

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

Held on 18 May 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)

Caroline Gunn (Consumer representative)

Prof Justin Roake (Canterbury DHB)

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

Dr Peter Jansen (ACC)

Dr Leona Wilson (ANZCA, CCDHB)

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

Guests: From CCDHB: Rachel Fluke and Sarah Maher – for item 8

From the Commission: Laura Ellis, Consumer Engagement Advisor – also for item 8

Karen Orsborn, General Manager – for item 5

Apologies: Bob Henderson (Airline pilot, psychologist)

Dr Nigel Willis (CCDHB)

Dr Will Perry (Registrar Medical Officer)

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 23 February 2017**

A correction was requested by Rosaleen Robertson, who will now represent NZPSHA as well as Southern Cross Hospitals. The actions list was considered. All items have been progressed or completed.

**Action:** the approved 23 February meeting minutes will be placed on the Commission website.

1. **Progress report**

The safe surgery monthly report to the end of April 2017 was received and discussed. More detail was provided about the auditor training workshops and the 2017 quarter one quality and safety marker results. The surgical safety culture survey report and the programme evaluation report were covered under subsequent agenda items.

The four regional auditor training workshops were completed, with 91 people attending. All 20 DHBs were represented at the workshops and five private providers sent auditors to be trained. Feedback on the workshops was very positive, however there is still a wide range of interpretation of team engagement by the trained auditors. An annual workshop/online refresh will now become a minimum standard, and development of recommendations on how to maintain inter-rater reliability at least between a DHB team of auditors (reiterating training and advice provided during the workshops) and then between DHB teams of auditors (through regular use of an online recalibration training tool).

The third quarter (January to March 2017) of Quality and Safety Marker (QSM) results were discussed. These will be publicly reported later in May. The Health Quality Evaluation team report an improvement in results across all three measures, between the second and third quarters. 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 group was advised that it is still too early to identify clear trends. The programme team will continue to support DHB surgical teams to collect and evaluate the audit data to inform teamwork and communication improvements.

1. **Surgical safety culture survey report – draft**

The second Surgical Safety Culture Survey draft report was received by the advisory group. The Commission conducted a Surgical Safety Culture Survey (SSCS) across DHBs in order to provide baseline data regarding patient safety and the quality of teamwork in operating theatres. This survey was conducted and reported on during late 2015. This research was conducted as an online survey. A total of 883 were considered to have completed enough questions to contribute to the overall data set, compared to 843 in 2015.

The results of the 2017 Surgical Safety Culture Survey are very encouraging – with improvements across most dimensions/factors since 2015. Dimensions/factors that have shown the most improvement have been with respect to communication, practical (adherence) and coordination. This is particularly encouraging given that (along with clinical leadership), communication and practical (adherence) were the lowest performing areas in 2015.

Clinical leadership has remained a poor performing area although there has been an improvement in the measure related to the tone of physicians throughout operations (+12% up to 54% agree/positive). In general, there appear to be fewer negative comments regarding the attitude of surgeons in 2017, although team culture issues within some surgical teams are still impacting on the overall success of the interventions.

The group asked if the results can be reported in the context of an estimated total sample size so the 883 responses can be expressed as a percentage of estimated surgical staff. The programme team will approach each of the professional groups to identify approximate sample size. Surgeon, anaesthetist and anaesthetic technician registration numbers are available from the relevant colleges, but nursing data is not publicly reported. An alternative source will be identified and approached for the theatre nurse registration numbers.

The survey tool was a modified version of a Surgical Safety Culture Survey developed by the Harvard School of Public Health, with amendments around language differences only (used with the permission of Harvard). The advisory group asked for a clear definition of physician, and use of local language wherever possible in the body of the report.

**Action:** the programme team will liaise with the research provider and request that the report include information about the estimated total sample size and a definition of physician.

1. **Safe Surgery NZ sustainability and programme plan 2017 – 2020**

At the April meeting, the Board considered the role of mortality review committees and the feasibility of integrating with quality improvement programmes. The group were advised that quality improvement programmes and mortality review committees will remain independent entities within the Commission, allowing the unique focus of each of these programme areas. As a consequence, the proposed alignment of the Safe Surgery NZ Programme and the Perioperative Mortality Review Committee will not proceed. The two programmes will continue to support one another and look for areas of shared interest and collaboration.

The Safe Surgery NZ Programme will be funded for at least three more years, at a reducing level, sufficient to continue providing expert advice to support teamwork and communication and support measurement and monitoring of the quality and safety marker. The advisory group will continue throughout this time.

The focus for 2017/18 will be on improving engagement with the checklist, the further establishment of briefing, and then debriefing, in all theatres in all DHBs. The introduction of briefing is seen as key to positive behavioural change in operating theatre teams. The culture survey will be repeated in 2018/19, and regional workshops and support for audit teams will be delivered across both these years.

1. **POMRC report recommendations and joint workshop plan**

Leona Wilson, Chair of POMRC provided an overview of the recommendations in the upcoming 2017 POMRC annual report. The report includes two new special topics, 30-day mortality following abdominal aortic aneurysm repair, and perioperative mortality of people living in areas with high socioeconomic deprivation. Key findings from these special topic areas include the number of admissions and perioperative mortality increases as socioeconomic deprivation increases, and people living in the most deprived areas had twice as many acute admissions than people living in the least deprived areas.

The committee recommend that ethnicity and socioeconomic deprivation should not impact outcomes, that all patients should have the option for inter-vascular AAA repair, and patients should have the risk of dying discussed with them prior to consenting to surgery. The committee will make research recommendations, specifically relating to outcomes for Māori.

The agenda for the POMRC/SSNZ joint workshop on 21 June 2017 is now finalised. The guest speakers will be Barry Smith, population health analyst at Lakes DHB, Professor David Storey, foundation chair and head of Anaesthesia, Melbourne and Professor Justin Roake, professor of surgery and specialist in vascular surgery in Christchurch. They will discuss NZ deprivation and inequity themes, factors that change practice and abdominal aortic aneurysm (AAA) repair, respectively.

The theme for the workshop is ‘making the wise choice simple’. The afternoon group workshop theme is ‘operative or non-operative surgery’, with six case studies for review. A strong focus will be ensuring a consumer lens for each case study review.

The final session of the workshop will have a Safe Surgery NZ focus, where the programme team will present the second surgical safety culture survey results and the findings of the programme evaluation and Professor Civil will present ‘Surgical culture and SSNZ – can we simulate our way into the future?’ talking about Safe Surgery NZ, MORSim and the RACS operating with respect programme interdependencies.

**Action:** the two programme teams will finalise the agenda and workshop details.

1. **MORSim update**

The Chair, also a member of the MORSim team, updated the group on recent progress. All five cohort one DHBs are progressing well. Enthusiasm is high however resourcing can be an issue. Fewer resourcing issues occur when DHBs schedule the MORSim programme resourcing needs into production plans. The MORSim team will make multiple rounds of visits to each participating DHB, with decreasing input as the DHB builds competency. There is early evidence that the programme is making a difference, at least to those that attend. There is evidence to support the value of practise (simulation) especially in emergency situations, even before factoring in the teamwork and communication benefits associated with the simulation exercises.

Training for the second cohort of five DHBs has been moved back six months and will now start at the end of 2017. All five second cohort DHBs are signed up and committed to the MORSim programme.

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

**Action:** the programme team will continue to support the MORSim programme where possible.

1. **Capital & Coast DHB Co-Design Project recommendations**



The advisory group received the safe surgery co-design project report. The report was the result of an invitation to Capital & Coast DHB to lead a co-design review of the national brochure “Keeping you safe during surgery”. The review of the brochure was carried out as part of the Partners in Care Programme co-design methodology. The report summarised the co-design masterclass process, the specifics of the project approach and detailed findings.

The original development of the brochure in 2013 was to inform patients why they will be asked the same questions multiple times. These questions are part of the World Health Organization Surgical Safety Checklist designed to ensure patients are receiving safe and correct surgery. The safe surgery team thought the brochure needed review, to ensure consumers are clear about why patients will be asked the same questions multiple times. In addition, they do not think that reference to a car Warrant of Fitness is particularly useful and some of the information is out of date.



The Capital & Coast DHB safe surgery co-design leads presented and overview of the review process and the key findings, with the full list of recommendations detailed in the report. For a proportion of consumers, being informed they will be asked the same questions multiple times by different staff prior to their procedure is important and promotes feelings of safety and assurance, so there is value in producing a new version of the brochure. As no single method of communication will reach all people, they recommended that other patient resources are developed; further work is required to inform what format or formats these should take.

The advisory group consumer representative described how brochures work well with older, well informed and health literate consumers who more typically have experience of surgery and the broader health system. The information also needs to meet the needs of the younger demographic who have less experience of the health system and sometimes lower health literacy levels, and are new to surgery. A wider range of communication channels will best reach more consumers and the new to surgery, target audience.

The consumer representative also suggested an advocacy tool could be developed, supporting consumers to support enquiry such as ‘what do you want to know?’ and ‘how do you want to be told?’.

Thank you to the Capital & Coast DHB team, especially Rachel Fluke, Project Manager and Sarah Maher, Associate Charge Nurse Manager at Kenepuru Operating Theatres for leading the project and presenting the findings to the advisory group. The group thanked them for their commitment to the co-design project and for the comprehensive and high quality findings and recommendations.

1. **Evaluation final report – draft**

The draft report was received by the advisory group at the 18 May meeting. The group supported the general direction of the evaluation but did have a few suggestions for further improving the accuracy and clarity of the report.

The executive summary now captures the key findings, although the description of the surgical safety culture survey results and the significance of the potential culture change needs to be better described. The group recommended a stronger section on the limitations of the evaluation work, in particular the cost benefit analysis model. The evaluation provider is working directly with private surgical providers and their Association to review the content specific to the private sector.

The Evaluation Steering Group will review the amended 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.

**Action:** the programme team will liaise with the evaluation provider, and ensure the advisory group feedback is included in the final report, before it goes to the steering group for sign off.

1. **Collaborating with Professional Colleges**

The programme team has made contact with the Perioperative Nurses College Chair, Johanna McCamish, and will meet with her later in May. Professor Civil has arranged a meeting with the RACS team and the Chair, Randall Morton on 22 May. Each of these meetings will be to progress discussions about aligning common messages, and opportunities for support.

**Action:** the clinical lead and programme team will continue to build working partnerships with the relevant professional colleges. Leona Wilson has agreed to support an approach to the college for anaesthetists, ANZCA.

1. **Potential Venous Thromboembolism (VTE) initiative**

A summary of a VTE focused meeting in April, between Southern Cross Hospitals, ACC and the Commission was provided. The initial purpose of the meeting was to discuss a collaboration between Southern Cross Hospitals, ACC and HQSC, to extend the reach of the Southern Cross ‘Blood clots and you’ patient focused information to a national audience. Also discussed at the meeting was a possible collaboration on clinician focused information. The following summary captures the key points raised.

Southern Cross has a long history of interest and investment in working with consumers to produce patient information materials, and has offered the results of the most recent review of their consumer focused information “Blood clots and You” to a national project. Southern Cross has also been working with their clinicians to review VTE events using a VTE Event Review Tool they have developed; linked with this Southern Cross is currently investigating a quality indicator relating to VTE events. Southern Cross has offered the clinician focused VTE events investigation tool to a national project. Southern Cross is willing to share their materials and experiences and would be very supportive of any national VTE prevention quality improvement initiative.

ACC has an interest in reducing harm from Surgery and VTE and would like to be involved in VTE Prevention activity, both consumer focused and clinician focused. ACC is due to release DHB data, then private provider data on DVT/PE claim numbers and costs.

The advisory group consumer representative attended the meeting and thought the existing ‘Blood clots and You’ information provided considerable benefits to Consumers. The existing information was an empowering tool, but could be improved by access through other technology based methods. There is value in a national approach to VTE prevention and including patients in the development of this project and any subsequent patient focused information.

The Commission is interested in understanding variation in health care and is aware that VTE prevention is approached differently in many DHBs. The national policy framework has supported the development of VTE guidelines, however DHBs have interpreted the framework differently when developing their own local VTE prevention guidelines, so some variation continues.

Further investigation is needed to clarify the opportunity to focus on reducing VTE and determining whether this is a priority for the Commission at this point in time. The Safe Surgery NZ programme will focus on the VTE management components of the Surgical Safety Checklist throughout 2017/18. Prof Civil is interested in investigating how well these components of the checklist are being used, and translated into post-operative care.

The advisory group appreciate the impetus from the sector, particularly Southern Cross, to reduce rates of VTE. The Commissionis very interested in supporting the ‘Blood clots and You’ consumer information and has agreed to the continued inclusion of the Commission brand on this resource.

1. **Other business; wrap up**

The next meeting, on 14 September will be in Wellington, as usual. However, the 23 November meeting with be the first of the advisory group teleconference meetings. The meetings will alternate between face to face and teleconference meetings for the remainder of the 2017/18 financial year, and subsequent years that the project is running.

**Action:** the programme team will allocate time on the next meeting agenda to discuss how to maximise the teleconference meetings.

The meeting finished at 2.00pm.

Next meeting; 14 September 2017

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