

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

Held on 23 February 2017, 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 and NZPSHA)

Caroline Gunn (Consumer representative)

Prof Justin Roake (Canterbury DHB)

Bob Henderson (Airline pilot, psychologist)

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

Guests: Richard Hamblin and Ying Li, HQSC for agenda item 4

Apologies: Dr Nigel Willis (CCDHB)

Dr Will Perry (Registrar Medical Officer)

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

Gillian Bohm (HQSC team)

Dr Peter Jansen (ACC)

Dr Leona Wilson (ANZCA, CCDHB)

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 24 November 2016**

A correction was requested to amend page two, paragraph five, changing the date of a survey from 2013 to 2014. The group then approved the minutes of the meeting held on 24 November. The actions list was considered. All items have been progressed or completed.

**Action:** the approved 24 November meeting minutes will be placed on the Commission website.

1. **Programme planning 2017/18**

The Senior Portfolio Manager outlined the recent draft Statement of Intent (SOI) strategic priorities in relation to the Safe Surgery NZ Programme. He then went on to outline the Commission quality improvement life cycle, highlighting that the Safe Surgery NZ programme will move into the ‘sustain’ phase at the end of 2017/18. This will still allow for some ongoing support of DHBs alongside monitoring of the process and outcome measures.

The key focus of the programme for 2017/18 will be around continue expert advice to support teamwork and communication, support measurement and monitoring of the quality and safety marker, disseminate programme evaluation findings, and continue with the co-design focus with two new DHBs.

With the proposed integration of Safe Surgery NZ (SSNZ) with the Perioperative Mortality Review Committee (POMRC), there is an opportunity to merge these existing priorities with the POMRC recommendations.

Discussion focused around the need to emphasise and encourage the establishment of briefing, and then debriefing, in all theatres in all DHBs. It was pointed out that the Surgeon is best placed to lead briefing. Anecdotally, the introduction of briefing has shown to lead to positive behavioural change in the workplace. A small scale research programme involving one or two DHBs, around the introduction of briefing would be ideal at this time. The professional colleges may want to be involved in this research.

**Action:** the programme team will present a further iteration of the programme plan at the 18 May advisory group meeting.

1. **Safe Surgery outcome measures**



The Health Quality Evaluation Director and Senior Analyst presented the risk adjustment model used on both programme outcome measures, Sepsis and Deep Vein Thrombosis and Pulmonary Embolism (DVT/PE). The Sepsis risk adjusted model was presented in detail to the advisory group at the 16 June 2016 meeting.

The HQE team described the process of developing the VTE/PE model. They highlighted that the predictive value of the VTE/PE model is 0.805; that is, it is a very good predictor of VTE/PE. All factors used in the model are statistically significant and listed by significance. The reducing trend/rate of VTE/PE started in 2011 but was not stable. From 2013 to 2016 numbers have dropped below the expected rates. In 2014 a stable downward shift began and in 2017 this downward shift is now stable. The rate is now at 88% of expected which is a more than 10% reduction.

The model uses public provider data only but the HQE team could also include private provider data if we are confident of the data. The private provider data does not have the same long term continuity which may be an issue.

The Sepsis risk adjustment model has been reviewed and new data has been added. WE now see an increase in sepsis since 2016. Sepsis risk is now at a rate of 1.19. The HQE team are looking into this but predict one factor is better recording of Sepsis diagnosis.

The HQE team also looked for any correlation at sites where briefing was being done and a possible impact on surgical teams’ quality of engagement data. At this point in time there is no correlation between the two quality activities, although it might just be too early to identify the relationship between the two. The HQE team recommend a measure around briefing, capturing whether the briefing has been done with a target of 95% of lists start with a briefing. This measure will reinforce the earlier decision to include briefing in the project interventions. If a measure of quality of engagement around the briefing was wanted this would require the development and testing of a suitable tool first.

**Action:** the programme team will liaise with the HQE team to represent these graphs at key points where new data becomes available.

1. **Progress report**

The safe surgery monthly report to the end of January 2017 was received and discussed.

The first round of Quality and Safety Marker (QSM) results were publicly reported on 19 December. The draft second quarter of QSM results (October to December 2016) were discussed. The Health Quality Evaluation team report no significant change in results between the two quarters. The programme team will continue to support DHB surgical teams to collect and evaluate the audit data to inform teamwork and communication improvements.

The second surgical safety culture survey went live from 1 – 24 February. All 20 DHBs participated, although Waitemata will distribute the survey to staff in late March due to an internal culture survey underway in February. Over 1000 responses were received. A report will be prepared and presented to the 18 May advisory group meeting.

Details for auditor training workshops to be held in April/May have been confirmed and surgical teams have been asked to identify attendees. The dates have been confirmed as South Island region 28 April, Central region 1 May, Northern region 8 May, and Midland region 9 May. An online auditor training resource has been drafted and will be finalised in March, with access to these resources sent to safe surgery project and quality leads.

The Board approved the Programme Evaluation Interim Report and after Communication Team review, will be placed on the website. A timeframe and process for review of the final report has been developed, with the draft report going to the advisory group at the 18 May meeting and the Evaluation Steering Group reviewing the report on 6 June. The final report findings will be presented by Sapere at the Perioperative Mortality Review Committee/ Safe Surgery NZ joint workshop on 21 June.

The two safe surgery project teams (Hutt Valley and Capital & Coast DHBs) participated in the Co-Design programme webinars and progressed their patient information projects. Each has consumers working alongside them on their co-design initiative.

**Action:** the programme team will present the culture survey report to the group when it becomes available.

1. **MORSim update**

The Chair, also a member of the MORSim team, updated the group on recent progress. Instructor training for the first cohort of five DHBs is well underway. The simulation training dates at each DHB are scheduled between February and May. The MORSim team is preparing simulation scenarios for the target specialties.

Training for the second cohort of five DHBs has been moved back six months and will now start at the end of 2017.

The second tranche of ACC funding, affecting the final 10 DHBs, will be decided before the end of 2017.

Baseline audit data has been collected at each of the first cohort DHBs. An independent auditor from the MORSim team undertook the observation audits using the WHOBARS team engagement rating scale. This is the same tool used by the DHB safe surgery auditors. Comparison of results from these two audit processes has highlighted a difference in scoring and the two project teams are investigating the scale of the differences and possible reasons.

**Action:** the programme team will work with the MORSim project team to investigate the differences in scores and present their findings at the next advisory group meeting.

1. **New articles and developments**

An article about surgical safety culture impacting outcomes was discussed. The group agreed that both *Use of Unsolicited Patient Observations to Identify Surgeons with Increased Risk for Postoperative Complications* (Cooper, et al) debunks the idea that you can have a terrible culture and still have consistently good outcomes. Media reported on this publication with the headline “Rude, disrespectful surgeons may also be more error-prone: study”.

A BMJ article, *Using the Safer Clinical Systems approach and Model for Improvement methodology to decrease Venous Thrombo-Embolism in Elective Surgical Patients* (Humphries, et al) was discussed. The article confirms standardised VTE prophylaxis guidelines lead to reduced incidence of VTE. This is the aim of a proposed future VTE project proposal, being considered by the Commission project prioritisation committee.

1. **POMRC/SSNZ joint workshop progress**

The agenda for the POMRC/SSNZ joint workshop on 21 June 2017 is progressing. The theme for the workshop is ‘making the wise choice simple’. Australian surgeon Ian Harris has yet to confirm whether he is available to present on ‘choosing wisely from a medical perspective. Minister Dunne has agreed to open the workshop, similar to the 2016 POMRC workshop. Justin Roake will speak on abdominal aortic aneurysm and Ian Civil will present the results of the risk adjusted model, released alongside the QSM data in December 2016.

The Safe Surgery NZ programme team will present the second surgical safety culture survey results and the findings of the programme evaluation.

**Action:** the two programme teams will finalise the agenda and distribute to workshop attendees.

1. **SSNZ as a working group of POMRC**

Further discussion about aligning the residual work programme of SSNZ with POMRC took place. There was general agreement about the shared goals of these two groups, and the possible gains of aligning governance members, staff and resources.

If the integration of SSNZ and POMRC is to proceed the advisory group will be dissolved and then re-established under a new terms of reference. The terms of reference will describe the differing links and relationships of the new entity. Existing funding for future years of the SSNZ programme will move across to the working group.

At the April meeting, the Board will continue to consider the role of mortality review committees and the feasibility of integrating with quality improvement programmes.

1. **Other business; wrap up**

Rosaleen Robertson was able to confirm that her role on the advisory group has broadened to representing the New Zealand Private Surgical Hospitals Association (NZPSHA) and Southern Cross Hospitals.

Dates for the final two meetings of 2017 were discussed. It was thought that aligning with the POMRC meetings would be efficient use of time for members on both the mortality review committee and the advisory group. The following dates follow the POMRC dates and were free for members present at the meeting:

* 14 September (in Wellington, 9.30am to 3.00pm)
* 23 November (teleconference, 9.30 to 11.30am)

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

The meeting finished at 12.45pm and the advisory group members were offered lunch.

Next meeting; 18 May 2017

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