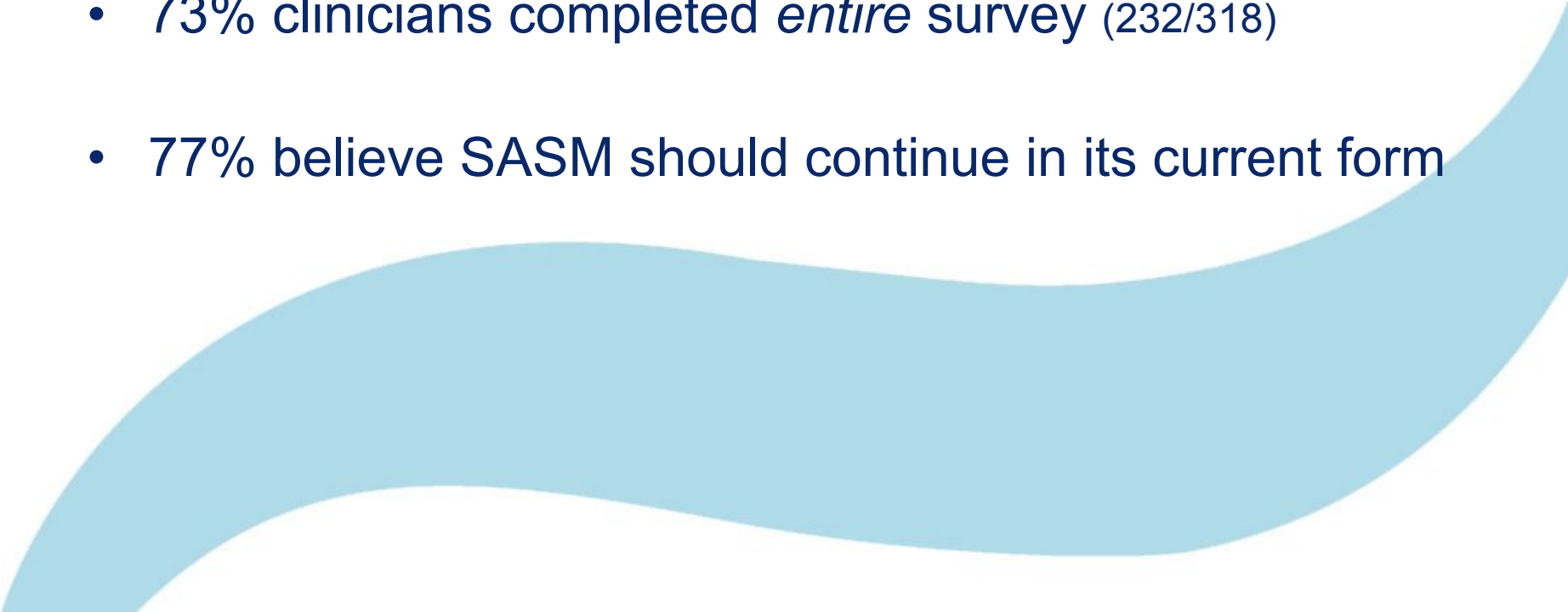


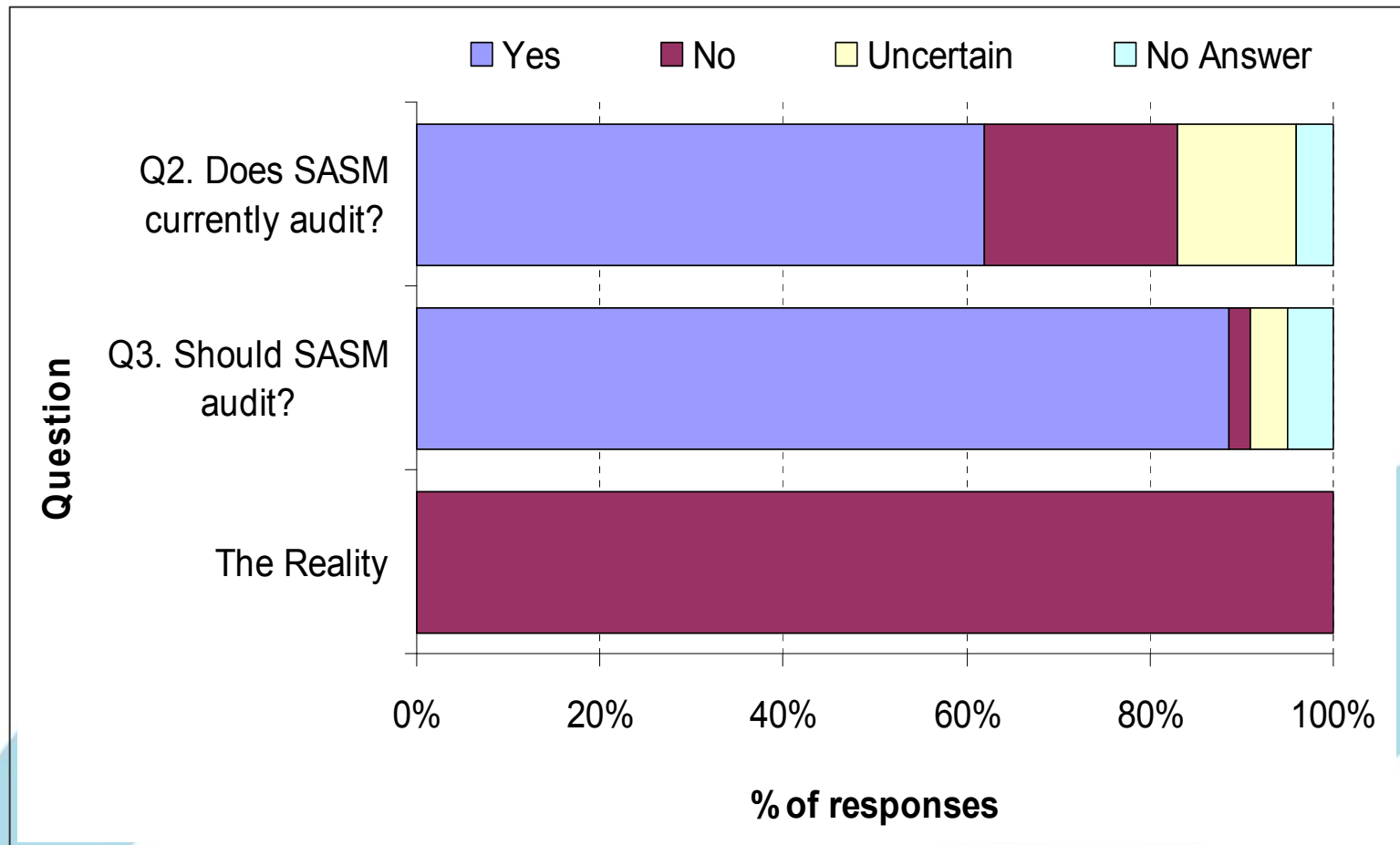
SASM Survey Results

A large, light blue wavy graphic that curves across the bottom of the slide.

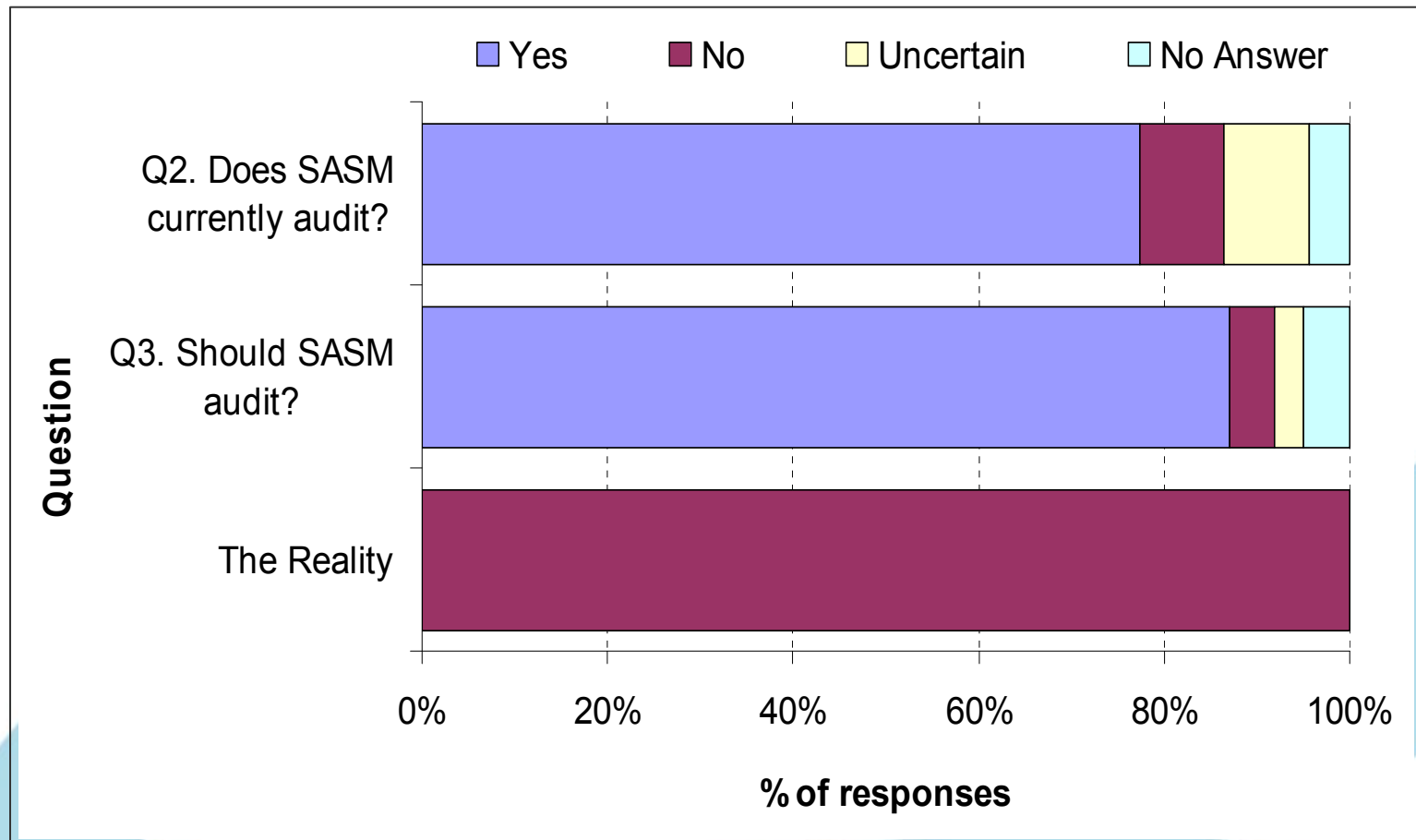
Introduction

- 14% clinicians filled in survey (318/2331)
 - 73% clinicians completed *entire* survey (232/318)
 - 77% believe SASM should continue in its current form
- 
- A large, light blue wavy graphic that starts from the bottom left and curves upwards towards the right, spanning the width of the slide.

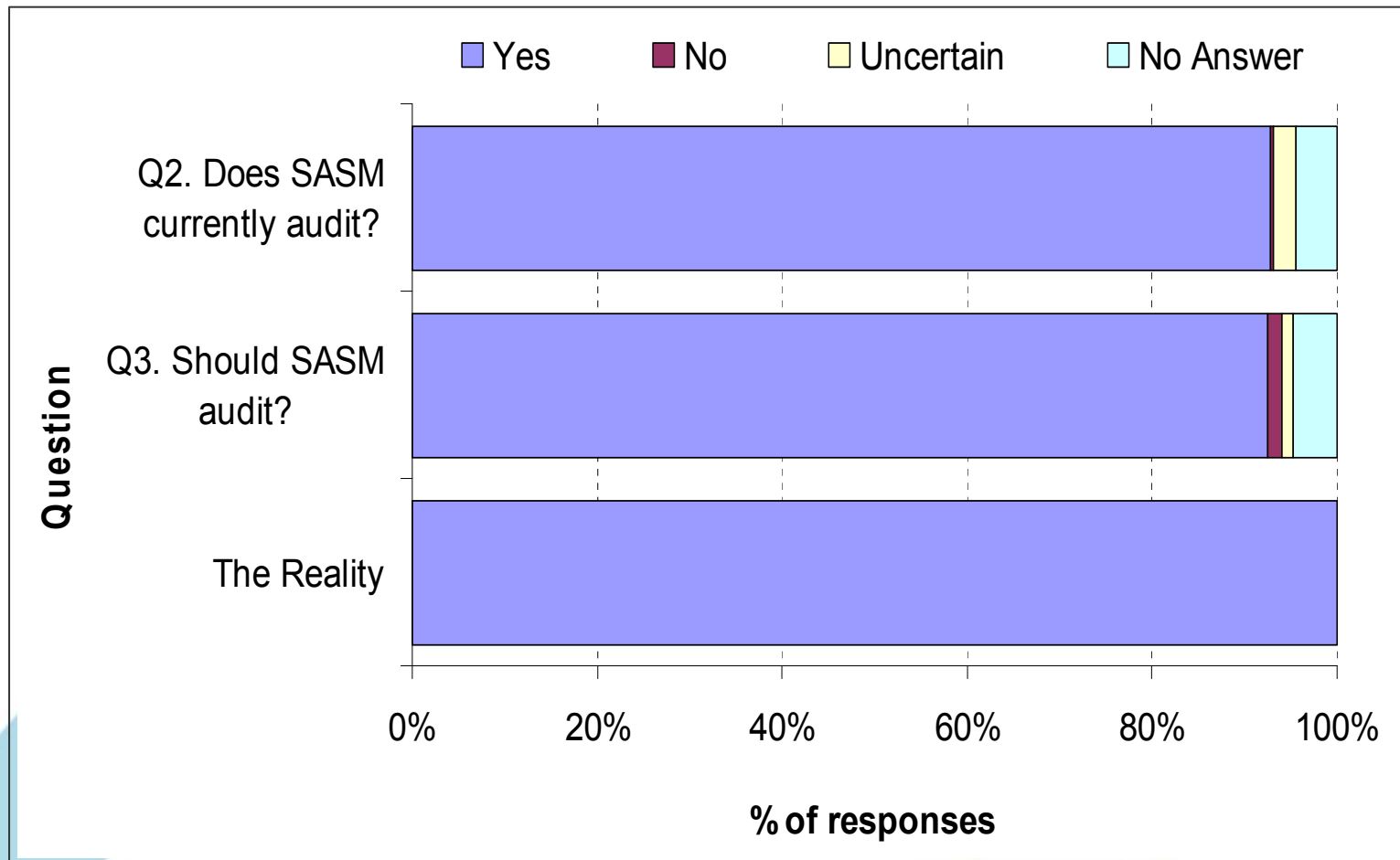
Patient admitted under the care of a surgeon,
operation on day 1, was discharged and **died at home** on 6th post operative day



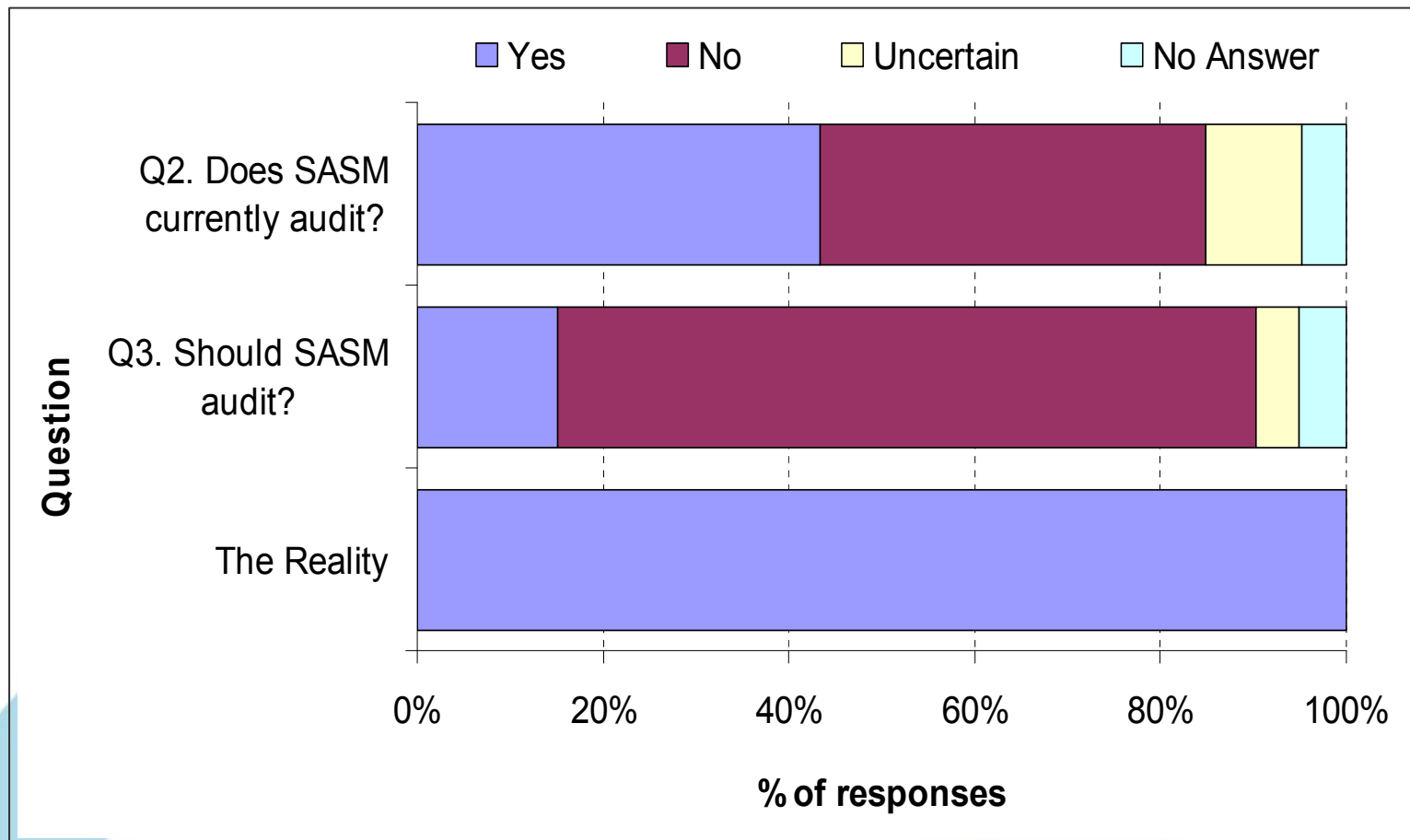
Patient admitted under the care of a surgeon,
operation on day 1, then transferred into care of
non-surgical specialty on day 4, died on day 6



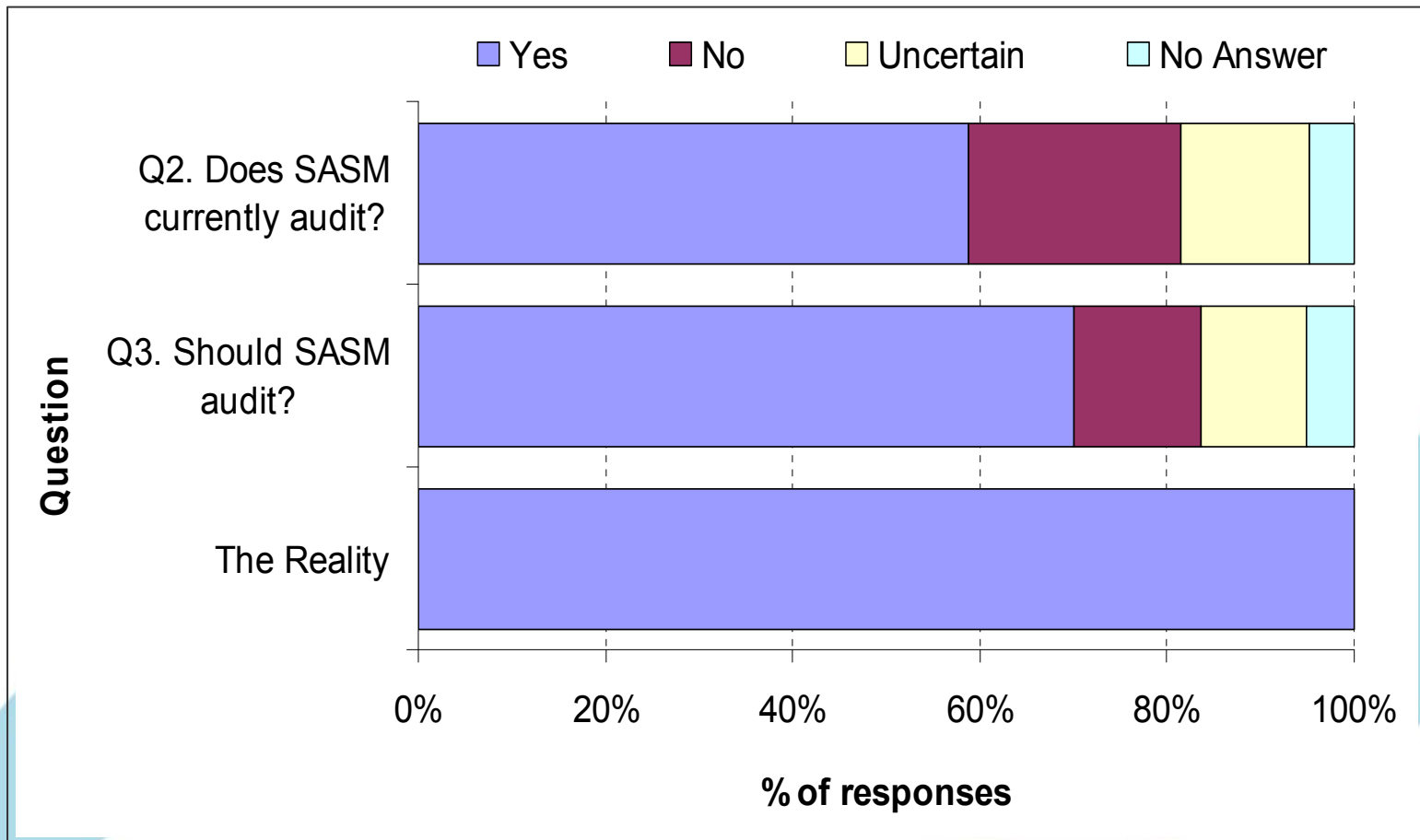
Patient admitted under the care of a surgeon,
operation on day 1, died still under care of a
surgeon on day 6



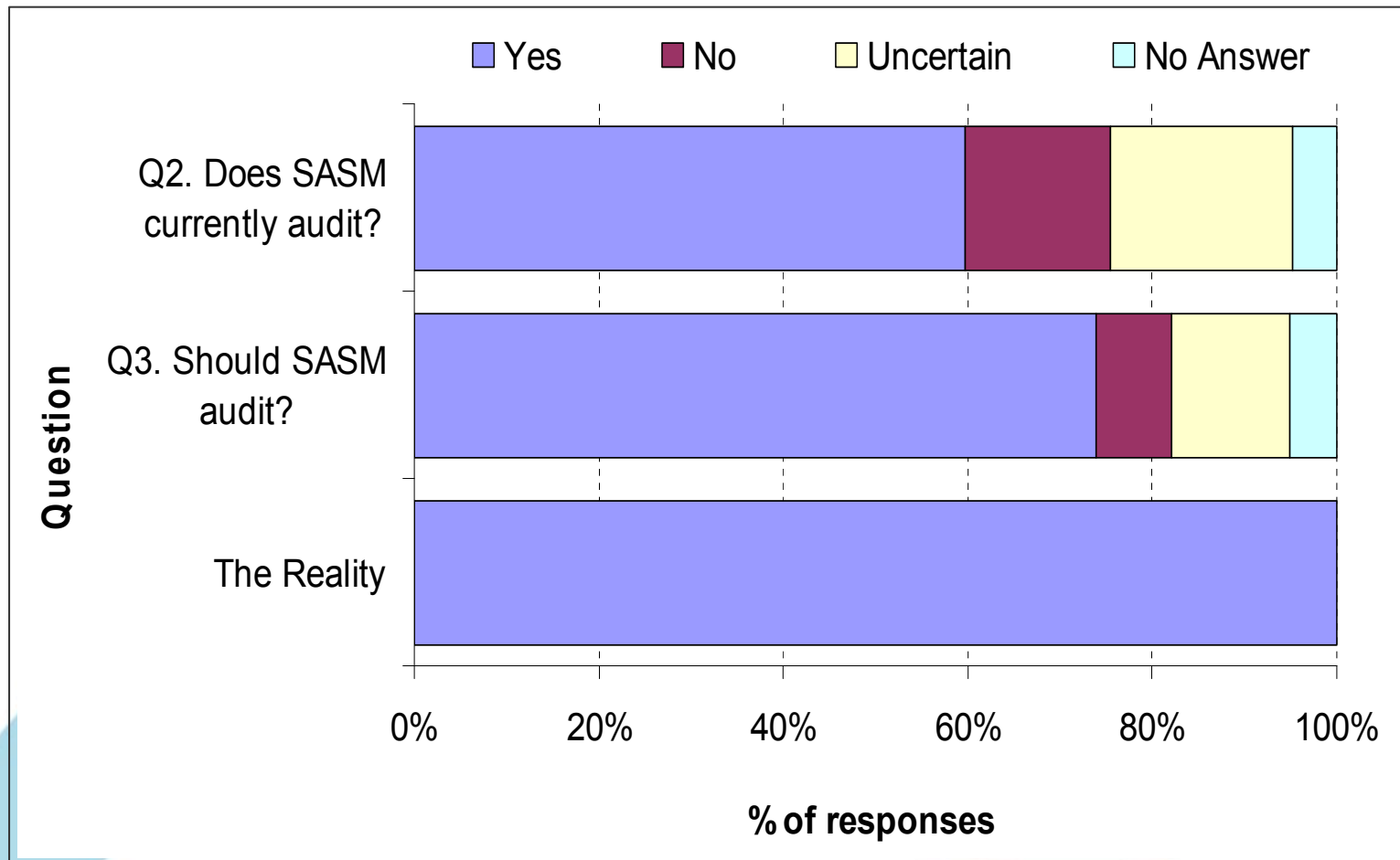
Patient admitted for **palliative care** onto surgical ward under the care of a surgeon on day 1 and died the same day



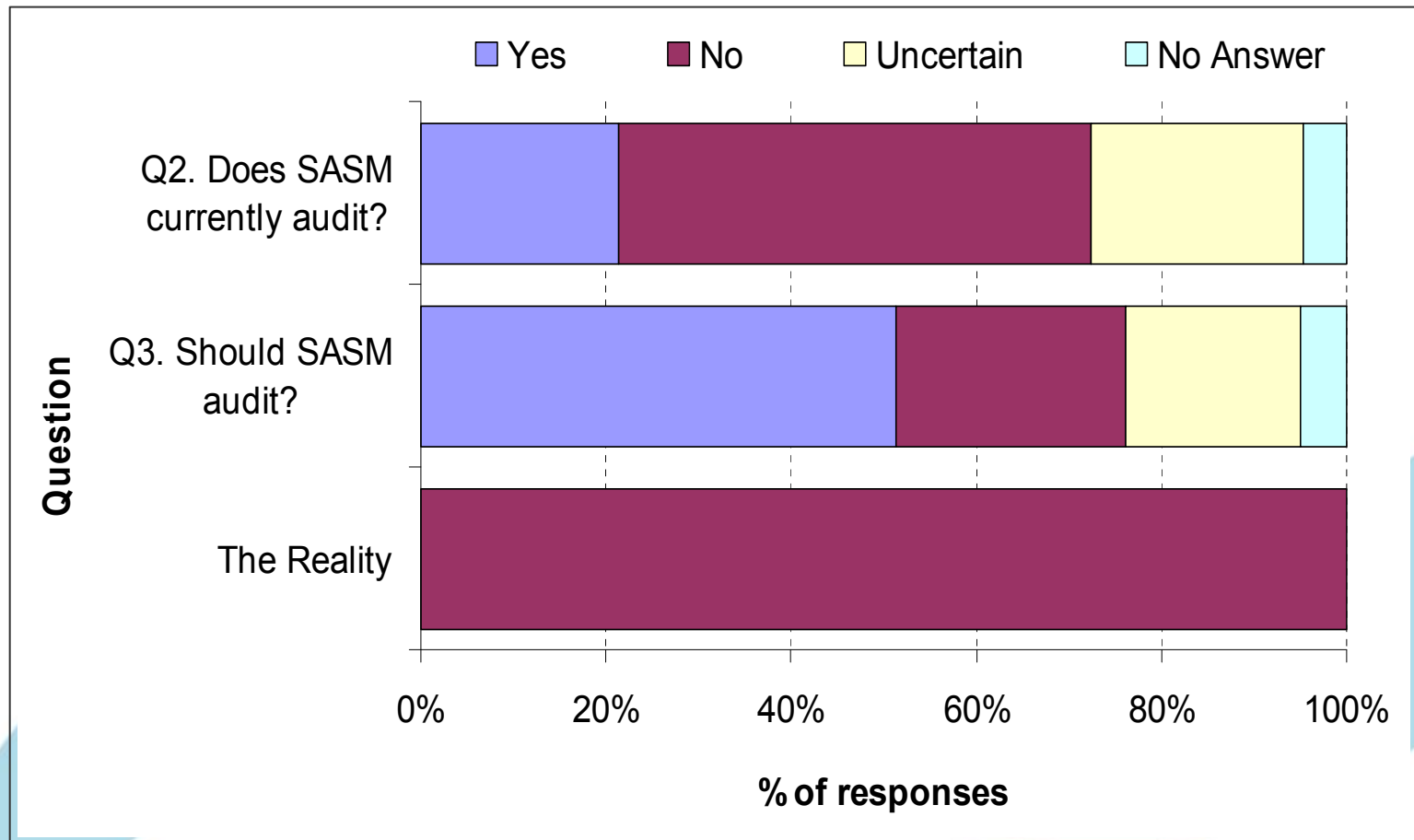
Patient admitted under the care of a surgeon on day 1, **no operation**, died on day 6 still under the care of a surgeon



Patient admitted under care of a surgeon on day 1,
operation on day 2, discharged home on day 6,
readmitted on day 20, died on day 32 whilst still an
 inpatient under the care of a surgeon



Patient admitted under the care of a surgeon on day 1, **no operation**, discharged home on day 4 and **died at home** on day 10



What does SASM actually audit?

SASM audits **inpatient deaths** under the **care of a surgeon**, including:

- palliative care
- non-operative deaths
- in-patient deaths 30+ days after admission

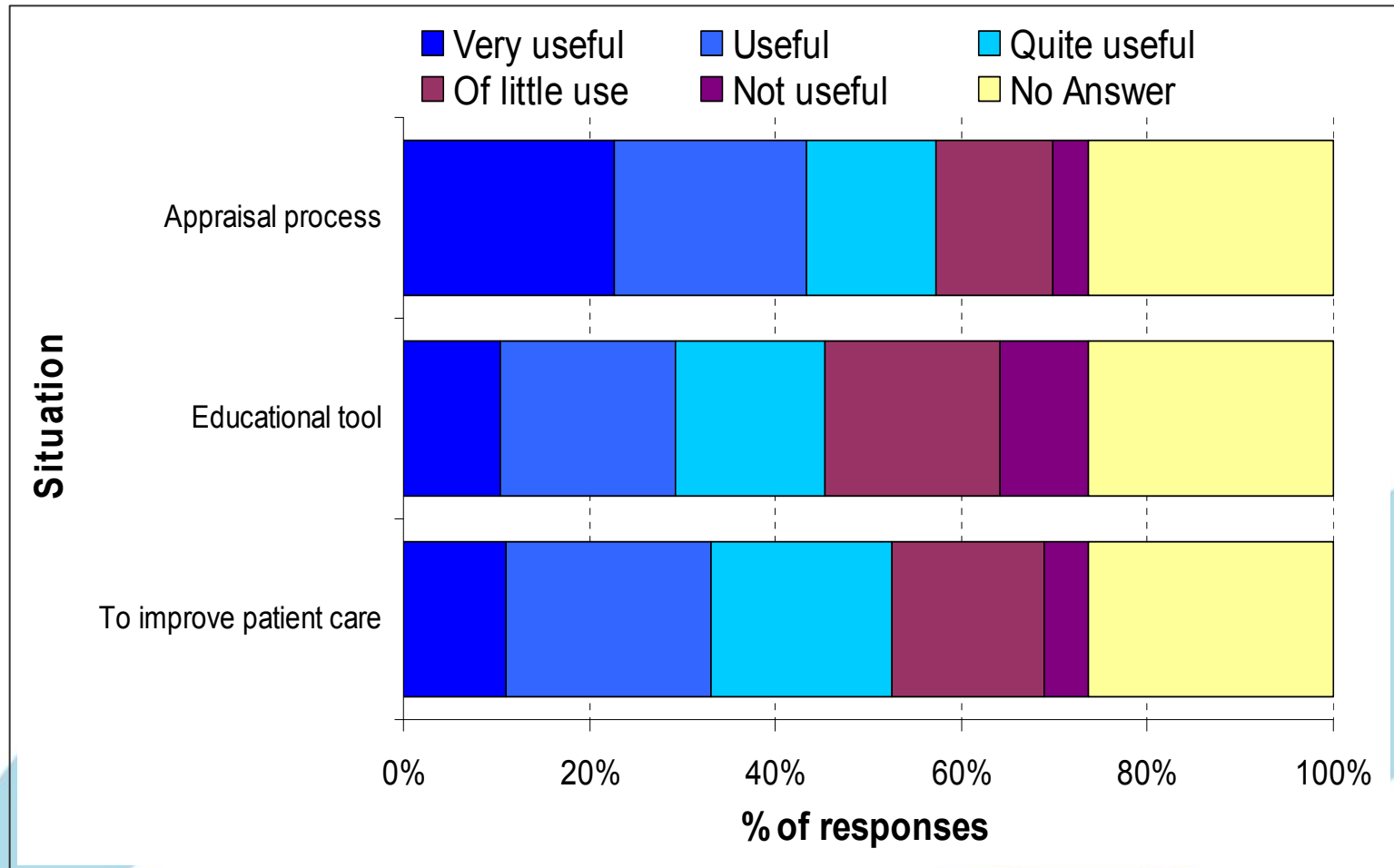
SASM does **not** audit patients who die:

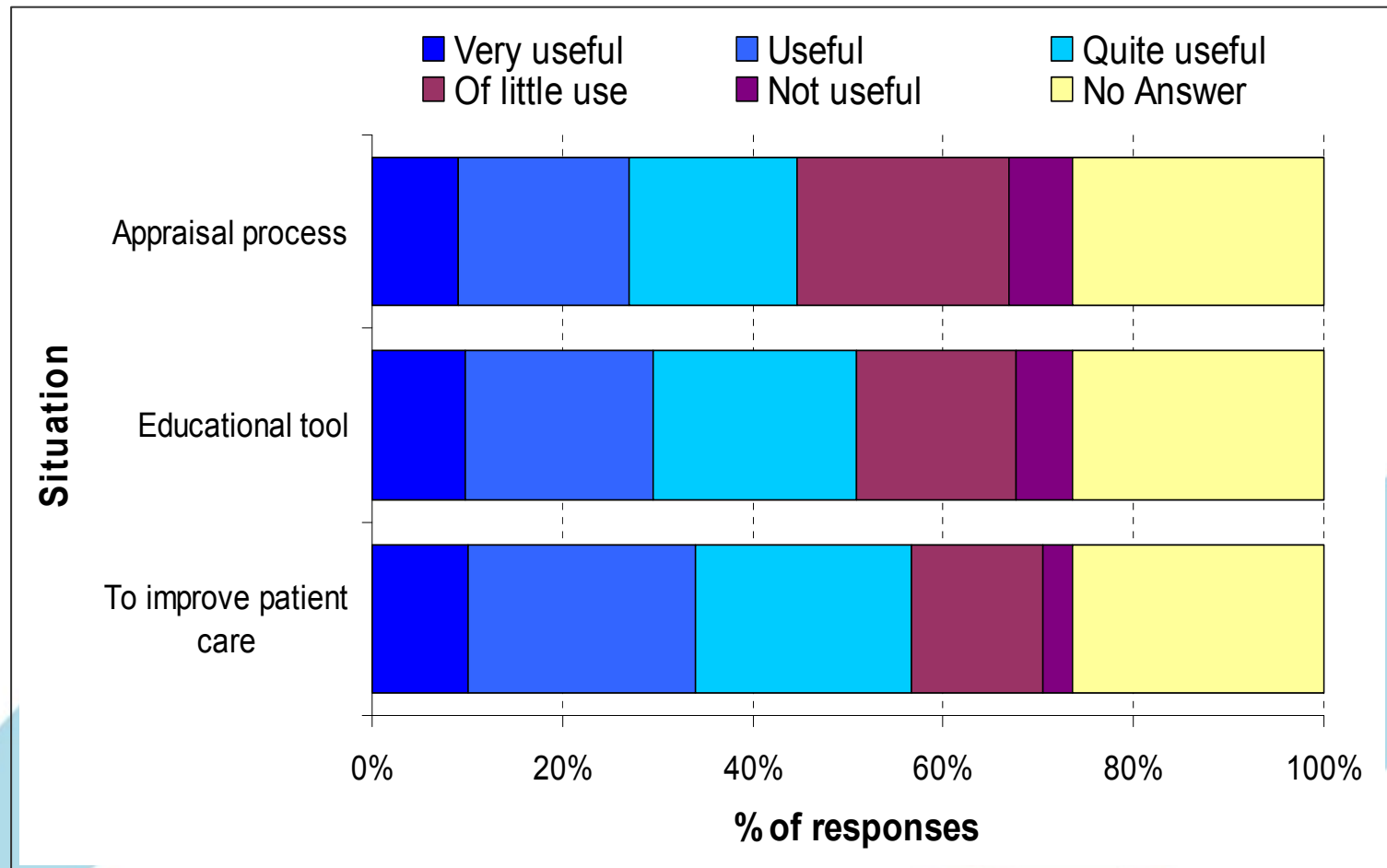
- at home
- in non-surgical specialties

You think SASM *should* audit:

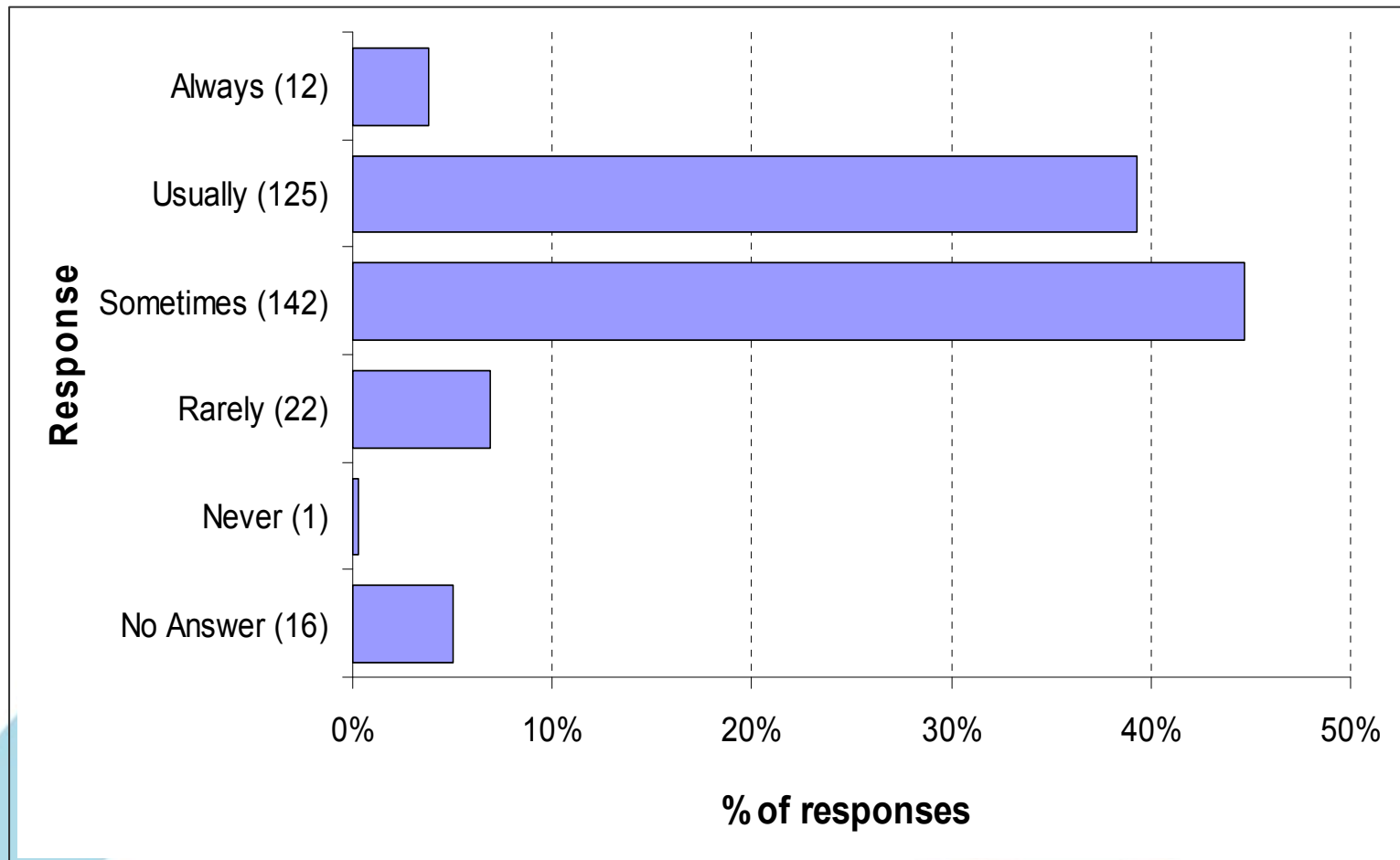
- 65% All deaths (208/318)
- 19% Deaths where a problem was identified (60/318)
- 11% Random sample (36/318)
- 4% No answer (14/318)

Individual Annual Reports (IARs)





When cases are reviewed at local M&M meeting, are lessons learned consistently applied thereafter?





- The SPSP is being implemented in every acute hospital across Scotland
- Co-ordinated by Healthcare Improvement Scotland
- The SPSP's objective is to improve the safety of hospital care across Scotland
- The SPSP has set the following targets:

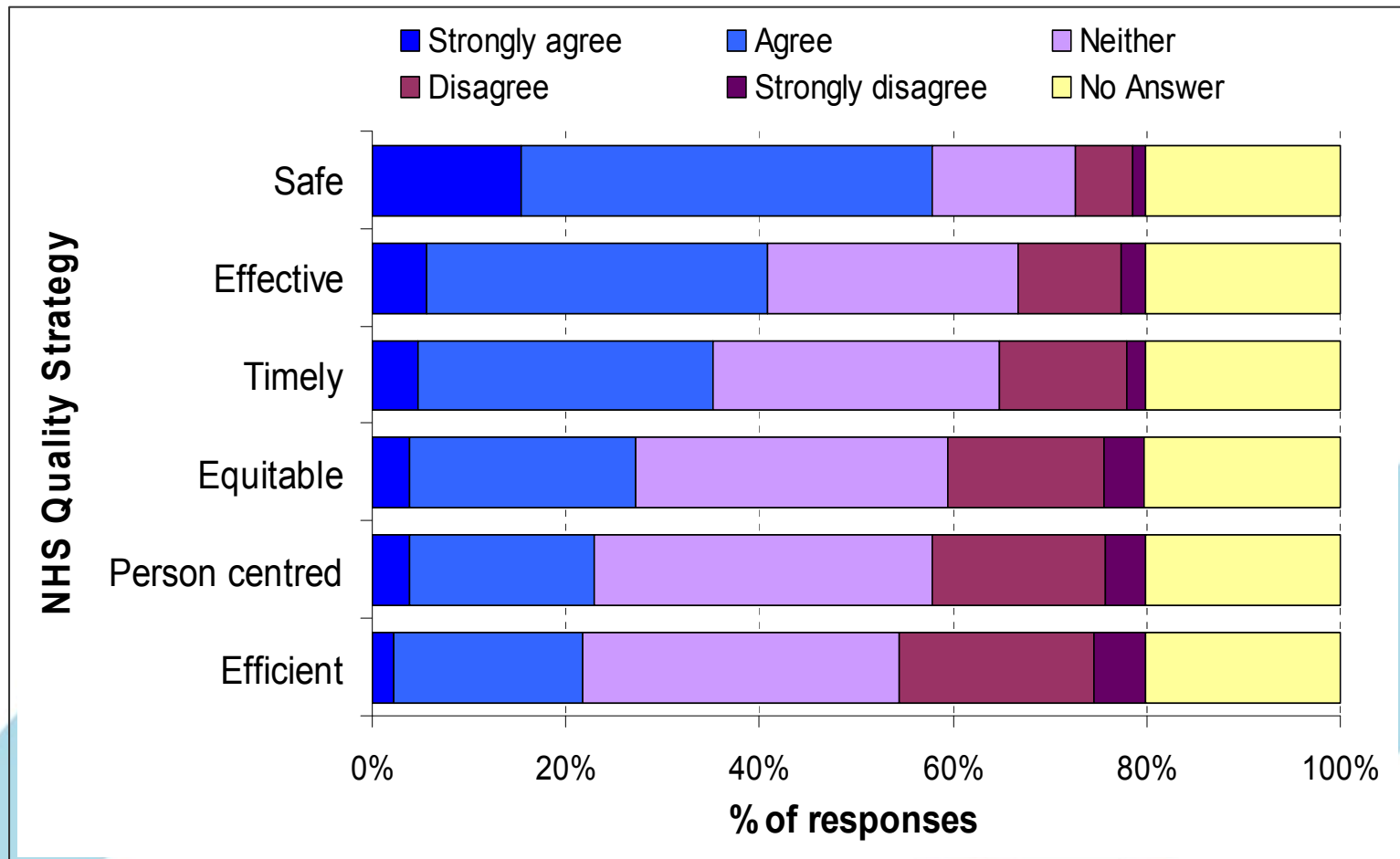
15% reduction in surgical mortality

30% reduction in adverse events

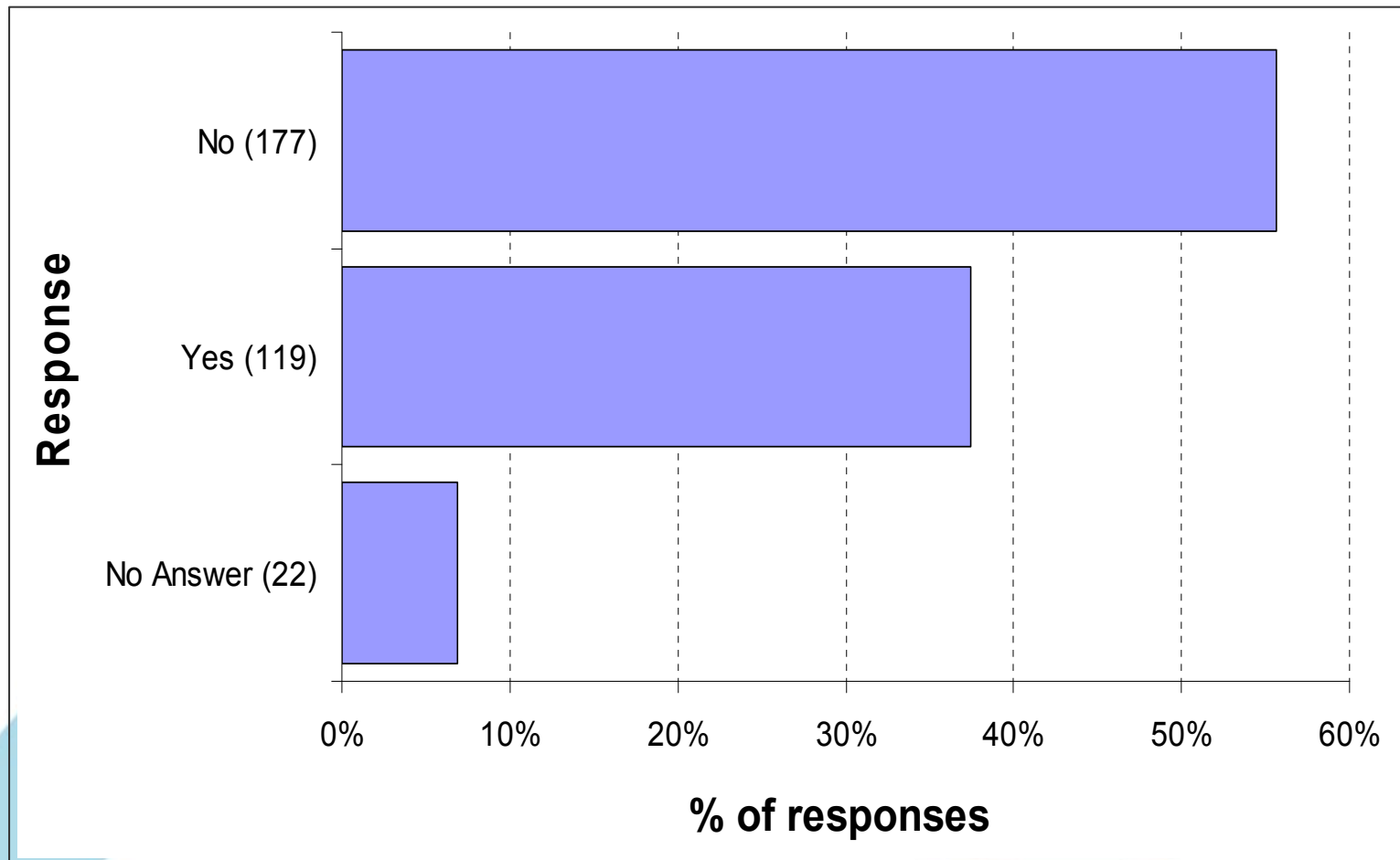


- 47% believe that SASM **can** impact on these targets
(149/318)
- 34% clinicians answered “No” (108/318)
- 19% clinicians didn’t answer (61/318)

To what extent do you agree that the information collected by SASM is in alignment with the Quality Strategy?



Do you think that SASM could do more to reduce surgical mortality?



Key Points Summary

- Poor response rate
- Poor understanding of what SASM does
- Disagreement about what it should do
- Lack of alignment with the Quality Strategy
- Reports are of limited use
- M&Ms do not always result in consistent improvement
- Only 38% respondents think SASM can do more

Free Text Comments

- What would you change in SASM?
- What else can SASM do to reduce surgical mortality?
- Is there additional information that SASM should collect?

Over 650 (often diametrically opposing) comments

Themes

- Case ascertainment needs to improve
- Turnaround time needs to be shortened
- Needs to link with local M&Ms
- Lack of a forum at which debate assessor's decision
- Limitations of single assessor process – inter-rater reliability
- Shared learning is needed
- Governance processes need to be tightened up

Themes

- Failure to recognise deterioration
- Communication issues at the interface
- Inappropriate surgical intervention v. palliative care
- Decisions not to operate – are we becoming risk averse?
- Need a system to evaluate and learn from ‘near-misses’
- Co-morbidity – need casemix adjustment?
- Need better denominator data

Themes

- Delays: referral, investigations, results, discharge
- Emergency theatre availability
- Bed availability (surgical and critical care)
- Seniority
- 'Out of hours' staffing levels and seniority
- Access to non-surgical specialties