Minutes of the meeting of the Safe Surgery NZ Advisory Group
Date: 9 October 2019 **Time:** 9.30am–1pm **Location:** Rydges Airport Hotel, Wellington

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Present: Prof Ian Civil – Chair (SSNZ Clinical Lead)
Victoria Aliprantis (Southern Cross Hospitals and NZPSHA)
Caroline Gunn (Consumer representative)
Miranda Pope (Canterbury DHB, Perioperative Nurses College NZNO)
Dr Michael Wadsworth (Registrar Medical Officer)
Bob Henderson (Human factors expert and psychologist)
Dr Nicola Hill (Royal Australasian College of Surgeons)

Guest: Michelle Irving (Mobius)

HQSC team: Gary Tonkin, Owen Ashwell, Gillian Bohm, Marie Talbot (minute taker), Ying Li, Alexis Wevers

Apologies: Dr Mike Stitely (Royal Australian and NZ College of O&G)
Prof Justin Roake (Canterbury DHB)
Dr Leona Wilson (ANZCA, CCDHB)

The meeting commenced at 9.30am

1. Welcome and apologies
Prof Ian Civil welcomed the group and read out the apologies.

2. Minutes and actions from the 21 November 2018 meeting
The minutes were approved. The action list was considered. All items have been progressed or completed.

Action: the approved 21 November meeting minutes will be placed on the Commission website.

3. Progress since last Advisory Group meeting

Safe Surgery (SS) work programme
A work programme update was presented and the discussion focused mainly on the following areas of focus.

Briefings
The 'Spend five to save lives' campaign to promote briefings was held in June and was very successful. The Commission received 63 team responses to the short survey that was part of the campaign, which indicates approximately 500 people participated in the day. Nearly 30 photo submissions were received from teams as well. Overall, 23 different hospitals responded, 16 DHBs and seven private surgical hospitals. This included 17 different surgical specialities. This participation is pleasing, and when considered alongside the finding that 84 percent of participants said their "team typically do start of list briefings," this provides the best indication we have had so

far that these briefings are now widespread. A media release summarising participation and key findings was released following the day.

The group suggested the Commission consider running a similar day next year. The focus could be 'use of the start of list process in an acute or out-of-theatre format'.

The group discussed applicability of briefings and the checklist more widely, in interventional radiology, cardiology, radiology oncology and acutely. It is unclear what the expectation is of colleges for these specialties in relation to briefings and the checklist. For acute situations, it has worked well in at least one example in Canterbury.

Recording of briefings is still an area in which improvement is needed and remains a focus for this financial year.

Actions: explore case study on use of checklist acutely in Canterbury; follow-up with colleges of radiology and cardiology about the expectation they have for use of checklist and briefings; undertake work on how 'Start of day briefings' are audited to improve the data collected for this area.

Process Quality & Safety Markers (QSMs)

Gary Tonkin presented the latest SSNZ QSM results. Overall the results are improving, though there is still variation and engagement with some DHBs will continue to be a focus.

Action: continue to engage based on QSM results, with a particular focus on DHBs where no QSM data is being provided.

Outcome QSM: DVT/PE

Ying Li and Alexis Wevers (Commission Health Quality Intelligence team) joined the meeting. Ying presented data and graphs based on the Observed versus Expected (OE) ratio of DVT/PE's, by DHB, on a quarterly basis from 2013-18. Ying explained the risk factor model that is applied to reported DVT/PE numbers to achieve the OE ratio. The discussion included the likely impact of confounding variables and potential to link engagement and culture with outcomes.

Action: Add data from 2016 to present to the analysis; and add SSNZ checklist achievement as a factor into the model, to see if that helps us understand the correlation between process (checklist) changes and outcomes (DVT/PE).

4. Culture Survey

Michelle Irving (Mobius) joined the meeting for this item and presented an overview of the latest Culture Survey results. The survey is sent to perioperative ward champions and then cascaded out from there. More than 800 people responded to the survey and the results for 2019 have continued the encouraging progress seen in the 2015 and 2017 surveys. Areas for improvement that were highlighted include briefings and debriefings being performed and inconsistency in attitudes of some surgical staff with respect to their buy-in to the surgical safety checklist.

Action: Michelle Irving to supply the source data so this can be broken down/analysed by DHB.

5. Advice to the Safe Surgery NZ programme

Gary Tonkin presented a paper regarding future advice for the SSNZ programme. The paper proposed that with the SSNZ now being a mature programme that has moved from an implementation to a sustaining phase, a formal group to advise the programme is no longer required. It was proposed that this be the final meeting of the SSNZ Advisory Group and ongoing advice/oversight could transition to a wider Hospital Advisory Group, that would include the SSNZ Clinical Lead.

The group agreed that the SSNZ Advisory Group would cease in its current format. Members indicated an interest in continuing to maintain a level of involvement with the programme and to contribute when required. It was agreed that members would continue as a SSNZ Reference Group, which receives updates on programme activity on at least a six-monthly basis, meets on an ad hoc basis if required, and is a network of experts for the Commission to call on for advice or feedback.

Action: confirm in the minutes that the SSNZ Advisory Group would cease in its current format; a SSNZ reference group consisting of current SSNZ Advisory Group members will receive quarterly safe surgery reports; meet on an ad hoc basis and provide advice or feedback as required.

6. Perioperative Mortality Review Committee (POMRC)

Owen Ashwell gave a verbal update on the upcoming POMRC report. The report includes 11 recommendations and will be considered by the Commission Board in early November. The focus on this year's report is on surgical outcomes for Māori following acute laparotomy. The central message of the POMRC's eighth report is that health equity gaps exist within our surgical systems between Māori and non-Māori, and there is evidence that the gap is widening.

The meeting finished at 1.10pm.