

Sutherland Hospital

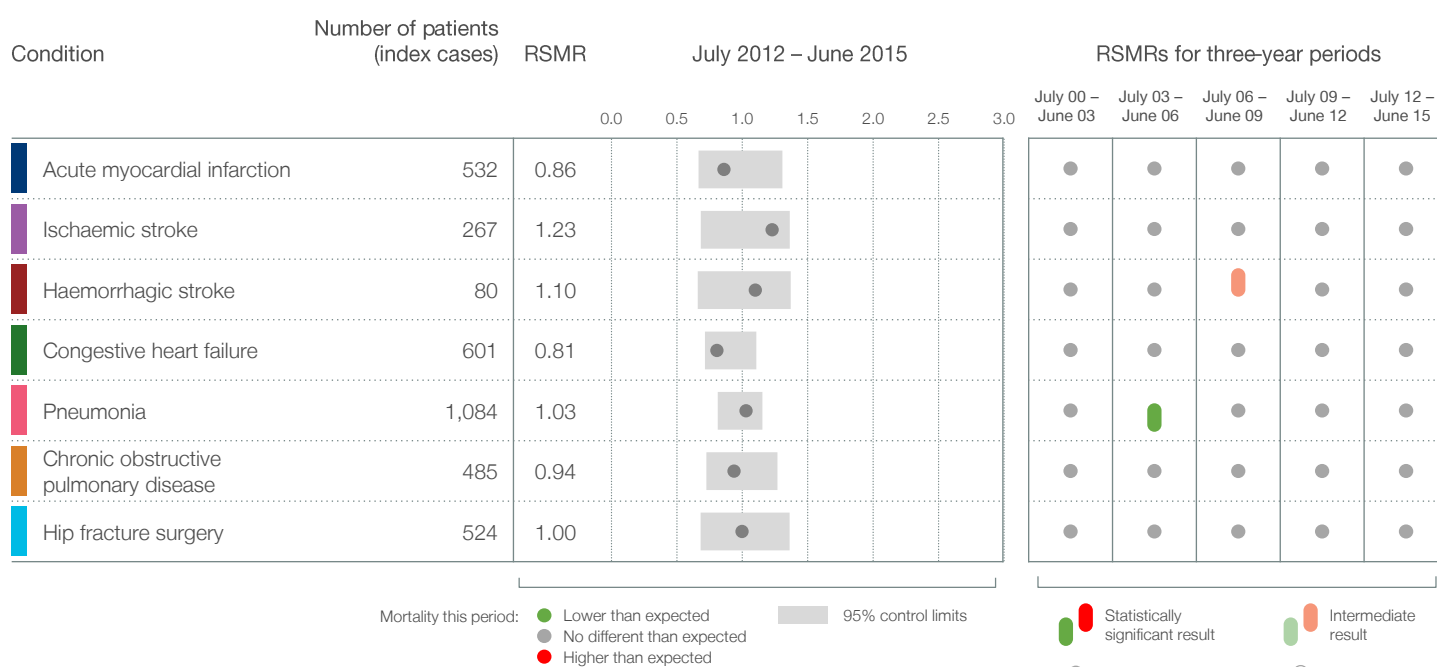
30-day mortality following hospitalisation for seven conditions

The risk-standardised mortality ratio (RSMR) is an indicator that describes, for each hospital's patient cohort, the 'observed' number of deaths divided by the 'expected' number of deaths¹. The 'expected' number of deaths takes account of the hospital's case mix and is estimated using a statistical model built using the NSW patient population characteristics and outcomes. A ratio of less than 1.0 indicates lower than expected mortality while a ratio greater than 1.0 indicates higher than expected mortality. Small deviations from 1.0 are not considered to be meaningful.

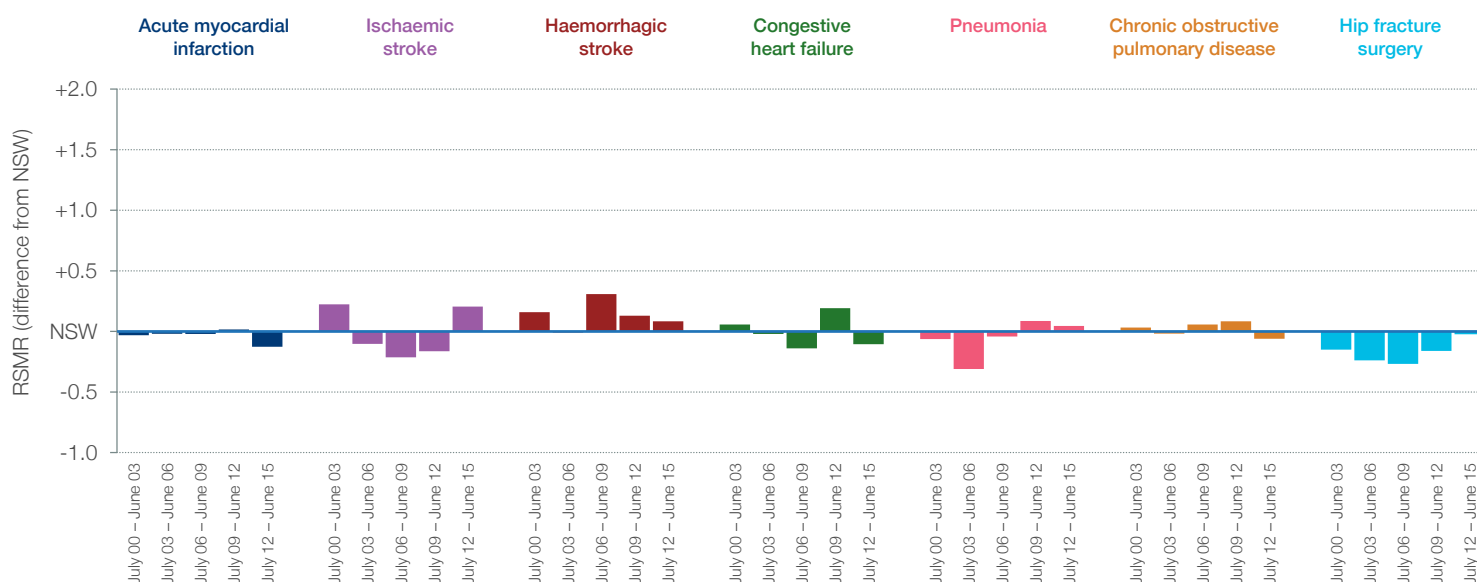
Funnel plots with 95% and 99.8% control limits around the NSW rate are used to identify outlier hospitals – those with 'special cause' variation that may warrant further investigation.

The measure is not designed to enable direct comparisons between hospitals. It assesses each hospital's results given its particular case mix. RSMRs do not distinguish deaths that are avoidable from those that are a reflection of the natural course of illness.

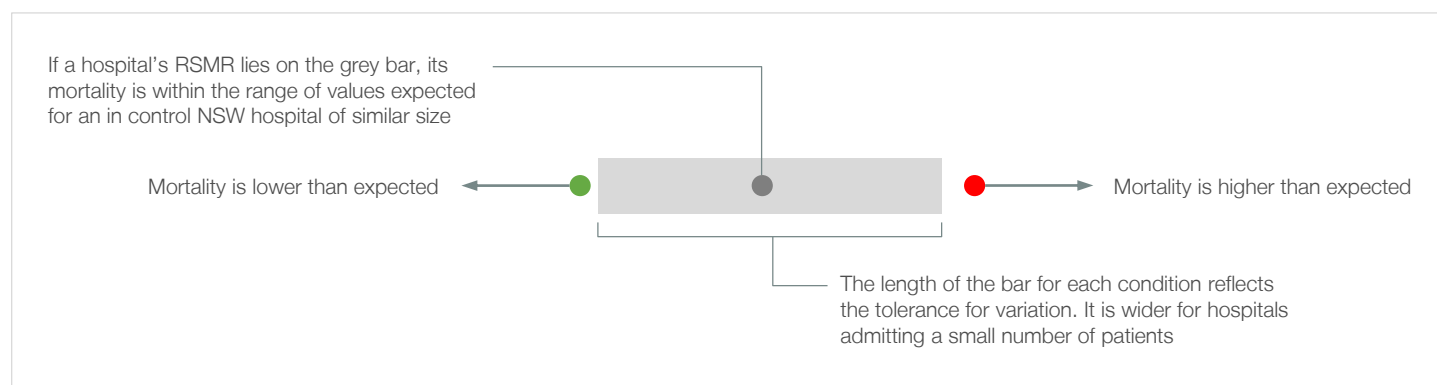
Risk-standardised mortality ratios (RSMRs) for seven conditions



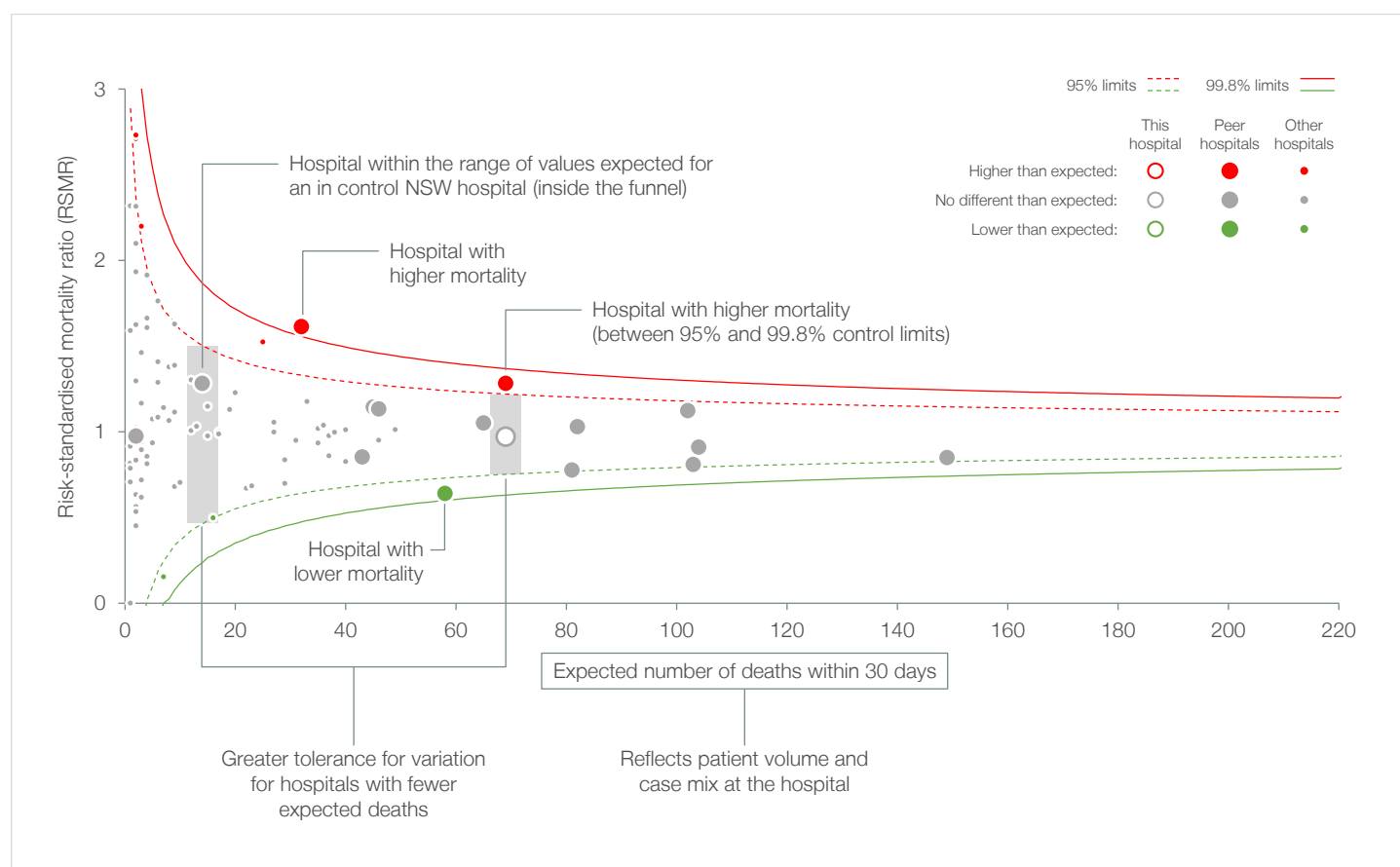
RSMRs for three-year periods, seven clinical conditions



How to interpret the dashboard



How to interpret a funnel plot

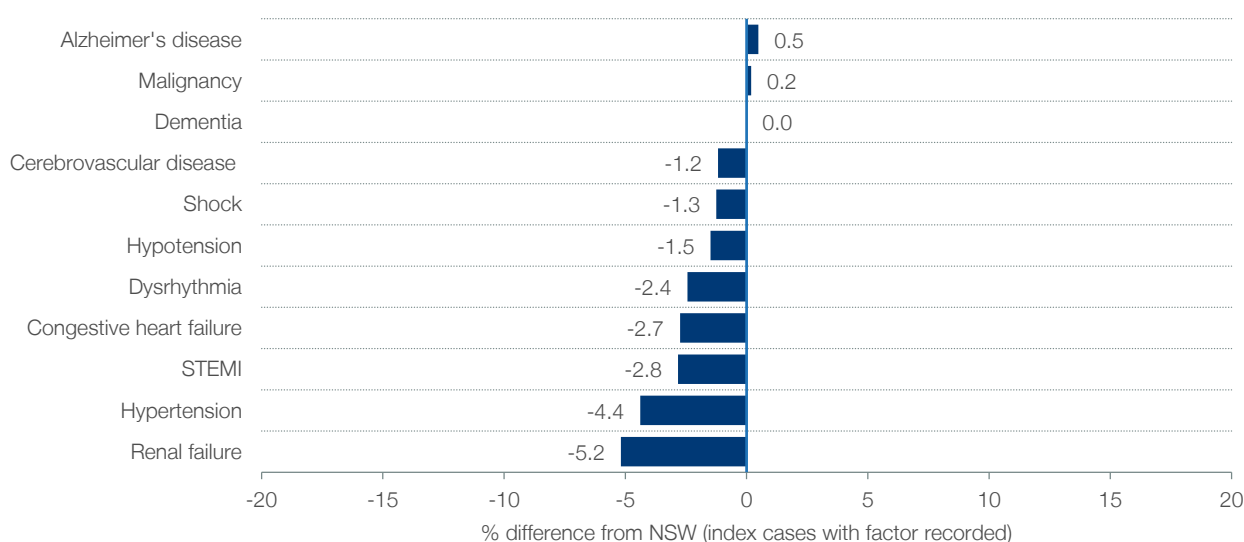


Sutherland Hospital

30-day mortality following hospitalisation for acute myocardial infarction, July 2012 – June 2015

	This hospital	NSW
Total acute myocardial infarction hospitalisations	579	38,352
Acute myocardial infarction patients		
Presenting patients (index cases) ¹	532	30,488
Patients transferred to another hospital within 30 days	450	14,797
Percentage of patients aged 65+ years* ²	66.0%	62.3%
Percentage of patients aged 75+ years* ²	46.6%	38.7%

Significant patient factors and comorbidities, this hospital, index cases³



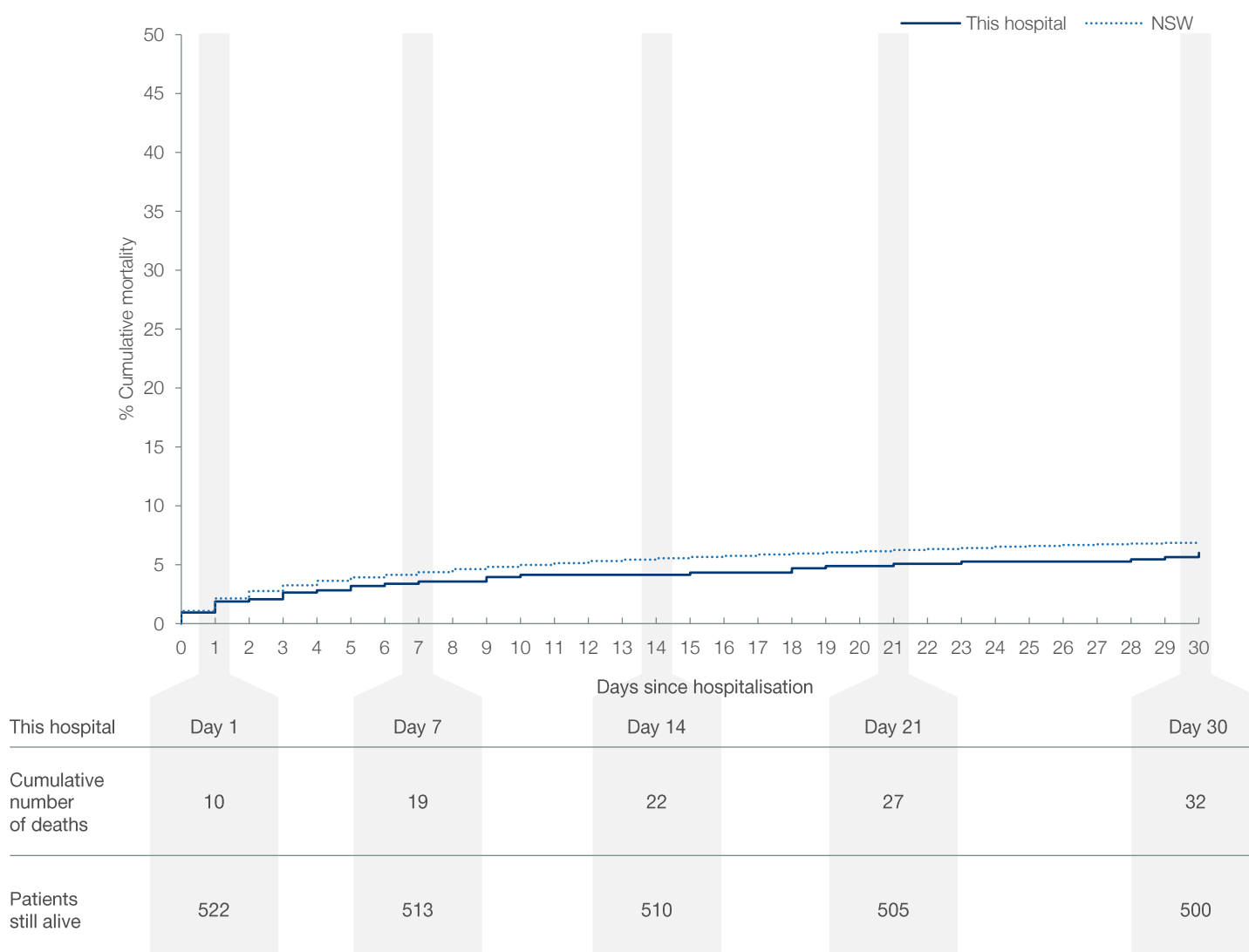
*Age was a significant factor in the final model of 30-day mortality following hospitalisation for acute myocardial infarction.

Sutherland Hospital

30-day mortality following hospitalisation for acute myocardial infarction, July 2012 – June 2015

	This hospital	NSW
Mortality (all causes) among 532 acute myocardial infarction index cases	32 (6.0%)	2,108 (6.9%)
Percentages: index cases who died within 30 days of hospitalisation		
Where deaths occurred:		
Percentage in this hospital	56.3%	63.4%
Percentage in another hospital following transfer	3.1%	4.6%
Percentage after discharge	40.6%	31.9%
When deaths occurred:		
Percentage on day of admission	15.6%	15.4%
Percentage within seven days	59.4%	63.1%

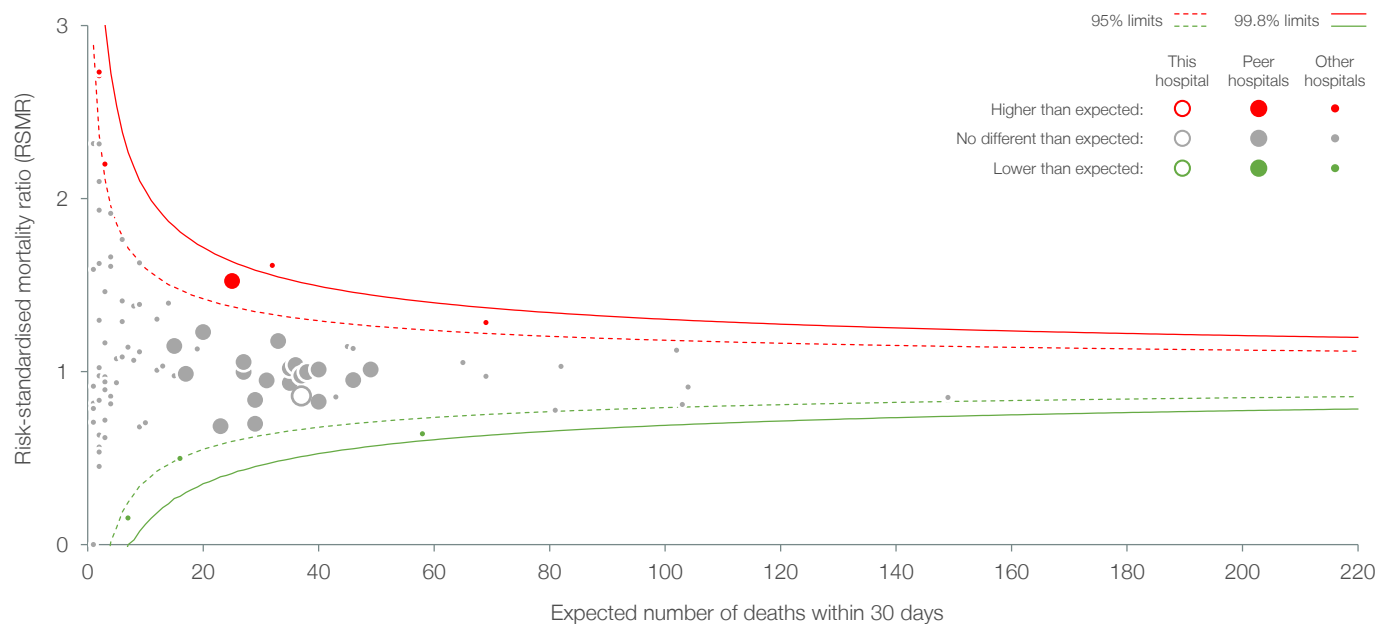
Cumulative mortality following hospitalisation for acute myocardial infarction, this hospital and NSW⁴



Sutherland Hospital

30-day mortality following hospitalisation for acute myocardial infarction, July 2012 – June 2015

Acute myocardial infarction risk-standardised mortality ratio by number of expected deaths, NSW public hospitals⁵



Illustrating the effect of standardisation, July 2012 – June 2015

In order to make fair comparisons, a number of risk adjustments are made to mortality data. These take into account patient factors that influence the likelihood of dying. The table below illustrates the effect of statistical adjustments on this hospital's results.

Unadjusted ratio	Age and sex standardised ratio	Risk-standardised mortality ratio
0.87	0.79	0.86

Ratio: ■ Lower than expected ■ No different than expected ■ Higher than expected

The extent to which comorbidities are coded in the patient record may affect risk adjustment. Therefore the 'depth of coding'⁶ has been assessed across NSW hospitals. In July 2009 – June 2012, the average depth of coding was 3.1 diagnoses in this hospital and 4.3 in NSW; and in July 2012 – June 2015, there were 3.7 diagnoses in this hospital and 4.8 in NSW.

Three-yearly RSMR and annual unadjusted mortality rates

The RSMR is calculated on the basis of three years of data. It takes account of differences in patient characteristics so that assessments of hospital performance are fair. To give an indication of results within the three-year period, the figure below shows the RSMR result for July 2012 – June 2015 alongside differences between this hospital and the NSW result for annual unadjusted mortality rates.

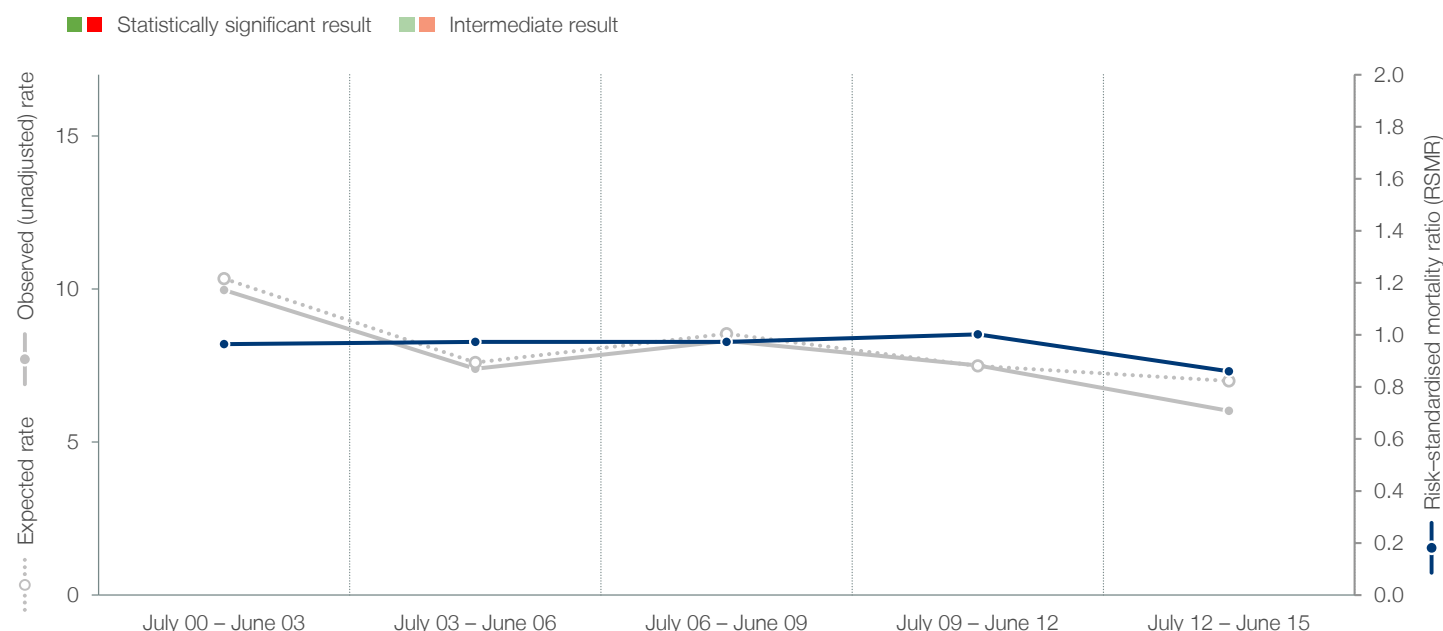
RSMR: ○ Lower than expected ○ No different than expected ○ Higher than expected



Sutherland Hospital

30-day mortality following hospitalisation for acute myocardial infarction, July 2012 – June 2015

Acute myocardial infarction, this hospital's risk-standardised mortality ratio, expected mortality rates and observed (unadjusted) mortality rates, July 2000 – June 2015



Notes

1. Data refer to patients who were discharged between July 2012 and June 2015 who were initially admitted to this hospital (regardless of whether they were subsequently transferred) in their last period of care, for an acute and emergency hospitalisation with AMI as principal diagnosis (ICD-10-AM codes I21, excluding I21.9). Deaths are from any cause, in or out of hospital within 30 days of the hospitalisation admission date.
2. Age at admission date.
3. Comorbidities as recorded on patient record, with one year look back from the admission date of the index case. Many are a result of end-organ damage resulting from comorbidities, such as diabetes. The Australian Commission on Safety and Quality in Healthcare comorbidity list was used for acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip fracture surgery. The Elixhauser comorbidity list was used for congestive heart failure and chronic obstructive pulmonary disease. STEMI refers to ST-elevation myocardial infarction. Only those conditions that were shown to have a significant impact on mortality ($P < 0.05$) are shown.
4. Cumulative percentage of deaths over the 30 days following admission to hospital for the relevant condition.
5. Results for hospitals with expected deaths < 1 are not shown. Peer hospitals are identified according to the NSW Ministry of Health's peer grouping as of April 2012.
6. The depth of coding has been defined as the average number of secondary diagnosis coded for the index cases. The one year look back method which is used for risk adjustment, to some extent accounts for possible lower depth of coding in some hospitals.

Details of analyses are available in *Spotlight on Measurement: Measuring 30-day mortality following hospitalisation, 2nd edition*.

Data source: SAPHaRI, Centre for Epidemiology and Evidence, NSW Ministry of Health.

Sutherland Hospital

30-day mortality following hospitalisation for ischaemic stroke, July 2012 – June 2015

	This hospital	NSW
Total ischaemic stroke hospitalisations	280	16,655
Ischaemic stroke patients		
Presenting patients (index cases) ¹	267	15,475
Patients transferred to another hospital within 30 days	28	3,847
Percentage of patients aged 65+ years* ²	86.1%	77.3%
Percentage of patients aged 75+ years* ²	64.0%	55.3%

Significant patient factors and comorbidities, this hospital, index cases³



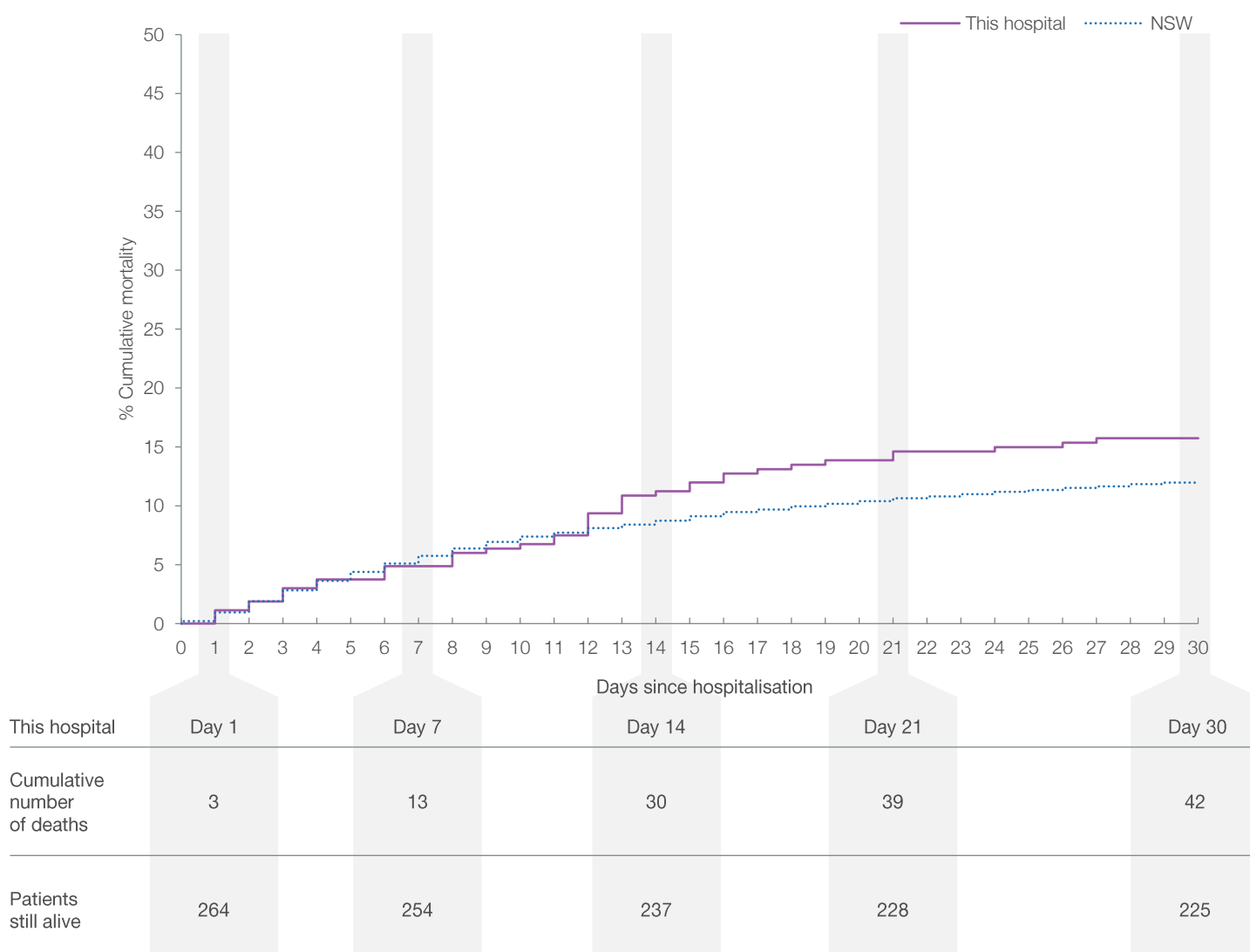
*Age was a significant factor in the final model of 30-day mortality following hospitalisation for ischaemic stroke.

Sutherland Hospital

30-day mortality following hospitalisation for ischaemic stroke, July 2012 – June 2015

	This hospital	NSW
Mortality (all causes) among 267 ischaemic stroke index cases	42 (15.7%)	1,861 (12.0%)
Percentages: index cases who died within 30 days of hospitalisation		
Where deaths occurred:		
Percentage in this hospital	71.4%	55.8%
Percentage in another hospital following transfer	0.0%	1.7%
Percentage after discharge	28.6%	42.6%
When deaths occurred:		
Percentage on day of admission	0.0%	1.7%
Percentage within seven days	31.0%	47.8%

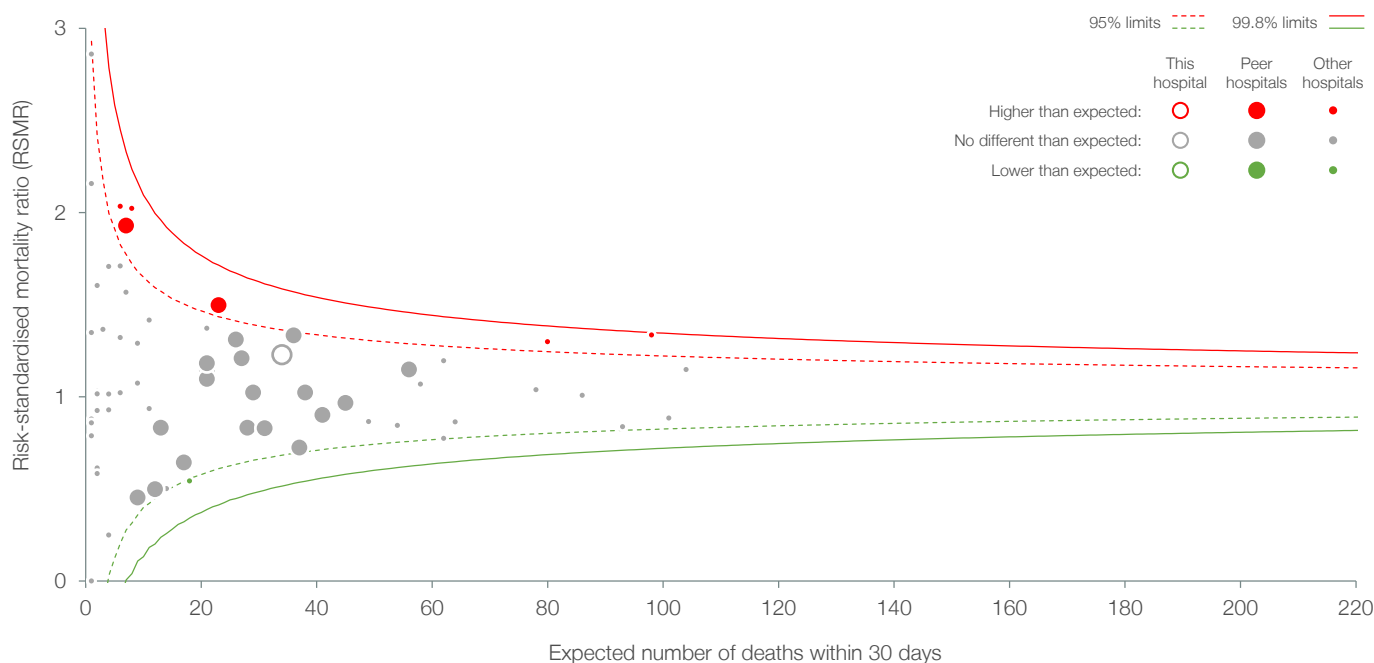
Cumulative mortality following hospitalisation for ischaemic stroke, this hospital and NSW⁴



Sutherland Hospital

30-day mortality following hospitalisation for ischaemic stroke, July 2012 – June 2015

Ischaemic stroke risk-standardised mortality ratio by number of expected deaths,
NSW public hospitals⁵



Illustrating the effect of standardisation, July 2012 – June 2015

In order to make fair comparisons, a number of risk adjustments are made to mortality data. These take into account patient factors that influence the likelihood of dying. The table below illustrates the effect of statistical adjustments on this hospital's results.

Unadjusted ratio	Age and sex standardised ratio	Risk-standardised mortality ratio
1.31	1.20	1.23
Ratio: ■ Lower than expected	■ No different than expected	■ Higher than expected

The extent to which comorbidities are coded in the patient record may affect risk adjustment. Therefore the 'depth of coding'⁶ has been assessed across NSW hospitals. In July 2009 – June 2012, the average depth of coding was 4.2 diagnoses in this hospital and 6.3 in NSW; and in July 2012 – June 2015, there were 6.1 diagnoses in this hospital and 7.0 in NSW.

Three-yearly RSMR and annual unadjusted mortality rates

The RSMR is calculated on the basis of three years of data. It takes account of differences in patient characteristics so that assessments of hospital performance are fair. To give an indication of results within the three-year period, the figure below shows the RSMR result for July 2012 – June 2015 alongside differences between this hospital and the NSW result for annual unadjusted mortality rates.

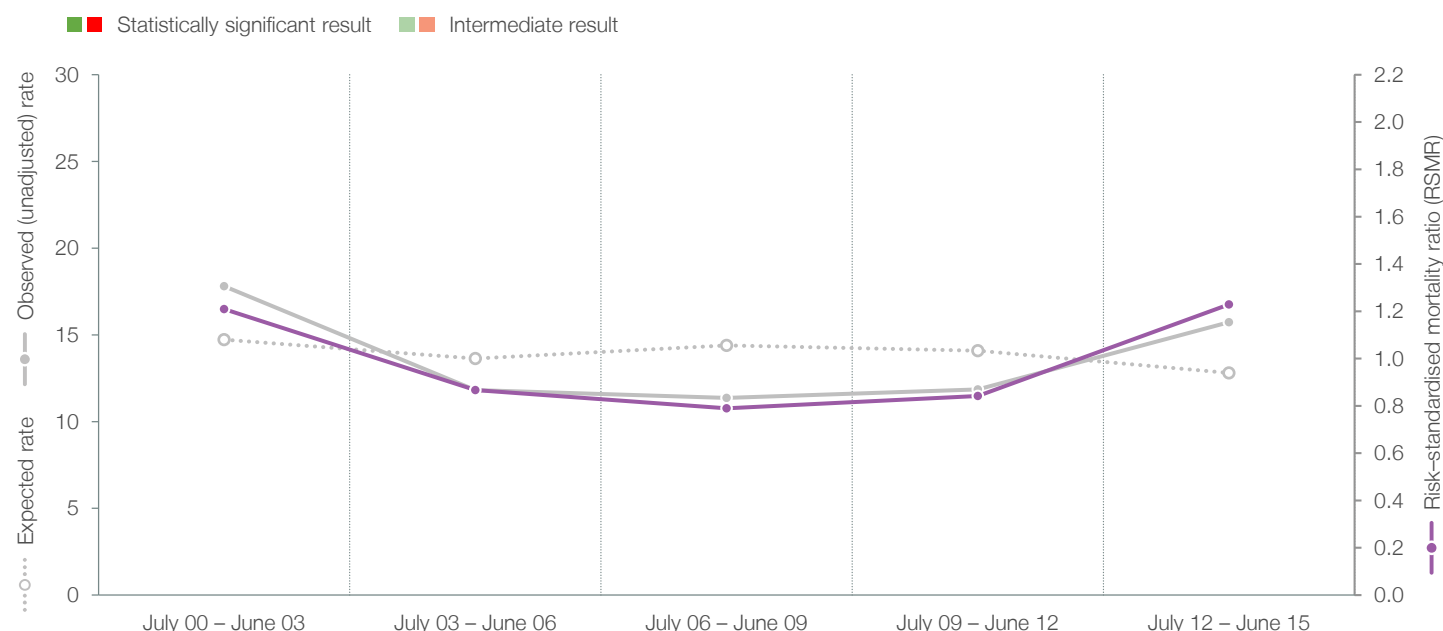
RSMR: ○ Lower than expected ○ No different than expected ○ Higher than expected



Sutherland Hospital

30-day mortality following hospitalisation for ischaemic stroke, July 2012 – June 2015

Ischaemic stroke, this hospital's risk-standardised mortality ratio, expected mortality rates and observed (unadjusted) mortality rates, July 2000 – June 2015



Notes

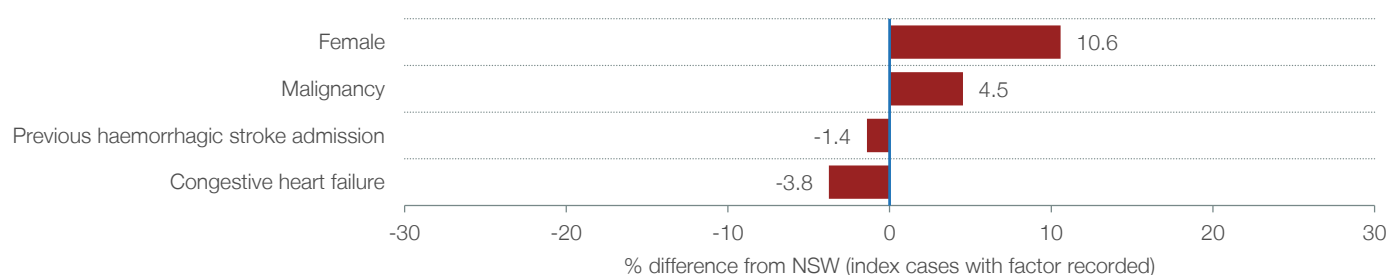
1. Data refer to patients who were discharged between July 2012 and June 2015 who were initially admitted to this hospital (regardless of whether they were subsequently transferred) in their last period of care, for an acute and emergency hospitalisation with ischaemic stroke as principal diagnosis (ICD-10-AM code I63). Deaths are from any cause, in or out of hospital within 30 days of the hospitalisation admission date.
 2. Age at admission date.
 3. Comorbidities as recorded on patient record, with one year look back from the admission date of the index case. Many are a result of end-organ damage resulting from comorbidities, such as diabetes. The Australian Commission on Safety and Quality in Healthcare comorbidity list was used for acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip fracture surgery. The Elixhauser comorbidity list was used for congestive heart failure and chronic obstructive pulmonary disease. STEMI refers to ST-elevation myocardial infarction. Only those conditions that were shown to have a significant impact on mortality ($P < 0.05$) are shown.
 4. Cumulative percentage of deaths over the 30 days following admission to hospital for the relevant condition.
 5. Results for hospitals with expected deaths < 1 are not shown. Peer hospitals are identified according to the NSW Ministry of Health's peer grouping as of April 2012.
 6. The depth of coding has been defined as the average number of secondary diagnosis coded for the index cases. The one year look back method which is used for risk adjustment, to some extent accounts for possible lower depth of coding in some hospitals.
- Details of analyses are available in *Spotlight on Measurement: Measuring 30-day mortality following hospitalisation, 2nd edition*.
- Data source: SAPHaRI, Centre for Epidemiology and Evidence, NSW Ministry of Health.

Sutherland Hospital

30-day mortality following hospitalisation for haemorrhagic stroke, July 2012 – June 2015

	This hospital	NSW
Total haemorrhagic stroke hospitalisations	82	6,469
Haemorrhagic stroke patients		
Presenting patients (index cases) ¹	80	5,659
Patients transferred to another hospital within 30 days	19	1,855
Percentage of patients aged 65+ years* ²	93.8%	77.7%
Percentage of patients aged 75+ years* ²	83.8%	57.6%

Significant patient factors and comorbidities, this hospital, index cases³



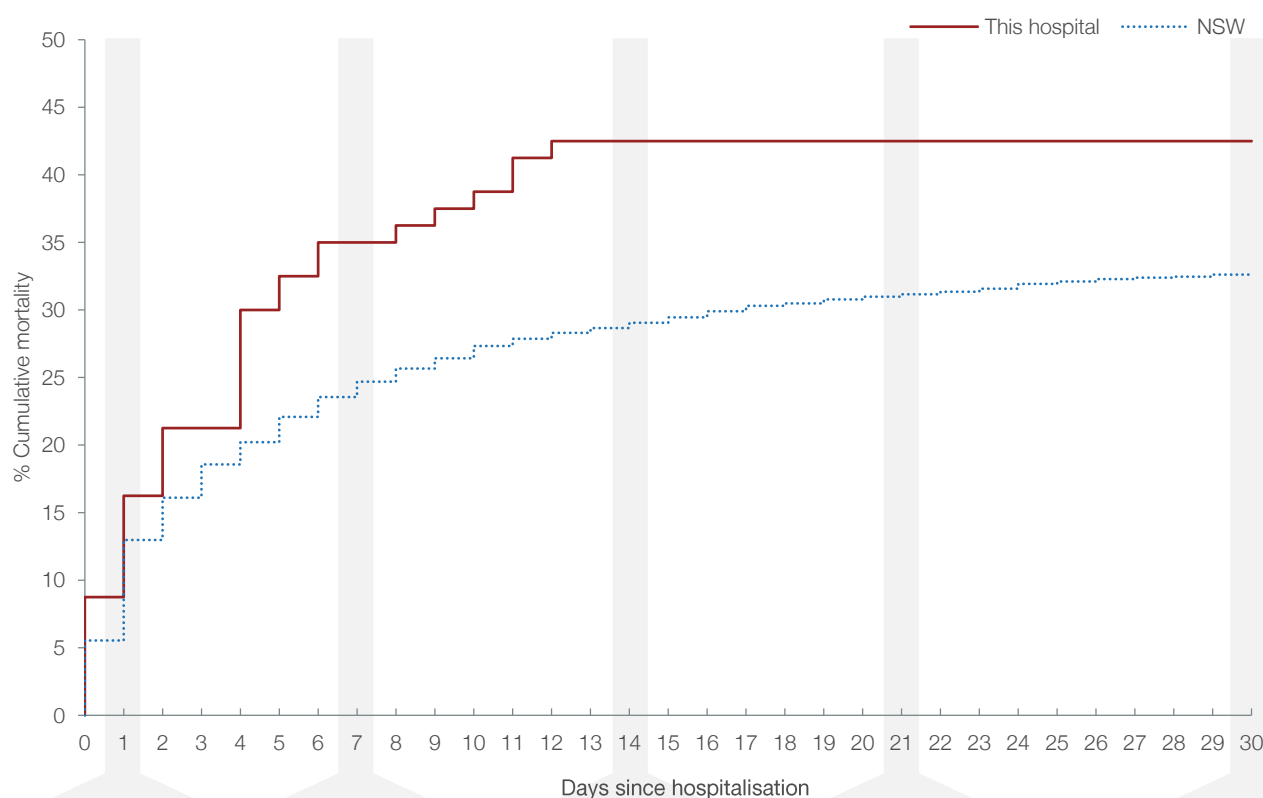
*Age was a significant factor in the final model of 30-day mortality following hospitalisation for haemorrhagic stroke.

Sutherland Hospital

30-day mortality following hospitalisation for haemorrhagic stroke, July 2012 – June 2015

	This hospital	NSW
Mortality (all causes) among 80 haemorrhagic stroke index cases	34 (42.5%)	1,855 (32.8%)
Percentages: index cases who died within 30 days of hospitalisation		
Where deaths occurred:		
Percentage in this hospital	79.4%	72.9%
Percentage in another hospital following transfer	0.0%	3.6%
Percentage after discharge	20.6%	23.5%
When deaths occurred:		
Percentage on day of admission	20.6%	16.9%
Percentage within seven days	82.4%	75.3%

Cumulative mortality following hospitalisation for haemorrhagic stroke, this hospital and NSW⁴

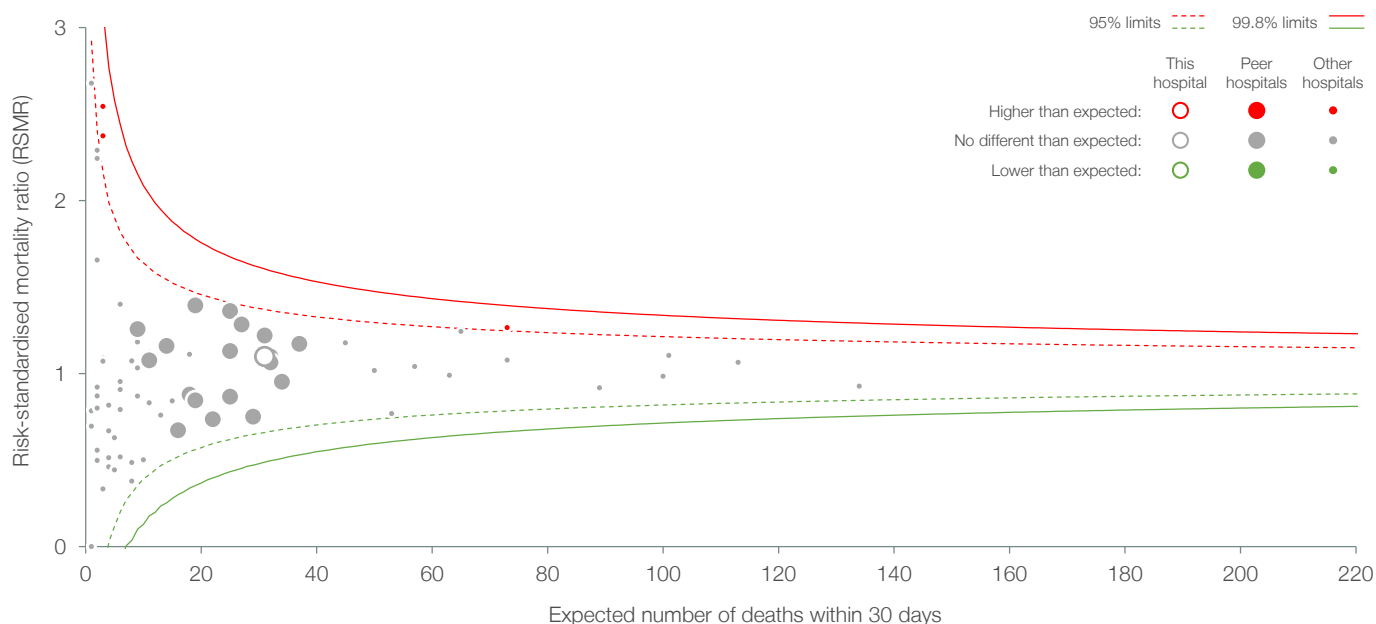


This hospital	Day 1	Day 7	Day 14	Day 21	Day 30
Cumulative number of deaths	13	28	34	34	34
Patients still alive	67	52	46	46	46

Sutherland Hospital

30-day mortality following hospitalisation for haemorrhagic stroke, July 2012 – June 2015

Haemorrhagic stroke risk-standardised mortality ratio by number of expected deaths, NSW public hospitals⁵



Illustrating the effect of standardisation, July 2012 – June 2015

In order to make fair comparisons, a number of risk adjustments are made to mortality data. These take into account patient factors that influence the likelihood of dying. The table below illustrates the effect of statistical adjustments on this hospital's results.

Unadjusted ratio	Age and sex standardised ratio	Risk-standardised mortality ratio
1.30	1.11	1.10
Ratio: ■ Lower than expected ■ No different than expected ■ Higher than expected		

The extent to which comorbidities are coded in the patient record may affect risk adjustment. Therefore the 'depth of coding'⁶ has been assessed across NSW hospitals. In July 2009 – June 2012, the average depth of coding was 3.8 diagnoses in this hospital and 5.1 in NSW; and in July 2012 – June 2015, there were 4.3 diagnoses in this hospital and 5.8 in NSW.

Three-yearly RSMR and annual unadjusted mortality rates

The RSMR is calculated on the basis of three years of data. It takes account of differences in patient characteristics so that assessments of hospital performance are fair. To give an indication of results within the three-year period, the figure below shows the RSMR result for July 2012 – June 2015 alongside differences between this hospital and the NSW result for annual unadjusted mortality rates.

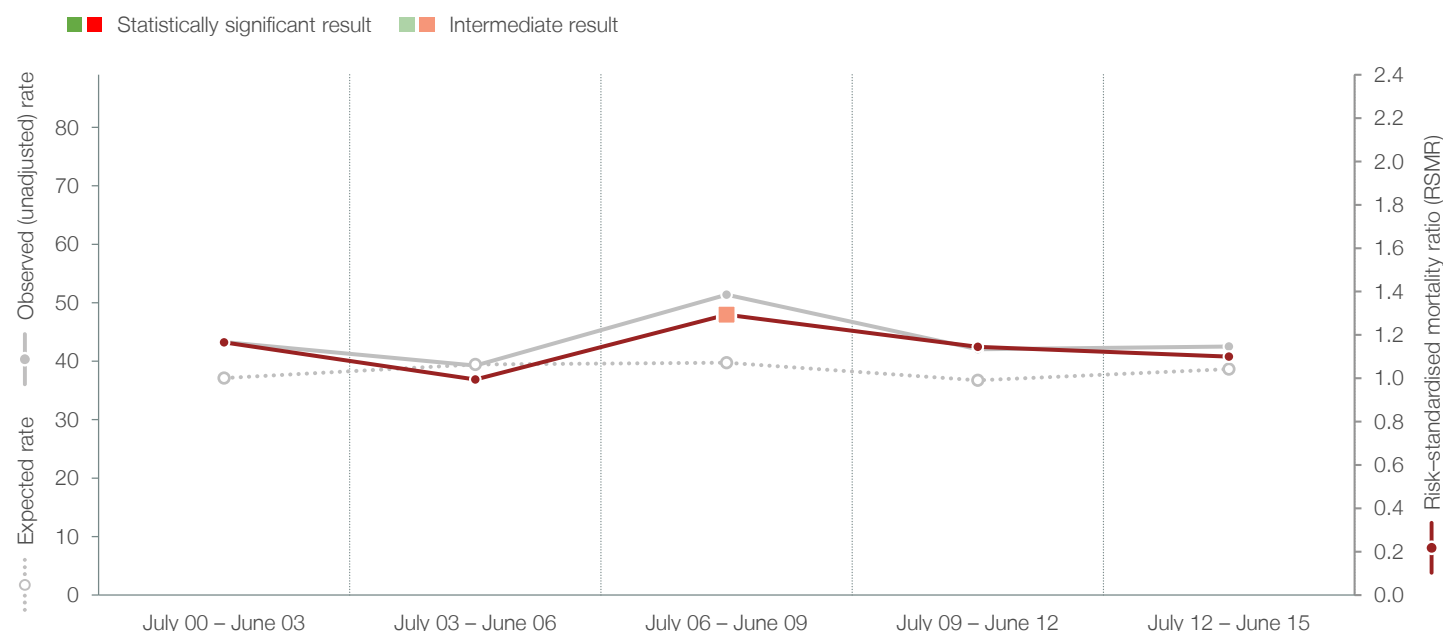
RSMR: ○ Lower than expected ○ No different than expected ○ Higher than expected



Sutherland Hospital

30-day mortality following hospitalisation for haemorrhagic stroke, July 2012 – June 2015

Haemorrhagic stroke, this hospital's risk-standardised mortality ratio, expected mortality rates and observed (unadjusted) mortality rates, July 2000 – June 2015



Notes

1. Data refer to patients who were discharged between July 2012 and June 2015 who were initially admitted to this hospital (regardless of whether they were subsequently transferred) in their last period of care, for an acute and emergency hospitalisation with haemorrhagic stroke as principal diagnosis (ICD-10-AM code I61, I62). Deaths are from any cause, in or out of hospital within 30 days of the hospitalisation admission date.
2. Age at admission date.
3. Comorbidities as recorded on patient record, with one year look back from the admission date of the index case. Many are a result of end-organ damage resulting from comorbidities, such as diabetes. The Australian Commission on Safety and Quality in Healthcare comorbidity list was used for acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip fracture surgery. The Elixhauser comorbidity list was used for congestive heart failure and chronic obstructive pulmonary disease. STEMI refers to ST-elevation myocardial infarction. Only those conditions that were shown to have a significant impact on mortality ($P < 0.05$) are shown.
4. Cumulative percentage of deaths over the 30 days following admission to hospital for the relevant condition.
5. Results for hospitals with expected deaths < 1 are not shown. Peer hospitals are identified according to the NSW Ministry of Health's peer grouping as of April 2012.
6. The depth of coding has been defined as the average number of secondary diagnosis coded for the index cases. The one year look back method which is used for risk adjustment, to some extent accounts for possible lower depth of coding in some hospitals.

Details of analyses are available in *Spotlight on Measurement: Measuring 30-day mortality following hospitalisation, 2nd edition*.

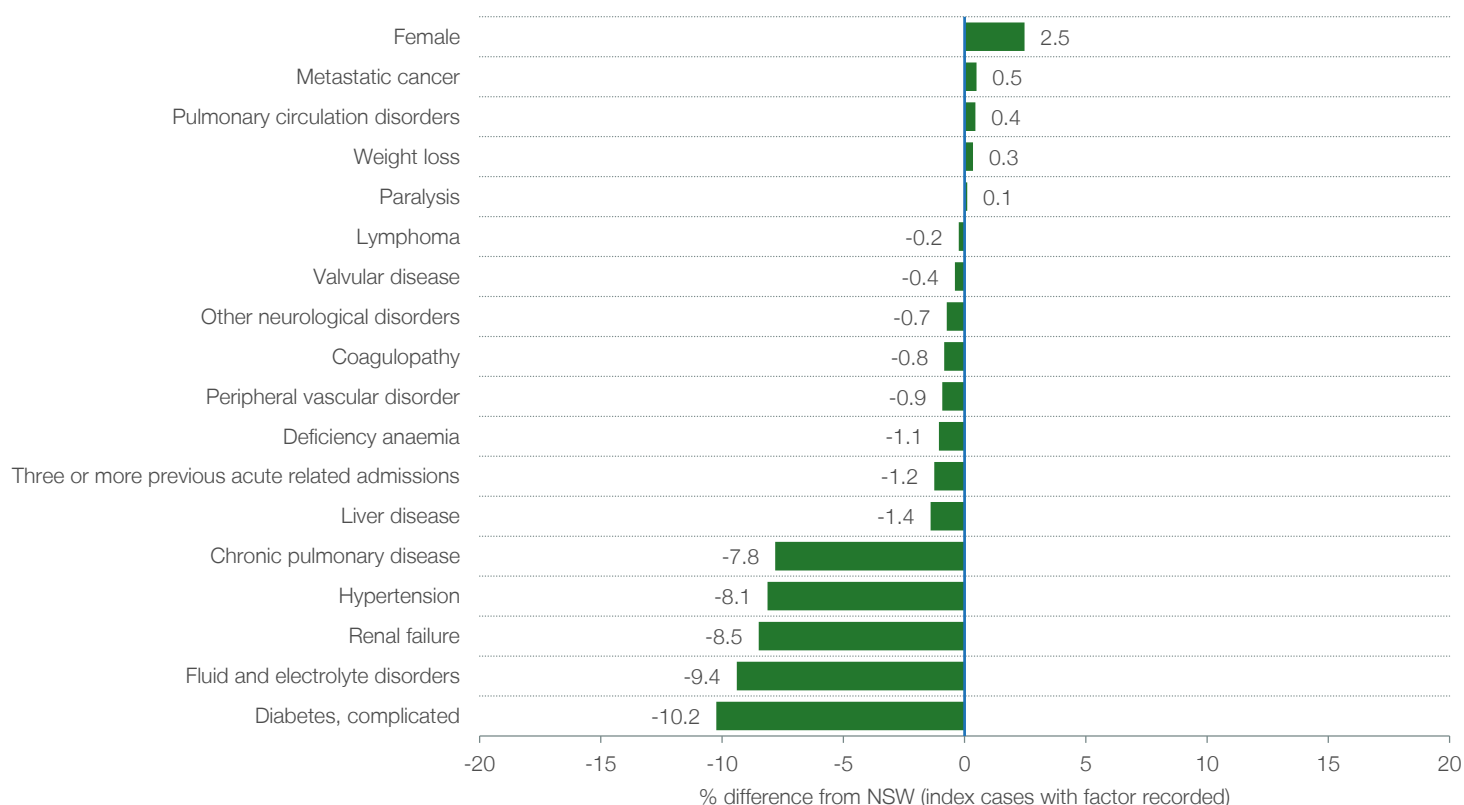
Data source: SAPHaRI, Centre for Epidemiology and Evidence, NSW Ministry of Health.

Sutherland Hospital

30-day mortality following hospitalisation for congestive heart failure, July 2012 – June 2015

	This hospital	NSW
Total congestive heart failure hospitalisations	781	40,670
Congestive heart failure patients		
Presenting patients (index cases) ¹	601	27,484
Patients transferred to another hospital within 30 days	114	4,200
Percentage of patients aged 65+ years* ²	95.0%	90.2%
Percentage of patients aged 75+ years* ²	81.5%	73.0%

Significant patient factors and comorbidities, this hospital, index cases³



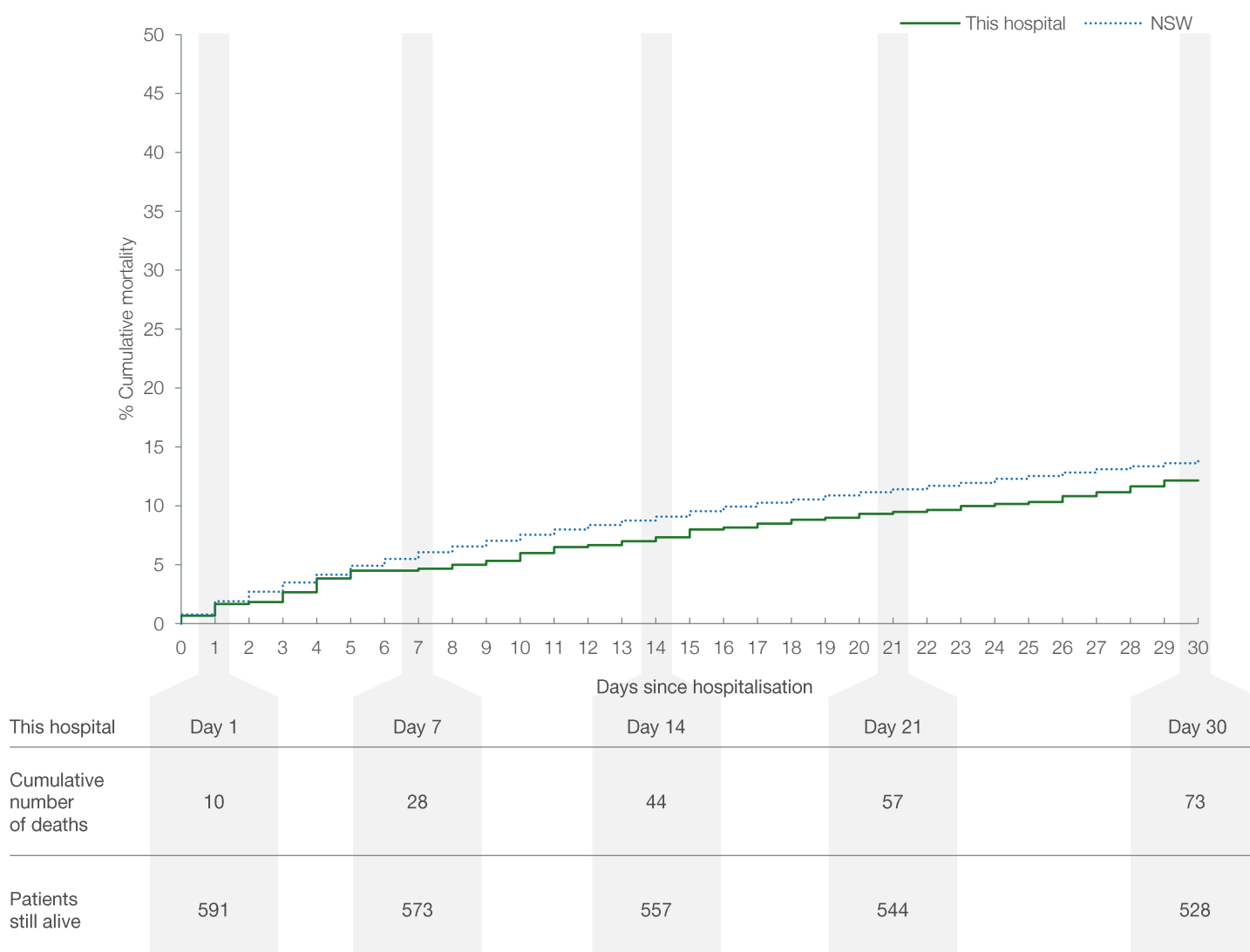
*Age was a significant factor in the final model of 30-day mortality following hospitalisation for congestive heart failure.

Sutherland Hospital

30-day mortality following hospitalisation for congestive heart failure, July 2012 – June 2015

	This hospital	NSW
Mortality (all causes) among 601 congestive heart failure index cases	73 (12.1%)	3,793 (13.8%)
Percentages: index cases who died within 30 days of hospitalisation		
Where deaths occurred:		
Percentage in this hospital	53.4%	57.2%
Percentage in another hospital following transfer	1.4%	1.5%
Percentage after discharge	45.2%	41.3%
When deaths occurred:		
Percentage on day of admission	5.5%	5.5%
Percentage within seven days	38.4%	43.9%

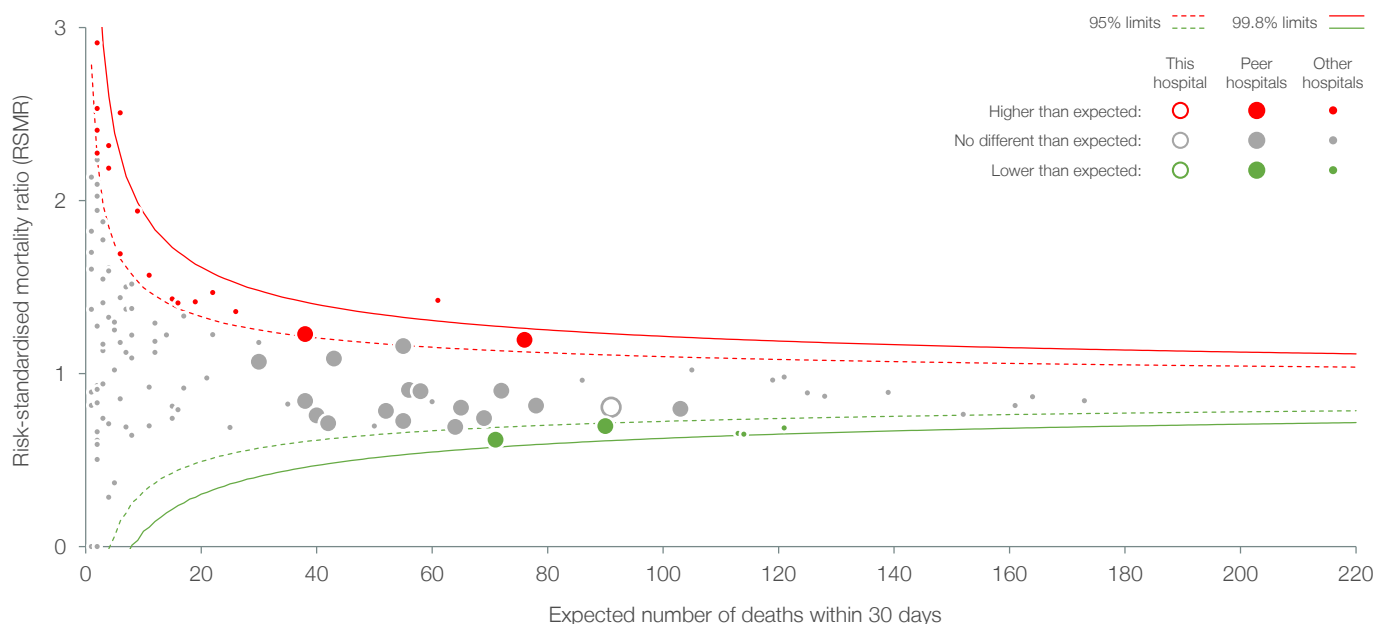
Cumulative mortality following hospitalisation for congestive heart failure, this hospital and NSW⁴



Sutherland Hospital

30-day mortality following hospitalisation for congestive heart failure, July 2012 – June 2015

Congestive heart failure risk-standardised mortality ratio by number of expected deaths, NSW public hospitals⁵



Illustrating the effect of standardisation, July 2012 – June 2015

In order to make fair comparisons, a number of risk adjustments are made to mortality data. These take into account patient factors that influence the likelihood of dying. The table below illustrates the effect of statistical adjustments on this hospital's results.

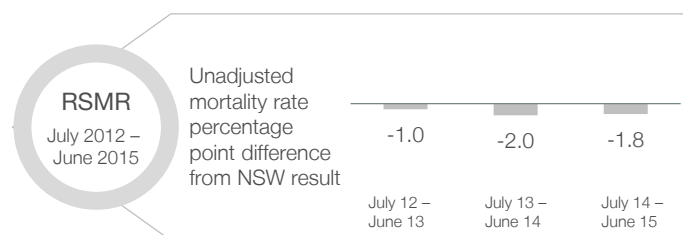
Unadjusted ratio	Age and sex standardised ratio	Risk-standardised mortality ratio
0.88	0.79	0.81
Ratio: ■ Lower than expected	■ No different than expected	■ Higher than expected

The extent to which comorbidities are coded in the patient record may affect risk adjustment. Therefore the 'depth of coding'⁶ has been assessed across NSW hospitals. In July 2009 – June 2012, the average depth of coding was 4.0 diagnoses in this hospital and 5.1 in NSW; and in July 2012 – June 2015, there were 4.7 diagnoses in this hospital and 6.0 in NSW.

Three-yearly RSMR and annual unadjusted mortality rates

The RSMR is calculated on the basis of three years of data. It takes account of differences in patient characteristics so that assessments of hospital performance are fair. To give an indication of results within the three-year period, the figure below shows the RSMR result for July 2012 – June 2015 alongside differences between this hospital and the NSW result for annual unadjusted mortality rates.

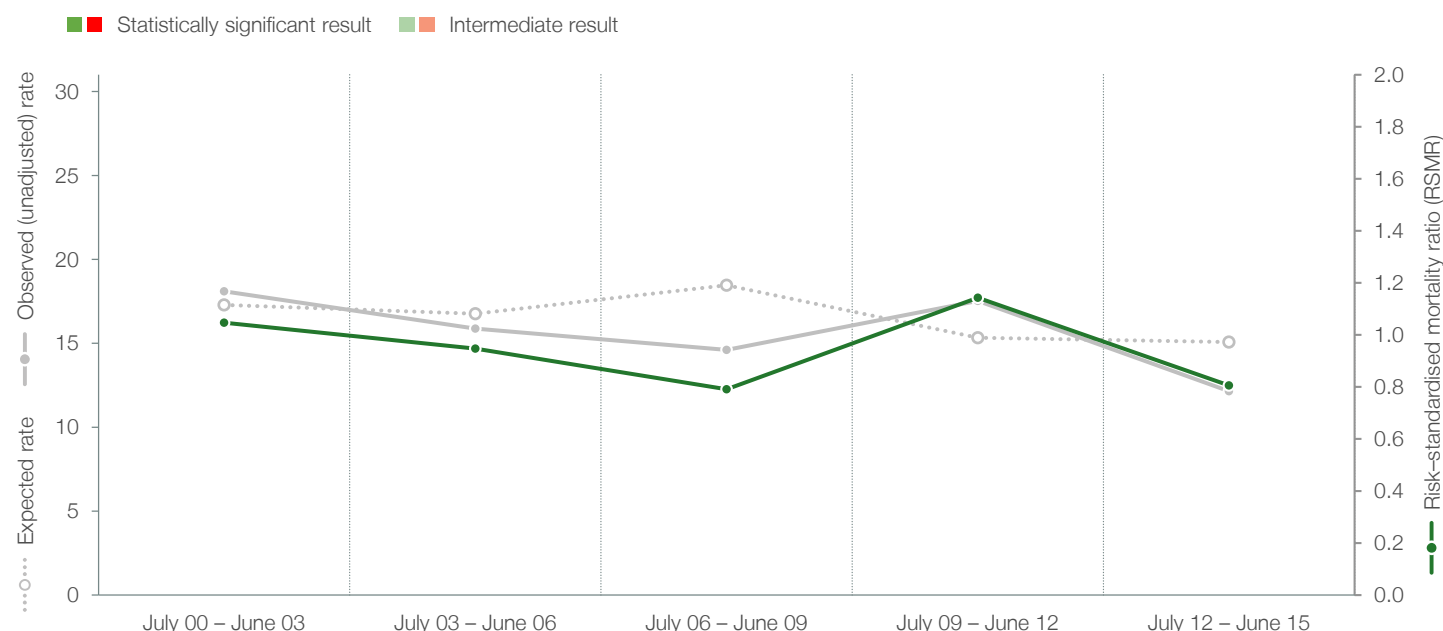
RSMR: ○ Lower than expected ○ No different than expected ○ Higher than expected



Sutherland Hospital

30-day mortality following hospitalisation for congestive heart failure, July 2012 – June 2015

Congestive heart failure, this hospital's risk-standardised mortality ratio, expected mortality rates and observed (unadjusted) mortality rates, July 2000 – June 2015



Notes

1. Data refer to patients who were discharged between July 2012 and June 2015 who were initially admitted to this hospital (regardless of whether they were subsequently transferred) in their last period of care, for an acute and emergency hospitalisation with congestive heart failure as principal diagnosis (ICD-10-AM codes I11.0, I13.0, I13.2, I50.0, I50.1, I50.9). Deaths are from any cause, in or out of hospital within 30 days of the hospitalisation admission date.
2. Age at admission date.
3. Comorbidities as recorded on patient record, with one year look back from the admission date of the index case. Many are a result of end-organ damage resulting from comorbidities, such as diabetes. The Australian Commission on Safety and Quality in Healthcare comorbidity list was used for acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip fracture surgery. The Elixhauser comorbidity list was used for congestive heart failure and chronic obstructive pulmonary disease. STEMI refers to ST-elevation myocardial infarction. Only those conditions that were shown to have a significant impact on mortality ($P < 0.05$) are shown.
4. Cumulative percentage of deaths over the 30 days following admission to hospital for the relevant condition.
5. Results for hospitals with expected deaths < 1 are not shown. Peer hospitals are identified according to the NSW Ministry of Health's peer grouping as of April 2012.
6. The depth of coding has been defined as the average number of secondary diagnosis coded for the index cases. The one year look back method which is used for risk adjustment, to some extent accounts for possible lower depth of coding in some hospitals.

Details of analyses are available in *Spotlight on Measurement: Measuring 30-day mortality following hospitalisation, 2nd edition*.

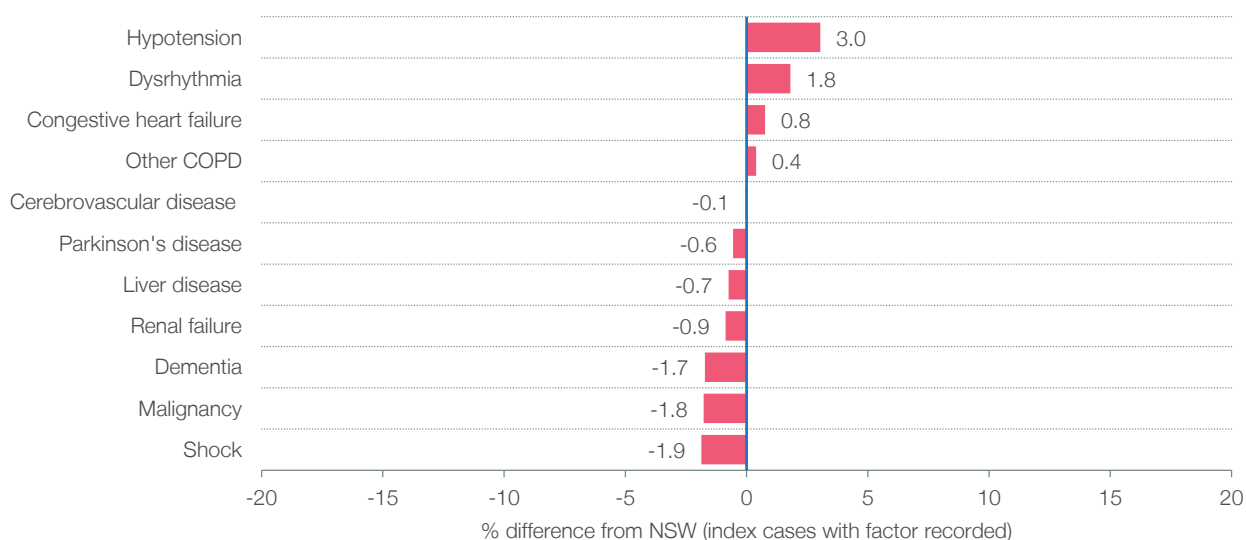
Data source: SAPHaRI, Centre for Epidemiology and Evidence, NSW Ministry of Health.

Sutherland Hospital

30-day mortality following hospitalisation for pneumonia, July 2012 – June 2015

	This hospital	NSW
Total pneumonia hospitalisations	1,214	54,478
Pneumonia patients		
Presenting patients (index cases) ¹	1,084	47,133
Patients transferred to another hospital within 30 days	131	6,564
Percentage of patients aged 65+ years* ²	80.8%	69.1%
Percentage of patients aged 75+ years* ²	66.9%	50.0%

Significant patient factors and comorbidities, this hospital, index cases³



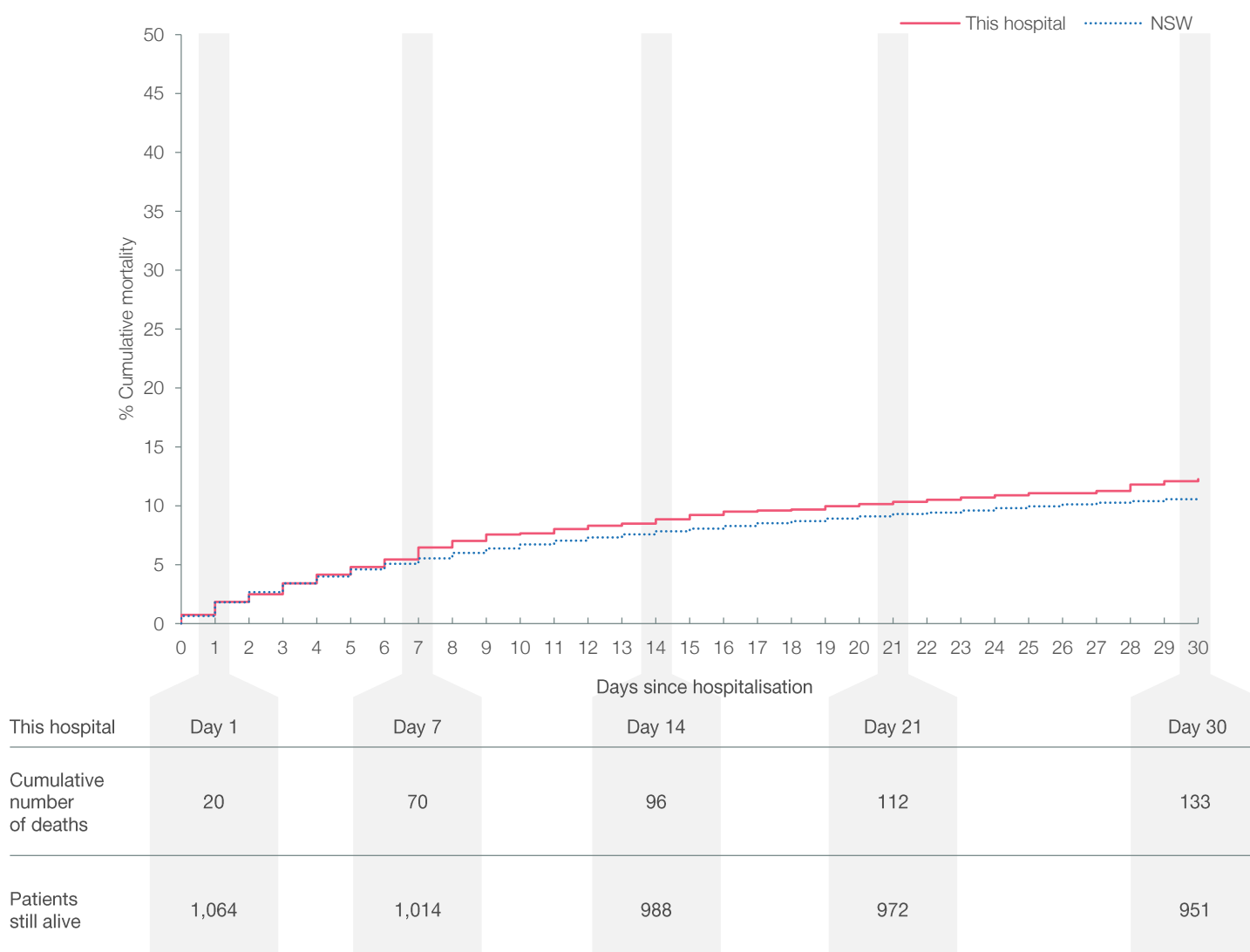
*Age was a significant factor in the final model of 30-day mortality following hospitalisation for pneumonia.

Sutherland Hospital

30-day mortality following hospitalisation for pneumonia, July 2012 – June 2015

	This hospital	NSW
Mortality (all causes) among 1,084 pneumonia index cases	133 (12.3%)	5,037 (10.7%)
Percentages: index cases who died within 30 days of hospitalisation		
Where deaths occurred:		
Percentage in this hospital	62.4%	60.3%
Percentage in another hospital following transfer	0.0%	1.4%
Percentage after discharge	37.6%	38.3%
When deaths occurred:		
Percentage on day of admission	6.0%	6.0%
Percentage within seven days	52.6%	51.8%

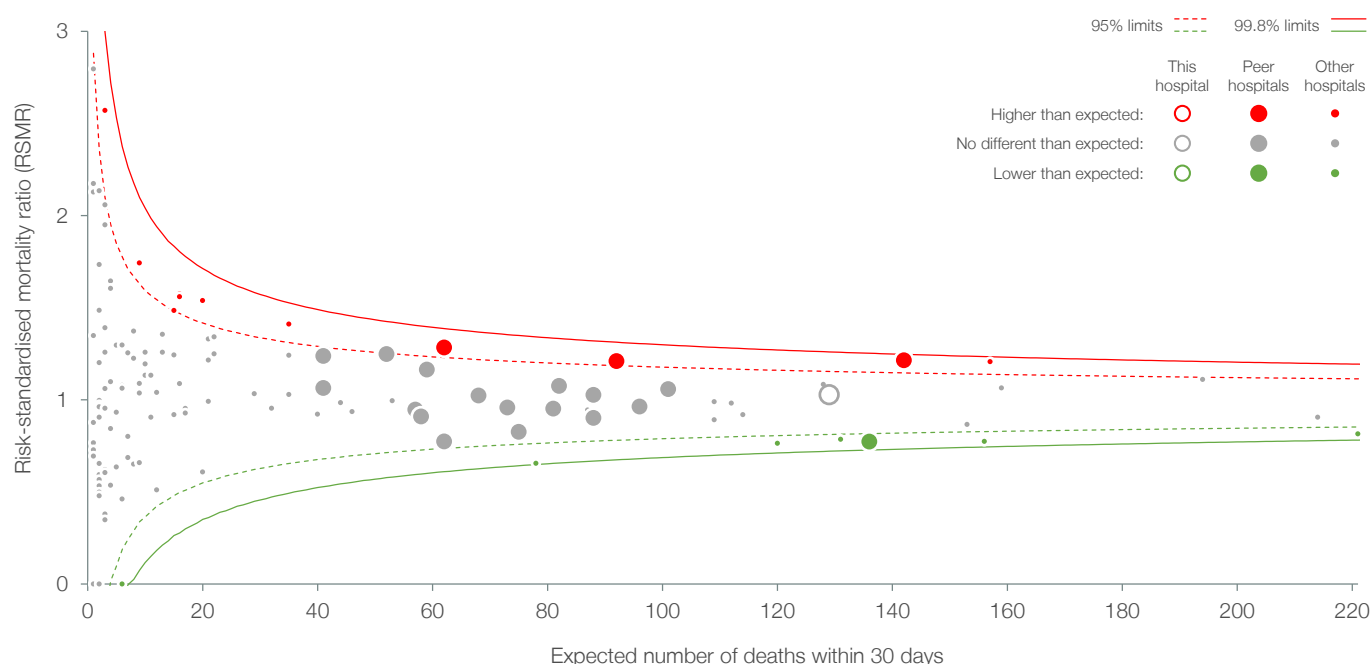
Cumulative mortality following hospitalisation for pneumonia, this hospital and NSW⁴



Sutherland Hospital

30-day mortality following hospitalisation for pneumonia, July 2012 – June 2015

Pneumonia risk-standardised mortality ratio by number of expected deaths,
NSW public hospitals⁵



Illustrating the effect of standardisation, July 2012 – June 2015

In order to make fair comparisons, a number of risk adjustments are made to mortality data. These take into account patient factors that influence the likelihood of dying. The table below illustrates the effect of statistical adjustments on this hospital's results.

Unadjusted ratio	Age and sex standardised ratio	Risk-standardised mortality ratio
1.15	0.97	1.03
Ratio: ■ Lower than expected	■ No different than expected	■ Higher than expected

The extent to which comorbidities are coded in the patient record may affect risk adjustment. Therefore the 'depth of coding'⁶ has been assessed across NSW hospitals. In July 2009 – June 2012, the average depth of coding was 3.2 diagnoses in this hospital and 3.8 in NSW; and in July 2012 – June 2015, there were 4.4 diagnoses in this hospital and 4.8 in NSW.

Three-yearly RSMR and annual unadjusted mortality rates

The RSMR is calculated on the basis of three years of data. It takes account of differences in patient characteristics so that assessments of hospital performance are fair. To give an indication of results within the three-year period, the figure below shows the RSMR result for July 2012 – June 2015 alongside differences between this hospital and the NSW result for annual unadjusted mortality rates.

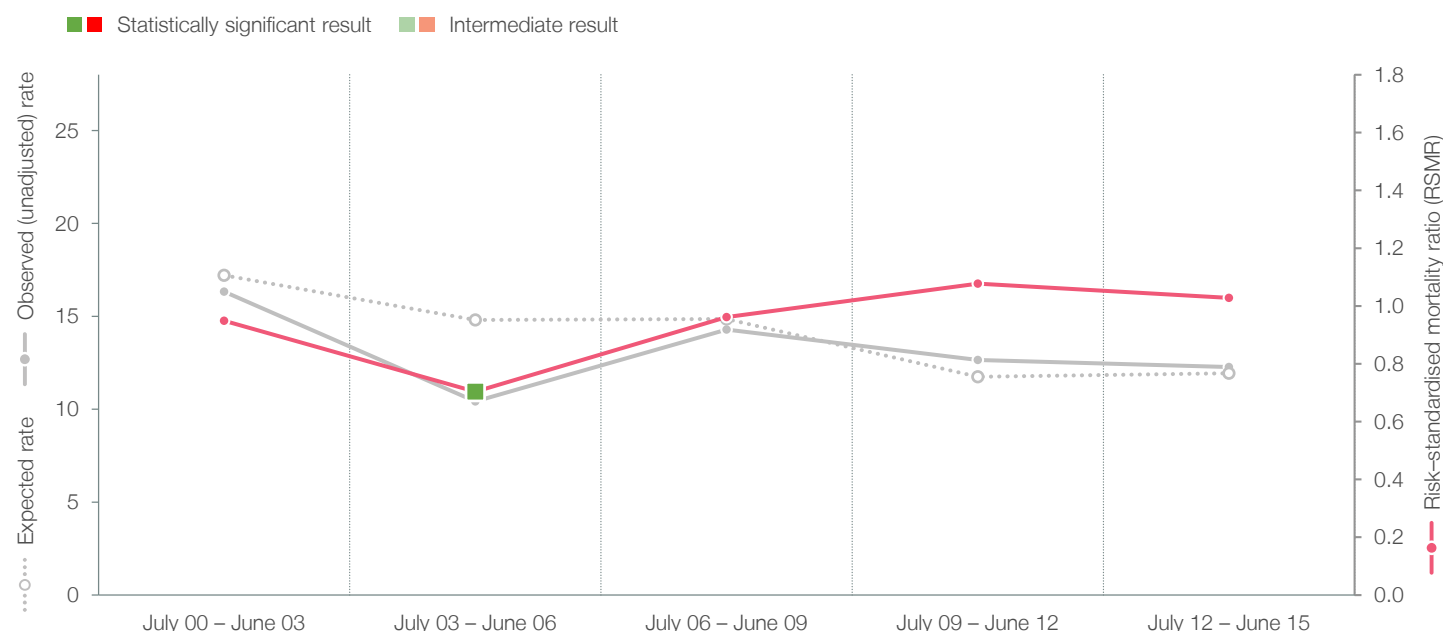
RSMR: ○ Lower than expected ○ No different than expected ○ Higher than expected



Sutherland Hospital

30-day mortality following hospitalisation for pneumonia, July 2012 – June 2015

Pneumonia, this hospital's risk-standardised mortality ratio, expected mortality rates and observed (unadjusted) mortality rates, July 2000 – June 2015



Notes

1. Data refer to patients who were discharged between July 2012 and June 2015 who were initially admitted to this hospital (regardless of whether they were subsequently transferred) in their last period of care, for an acute and emergency hospitalisation with pneumonia as principal diagnosis (ICD-10-AM codes J13, J14, J15, J16, J18). Deaths are from any cause, in or out of hospital within 30 days of the hospitalisation admission date.
2. Age at admission date.
3. Comorbidities as recorded on patient record, with one year look back from the admission date of the index case. Many are a result of end-organ damage resulting from comorbidities, such as diabetes. The Australian Commission on Safety and Quality in Healthcare comorbidity list was used for acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip fracture surgery. The Elixhauser comorbidity list was used for congestive heart failure and chronic obstructive pulmonary disease. STEMI refers to ST-elevation myocardial infarction. Only those conditions that were shown to have a significant impact on mortality ($P < 0.05$) are shown.
4. Cumulative percentage of deaths over the 30 days following admission to hospital for the relevant condition.
5. Results for hospitals with expected deaths < 1 are not shown. Peer hospitals are identified according to the NSW Ministry of Health's peer grouping as of April 2012.
6. The depth of coding has been defined as the average number of secondary diagnosis coded for the index cases. The one year look back method which is used for risk adjustment, to some extent accounts for possible lower depth of coding in some hospitals.

Details of analyses are available in *Spotlight on Measurement: Measuring 30-day mortality following hospitalisation, 2nd edition*.

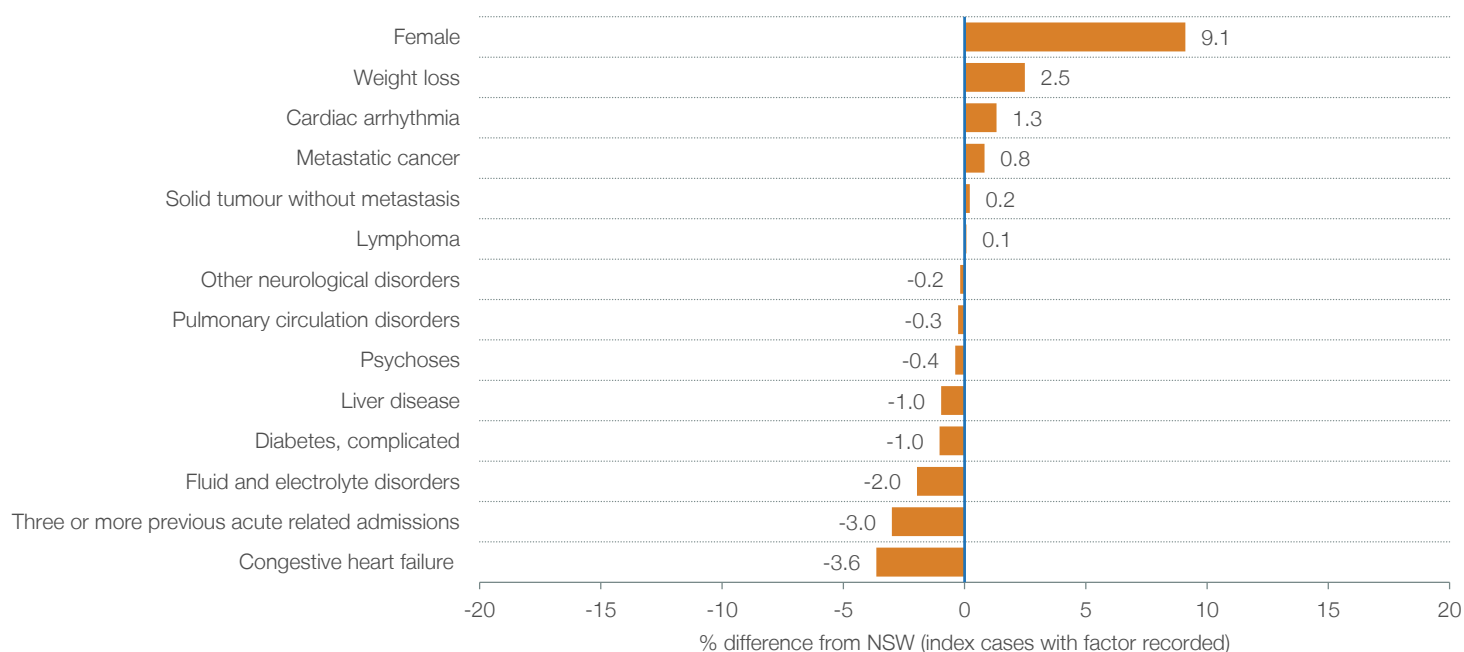
Data source: SAPHaRI, Centre for Epidemiology and Evidence, NSW Ministry of Health.

Sutherland Hospital

30-day mortality following hospitalisation for chronic obstructive pulmonary disease, July 2012 – June 2015

	This hospital	NSW
Total chronic obstructive pulmonary disease hospitalisations	759	58,675
Chronic obstructive pulmonary disease patients		
Presenting patients (index cases) ¹	485	30,525
Patients transferred to another hospital within 30 days	49	3,337
Percentage of patients aged 65+ years* ²	87.2%	79.5%
Percentage of patients aged 75+ years* ²	63.3%	50.7%

Significant patient factors and comorbidities, this hospital, index cases³



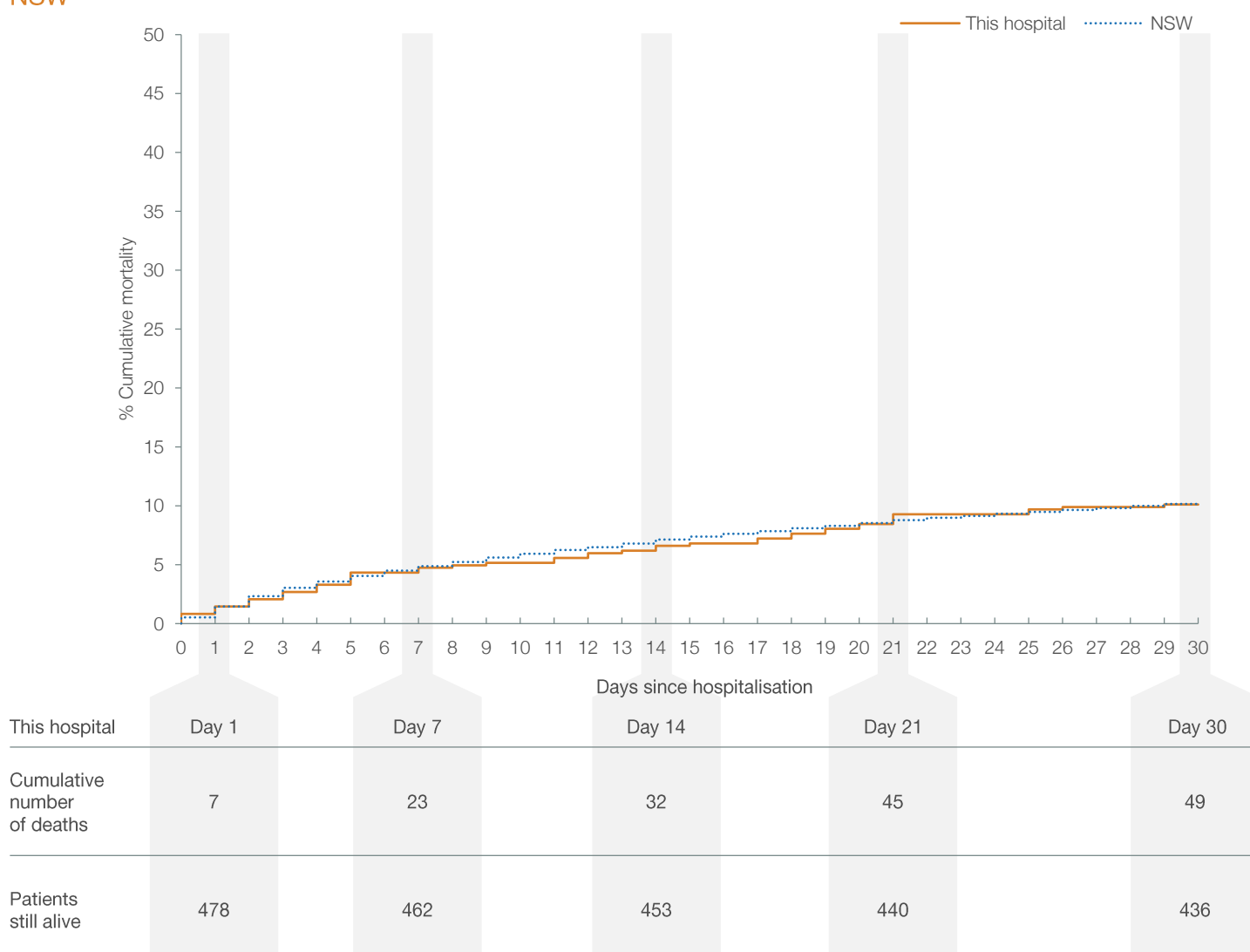
*Age was a significant factor in the final model of 30-day mortality following hospitalisation for chronic obstructive pulmonary disease.

Sutherland Hospital

30-day mortality following hospitalisation for chronic obstructive pulmonary disease, July 2012 – June 2015

	This hospital	NSW
Mortality (all causes) among 485 chronic obstructive pulmonary disease index cases	49 (10.1%)	3,160 (10.4%)
Percentages: index cases who died within 30 days of hospitalisation		
Where deaths occurred:		
Percentage in this hospital	59.2%	55.8%
Percentage in another hospital following transfer	0.0%	1.4%
Percentage after discharge	40.8%	42.8%
When deaths occurred:		
Percentage on day of admission	8.2%	5.1%
Percentage within seven days	46.9%	47.1%

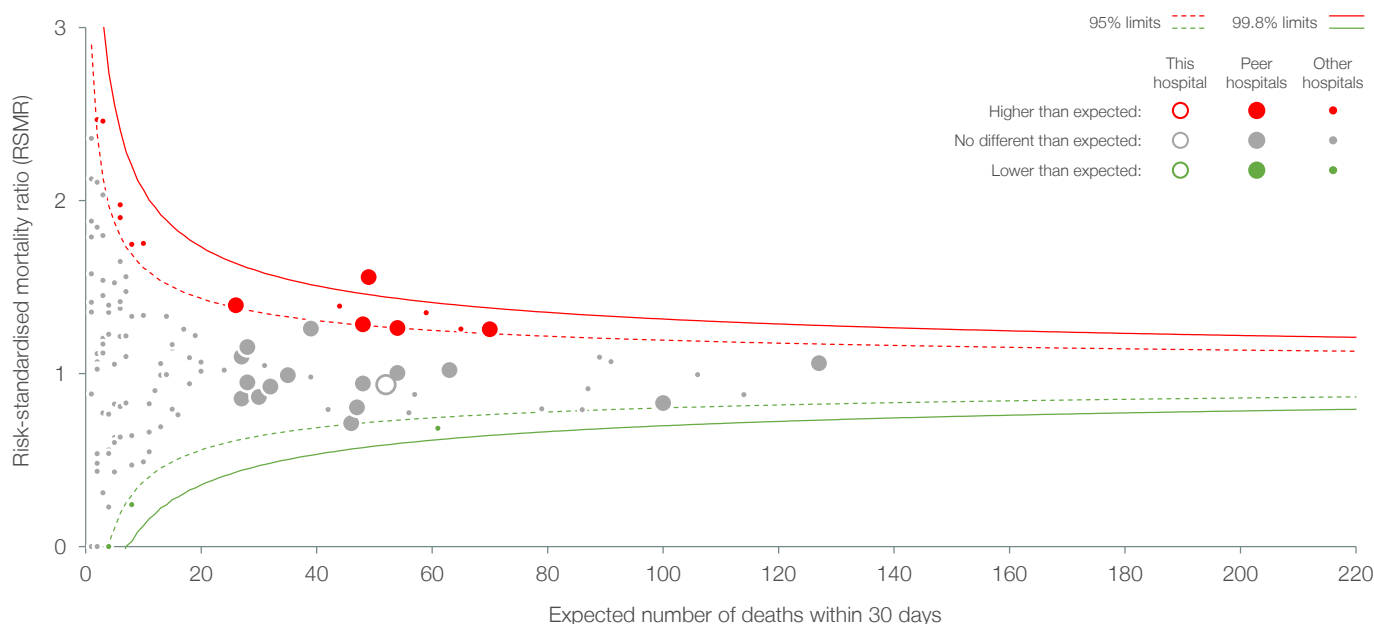
Cumulative mortality following hospitalisation for chronic obstructive pulmonary disease, this hospital and NSW⁴



Sutherland Hospital

30-day mortality following hospitalisation for chronic obstructive pulmonary disease, July 2012 – June 2015

Chronic obstructive pulmonary disease risk-standardised mortality ratio by number of expected deaths, NSW public hospitals⁵



Illustrating the effect of standardisation, July 2012 – June 2015

In order to make fair comparisons, a number of risk adjustments are made to mortality data. These take into account patient factors that influence the likelihood of dying. The table below illustrates the effect of statistical adjustments on this hospital's results.

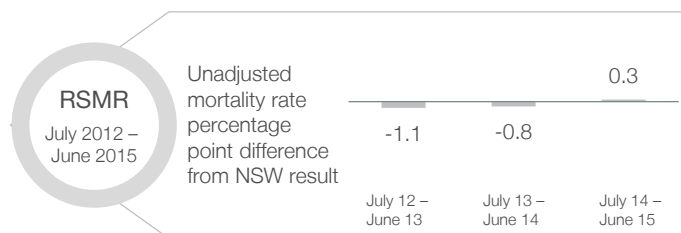
Unadjusted ratio	Age and sex standardised ratio	Risk-standardised mortality ratio
0.98	0.93	0.94
Ratio: ■ Lower than expected ■ No different than expected ■ Higher than expected		

The extent to which comorbidities are coded in the patient record may affect risk adjustment. Therefore the 'depth of coding'⁶ has been assessed across NSW hospitals. In July 2009 – June 2012, the average depth of coding was 3.0 diagnoses in this hospital and 3.6 in NSW; and in July 2012 – June 2015, there were 4.1 diagnoses in this hospital and 4.3 in NSW.

Three-yearly RSMR and annual unadjusted mortality rates

The RSMR is calculated on the basis of three years of data. It takes account of differences in patient characteristics so that assessments of hospital performance are fair. To give an indication of results within the three-year period, the figure below shows the RSMR result for July 2012 – June 2015 alongside differences between this hospital and the NSW result for annual unadjusted mortality rates.

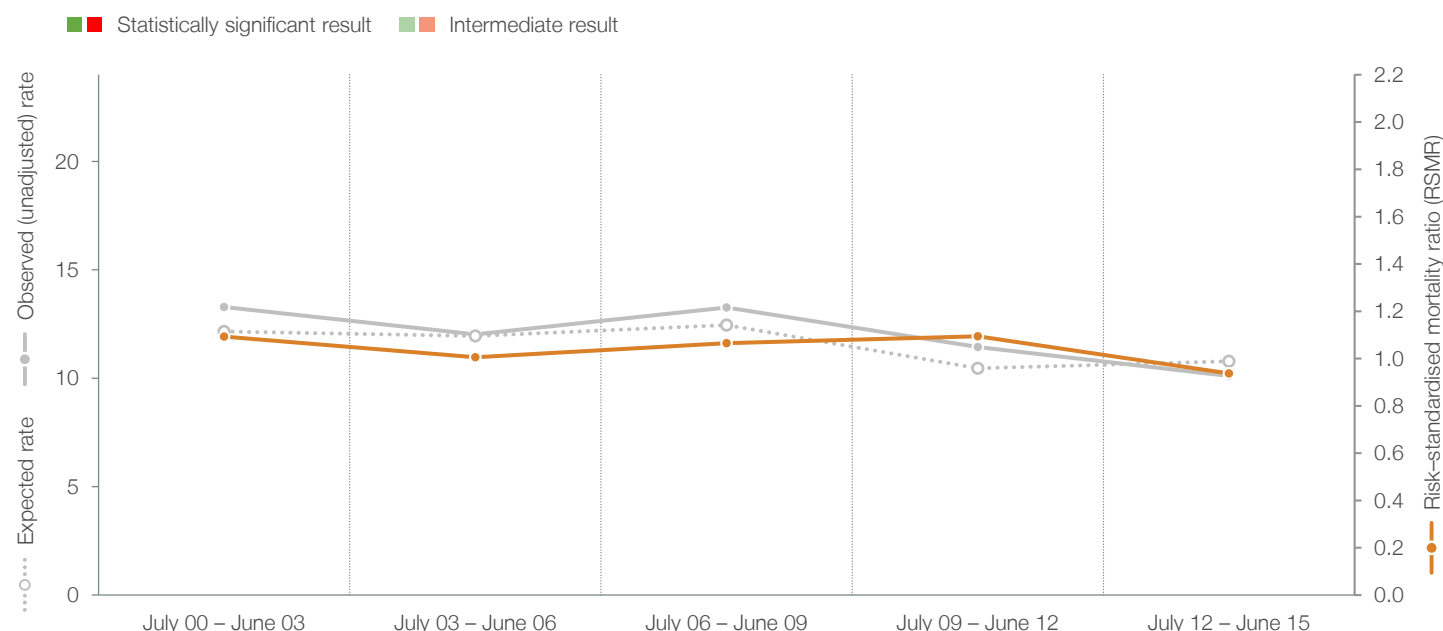
RSMR: ○ Lower than expected ○ No different than expected ○ Higher than expected



Sutherland Hospital

30-day mortality following hospitalisation for chronic obstructive pulmonary disease, July 2012 – June 2015

Chronic obstructive pulmonary disease, this hospital's risk-standardised mortality ratio, expected mortality rates and observed (unadjusted) mortality rates, July 2000 – June 2015



Notes

1. Data refer to patients who were discharged between July 2012 and June 2015 who were initially admitted to this hospital (regardless of whether they were subsequently transferred) in their last period of care, for an acute and emergency hospitalisation with COPD as principal diagnosis (ICD-10-AM code J41, J42, J43, J44, J47, and J20 and J40 if accompanied by J41, J42, J43, J44 and J47 in any secondary diagnoses). Deaths are from any cause, in or out of hospital within 30 days of the hospitalisation admission date.
2. Age at admission date.
3. Comorbidities as recorded on patient record, with one year look back from the admission date of the index case. Many are a result of end-organ damage resulting from comorbidities, such as diabetes. The Australian Commission on Safety and Quality in Healthcare comorbidity list was used for acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip fracture surgery. The Elixhauser comorbidity list was used for congestive heart failure and chronic obstructive pulmonary disease. STEMI refers to ST-elevation myocardial infarction. Only those conditions that were shown to have a significant impact on mortality ($P < 0.05$) are shown.
4. Cumulative percentage of deaths over the 30 days following admission to hospital for the relevant condition.
5. Results for hospitals with expected deaths < 1 are not shown. Peer hospitals are identified according to the NSW Ministry of Health's peer grouping as of April 2012.
6. The depth of coding has been defined as the average number of secondary diagnosis coded for the index cases. The one year look back method which is used for risk adjustment, to some extent accounts for possible lower depth of coding in some hospitals.

Details of analyses are available in *Spotlight on Measurement: Measuring 30-day mortality following hospitalisation, 2nd edition*.

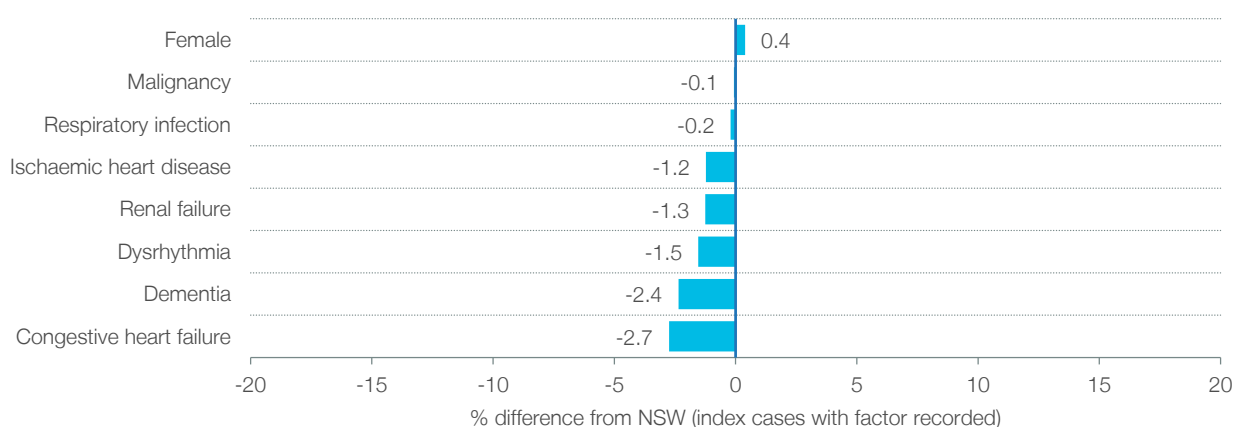
Data source: SAPHaRI, Centre for Epidemiology and Evidence, NSW Ministry of Health.

Sutherland Hospital

30-day mortality following hospitalisation for hip fracture surgery, July 2012 – June 2015

	This hospital	NSW
Total hip fracture surgery hospitalisations	680	23,914
Hip fracture surgery patients		
Presenting patients (index cases) ¹	524	16,193
Patients transferred to another hospital within 30 days	98	6,987
Percentage of patients aged 65+ years* ²	95.0%	94.3%
Percentage of patients aged 75+ years* ²	86.8%	81.6%

Significant patient factors and comorbidities, this hospital, index cases³



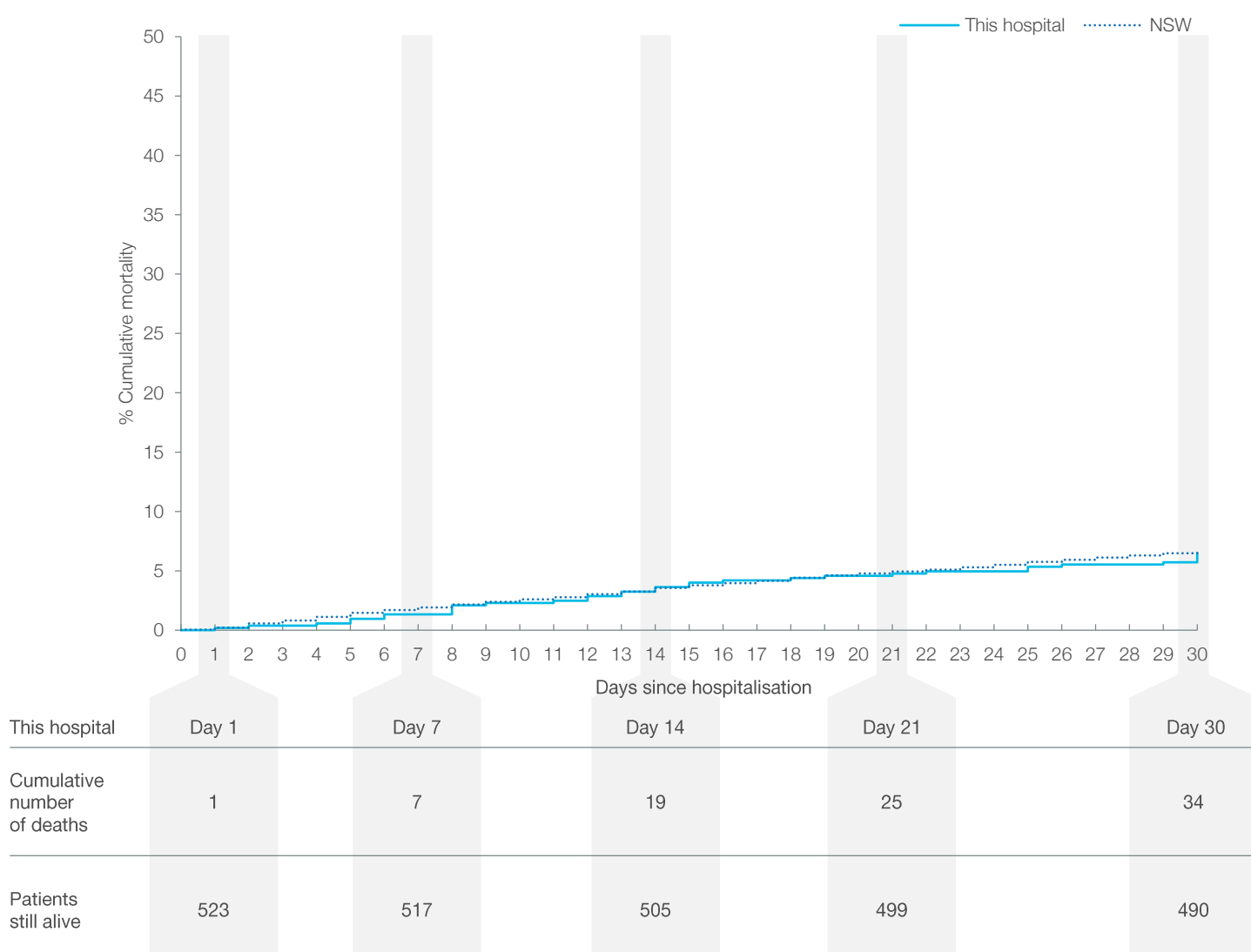
*Age was a significant factor in the final model of 30-day mortality following hospitalisation for hip fracture surgery.

Sutherland Hospital

30-day mortality following hospitalisation for hip fracture surgery, July 2012 – June 2015

	This hospital	NSW
Mortality (all causes) among 524 hip fracture surgery index cases	34 (6.5%)	1,093 (6.7%)
Percentages: index cases who died within 30 days of hospitalisation		
Where deaths occurred:		
Percentage in this hospital	44.1%	46.9%
Percentage in another hospital following transfer	2.9%	0.4%
Percentage after discharge	52.9%	52.7%
When deaths occurred:		
Percentage on day of admission	0.0%	0.5%
Percentage within seven days	20.6%	28.4%

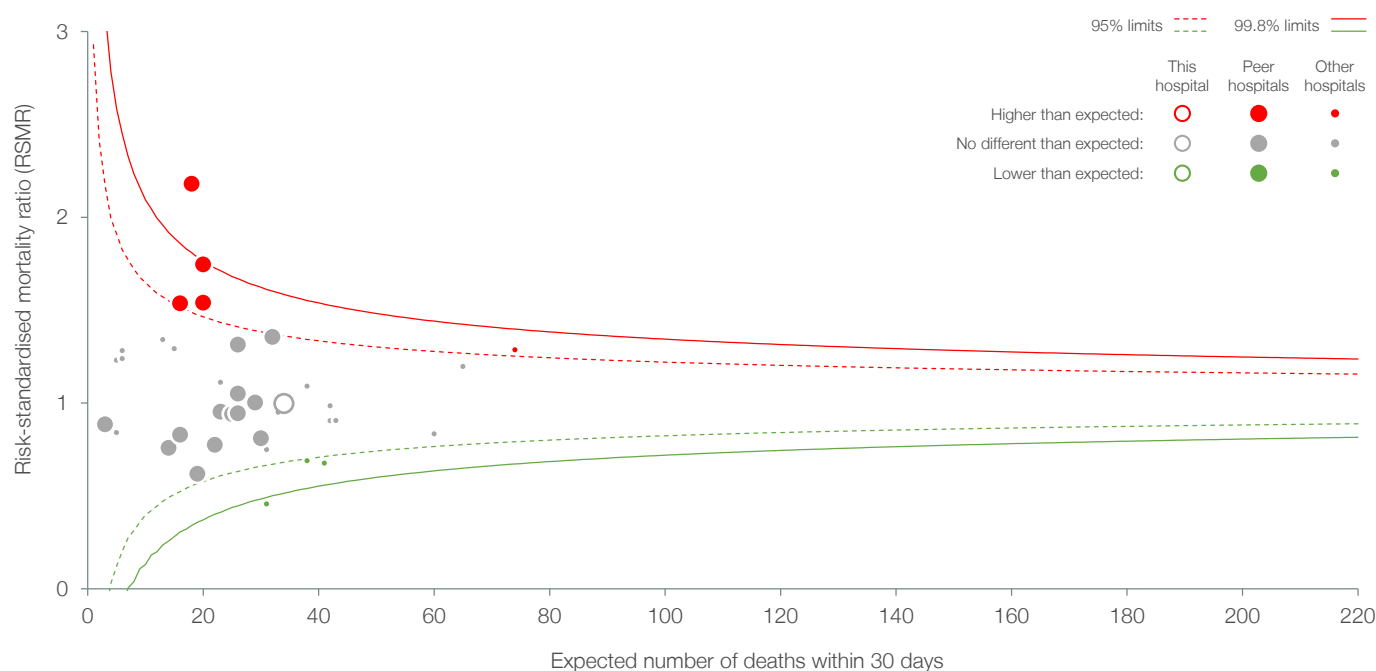
Cumulative mortality following hospitalisation for hip fracture surgery, this hospital and NSW⁴



Sutherland Hospital

30-day mortality following hospitalisation for hip fracture surgery, July 2012 – June 2015

Hip fracture surgery risk-standardised mortality ratio by number of expected deaths,
NSW public hospitals⁵



Illustrating the effect of standardisation, July 2012 – June 2015

In order to make fair comparisons, a number of risk adjustments are made to mortality data. These take into account patient factors that influence the likelihood of dying. The table below illustrates the effect of statistical adjustments on this hospital's results.

Unadjusted ratio	Age and sex standardised ratio	Risk-standardised mortality ratio
0.96	0.91	1.00
Ratio: ■ Lower than expected	■ No different than expected	■ Higher than expected

The extent to which comorbidities are coded in the patient record may affect risk adjustment. Therefore the 'depth of coding'⁶ has been assessed across NSW hospitals. In July 2009 – June 2012, the average depth of coding was 7.3 diagnoses in this hospital and 8.5 in NSW; and in July 2012 – June 2015, there were 8.4 diagnoses in this hospital and 9.4 in NSW.

Three-yearly RSMR and annual unadjusted mortality rates

The RSMR is calculated on the basis of three years of data. It takes account of differences in patient characteristics so that assessments of hospital performance are fair. To give an indication of results within the three-year period, the figure below shows the RSMR result for July 2012 – June 2015 alongside differences between this hospital and the NSW result for annual unadjusted mortality rates.

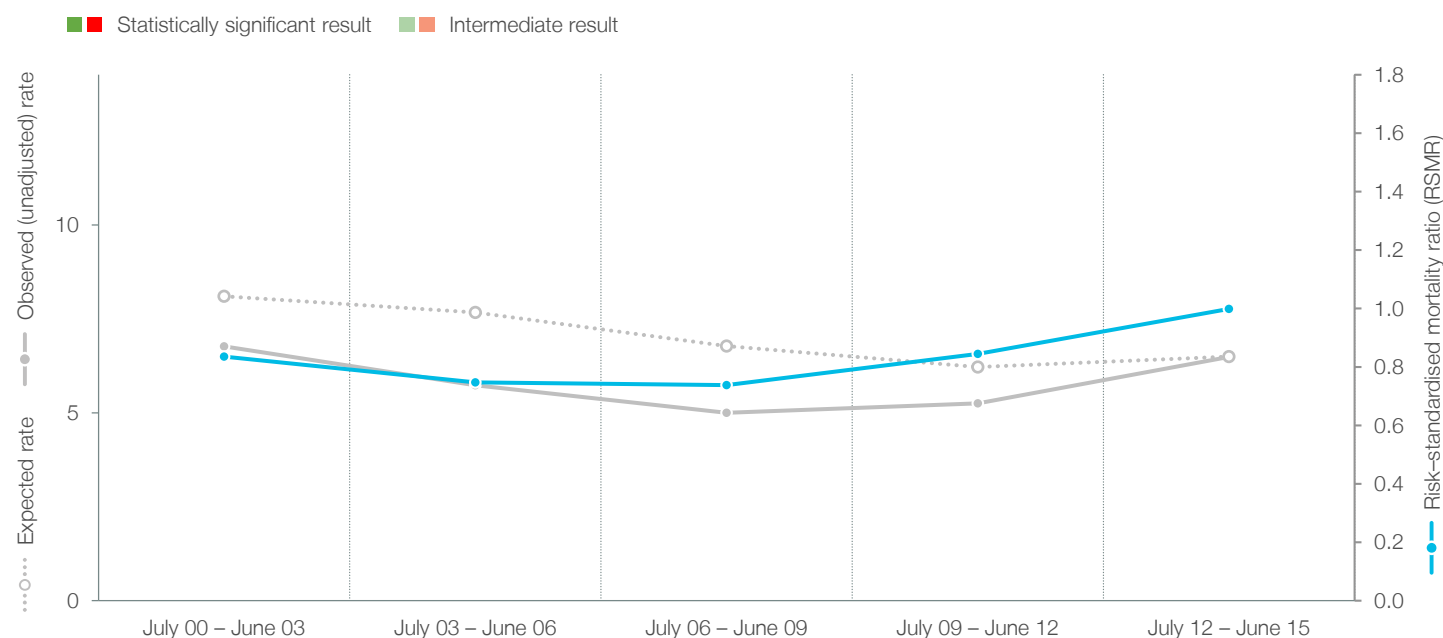
RSMR: ○ Lower than expected ○ No different than expected ○ Higher than expected



Sutherland Hospital

30-day mortality following hospitalisation for hip fracture surgery, July 2012 – June 2015

Hip fracture surgery, this hospital's risk-standardised mortality ratio, expected mortality rates and observed (unadjusted) mortality rates, July 2000 – June 2015



Notes

1. Data refer to patients who were discharged between July 2012 and June 2015 who were initially admitted to this hospital (regardless of whether they were subsequently transferred) in their last period of care, for an acute hospitalisation with hip fracture as principal diagnosis and treated with surgery (ICD-10-AM codes for hip fracture S72.0, S72.1, S72.2 accompanied with a fall codes W00-W19 and R29.6 and treated with a surgical procedure). Deaths are from any cause, in or out of hospital within 30 days of the hospitalisation admission date.
2. Age at admission date.
3. Comorbidities as recorded on patient record, with one year look back from the admission date of the index case. Many are a result of end-organ damage resulting from comorbidities, such as diabetes. The Australian Commission on Safety and Quality in Healthcare comorbidity list was used for acute myocardial infarction, ischaemic stroke, haemorrhagic stroke, pneumonia and hip fracture surgery. The Elixhauser comorbidity list was used for congestive heart failure and chronic obstructive pulmonary disease. STEMI refers to ST-elevation myocardial infarction. Only those conditions that were shown to have a significant impact on mortality ($P < 0.05$) are shown.
4. Cumulative percentage of deaths over the 30 days following admission to hospital for the relevant condition.
5. Results for hospitals with expected deaths < 1 are not shown. Peer hospitals are identified according to the NSW Ministry of Health's peer grouping as of April 2012.
6. The depth of coding has been defined as the average number of secondary diagnosis coded for the index cases. The one year look back method which is used for risk adjustment, to some extent accounts for possible lower depth of coding in some hospitals.

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Data source: SAPHaRI, Centre for Epidemiology and Evidence, NSW Ministry of Health.