Minutes of the meeting of the Safe Surgery NZ Advisory Group
Held on 10 March 2016, at the Sunderland Room, Wellington Airport

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Present:	Prof Ian Civil – Chair (Auckland DHB) Miranda Pope (Canterbury DHB, Perioperative Nurses College NZNO) Rosaleen Robertson (Southern Cross Hospitals) Bob Henderson, (Airline pilot, psychologist) Dr Will Perry (Registrar Medical Officer) Dr Mike Stitely (Royal Australian and NZ College of Obstetricians and Gynaecologists) Prof Justin Roake (Canterbury DHB) Caroline Gunn (Consumer representative)
HQSC attendance:	Gabrielle Nicholson, Jane Cullen, Maree Meehan-Berge (minutes), Owen Ashwell (afternoon only).
Guests:	Sarah Upston, HQSC for agenda item 9.
Apologies:	Dr Leona Wilson (ANZCA, CCDHB) Dr Nigel Willis (CCDHB) Dr Peter Jansen (ACC) Gillian Bohm (HQSC)

The meeting commenced at 9:30am.

1. Welcome and apologies

The Chair welcomed the group and apologies were accepted.

Caroline Gunn, the new consumer representative, was welcomed and introduced herself to the group. Caroline works at the Liggins Institute in Auckland, has qualifications in microbiology and nutrition, and has taught physiology at EIT and Massey University to both nursing and health science students at undergraduate and postgraduate levels. Caroline has working relationships with several community organisations including local (Hawkes Bay) Maori, Pacific and Chinese organisations. Her Liggins Institute role involves liaising with representatives from many community groups representing Pacific people, Asian people (Chinese New Settlers Trust) and health promotion groups such as the Health Promotion Agency and Agencies for Nutrition Action. We look forward to working with Caroline on all aspects of the safe surgery programme, and in particular the consumer focused activity.

The group was advised that Prof Alan Merry has stood down but will remain able to comment and advise the safe surgery programme as Chair of the Commission. Ian advised the group that he will thank Alan personally for his contribution to the programme.

2. Minutes and actions from meeting held on 19 November 2015

The programme team requested further discussion and additional detail under item five and discussed the proposed new wording below:

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?"*

It was agreed that every organisation should have a checklist that has been reviewed and made relevant to that environment and that this might mean different checklists for different specialities (e.g. an example that has been shared with members of the team is where, in paediatrics, blood loss is not discussed in front of the child during sign in as this might be upsetting – local policy and the approved checklist could shift this item to time out for paediatric cases). The agreed checklist(s) should be used as the auditing reference tool and teams' levels of engagement will be measured following full review of each component of the checklist.

The Chair is meeting with the Auckland DHB surgical leads regarding their concerns about the 'review all components' requirements of the observational audit approach. The advisory group will receive an update at the 16 June meeting. If necessary, an additional or follow up meeting including other Expert Advisory Group (EAG) members can be arranged.

During the discussion around the surgical safety checklist it became apparent that a Frequently Asked Questions document for distribution, with covering note from the EAG, and section on the website would assist DHB interpretation of the checklist completion and data collection requirements. Areas to be included in the FAQ page include:

- Local checklists: tailored to the environment; reviewed by local teams; regular review; examples of how non-covered items can be managed.
- Infection prevention and control: checklist posters are laminated so they can be cleaned; follow up and linkage to guidelines for what can go on operating theatre walls (if in existence); alternatives such as hand held laminated prompt cards or electronic display screens.
- Data: the Commission not gathering the data; Quality Hub supply Quality and Safety Marker (QSM) data only to the Commission; all data visible to local teams only; option to collect non-invasive surgery data but best entered under 'untrained auditor' section of the app so it is not included in QSM data.
- Scope of the project; focused on full surgical procedures (anaesthesia required).

After this discussion the group approved the minutes of the meeting held on 19 November, with the additional detail included.

The actions list was considered and agreed.

Action: Programme team to develop a FAQ section on the Safe Surgery website page.

3. Teamwork and communication roll-out

Progress report
Explanation of training activity to date; all learning sessions complete; all of cohort one has had local intervention training delivered and cohort two well underway. Also, one of three auditor training days has been delivered with cohort two and three dates booked for 1 April

and 6 May. An option to attend either the Wellington or Christchurch venues has been offered to cohorts two and three to ensure cost effective access to the training.

Action: the programme team are to identify the trained observational auditors as Gold Auditors, consistent with Hand Hygiene terminology, with the idea being that only Gold Auditors can then go on to train other auditors within their organisation. The University of Auckland trainers will also be notified so this can be included in the auditor training content.

Endoscopy and 'other' procedures discussion
There was discussion about the environment, systems and risks being similar across these and that most already have checklists, reviewed and adapted to the procedures. It was agreed that use of surgical safety checklist is appropriate and will be generally supported and encouraged, however the project implementation will remain focused on operating theatre environments. In particular, some DHBs have asked us to add Interventional Radiology and Endoscopy to the specialty drop down options.

Action: the programme team to request the addition of Interventional Radiology and Endoscopy to the specialty options on the app.

4. Programme evaluation; first fieldwork report
The Senior Portfolio Manager outlined the purpose of the fieldwork reports – they are intended to enable action / change in approach following early evaluation recommendations and are intended to support continuously improvements within the programme as the teamwork and communication roll out progresses.

The first report is broadly positive, however two issues were discussed in depth; an update on the positive impact of additional communication with heads of department to improve surgeon and anaesthetist attendance at training opportunities; and inclusion of private surgical provider activity in the programme evaluation.

Action: the programme team will liaise with Sapere, and negotiate the inclusion of private surgical provider activity in the programme evaluation.

5. National workshop speaker
The POMRC speaker, Clifford Ko, did a national series of workshops for the Safe Surgery Programme in 2015. The June 2016 POMRC conference speaker was confirmed in March, so there is insufficient time to repeat this approach. A joint approach will be used for 2017.

The group discussed a range of possible speakers, with a preference for Professor Cliff Hughes, President of the International Society for Quality in Health Care and previous Chief Executive Officer of the Clinical Excellence Commission.

Action: Chair to contact Cliff Hughes, and invite him to NZ sometime between July and September 2016, requesting a roadshow going to four locations.

6. Deteriorating patient programme update
The Deteriorating Patient Advisory Group has been looking at three work streams, phased over a five year period (with the fifth year having reduced investment):

- Rapid Response System: standardised vital sign charts, early warning scores (EWS) and guidance regarding appropriate response arms, allowing for size and location of the provider. Currently wide variation in systems and tools between DHBs. Evidence supports a standardised system and has shown improvement in patient outcomes and safety culture. This workstream is generally well accepted and yet standardisation is challenging. The private surgical facilities may need to have a more sensitive trigger to escalate concerns to the doctor/s where there is 'no-doctor-in-the-house', whilst still

aligning with a national EWS so communication with the DHB is based on a standardised shared-language. This is essential for unplanned transfers to a DHB for a higher level of care or diagnostic services.

- Patient and family/whanau escalation of care. Evidence suggests that providers that allow patient and family/whanau escalation result in better relationships, happier staff and some reduction in 'missed' deterioration, although there is limited data regarding patient outcomes. International experience indicates that this approach does not result in a big increase in call outs and once this is understood resistance typically reduces.
- Goals of treatment. This workstream is aimed at patients and clinicians discussing and agreeing goals for the particular episode of care (i.e. independent of existing Advance Care Plans (ACP) and / or not requiring an ACP to already be in place). All DHBs use some form of DNR form but Medical Emergency Teams are reporting (anecdotally approximately 30%) that often they are making DNR decisions at the bedside of a patient that they've never engaged with before and really this and other aspects of care should have been agreed with the patient shortly after admission. Health literacy could be challenging, both from patient perspective and also clinicians who are having these conversations. The other two work streams will support this activity, which is why it is phased to roll out last.

A proposal will go to the Board in April with implementation planned to commence in July 2016.

7. Programme measurement

Process measure; QSM

Progress towards finalising the process measure (the QSM) was outlined, including the Evaluation and Measurement team requirement that we provide 300 observational audit 'moments' of team engagement around sign in, time out or sign out in order to assist them to finalise the new QSM. The advisory group questioned the process and advised that analysing a sample of pre-implementation data should not inform the final target. The Safe Surgery NZ Advisory Group believes they should set the target and have enough understanding of the sector and safe surgery issues to ensure that it is one that improves safety. The programme team advised that the Measurement and Evaluation team manages all of the Commission's QSMs and that the process being taken is the 'typical' one for development of a new QSM. As with other QSMs, the Board is the QSM governance group and will have the final decision. The programme team agreed to take the EAG's feedback back to the Measurement and Evaluation team.

Outcome measure; VTE and Sepsis data

Progress on development of the outcome measure was discussed; although the trial sepsis and VTE double run charts that were tabled generated more questions than answers. It was agreed that this agenda item should be carried over to the 16 June advisory group meeting and the programme team should ensure that the Director of the HQE team attends in order to discuss these concerns. The group want a variation on this data presented, changing the new parallel data line to readmissions within 90 days post-operative due to sepsis or VTE.

Action: the programme team to ensure programme measurement is on the next meeting agenda and invite the Director HQE.

8. New articles and developments

Four articles were discussed, initially with a focus on recommending one to surgeons' Journal Clubs to review. The advisory group then revisited this earlier decision about presenting information this way. Instead, a targeted one pager was agreed, with the latest evidence, in a newsletter format, to be placed in the Surgical News or Cutting Edge. The Commission's Principal Advisor, Communications may be able to assist with content.

Action: programme team to raise the request with the Principal Advisor, Publications.

9. Serious Adverse Events

Sarah Upston joined the meeting and she and Owen outlined the recent focus of the Serious Adverse Events (SAE) team. In the past few years reporting has been emphasised and encouraged, so current data is more likely a reasonable reflection of what is occurring. Also noted was a trend towards near misses being reported which is seen as a positive outcome. There are events occurring in interventional radiology which reinforced the earlier discussion about including this group in the safe surgery improvement measures.

The Serious Adverse Event Policy is currently being reviewed, with a draft to go out to the sector for consultation. The review will include clarification of definitions and the depth of review required for each type of event. The SAE team want to change the focus from collecting data to assisting teams to conduct meaningful review leading to system improvements to address the failures. Future reports will have a learning focus, reporting on reviewed events.

10. Programme sustainability partnerships

The Chair outlined the intended duration of the programme, with a further one to two years of activity planned, and summarised some sustainability plans.

POMRC

An initial joint meeting between SSNZ & POMRC was held on 7 December. The proposal is that residual safe surgery activity, such as the bi-annual culture survey, is absorbed into POMRC. The mortality review committee is moving to more of an intervention and quality improvement focus, including a refocus of the annual national workshop.

MORSim

A 2013 University of Auckland research project evidenced that the multidisciplinary simulation work was effective at producing positive teamwork and communication outcomes. ACC is funding this programme over five years, with potential for a further five, with a goal of having simulation and training resources in all DHBs. Early planning indicates that a February 2017 launch is likely and in four to five years each DHB will be able to run local simulation training independently of the project team. The SSNZ and MORSim projects have the same safe surgery teamwork and communication focus and there is agreement to align key messages and work programmes wherever possible.

Regional patient safety networks

Originally these networks/alliances had an Open for Better Care Campaign focus, with Northern and Southern networks already in existence and Midland and Central established at the beginning of the Campaign. The Commission has signalled a shift from the campaign/communication role, moving to a quality improvement focus and the networks have adjusted to reflect this. The networks are now pivotal to the sustainability of our quality improvement programmes, including safe surgery. Key activities for 2016/17 in the safe surgery programme plan are to move delivery of training from three cohorts to four regional groups, to maximise the existing infrastructure, and to connect more closely with the regional groups to start a governance and support ‘handover’ process. A need was noted to provide reliable access and inclusion for non-DHB providers.

11. 2016/17 programme plan overview

The programme team talked to the programme planning overview document, including the programme driver diagram, measures of success, and an outline of the planned activity 2016 through to 2019. The advisory group are very aware that the 2015/16 year focus was the surgical safety checklist; and the 2016/17 year will focus on briefing and debriefing. 2016/17 is also an opportunity to work on residual surgical safety checklist activity such as supporting

poor performing DHBs, and investigate a second QSM around the briefing and debriefing activity.

The group discussed the proposed consumer activities and agreed that the team should consult further with the consumer representative on the advisory group around consumer engagement objectives and activities. The proposal to investigate and develop a consumer focused brochure about safe surgery best practice and how this will impact the patient experience was agreed. It was also agreed that further investigation should go into whether or not two DHBs could be supported to work with consumers to co-design surgery-related improvements.

The existing national patient focused brochure "keeping you safe during surgery" is popular but is in need of review; addition of encouraging patients to ask questions suggested. However the question was raised whether another area of activity might be more useful to consumers; post-op advice often requested and is an area of harm. Consultation with the advisory group consumer representative will inform any consumer engagement and focus group work to answer this question.

The co-design activity will be focused around the Ko Awatea co-design programme (and Ko Awatea would need to support / deliver this, which has cost implications). Southern Cross has good experience of using this approach to develop the "blood clots and you" VTE prevention consumer brochure. The key requirement of the co-design programme is to have one clinician and one consumer working alongside one another for the duration of the development project. There is an expectation that project outcomes will be scalable and able to be adopted by all DHBs and other providers.

The Chair suggested that as we near the end of the safe surgery programme, now is a good time to consider a new initiative to go forward to the Commission project prioritisation process. A possible new project in the teamwork/human factors area was discussed; communication in health care was the broad topic. There is significant opportunity to reduce harm in many areas through improving teamwork and communication; a culture change in the health sector and speaking-up. Difficulties and non-standard approaches to handover and team briefings was raised as an area of concern, with increasing demands on the sector compounding this issue.

Recent external reviews of the Commission have highlighted; 1) HQSC is a known force in NZ healthcare; and 2) HQSC has to have more edge/punch, and hold people to account. This aligns with Board conversations on driving a culture change in the health sector.

All new initiatives are measured against the prioritisation criteria. Please see below an excerpt from the Commission project prioritisation framework to assist the advisory group when considering future possible projects. This conversation is to be progressed at the next advisory group meeting.

A. EVIDENCE
What is the problem to be addressed? • Does the proposal relate to a known and explicit problem? • What is the size and impact of the problem? • Does the problem affect some population groups more than others? Does it contribute to inequity of health outcomes?
How strong is the evidence for the proposed change in practice or interventions?

What evidence is there to show that the problem is amenable to change?
If this is an area of innovation, describe the proposed strategy to be tested and how outcomes will be measured.
B. STRATEGIC FIT
Which HQSC strategic priorities is this initiative aligned with? • Consumer engagement • Building leadership & capability for improvement • Measurement
Which HQSC focus areas does the proposal align with? [Aged Residential Care, Primary Care]
To what extent does the proposal align with other agencies' and health sector priorities?
C. BENEFITS REALISATION
• What are the benefits of the solution? • Is there potential for significant health gain or removal of risk/harm? • How will the proposal seek to promote health equity?
• How will the change be sustained over time?
D. VALUE FOR MONEY
What are the costs of the change – HQSC and sector?
To what extent is the proposal good value for money?
ANY OTHER INFORMATION
Do you have any other information you wish to provide in relation to this proposed initiative

12. Other business

Proposed change to end of year meeting not possible for a number of members; staying with 24 November 2016 was agreed. New proposal is a joint meeting with POMRC in the first or last week of October.

Action: create a doodle poll and send to advisory group and POMRC members.

Gabrielle recommended the advisory group meeting minutes be placed on the Commission website; this will be in keeping with other advisory groups.

Agreed to minutes of advisory group meetings to go onto the website, after review for confidential content, in draft, then in final after the approval at the next advisory group meeting.

Action: programme team to review the approved 19 November 2015 minutes for sensitive content, and place on the Commission website; and same for the draft 10 March minutes after collating member feedback.

Next meeting; 16 June 2016
Chartered Accountants, Level 7, 50 Customhouse Quay