Minutes of the meeting of the Safe Surgery NZ Advisory Group
Held on 24 November 2016, at the Health Quality & Safety Commission, Wellington

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Present:	Prof Ian Civil – Chair (Auckland DHB) Dr Leona Wilson (ANZCA, CCDHB) Miranda Pope (Canterbury DHB, Perioperative Nurses College NZNO) Rosaleen Robertson (Southern Cross Hospitals) Caroline Gunn (Consumer representative) Dr Peter Jansen (ACC) Dr Mike Stitely (Royal Australian and NZ College of O&G)
HQSC team:	Gary Tonkin, Maree Meehan-Berge (minute taker), Hilary Sharpe (after 10.30am)
Guests:	Sarah Upston and Kiri Rikihana, HQSC for agenda item 7
Apologies:	Dr Nigel Willis (CCDHB) Dr Will Perry (Registrar Medical Officer) Prof Justin Roake (Canterbury DHB) Bob Henderson (Airline pilot, psychologist) Gillian Bohm (HQSC team) Owen Ashwell (HQSC team)

The meeting commenced at 9:00am.

1. Welcome and apologies
The Chair welcomed the group and apologies were accepted.

2. Minutes and actions from meeting held on 1 September 2016
The group approved the minutes of the meeting held on 1 September. The actions list was considered. All items have been progressed or completed.

Action: the approved 1 September meeting minutes will be placed on the Commission website.

3. Progress report
Safe surgery monthly report to end of October 2016 received.

A summary of the *Safe Surgery with Professor Cliff Hughes* regional workshops was tabled. Over 180 surgical team members attended across the four workshops. Evaluation feedback was particularly positive with over 95% of participants rating the overall quality of the workshop as good or excellent. A letter of thanks was sent to Cliff Hughes, from Professor Alan Merry.

The group discussed the early adoption of briefing and debriefing in many DHBs. The advisory group members cautioned against any claims of 100% coverage in all theatres in any DHBs at this time, as it is highly likely there is a percentage of patient lists that are still starting without a briefing. It is reasonable that it will take time for teams to build momentum for briefing, and then debriefing. It is anticipated that resistance to participating in start-of-list briefings will eventually be considered as not working within standard practice guidelines.

The first quarter of Quality and Safety Marker (QSM) results were discussed. Nineteen DHBs now have a baseline result; all have areas they need to improve. Any team that did not achieve the target of 50 observed audit moments of each of Sign In, Time Out and Sign Out will be encouraged to develop a plan to achieve this target in subsequent quarters. Any team that did not achieve the 100% target that all components of the checklist are reviewed by the team (uptake) must prioritise improving this result. The earlier QSM that was retired in 2015 measured uptake and DHBs results were consistently high, with the then 95% target consistently achieved by most teams for all three steps of the surgical safety checklist. The quality of engagement between professions around the checklist (engagement) results will improve over time, but again teams will be encouraged to develop a plan, and offered support, to achieve the QSM engagement targets.

Before the results are released publicly, each DHB will be sent their data so we can confirm accuracy, and an offer of support from the safe surgery programme team to assist with improvement planning.

Action: the programme team will work with each DHB safe surgery project team to confirm QSM results and provide support with improvement planning.

An overview of progress on the co-design and consumer engagement approach was presented to the group. Hutt Valley DHB (HVDHB) and Capital & Coast DHB (CCDHB) have safe surgery teams attending the Partners in Care co-design training. HVDHB is working on a surgical admissions information project and CCDHB is working on reviewing the Commission's 'keeping you safe during surgery' pamphlet. The co-design workshop dates at HVDHB are 1 November and 8 February. The 1 November workshop was well attended and well received. There is a series of supporting webinars, with the first follow up webinar planned for 10 November. The Safe Surgery Project Manager is attending the training and supporting these two teams' projects.

Southern Cross has asked the Commission and ACC to participate in their review of the "blood clots and you" brochure. The Commission (and ACC) is considering endorsing the brochure and using this as a national resource. The group were interested in the review process and the subsequent improvements to this well regarded patient information tool. In 2014, a Southern Cross patient survey showed 82% of discharged patients agreed they were satisfied they had adequate information about detecting and preventing blood clots. In 2016, patient survey showed this had increased to 94% satisfaction with patient information about blood clots.

Additional wording suggestions were raised by the group, which will be considered by Southern Cross. The review has also resulted in improvements to the Southern Cross website, including additional references and clearer instructions around wearing of pressure stockings.

Action: the programme team will liaise with Southern Cross and ACC about agreeing and endorsing the "blood clots and you" patient information brochure.

4. Programme planning 2017/18

The advisory group discussed the core components of the programme that will continue into subsequent years. These were identified as maintaining a trained auditor group in each DHB, a national auditor training support programme, monitoring QSM results, and supporting local surgical teams to improve surgical safety culture and performance where required. Additional activities could include monitoring international developments and addressing local trends that auditors and experts are observing.

Long term advice and support of the programme activity has yet to be determined, although discussions with the Perioperative Mortality Review Committee are progressing well. It is the Commission's intention that the work programme and Clinical Lead will continue to be supported by a group providing advice at a national level. Future support and resourcing will be primarily focused on maintaining the momentum that will result in an improved surgical safety culture across all surgical teams in the country.

Action: the programme team will develop a 2017/18 plan, with associated budget, for the Board to consider in February.

5. POMRC/SSNZ joint workshop progress

The agenda for the POMRC/SSNZ joint workshop on 21 June 2017 is progressing. POMRC has identified areas of focus for the joint workshop such as the annual report, aortic aneurysm outcomes, and the effect of deprivation on outcomes. SSNZ will present the second surgical safety culture survey results and the findings of the programme evaluation. The Chair recommended advisory group member Mr Justin Roake as a possible speaker on abdominal aortic aneurysm if POMRC had not yet identified a speaker on this topic.

Action: the two programme teams will progress the agenda and present a draft to the next advisory group meeting.

6. Evaluation progress – interim findings report

Karen Orsborn, General Manager HQSC and Hilary Sharpe, Senior Analyst HQSC joined the meeting.

The group were updated on the follow up actions from their review and input into an early draft of the second fieldwork report in September. A number of recommendations about improving the second fieldwork report were acted upon. The group's recommendation that Sapere widen the breadth of interviewees, especially to include more surgeons, was actioned by the research team (a number of surgeons were interviewed while attending the Northern Region safe surgery workshop in October).

Discussion focused on the benefits realisation and value for money sections of the near final report. The programme benefits realisation results are inconclusive at this stage, with no obvious decline in adverse events, albeit the reported numbers are small. The value for money section includes an updated cost benefit analysis from the 2012 information. This now includes the actual costs of the programme and provides a number of scenarios. All scenarios demonstrate positive cost benefit outcomes.

The evaluation steering group had earlier identified that the benefits realisation has yet to demonstrate any difference, acknowledging that very early data only has been included, and the risk adjusted Sepsis and VTE models and subsequent QSM data will make a difference. Similarly, the value for money findings are from early data, however this already demonstrates significant gains.

The private provider representative on the group raised a concern about the methodology of the private surgical provider survey approach. A further round of review and amendments was agreed.

Information about the MORSim programme research approach was presented to the group. It was suggested that the SSNZ programme has created a focus and raised the profile of quality improvement and patient safety in the surgical setting. We expect to see improvement regardless of MORSim, but also anticipate improvement triggered by MORSim.

Action: the programme team will liaise with Sapere about the private surgical provider survey and further review.

Karen Orsborn and Hilary Sharpe left the meeting.

SSNZAG - Reportable events policy update 2

7. National reportable events – consultation

The Chair welcomed the Reportable Events team members to the meeting. Sarah Upston lead coordinator for the adverse events learning programme and Kiri Rikihana, project manager presented the recent adverse events report, a reportable events policy options paper, and an accompanying discussion paper.

The latest adverse events report included a description of the reporting process, and the Part A and Part B steps. There was a small decrease in total reporting and most significantly a significant decrease in falls reports.

The adverse events team are still seeing surgery related adverse events, mainly in the interventional theatres and some complex wound care. POMRC had requested a summary of surgery related adverse events leading to death however there are very few.

The reportable events policy is open for consultation, closing 1 February 2017. The document was out for wider sector engagement and also a publicly available document. The review aims to ensure the policy will be relevant to more, ideally all, health care settings.

The key themes for change are outlined in the attached presentation. The advisory group consumer representative was heartened that there is a focus on consumers, encouraging consumer input and looking at the consumer aspects of an adverse event. When asked how consumers will be involved in reviewing adverse events the adverse events programme team outlined how consumers will have input into the draft reports on adverse and never events. There will be review guides developed and 'how to' engage with consumers advice provided.

The advisory group perioperative nursing representative signalled the interest of this group providing input to the policy review document and will liaise with the adverse events team around timing.

Safety 2 principles are being considered as a future adverse events prevention focus – that is, reviewing what works consistently well. The advisory group recommended current adverse event reporting include more narrative around the surgical adverse events, and that never events be reported in more detail in DHB specific reports.

8. Other business

No other business was raised before the meeting closed.

The meeting finished at 12.15pm. Advisory group members had been invited to an afternoon workshop for HQSC staff by Dr Jocelyn Cornwell, founder and chief executive of the Point of Care Foundation.

Next meeting; 23 February 2017
Health Quality and Safety Commission, Level 9, 17-21 Whitmore Street, Wellington.