

1 GENERAL DATA

Compiled by: F Whimster

1. GENERAL DATA

INTRODUCTION

Key Point

- *The period covered by this report was one of transition between voluntary and mandatory participation as clinical governance systems were being introduced.*

The data presented in this report relate to deaths occurring between 1 April 1998 and 31 March 1999. The period during which questionnaires were despatched ran through until 31 August 1999 with the final deadline for return being 31 December 1999. These dates are of particular significance as this year has been one of transition between voluntary participation in NCEPOD and the requirements of clinical governance, introduced in April 1999. The protocol shown in Appendix D is that which has been adopted since the introduction of clinical governance; it must be remembered, however, that the data presented in this report spanned the crossover from a system of voluntary to mandatory participation.

The concept of clinical governance was first described in 'The new NHS Modern Dependable'⁵ and this was elaborated on in 'A First Class Service'⁶ which 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)*". Further guidance was then given in 'Clinical Governance: Quality in the new NHS'⁷ which stated that "*NHS Trusts have a responsibility for ensuring that all hospital doctors take part in national clinical audits and confidential enquiries*".

To assist Trusts in fulfilling their obligations, NCEPOD has introduced systems to ensure Trust Medical Directors and NCEPOD Local Reporters are aware of those to whom questionnaires have been sent. From April 1999, NCEPOD began copying the covering letters addressed to clinicians to Medical Directors and Local Reporters. In addition, a report was sent to each Trust in late 1999 indicating their response rate in order that outstanding questionnaires could be chased up before the deadline. There were, however, significant numbers of cases where all correspondence with the clinician had occurred before the introduction of clinical governance and in these instances no names were revealed.

The sample reviewed in detail during this period was a random 10% of the total deaths reported. The selection of this group has enabled NCEPOD to make direct comparisons with data collected in 1990 (1 January – 31 December) and published in 1992⁴ when a similar randomised group was reviewed. The anaesthetic, surgical and pathology sections of this report will use the 1990 data as a comparative group. Similar comparisons have been made wherever possible in this general data section although differences in NHS regional structures and systems of data collection and analysis mean that these comparisons should be viewed with some caution.

In addition, direct comparisons have been made with the data published in last year's report 'Extremes of Age'² in an attempt to show the early effects of the introduction of clinical governance.

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, the majority of 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 1998 and 31 March 1999, 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

Key Points

- *The provision of adequate information systems to support clinical activity is a fundamental cornerstone of clinical governance which the NHS can no longer ignore.*
- *Local Reporters must be given support, in terms of time and resources, to enable them to report all relevant deaths in a complete and timely fashion.*
- *NHS Trusts should review their systems for identifying NCEPOD cases and Hospital Episode Statistics and understand the reasons if differences in the data sets are identified.*

Figure 1.1 shows that a total of 21 253 reports were received. Of these, 1421 were excluded from further analysis: 1015 were deemed inappropriate according to the NCEPOD protocol (Table 1.1 and Appendix D), 361 were received after the deadline of 31 August 1999 and 45 remained incomplete despite all efforts to identify missing information. It is interesting to note that although the total number of deaths reported in this period showed an increase of 506 over that for the previous year, the number of cases that could be included rose by only 189.

These figures do not include inappropriate reports returned 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.

Table 1.1 shows that there have been changes since 1990 including an increase in reported procedures performed by a non-surgeon from ten in 1990 to 235 in 1998/99. These were performed by physicians, cardiologists and radiologists; the majority of procedures were endoscopies.

A total of 485 duplicate reports were received in 1998/99 representing an increase of approximately 80% over the previous year's figures, and a vastly differing situation to that in 1990 when only six duplicate reports were noted. Duplicate reporting was spread throughout the regions and most probably represents an effort on behalf of Trusts to ensure they are fulfilling their clinical governance requirements and not under-reporting. Whilst representing an additional administrative burden for NCEPOD this is clearly preferable to cases being missed and it is hoped that as Trusts' reporting systems become stabilised such duplication may decrease.

The number of cases reported from non-participating independent hospitals has decreased from 14 (1997/98) to four as the number of hospitals who formally participate in the Enquiry has increased.



A regional breakdown of the remaining 19 832 deaths is shown in Table 1.2. Comparison with the figures shown for 1990 should be treated with caution due to the effect of alterations in the regional structure of the NHS, hospital mergers/closures and a lack of denominator data to indicate possible changes in the total number of operations performed. Regional boundaries were changed once again in April 1999, but the current data have been shown according to the regional structure in place at the time death occurred. As data from 1990 have not been retained other than in printed form it is impossible to attribute cases precisely to their current regions; the basis on which these figures have been estimated is shown in the right hand column of the table.

Table 1.1: Inappropriate reports received and excluded

Reason for exclusion	1998/99	1997/98	1990
Death occurred more than 30 days after operation	230	220	327
Procedure not performed by a surgeon	235	221	10
Duplicate report	485	271	6
No surgical procedure performed or procedure excluded by NCEPOD criteria	59	106	4
Procedure performed in non-participating independent hospital	4	14	2
Maternal death	1	2	0
Procedure performed overseas	1	0	0
Patient still alive	0	2	1
Total	1015	836	350

Table 1.2: Deaths reported to NCEPOD by region

1998/99 regions	1998/99	1997/98	1990	1990 regions
Anglia & Oxford	1913	1720	1367	East Anglia + Oxford
North Thames	2268	2252	2554	NE Thames + NW Thames + Special Health Authorities
North West	2726	2698	2736	Mersey + North Western
Northern & Yorkshire	2881	3018	2464	Northern + Yorkshire
South & West	2340	2288	1997	South Western + Wessex
South Thames	1960	2202	2457	SE Thames + SW Thames
Trent	2237	2301	1722	Trent
West Midlands	1638	1559	1826	West Midlands
Wales	1299	915	1102	Wales
Northern Ireland	346	462	316	Northern Ireland
Guernsey	16	15	39	Guernsey
Jersey	14	28	22	Jersey
Isle of Man	16	16	25	Isle of Man
Defence Secondary Care Agency	2	5	60	Defence Medical Services
Independent sector	176	164	130	Independent sector
Total	19 832	19 643	18 817	

Table 1.2 shows that in the majority of regions the number of deaths reported has remained constant or increased between 1997/98 and 1998/99, with an increase likely to indicate improved systems of local reporting, possibly as a direct result of clinical governance activities. It is notable, however, that Northern & Yorkshire, South Thames, Trent, Northern Ireland and Jersey all show a reduction in the number of deaths reported.

New systems of quarterly feedback to Trusts (via Medical Directors and Local Reporters) introduced by NCEPOD in April 2000 will indicate both reporting and returning rates, with corresponding figures for the previous two years for comparison. We hope that this will prompt Trusts to look carefully at their local systems to ensure that full reporting can occur; we are well aware of the enormous difficulties and pressures placed upon Local Reporters, all of whom have multiple other duties to perform, and would urge Trusts to ensure that Local Reporters are given all the support they need to fulfil this function.

NCEPOD has also asked all Medical Directors to look at the systems used to collect and collate the data submitted as Hospital Episode Statistics (HES) to the Department of Health. These data are used by the Department of Health for a number of purposes including the calculation of the new NHS Performance Indicators. Although direct comparison between the number of deaths reported to NCEPOD and those shown in Performance Indicators cannot be made, due to differences in inclusion criteria, NCEPOD has been puzzled by the often large differences between the two data sets, both at an individual Trust level and for perioperative deaths overall. It would be expected that if such differences were due only to the different inclusion criteria then a pattern would emerge; since Performance Indicator data, for example, include a wider range of procedures and those performed by non-surgeons, it would be expected that most Trusts would show larger figures in Performance Indicator tables than in NCEPOD returns. This is not by any means the case; for some Trusts the figures are almost identical whilst in many others wide variations are not uncommon and may be larger for either data set. NCEPOD urges Trusts to examine how these two sets of data are being compiled and to understand the reasons if differences are identified.

The Performance Indicators for 1998/99^s give a total of 32 956 deaths in hospital within 30 days of an operative procedure (24 920 after emergency surgery and 8036 after non-emergency surgery). The denominator data used in the Performance Indicators, based on all patients undergoing eligible procedures, show that a total of 2.3 million procedures were undertaken (644 463 emergencies and 1.7 million non-emergencies). This indicates an approximate mortality rate of 1.4% (3.9% after

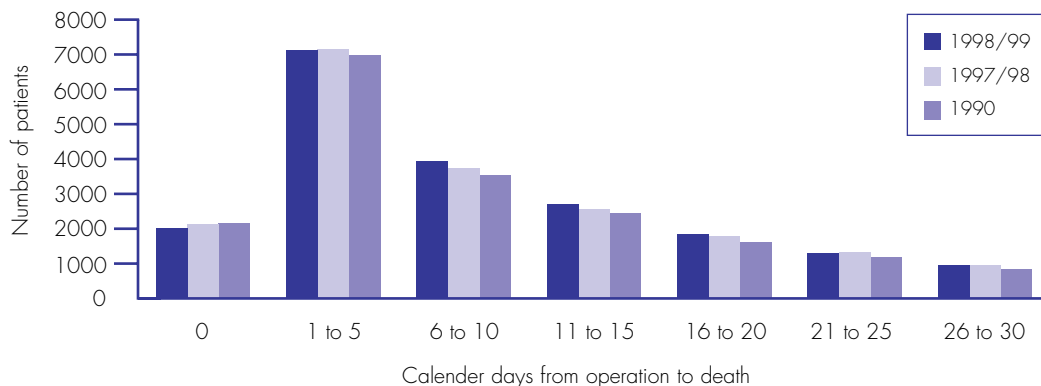
emergency surgery or 0.5% after non-emergency surgery).

Figure 1.2 shows the distribution of the number of calendar days between operation (day 0) and death, with 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 at time of death, which is broadly similar to 1990 but with a notable increase in the number of elderly patients. The figures for 1997/98 are not shown as the data retained after publication of the report gives age groups which are not directly comparable (i.e. 0-9, 10-19 years etc); the pattern, however, is no different from that seen in the current data set.

The distribution between the sexes is unchanged; in 1990, 53% (9885/18 817) of patients were male compared to 52% (10 277/19 832) in the current group.

Figure 1.2: Calendar days from operation to death



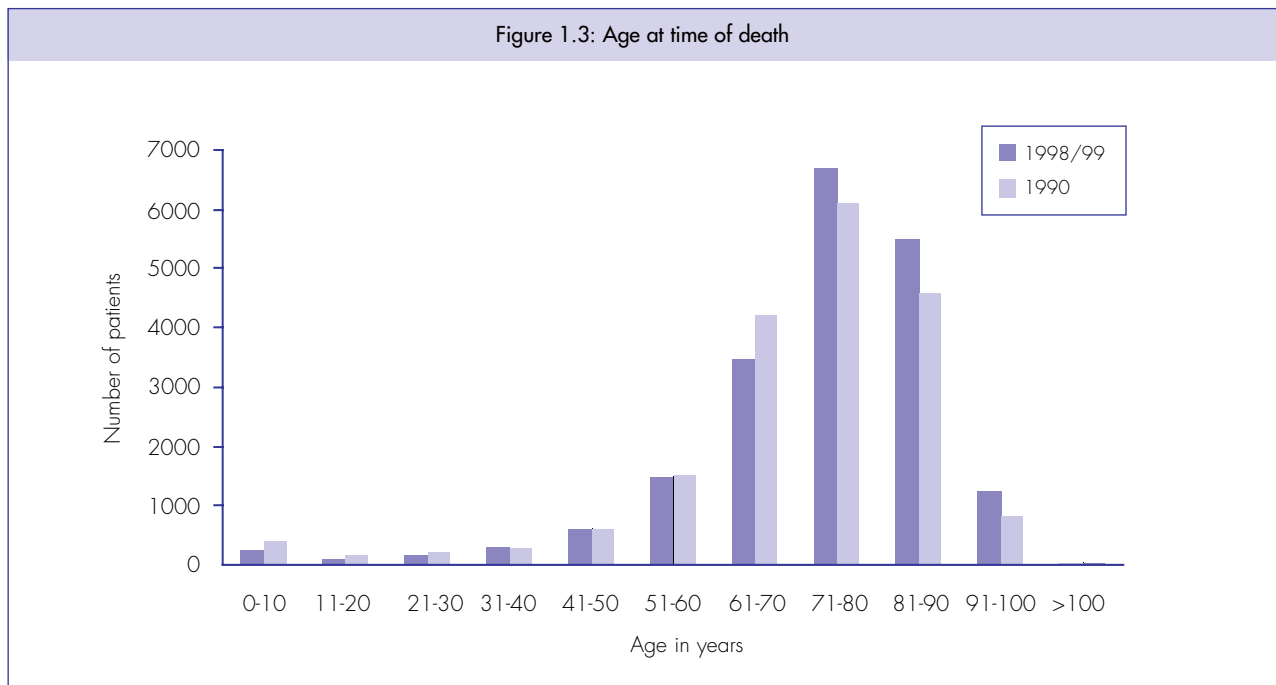
The number of days taken for Local Reporters to inform NCEPOD of deaths is shown in Table 1.3. This data is not available for 1990. Local Reporters are volunteers nominated by their Trust/hospital to collate this data and use a variety of different collection methods. It is of concern that the percentage of deaths being reported in less than 30 days has fallen whilst those taking in excess of six months has risen. Figure 1.1 also illustrates this problem, indicating that 361 reports of deaths were received too late (i.e. after 31st August 1999) for inclusion; this is an increase on the 245 notifications received too late in 1998, although an improvement on the situation in 1990 (497 cases).

Calendar days (i.e not 24-hour periods)	Number of deaths reported			
	1998/99		1997/98	
	Count	%	Count	%
1-29	4137	21%	4587	23%
30-59	4398	22%	4245	22%
60-89	3033	15%	3182	16%
90-119	2134	11%	2301	12%
120-149	1724	7%	1721	9%
150-179	1099	6%	1170	6%
180+	3307	17%	2437	12%
Total	19 832		19 643	

If there is a six-month delay before NCEPOD becomes aware of a death, then there is, of necessity, a considerable time lapse between death and receipt of a questionnaire by a clinician. This is particularly problematical for anaesthetists, since Local Reporters are often unable to provide the name of the relevant consultant. This then needs to be ascertained from correspondence with the local anaesthetic College tutor. The earlier questionnaires can be despatched to clinicians, the more likely it is that the medical records will be available, the case clearly remembered and the relevant clinicians (especially junior staff) 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.

The following comment from a consultant anaesthetist graphically illustrates this problem:

“This GA took place 17 months ago – it is difficult to be certain about some of the details at that distance in time, even when case discussed with anaesthetist directly concerned (who, under other circumstances, might not even have been available)”. Date of operation: 16/6/98, date of death: 5/7/98. Local report form received on 24/8/99. Letter sent to tutor on 27/9/99. Reminder sent to tutor on 2/11/99. Tutor reply received and anaesthetic questionnaire sent on 23/11/99. Anaesthetic questionnaire returned on 6/12/99.



The following quote from a Local Reporter asked to ascertain the name of the surgeon and anaesthetist for a particular case illustrates the system problems in some hospitals:

“It’s taken me three weeks to find this information. Notes are lost. Theatre information system here is awful – hand written register with patients not always in the correct book, or even listed under the correct surgeon. So much for NCEPOD recommendations!”

One has to agree with his concluding statement and ask why, once again, NCEPOD has had to raise this issue in this year’s report. The provision of adequate information systems to support clinical activity is a fundamental cornerstone of clinical governance which the NHS can no longer ignore. NCEPOD is reliant upon the efforts of Local Reporters to obtain this most basic of information on patients who have died; it is unacceptable that they are required to fulfil this now obligatory requirement without adequate resources in terms of time and information systems.

SAMPLE DATA ANALYSIS

Key Points

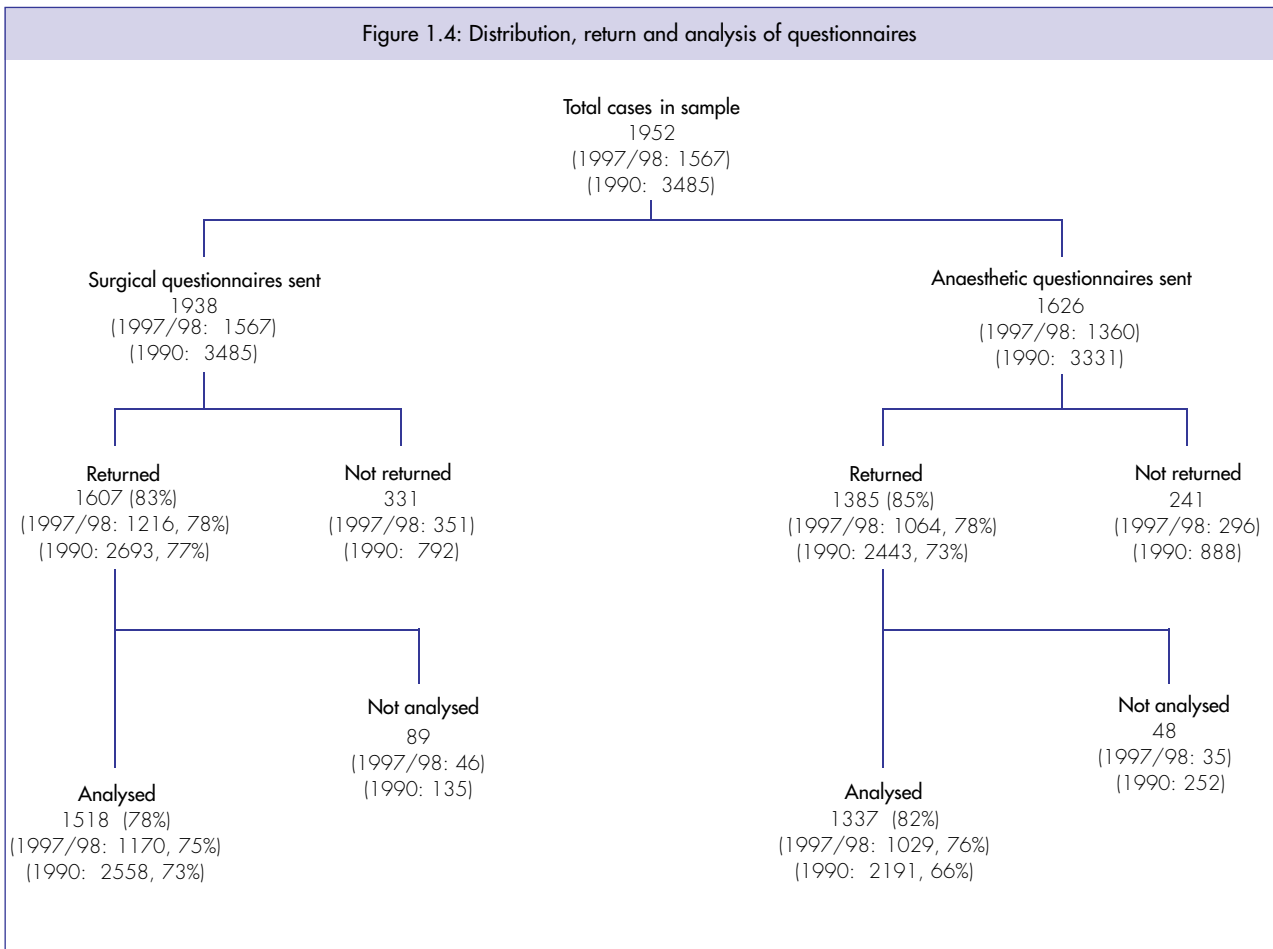
- *The return rates of 83% for surgeons and 85% for anaesthetists are the highest ever recorded by NCEPOD.*
- *Ninety percent of participating clinicians were asked to complete no more than two questionnaires.*
- *Return rates in the independent sector were comparatively poor; if the independent sector wish to apply the principles of clinical governance to their practice they will need to improve their compliance rates.*

The sample selected for review in 1998/99 was a randomised 10% of the total deaths reported, with cases for inclusion being identified by the NCEPOD computer system on entering basic case details onto the main database. This sample was chosen to allow direct comparison with the data collected in 1990, which represented a random 20% of the total deaths reported. The number of cases reviewed is, therefore, smaller but randomised selection makes direct comparison possible. A randomised sample also has the advantage, particularly with the introduction of mandatory participation, of ensuring that no clinicians feel that they, or their specialty, are being unfairly burdened. The reduction in the sample from 20% to 10% was also made in order not to overburden already busy clinical staff.

Questionnaires were sent to a total of 1298 different consultant surgeons and 1089 different consultant anaesthetists. The majority (66% of surgeons and 67% of anaesthetists) received only one questionnaire in the year. Those receiving two questionnaires for completion comprised 24% of surgeons and 23% of anaesthetists. The remaining 10% of surgeons received between three and seven questionnaires; the remaining 10% of anaesthetists received between three and eleven questionnaires. It is important to stress that forms are sent to consultants, but relate to cases conducted not only by

themselves but also by a range of non-consultant or locum staff. This is particularly the case for anaesthetists, where it is common for all forms relating to cases conducted by non-consultants to be sent to a single designated consultant who has taken responsibility for the completion of NCEPOD returns. These figures do not, therefore, reflect poor practice.

Figure 1.4: Distribution, return and analysis of questionnaires



In relation to the 1998/99 sample, 14 surgical questionnaires were not sent as NCEPOD had already been notified that the consultant had left the Trust/hospital.

In the 326 cases where no anaesthetic questionnaire was sent this was either because the procedure was performed without an anaesthetist present (120), the name of the appropriate consultant was unobtainable or notified too late (200), or because NCEPOD had been notified that the appropriate consultant had left the Trust/hospital (6).

One thousand six hundred and seven surgical questionnaires (1607/1938, 83%) and 1385 anaesthetic questionnaires (1385/1626, 85%) were returned (Figure 1.4). It is commendable, and perhaps an indication of the early effects of clinical governance, that these are the highest return rates ever achieved by the Enquiry.

Table 1.4: Reasons for exclusion of surgical questionnaires from analysis

Reason for exclusion	1998/99	1997/98	1990
Questionnaire completed for earlier operation	54	17	0
Questionnaire received too late	32	11	128
Questionnaire incomplete	3	16	7
Questionnaire related to excluded procedure	0	2	0
Total	89	46	135

Table 1.5: Reasons for exclusion of anaesthetic questionnaires from analysis

Reason for exclusion	1998/99	1997/98	1990
Questionnaire completed for earlier operation	18	10	0
Questionnaire received too late	26	10	251
Questionnaire incomplete	4	12	1
Questionnaire related to excluded procedure	0	1	0
No anaesthetic given	0	2	0
Total	48	35	252

Eighty-nine surgical questionnaires were excluded from analysis for the reasons given in Table 1.4. Similar exclusions occurred for 48 anaesthetic questionnaires (Table 1.5). Comparison with cases excluded in 1997/98 and 1990 are included in the tables.

These reasons warrant further review since it is a waste of valuable time, particularly on behalf of the clinician completing the questionnaire, if it subsequently has to be excluded. The 1998/99 period has seen a large increase in the number of questionnaires completed for an earlier operation, rather than the final procedure before death. This is particularly the case for surgical questionnaires. Unfortunately, since no paper records are retained by NCEPOD after publication of a report, it is impossible to revisit in detail the 17 surgical and 10 anaesthetic questionnaires completed for previous operations in 1997/98. Those having to be excluded for this reason in 1998/99 have been reviewed and fall primarily into two categories:

- those where the clinician completed the questionnaire for the procedure requested by NCEPOD (i.e. according to the information provided by the Local Reporter) but where the questionnaire itself, or accompanying documentation, shows this not to have been the final procedure.
- those where the clinician has completed the questionnaire in relation to a different and earlier procedure to that requested by NCEPOD; this usually relates to a more major operation.

The former group is probably unavoidable. The latter indicate a misunderstanding of the NCEPOD protocol and an erroneous belief that NCEPOD is interested primarily in the cause of death. The questionnaire clearly states that *“this questionnaire should be completed with reference to the final operation before death of the patient specified. If you feel that this was not the main operation in the period before the patient’s death, please give additional information.”* It is possible that, with the increasing pressures of clinical governance, a number of consultants are

completing the questionnaire for a previous procedure which they consider is more relevant to the cause of death. In order to avoid wasted time and effort we would stress once again that it is the *final procedure* before death that is of relevance to NCEPOD, even if this was relatively minor and unrelated to the cause of death. If in doubt, clinicians are always welcome to ring the NCEPOD offices for clarification before completing the questionnaire.

The increase in questionnaires returned too late over the last two years is probably due to a combination of pressure to conform to clinical governance requirements and the problems caused by delayed reporting of deaths and availability of medical records, highlighted elsewhere in this section. This is, however, very clearly an improvement on the situation in 1990, primarily due to changes in systems for distributing questionnaires – in 1990, all questionnaires were sent to consultant surgeons, who were asked to pass on the anaesthetic form to the relevant anaesthetist.

Recent improvements to systems at NCEPOD should result in fewer questionnaires completed for previous operations and those returned incomplete; questionnaires will be reviewed by administrative staff well before the deadline for return and, if found to be unusable for these reasons, will be sent back to the consultant for correction.

Table 1.6: Regional return rates

Current Regions	Return Rate							
	1998/99		1997/98		1990		Old Regions	
	SQ	AQ	SQ	AQ	SQ	AQ	SQ	AQ
Anglia & Oxford	83%	90%	89%	86%	East Anglia		76%	71%
					Oxford		76%	70%
North Thames	77%	77%	73%	80%	NE Thames		64%	47%
					NW Thames		82%	72%
					Special Health Authorities		50-100%	33-100%
North West	79%	83%	77%	81%	Mersey		76%	70%
					North Western		69%	62%
Northern & Yorkshire	85%	90%	83%	76%	Northern		78%	72%
					Yorkshire		74%	71%
South & West	91%	92%	85%	82%	South Western		70%	66%
					Wessex		75%	68%
South Thames	83%	84%	76%	76%	SE Thames		72%	61%
					SW Thames		79%	72%
Trent	88%	84%	75%	72%	Trent		74%	69%
West Midlands	80%	88%	67%	77%	West Midlands		73%	65%
Wales	76%	77%	61%	68%	Wales		72%	64%
Northern Ireland	94%	94%	73%	72%	Northern Ireland		88%	65%
Guernsey	100%	100%	100%	100%	Guernsey		100%	85%
Jersey	-	-	100%	50%	Jersey		100%	100%
Isle of Man	100%	100%	100%	50%	Isle of Man		50%	-
Defence Secondary Care Agency	-	-	-	-	Defence Medical Services		100%	82%
Independent sector	67%	64%	80%	100%	Independent sector		72%	88%

Table 1.6 shows the return rates by region and it is impressive to note that, without exception, those in the NHS have improved their return rates since 1990. Very few regions now have return rates under 80%, with the exceptions being the anaesthetists and surgeons of North Thames, the surgeons of North West and the anaesthetists and surgeons of Wales.

The early effects of clinical governance can be seen in that virtually all regions have been able to demonstrate improvement on their 1997/98 return rates; notable exceptions are the surgeons of Anglia & Oxford and anaesthetists of North Thames. Individual Trusts will continue to be kept regularly informed of their return rates as described previously and we hope that the small number of Trusts where return rates are not improving will take note and respond to the reasons given by their clinical staff for inability to complete a questionnaire.

By far the most poor in respect of their return rates are the hospitals in the independent sector, where rates have not only fallen since the previous period

but are lower than in 1990. If the independent sector wishes to apply the principles of clinical governance to their practice, as they have clearly indicated, then they will need to improve their compliance rates dramatically.

The quarterly reports now being sent to individual Trusts and hospitals include not only the names of those who have questionnaires outstanding, but also an indication of any reason given for an inability to complete the questionnaire. The reasons commonly given for non-return are discussed below and we are optimistic that by providing feedback to Trusts and hospitals they will be able to introduce systems able to support their clinicians in complying with the requirement of participation in the Enquiry.

Reasons for non-return of questionnaires

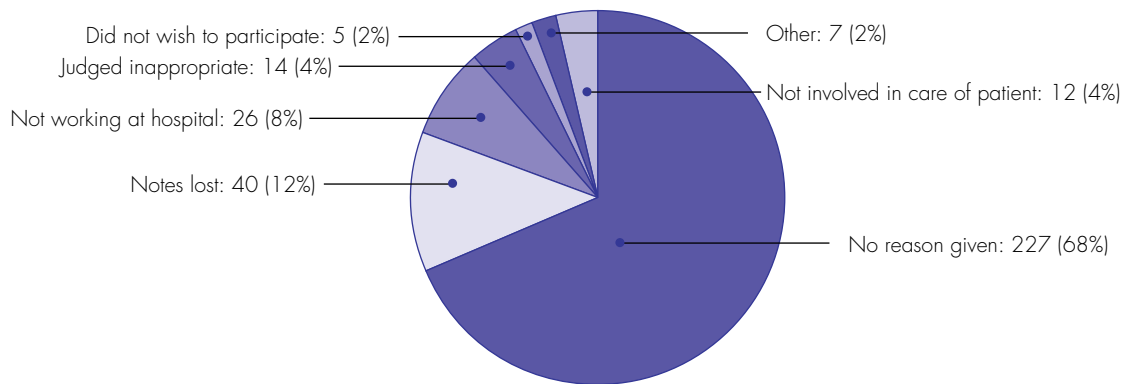
Key Point

- *The vast majority of clinicians willingly cooperate and complete NCEPOD questionnaires in good time. It is no longer acceptable for a few individuals to state that they do not wish to participate or consider the case inappropriate for NCEPOD review.*

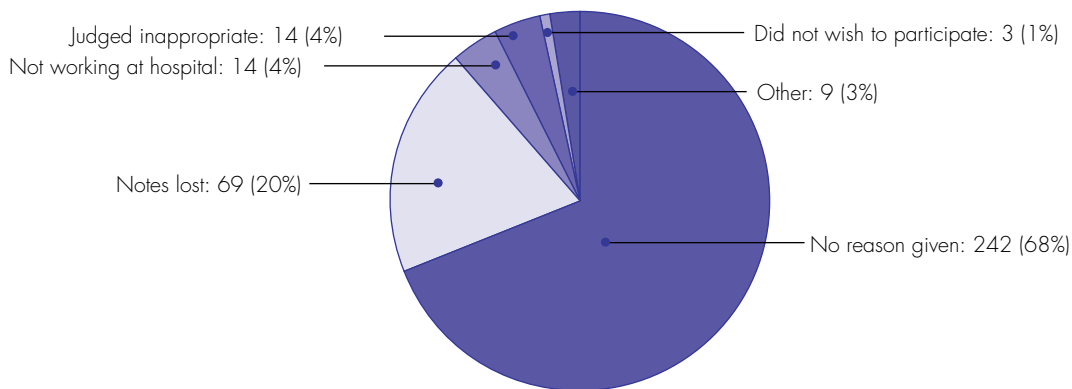
The introduction of clinical governance and mandatory participation has placed a particular emphasis on the need to know why clinicians are unable to return a questionnaire if this is the case.

The level of detail shown in Figures 1.5 and 1.6 was not recorded in 1990, when participation was voluntary.

Figure 1.5: Reasons for non-return of surgical questionnaires

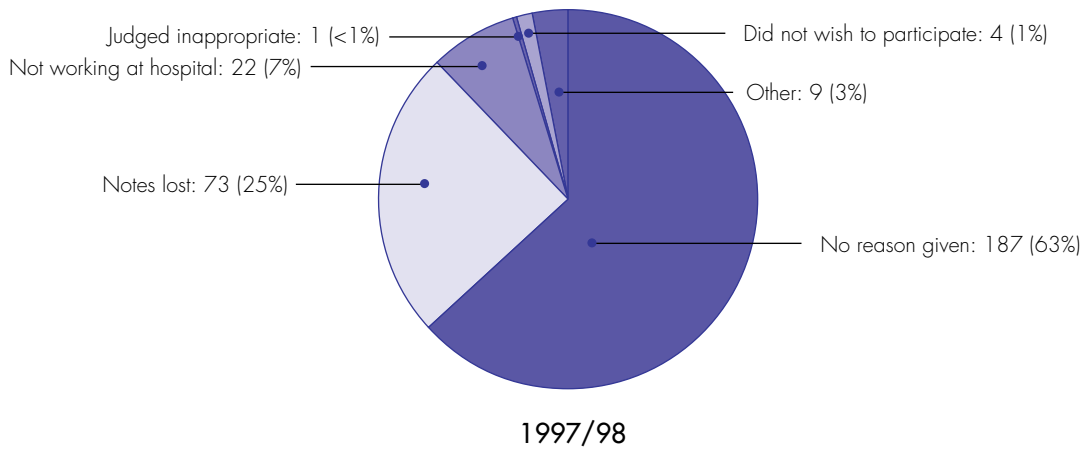
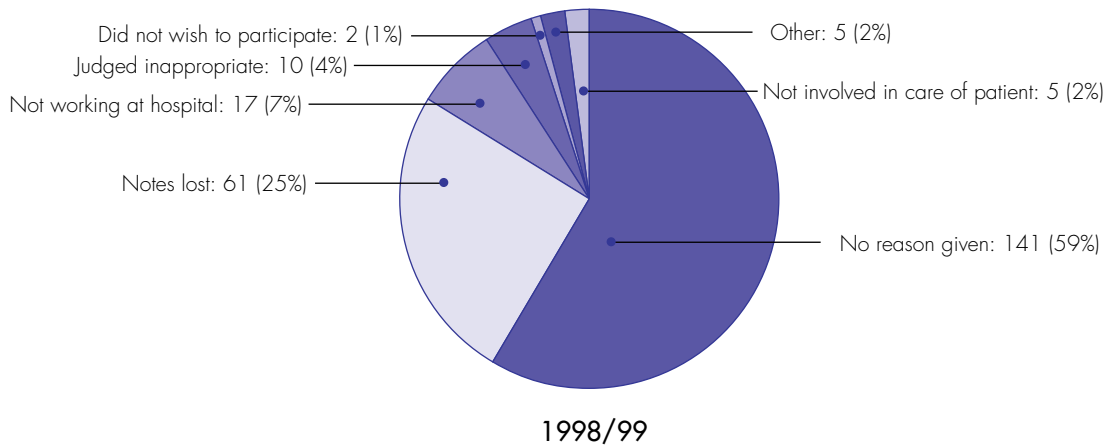


1998/99



1997/98

Figure 1.6: Reasons for non-return of anaesthetic questionnaires



The figures for the last two years show little or no change in the high percentage of cases where no reason is offered for non-return of a questionnaire. Regular feedback to Trusts and hospitals indicating any valid reasons for non-return will, of course, highlight those cases where no contact has been made with NCEPOD to explain the inability to complete the questionnaire. We would hope and expect to see this group diminish in size as the new feedback system becomes established.

There are other small percentages shown in these figures, which should disappear if Trusts take their clinical governance responsibilities seriously; namely, those who state that they ‘do not wish to participate’ or that, in their opinion, the case is ‘inappropriate’ for review.

The vast majority of clinicians willingly cooperate and complete the NCEPOD questionnaires they receive in good time. It is no longer acceptable for a few individuals to make statements such as the selection shown here:

“There were no technical problems with the conduct of anaesthesia or surgery.... I do not feel that completion of an NCEPOD form is relevant in this case as the procedure performed was not relevant to the outcome.”

“The tracheostomy was performed as a routine aspect of intensive therapy management and had nothing to do with the outcome in this patient. I do not feel that it is relevant to complete an NCEPOD form in this circumstance.”

“The operation that you refer to was conducted by a consultant surgeon in the presence of a consultant anaesthetist, there were no problems with the conduct of that operation from either surgical or anaesthetic perspective, but death was inevitable.”

“The ‘operation’ to which you refer was performed in desperation during a cardiac arrest and I do not feel that it is relevant to complete an NCEPOD form for this.” A second request to complete the form was made by the NCEPOD Chief Executive and the following was received in response: “I have reviewed this patient’s notes again and I feel that it is not appropriate to fill in the NCEPOD questionnaire in respect of the emergency reopening of the chest following cardiac arrest as many of the questions are inappropriate.”

“I do not feel it appropriate to complete this form in respect of the minor procedure which happened to precede death.”

“This utterly futile audit has taken 1-2 hours of my valuable time. I completely resent this.”

“My fee for attempting to fill in this form and recovering the notes of a patient I had no dealings with whatsoever is £50, or perhaps I am contracted to perform this task as a hobby in my spare time.” A comment written on a very poorly completed questionnaire received from a consultant anaesthetist, who indicated he was the duty consultant at the time a member of the junior staff, whose grade and qualifications he professed not to know, gave the anaesthetic at 01.30.

Lost medical records

Key Points

- *Trusts should establish systems to ensure that ‘NCEPOD case notes’ are retrieved and passed from surgeon to anaesthetist.*
- *Medical records departments should ensure adequate tracer systems are in place in relation to the records of deceased patients.*

The final group needing particular attention is that where clinicians stated that they were unable to complete the questionnaire as the notes were lost or otherwise unavailable. Although some improvement has been seen in relation to surgical questionnaires (1998/99: 12%; 1997/98: 20%) the situation for anaesthetists has remained unchanged with 25% indicating that the notes were not available.

Virtually every report published by NCEPOD has made references to inadequacies in medical records departments:

- *“Hospital notes about dead patients tend to be given a low priority by records staff.”⁴*
- *“Managers should urgently review the storage and retrieval of medical notes.”⁹*
- *“Managers need to improve the services provided by medical records departments so that notes are available when required.”¹⁰*
- *“Systems should be implemented by Trusts to improve the retention and availability of all notes and records of clinical activity.”¹¹*

• *“Clinical records and data collection still need to be improved.”¹²*

• *“Action is required to improve hospital record systems; this is within the remit of clinical governance.”²*

In 1990, it was reported that in 90/3485 (3%) cases the notes were ‘lost’. This compares with 93/1952 (5%) in the 1998/99 period. It appears, therefore, that despite repeated recommendations no change has occurred and in fact the situation has deteriorated. A more detailed review of those cases where NCEPOD was told that the notes were unavailable during 1998/99 was therefore conducted.

The figures in Table 1.7 relate to the 84 cases where both an anaesthetic and a surgical questionnaire were sent.

The 60 cases where one questionnaire had been received and the other had not, because of unavailability of the records were reviewed in further detail, as summarised in Table 1.8.

Table 1.7: Cases where medical records were lost/unavailable

Situation	Number
Anaesthetist stated notes lost/unavailable; surgical questionnaire returned	43
Surgeon stated notes lost/unavailable; anaesthetic questionnaire returned	17
Surgeon and anaesthetist stated notes lost/unavailable	8
One clinician stated notes lost/unavailable, no response from other; neither questionnaire returned	11
One clinician stated notes lost/unavailable, other gave a different reason; neither questionnaire returned	5
Total	84

Table 1.8: Cases where one questionnaire was received

Cases with one questionnaire	Number
Returned questionnaire included photocopies from medical records	52
Returned questionnaire did not include photocopies but indicated medical records were available	7
Returned questionnaire did not include photocopies and impossible to know if medical records were available	1
Total	60

It is therefore clear that in all cases (with one possible exception) the notes were not 'lost' but had been retrieved by the other consultant required to complete a questionnaire relating to the same case. This explains the much greater number of anaesthetists (43) than surgeons (17) stating that they could not trace the records since the frequent need to ascertain the name of the appropriate consultant anaesthetist from the clinical tutor means that anaesthetic questionnaires are very often sent out later than corresponding surgical questionnaires. In this group of 60 cases, in 15 instances the questionnaires were despatched on the same day, in 44 cases the surgical questionnaire was sent first and in only one case was the anaesthetic questionnaire the first to be posted.

The number of questionnaires unable to be completed due to 'lost' notes could therefore be virtually eliminated by the use of three simple strategies:

- Trusts/hospitals should establish systems to ensure that all 'NCEPOD case notes' are retrieved and passed from surgeon to anaesthetist.
- If clinicians are informed by medical records departments that the notes are lost/missing, they should first enquire of their surgical/anaesthetic colleagues who may well have the records (this applies particularly to anaesthetists who would be well advised to scour the desks of their surgical colleagues).
- Medical records departments should ensure that adequate tracer systems are in place in relation to the medical records of deceased patients.

None of these recommendations is complex; much emphasis has been placed on the improvements that will occur when patient records are stored electronically. The following quote should perhaps serve as a word of caution to those believing this will be a panacea:

"Notes filed at random. Since 'everything is computerised' much is inaccessible. The form is my best effort."

--