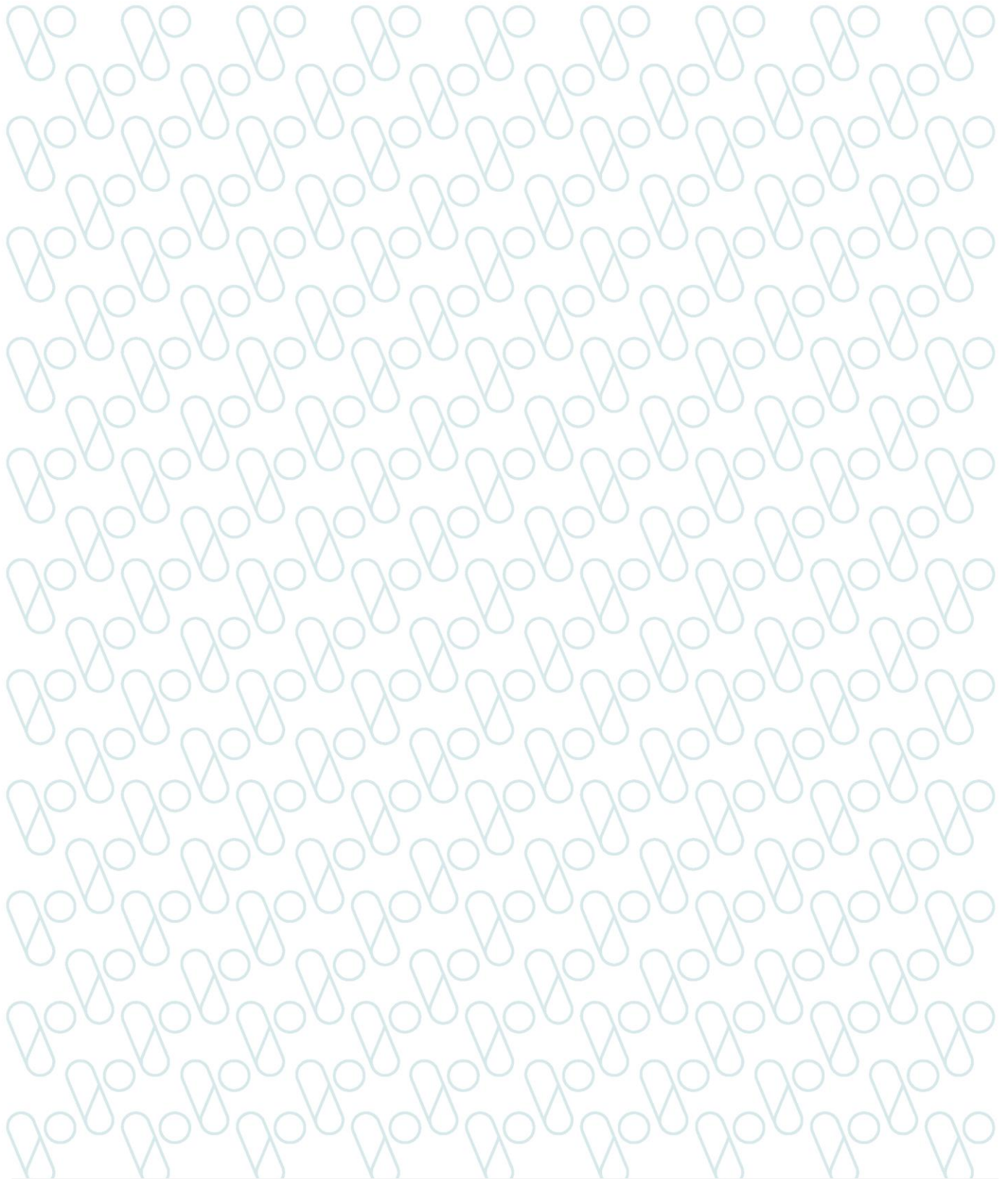


May 2019

The Victorian Perioperative Consultative Council

Improving the review of
perioperative mortality and
morbidity in Victoria





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Executive summary

Patients and their families expect and deserve the best possible procedural outcomes. This is achieved in the first instance by having appropriately trained and skilled healthcare practitioners working in an effective and safe healthcare system. Secondly, when adverse events happen, these incidents need to be investigated, and the learnings from the investigation shared with the individuals involved and the wider organisation.

In response to a recommendation in *Targeting Zero* (Duckett 2016) Safer Care Victoria (SCV) undertook a review to evaluate the Victorian Surgical Consultative Council (the surgical council) and the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (the anaesthetic council). The aim of the review was to evaluate both the surgical and anaesthetic councils to determine the strengths and weaknesses of their current operating models, including mechanisms for reporting mortality and morbidity. To assist with this review, SCV sought clinical expertise from Professor David Watters, past president of the Royal Australasian College of Surgeons, and Professor David A Scott, past president of the Australian and New Zealand College of Anaesthetists.

The review found the following:

- There is a clear need for ongoing case review that is objective, well-informed and timely.
- The surgical and anaesthetic councils and the Victorian Audit of Surgical Mortality (VASM) operate essentially as silos due to administrative and legislative barriers, including the differing protective legislations (federal for VASM and state for the consultative councils). Duplication of case reviews can occur due to the existence of these silos, which prevents information flow and case matching.
- Under the current model, there is the potential for case clusters to be missed and opportunities for multidisciplinary approaches to improve quality and safety are limited.
- There is little capacity for specific case feedback to hospitals – only VASM currently has a formal (confidential) feedback interaction with individual clinicians.
- Current legislation prevents the sharing of key learnings and information between the surgical and anaesthetic councils, health services and VASM.
- Both the surgical and anaesthetic councils are under-resourced, especially in comparison to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (the obstetric and paediatric council). This is reflected in the depth of case review and timeliness of public reporting.
- There is no efficient structure for a comprehensive perioperative approach to case and event review. Procedures which result in mortality or significant morbidity involving other specialties (including, for example, gastroenterology, radiology or cardiology) may be missed. Likewise, events occurring post-procedurally (for example, respiratory arrest or myocardial infarction) are not systematically captured.

A series of recommendations have been made to address and improve appropriate perioperative review. These recommendations will aim to increase multidisciplinary review of adverse perioperative events, which will result in the creation of more effective and frequent learnings to be shared with the sector, which in turn will drive system and health service improvement.

A reduction in perioperative morbidity and mortality will result in better patient outcomes and reduce avoidable costs of healthcare. In turn, more public and transparent reporting will increase community trust and confidence in our health system, while further improving the quality and safety of perioperative healthcare in Victoria.

RECOMMENDATIONS

1. Both the surgical and anaesthetic councils should be dissolved at the completion of their current term (30 June 2019).
2. A Victorian Perioperative Consultative Council (the perioperative council) should be created and implemented by July 2019, without a gap in monitoring and review of perioperative mortality and morbidity.
3. The perioperative council should:
 - a. include broad representation of members, who review relevant perioperative and peri-procedural morbidity and mortality
 - b. ensure a high level of legal protection for case and event analysis and review
 - c. include two major subcommittees – one to review anaesthesia mortality and morbidity and the other to review surgical mortality and morbidity – that have the ability to co-opt relevant disciplines or specialties to ensure case reviews are conducted with sufficient expert input
 - d. have reporting structures in place to complement, rather than duplicate, case review by VASM.
4. Replicate the legislation that applies to the obstetric and paediatric council that states that adequate resources must be provided by the Secretary of the Department of Health and Human Services to support both the functions and members of the council.
5. The following inputs and reporting should be made available to the perioperative council for review:
 - a. Mandated health service reporting for specified key perioperative mortalities, morbidities and events as determined by the perioperative council, as well as voluntary reporting of other defined morbidities and adverse events.
 - b. Anaesthetic-related mortality cases identified by VASM.
 - c. Mortality cases identified by VASM that require multidisciplinary review.
 - d. Coroners' reports.
 - e. Relevant issues identified through departmental data sources including, but not limited to the Victorian Health Incident Management System and Sentinel Events.
6. A formalised, confidential, information sharing partnership should be created between the perioperative council and VASM for the purposes of:
 - a. sharing notifications of mortality from the health sector
 - b. validating notifications received by each body to confirm the accurate capture and triage of mortality; and avoidance of case duplication.
7. Legislatively protected information sharing pathways should be explored, to establish a protected mechanism for sharing feedback and relevant information between the Council and health services.

8. Annual and triennial reports should be published in a timely manner and include:
 - a. three- to five-year rolling trends and summaries
 - b. key focus areas, which are reflective of issues reviewed and highlighted by the council that year
 - c. de-identified case studies.
9. A process for the council to escalate serious issues of concern to SCV is required, which does not breach legislative protections, and enables a rapid response or messaging to prevent further similar avoidable events.
10. In dissolving the surgical and anaesthetic councils it should be communicated with the sector that:
 - a. there will be no gap in the oversight of quality and safety in perioperative care during transition to the new council
 - b. perioperative morbidity review will be expanded for the benefit of quality improvement
 - c. significant investment in perioperative mortality and morbidity oversight and review will be made.

Consideration should be given to announcing the chairperson of the perioperative council prior to dissolution of the existing surgical and anaesthetic council. The chairperson should be a leading surgeon or anaesthetist, experienced in quality and safety.

Introduction

Victoria has one of the safest healthcare systems in the world. However, adverse events still occur, ranging from 'near misses' to significant patient harm and even death. There is a justifiable expectation that review of adverse events occurs, learnings from these cases are implemented, and preventable harm in the hospital system is minimised by a continually improving system. Learning from these events is key to preventing them from recurring.

Victoria has systems in place to facilitate continual review and improvement including central monitoring of key performance indicators and thorough review of sentinel and adverse events. This is where confidential reporting and review play an integral role, and why since 1962, there have been specialised consultative councils – one surgical, one anaesthetic, and one obstetric and paediatric – progressively established to consider, report and advise the community, via the Minister of Health, of areas for improvement in care.

This review relates specifically to the work of two councils – the surgical council and the anaesthetic council – which were established to review and reduce avoidable causes of morbidity and mortality. *Targeting Zero* (Duckett 2016) recommended that oversight of surgical and anaesthetic mortality and morbidity in Victoria be enhanced by dissolving the surgical council and consideration given to dissolving the anaesthetic council, with functions of these two Councils taken up by another appropriate body. In considering how this recommendation might be implemented, SCV commissioned this review to evaluate the surgical and anaesthetic councils to determine how best those functions could be delivered.

To assist with this review, SCV sought clinical expertise from Professor David Watters, past president of the Royal Australasian College of Surgeons, and Professor David A Scott, past president of the Australian and New Zealand College of Anaesthetists. Both Professor Watters and Professor Scott are highly experienced senior clinicians with specialist knowledge of the perioperative sector in Victoria. Their consultancy and advice have informed SCV's view on how to improve the quality and safety of perioperative healthcare in Victoria.

MORTALITY AND MORBIDITY REVIEW

Mortality and morbidity review have historically played an important role in the oversight of quality and safety in the Victorian health sector. This retrospective review process focuses on individual and system-wide health service performance, through the analysis of adverse events. Learning from these events is seen as one of the most valuable opportunities to support improvements in care and enhance service delivery.

Often these incidents occur in highly complex social and technical systems where human errors may be inevitable. As our healthcare environment becomes increasingly complex, the ongoing importance of learning from these incidents cannot be underestimated.

In Victoria, there is a long and documented history of mortality and morbidity review through ministerially appointed, multidisciplinary consultative councils. There are currently three consultative councils operating in Victoria, as described in Box 1. The legislated functions of the councils are outlined in the *Public Health and Wellbeing Act 2008*.

The councils publish and disseminate relevant information and findings of their deliberations to improve clinical practice and regularly respond to and report on specific matters referred to the council by the Minister for Health.

In addition, the Victorian Department of Health and Human Services (the department) funds VASM, a collaboration between the department and the Royal Australasian College of Surgeons. This audit aims to gather information on factors involved in the death of patients undergoing surgical treatment and develop strategies to redress any system or process errors identified.

Box 1: The Victorian consultative councils

The obstetric and paediatric council was established in 1962. The functions of the obstetric and paediatric council are to conduct study, research and undertake analysis into the incidence and causes of the deaths of Victorian children, adolescents and maternal women. Reporting of deaths and morbidity to this council is mandatory as per legislation. The obstetric and paediatric council oversees a perinatal data collection for collecting, studying, researching and interpreting information on and in relation to births in Victoria.

The anaesthetic council was established in 1976. The anaesthetic council is the advisory body to the Minister and the department on anaesthetic related mortality and morbidity. Reporting of anaesthetic deaths and morbidity to the council is currently voluntary, but strongly encouraged in the sector.

The surgical council was established in 2001. The surgical council is the advisory body to the Minister and the department on surgical related mortality and morbidity. Since the establishment of VASM in 2007, there has been a significant reduction in surgical mortality considered by the council.

SCV Victoria and the Victorian Agency for Health Information also play important roles in incident review, overseeing the sentinel events program and Victorian Health Incident Management System (VHIMS), respectively. Sentinel events are unexpected events that result in death or serious harm to a patient while in the care of a health service. In Victoria, public and private hospitals must report sentinel events to SCV. VHIMS is a standardised dataset for collecting and classifying clinical incidents, occupational health and safety incidents, hazards and consumer feedback.

QUALITY AND SAFETY OVERSIGHT

The department has recently redeveloped in the way it approaches quality and safety in the Victorian health system. In 2016, following the discovery of a cluster of tragically avoidable perinatal deaths, the Minister for Health commissioned *Targeting Zero*. The review, led by Professor Stephen Duckett, provided a detailed and comprehensive analysis into how the department oversees and supports quality and safety of care across the Victorian hospital system. Additionally, the review identified the importance of an independent, coherent and unified system for hospital safety reporting and mortality review, specifically in the perioperative setting.

Professor Duckett made a series of recommendations which were reflective of an increasing emphasis on a system-oriented approach and development of comprehensive governance structures. Of particular note was a recommendation that the surgical council be dissolved, with its oversight functions taken up by VASM and departmental performance management, and its improvement functions taken up by a newly formed clinical network for surgery. The report also recommended that consideration be given to dissolving the anaesthetic council.

In response to this recommendation, this review was commissioned for the purpose of evaluating both the surgical and anaesthetic councils to determine the strengths and weaknesses of:

- their current operating models
- the current mechanisms for reporting mortality and morbidity to the Surgical and Anaesthetic councils.

In evaluating both councils, the review team was also asked to consider whether a new combined perioperative council would be a more efficient and effective model for monitoring, reviewing and improving the quality and safety of perioperative care in Victoria. In reaching this decision, the review team was asked to determine how a new perioperative council could be developed, so it:

- is proactively engaged with the perioperative sector
- reviews relevant mortality and morbidity cases thoroughly
- provides accurate, timely advice to the Minister, health sector and community to improve perioperative care in Victoria
- considers how mechanisms for reporting perioperative mortality and morbidity could be improved
- is appropriately and effectively supported in its functions and operations.

The review's terms of reference are included at **Appendix A**.

METHODOLOGY

The current terms of both the surgical and anaesthetic councils are due to expire on 30 June 2019. Given the impending expiration of the current council terms, it was determined that a decision should first be reached as to whether to continue with a modified form of the current councils and thus undertake an appointment process for new three-year terms, or create a new perioperative council. To reach this decision the following tasks were undertaken:

Environmental scan of national and international mortality and morbidity committees

An environmental scan of similar mortality and morbidity committees was undertaken to inform the findings and recommendations of this review. Two international and two national committees were found to be relevant to the context of this review.

Stakeholder consultations

Individual discussions were held by Professor Watters and Professor Scott with key stakeholders. The review team recognised the importance of seeking feedback and understanding the views of those directly and indirectly involved in both the surgical and anaesthetic councils. These consultations have helped to inform the outcomes of this review.

SWOT Analysis of both the surgical and anaesthetic councils

A strengths, weaknesses, opportunities and threats (SWOT) analysis was undertaken to obtain a thorough understanding of the current context of the surgical and anaesthetic councils.

WHAT THE PERIOPERATIVE HEALTH SECTOR NEEDS

There is an ongoing and vital role for both mortality and morbidity reporting, related to perioperative care, to drive improvement of the safety and effectiveness of healthcare in Victoria. The obstetric and paediatric council is an example of a well-resourced council and has components which can be reproduced in the perioperative council. What is required is a system of morbidity and mortality review that is transparent, accountable, protected to an appropriate degree by legislation, which mandates mortality and certain key morbidities to be reported (while encouraging voluntary morbidity reporting of non-key areas).

Perioperative issues and major events should ideally be first reported and investigated locally at an individual health service level (where the lessons are most likely to be learned) with subsequent multidisciplinary review by the perioperative council and its subcommittees. For transparency, responsiveness and efficiency reasons, protected two-way flow of information between hospitals, clinicians, the department, SCV and the councils is required.

Benefits to the health sector

Errors in perioperative care are a leading cause of avoidable harm in the Australian healthcare system, resulting in unwarranted morbidity and mortality, hospitalisations, longer length of stays and unplanned readmissions. In 2015–16, adverse events occurred in approximately eight per cent of surgical admissions in Australia (Australian Institute of Health and Welfare 2018). Many of these errors are the result of identifiable system failures.

System-wide reporting and review are important mechanisms for improving patient safety. They allow information to be collated and advice disseminated to multiple sites, as well as increasing analytic power and allowing detection of emerging issues (Institute of Medicine 2000).

Since the surgical and anaesthetic councils were established, the healthcare environment has experienced significant developments in cultural attitudes and approaches towards quality and safety. The scope of perioperative medicine has increased, new specialities have emerged, and patients are becoming older, with more complex comorbidities and more multidisciplinary care pathways.

While the surgical and anaesthetic councils have progressed against their terms of reference and legislation since their inception, their effectiveness has been constrained. This review concluded that a combined perioperative council will be a more efficient model for monitoring, reviewing and improving the quality and of perioperative care in Victoria going forward.

In replacing the surgical and anaesthetic councils with the perioperative council there will be increased multidisciplinary review of adverse perioperative events. These reviews will result in the creation of more effective and frequent recommendations to drive and guide both system and health service improvement. A reduction in perioperative morbidity and mortality will result in better patient outcomes and decreased financial costs of healthcare. An increase in community trust and confidence in our health system will be also achieved through more regular and transparent public reporting, informed by improved data collection.

A culture of reporting adverse events to the perioperative council will be fostered in the sector, encouraging health services and clinicians to report transparently in the context of learning rather than blaming, without fear of a breach of confidentiality. The review of perioperative morbidities and mortalities by individual health services prior to sharing with the perioperative council will improve systems locally, where lessons are most likely to be learned, and any gaps in healthcare that require particular focus will be identified.

Key considerations

Please consider the following when evaluating the findings and recommendations of this review:

1. The scope of 'operative' procedures is not just surgical – it may include diagnostic and interventional procedures undertaken by a range of specialist practitioners including interventional radiologists, gastroenterologists, cardiologists, intensive care specialists and emergency medicine practitioners. Many of these (but not all) involve anaesthesia, including sedation. The council model proposed may make determinations to define or extend the operative procedures in scope.
2. The timing of adverse events and mortality related to operative procedures is broader than just the intraoperative period, as there are often multiple factors contributing to these outcomes. The 'perioperative' period more appropriately encapsulates this – embracing pre-procedural assessment and preparation, the procedure itself, and post-procedural management until return to non-acute care. Evaluation of adverse outcomes in this context involves an in-depth understanding of surgery, anaesthesia (including acute pain medicine) and multidisciplinary care.
3. Mortality reporting and review are widely accepted as being of value. The contribution of Victoria to national mortality reporting is of significant community value. To this end, consistent classifications for such high-level reporting must be maintained, even if improved 'fit for use' local classifications of events are adopted.
4. Morbidity reporting and review provide valuable insights into systems and processes that can lead to prevention of harm, including death. Morbidity data are currently only available via voluntary reporting to the anaesthetic council or mandated reporting to the sentinel event program (which fits in their defined categories only). Mandating reporting of key morbidity areas will not only increase the volume of morbidity cases reviewed by the council but also encourage review at hospital level, which has the potential to identify opportunities for improving quality and safety. Three examples of key morbidities include:
 - a. **Unplanned return to theatre (URT).** This is now listed as one of the 16 recognised hospital-acquired complications monitored by the Australian Commission on Safety and Quality in Health Care. This field is not currently captured in Victorian data. However, analysis using alternative methods for determining URT provides a conservative estimate of URTs occurring at a rate of 30 patients per 1,000 surgical procedures.
 - b. **Perioperative cardiovascular events.** These represent multidisciplinary adverse events where the opportunities to improve inefficiencies in care might span preoperative, intraoperative and postoperative care. These events are relatively infrequent if limited to cardiac arrest, perioperative myocardial infarction and cerebrovascular accidents (strokes).
 - c. **Perioperative respiratory events.** These present opportunities to reduce inefficiencies or deficiencies in care spanning preoperative preparation, intraoperative events and postoperative care. They should be limited to critical areas such as respiratory arrest, aspiration or respiratory failure requiring escalation of care.

Findings

ENVIRONMENTAL SCAN

From the national and international committees reviewed, no single model was identified as performing all the functions required of the surgical and anaesthetic councils. However, some components of each of the committees were highlighted as functions which should be incorporated into the new council structure. These included:

- enhanced annual reporting
- mandatory reporting from health services for selected mortalities and morbidities
- requirement for legislative protections and confidentiality between health services and the council
- retention and expansion of voluntary reporting from practitioners, especially for relevant morbidity.

A detailed list of the configuration and operating models of the comparative entities is provided at **Appendix B**.

STAKEHOLDER CONSULTATIONS

Consultation with stakeholders highlighted several strengths of the current system but also identified room for improvement. Several key themes were identified.

Scope

Stakeholders agreed that there is an ongoing and vital role for both mortality and morbidity reporting in Victoria, covering the whole perioperative period. Consultative councils must also move towards a focus on system-level improvements, as well as responses to individual events. When considering work with private hospitals, health insurers could potentially play an important role in engaging and encouraging reporting.

Structure and support

Surgical, anaesthetic and multidisciplinary representation is key to the success of the councils. Where appropriate, councils should be able to access additional sub-specialist advice as required. Councils must be sufficiently resourced, particularly to address morbidity review which will encompass a greater number of reports than mortality review.

Process

Concerns were raised that the current separation of surgical and anaesthetic councils is leading to duplication of effort and resources across councils, which is not creating improvement in care in the sector. Council processes need to be more transparent to both members and the sector, and reporting must be more frequent and timelier to enable effective response.

Voluntary reporting is valuable and should be encouraged in the sector. However, mandatory reporting of mortality as well as of a set of defined key morbidities by health services would also be supported. The new council must identify morbidities that, if reported and reviewed, would lead to system improvement and better individual case management in health services.

Importantly, legal protections are vital to the success of consultative councils. However, these should not impair feedback and learning, or communications between hospitals, practitioners and the council.

A full list of stakeholders consulted is provided at **Appendix C**.

SWOT ANALYSIS OF BOTH THE SURGICAL AND ANAESTHETIC COUNCILS

As shown in Tables 1 and 2, a SWOT analysis highlighted features of the current councils that support effective working and identified areas for improvement.

Table 1: Surgical council SWOT Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> Established history in the sector Engaged council members Well-defined legislation 	<ul style="list-style-type: none"> Small number of case reviews undertaken Lack of feedback to health services Inadequate resources to support council Delayed reporting Minimal review of surgical morbidity Duplication in effort with the anaesthetic council and VASM.
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> Increase in volume of cases reported to council Modifications to legislation to enable two-way feedback Stronger focus on morbidity Enhanced annual reporting Enhanced engagement with sentinel event review 	<ul style="list-style-type: none"> VASM could subsume role Inability to modify legislation Disengagement from the sector and council members due to low volume of case reviews, limited feedback and reporting

Table 2: Anaesthetic council SWOT analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Long established history and reputation (credibility) in the sector • Engaged council members • Well defined legislation • Anaesthesia community aware of and trust reporting pathways • Significant volume of cases reviewed • Review of morbidity as well as mortality 	<ul style="list-style-type: none"> • Lack of feedback to health services or clinicians • Inadequate resources to support council • Delayed reporting • Voluntary reporting only for anaesthetic morbidity • Case review workload significant for council members • Decreasing culture of reporting in the sector • Duplication in effort with VASM (and to a lesser extent the surgical council)
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Increase in volume of cases report to council • Modifications to legislation to enable two-way feedback • Stronger focus on morbidity • Enhanced engagement with sentinel event program review • Enhanced annual reporting 	<ul style="list-style-type: none"> • Inability to modify legislation • Disengagement from sector and council members due to low volume of case reviews • Lack of engagement from the sector

Review and implementation

ENGAGEMENT WITH THE PERIOPERATIVE HEALTH SECTOR

Many stakeholders, including members of the existing surgical and anaesthetic councils, reported a need for more effective communication between a new perioperative consultative council and key stakeholder groups. A lack of engagement between the perioperative council and the sector would have the potential to impact on the volume of events reported and thus council effectiveness. Increased engagement is necessary to establish the perioperative consultative council as a credible and trusted body in the perioperative sector. This will be achieved by forming strong relationships and communication networks with stakeholders across the service system, and by articulating and focusing on clear strategic priorities.

Where we are now

The volume of notifications to the anaesthetic council has fluctuated in recent years. In mid-2016, the introduction of online reporting of mortality and morbidity cases to the anaesthetic council led to an immediate increase in the number of voluntary notifications and has improved the timeliness of the council's analysis and reporting. Simultaneously VASM also began sharing case information with the anaesthetic council where anaesthetics were identified as having possibly contributed to the death. Where necessary, the anaesthetic council can request information relating to these deaths directly from the relevant health service using provisions in the *Public Health and Wellbeing Act 2008*.

Prior to the inception of VASM in 2007, the surgical council received and reviewed direct reports of surgical mortality. This role has been subsumed by VASM, which is now the main collector of surgical mortality data in Victoria. VASM has sporadically shared deidentified cases with the surgical council over the past decade. However, this process is of limited value, as generally the surgical council requires identifying or additional information to allow adequate review.

The Commonwealth Qualified Privilege (QP) scheme that VASM operates under allows information sharing between VASM and the surgeon responsible for the surgical care, but it prohibits information sharing with anyone else. Since 2007, the surgical council has relied on voluntary reports of surgical morbidity from surgeons and surgical sentinel events provided by SCV's incident response team. The surgical council's ability to monitor, analyse and report on surgical-related adverse events is very limited due to the low volume of direct reports, demonstrating the need for improved reporting processes and awareness in the sector.

Processes for timely delivery and feedback of recommendations, outcomes and advice to the sector needs to be a key component of the perioperative council. This is an identified gap as both existing councils are currently only publishing public reports triennially.

COUNCIL STRUCTURE

It is proposed that the perioperative council is established in the same manner as the obstetric and paediatric council, with an overarching council consisting of members with suitable technical and professional expertise, responsible for overseeing two substantive subcommittees. As illustrated in Figure 1, two key subcommittees will report to the perioperative council: one with a focus on anaesthesia-related mortality and morbidity and the other on surgical mortality and morbidity. A chairperson and deputy chairperson will be appointed to the overarching perioperative council, as well as to each subcommittee. Mortality and morbidity cases will be reviewed and classified by speciality clinicians on each of the subcommittees.

Figure 1: Proposed perioperative council structure



Membership

Both the chairperson and the perioperative council members will be officially appointed by the Victorian Minister for Health. It is recommended that the perioperative council chairperson be appointed in the first instance, to allow their input in finalising the perioperative council terms of reference, and in appointing the perioperative council members.

It is recommended that the perioperative council and subcommittee membership nominations are sought from relevant professional groups, such as:

- the Royal Australasian College of Surgeons (RACS)
- the Australian and New Zealand College of Anaesthetists (ANZCA)
- the Australasian College for Emergency Medicine (ACEM)
- the State Coroner's Office
- the Victorian Institute of Forensic Medicine (VIFM)
- the Australian College of Perioperative Nurses (ACORN)
- the College of Intensive Care Medicine (CICM)
- the Royal Australasian College of Medical Administrators (RACMA)
- the Royal Australasian College of General Practitioners (RACGP)
- the Australian Orthopaedic Association (AOA)
- the Australian Society of Anaesthetists (ASA)
- General Surgeons Australia (GSA).

In addition, representation should be sought from:

- CEOs of metropolitan and rural health services, including the private hospital sector
- Department executive, to provide strategic oversight
- the Victorian Audit of Surgical Mortality
- consumer representative organisations.

It is recommended that the Manager of SCV's Consultative Council Unit attend all perioperative council meetings for consistency of oversight.

To maintain continuity, current members of the surgical and anaesthetic councils would be strongly encouraged to apply for membership to the council or its subcommittees. SCV will ensure that membership of the perioperative council accurately reflects the composition of the Victorian community and will encourage participation of under-represented groups.

NEXT STEPS

It is recommended that a public announcement be made announcing the establishment of the new perioperative council, the inaugural chairperson and that there will be no gap in perioperative mortality and morbidity review while there is a transition from the surgical and anaesthetic councils to the new perioperative council.

To increase engagement between the perioperative council and the perioperative sector, SCV and the perioperative council will undertake the following steps:

- A suite of promotional tools will be developed, including:
 - a new perioperative council webpage
 - factsheets and brochures on the work of the perioperative council (including information on mandatory and voluntary reporting and the relationship between the activities of the council and other quality and safety initiatives).
- The VASM case notification, triage and review process will be explored and structures modified to allow the perioperative council to review identified surgical mortality, as well as anaesthetic mortality, while preserving legal protections.
- The perioperative council will produce quarterly de-identified case reports and factsheets summarising the key recommendations arising from their review of mortality and morbidity reports. These will be published on the website and will be included in the SCV e-newsletter.
- The perioperative council will host regular seminars (at least annually) to provide education and increase awareness in areas of concern in the perioperative sector.
- Subject to the creation of appropriate legislative protections, the perioperative council will engage in two-way feedback with health services who report cases to the council.
- The perioperative council will produce timely annual and triennial reports. The reports will include three-to-five-year rolling trends, summaries and key focus areas, which are reflective of issues reviewed and highlighted by the council that year.

Inputs

Perioperative morbidity review will be an integral component of the council's work. The council will develop a list of key morbidities for mandatory reporting, which will enable the council to detect early signs of potential risk and harm to patients. This will increase the volume of cases reviewed by the perioperative council and will encourage review at the hospital level, which has the potential to identify opportunities for improving quality and safety locally. The nature of this list will be determined periodically by the perioperative council.

VASM and the anaesthetic council currently have a collaborative relationship, where VASM shares case notifications (not including clinical case details) with the anaesthetic council on surgical mortality cases that have an anaesthetic component. It is anticipated that the perioperative council will build on this relationship, to create a more formalised partnership to share notifications of mortality from the health sector and to confirm an accurate capture of surgical mortality. Two potential models of efficient and protected VASM case-sharing structures are provided at **Appendix D**.

Departmental sources of case information will also be explored by the perioperative council. The sentinel event program, run by SCV's incident response team, has the potential to be a rich source of data on perioperative adverse events. As per the *Public Health and Wellbeing Act 2008*, the perioperative council will have the legislative powers to request relevant documentation from health services as required. Case reviews and issues identified through mortality and morbidity committee review will be sought to assist the perioperative council with case classification.

Outputs

The perioperative council will be required to publish public reports both annually and triennially. Publication of reports at these intervals will allow the council to summarise issues reviewed and highlighted in each 12-month period, as well as providing analysis of longer-term, system-wide trends. Triennial reporting will provide an opportunity to see whether improvement has been made on system issues previously identified. The legislative powers that the new council will be awarded will enable them to create a rich dataset that will be used to inform and develop these reports. The reports will play an important role in the sector, providing useful reflective reading and advice to underpin safe practice.

In addition, de-identified case studies will be published quarterly by the council, to provide the sector with useful learnings. These case studies will assist in forming the annual and triennial reports.

Escalation process

Currently, under Section 41 of the *Public Health and Wellbeing Act 2008*, the surgical and anaesthetic councils **may** (if they consider it in the public interest to do so) provide information obtained through mortality or morbidity review to a prescribed list of individuals or organisations. This includes the Minister for Health, the Secretary of the department and individual health services.

However, strengthening escalation processes for reporting avoidable harm is proposed, by amending the Act to align with that of the obstetric and paediatric council. This would require a report to be provided to the Secretary of the department any time the council determines that an incident of perioperative mortality or severe morbidity was likely to have been preventable. Currently, this legislative responsibility has been delegated to SCV's Chief Executive Officer by the Secretary of the department. Reports to the Secretary would need to include:

- the type of incident causing the mortality or morbidity
- the health service connected with the mortality or morbidity
- how the mortality or morbidity may have been prevented
- the status of any perioperative council investigation of the incident
- any remedial action taken by the relevant health service.

Support for the Victorian Perioperative Consultative Council

Due to the increased volume of cases that the perioperative council will receive, a team of senior medical advisors should be appointed by SCV to triage cases, drawing parallels with similar roles in the obstetric and paediatric council. Following consultation with key stakeholders, it is proposed that these role(s) be comprised of senior clinical experts with expertise across a number of clinical areas, rather than a single individual. This group will work closely with the chairperson of the perioperative council and will triage cases to the subcommittees. All clinicians appointed as senior medical advisers will be required to also be appointed as members of the perioperative council, or its subcommittees.

SCV will provide administrative, secretariat and research support to the perioperative council through the consultative councils unit.

Currently, the obstetric and paediatric council has significant resources to support the functions of their council and subcommittees. It is anticipated that for the perioperative council to make a meaningful contribution to the sector, a similar resource allocation as that of the obstetric and paediatric council will be required so that the perioperative council can operate effectively and efficiently.

Conclusion

The Victorian perioperative sector is a complex healthcare environment involving freestanding 'day-care' procedure centres, public health services and private hospitals, all of which differ in the volume and type of procedures they undertake. National and international approaches to the oversight of perioperative morbidity and mortality have recognised the need to focus on systemic, rather than individual issues. Avoidable and preventable perioperative adverse events do not usually happen because of a single error, lapse or mishap, but rather represent multidisciplinary weaknesses, that through retrospective recognition and review, offer a number of opportunities to improve the system.

Ongoing morbidity and mortality review is vital, but the current models of both the surgical and anaesthetic councils have weaknesses which impede on their functionality and provide limited improvement to the sector more broadly. Until now, there has been no overarching body to review and advise surgeons, anaesthetists and other proceduralists about issues that may have impacted on perioperative mortality and morbidity. The dissolution of the separate surgical and anaesthetic councils and the creation of a new combined perioperative council will reduce duplication of function and facilitate more comprehensive review, reflecting contemporary patient care models and better information flow.

The perioperative council will consist of engaged, appropriately qualified perioperative-related experts, who will review cases under well-defined legislation, with the potential of two-way protected feedback between the council and health services. Legislative and regulatory changes will afford greater protection to those reporting adverse events and will foster a greater culture of reporting and confidence in the review process, which is essential to its success.

A key focus of the perioperative council will be reviewing perioperative morbidity and mortality. As surgical and anaesthetic mortality in Victoria is fortunately low, there is increasing interest in reviewing perioperative morbidity to monitor perioperative health and to guide improvement in perioperative care.

To be more engaged with the sector, a formal communication strategy will outline the roles and responsibilities of the perioperative council, the relationship between their activities and other quality and safety initiatives, the key stakeholders that the council will regularly engage with, and the nature and frequency of interactions with targeted stakeholder groups.

The perioperative council needs to establish itself as a credible and trusted body, form strong relationships and communication networks, identify and implement strategic priorities, and develop effective change strategies. Prepared implementation, effective and frequent communication with the sector and strong leadership, are integral to achieving these goals.

More regular reporting, improved monitoring of performance and enhanced processes for identifying risk will be key priorities for the council after its establishment. The department and SCV will provide adequate resourcing to support this, to allow the perioperative council further improve the quality and safety of perioperative healthcare in Victoria.

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Appendices

APPENDIX A: TERMS OF REFERENCE

Commissioned by	Professor Euan Wallace, Chief Executive Officer, SCV
Project lead	Sam Green, A/Manager, Clinical Safety and Monitoring, SCV
Project coordinator	Carla Donnery, Project Officer, Clinical Safety and Monitoring, SCV
Clinical experts	Professor David Watters, Professor of Surgery, Barwon Health and Deakin University Professor David Scott, Director of Anaesthesia and Pain Medicine, St Vincent's Hospital

Background

1. In 2016, following the discovery of a cluster of tragically avoidable perinatal deaths, *Targeting Zero; the review of hospital safety and quality assurance in Victoria*, was commissioned by the Minister for Health.
2. The review was a detailed and extensive analysis into how the Department oversees and supports quality and safety of care across the Victorian hospital system.
3. The review recommended that the Victorian Surgical Consultative Council (the surgical council) be dissolved, with their oversight functions taken up by the Victorian Audit of Surgical Mortality (VASM) and departmental performance management and their improvement functions taken up by a newly formed clinical network for surgery. Consideration should be given to whether the Victorian Consultative Council for Anaesthetic Morbidity and Mortality (the anaesthetic council) should also be dissolved.
4. Both the surgical and anaesthetic council are both ministerial established and appointed consultative councils established under the *Public Health and Wellbeing Act 2008*.
5. The purpose of the councils is to report on highly specialised areas of healthcare (anaesthesia and surgical care), to reduce mortality and morbidity, through education, system improvement and reform.

Purpose

6. The purpose of the project is to evaluate the surgical council and the anaesthetic council to determine the strengths and weaknesses of:
 - (a) their current operating models, and
 - (b) the current mechanisms for reporting mortality and morbidity to the surgical council and the anaesthetic council.
7. The review will also consider whether a combined Victorian Perioperative Consultative Council (perioperative council) would be a more efficient model for monitoring, reviewing and improving the quality and safety of perioperative care in Victoria.

8. In reaching this decision, the review will determine how the perioperative council will be developed, so that it:
 - (a) is proactively engaged with the perioperative sector
 - (b) reviews relevant mortality and morbidity cases thoroughly
 - (c) provides accurate, timely advice to the Minister, health sector and community to improve perioperative care in Victoria.
9. The review will consider:
 - (a) what mechanisms for reporting perioperative mortality and morbidity can be improved
 - (b) how to increase engagement with the perioperative sector
 - (c) identify what supports mechanism and resources are required to support the functions and operations of the surgical council, the anaesthetic council or a new perioperative council.

Project objectives

10. The objectives of the project are to:
 - (a) identify what the best practice examples of perioperative review are nationally and internationally
 - (b) review the current operating models of both the surgical and anaesthetic councils, including an analysis of each of the council's strengths and weaknesses
 - (c) review current mechanisms for reporting perioperative mortality and morbidity cases to the councils and identify initiatives to enhance these processes
 - (d) identify methods for increasing engagement between the council(s) and the perioperative sector
 - (e) review current support mechanisms and resources for both councils and identify what resources would be required for the councils to function more efficiently
 - (f) establish a potential structure and operating model for the perioperative council.

Deliverables

11. The proposed deliverables of the project are:
 - (a) development of project plan and methodology
 - (b) environmental scan of the perioperative mortality and morbidity review systems, both nationally and internationally
 - (c) SWOT analysis of the current operating models for both the surgical and anaesthetic councils, including a report with recommendations for improvement

- (d) consultation with key stakeholders and the sector on the design of the perioperative council (if this decision is reached), including a list of sector requirements
- (e) development of a proposed structure and operating model for the perioperative council (if this decision is reached), incorporating evidence from the literature review and SWOT analysis in addition to the intel and feedback from key stakeholders
- (f) review of the current staffing resources allocated to support the surgical and anaesthetic councils, including the identification of the resources and support mechanisms required for either the perioperative council or the existing councils to function more efficiently
- (g) provide an interim report to the Minister for Health with our recommendations by mid-December
- (h) a final report, including further detail on the scope, functions and operating model, by May 2019.

Key stakeholders

12. The following list of key stakeholders should be consulted with as part of the project:
 - (a) Dr Andrea Kattula, Chair, anaesthetic council chairperson
 - (b) Associate Professor Trevor Jones, surgical council chairperson
 - (c) Adjunct Professor Tanya Farrell, obstetric and paediatric council chairperson
 - (d) Existing and previous members of the anaesthetic council (members to be confirmed)
 - (e) Existing and previous members of the surgical council (members to be confirmed)
 - (f) The Australian and New Zealand College of Anaesthetists (ANZCA)
 - (g) Royal Australasian College of Surgeons (RACS)
 - (h) Mr Philip McCahy, Clinical Director, VASM
 - (i) Claudia Retegan, Project Director, VASM
 - (j) Staff in SCV and the Department of Health and Human Services (staff to be confirmed)
 - (k) Selected stakeholders in the perioperative sector.

Timelines

13. The project is expected to start in early October, with all deliverables completed by April 2019.
14. A final briefing will be provided to the Minister of Health in May 2019.

Budget and finances

15. A budget of \$80,000.00 (ex GST) has been provided for this project.
16. A final funding acquittal will be provided at completion of the project.

APPENDIX B: ENVIRONMENTAL SCAN OF SIMILAR MORTALITY AND MORBIDITY COMMITTEES

Special Committee Investigating Deaths Under Anaesthesia – NSW

Overview

- The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) reviews deaths which occurs while under, as a result of, or within 24 hours following the administration of anaesthesia or sedation.
- The purpose of SCIDUA is to identify any area of clinical management where alternative methods could lead to a more favourable result.
- SCIDUA is an expert committee appointed by the Secretary of NSW Health.
- All SCIDUA documentation is privileged from subpoena (S23, *Health Administration Act 1982*). All communications between the reporting anaesthetist and the Committee is strictly confidential.
- The NSW *Public Health Act 2010* requires the health practitioner who is responsible for the administration of the anaesthetic or sedative drug, to report the death to the Secretary of NSW Health, via SCIDUA.
- All reported deaths are reviewed by a two- to three-member subcommittee, which will either classify the death due to factors not falling under the control of the health practitioner or request further information.
- Where further information is required, the reporting anaesthetist is requested to provide more information which is then shared with other members of SCIDUA. Cases are then discussed and classified by the broader committee.
- After determining the cause of death, a **confidential** reply is sent to the health practitioner explaining the committee's finding.
- The committee has nine members (predominantly anaesthetists).

Benefits

- Strict legislation which enables communication between committee and health practitioner.
- Broad scope.
- Thorough review process.

Challenges

- Reporting is clinician led, not health service led.
- Minimal representation of other clinical areas or specialities.
- Reporting is not mandatory. That is, they only 'know what they know'.
- Limited interaction with other bodies.

Perioperative Mortality Review Committee – New Zealand

Overview

- The Perioperative Mortality Review Committee (POMRC) is an independent mortality review committee that advises the Health Quality and Safety Commission on how to reduce the number of perioperative deaths in New Zealand.
- The POMRC is a statutory advisor to the commission and reviews perioperative mortality cases as defined:
 - a death that occurred during or after an operative procedure, within 30 days
 - after 30 days, but before discharge from hospital (to either home or a rehab facility)
 - a death that occurred whilst under the care of a surgeon in hospital, even though an operation was not undertaken.
- The POMRC gathers information from a wide range of sources, to assist in reviewing deaths. This information is collected for the sole purpose of reviewing and classifying perioperative deaths.
- The POMRC operates under strict legislation which enables the committee to collect all relevant data, with strict protections placed on the gathering, use and viewing of this information.
- Information sources include:
 - patient records
 - clinical advice
 - interview questions to health practitioners
 - information that becomes available due to declared quality assurance activity
 - other sources as required.
- Reporting is not mandatory; however, work is being constantly done to improve the reporting culture of health services.
- Morbidity is currently not a strong focus of POMRC due to resource constraints and challenges in defining and capturing morbidity accurately.
- It is a 10-member multidisciplinary council with two advisors, made up of surgeons, anaesthetists, perioperative nurses, consumers and epidemiologists.

Benefits

- Strict legislative protections which encourage reporting from health services.
- Multiple data sources to inform review.
- Multidisciplinary committee.
- National review of perioperative mortality.
- High standard of annual reporting.
- Systems approach to mortality review.

Challenges

- Strong data focus, with no opportunity for in-depth case reviews.
- No mandatory reporting or morbidity review.
- No feedback channel for clinicians.

National Confidential Enquiry into Patient Outcome and Death – UK

Overview

- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) undertakes confidential enquiries and make recommendations for clinicians and service providers.
- The NCEPOD is commissioned to undertake the Medical & Surgical and the Child Health Clinical Outcome Review Programmes, by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, the Welsh Government, the Department of Health in Northern Ireland, the Scottish Government and the States of Jersey, Guernsey, and the Isle of Man.
- An open call for topic enquiries is made annually, with a range of stakeholders able to provide topics for the NCEPOD to undertake.
- Once a topic has been selected (for example, cardiac surgery), a study advisory group with topic-specific experience is convened. The study advisory group is responsible for:
 - agreeing on the issues of concern
 - developing the aims and objectives of the study
 - defining the population required
 - identifying any pre-existing standards or guidelines to be used as a comparator, to ensure a robust review grounded in existing evidence
 - reviewing the findings from the test data collection, to determine fit for purpose.
- Once the study design has been developed, data collection occurs:
 - NCEPOD has a primary contact in every UK hospital, which is known as the local reporter. The local reporters are required to identify and pool cases which meet the requirements of the study. These cases form the collection, from which a randomly selected sample will be drawn.
 - Cases are then sampled from applicable services across the UK. A minimum of five cases are selected from each hospital.
 - Once the cases have been selected in each health services, a clinical questionnaire is sent to the clinicians involved in the case and an organisational questionnaire is sent to the local reporter for completion.
- Once both questionnaires are received the cases are reviewed by the case review team.
 - Approximately 30 case reviewers are involved in each enquiry or study.
 - A mixture of clinicians and specialties are included from a range of different health services.
 - The case review team undertakes training to ensure quality assurance in the peer-review process and to identify any case review members who may review cases inconsistently.

- Reviewers don't review cases from their hospital or cases from anyone they recognise. Each case review member reviews cases individually and then shares their findings with the case review team.
- During a case review meeting, a case may be classed as a cause for concern, due to evidence which suggests clinical or organisational behaviour had an adverse impact on a patient. Where this occurs, the CEO of NCEPOD notifies the medical director at the relevant hospital to review the case and take action where necessary.
- Data collection
 - The quantitative data in the organisation and clinician questionnaires are aggregated and analysed by the case review team. The review data created by the case review team are also aggregated. These data are then presented to the study advisory group and NCEPOD steering group to provide context to the findings.
 - The reviewers and the study advisory group are responsible for reviewing both datasets and developing recommendations for improvement.
 - A report is then published on the findings and the areas for improvement. The report is available free of charge, and attached is a self-assessment checklist for hospitals and an audit tool to measure change locally. Included in the report are anonymised organisation data, which hospitals can use to benchmark their facilities against.

Benefits

- Tested, evidence-based methodology.
- Targeted, specific areas for reporting/improvement.
- Mandatory reporting.
- Evidence based, with organisational/system view for improvement.
- Communication channel with health service for raising issues of concern.

Challenges

- Only certain components of mortality are in scope.
- Only aggregated is available.
- Minimal feedback to clinicians.

Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee

Overview

- The Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee (QPPAMRC) collect and analyses information regarding perioperative and periprocedural anaesthetic mortality in Queensland to identify statewide specific trends.
- Reporting deaths to QPPAMRC is voluntary.
- All data held by the QPPAMRC is protected which restricts members being required to divulge evidence in court, tribunal etc.
- Their role is to make recommendations to the Minister for Health on standards and quality indicators of perioperative and periprocedural anaesthetic clinical care, to enable health providers in Queensland to improve quality and safety.
- The committee operates under the *Hospital and Health Boards Act 2011*.
- Deaths are recorded and reported to QPPAMRC using the standardised reporting forms.
- Deaths are then reviewed by the committee bi-monthly with feedback provided.

Benefits

- Strict legislation which protects privacy and encourages reporting.
- Covers a broad view of perioperative care.

Challenges

- Reporting is voluntary.
- No direct feedback to clinicians.

APPENDIX C: STAKEHOLDERS CONSULTED

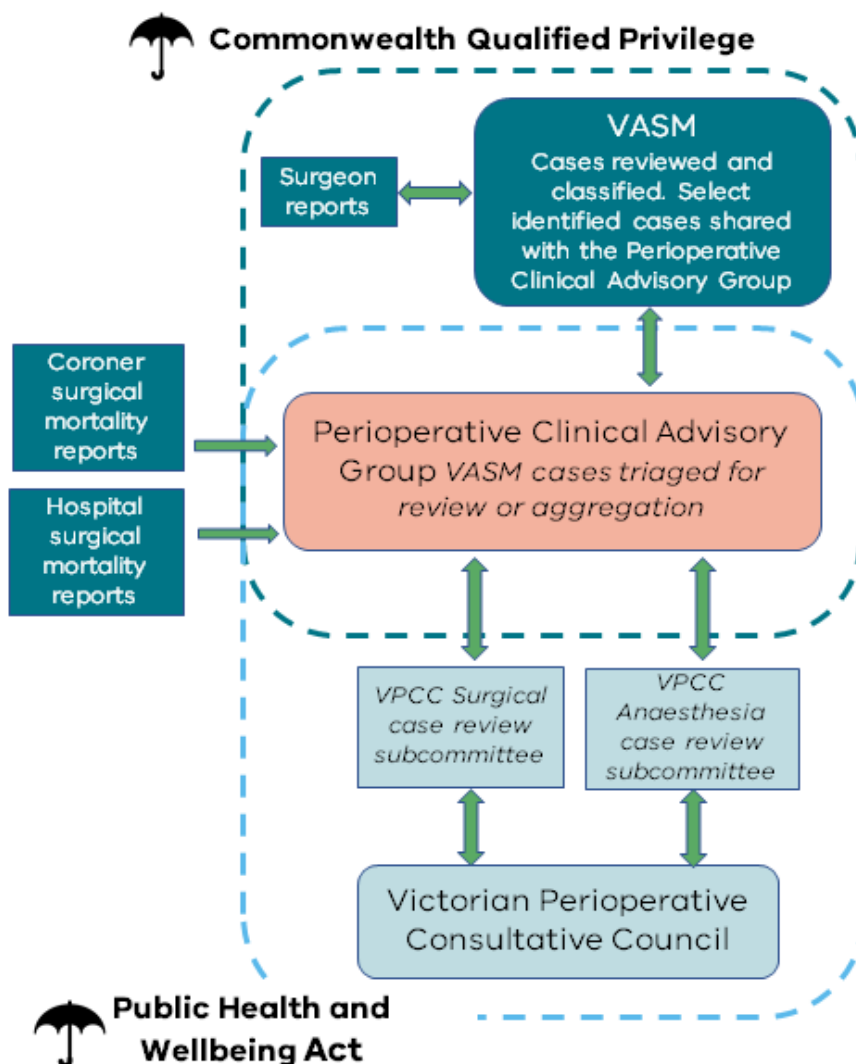
Name	Role
Dr Andrea Kattula	Chair of the anaesthetic council
Associate Professor Trevor Jones	Chair of the surgical council
Adjunct Professor Tanya Farrell	Chair of the obstetric and paediatric council
Professor Wendy Brown	Member of the surgical council
Mr Stephen Clifforth	Previous member of the surgical council
Mrs Rebekah Kaberry	Member of the surgical council
Professor Stephen Duckett	Health Program Director, Grattan Institute.
Professor Euan Wallace	Chief Executive Officer, SCV
Ms Glenda Gorrie	Director Stewardship and Support, SCV
Mr Philip McCahy	Clinical Director, VASM
Ms Claudia Retigan	Project Manager, VASM
Australian and New Zealand College of Anaesthetists, Safety and Quality Committee	Attended meeting and spoke with all members
Australian and New Zealand College of Anaesthetists, Mortality Subcommittee	Attended meeting and spoke with all members
Australian and New Zealand College of Anaesthetists, Victorian Regional Committee	Attended meeting and spoke with all members
Victorian Consultative Council on Anaesthetic Mortality and Morbidity	Attended meeting and spoke with all members
Victorian Consultative Council on Anaesthetic Mortality and Morbidity Subcommittee	Attended meeting and spoke with all members
Victorian Surgical Consultative Council	Attended meeting and spoke with all members
Royal Australasian College of Surgeons Victorian Regional Committee	Attended meeting and spoke with all members

APPENDIX D: VASM CASE-SHARING OPTIONS

The following two diagrams illustrate two options for the perioperative council to receive mortality notifications from VASM, subject to legal protections. Please note, these are only preliminary ideas for sharing information and post endorsement will require investigation and collaboration with VASM to determine their effectiveness.

VASM case sharing option 1

A Perioperative Clinical Advisory Group receives and triages hospital and coroner reported mortality cases to the Victorian Perioperative Consultative Council and to VASM for review. Information sharing between VASM and the Perioperative Clinical Advisory Group is protected by the Commonwealth Qualified Privilege Scheme **and** the Public Health and Wellbeing Act.



VASM case sharing option 2

VASM share all surgical mortality notifications received from hospitals with the VPCC for review and validation. The hospital notification system is not covered by QP legislation. The VPCC requests case information on these cases from the health services directly, under the provisions of the Public Health and Wellbeing Act, for the cases to be reviewed by the VPCC subcommittees. The VPCC validates the hospital notifications and communicates this information back to VASM.

