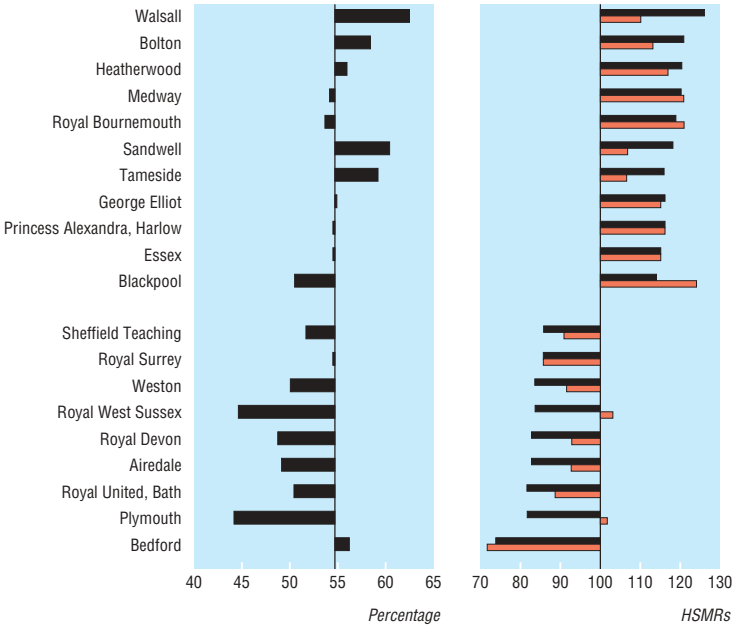

Percentages of deaths occurring in NHS hospitals for catchment areas of hospitals (vertical line is percentage for England) and hospital standardised mortality ratios (HSMRs) as published (black) and after adjustment (red). Hospitals are plotted in ranking order of published HSMRs[1]

Statistics on place of death (NHS hospital, hospice, home, etc) of residents of different areas are published routinely.[4] These were available for two of the three years on which the published hospital league tables were based (1999 and 2000). We used hospital episode statistics to identify the individual health authorities that corresponded most closely to the catchment area of the 20 selected hospitals, and we used the published figures on place of death to calculate the percentage of deaths of residents of each catchment area that occurred in NHS hospitals. We then adjusted the published HSMRs to allow for geographic differences in the percentages of deaths occurring in hospital in the hospitals' catchment areas. We did this by scaling down the values when proportionately more deaths of residents occurred in NHS hospitals compared with England as a whole and scaling up those when proportionately fewer deaths occurred in hospital. For instance, for every 1000 deaths of residents of Walsall Health Authority, on average 623 occurred in NHS hospitals. For England overall, the average was 546. We reduced the published HSMR for the Walsall hospitals, 126, by the scaling factor 0.88 (546/623), which gave an adjusted HSMR of 110.

The percentages of deaths of residents of health authorities that occurred in NHS hospitals varied from less than 45% in Plymouth and West Sussex to over 60% in Walsall and Sandwell (figure, and see table on bmj.com). In most cases the adjustment brought the HSMRs closer together and closer to 100. It also changed the rankings.

Comment

Geographical differences in the provision of facilities for the dying are a plausible explanation for some of the differences between hospitals in their in-hospital death rates. Calculation of in-hospital death rates, aggregated across a wide clinical spectrum, including a mixture of admissions for treatment, cure, and palliative and terminal care, gives rates that are difficult to interpret as quality measures.

We thank Pamela Evans for typing the manuscript.

Contributors: MJG proposed the study; VS analysed the data. Both designed the study, wrote the manuscript, and will act as guarantors.

Funding: VS is funded by the Research and Development Directorate of the Department of Health and Social Care (South). MJG holds a grant from the Department of Health for the Oxford site of the National Centre for Health Outcomes Development (NCHOD). The funding body had no role in the design or writing of the work covered by this report.

Competing interests: None declared.

Ethical approval: Not needed.

1 *The good hospital guide.* 6 April 2003. www.timesonline.co.uk (accessed 1 Aug 2003).
2 Ellis R. The Good Hospital Guide 2002. A deadly lottery: you are twice as likely to die at the worst hospitals. *Mail on Sunday* 2002 March 10.
3 Jacobson B, Mindell J, McKee M. Hospital mortality league tables. *BMJ* 2003;326:777-8.
4 *Review of the registrar general on deaths in England and Wales, 2000.* Norwich: Stationery Office, 2000. (DH1, No 33.)
5 *Hospital guide.* www.drfoster.co.uk (accessed 1 Aug 2003).

(Accepted 17 December 2003)

doi 10.1136/bmj.38058.517118.47

Corrections and clarifications

Preventing childhood obesity by reducing consumption of carbonated drinks: cluster randomised controlled trial
Two errors crept into table 2 of the full version (on bmj.com only) of this paper by Janet James and colleagues (22 May, p 1237). Firstly, the parentheses should be around the second set of values (which are the percentages) not the first set of values (which are the numbers). Secondly, the control girls consumed 95 (not 5) glasses of carbonated drinks in three days. The authors also want to make clear that data in the table relate to overweight children who fall between the 91st and 98th centiles and to obese children above the 98th centile.

Minerva
Minerva was reminded by a reader that she had forgotten to insert a reference for one of the items in the issue of 24 April (p 1024). The reference for the final item (about fatigue in patients with primary biliary cirrhosis) is *Gut* 2004;53:587-92.

Length of patient's monologue, rate of completion, and relation to other components of the clinical encounter: observational intervention study in primary care
In this Primary Care paper by Israel Rabinowitz and colleagues (28 February, pp 501-2), a misspelling of the surname of the second author (Rachel Luzzati) persisted to publication. There is only one "t" in Luzzati (not two). This has been corrected on bmj.com.

Integrating health care for mothers and children in refugee camps and at district level
The name of the first author in reference 8 was wrongly spelt in this Education and Debate article by Assad Hafeez and colleagues (3 April, pp 834-6). The correct spelling is Rahman.