BMJ QUALITY AND SAFETY

Around 12,000 acute hospital deaths each year in England are preventable

Although substantial, latest figures are much lower than previous estimates

[Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review Online First doi: 10.1136/bmjqs-2012-001159]

Around 12,000 deaths in acute hospitals in England each year could be prevented, suggests a data analysis published online in *BMJ Quality and Safety.*

Poor clinical monitoring and diagnostic errors account for the lion's share, the analysis indicates.

Although still substantial, these latest figures are much lower than previous estimates of between 60,000 to 255,000 cases of serious disability or death as a direct result of treatment in the NHS, say the authors.

They base their findings on the case record reviews of 1,000 adult patient deaths at 10 randomly selected acute hospitals across England in 2009.

Doctors skilled in this type of assessment looked for potential acts of omission, such as failure to treat/diagnose correctly, or acts of commission, such as incorrect treatment or unintended complications of healthcare.

They then made judgements as to whether any problems they picked up had caused the death, and so could have been prevented, taking account of the patients' overall health at the time.

They used a scale, ranging from 1 (definitely not preventable) to 6 (definitely preventable). They also estimated the life expectancy on admission to gauge which groups of patients were most affected.

In all, 131 patients were judged to have experienced a problem in the care they received, which contributed to their death. And they were almost twice as likely to be admitted under surgical specialties.

Fifty two (5.2% of all deaths) had a 50% or greater chance of not having happened, but for certain aspects of the care the patients had received while in hospital.

Problems occurred at all stages of care, but 37 problems (44%) contributing to preventable death had occurred during ward care.

Preventable deaths were associated with poor clinical monitoring in almost one in three cases (31%); the wrong diagnosis in just under 30% of cases; and poor drug or fluid management in one in five cases (21%).

If the 5% proportion of preventable deaths were extrapolated across all acute hospital admissions in England, the overall tally would be just under 12,000 (11,859) - a figure that is considerably less than previous estimates have suggested.

And over half of all these deaths (60%) were in frail, elderly patients with multiple health problems who were not expected to live for more than a year.

“While the spectre of preventable hospital deaths may prove helpful in raising interest in patient safety and a commitment to improvement, overestimating the size of the problem and the risk to patients may induce unjustified levels of anxiety and fear among the public,” say the authors.

“In addition, confirmation of the relatively small proportion of deaths that appear to be preventable provides further evidence that overall hospital mortality rates are a poor indicator of quality of care.”

These may not be the most productive focus for identifying modifiable gaps in care quality that could have an impact on outcomes, they suggest.