



SASM Workshop 13TH March 2012 Taking Stock and Scoping the Future Summary of Main Themes

The delegates discussed the fundamental purpose and ambitions for SASM. The summary is outlined below and we would welcome your feedback on the Workshop now that time has elapsed.

CONTEXT

SASM should promote improvements in patient care by supporting local and national measurement for improvement.

SASM should support efforts to improve outcomes for patients. Outcomes include mortality. Many clinicians didn't know mortality rates in their hospitals for common high risk surgical subgroups. It is recognised that mortality rate alone is a crude evaluation dependent on complex factors and may not be the only or best assessment of the quality of care.

UK evidence demonstrating widespread deficiencies of care in our systems was acknowledged.

SASM activities should be aligned to strategy and other national pieces such as HSMR, Surgical Profiles and SPSP to avoid duplication and explore opportunities for synergies

There was recognition of the need to develop communication between SASM and individual teams, the public and the press.

OPERATIONAL IMPROVEMENT

Currently there is not a reliable system in place to identify deaths and submit timely case note reviews. In relation to eSASM further evaluation following the meeting showed that the major reason for failure is where a nominated surgeon has neither accepted nor rejected the case. There is a need to make it quick and easy for staff to submit case note evaluations. Self generation of a SASM report by any clinician involved with the case has been proposed. Urgent testing of systems to identify deaths, perform local timely case note review and submission to SASM is required.

There was recognition that the current SASM form (and process) was not the ideal tool to evaluate key markers of care and that the current SASM questions need to be changed. We recognised that some questions may be generic, but others different for different patient groups.

The trigger for case note evaluation should continue to be death though future use of other selection criteria to trigger case note review were not discounted. The ability to submit and assess near misses and critical incidents was identified as a possibility.

We agreed that data collection should be rewarded by timely feedback to local teams. There was interest to involve other health care professionals.

There was a will to see greater alignment of the SASM process with local clinical governance and morbidity /mortality meetings.

LEARNING

We recognised that SASM could be a conduit for education, learning and sharing examples of good care and excellence.

FUTURE DEVELOPMENT

Measurements need to be clinically valid. There was agreement to include evaluation of the process in relation to “ human factors” e.g. communication at the interface. We recognised that the current SASM form questions need to be changed and that these may need to vary for different patient populations or surgical specialties. Specific patient subgroups at high risk of death were identified as priority areas. Two groups highlighted were emergency laparotomy and fixation of neck of femur fracture. A number of teams offered to develop and test new questions and forms.

There was support for a team based analysis of care and a worked example where a surgeon and anaesthetist met and collaborated to evaluate a patient death and complete a single new SASM form. There is interest to evaluate whole system care from door to death for our highest risk patients, looking beyond the intra-operative performance of anaesthetist and surgeon.

Better understanding of clinician’s local systems will allow better targeted interventions to improve care and outcomes for patients.

We recognised the importance of designing systems to deliver simple things reliably including:-

- rescue of the deteriorating patient
- early recognition and treatment of sepsis
- administration of antibiotics
- prevention of VTE
- prevention of surgical site infection
- avoidance of medication error
- mitigation of human factors

Interventions associated with reduced mortality and complications such as the SURPASS system and The Surgical Safety Checklist was recognised.

The possibility to develop the involvement of patient and family members with SASM was discussed. There was support from the patient representative at the meeting. However clinicians held varying views, no concrete agreement made.