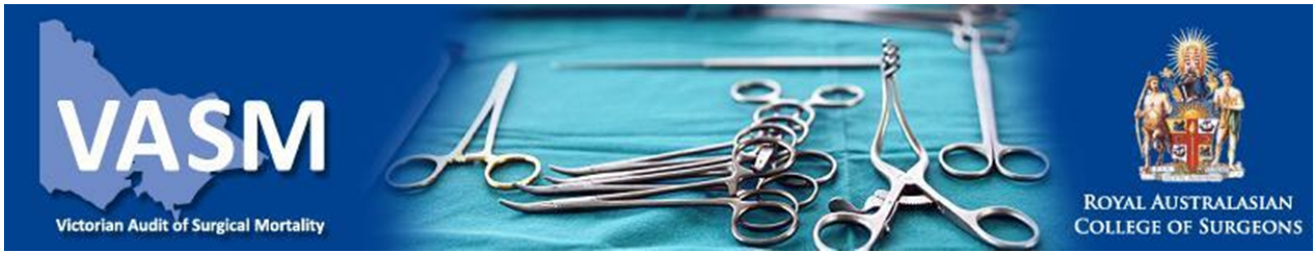

2014 VASM Report

Plain Language Statement

Victorian Audit of Surgical Mortality (VASM)
Royal Australasian College of Surgeons
Research, Audit and Academic Surgery (RAAS) Division
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About the Victorian Audit of Surgical Mortality (VASM)

The Royal Australasian College of Surgeons (RACS) has cited a significant reduction in the number of deaths of patients while receiving surgical care in both private and public hospitals in Victoria over the past seven years according to the 2014 report of the VASM, released today.

The VASM is a program collaboration between the Victorian Government's Department of Health and Human Services, the Victorian Surgical Consultative Council and RACS. This program is funded by the Victorian Department of Health and Human Services.

The aim of the program is to improve the quality of care in Victorian hospitals by examining the deaths of patients who received surgical care. The audit program involves independent clinical review of all cases where patients have died in hospital while under the care of a surgeon.

The surgically-related deaths are notified to the VASM by Victorian hospitals. Each death is reflected upon by the treating surgeon and peer reviewed by at least one surgeon practicing in the same surgical specialty, but from a different hospital

The surgeon who peer reviews the death is called a 'first-line assessor'. To ensure patient confidentiality, the assessor is unaware of the identity of the treating surgeon, the hospital in which the death occurred and the name of the patient.

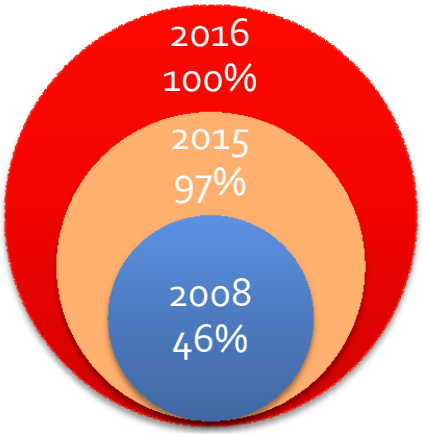
The purpose of the peer review is to identify any issues relating to the care of the patient and to provide constructive criticism.

The 2014 VASM Report is available on the RACS website: www.surgeons.org/vasm under the 'Reports and Publications' section.

Where are we now?

PARTICIPATION

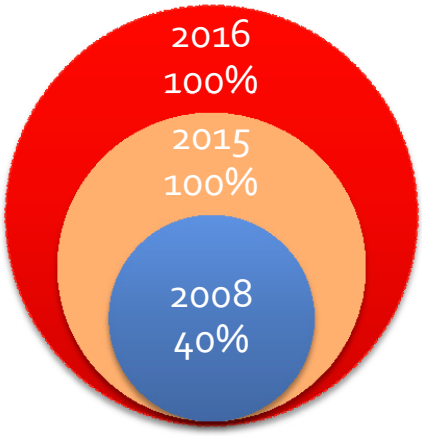
Surgeon Participation



* Surgeons are actively involved in this program and view it as a way to improve provision of surgical care to patients. The current participation rate is 97% and by 2016 it is hoped to achieve 100%.

High hospital and surgeon participation reached!

Hospital Participation



*All surgical hospitals are actively involved in this program and view it as a way to improve provision of surgical care to patients. The current participation rate has reached the targeted 100%.

TRENDS

	Surgery	Mortality
2007-2010	1,434,824	0.4%
2010-2011	608,069	0.4%
2011-2012	628,628	0.3%
2012-2013	634,609	0.3%
2013-2014	663,768	0.3%
Audit period	3,969,898	0.3%

These deaths were primarily among elderly patients with pre-existing complex health conditions.

* The information collected by the audit program is compared to a governmental report that records if patients had surgery. There ***were 3,969,898 patients that had surgery*** in Victoria in the last seven years and the report has identified low patient-related deaths as 0.3% (13,526).

* The focus of the 2014 VASM Report was on the last 12 months (1 July 2013 and 30 June 2014) where 663,768 patients underwent surgical procedures; resulting in ***very small number*** of 0.3% (1,924) deaths. There has been a reduction from 0.4% to 0.3% during the seven year audit period.

VASM findings

The 2014 VASM Report contains clinical information on 4,905 deaths that were associated with surgical care which have undergone an assessment review process through the VASM over the past seven years.

Patient Demographics:

* The median age of the patients was 79 years,
* 54% were male and 46% female,
* 85 % of patients were admitted as emergency,
* 88% of patients had a very high risk of death due to existing illness,
* 91% of patients had at least one coexisting illness and
* Cardiovascular, respiratory and renal were the highest comorbidities.

Lessons learned:

Since the audit started in 2007 there has been a significant decrease in the frequency of clinical management issues resulting in a continuing improvement in surgical care. The goal in 2016 is to reduce these further.

Some important issues remain the focus for future education activities such as reducing delays in treatment, particularly for patients admitted as emergencies with several life threatening existing conditions.

Comparative checks between the opinion of the treating surgeons and assessors are considered and these confirm the value of the audit and the peer-review process.

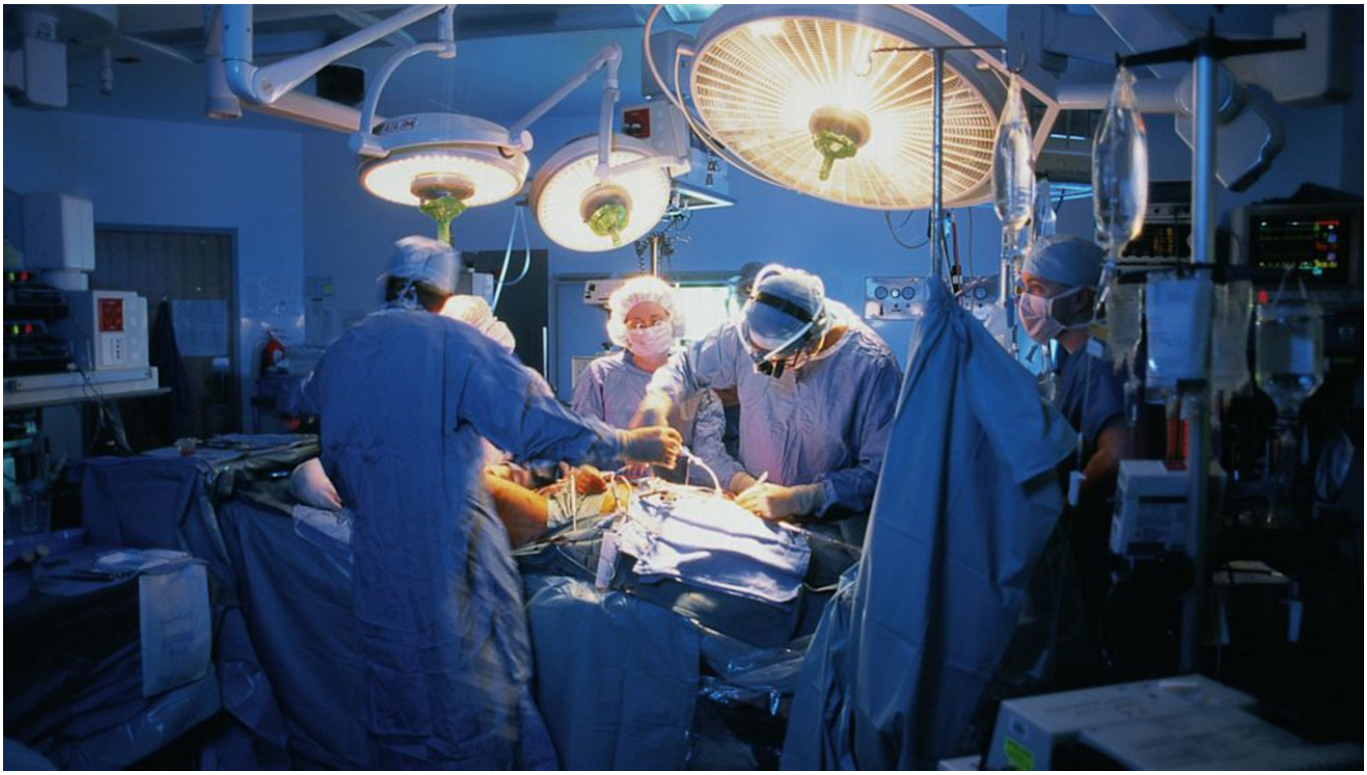
All reviewed assessments of patient management are forwarded to the treating surgeons to improve further the quality of surgical care.

2016 VASM goals

Many of the VASM ***objectives had been implemented*** from previous reports.

The VASM's aim is to review surgical deaths and assess the surgical treatment provided. If surgical care suggests that treatment was less than optimal, feedback is provided directly to the treating surgeon. This achieves another goal, that of the ***audit being an educative*** rather than a punitive process.

A secondary goal is the ***identification of clinical problems*** which will be the focus of further work in the future ***to improve patient care*** in Victoria.



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