Minutes of the meeting of the Safe Surgery NZ Advisory Group
Held on 27 November 2017, via teleconference

Present:	Prof Ian Civil – Chair (Auckland DHB) Rosaleen Robertson (Southern Cross Hospitals and NZPSHA) Dr Mike Stitely (Royal Australian and NZ College of O&G) Miranda Pope (Canterbury DHB, Perioperative Nurses College NZNO) Dr Peter Jansen (ACC) Bob Henderson (Airline pilot, psychologist) Dr Michael Wadsworth (Registrar Medical Officer) Dr Peter Jansen (ACC)
HQSC team:	Gary Tonkin, Owen Ashwell, Maree Meehan-Berge (minute taker)
Apologies:	Dr Leona Wilson (ANZCA, CCDHB) Caroline Gunn (Consumer representative) Prof Justin Roake (Canterbury DHB)

The meeting commenced at 10:00am.

1. Welcome and apologies

The Chair welcomed the group and apologies were accepted. The Chair welcomed the new RMO representative, Dr Michael Wadsworth, an anaesthetist from Waikato DHB. The Chair also thanked the outgoing RMO representative, Dr Will Perry. The Chair wanted to acknowledge the contribution of the member over the four years of his involvement, providing both a practical contribution and a research perspective to discussion.

2. Minutes and actions from meeting held on 14 September 2017

There was a request to amend the minutes to reflect the agreement around future reporting of VTE rates as acute admissions and elective admissions separately. The elective cohort will provide a benchmark for the private surgical sector.

The actions list was considered. All items have been progressed or completed.

Action: the approved 14 September meeting minutes will be placed on the Commission website.

3. Progress report

The safe surgery monthly report to the end of October 2017 was received and discussed. More detail was provided about the perioperative nursing conference in Napier on 19-21 October. The exhibitor stand was very busy and engagement with delegates was very positive and informative. The programme team presented 'Safe Surgery NZ – programme progress', working with the conference theme of 'advice from the ocean'. The presentation was well received and generated good discussion.

The auditor recalibration/ reliability online resource is now ready for release to surgical teams, The University of Auckland team has also completed the teamwork and communication online resource. Both online resources will be available to surgical teams as soon as an online platform host is confirmed.

Action: the programme team will work to identify an online platform host.

The latest QSM results (Q3 2017) has shown the best results to date. The national summary data demonstrates continuing improvement in results across all three measures. More DHBs achieved the data collection target, more DHBs considered all elements of the surgical safety checklist and more DHBs achieved higher engagement around the checklist. The report identified two outlier DHBs, and a plan to work with each of these teams has been developed by the programme team.

Action: the programme team will work with the outlier DHBs to support the full implementation of the safe surgery interventions.

Quality Hub has contracted with a small number of DHBs (two confirmed). Auckland DHB has signalled they will develop their own tool; however we are negotiating with them around improvements to the data collection tool that may lead to their continuing use of the tool.

Action: the programme team will work with Quality Hub and DHB funding and service managers to ensure all 20 agree to a contract.

4. Regional workshop update

Regional workshops are scheduled for March 2018. Prof Bill Berry has agreed to headline three workshops, in Auckland, Wellington and Christchurch. MORSim and RACS have been invited to present alongside the safe surgery clinical lead, on a session highlighting the interdependencies between the three initiatives. The workshops will focus on presenting evidence of progress to date and where attention still needs to be directed by both the safe surgery programme team, and public and private surgical teams.

Action: the programme team will progress the workshop series in liaison with Prof Berry.

5. Culture survey perspective piece

The Chair has approached the ANZ Journal of Surgery about a follow up perspective piece, this time on the link between operating room culture and patient outcomes. The Commission staff publications writer has agreed to support the development of the piece.

Action: the Commission publications writer will work with the Chair to write a perspective piece for the ANZ Journal of Surgery.

6. Operating with respect principles and the safe surgery programme

The Chair described the differences and interdependencies between the two programmes. The operating with respect programme describes a range of overarching principles and skills for surgeons aimed at improving self-awareness, team dynamics and therefore patient safety. The Chair also went on to describe where the MORSim programme, an in theatre crisis management training programme, fits within the range of patient safety initiatives currently underway in New Zealand hospitals. All three programmes reinforce the key principle of teamwork and communication to improve patient safety culture.

Action: the Chair will provide a copy of the operating with respect manual to the programme team.

7. Collaborating with professional colleges – update

The programme team had meetings with the chairs of NZATS and ANZCA went ahead on 14 and 15 November respectively. The discussion was very positive with both groups and each is interested in supporting the programme with newsletter items and promoting the teamwork and communication online training tool. The team progressed conversations with the PNC chair about building a stronger partnership, including a subsidised or free exhibitor stand at their next conference.

Action: the programme team will provide information and links to the new training resources, to the professional colleges as soon as these are available.

8. Commission future focus and programme plan impact

The Senior Portfolio Manager outlined the current situation for some Commission programmes. The Commission is realigning teams into two key functions, an improvement hub and an intelligence hub. A key focus of the review will be a stronger alignment of work programmes between the two 'hubs' of the Commission. Some structural changes are likely to be made.

There is an increasing number of quality improvement programmes, and yet no further funding has been received. This will require scaling back of some programmes and winding up those near the end of their project cycle. This will impact the safe surgery programme, with options being scaling back investment for the 2018/19 and 2019/20 years or continue to invest at the same level for one year only.

The advisory group discussed the impact of these options, without accepting either option. A key concern was that although the procedural activity of the interventions is near complete, the cultural change activity has not progressed to anywhere near complete. The patient culture safety change could up to 10 years to firmly establish.

The private surgical hospitals representative member raised concerns about the impact of the outlined plan, and concerns with the current focus on private provider teams. While acknowledging many private providers' commitment to all components of the safe surgery programme, the request was for the programme team to be more inclusive of private hospital teams at every stage of the work programme.

The group discussed what the essential elements of the programme are, that could continue within a different structure or format. Clinical leadership and a national advisory function, with some internal coordination were discussed.

It was agreed that the safe surgery programme will continue to focus on embedding the safe surgery process and outcomes measures through clinical support and reporting. Focus will move to finding methods to ensure the sustainability of activities through partnership with professional colleges and public and private surgical teams. A final round of regional workshops will be developed and delivered, and a third surgical safety culture survey will be administered by June 2019.

The clinical lead will continue to offer support public and private hospitals, visiting surgical teams where needed. Speaking at relevant conferences and developing articles for college publications are a few of the supporting activities likely to continue into 2018/19.

Quality Hub has partnered with the Commission since the very first stages of the safe surgery programme. Quality Hub and the Commission have been covering the DHB costs of using the data collection tool since July 2016. From the outset of the data collection, we signalled that the cost of using the tool will move to the DHBs. This has been signalled to Chief Operating Officers and Chief Executive Officers, and will take effect from 1 January 2018. The programme team will work with Quality Hub to ensure contracts are in place before the end of 2017. Private surgical providers are also working with Quality Hub to access the data collection tool for measurement and quality improvement purposes.

Each year the Commission agrees a range of deliverables with the Minister of Health. The SSNZ programme team propose to include a similar deliverable to this year. The deliverable we are currently working to is – expert advice, tools and guidance will be provided to the sector to support teamwork and communication in DHB operating theatres.

Agreed: the advisory group support the current approach of the programme plan but have reservations about programme activity ending in 2018/19. This will be fed back to the Director, Improvement Programmes to be considered as part of the Improvement Hub's development.

Action: the programme team will progress the 2018/19 work programme and present an update on the sustainability options to the next advisory group meeting.

9. Articles of interest

An Annals of Surgery Editorial piece, *The Checklist Paradox* (Urbach) and another Annals of Surgery article *Mortality Trends After a Voluntary Checklist-based Surgical Safety Collaborative* (Haynes et al) including co-authors Gawande and Berry, were discussed. The editorial questions whether the checklist is a simple patient safety intervention or a complex social, leadership and culture change, requiring extensive training and coaching. The editorial references the article by Haynes et al for answers to this question.

The article by Haynes et al suggests real progress in surgical safety will require not only creative new approaches to quality improvement, but also scientifically rigorous evaluations to determine whether promising approaches actually made a difference. The key reference article for the Haynes paper is the previously discussed Molina et al article. This study has shown improvements in surgical culture are associated with a decrease in 30-day postoperative death rates. Improved responses to questions on respect, clinical leadership and assertiveness were associated with the greatest reduction in death rates.

As discussed at the September advisory group meeting, the authors and journal are prestigious and the findings confirm and support the safe surgery programme approach. These findings should be promoted to public and private surgical teams.

Action: the programme team will identify ways to promote the Molina et al and Haynes et al papers.

10. Other business; wrap up

A new RACS representative member for the advisory group will be sought. The Chair will approach the college and request a recommendation for a representative.

Action: the Chair will liaise with RACS to identify a new representative.

The 2018 meeting schedule will include two face to face meetings and two teleconference meetings between these. The first meeting for the year will be in March/April and will be a face to face meeting in Wellington. A doodle poll will be used to identify a date.

Action: the programme team will liaise with the advisory group members to identify meeting times for 2018.

The meeting finished at 12:00pm.