

**Minutes** of the meeting of the Safe Surgery NZ Advisory Group

Held on 1 September 2016, at the Health Quality & Safety Commission, Wellington

Present: Prof Ian Civil – Chair (Auckland DHB)

Miranda Pope (Canterbury DHB, Perioperative Nurses College NZNO)

Rosaleen Robertson (Southern Cross Hospitals)

Caroline Gunn (Consumer representative)

Dr Peter Jansen (ACC)

Dr Mike Stitely (Royal Australian and NZ College of O&G)

Prof Justin Roake (Canterbury DHB)

Bob Henderson, (Airline pilot, psychologist)

HQSC team: Gary Tonkin, Gillian Bohm, Owen Ashwell, Maree Meehan-Berge (minute taker), Hilary Sharpe (afternoon only)

Guests: Chris Walsh and Deon York, HQSC for agenda item 7

Richard Hamblin, HQSC for agenda item 9

Emma Forbes and Jenny Hill, HQSC for agenda item 11

Apologies: Dr Nigel Willis (CCDHB)

Dr Leona Wilson (ANZCA, CCDHB)

Dr Will Perry (Registrar Medical Officer)

The meeting commenced at 9:30am.

1. **Welcome and apologies**

The Chair welcomed the group and apologies were accepted.

1. **Minutes and actions from meeting held on 16 June 2016**

The group approved the minutes of the meeting held on 16 June. The actions list was considered. All items have been progressed or completed.

**Action:** the approved 16 June meeting minutes will be placed on the Commission website.

1. **Progress report**

Safe surgery monthly report to the end of August received.

The upcoming *Safe Surgery with Professor Cliff Hughes* regional workshops were discussed. Registrations for all four workshops are progressing well, although surgeon numbers are low, particularly in the Midland region. The advisory group thought commitment from DHB management teams and practical support to allow more opportunity for surgeons and surgical teams to attend the workshops would be critical to registrations numbers.

**Action:** the programme team to send out reminders and further promotion around the Cliff Hughes workshops.

The July to September quarter of Quality and Safety Marker data collection is progressing well, with 17 DHBs entering checklist completion and team engagement scores into the online data collection tool. The DHBs that had yet to collect data were all small services with small auditing teams.

**Action:** the programme team to identify ways to support data collection for all 20 DHBs.

Research company, Mobius is again the provider for the repeat Surgical Safety Culture Survey. The contract requirements are in development, with the likely timing for the survey of February 2017. The survey report will then be available to include in the programme evaluation final report, due June 2017.

The University of Auckland team has been approached to continue their contract delivering safe surgery auditor training and resources. The contract will include three key deliverables; development of a trainer training resource for local auditor teams; four regional ‘refresher’ auditor training workshops; and development of an online learning resource.

Two DHB surgical teams have been approached to participate in the Partners for Care co-design training, with a Safe Surgery project focus. Lynn Maher has been contracted to provide two onsite workshops and provide regular webinar contact for the seven month duration of the co-design activity. At this stage we are waiting to hear if Hutt Valley and Wairarapa DHBs will agree to participate.

**Action:** the programme team to support two DHBs to identify suitable safe surgery co-design initiatives.

1. **Perioperative Mortality Review Committee (POMRC) and Safe Surgery NZ (SSNZ) joint meeting**

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The advisory group discussed the sustainability of the programme and beginning to work with POMRC, proposing integration of the programmes. The issue is that the investment in SSNZ is budgeted to reduce from July 2017. The Commission and Advisory Group are committed to ensuring the gains the Safe Surgery programme has made to date are sustained and can continue to be built on, despite the reduced investment. POMRC has been identified as one of the sustainability options for the SSNZ Programme.

POMRC and SSNZ already share a common focus on reducing harm and morbidity and integrating the programmes would make optimal use of the funding and resource available for this area. Each programme has features other than funding that can be mutually beneficial (e.g. POMRC data, SSNZ sector networks) and the programmes are at a stage of development that will allow a change in structure over the next year. The consumer perspective was raised, highlighting the preventative focus of SSNZ and the need to maintain the quality improvement focus alongside the current demographic focus of POMRC.

**Action:** The SSNZ and POMRC programme teams will prepare a paper for the meeting between the Chairs of SSNZAG and POMRC, to be held on 5 October.

**Action:** The SSNZ and POMRC programme teams will provide an update to the September Board meeting, via the Chief Executive Report.

**Action:** The SSNZ and POMRC programme teams will submit a proposal to the November Board meeting, for a safe surgery focused MRC.

1. **MORSim update**

The Chair, also a member of the MORSim team, updated the group on recent progress. The first cohort of five DHBs are preparing for the November trainer training and February simulation training.

There was discussion about how private surgical providers might access MORSim training. As MORSim is funded by ACC, Dr Peter Jansen, the ACC member on the advisory group, offered to assist NZPSHA by introducing them to the right people within ACC to discuss this further.

**Action:** the programme team will progress MORSim discussions at a meeting with the NZPSHA Executive Director next week.

1. **New articles and developments**

A 2016 World Journal of Surgery article, *Postoperative Adverse Events Inconsistently Improved by the World Health Organization Surgical Safety Checklist: A Systematic Literature Review of 25 Studies* was discussed. It concluded that the checklist may be associated with a decrease in surgical adverse events and this effect seems to be greater in developing nations. The authors, de Jager et al, observed overall poor study designs and possible positive results might be due to confounding factors and publication bias. They suggested a need for more consistent positive literature before claiming improvement attributable to the checklist. Exceptions were; the reduction in Surgical Site Infections with timely, right dose antibiotics; and reduced mortality from trauma by up to a half however, the authors were uncertain if this is a process or teamwork effect.

1. **Partners in care and co-design presentation**



The Chair welcomed the Partners in Care team members to the meeting. Dr Chris Walsh (Director) and Deon York (Programme Manager) presented an overview of the Commission work in this area. Experience and evidence support consumer engagement, with co-design recognised as the preferred consumer engagement approach. Co-design principles can be simplified to: capture the experience; understand the experience; improve the experience; and measure the improvement.

A number of Commission co-design examples were presented to the group, for example the surgical site infection information pamphlet and a hand hygiene advocacy tool.

The Commission has worked with Lynne Maher for over five years, providing co-design training to DHB teams. After a 2015 review the Partners in Care team moved to working intensively with two DHBs per year, offering onsite co-design training and support. This year it is Taranaki DHB and Hutt Valley DHB. Hutt Valley has a surgical team co-design project and a Capital and Coast DHB surgical team has been invited to join the co-design programme.

1. **Evidence summary**

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The review includes a small number of new articles. Key changes to the review document include; a strong recommendation that referring to the checklist is essential; the briefing and debriefing evidence has been strengthened, and inclusion of more in depth commentary about the human factors that influence outcomes. System resilience and theatre efficiency are better described in this latest summary.

**Action:** the programme team will place the finalised evidence review on the website. Printed copies will be distributed at the upcoming Prof Cliff Hughes regional workshops.

1. **Evaluation progress; final second fieldwork report**

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The group considered an early draft of the second fieldwork report from Sapere. The work to date was acknowledged and it was noted that a number of interesting findings are starting to come through the evaluation process. A number of recommendations about improving the second fieldwork report were noted, including confirming the accuracy of DHB information, and strengthening the executive summary by including early findings and possible recommendations. Also noted was the small number of surgeons that had been interviewed to date. The group recommended Sapere widen the breadth of interviewees, including more surgeons.

**Action:** programme team to provide feedback to Sapere to ensure a wider range of surgical team members, especially surgeons, are included in the next round of interviews.

The group anticipate the evaluation Interim Findings Report, now due on 14 October, will start to clearly articulate the evaluation findings, including areas for improvement in the programme design and structure.

1. **Safe surgery outcome measures**

The Health Quality and Evaluation (HQE) Director updated the group on recent progress with programme outcome measures and the proposed new process measure. The group had requested details about the Sepsis definition that was used for the development of the Sepsis risk adjusted model. The group were advised that the Health Quality Measures New Zealand definition had been used, which is consistent with OECD definitions. There was discussion about readmissions, sepsis as primary or secondary diagnosis, and the reliability of coding.

The Venous Thrombo Embolism (VTE) risk adjusted model development has been delayed due to resourcing priorities but will be developed before the end of the year. The HQE team will present the findings to the advisory group at the 23 February meeting.

The HQE team are recommending that before developing a new briefing Quality and Safety Marker (QSM) measure and board paper, they will compare engagement data from those DHBs who are using briefing versus the engagement data of those not doing briefing. The hypothesis is that there is a link between doing start-of-list briefing and higher quality of engagement.

**Action:** the programme team will ensure the HQE team are on the agenda for the 23 February meeting and present the VTE risk adjusted model findings.

**Action:** the programme team will develop a new QSM discussion paper, to go the Board in February and report back to the advisory group on 23 February.

1. **Deteriorating patient programme presentation**

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Emma Forbes, Project Manager and Jenny Hill, Specialist Advisory for the Deteriorating Patient Programme presented to the advisory group. The presentation slides are attached.

The Commission has Board approval for a five-year quality improvement programme that aims to improve the recognition of and timely, patient-specific responses to clinical deterioration for all adult inpatients in NZ. There is a phased approach to the three key focus areas of the programme, including: recognition and response system (2016-18); patient, family and whanau escalation (2017-19); and goals of treatment (2018-20). Measurement and evaluation of the programme will go across the 2017 to 2021 span of the programme.

An Expert Advisory Group has been recently established and Evidence Summary and Sector Feedback documents published. There has been discussions with regions and engagement with national groups.

The next steps include developing a protocol for a national vital signs chart with early warning scores, response processes and responder competencies. Agree on local and national measures through further engagement with national groups.

The advisory group are particularly interested in the sub-set of deteriorating patients who had recently undergone surgery, or where surgery was planned to occur.

1. **Combined POMRC/SSNZ forum – speaker suggestions**

The group considered possible speakers for the June 2017 joint forum. They recommend the following speakers are considered by the POMRC committee, at their 21 September meeting:

* Professor the Lord Ara Darzi – might attract a large crowd and could run an all-day forum with a cost recovery approach
* Professor Ian Harris – Australian Orthopaedic Surgeon, may still be interested in promoting his recent book
* Professor Keith Willett – UK based Trauma and Orthopaedic Surgeon and National Clinical Director for Trauma Care.

The Principal Advisor suggested to the group that ‘system resilience’ is a current topic of interest to health professionals and an expert on “Resilience in the Surgical System” may be of interest to the sector.

**Action:** The programme team will look further into a possible speaker to talk to a resilience theme.

1. **Other business**

The joint meeting with POMRC will be on the morning of 5 October, before the Wellington Safe Surgery NZ regional workshop with Professor Cliff Hughes presenting.

**Action:** the programme team to develop a discussion paper for the Safe Surgery NZ Advisory Group and Perioperative Mortality Review Committee meeting. This will be circulated to both groups’ members prior to the meeting.

Dates were found for the first two meetings in 2017; 23 February and 18 May.

**Action:** the programme team will send calendar invites to all advisory group members for these two dates.

Next meeting; 23 November 2016

Health Quality and Safety Commission, Level 9, 17-21 Whitmore Street, Wellington.