**Minutes** of the meeting of the Safe Surgery Advisory Group
Held on 19 November 2015, at the NZ Institute of Chartered Accountants, Wellington

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| Present: | Prof Ian Civil – Chair (Auckland DHB)<br>Miranda Pope (Canterbury DHB, Perioperative Nurses College NZNO)<br>Dr Will Perry (RMO)<br>Bob Henderson (Airline pilot, psychologist)<br>Prof Justin Roake (Canterbury DHB)<br>Dr Peter Jansen (ACC) |
| HQSC attendance: | Catherine Proffitt, Gabrielle Nicholson, Gillian Bohm, Owen Ashwell, Jane Cullen, Maree Meehan-Berge (minutes). |
| Guests: | Hazel Rook and David Moore from Sapere for agenda item 7. |
| Apologies: | Prof Alan Merry (Commission Board Member, ADHB, Auckland University)<br>Rosaleen Robertson (Southern Cross Hospitals)<br>Dr Mike Stitely (RANZCOG)<br>Dr Leona Wilson (ANZCA, CC DHB)<br>Dr Nigel Willis (RACS, NZOA, CC DHB) |

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The meeting commenced at 9:30am.

**1. Introductions**
The Chair welcomed the group and apologies were accepted.

**2. Minutes and actions from meeting held on 31 July 2015**
The group approved the minutes of the meeting held on 31 July 2015. The actions list was considered and an updated version agreed.

**3. Consumer representation**
The consumer representative interview panel was made up of SSNZAG and HQSC members. The skills and experience of the two consumer representative candidates, Caroline Gunn and David Sibley, were presented to the group.

Both candidates were very strong in their interview and demonstrated good skills and experience. David will need support establishing connection to consumer groups, which Chris Walsh has agreed that she will facilitate. David is a solicitor and is also involved in a local health governance group. Caroline has strong links to local and Maori/Pasifika community groups, and is a nutritionist with a PhD.

The panel recommended the appointment of both consumer representatives to the Advisory Group, noting that it is good practice to have more than one consumer representative.

The group:

**Agreed** to invite both consumer representative candidates to join the advisory group.

**Action:** Programme team to proceed with invitation to each candidate and develop an induction programme, with a focus on the Partners in Care and Safe Surgery programmes. The induction will be completed prior to the next advisory group meeting.

**4. Teamwork and communication roll-out**

There has been considerable activity since the previous advisory group meeting, with all three cohorts progressing well through both preparation and implementation activity. Cohort one has moved into implementation phase, with the 31 August learning session and intervention training now complete for all DHBs. Auckland and Lakes DHBs declined intervention training due to well established use of the paperless surgical safety checklist.

Cohort two started the preparation phase with the 11 November learning session and all but one DHB has indicated their preferred intervention training dates. The University of Auckland team are confirming facilitator availability for each of these and have started to confirm some of the February and March dates with the DHB project teams.

Cohort three has been invited to a 12 February 2016 learning session in Christchurch, and they will be asked to indicate their preferred intervention training dates by mid-December so these dates can be confirmed early in the New Year.

The first auditor training is booked for 1 December in Auckland. This is a one day programme, covering the principles of auditing and then observing videos of sign in, time out and sign out, and rating team engagement. The aim is to increase the levels of inter-rater reliability amongst the auditor group throughout the day. There will be annual retraining of the Gold Auditors to ensure sustained reliability; similar to the hand hygiene auditor training programme.

Bob Henderson outlined the process of peer review airlines use for pilots. This is undertaken annually, with multiple pilots rating a peer and rating reliability confirmed amongst the peer group. This system has been in place for over twenty years.

**Action:** Bob will provide the programme team with the airline pilot peer review process.

A number of DHBs have had difficulty attracting surgeons to the intervention training. Surgeon attendance is seen as critical to the success of the roll out of teamwork and communication so the programme team has developed the following approach to each of the DHBs in cohort two and three:

1. Negotiate future intervention training dates as early as possible (cohort two training dates for February and March currently being confirmed).
2. Continue to recruit trainees through the project leads at each DHB.
3. The University of Auckland facilitator team utilise their networks and approach surgeon and anaesthetist colleagues at the DHBs to encourage attendance.
4. Letters will also be sent to the Director of Surgery, Director of Nursing, Director of Anaesthesia and Head of Anaesthetic Technicians at each DHB outlining the training opportunity. Safe Surgery medical clinical lead will then follow up with a telephone call to the Director of Surgery.

In the month leading up to cohort two training dates, we will closely monitor confirmed attendees, ensuring a mix of staff from all the surgical teams/disciplines are recruited.

It was agreed that surgeon to surgeon discussion about participation in the training opportunities related to the safe surgery programme would work well alongside the formal

letter to each of the heads of surgical professions; surgeons, nursing, anaesthetics and anaesthetic technicians.

**Action:** The Chair will, with programme team support (e.g. confirming contact info), approach each DHB's Director of Surgery prior to cohort two and three intervention training to discuss the safe surgery programme and request a time slot on an upcoming Surgeons (business) meeting agenda.

Surgeons' journal clubs were suggested as useful forums for raising awareness of the safe surgery programme and the need for surgeon participation in each stage of the improvement programme. An article supporting the programme would be the ideal introduction.

**Action:** Programme team to liaise with RMO representative regarding this and Advisory Group team members to identify potential articles from the recent literature review.

Private Surgical Hospitals (PSH) have been given access to all of the programme implementation resources, including the guide, and all three "vanilla" checklist posters. Private hospital surgical teams have been made aware of, and attended, the learning sessions and intervention trainings provided to date. We have provided the DHBs with the PSHs contact details and vice versa. We have relied on the DHBs to invite their local private colleagues to the relevant training events. Additionally, the programme clinical leads have presented at numerous events where private surgical team members were present; the programme team presented at a Southern Cross Theatre Managers Meeting in November; and another advisory group member has been invited to speak at the Private Surgical Hospitals Meeting in March 2016.

**Action:** Programme team to send through the safe surgery presentation slides to support the PSH meeting presentation in March.

**5. Establishing the new QSM**

Work done with the measurement and evaluation team was outlined. An initial paper went to the Board in October, and a final paper will go to them in February 2016. Final wording of the QSM will require careful consideration, especially around the data threshold. Currently the threshold has been set so it is achievable by a small DHB.

Sign out data will be the issue with timing of this event being difficult to predict and therefore difficult for the auditor to observe. We are considering members of the surgical team observing this part of the checklist and submitting data. The natural bias of the team member would need to be managed but this is already a component of the auditor training, along with other bias management. Alternatives were discussed, around trigger activity that would signal to the auditor that sign out was about to begin, e.g. the anaesthetic technician is typically called back into theatre at this time and a call for the next patient to be readied to go in is also done around this time. The Advisory Group agreed that timing will be an issue and that they supported the idea of a team member completing this aspect of the observational audit. Their suggestion was that the Anaesthetic Technicians would be the least biased / most impartial and would be the logical team member to do this. It was agreed that further consideration would be given to this and the Advisory Group would be kept up to speed via the more substantive update on the QSM's development at the February meeting.

The web-based data collection tool was presented to the group, and although there was generally positive feedback about the app careful critique of the wording and logic of each step indicated a number of amendments. The amendments were about wording of questions, the logic and flow of questions, and the accuracy and readability of the results and graphs on the dashboard.

There was much discussion around the existing wording of the question about completion of the checklist. The advisory group agreed that full completion of the checklist was a prerequisite to measuring surgical team engagement. The group were adamant that we should not be accepting incomplete checklist engagement data. The group agreed that the key objective is that each element of the paperless checklist should be reviewed and a secondary objective is for the checklist to be used with a high level of surgical team engagement.

The group:
**Agreed** to amend the data collection tool wording to "Was every component of the sign in/time out/sign out reviewed?"

**Action:** the programme team will capture the amendments and pass these on to Quality Hub prior to releasing the data collection tool to cohort one DHBs.

The advisory group were also informed of a recent offer from Quality Hub to fund 10 DHBs to use the tool for the next two years, meaning that, when added to the Commission's budget, which covers another 10 DHBs, all DHBs can be fully funded to use the data tool. Quality Hub has done this in order to treat the first two years as 'piloting', assuming that DHBs will want to continue to use the tool beyond this period.

Lastly, the ongoing work on the outcome measure was outlined. The OECD data standard now excludes pre-existing conditions on admission, but because this is a recent change we only have two years of data consistent with this new standard.

The evaluation team recommend that we run our two data sets as a double run chart, so we are better able to attribute any reduction in harm to the introduction of the safe surgery programme.

**Action:** the programme team will present a full report on the process and outcome measures at the next meeting.

## 6. New articles and developments

There was discussion about the purpose of this standing item, and agreement that advisory group members will share recent articles, when available.

The Chair brought the group's attention to the Will Perry, et al article *Reducing perioperative harm in New Zealand: the WHO surgical Safety Checklist, briefings and debriefings, and venous thrombembolism prophylaxis,* in the October NZMJ publication.

**Action:** The Chair will circulate relevant article titles ahead of future advisory group meetings.

## 7. Programme evaluation

David Moore and Hazel Rook from Sapere presented an overview of the draft Safe Surgery Programme Evaluation Plan. Discussion was focused on confirming the focus of the Evaluation and the research questions.

There was discussion about difficulties in attributing affect directly as improvement will happen independent of the programme and other interventions/programmes will occur simultaneously to the Safe Surgery Programme.

The current evaluation plan does not include a specific survey of patient experience; however the Sapere team will look at existing patient survey data for any relevant or related questions and incorporate if available.

All DHBs will be interviewed about their experience of the improvement programme, with six then selected for in-depth interviews. The advisory group recommended that the in-depth interviews are spread across both the North and South Islands, include a range of tertiary and provincial hospital services, and that those DHBs who have had most difficulty in preparing and implementing the programme are not excluded as these sites will possibly have significant learnings for future improvement programmes.

**Action:** the programme team will distribute the evaluation research questions to advisory group members, for feedback by 12 December.

## 8. Surgical Safety Culture Survey report release

The programme Senior Analyst recapped the survey process to date and outlined the purpose of the agenda item. The programme team wanted to capture any concerns about the report prior to finalising, and gain advice on how to best release and promote the report. The safe surgery advisory group:

- thought the report was a good piece of work and were supportive of the release
- recommended a release via the website with a full set of FAQs attached
- recommended a foreword be added, by the safe surgery Chair, situating the report within the context of the programme
- suggested the FAQs contextualise the qualitative comments, i.e. the comments highlight the need for the programme to focus on teamwork and communication, and that we expect to see an improvement over time.

## 9. Capability Building

The Commission Principal Advisor outlined the Commission's position on building sector capability, and outlined the objectives and content of the quality improvement Capability Framework. The framework sets out capabilities by health care role, including consumers. New Zealand is the first country to include consumers in a capability framework. The framework will inform a range of training and development programmes to support health care practitioners.

In terms of the safe surgery programme training participants, it was agreed that where possible the quality improvement knowledge should be woven into existing topics of interest to surgical teams.

Possible quality improvement questions raised by the group:

- can all clinicians/staff frame an improvement question?
- can all clinicians/staff do a PDSA cycle?

Bob Henderson highlighted a recent airline Safety Culture report that he thought would be of interest to the group and would inform both the capability framework and the safe surgery programme.

**Action:** Bob will forward the Safety Culture report to the programme team who will then circulate to advisory group members.

## 10. 2016/17 planning

The Senior Portfolio Manager outlined the work already undertaken by the programme team, identifying existing priorities for 2016/17 and developing an approach that will progress the programme implementation and revitalise participation.

The Safe Surgery consumer workstream will be strengthened in the 2016/17 plan. We discussed feedback that patients are concerned by the repetition of requests to confirm their name and details on the day of surgery. A patient brochure is a possible approach, informing patients about what to expect and the reason for these procedures. Also, we will look at ways to support DHBs to work with consumers, possibly through co-design, with one or two DHB theatre teams. The new consumer representatives on the advisory group will be asked to inform this planning.

**Action:** the programme team to review existing patient brochures in this space.

The safe surgery national workshop for 2016/17 will be developed alongside the Commission's capability building team. Speaker invitations have gone out to Peter Pronovost and Lord Ara Darzi but no responses have been received as yet.

Differentiating 2016/17 programme activity from previous activity is important so there will be an emphasis away from the checklist, especially in DHBs where this has been well implemented, and shifting the focus to briefing and debriefing. This focus may be supported by a new QSM specific to briefing and debriefing. Because briefing is Surgeon led the programme activity may focus on surgeon engagement, possibly through RACS.

A focus of the programme quality improvement activity could be tying the quality improvement process to the briefing/debriefing cycle, offering process mapping tools to ensure the learnings from debriefing are captured and actioned by local teams.

The idea of a Masterclass on the surgical safety checklist, briefing and debriefings was raised. This could be the prior; concurrent; or separate to the standard four hour intervention training; to attract interest amongst the local surgeons. Creating a series of masterclasses was another idea.

Possible post-operative initiatives were discussed, with conversation around how this could be linked to the developing deteriorating patient programme. Will outlined an initiative he is involved in, testing a post-operative checklist.

### 11. Other business

Nil

**Next meeting:** 10 March 2016, NZ Institute of Chartered Accountants, Level 7, Tower Building, 50 Customhouse Quay, Wellington.

All meeting dates for 2016 were agreed, they are:

- 10 March
- 16 June (please note change from 2 June)
- 1 September
- 24 November

The meeting closed at 3.00pm.