



Newsletter - March 2011

MESSAGE FROM THE CHAIR

Welcome to the first newsletter for 2011! Council welcomed new members Dr Amanda Dennis and Ms Gina Butler at its recent meeting who will be undertaking the 2nd UTAS and DHHS representative roles respectively in the current term. Preparations for the 2009 Annual Report are well underway with a view to complete as soon as possible once data auditing processes have been finalised by *Clinical Data Services* and data is finally released to Council for processing and reporting etc. Key issues arising will be reported in future newsletters in the interim prior to final release of the 2009 Annual Report. I wish to sincerely thank our Manager and Members for their continued support and significant contributions to Council and its ongoing activities.

A/Prof Peter Dargaville
Chairperson
Council of Obstetric & Paediatric Mortality & Morbidity

COUNCIL NEWS

Membership for the current term in accordance with the Terms of Reference includes: A/Prof Peter Dargaville (Chair); Professor Allan Carmichael; Dr James Brodribb; Dr Geoff Shannon; Ms Ros Escott; Ms Flo Jensen, Dr Amanda Dennis, Mr Paul Mason; Dr Michelle Williams & Ms Gina Butler.

The Council website continues to archive newsletters, Annual Reports and other relevant resource information. The updated website address is as follows:

<http://www.dhhs.tas.gov.au/copmm>. Please note that *RHH Clinical Practice Guidelines and Protocols* can be accessed from the intranet link included in Council's website.

Manager, Contact Details: Dr Jo Jordan; email: jo.jordan@dhhs.tas.gov.au

CLINICAL MATTERS

- 1. Child Death and Serious Injury Council update** – The "*Child Death and Serious Injury Council of Tasmania*" (CDSIC) that will comprise broad membership from relevant stakeholders, including COPMM, will have the power to require that other Governmental Departments or instrumentalities of the Crown provide detail on how recommendations derived from reviews would be implemented. In response to concerns raised by the Magistrates Court, it has been agreed and supported to redraft the Bill to adjust original membership so that the Coroner will no longer constitute part of membership. It is expected that the Bill will be progressed to meet the approval of the Minister and Cabinet before it can be progressed to Parliament for discussion. It is hoped to be finalised by mid-2011. The Commissioner for Children will Chair this Council once established.



- 2. Clinical Advice and Network Development Unit (CANDU)-** The Department of Health and Human Services (DHHS) has established a new clinical network for Women's and Children's Services (WACS) across Tasmania. This is in line with the initiatives outlined in Tasmania's Health Plan recommending the establishment of clinical networks across a number of clinical disciplines including WACS services. The establishment of the WACS Clinical Network has been supported by the Clinical Advisory and Network Development Unit (CANDU). The establishment of the Women's and Children's Clinical Network (WACSCN) with Dr Amanda Dennis and Mrs Francine Douce as Clinical Co- Leaders calls on all private and public sector health professionals, stakeholders and consumers across the continuum of WACS to work together to develop a system that is able to achieve equitable access, quality, consistency, coordination, continuity and cost-effectiveness of patient care for all Tasmanian Women and Children across the continuum. For more information about the Tasmanian Clinical Networks or to become a member of a Clinical Network please visit <https://clinicalnetworks.dhhs.tas.gov.au/display/HOME/Home+Page> or contact the CANDU team on phone: 6233 3358.
- 3. Electronic Perinatal Database (ObstetrixTas)-** This system is now live and implemented Statewide for Perinatal data collection. A few issues arising from the project are currently being addressed by the Project Manager and system administrator in IT services. Difficulties have been identified with the system in relation to (i) input of information; (ii) retrieval of information; and (iii) communication between EMR and EPD systems at the RHH. Problems have further been identified with regard to report content provided to GPs as well as the systems efficacy in regards to providing a clinical tool. In view of these queries, further investigation and refinement of the system will be required. It has been highlighted that the RHH will not be using the system for antenatal visits. It has been advised that the Vendor is currently completing model changes and enhancements in regards to rules and reporting with site coordinators required to assess effectiveness of these changes. Furthermore, the processes to allow improved communication of information from the ObstetrixTas system to GPs, CHAPS and the DMR will undergo final refinement in the near future. Recommendations are currently being formulated to identify the best phase for project completion particularly in view of current concerns relating to alignment of the model with business processes, generation of statistical reports and content of various reports to satisfy user needs. A key recommendation will be to ensure that site coordinators continue to provide a supporting role for their site. It has been highlighted that the site coordinator at the RHH has recently retired and there has been no resolution or progress undertaken to replace this role as yet. It has also been recommended that a systems owners group be established following closure of the project to ensure that ongoing priorities and policies are managed appropriately. There will be a need to resource a position to coordinate such ongoing support and management of the system. Council agreed to support the need to ensure that a "local champion" be established at each centre to ensure that maintenance and improvement in the system is effectively achieved. Council also agreed that it was important for the DHHS to ensure that there was continued coordination and consistency within the use of the system and problems were managed effectively. Council suggested that the WACS Clinical Networks may be a key resource available to assist with the provision of continued support for EPD system.
- 4. Coroner Recommendations on Unexplained Infant Deaths–** Council commended the recommendations recently put forward by Coroner McTaggart following investigations into infant deaths in Tasmania. In particular, specific recommendations included the following where the Coroner believed that the DHHS should adopt a lead role in (i) developing a single set of consistent guidelines that



define the appropriate strategies to be implemented by parents, carers, and health professionals for the reduction of risk factors in sudden unexpected deaths of infants; (ii) publishing the guidelines amongst the medical and nursing professions in both the public and private sector; (iii) publishing the guidelines in the wider community generally, including amongst current and future parents (eg. in antenatal classes and secondary schools); (iv) conducting a SIDS education program statewide (perhaps by employing a SIDS educator), with particular reference to any high risk sub-groups; (v) implementing a requirement that all child health nurses/community nurses receive updated training about the guidelines, and (vi) ensuring that SIDS risk assessments are conducted with parents upon the mother's discharge from hospital, with appropriate information about the guidelines provided to them.

5. **Child Death Review Update-** It had been highlighted that the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) has sought support from jurisdictions regarding a submission to the Commonwealth Department for Families, Housing, Community Services and Indigenous Affairs (FAHCSIA) concerning a project to be undertaken into preventable infant mortality (ie., infant deaths upto 28 days to 12 months). Mortality data available from child death review mechanisms in each jurisdiction would be utilised in order to assist the Commonwealth to establish an evidence-based national agenda for the further prevention of infant deaths by addressing modifiable risks. Council has agreed to support the project in terms of utilising an Option where responsibility for the completion of the project would rest with the Commission for Children and Young People and Child Guardian, Queensland (as current chair of the ANZCDR&PG) subject to funds being made available for the appointment of a project officer. Council agreed to collaborate as required but recognised that some data from Tasmania with regard to child protection status may be incomplete particularly with regard to neonatal deaths and paediatric deaths reviewed prior to 2006. COPMM representation on ANZCDRPG is currently being reviewed following changes in appointments of relevant members etc.
6. **Standardisation of Perinatal Review in Tasmanian Hospitals-** Council has agreed to support the proposal to implement the use of a standardised form as part of all Tasmanian public and private hospitals reporting of all perinatal mortality cases by their respective Mortality and Morbidity Committees. The proposed form is derived from the **Perinatal Mortality Confidential Case Summary** as per Section 2 (of 7)-*Institutional Perinatal Mortality Audit from the Perinatal Society of Australia and New Zealand*. Council has agreed that this form would provide all hospitals with an effective opportunity to standardise the process of audit for perinatal mortality cases. Council is currently sourcing support from all Tasmanian hospitals to adopt and utilise this form by their respective M&M Committees. It is hoped that this process will allow relevant case summary reports to be readily provided to Council's Perinatal M&M subcommittee from local M&M Committees to assist in review and classification processes undertaken by COPMM and its relevant subcommittees. It is understood that restrictions will apply to privileged information maintained by the local M&M Committees and the form will reflect this requirement.
7. **DHHS Statewide Clinical Governance Committee (SCGC)-** Council has welcomed the establishment of the new SCGC by DHHS which will meet monthly. Membership includes the Deputy Secretary of Health and Hospitals (Chair); Chief Health Officer; Chief Nurse and Allied Health; Medical Director Safety and Quality; Medical Adviser Safety & Quality; Director of Medical integration Primary & Rural Health; Chief Medical Officer/Medical Director (Chair of Serious Incident Panel) from each of the Operating Units; Senior Clinician and Legal Adviser. This Committee's role and function will be to contribute towards the provision of high quality services



provided by the DHHS. The SCGC will report annually to the DHHS Secretary using exclusively de-identified data and will include recommendations for the future work of the Committee etc. In particular, this Committee which met in February 2011 had tabled the recommendations outlined in COPMM's recent Annual Report and actions arising from discussions propose that DHHS write to the Directors of Medical Services within Area Health Services to request that they complete a self assessment of the actions taken in response to COPMM recommendations. An implementation status report will be sought by the Committee within 12 months. Council agreed that the establishment of this Committee in the DHHS will provide a very valuable and useful avenue for COPMM recommendations to be considered by the DHHS and its Secretary so that appropriate actions can be consolidated and expedited more efficiently by the Department in the future.

SUBCOMMITTEES

PAEDIATRIC Mortality & Morbidity

This subcommittee continues to meet bimonthly to review statewide paediatric deaths and progress actions as they arise. The Committee welcomed the new Commissioner for Children, Ms Aileen Ashford as representative on this committee for the next 6 months. In view of the Commissioner for Children having been proposed to Chair the CDSIC once it is finally established, it has been considered appropriate that she does not continue representation on the Paediatric M&M subcommittee due to possible conflict of interest in roles. The completed draft of 2009 Paediatric Report is currently being reviewed by members. Review and classification of 2010 cases is near completion. Following its recent meeting, the review of a paediatric death following a farming accident has sparked its recommendation to ensure that educational information is appropriately distributed within the community to highlight potential risks and dangers of farming equipment (e.g., tractors, rotary hoes etc.) to children. It was suggested that it would be worthwhile to ensure that such messages of alert and information be reinforced via distribution at AgFest 2011.

PERINATAL Mortality & Morbidity

Review and classification of perinatal deaths (including stillbirths and neonatal deaths) for 2009 is being progressed. The respective reports for 2009 from this Committee will be drafted as soon as possible for inclusion in the 2009 Annual Report.

MATERNAL Mortality & Morbidity

No maternal death cases were reported in 2009. The three maternal death cases identified in 2010 will be reviewed and classified by the committee as soon as possible following confirmation of the nominated Chair for this committee. Recommendations will be formulated as appropriate. Progress of the *Australian Maternity Outcomes Surveillance System* (AMOSS Project) will continue to be tracked and its relevance to Tasmania's reporting's assessed etc.

DATA MANAGEMENT

A meeting is scheduled to be held on March 10th, 2011 to progress issues related to the 2009 Annual Report and Electronic Perinatal Database.



MEMBERSHIP CHANGES

Membership updated for the current 2009-2012 term Membership includes: A/Prof Peter Dargaville (Chair); Professor Allan Carmichael (UTas rep); Dr Amanda Dennis (UTas Rep), Dr James Brodribb (RANZCOG rep); Dr Geoff Shannon (RACGP rep); Ms Ros Escott (Community Rep); Ms Flo Jensen (ACMTas rep), Mr Paul Mason (Commissioner for Children); Dr Michelle Williams (Tasmanian Branch of the Paediatric Health Division of the RACP rep) & Ms Gina Butler (DHHS rep). In view of news that Professor Mark Brincat will not be arriving in Tasmania to undertake the appointment as Head of Obstetrics and Gynaecology at the Royal Hobart Hospital, Professor Carmichael will be seeking support from the Acting VC for nomination to extend Dr Amanda Dennis' representation on Council as second UTas representative until the end of the current term (July 2010).

MEETINGS FOR 2011

Next Council Meetings:

- Thursday 26 May, 12.30-2.00pm, venue tbc
- Thursday 18 August, 12.30-2.00pm, venue tbc
- Thursday 17 November, 12.30-2.00pm, venue tbc

Note: Subcommittee meetings will be advised.