

## 10

**DEATHS REPORTED TO NCEPOD****INTRODUCTION**

Consistent with previous annual data collection, all deaths occurring in hospitals within 30 days of a surgical procedure, performed by a surgeon or gynaecologist during 2001/02, were requested by NCEPOD. This chapter provides an overview of these cases. Unlike previous NCEPOD studies, the data was not sampled, and was collected separately to the data in the preceding chapters. However, some interesting observations from the data can still be made.

## DATA COLLECTION

The data collection period at NCEPOD runs on a financial year basis and the data presented here reports deaths occurring between 1<sup>st</sup> April 2001 and 31<sup>st</sup> March 2002.

A nominated local reporter in each hospital reports data on deaths to NCEPOD. Often local reporters report for more than one hospital and their hard work is greatly appreciated. Historically, histopathologists have filled this role as they had the best knowledge and access to data on deaths occurring in their hospital. However, with the increased availability of such data on patient administration systems (PAS) we are now finding that many of the local reporter roles are being transferred to people in clinical governance and information departments. This change benefits NCEPOD as it facilitates our move away from submission of data on hand written forms and towards a preferred method of electronic submission using a spreadsheet. Information departments are much better placed to download and manipulate the data from their hospital PAS.

The method of reporting deaths following surgery using a standard format has been used since NCEPOD started although we cannot take credit for this method as it actually precedes NCEPOD by some 130 years. Florence Nightingale originally described this method in 1859 [25]. Her ‘model forms’ were designed to ascertain hospital mortality in different hospitals in different regions of the country, although one would assume that the surgical procedures have evolved somewhat since then. As mentioned in previous reports it is now mandatory for all hospitals, including the private sector, to participate in the work of the confidential enquiries [26,27,28]. However, despite updates to medical directors on a quarterly basis, indicating the number of deaths reported from their hospital/s, there are a number of hospitals/Trusts that still fail to send us data during the allocated collection period. Appendix A displays the number of deaths from 2001/02 compared with 2000/01 by hospital/Trust.

Data related to deaths are requested by NCEPOD from all NHS hospitals in England, Wales and Northern Ireland. Data are also reported from Guernsey, Jersey, the Isle of Man, Defence Secondary Care Agency and the majority of the independent sector. Data was not collected from Scotland where the Scottish Audit of Surgical Mortality (SASM) performs a similar function.

## ANALYSIS OF THE DATA

In the original ‘Who Operates When?’ report of 1995/96 (WOW I), no analysis was performed on the reported deaths. A summary of the number of deaths by region was described, although due to ever changing regional boundaries a direct comparison cannot be made with this year’s data. However, the total number of 19,841 deaths reported in 1995/96 is comparable with the 20,130 deaths reported during this data year 2001/02 and the 21,991 deaths reported in 2000/01. Therefore any comparisons made in this chapter will be with the previous data year only.

### Regional spread

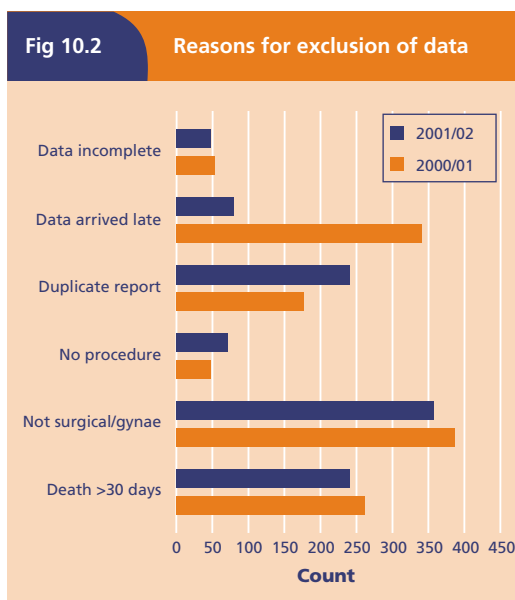
Figure 10.1 shows the number of deaths reported by region as a percentage of the total. These regions are as they were at the time of data collection. Regions are now divided into four Regional Directorates of Health and Social Care and further divided by Strategic Health Authority.

**Fig 10.1** Percentage of deaths by region

Region	2001/02 (%) n=20130		2000/01(%) n=20736	
Eastern	1561	(7.8)	1764	(8.5)
London	2365	(11.7)	2718	(13.1)
North West	2711	(13.5)	2866	(13.8)
Northern & Yorkshire	2823	(14.0)	3004	(14.5)
South East	2849	(14.2)	2758	(13.3)
South West	2205	(11.0)	2147	(10.4)
Trent	1834	(9.1)	2077	(10.0)
West Midlands	1994	(9.9)	1723	(8.3)
Wales	1093	(5.4)	1017	(4.9)
Northern Ireland	436	(2.2)	399	(1.9)
Guernsey	22	(0.1)	22	(0.1)
Jersey	16	(0.1)	21	(0.1)
Isle of Man	31	(0.2)	26	(0.1)
Defence Secondary Care Agency	0	(0.0)	0	(0.0)
Independent	190	(0.9)	194	(0.9)

## Exclusions

Of the 21,251 cases reported to NCEPOD, approximately 5% were excluded, the details of which are shown in Figure 10.2.



We are pleased to report that there is a marked decrease in the amount of data returned after the deadline of 31<sup>st</sup> September 2002. This is very encouraging as it is a 23% reduction on the amount of data returned late in the previous year.

Unfortunately no such improvement was seen in the amount of data returned incomplete despite an increase in clinical governance activity. This indicates that all information related to each patient is still not being recorded in their notes.

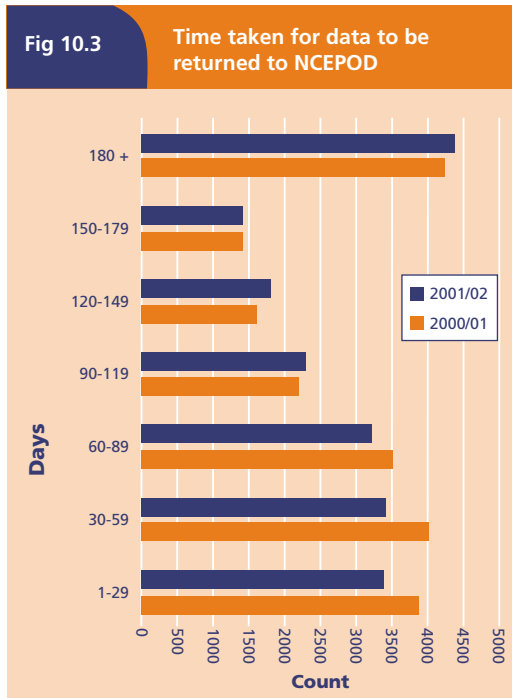
Prior to the 1999/00 collection year, NCEPOD noted an annual increase in the number of duplicate reports returned. This may have been associated with an increase in willingness to participate and local reporters ensuring that all data was reported to NCEPOD. However, in 1999/00 there was a marked decrease in the number of duplicates (but not in the overall data) indicating that data return was stabilising. However, each data collection year since has shown a small increase in the number of duplicates by approximately 2% per annum. This is also the case this year. This may represent the change in local reporters and it will be interesting to see how this changes in the future; with new data being submitted electronically we would expect to see a decline in duplication.

There has been no change in the proportion of procedures reported to us where death has occurred more than thirty days following a surgical procedure. We assume that such cases are sent to us simply because local reporters are wary about under reporting. It is important to note here that such cases are not excluded from the 2002/03 data collection year. From 1<sup>st</sup> April 2002 all deaths are reported to NCEPOD, regardless of whether or not a surgical procedure was performed. This data set includes the last six procedures performed prior to death but independent of specialty e.g. procedures performed by physicians will be included which will overcome the issue of the number of cases reported to NCEPOD each year where the procedure was not performed by a surgeon or gynaecologist. This will be relevant for the 2002/03 NCEPOD study as the data will be sampled for all patients that have died within 30 days of a therapeutic endoscopy regardless of the operator specialty. Interestingly, of the deaths excluded from the data set represented in this report because the patient was under the care of a physician, 65% were following an endoscopic procedure. The increased remit also overcomes the issue of the number of cases reported to NCEPOD each year where no procedure was performed.

As with previous years, we also have a number of cases, too small to warrant a group of their own, that falls into 'other'. This mainly includes data that is incorrect but also deaths at home, of which there was one, and deaths in the community of which there were two, although as of 1<sup>st</sup> April 2002, NCEPOD will also collect data from primary care Trusts as we extend our remit into primary care. The two cases of most concern were the two patients who had not in fact died.

### Time between death and data return to NCEPOD

It is disappointing to note from Figure 10.3 that the time in which it takes for data to be returned to NCEPOD appears to be increasing. More deaths were reported after four months and the majority of data was returned more than six months late. There are a number of hospitals that do report in a very timely manner and we very much appreciate this. Late return of data can have a large impact on our studies as it becomes much harder for associated patient notes to be traced and makes it harder for clinicians to complete the questionnaires. It can also mean that a sudden flurry of questionnaires is sent to clinicians resulting in a bulk workload for them instead of receiving the questionnaires at more staggered intervals. We are aware however that often the data is late as it has not been made available to the local reporter.



### Age at death

Of the 20,130 cases included in this data set there seems to be little change in the mean age at which patients died compared with the previous year; this can be seen in Figure 10.4

It can be seen from Figure 10.4 that females have been operated on and subsequently died at an older age. The median age between females and males differs by approximately five years (79 v 75 in 2001 and 80 v 75 in 2000) and this is supported by the fact that females live to an older age in the general population [29]. This also suggests that the data reported to NCEPOD on an annual basis is consistent.

### Time between surgery and death

It can be seen from Figure 10.5 that, consistent with the previous year, patients most commonly die within the first five days following surgery.

