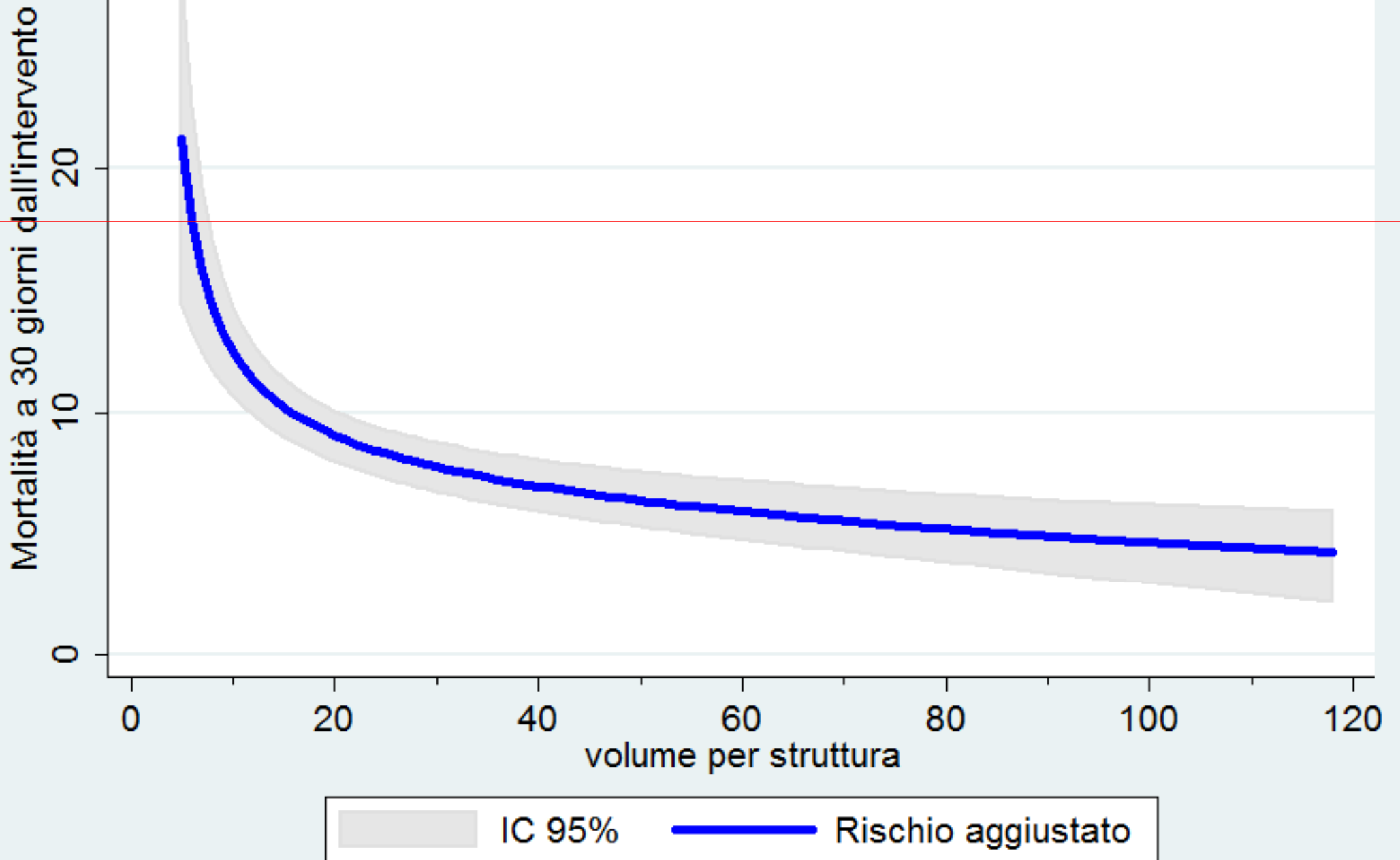
Treatment: surgery

- ▶ All patients should have antithrombotic (grade A, 1b) and antibiotic prophylaxis (grade C) instituted at an appropriate time in relation to surgery and postoperative recovery.
- ▶ Oesophageal and gastric cancer surgery should be performed by surgeons who work in a specialist MDT in a designated cancer centre with outcomes audited regularly (grade B).
- ▶ Surgeons should perform at least 20 oesophageal and gastric resections annually either individually or operating with another consultant both of whom are core members of the MDT. The individual surgeon and team outcomes should be audited against national benchmarked standards (grade B).

TAB.16 Chirurgia CA Stomaco; Risultati Revisione Sistemática**Volume di attività ospedaliera**

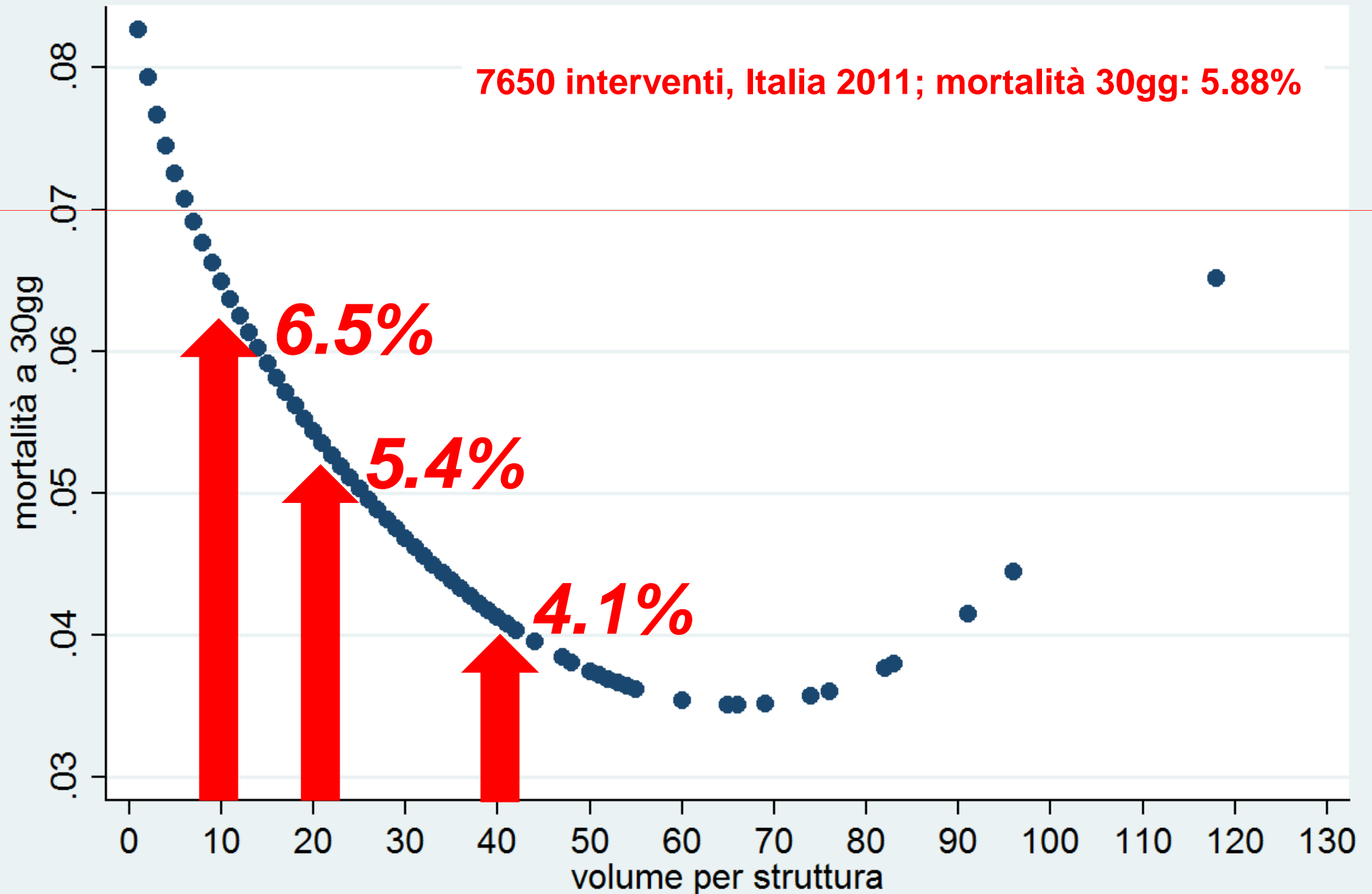
Esito:	Mortalità ospedaliera o a 30 giorni	Sopravvivenza
N ° studi (partecipanti)	25 (120.347)	5 (32.654)
N ° studi con associazione positiva (partecipanti)	17 (99.387)	2 (31.302)
Cut off alto volume (casi/anno)	range 6-12* media 10 mediana 11	11
Metanalisi: Referenza N ° studi (partecipanti) Odds Ratio(95% IC) Cut off alto volume (casi/anno)	<u>Gruen 2009</u> 14 (179.540) 0.88 (0.86-0.91) 33	/

Fig 16.2 Chirurgia CA Stomaco. Analisi dell'associazione tra mortalità a 30 gg e volume di attività per Struttura. Italia 2011



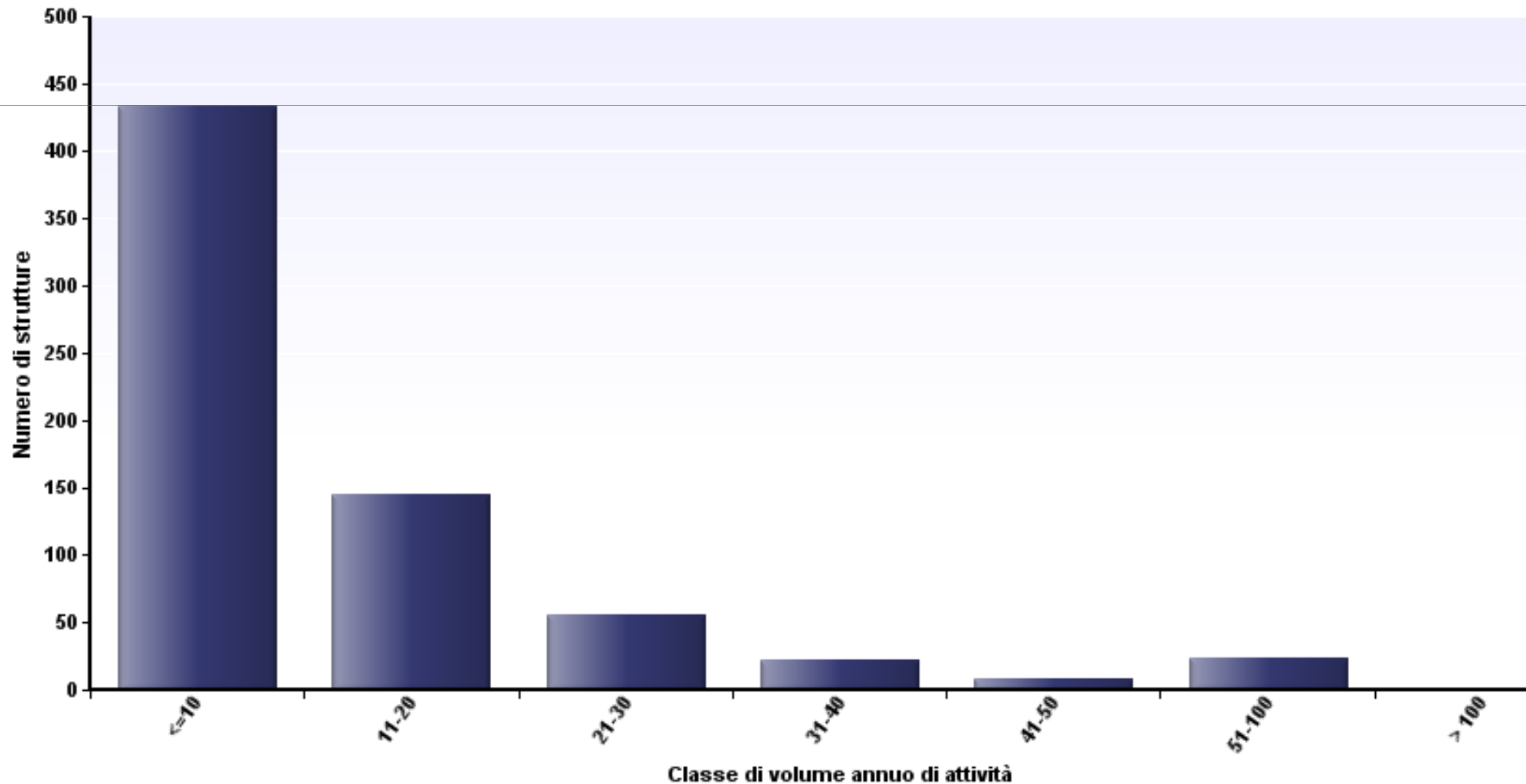
Intervento chirurgico per tumore maligno stomaco

Volumi di attività e mortalità a 30gg



Intervento chirurgico per tumore maligno stomaco.

Volumi di attività per struttura. PNE 2011



Hospital services in and around london for Cancer of the stomach

We found **184 hospital services** within of for **Cancer of the stomach**

Are you looking for: **hospital services** with london in the name?

(Distances given are in a straight line but travel routes may be longer. Please check before starting your journey.)

NHS or Independent hospital (select at least one)

NHS Hospitals

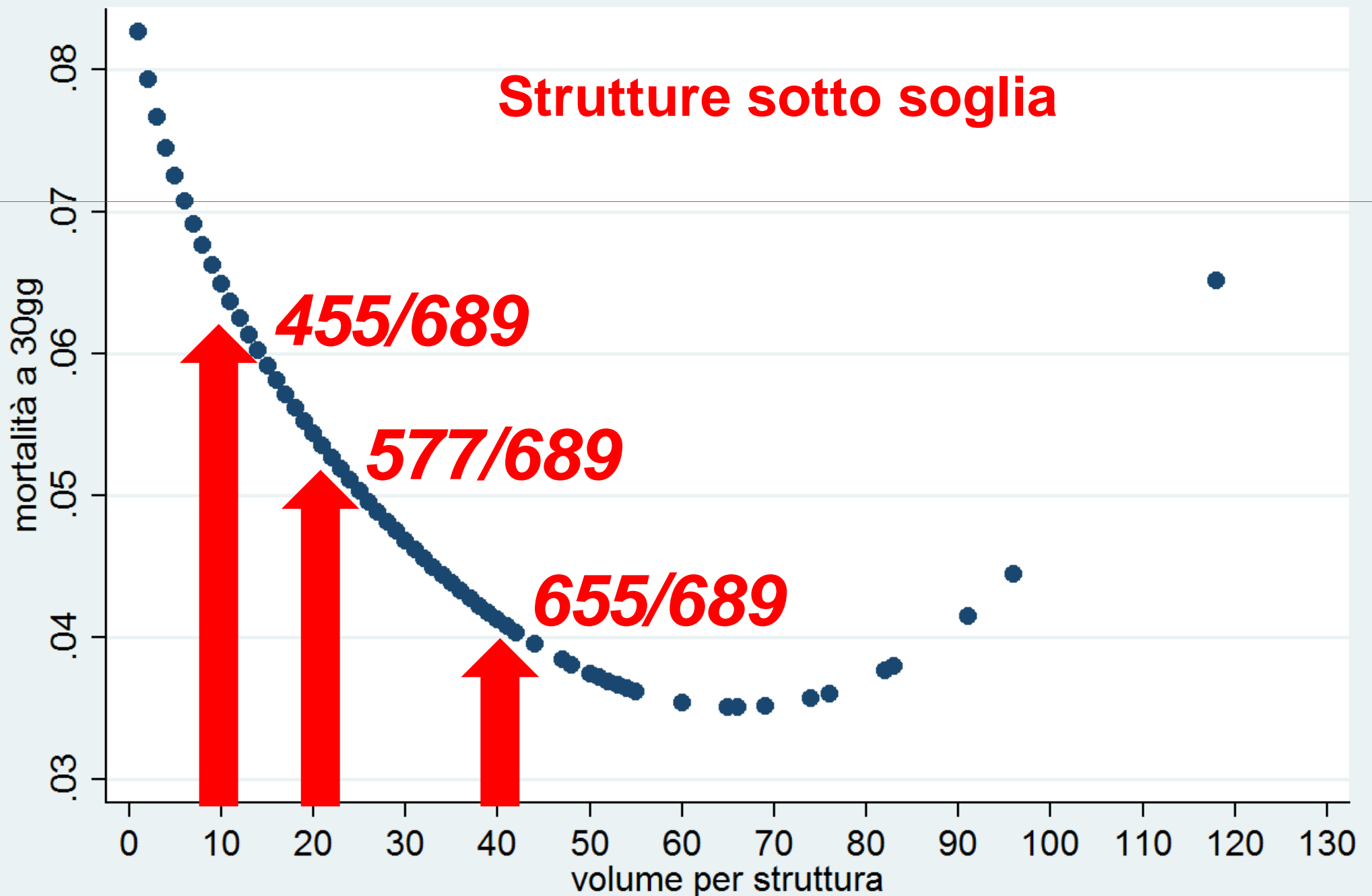
Independent hospitals with free NHS services

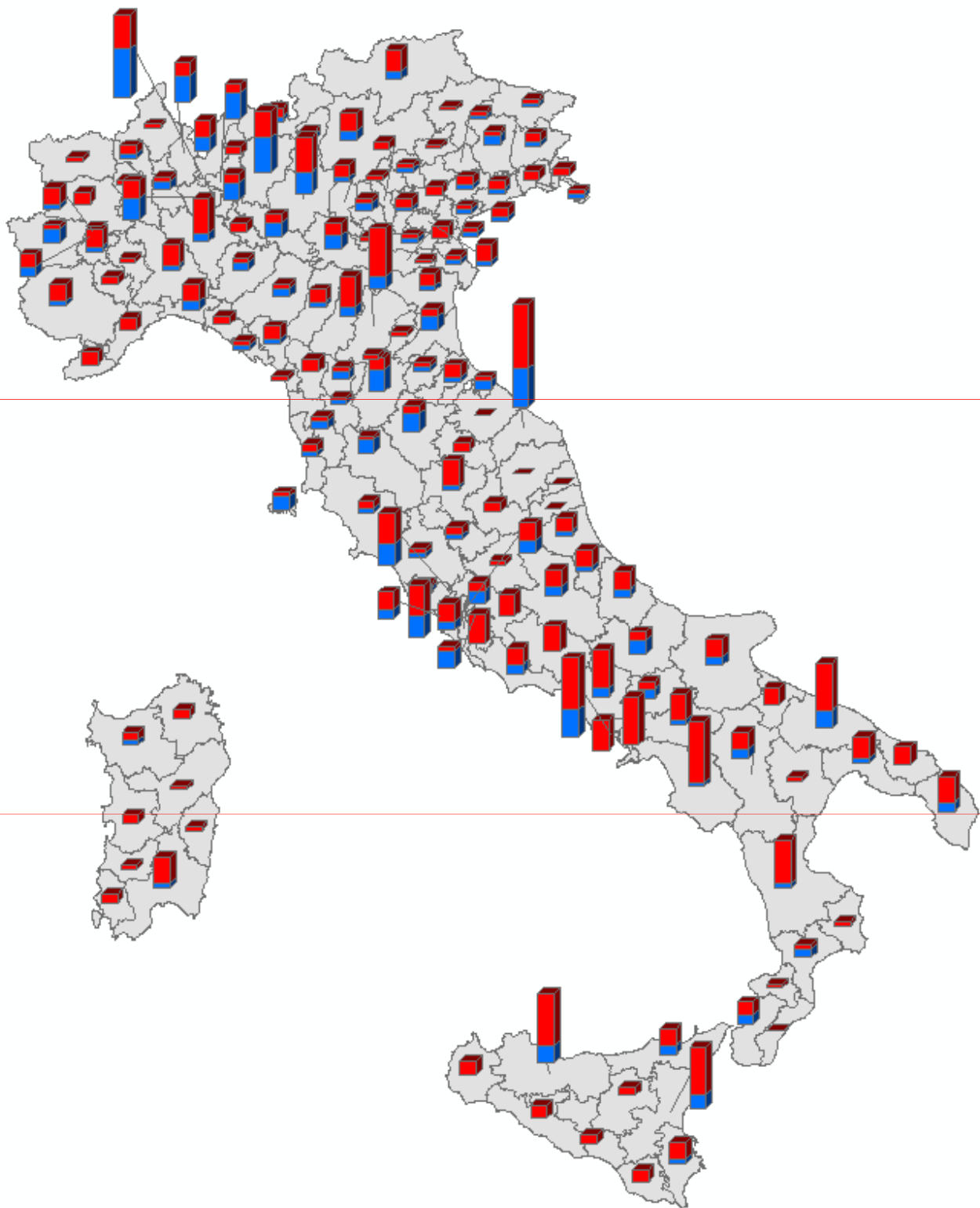
Update results >

or [start a new search](#)

Intervento chirurgico per tumore maligno stomaco

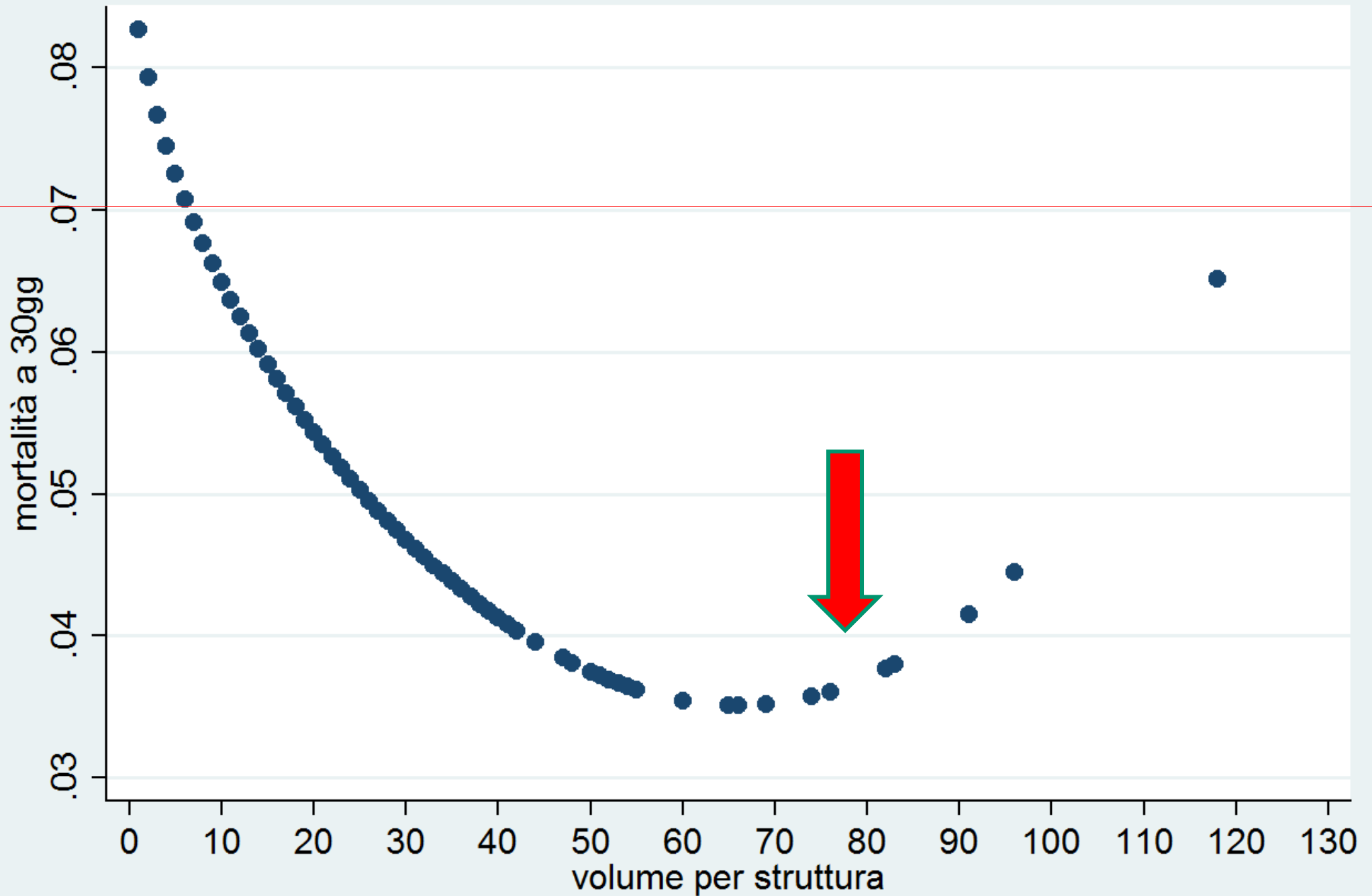
Volumi di attività strutture–Esiti. 2011





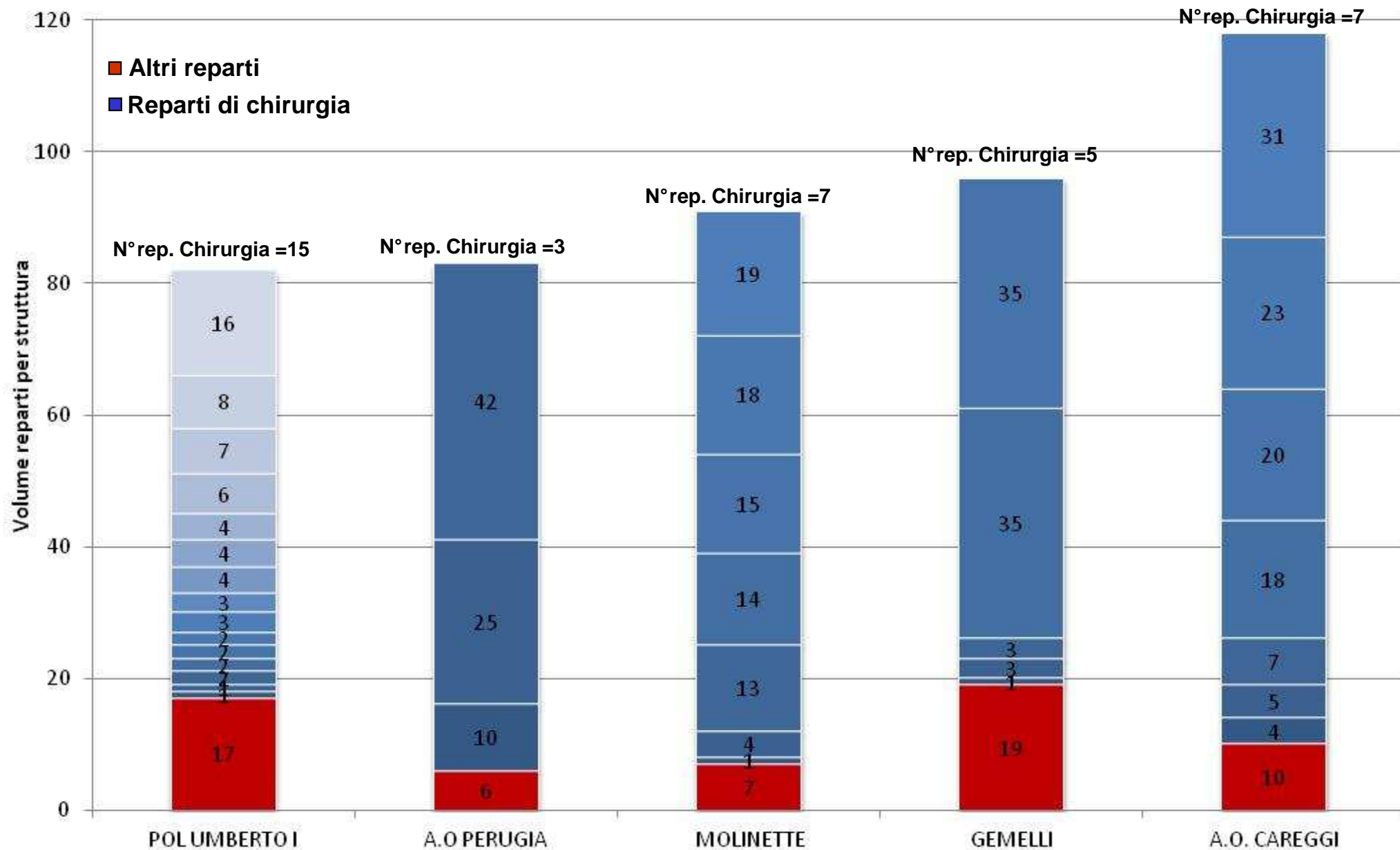
Intervento chirurgico per tumore maligno stomaco

Volumi di attività – Mortalità a 30 gg/struttura 2011



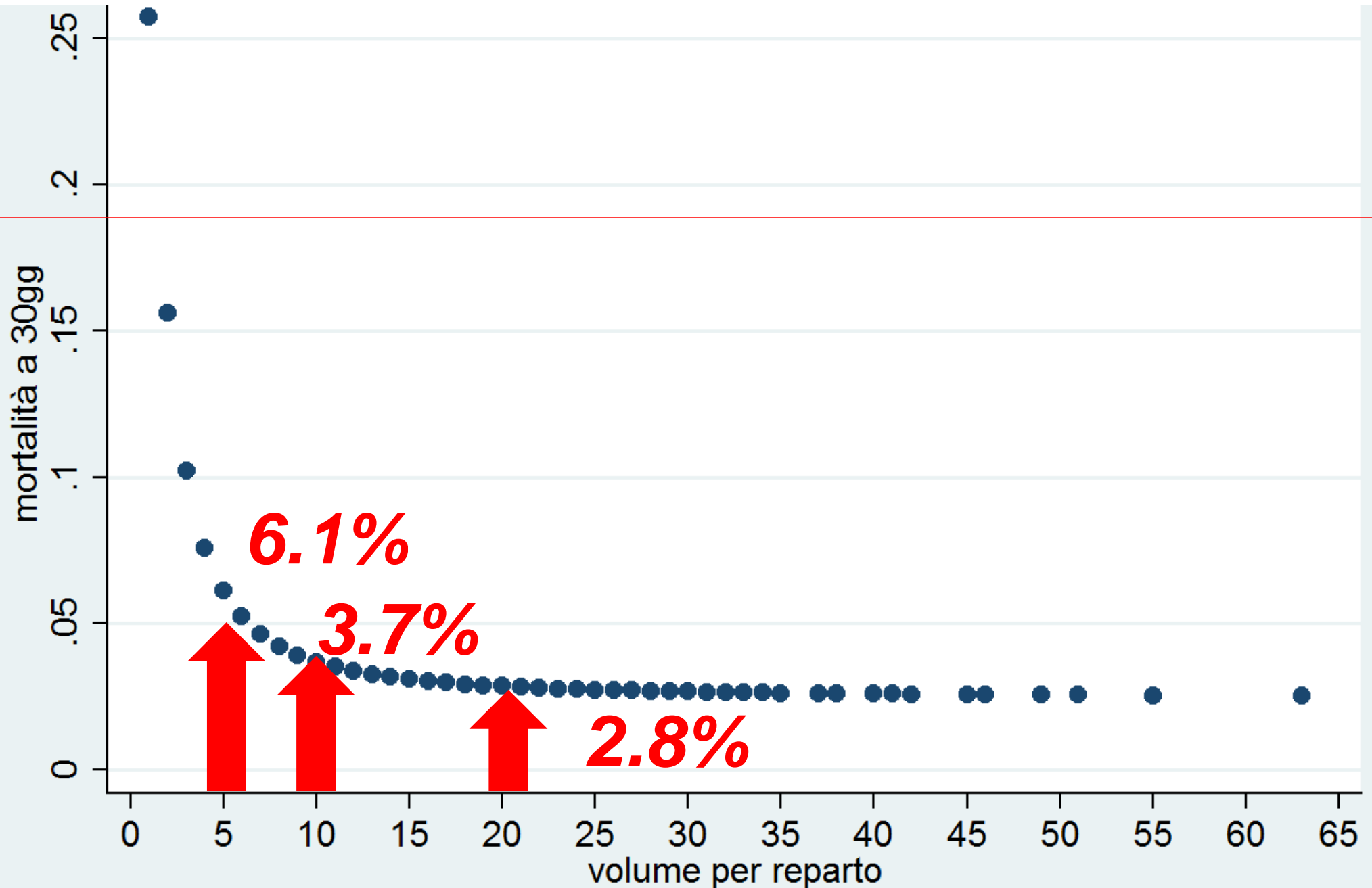
Tumore gastrico maligno - Strutture con volume di attività/anno > 80. PNE 2011

Italia 2011.



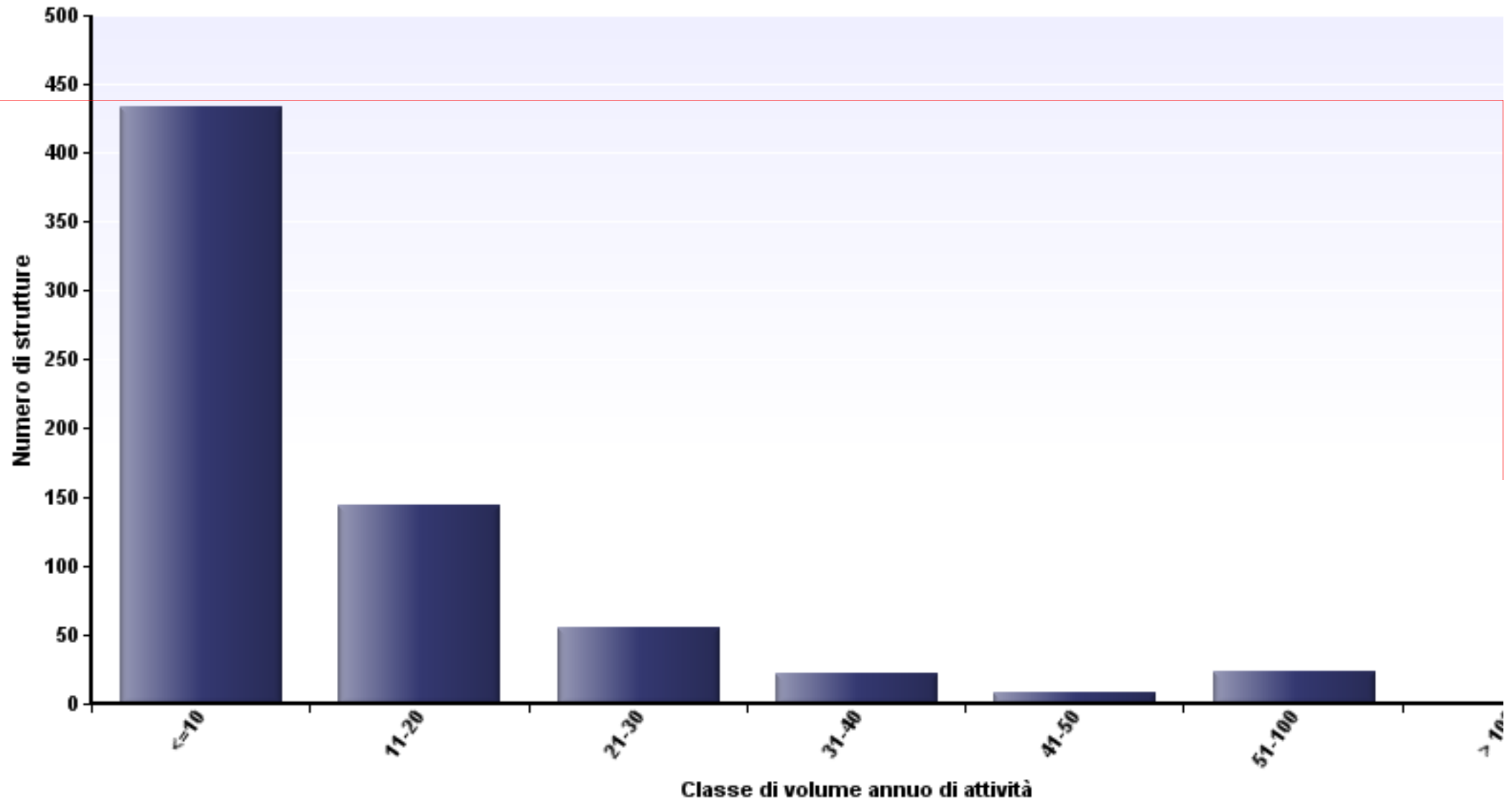
Intervento chirurgico per tumore maligno stomaco

Volumi di attività reparto–Mortalità 30 gg. PNE 2011



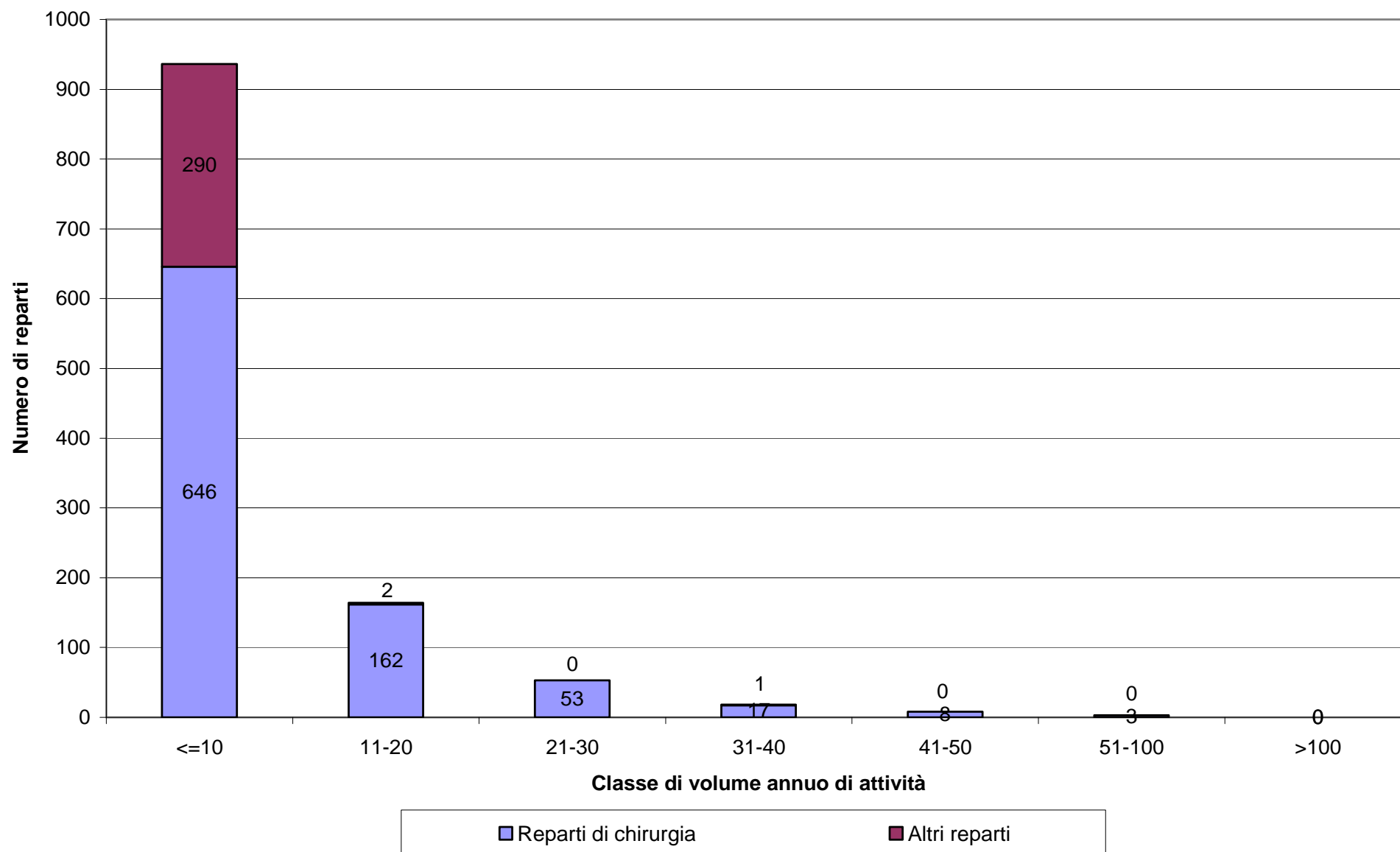
Intervento chirurgico per tumore maligno stomaco.

Volumi di attività per struttura. PNE 2011



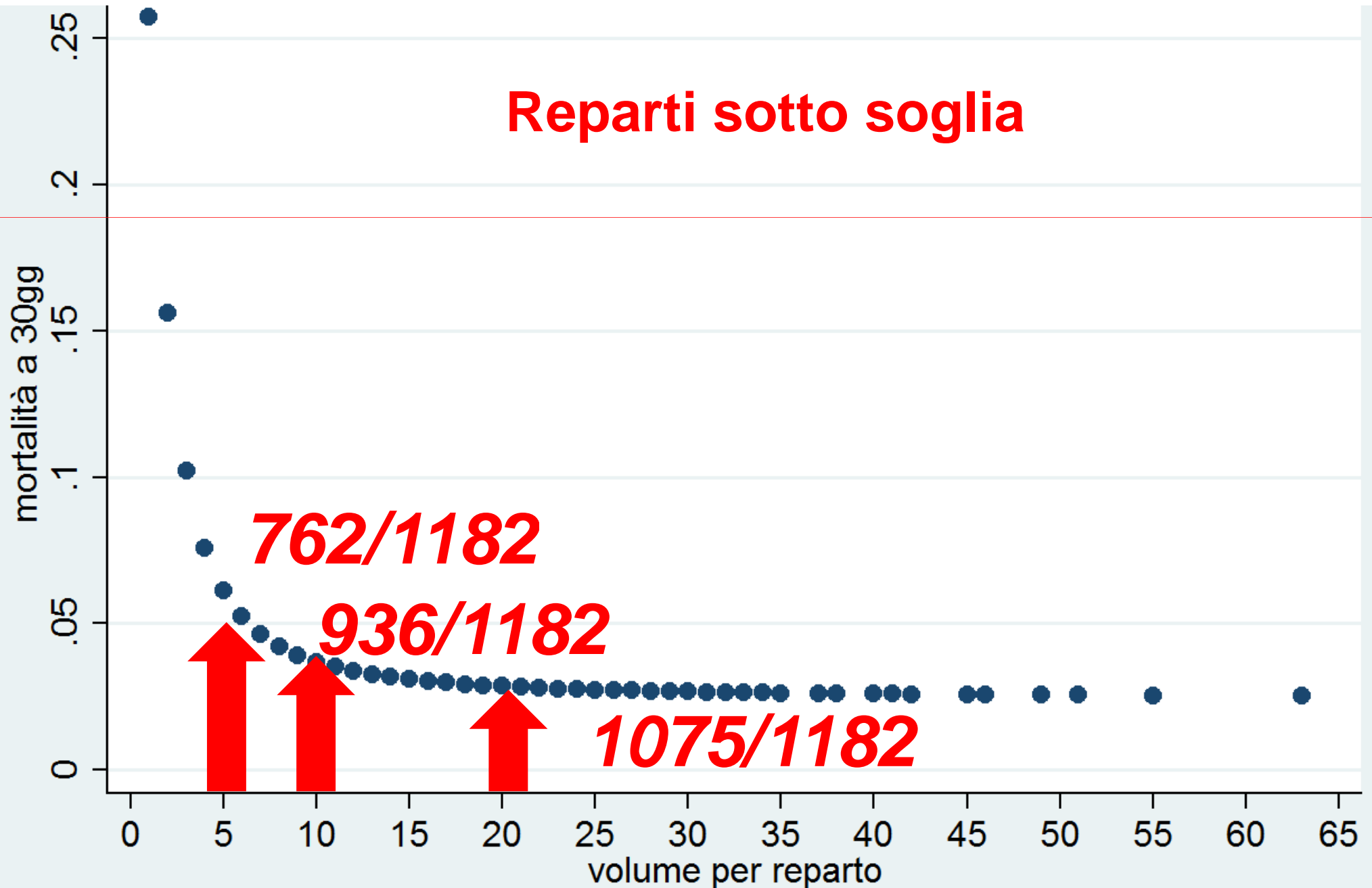
Intervento chirurgico per tumore maligno stomaco.

Volumi di attività per reparto. PNE 2011



Intervento chirurgico per tumore maligno stomaco

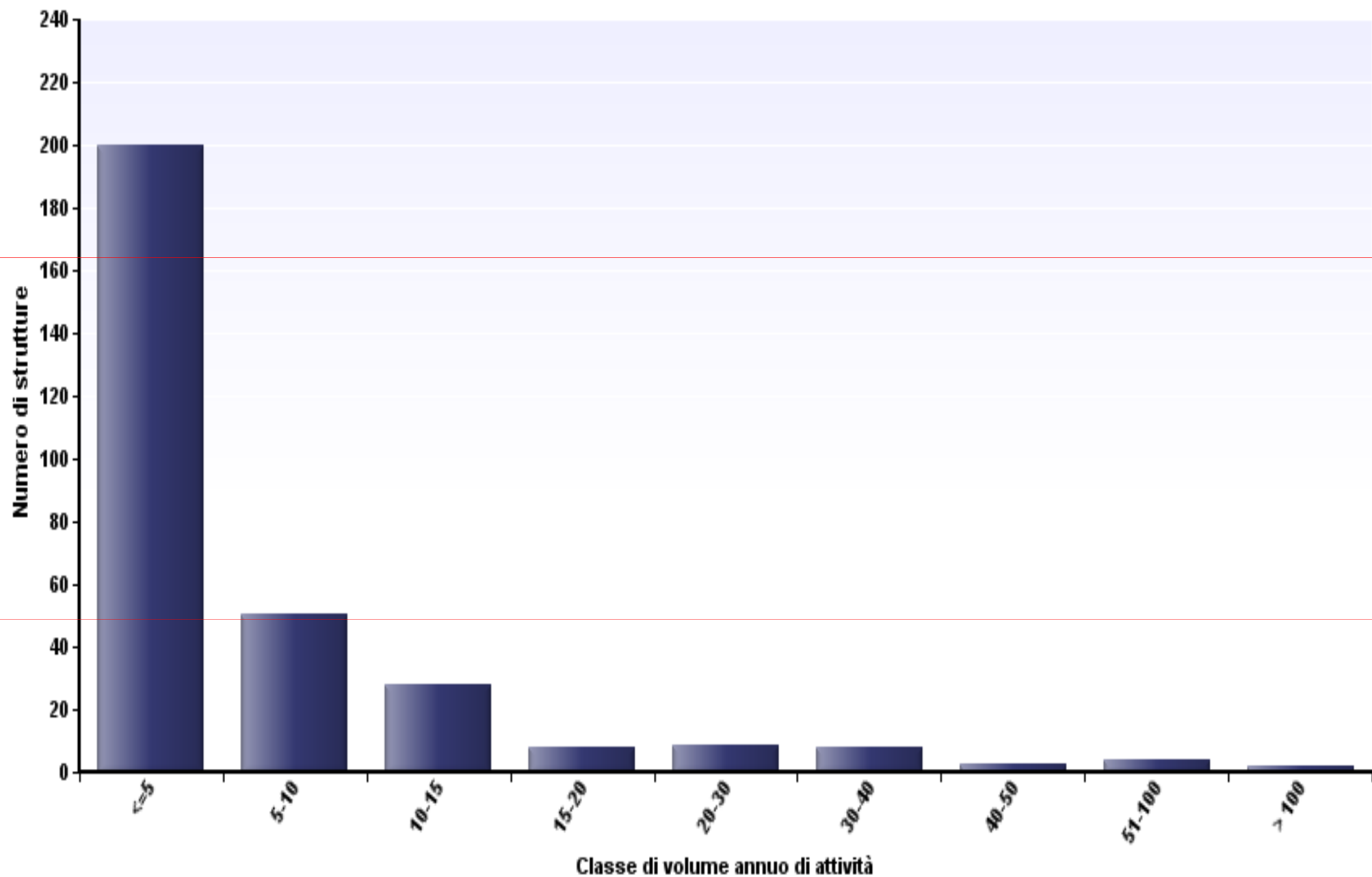
Volumi di attività reparto–Esiti. 2011



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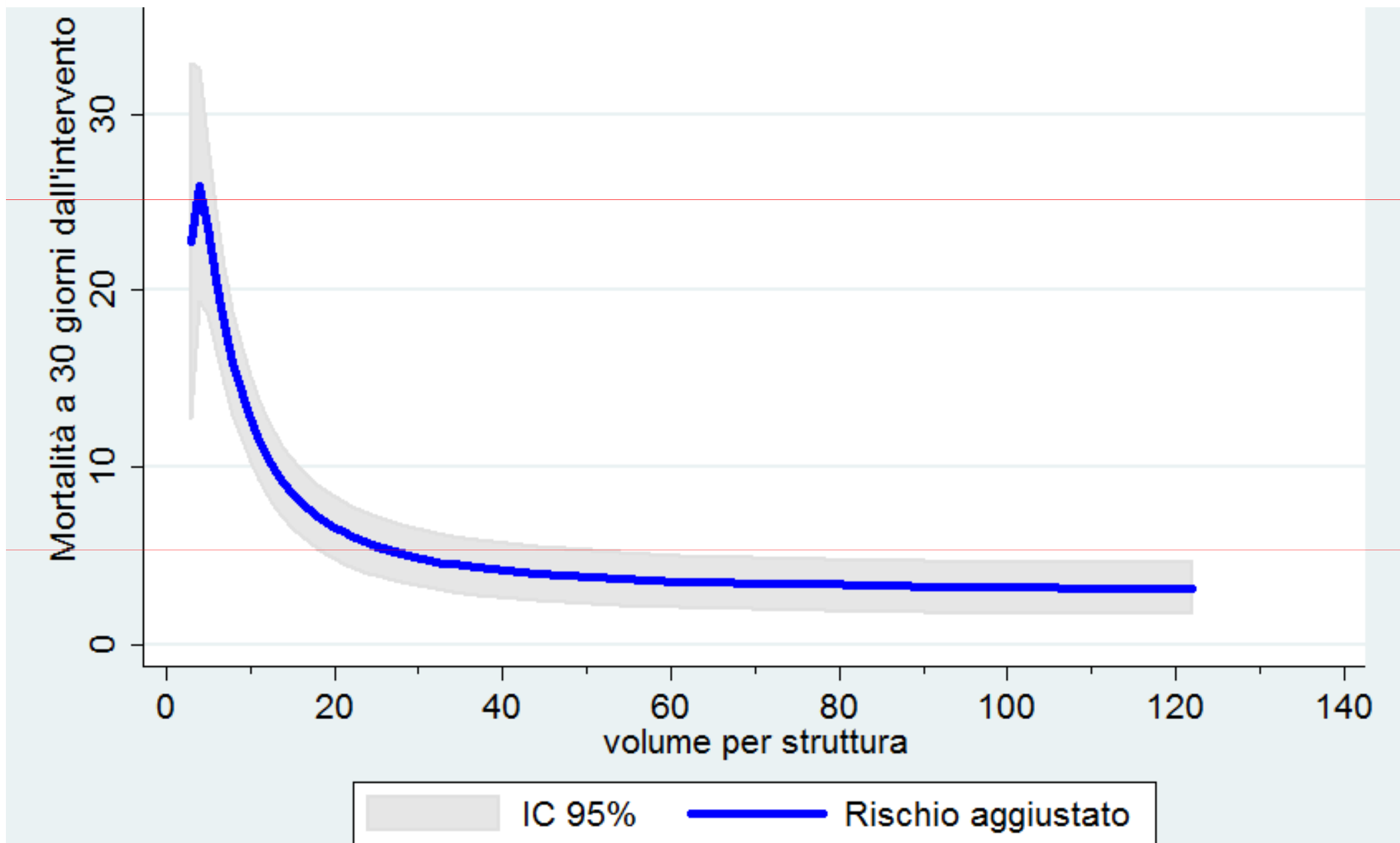
Intervento chirurgico per tumore maligno pancreas



**TAB.12 Chirurgia CA Pancreas; Risultati Revisione Sistemática
Volume di attività ospedaliera**

Esito:	Mortalità ospedaliera o a 30 giorni	Sopravvivenza overall e a 2/5 anni
N° studi (partecipanti)	42 (133.575) *	7 (28.531)
N° studi con associazione positiva (partecipanti)	29 (116.633)**	5 (24.114)
Alto volume (casi/anno)	range 3-89*** media 19.4 mediana 12	range 8-10****
Metanalisi N° studi (partecipanti) Odds Ratio (95% IC) Cut off alto volume (casi/anno)	<u>Gooiker 2011</u> 8 (127.948) 0.32 (0.16-0.64) 7	<u>Gooiker 2011</u> 2 (13.962) 0.79 (0.70- 0.89) 8
Metanalisi: Referenza N° studi (partecipanti) Odds Ratio (95% IC) Cut off alto volume (casi/anno)	<u>Gruen 2009</u> 30 (64.215) 0.78 (0.73-0.84) 20	/

Fig 12.1 Chirurgia CA Pancreas. Analisi dell'associazione tra mortalità a 30 gg e volume di attività per Struttura. Italia 2011



Chirurgia CA mammella

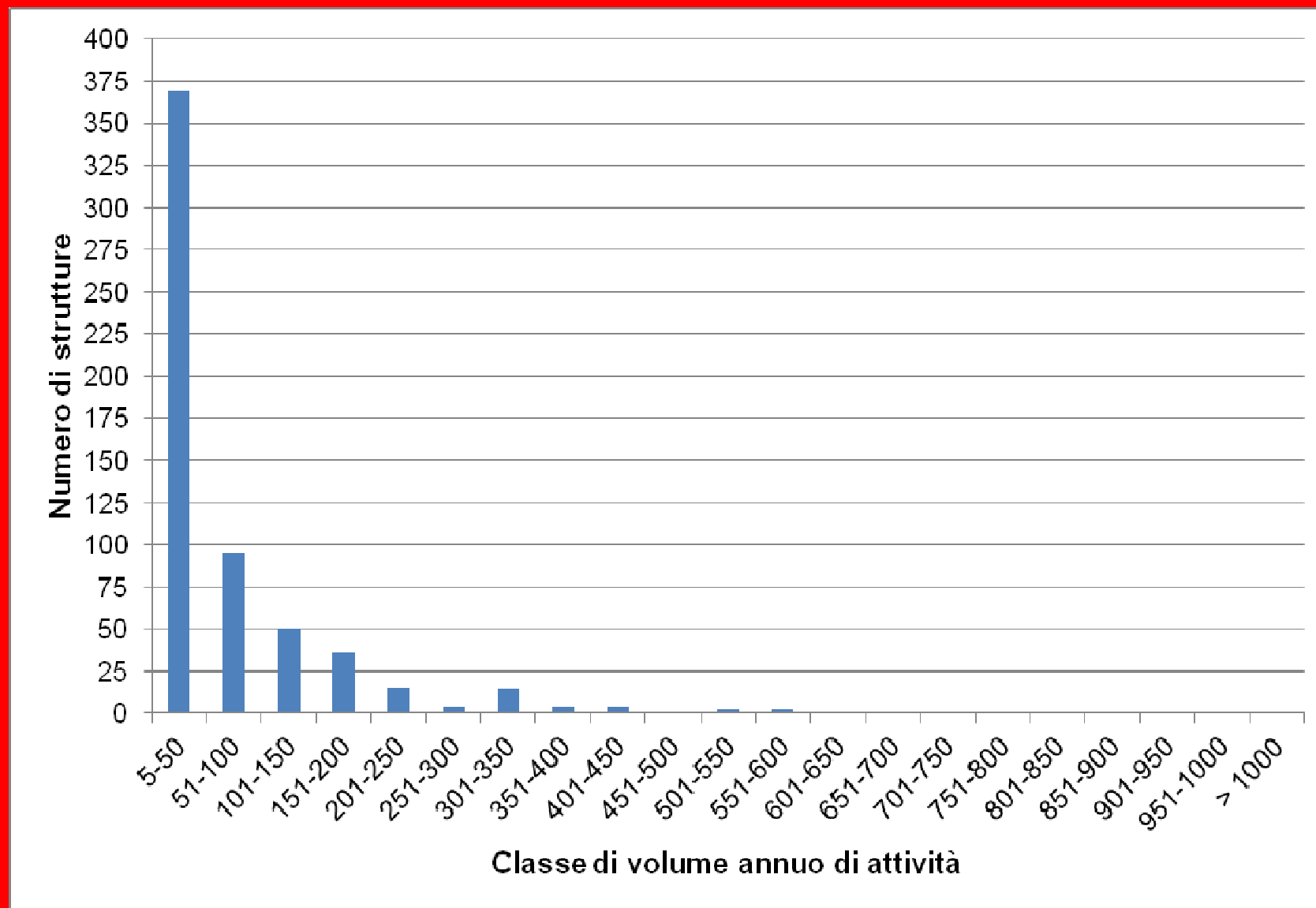
TAB.11 Chirurgia CA Mammella; Risultati Revisione Sistemática

Volume di attività ospedaliera

Esito	Mortalità ospedaliera o a 30 giorni	Sopravvivenza a 5 anni	Frequenza chirurgia conservativa
N° studi (partecipanti)	10 (351.089)	4 (74.489)	4 (1.298)**
N° studi con associazione positiva (partecipanti)	8 (338.645)	2 (59.219)	2 (1.259)**
Alto volume (casi/anno)	range: 40-195 media: 90 mediana: 88	range: 26-150 media: 81.7 mediana: 75.5	range: 101-499*** media: 233 mediana: 101
Metanalisi N ° studi (partecipanti) Odds Ratio (95% IC) Cut off alto volume (casi/anno)	<u>Gooiker 2010[^]</u> 2 (247.593) 0.40 (0.22-0.74) 70	/	/
Metanalisi N ° studi (partecipanti) Relative Risk (95% IC) Cut off alto volume (casi/anno)	<u>Gooiker 2010^{^*}</u> 6 (67.108) 0.83 (0.75-0.92) 40	/	/

Chirurgia CA mammella

Fig 11.1 Distribuzione del numero di Strutture per Volume di Attività. Italia 2011



Impact of Procedure Volumes and Focused Practice on Short-Term Outcomes of Elective and Urgent Colon Cancer Resection in Italy

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Abstract

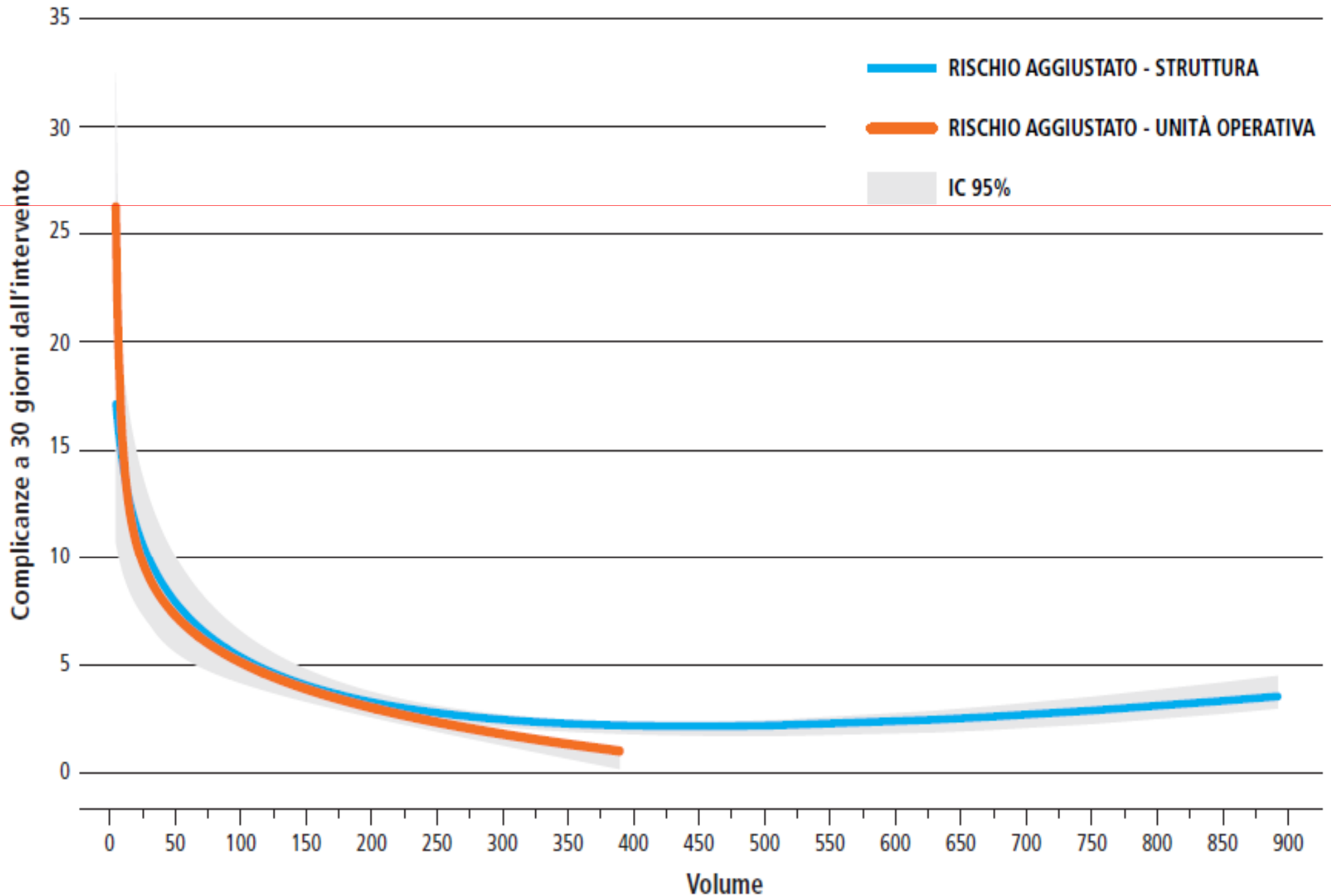
Background: The relationship between hospital volumes and short-term patients' outcomes of colon cancer (CC) surgery is not well established in the literature. Moreover, evidence about short-term outcomes of urgent compared with elective CC procedures is scanty. The aims of this study are 1) to determine whether caseloads and other hospital characteristics are associated with short-term outcomes of CC surgery; 2) to compare the outcomes of urgent and elective CC surgery.

Methods: A total of 14,200 patients undergoing CC surgery between 2005 and 2010 in the General Surgery Units (GSUs) of the hospitals of Emilia-Romagna region, Northern Italy, were identified from the hospital discharge records database. The outcomes of interest were 30-day in-hospital mortality, re-intervention and 30-day re-admission. Using multilevel analysis, we analyzed the relationship of GSU volumes and focused practice, defined as the percentage of CC operations over total operations, with the three outcomes.

Results: High procedure volumes were associated with a lower risk of 30-day in-hospital mortality, after adjusting for patients' characteristics [aOR (95% CI) = 0.51 (0.33–0.81)]. Stratified analyses for elective and urgent surgery showed that high volumes were associated with a lower 30-day mortality for elective patients [aOR (95% CI) = 0.35 (0.17–0.71)], but not for urgent patients [aOR (95% CI) = 0.72 (0.42–1.24)]. Focused practice was an independent predictor of re-intervention [aOR (95% CI) = 0.67 (0.47–0.97)] and re-admission [aRR (95% CI) = 0.88 (0.78–0.98)].

Conclusions: The present study adds evidence in support of the notion that patients with CC undergoing surgery at high-volume and focused surgical units experience better short-term outcomes.

Colecistectomia laparoscopica; complicanze a 30gg.





MINISTERO DELLA SALUTE, BOZZA DECRETO

Regolamento recante: "Definizione degli standard qualitativi, strutturali, tecnologici e quantitativi relativi all'assistenza ospedaliera, in attuazione dell'articolo 1, comma 169, della legge 30 dicembre 2004, n. 311" e dell'articolo 15, comma 13, lettera c), del decreto-legge 6 luglio 2012, n. 95 convertito, con modificazioni dalla legge 7 agosto 2012, n. 135 .

IL MINISTRO DELLA SALUTE

di concerto con

IL MINISTRO DELL'ECONOMIA E DELLE FINANZE

Visto l'articolo 1, comma 169, della legge 30 dicembre 2004, n. 311, il quale dispone che, al fine di garantire che l'obiettivo del raggiungimento dell'equilibrio economico finanziario da parte delle regioni sia conseguito nel rispetto della garanzia della tutela della salute, ferma restando la disciplina dettata dall'articolo 54 della legge 27 dicembre 2002, n. 289, per le prestazioni già definite dal decreto del Presidente del Consiglio dei Ministri 29 novembre 2001 e successive modifiche e integrazioni, anche al fine di garantire che le modalità di erogazione delle stesse siano uniformi nell'intero territorio nazionale coerentemente con le risorse programmate per il Servizio

Soglie volumi di attività specifica

Attività	Soglia	Soglia applicata
Colecistectomia laparoscopica	100	90
Intervento chirurgico per K Colon	20	18
Intervento chirurgico per K Retto	20	18
Intervento chirurgico per K Stomaco	10	9
Intervento chirurgico per K Polmone	50	45
Intervento chirurgico per K Prostata	100	90
Intervento chirurgico per K Mammella	100	90
Endoarterectomia carotidea: Endo	50	45
Endoarterectomia carotidea: Stenting	50	45
Int. Aneurisma Aorta Addominale	30	27
Frattura del collo del femore	50	45
Bypass	150	135
Valvuloplastica	150	135
IMA	100	80
PTCA	250	200

Selezione la	Lombardia
	Lombardia
Specialità	P.A. di Bolzano Emilia-Romagna Marche Lazio
	Abruzzo Campania Sardegna
Totale	
Totale chirurgia	
Chirurgia generale	
Chirurgia toracica	
Chirurgia vascolare	
Cardiochirurgia	
Ortopedia	
Cardiologia	

Specialità	N° Interventi totali	N° Interventi in reparti sotto soglia	N° di Interventi per le procedure considerate (vedi tabella) in reparti sotto soglia	% Interventi in reparti sotto soglia	N° reparti sotto soglia	N° reparti totale	% reparti sotto soglia
Totale	1085971	236601	27026	21,8	715	2187	32,7
Totale chirurgia	784321	183829	22259	23,4	543	1710	31,8
Chirurgia generale	360243	85910	16781	23,8	327	843	38,8
Chirurgia toracica	13219	809	257	6,1	10	47	21,3
Chirurgia vascolare	40103	1843	701	4,6	24	130	18,5
Cardiochirurgia	30639	4683	2707	15,3	22	72	30,6
Ortopedia	340117	90584	1813	26,6	160	618	25,9
Cardiologia*	301650	52772	4767	17,5	172	477	36,1

* Il numero dei reparti totale include quelli che non effettuano ricoveri per IMA e PTCA:

Seleziona la Regione:	Emilia-Romagna
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080

Specialità	N° Interventi totali	N° Interventi in reparti sotto soglia	N° di Interventi per le procedure considerate (vedi tabella) in reparti sotto soglia	N° Interventi residenti	% Interventi sotto soglia	N° reparti sotto soglia	N° reparti totale	% reparti sotto soglia
Totale	160603	29013	2621	131035	18,1	88	293	30,0
Totale chirurgia	123302	24890	2201	98490	20,2	59	216	27,3
Chirurgia generale	46330	8472	1433	43093	18,3	33	94	35,1
Chirurgia toracica	2652	9	3	2386	0,3	1	9	11,1
Chirurgia vascolare	6394	119	81	5638	1,9	2	17	11,8
Cardiochirurgia	3530	842	458	2997	23,9	3	7	42,9

Reparti con volume di attività specifica sotto soglia. Lazio 2011

Specialità	N° ricoveri sotto soglia	N° totale di ricoveri	% ricoveri sotto soglia	N° reparti sotto soglia	N° totale di reparti	% reparti sotto soglia
Chirurgia generale	18715	57156	32.7	72	172	41.9
Chirurgia toracica	209	2162	9.7	2	8	25.0
Chirurgia vascolare	364	5463	6.7	2	22	9.1
Ortopedia	11066	48333	22.9	24	109	22.0
Cardiochirurgia	339	4448	7.6	3	11	27.3
Totale chirurgia	30693	117562	26.1	103	322	32.0
Cardiologia	10727	46795	22.9	45	77	58.4
Totale	41420	164357	25.2	148	399	37.1

- *Alti volumi x accreditalamento*
- *Valutazione comparativa*
esiti
- *Selezione avversa gravità*
- *Trattamento bassa gravità*
- *Inappropriatezza*
- *Espansione prestazioni*
inappropriate in popolazione

***Volumi
Provider***

You are here: [The NHS in England](#) / [The Keogh Review](#)

The Keogh Review

On February 6 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that are persistent outliers on mortality indicators. A total of 14 hospital trusts are being investigated as part of this review.

The review will be guided by the NHS values set out in the [NHS Constitution](#) and underpinned by the following key principles:

- Patient and public participation
- Listening to the views of staff
- Openness and transparency
- Co-operation between organisations



Terms of reference

Find out why Professor Sir Bruce Keogh was asked to review the quality of care and treatment for some NHS trusts and foundation trusts and what the aims of the investigations are.



Hospitals under investigation

Find a full list of the NHS trusts and NHS foundation trusts that will be



HOW TO RAISE CONCERNS



If you want to submit any information or raise any concerns you may have about any of the 14 hospital trusts covered by this review you can do so in the following ways:

By email: brucekeogh.review@nhs.net

By letter

Bruce Keogh Review
c/o NHS Commissioning Board
1st Floor Quarry House
Quarry Hill
Leeds
LS2 7UE

By phone: call the Care Quality Commission on 03000 61 61 61 and select option 2

All information submitted will be treated confidentially but may be shared with other statutory organisations, for

