

Division:	Fellowship Engagement	Ref. No.	TOR-3094
Department:	Morbidity Audits		
Title:	ANZELA-QI Steering Committee		

1. PURPOSE AND SCOPE

This document defines the structure and scope of the ANZELA-QI Steering Committee (AQSC).

2. KEYWORDS

Emergency Laparotomy, Quality Improvement, Benchmark standards, Audit

3. BODY OF POLICY

3.1 Background

The ANZELA-QI project is co-led by the Royal Australasian College of Surgeons (RACS) and the Australian and New Zealand College of Anaesthetists (ANZCA), and collaborates closely with other clinical colleges, specialty societies, consumer representatives and government authorities.

This quality improvement initiative has been established to enable capture of high quality bi-national prospective data.

There are two key purposes; to benchmark emergency laparotomy care against evidence based international standards and to introduce quality improvement through performance run charts, clinical care bundles and the establishment of a network for shared understanding and learning.

Emergency laparotomy patients, irrespective of age or comorbidity, are a high risk group with a 30-day mortality of between 12 and 20 %. Typically, they involve elderly, acutely unwell patients with multiple co-morbidities. This results in an even greater risk of death in those over 80 years (25% at 30 days), while placing considerable demand on healthcare resources. In addition, there is growing evidence demonstrating variation in standards of care and outcome between centres.

A number of initiatives have been set up to specifically address these issues, including the National Emergency Laparotomy Audit in England and Wales (NELA). This was commissioned in 2012 to collect and publish high quality comparative data from all hospitals performing emergency laparotomies, in order to drive quality improvement. It has demonstrated both improvements in care process and mortality outcome. There have also been Quality Improvement projects with the implementation of clinical care bundles demonstrating lower mortality rates. Despite this, there has generally been poor compliance in the implementation of such evidence based care bundles in Australia and New Zealand.

In addition, the significant mortality and morbidity following hospital discharge suggests that a number of emergency laparotomies have had limited benefit and there is growing concern that some of the highest risk patients are not being appropriately triaged to non-operative management.

3.2 Objectives

The primary objective of the ANZELA-QI Steering Committee is to provide strategic direction for the establishment and subsequent operation of a bi-national data collection program, with the aim of improving the quality of care associated with emergency laparotomy, by:

- Suggest potential funding avenues for the project.

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- Overseeing the ethical and legal obligations.
- Engaging with key stakeholders, particularly the Australasian College for Emergency Medicine (ACEM), College of Intensive Care Medicine of Australia and New Zealand (CICM), General Surgeons Australia (GSA), the New Zealand Association of General Surgeons (NZAGS), Australian and New Zealand Intensive Care Society, Colorectal Surgical Society of Australian and New Zealand, ANZ Gastric and Oesophageal Surgery Association (ANZGOSA), ANZ Hepatic Biliary and Pancreatic Surgery Association (ANZHPBA), New Zealand Society of Anaesthetists (NZSA), Australian Society of Anaesthetists (ASA), Perioperative Medicine SIG (PMSIG), health consumer groups, government health departments, the Australian Commission on Safety and Quality in Healthcare and the Health Quality and Safety Commission in New Zealand.
- Ensuring a baseline bi-national organisational audit is undertaken to understand the infrastructural, human and IT resources of each hospital.
- Determining the key outputs.
- Determining a minimum dataset to provide data for the key outputs.
- Providing a secure data collection mechanism that is available online, under the auspices of and day to day management of the RACS Research, Audit and Academic Surgery Division.
- Ensuring the audit is able to provide real-time measurement of key processes of care and risk-adjusted outcomes in order to generate high quality, contemporaneous and meaningful data. This will be presented in the form of run charts, dashboards and other QI techniques so enabling comparison within and between hospitals.
- Ensuring benchmarking of processes and outcomes against evidence based standards such as the Surviving Sepsis Campaign, the Department of Health/Royal College of Surgeons of England's 'Higher Risk General Surgical Patient (2011)', NELA and other international publications of emergency abdominal surgery.
- Ensuring open, transparent access to data for comparative benchmarking.
- Establishing standards of care appropriate to Australasian practice.
- Providing key performance indicators to drive quality improvement in standards of care, both locally and bi-nationally.
- Developing and disseminating quality improvement best practice initiatives, such as clinical care bundles.
- Providing appropriate information to patients and families facing an emergency laparotomy.
- Coordinate the promotion and engagement of the project across both countries.
- Make recommendations to the ANZELA-QI Governance Committee on matters regarding access to clinical data by non-participating organisations and data ownership.
- Provide quarterly reports to the ANZELA-QI Governance Committee.

If long-term external project funding is not secured by March 2019, the project will be wound up.

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3.3 Membership

Membership of the Steering Committee will provide key stakeholders (RACS, ANZCA, ACEM, CICM, GSA, NZAGS, NZSA, ASA, Perioperative Medicine SIG) with representation to aid in the strategic oversight of this quality improvement initiative, and shall include:

- Two representatives from RACS, one of whom shall be a Councillor, and neither of whom will also be the representatives of GSA or NZAGS.
- Two representatives from ANZCA
- One representative from all other key stakeholders
- The members are also expected to represent their home Australian state/territory or New Zealand. If there is no representative from a region then another individual will be sought for that representation.
- A consumer representative who has skills that are relevant to the project.

Attendees:

- RACS Morbidity Audits Manager
- RACS Surgical Audits Manager
- RACS General Manager, Research, Audit and Academic Surgery Division
- RACS CEO or delegate

3.4 Tenure and Method of Appointment

All nominations for appointment to the Committee are to be made in writing to and determined by the ANZELA-QI Governance Committee.

The Chair will be appointed by the Governance Committee. The Vice Chair will be appointed by the Steering Committee.

Nomination for membership of the Steering Committee will be for three year terms, renewable three times (maximum of nine years).

The Chair and Vice Chair positions will be held by RACS and ANZCA representatives normally by rotation or as otherwise agreed by the Governance Committee.

3.5 Powers

The Steering Committee can create sub-committees and working parties.

The Steering Committee shall elect an Operations Committee. The Operations Committee will be composed of the Chair and Vice Chair of the Steering Committee as well as two other clinical representatives elected by the Steering Committee. This will normally meet monthly to ensure that consistent strategic oversight is provided and key decisions can be made in a timely fashion. It will report to the full Steering Committee.

The Chair may invite guest speakers or temporarily co-opt individuals or representatives of specialist Societies with specific experience, as needed. These individuals are not members but attendees:

- Attendees provide advice or expertise in areas where the Steering Committee considers it has a lack of expertise or could benefit from a wider breadth of experience.

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- The presence of these non-members should be noted in the agenda and minutes.
- Non-members typically only attend the meeting for the duration of the agenda item they are concerned with.
- Attendees are not involved in decision-making and have no voting rights (they are typically not present while the Steering Committee deliberates and makes decisions). College staff who attend may remain while decisions are deliberated although they do not vote.

3.6 Quorum

A quorum shall be 50% of the membership, plus one person.

3.7 Meetings

The Steering Committee will meet at least four times per annum. Out of session deliberations will be conducted as required.

Decisions can be taken with a quorum of 50% of the membership plus one person. The Chair has a casting vote where the decision is otherwise split. A 75% majority is required for e-voting.

Proxies will be permitted, providing the representatives details are submitted to the Chair at least 24 hours prior to a scheduled meeting.

A declaration of conflict of interest is required and will be recorded in the minutes.

A record will be maintained of agendas and papers circulated with them; papers tabled at meetings; papers circulated other than with agendas; minutes; and pertinent correspondence.

The RACS will provide a secretariat service through the Research, Audit & Academic Surgery (RAAS) Division.

3.8 Accountability and Reporting Structure

Clinical governance of ANZELA-QI will reside in this Steering Committee and be under the joint authority of the Councils of RACS and ANZCA through the ANZELA-QI Governance Committee.

The Steering Committee will be responsible for reporting on their progress to the Councils of the Colleges through the ANZELA-QI Governance Committee and Boards of the Societies (via the Working Parties and Special Interest Groups where they exist).

The Steering Committee will be responsible for production of an annual report that will provide information on the operation of the audit and quality improvement data at national, state and hospital level. These will be adjusted for risk and will document whether relevant standards are being met. Hospitals will be able access their data outside of the official reporting periods.

Data will not be published at individual clinician level, as the care of these patients depends on multiple clinicians and hospital processes.

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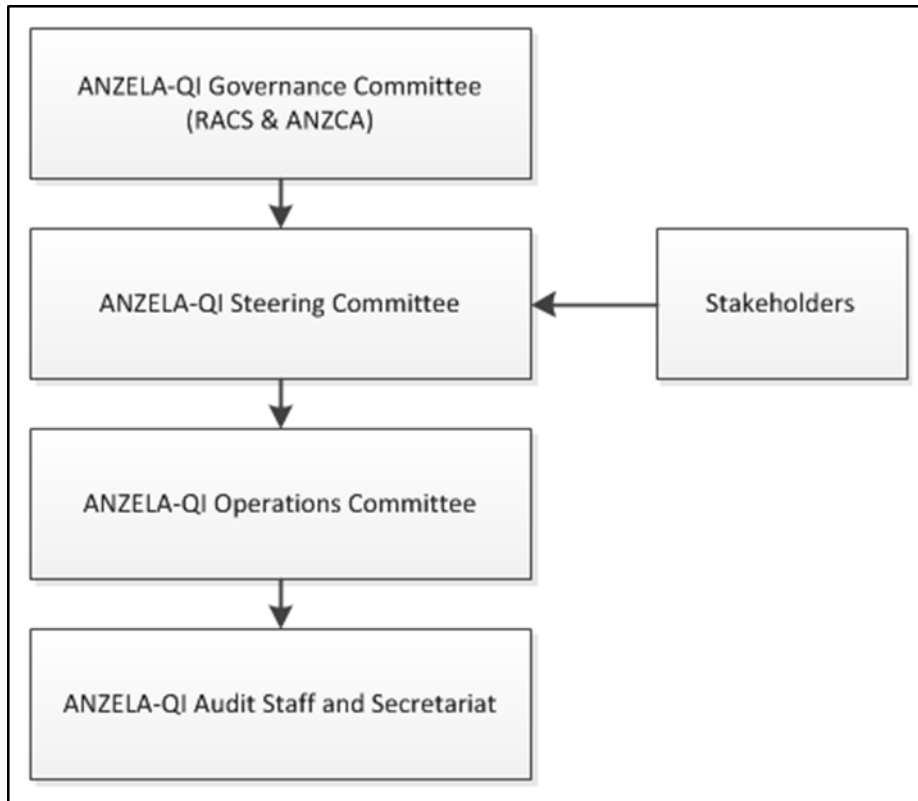


Figure 1 Reporting structure of the ANZELA-QI Steering Committee

4. REVIEW

These terms of reference will be reviewed annually by the Steering Committee and approved by the ANZELA-QI Governance Committee.

5. ASSOCIATED DOCUMENTS

Terms of Reference, ANZELA-QI Governance Committee

Approver CEO
Authorisers RACS Council and ANZCA Council