



Changes to the Annual Report

This year a limited number of paper copies of the Annual Report with data from deaths occurring in 2007 will be made available at the launch on Wednesday 10th December 2008 at the Assessors meeting. The full Annual Report will however be available on the SASM website at www.sasm.org.uk from 9.30 that morning and participants are encouraged to download the report from the site.

There has been concern that the lag period between data collection and feedback via Individual Annual Reports and the Annual Report is too long to be meaningful. In order to improve this, from 2009, the audit proposes to accelerate the process giving fixed time limits on participants, assessors, case-

note reviewers, co-ordinators and the audit staff at Cirrus.

The key differences to the process are

- it is expected that surgeons will complete and return their proformas within 4 weeks
- surgeons will be asked to identify the anaesthetist, intensivist and interventional radiologists who were involved in that patients care
- SASM will then send forms to the appropriate individuals who will also have a 4 week period to return the completed forms
- assessors and coordinators are expected to respond within a 2 week time-frame

- case note reviewers will be given 4 weeks to complete and return their case note reviews.

The SASM office will send out regular reminders if these time limits are missed. It is planned that the annual report on deaths occurring in 2008 will be published in August 2009 with individual reports being sent out in September 2009 and hospital reports available in October 2009. Your co-operation in trying to meet these targets to aid the governance process is essential.

Heather Hosie
West of Scotland
Anaesthetic Coordinator

New Coordinators

Three new coordinators were elected to SASM in the autumn and were welcomed to their first management committee meeting in November. They are Barry McGuire, from Tayside replacing Charles Wallis as East of Scotland Anaesthetic Coordinator, David Smith, also from Tayside, replacing Angus Smith as East of Scotland Surgical Coordinator and Roy Scott from Lanarkshire replacing John Drury as Vascular Surgery Coordinator. The Management Committee would like to thank Charles, Angus and John for their contribution over the past few years and anticipate that they will continue to contribute to the audit.

Two more coordinators posts will become vacant next year with

George Gray, the West of Scotland Surgical Coordinator and Heather Hosie, the West of Scotland Anaesthetic Coordinator coming to the end of their terms of office. The SASM Management Committee propose appointing co-ordinators to these posts by interview rather than election as it concerns members of the committee that very able and active participants in the audit may be disadvantaged by not being well-known outside their Health Board. Details of the process will be published in further newsletters.

Heather Hosie
West of Scotland
Anaesthetic Coordinator

Chair of Liaison Group demits office

Harry McFarlane, who has been involved with SASM since its inception has stood down as Chair of the Liaison Group. All at SASM are extremely grateful to Harry for his continued contribution and enthusiasm to the audit over many years. We will miss his wise words but expect him to continue his involvement in other ways.

Heather Hosie
West of Scotland
Anaesthetic Coordinator

Why look at deaths occurring more than 30 days after operation?

The criteria for including patients within the SASM process were defined in 1994 when SASM began as a result of the national extension and fusion of the Lothian Mortality Study and the Glasgow Audit of Surgical Deaths. That definition includes all patients admitted under surgical care who die within 30 days of surgery or who die during the same admission.

As part of the ongoing dialogue with participants, the question of whether we should continue to examine patients dying more than 30 days after surgery was raised. The point was made that memories diminish over time, it is hard to recollect events accurately and that for many very elderly patients death is, in many cases, inevitable.

The database was scrutinised to examine whether any

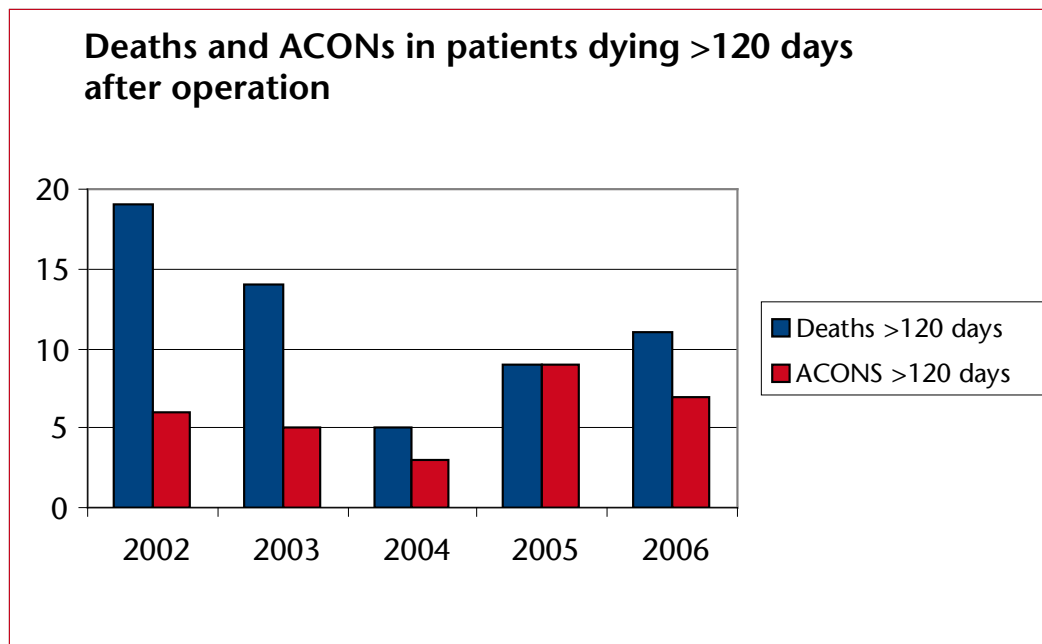
meaningful conclusions can be drawn from deaths occurring in patients more than 30 days after surgery. The database can only be interrogated for operation date from 2002 and so complete data from 2002 – 2006 are included. The proportion of patients who died more than 30 days after operation is remarkably constant over this period.

Year	Total	Deaths	Percentage
2002	1623	211	13.0%
2003	962	133	13.8%
2004	1716	211	12.3%
2005	1705	199	11.7%
2006	1528	182	11.9%

Memories and recollections may fade but does that mean that in these patients fewer areas for consideration or concern are seen? From the database, the opposite appears to be the case, with an increasing proportion of ACONs and higher proportion of late deaths being associated with ACONs.

Year	<30 days	ACONs	%	>30 days	ACONs	%
2002	1412	516	36.5%	211	49	23.2%
2003	829	234	28.2%	133	35	26.3%
2004	1505	785	52.2%	211	119	56.4%
2005	1506	798	53.0%	199	107	53.8%
2006	1346	622	46.2%	182	134	73.6%

Most of the deaths occurring after 30 days occur in the period 31 – 60 days but there is a small consistent tail of patients dying more than 120 days after operation who have been evaluated over this 5 year time-frame. In this group of 58 patients, 38 (65%) had no ACONs and this may reflect the inevitability of death in some patients. In the remaining 20 patients, 30 ACONs were identified.



A mapping exercise on the ACONs for patients dying more than 120 days after surgery was performed using the new codebook, introduced in 2007, to classify them as errors of delay, omission, commission, communication, resource or as a clinical event. ACONs are further classified as to involving presentation, diagnosis, resuscitation, preparation, operative, endoscopy, anaesthetic, bleeding/blood, postoperative care, critical care, infection, nutrition, drugs or miscellaneous. It was possible to directly map 19 of the original ACONs directly onto the new coding structure with 1 now classified as a clinical event (patient/relatives refused treatment). Of the 10 ACONs that could not be directly mapped to a single code, 4 were mapped under the broader classifications and 6 remain unmapped. These were skin complication (1), miscellaneous complication (2), transfer should have occurred (1), respiratory tract (1) and patient factors (1).

	Delay	Omission	Commission	Communication	Resource
Presentation	2				
Diagnosis		1			1
Operative			6		
Endoscopy			1		
Anaesthesia		2	1		
Bleeding/blood	1				
Postop care	1				
Drugs		1			
Miscellaneous		1		5	

It would seem that, in this small subgroup of patients dying some considerable time after operation, areas for consideration or of concern can still be identified; some of these relate to pre and perioperative phases of care and thus are still relevant to the teams concerned.

Heather Hosie, West of Scotland Anaesthetic Co-ordinator
Garry Hecht, SASM Analyst

SASM form process and timescales

