

1 GENERAL DATA

Compiled by: F Whimster

RECOMMENDATIONS

- Clinicians are still unable to return data to NCEPOD as a result of missing patient records. Action is required to improve hospital record systems; this is within the remit of clinical governance.
- NHS Trusts must take responsibility for ensuring that all relevant deaths are reported and questionnaires returned to NCEPOD as part of their clinical governance duties.

1. GENERAL DATA

INTRODUCTION

The NCEPOD protocol used during the 1997/98 data collection period is shown in Appendix D. This is currently under review to take into account important changes arising as a result of the white paper ‘The new NHS Modern Dependable’, ‘A First Class Service’² and ‘Clinical Governance: Quality in the new NHS’³. These changes brought NCEPOD under the aegis of the National Institute for Clinical Excellence (NICE) and, most significantly, stated that “*all relevant hospital doctors and other health professionals will be required to participate in the work of the National Confidential Enquiries. Results from their findings will be fed into appropriate NICE guidance and standard setting and will be an important part of ensuring effective clinical governance locally which is to be independently scrutinised by the Commission for Health Improvement (CHI)*”².

It was also stated that “*NHS Trusts have responsibility for ensuring that all hospital doctors take part in national clinical audits and confidential enquiries*”³. This requirement, coupled with improved centralised national data should, in the future, enable clinicians to measure and compare outcomes. It is, therefore, essential that the current rates of reporting deaths and returning questionnaires to NCEPOD be increased. The profession will need to improve compliance, or explain the obstacles to participation, if criticism is to be avoided.

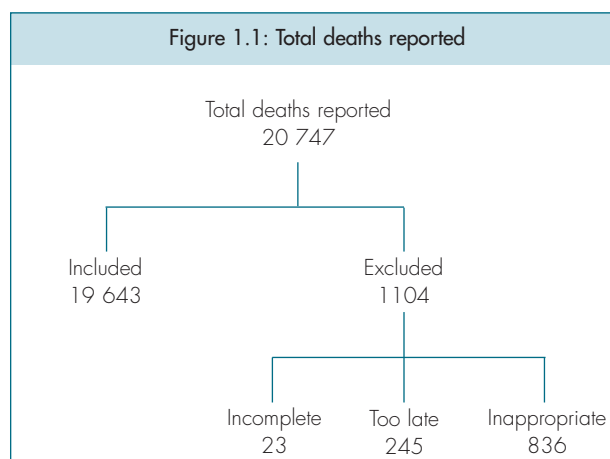
The introduction of clinical governance and compulsory participation from April 1999 will in no way compromise the confidentiality and anonymity with which data received by the Enquiry will be treated.

It should be remembered, however, that the data presented in this Report was gathered *before* the advent of clinical governance and mandatory participation.

DATA COLLECTION

Data was requested from all NHS hospitals in England, Wales, Northern Ireland, Guernsey, Jersey, Isle of Man and the Defence Secondary Care Agency. In addition, many hospitals in the independent sector contributed data. Data was not collected from Scotland where the Scottish Audit of Surgical Mortality (SASM) performs a similar function.

Deaths occurring in hospital, between 1 April 1997 and 31 March 1998, and within 30 days of a surgical procedure, were reported to NCEPOD by the designated Local Reporter for each hospital (Appendix E). A few reports of deaths occurring at home were also received.



GENERAL DATA ANALYSIS

Figure 1.1 shows that a total of 20 747 reports were received. Of these, 1104 were excluded from further analysis: 836 were deemed inappropriate according to the NCEPOD protocol (Table 1.1 and Appendix D), 245 were received after the deadline of 30 September 1998 and 23 remained incomplete despite all efforts to identify missing information.

Table 1.1: Inappropriate reports received and excluded

Reason for exclusion	Number
More than 30 days (day of operation to day of death)	220
Procedure not performed by a surgeon	221
Duplicate report	271
No surgical procedure performed or procedure excluded by NCEPOD criteria	106
Procedure performed in non-participating independent hospital	14
Patient still alive	2
Maternal death	2
Total	836

These figures do not include inappropriate reports included in computer printout format. Some hospital information systems cannot easily filter out inappropriate reports, such as deaths following procedures by physicians, or deaths following procedures excluded by NCEPOD.

A regional breakdown of the remaining 19643 deaths is shown in Table 1.2. Comparisons with previous years' figures should be treated with caution due to the effect of alterations in the regional structure of the NHS together with a lack of denominator data to indicate possible changes in the total number of operations performed.

Table 1.2: Deaths reported to NCEPOD by region

	1997/98	1996/97	1995/96	1994/95	1993/94	1992/93	1991/92	1990	1989
Anglia & Oxford	1720	1578	1672	1361	1577	1862	1556	1367	1371
North Thames	2252	2292	2081	1944	2703	2515	2127	2554	2609
North West	2698	2634	2736	2618	2636	2378	2509	2736	2864
Northern & Yorkshire	3018	2870	3110	2549	2637	2671	2267	2464	2685
South & West	2288	2201	2508	2469	2561	2493	1847	1997	2306
South Thames	2202	2330	2166	2246	2531	2445	2465	2457	2840
Trent	2301	2218	2397	2386	2342	2036	2014	1722	1849
West Midlands	1559	1527	1595	1531	1578	1565	1578	1826	1902
Wales	915	1102	840	933	1078	1072	1079	1102	1162
Northern Ireland	462	480	469	497	529	474	375	316	380
Guernsey	15	27	33	12	33	26	18	39	32
Jersey	28	18	26	17	27	32	25	22	26
Isle of Man	16	26	0	0	25	41	25	25	7
Defence Secondary Care Agency	5	8	7	17	36	40	75	60	94
Independent sector	164	185	201	148	149	166	172	130	120
Total	19 643	19 496	19 841	18 728	20 442	19 816	18 132	18 817	20 247

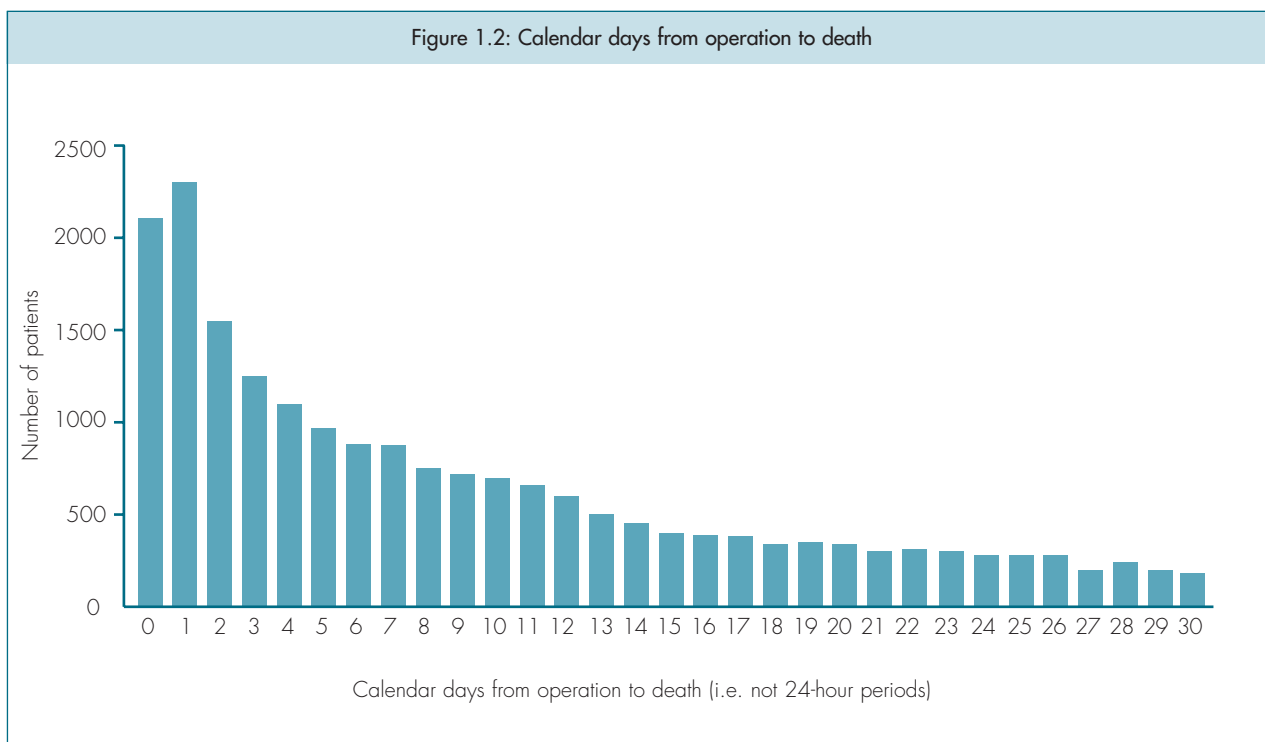
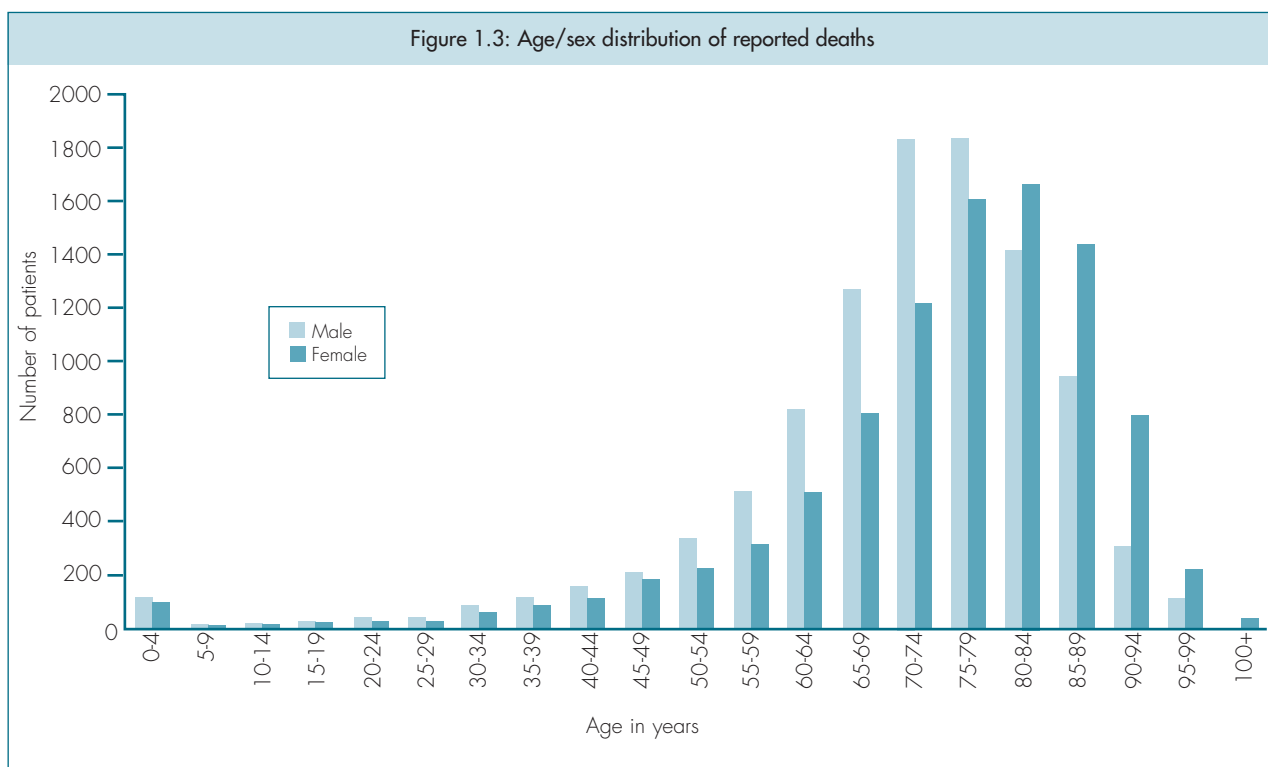


Figure 1.2 shows the distribution of the number of calendar days between operation (day 0) and death, with a peak at day 1, and almost half of deaths occurring within the first five days. This distribution has remained remarkably unchanged over the years.

Figure 1.3 shows the distribution of age and sex.

The number of days taken for Local Reporters to inform NCEPOD of deaths is shown in Table 1.3.

Variations in the length of time are largely due to the different data collection methods used by Local Reporters. Whilst understanding constraints on the time available, a reduction in days taken to report deaths would undoubtedly be helpful. The sooner questionnaires can be dispatched to clinicians, the more likely it is that the medical records will be available, the case clearly remembered and the relevant clinicians still working at the same hospital. In addition, it allows more time for questionnaires to be completed and



returned by the annual deadline of 31 December. For this reason, the deadline for reporting deaths has, from 1999, been brought forward to 31 August from 30 September.

SAMPLE GROUPS FOR DETAILED REVIEW

Two sample groups were selected for detailed review: deaths of children aged less than 16 years (i.e. until the day preceding the 16th birthday) and deaths of those aged 90 years and over (i.e. from the day of the 90th birthday).

Table 1.3: Calendar days between death and receipt of report by NCEPOD

Calendar days (i.e not 24-hour periods)	Number of deaths reported
1-29	4587
30-59	4245
60-89	3182
90-119	2301
120-149	1721
150-179	1170
180+	2437
Total	19 643

On this basis, from the total of 19 643 deaths, 1567 (8%) were initially included. This represented 139 in the less than 16 years age group and 1428 in the 90 years and over group (Figure 1.4).

Children

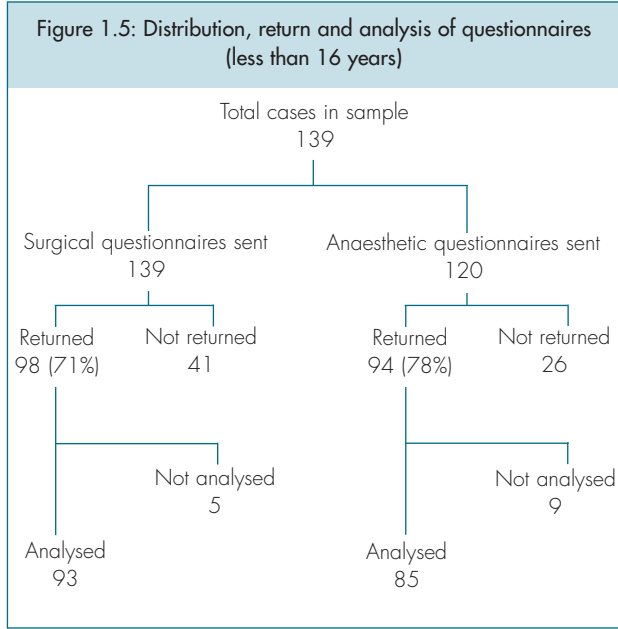
There were 139 deaths in the less than 16 years sample for which a surgical questionnaire was required and 120 deaths for which an anaesthetic questionnaire was needed (Figure 1.5).



In the 19 cases where no anaesthetic questionnaire was sent this was either because the procedure was performed without an anaesthetist present (5) or because the name of the appropriate consultant was unobtainable or notified too late (14).

Table 1.4: Reasons for exclusion of surgical questionnaires from analysis (less than 16 years)

Reasons for exclusion	Number
Questionnaire completed for wrong operation	2
Questionnaire received too late	1
Questionnaire related to cardiac case (excluded by the NCEPOD protocol)	2



Following the exclusion of this small number of cases there were 93 surgical and 85 anaesthetic questionnaires for consideration. This represents 67% and 71% of the sample respectively. The return rate for questionnaires must be improved.

Table 1.5: Reasons for exclusion of anaesthetic questionnaires from analysis (less than 16 years)

Reasons for exclusion	Number
Questionnaire incomplete	3
Questionnaire completed for wrong operation	4
Questionnaire received too late	1
Questionnaire related to an inappropriate procedure according to NCEPOD protocol	1

Ninety-eight surgical questionnaires (98/139, 71%) and 94 anaesthetic questionnaires (94/120, 78%) were returned (Figure 1.5). Five surgical questionnaires were excluded from analysis for the reasons given in Table 1.4. Similar exclusions occurred for nine anaesthetic questionnaires (Table 1.5).

