Minutes of the meeting of the Safe Surgery NZ Advisory Group
Held on 16 June 2016, at the Chartered Accountants House, 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) Dr Leona Wilson (ANZCA, CCDHB) – afternoon only
HQSC attendance:	Gabrielle Nicholson, Gillian Bohm, Maree Meehan-Berge (minute taker)
Guests:	David Peploe (ACC) for the duration of the meeting Richard Hamblin and Ying Li, HQSC for agenda item 9
Apologies:	Bob Henderson, (Airline pilot, psychologist) Dr Nigel Willis (CCDHB) Dr Peter Jansen (ACC) Dr Will Perry (Registrar Medical Officer) Dr Mike Stitely (Royal Australian and NZ College of O&G) Prof Justin Roake (Canterbury DHB) Owen Ashwell (HQSC)

The meeting commenced at 9:30am.

1. Welcome and apologies

The Chair welcomed the group and apologies were accepted. Due to the number of apologies it was declared that there was not a quorum of members in attendance. Therefore, discussions would proceed but the decision paper (item 10) would be circulated by email for an out of meeting decision.

2. Minutes and actions from meeting held on 10 March 2016

It was noted that the minutes did not reflect that Caroline Gunn was in attendance at the March meeting. The group approved the minutes of the meeting held on 10 March, with the additional detail included.

The actions list was considered and agreed. Two further actions were identified from discussion about the auditor training programme. There has been feedback from some trained auditors about additional information and support to assist local training of additional auditors. The train the trainer approach was covered during the nationally run auditor training events but additional resources would improve the quality and consistency of local auditor training. Using the term Gold Auditor for the safe surgery fully trained auditors has been questioned by a number of DHBs, who associate this with the Hand Hygiene programme specifically. The Safe Surgery programme will identify an alternative name for the nationally trained safe surgery auditors.

Action: a 'How To' guide is to be produced to support nationally trained auditors to deliver local training to additional auditors.

Action: further discussion on an alternative name to describe the auditors that have received training directly from the University of Auckland team.

3. MORSim update

The Chair, also a member of the MORSim team, updated the group on recent progress. Roll-out of MORSim is in four cohorts, with five district health boards (DHBs) in each cohort. For cohort one, instructor training will start in November 2016, and local MORSim courses in February 2017. Training for cohorts two, three and four will follow at nine-month intervals.

The cohorts are:
Cohort 1; Waitemata, Capital & Coast, Nelson Marlborough, Whanganui and Tairawhiti
Cohort 2; Auckland, Waikato, Hawke's Bay, Taranaki and Wairarapa
Cohort 3; Counties Manukau, Bay of Plenty, MidCentral, Hutt Valley and South Canterbury
Cohort 4; Canterbury, Southern, Northland, Lakes and West Coast

MORSim involves interactive sessions, including challenging simulated surgical cases, debriefings and communication skills training. The scenarios include cases for the main five surgical specialties, and engage each member of the multidisciplinary surgical team.

Each DHB will be supported to implement MORSim. The MORSim team will provide comprehensive instructor training. ACC funding provides simulators (where required) and surgical models. Three MORSim courses will be run in each DHB with support during the transition to locally-led, ongoing MORSim training also provided. The goal is for MORSim to become business as usual in each DHB, and for each surgeon, anaesthetist, anaesthetic technician and theatre nurse to regularly participate in the training.

The full five year business case has been approved by ACC, but only half the funding has been agreed to date. The MORSim team has been advised by ACC that the second half of the funding is dependent on them being able to demonstrate improved outcomes (i.e. reductions in treatment injuries). The MORSim team see this as an issue as it is known that culture change takes time and attribution is hard to identify. Also, if the second tranche of money does not eventuate half the DHBs will miss out. If the second tranche of money does not eventuate then there is the risk of increased variation between DHBs. David Peploe, representing ACC at the meeting, advised that ACC's funding and investment model is very well defined and designed to measure value for money. He advised that getting ACC's medical staff to work with ACC Finance may prove beneficial to ensure a shared understanding of the programme, risks and ideal/ likely outcomes. This may smooth the process out somewhat. David also advised that the ACC Board and Minister are very enthusiastic about MORSim, so receiving the second tranche of money is highly likely.

The Chair also advised that the MORSim programme is not currently using the ACC branding due to perceived difficulties in approvals and logistics. This was seen as a lost opportunity for demonstrating collaboration. The Senior Portfolio Manager advised that the Commission and ACC have agreed a quick and easy process for seeking approval for branding for the Surgical Site Infection Improvement Programme, which ACC has invested in.

Action: the programme team to share the SSIIP branding / logo sign off process with the MORSim team.

Private surgical providers also need access to the MORSim training. Simulation theatres for the training may be an issue for some private providers but private could be included in DHB training. This would be a similar model to the Safe Surgery programme approach of included private providers wherever possible.

Action: Chair to follow up with MORSim team and advise re Private Surgical Hospitals.

4. New articles and developments

A South Carolina article published in the JACS (2016, Molina, et al. Implementation of the Surgical Safety Checklist in South Carolina Hospitals is associated with improvement in perceived perioperative safety) was discussed. Surgical team members were surveyed and results highlighted positive change post introduction of the WHO surgical safety checklists.

Action: the programme team to look at the comparability between this surgical safety culture survey and the safe surgery programme culture survey.

5. Summary of 2015/16

Safe surgery monthly report received. The group agreed that it is beneficial to view this each quarter with a focus on amber (and red, if any) coded activity.

University of Auckland intervention and auditor training final reports received. The group acknowledged the professional and expert services delivered by the training team and the outstandingly positive feedback from participants of both programmes.

The programme team is working with the University of Auckland team on an extension to the auditor training contract. This will likely include four regional workshops plus an online learning tool. It was identified earlier in the meeting, that a 'How To' guide is to be produced to support nationally trained auditors to deliver local training to additional auditors. This will be included in the contract extension brief.

Action: the programme team to ensure a key is added to the graphs and change colours for ease of interpretation. The programme team will also attach the evaluation form used at each training event. The reports can then be published on the Commission website.

6. Planning for 2016/17

Consumer engagement was considered, and the group agreed there is a need to review patient safety brochures currently available, including the Commission's "Keeping you safe during surgery" brochure. Alternate methods of delivery were discussed, and using text messaging was considered. Mental Health and Maternity already use this technology to deliver key messages at times when the information would be most useful. Games and apps are other technology driven information sharing options.

The Southern Cross VTE Blood clots and YOU brochure, a previous Patient Safety Week resource, was well received by both private and public surgical service providers and the Commission plans promoting the tool as a national resource.

Action: obtain current version of Southern Cross Blood clots and YOU tool for the Commission's review.

The Safe Surgery with Professor Cliff Hughes series of regional workshops on briefing and debriefing were discussed. The Principal Advisor provided the results of a survey of medical staff to ensure they participated in the Emerging Leaders programme. Taking these recommendations into consideration, it was decided that the workshop will be held in the afternoon, starting with a networking lunch, and moving into the four hour workshop between 1.00 and 5.00pm. Cliff Hughes and Ian Civil will be the main speakers, both focusing on the evidence and case for introducing briefing and debriefing alongside the paperless surgical safety checklists.

Action: the programme team will liaise with Cliff and Ian to develop a schedule for the four days, 4 to 7 October, and a timetable for the four hour workshop.

The advisory group revisited an earlier discussion about the sustainability of the Safe Surgery programme, including partnerships with MORSim, POMRC and the DHB Regional Patient Safety Groups.

A joint meeting with POMRC will proceed early October, with a discussion paper outlining the current focus of each group/programme and the impact to date. Discussions will focus on possible joint programme activity and sharing of data, resources, networks and partnerships.

Action: the programme team will draft a discussion paper for the joint meeting between SSNZAG and POMRC.

The original focus of the regional networks was the Campaign patient safety activity, however this is now complete. These regional patient safety groups are changing their scope to support quality improvement and patient safety more broadly. The Commission has requested they start topic specific sub groups, as they have for falls. Regional surgical safety networks are being recommended and supported. Private providers involvement in regional safety network activity was raised and the advisory group agreed that inclusion of private providers wherever possible across quality improvement activities would support patient safety. The coming year for the Safe Surgery NZ programme will shift DHBs from working in the three cohorts agreed for 2015/16 to working in their regional groups. From this regional networks should be established and left as part of the sustainability / legacy of the programme. These networks will need to connect in with the regional quality and safety governance arrangements.

Leona Wilson joined the meeting.

7. POMRC Conference consumer focused presentation

The Chair invited consumer representative Caroline Gunn to repeat the presentation she delivered to the annual POMRC Conference delegates on 13 June. This presentation was focused on the consumer experience of surgery. Caroline then responded to a number of questions from the advisory group and this was linked back to some of the earlier discussion around consumer engagement activity in 2016/17.

8. Evaluation progress

The group considered an early draft of the second fieldwork report from Sapere. The work to date was acknowledged and it was noted that a number of interesting findings are starting to come through the evaluation process. A number of recommendations about improving the second fieldwork report were noted, including confirming the accuracy of DHB information, and strengthening the executive summary by including early findings and possible recommendations.

Action: programme team to provide feedback to Sapere and ensure the report is ready to go to the Evaluation Steering Group meeting on 20 July.

The group anticipate the evaluation Interim Findings Report, due on 30 September, will start to clearly articulate the evaluation recommendations, including areas for improvement in the programme design and structure.

9. Safe surgery outcome measures

The health quality evaluation team presented a risk adjusted model for measuring sepsis outcomes. They explained how this was developed, including definitions of sepsis. This led to discussion about how closely sepsis results, with the current definition, can be tied to surgery outcomes. This could only be achieved by changing the definition of sepsis (i.e. narrowing it to post-operative sepsis) and then we would no longer be consistent with OECD data and would then miss out on the benefits of comparing with this group of countries.

Action: HQE Director to send the current Sepsis definition to inform further discussion at the 1 September meeting.

Since 2005, sepsis data has trended up, with the likely cause being an increase in high risk patients. The group will continue to debate whether the current definition of sepsis is suitable as an outcome measure for the safe surgery programme.

Also discussed was what happened to the data of private sector patients who are admitted to the public setting; some will be excluded if private data is not in the National Minimum Data Set (NMDS) repository.

The group then discussed deep vein thrombosis and pulmonary embolism (DVT/PE) data and trends. DVT/PE rates might be trending down. Again, applying a risk adjustment model would provide a more accurate picture of the key contributors to the DVT/PE trends. This measure will directly demonstrate the impact of the Safe Surgery programme.

Action: the health quality evaluation team to develop a risk adjustment model for DVT/PE, to be presented at the 1 September advisory group meeting.

A discussion on introducing a briefing and debriefing QSM focused on the need to balance the value of introducing a second process QSM against the burden of increasing surgical team audit requirements. The Commission will need this QSM to demonstrate commitment to start-of-list briefing and measure the impact of introducing start-of-list briefing and end-of-list debriefing.

There is a possible link between doing start-of-list briefings and a better surgical safety checklist engagement. We will be better able to explore this correlation after a briefing QSM is introduced.

The briefing audit could be linked to the first ‘sign in’ of the day/list with a question about whether the briefing had been completed or not. This question would not capture the quality of the team engagement around the briefing checklist. There is no current evidence to support a quality measure around briefing, unlike the WHOBARS evidence associated with the surgical safety checklists. Alternatives, such as reporting back on data from the app (rather than a national QSM) were also discussed.

The group agreed:
A new process QSM around start-of-list briefing will be proposed to the Board, for their consideration. Wording will be along the lines of “Was a briefing including all three teams, done at the start of the list?” with a Yes/No response required. All new QSM proposals must first be approved by the Board.

Action: the programme team will develop a new QSM discussion paper, to go the Board in August and report back to the advisory group on 1 September.

10. Anaesthetic Technicians auditing own teams; decision

The general approach DHB auditing teams will be taking to achieving the data collection targets was outlined. In most DHBs, all members of the surgical team, Surgeons, Anaesthetists, Anaesthetic Techs and Nursing staff have been encouraged to consider training as auditors, and of course quality staff are obvious candidates for the auditing role.

The University of Auckland trainers have trained 94 auditors to date, and this group can now expand their local DHB teams by working with them using a Train the Trainer resource.
All three moments, Sign In, Time Out and Sign Out can be audited by any member of the auditing team, however the Sign Out was identified as a particular problem due to the auditor timing their arrival in theatre and observing Sign Out. It is this moment only that we would envisage the Anaesthetic Technician auditing his/her own team's engagement around the checklist. These staff would still need to be trained as safe surgery observational auditors.

Leona Wilson thought the Technician would be available at the Sign Out moment, which is also when the Anaesthetist is fully available to participate in the checklist engagement. Leona supports the decision, as did all other attending members.

Action: the programme team will request an 'out of meeting' decision about Anaesthetic Technicians auditing own teams.

In an out of meeting decision, the group agreed:
Anaesthetic technicians can now audit their own team engagement during the Sign Out phase of the checklist. All three parts of the surgical safety checklist (Sign In, Time Out and Sign Out) can be audited by any member of the audit team; however, Sign Out was identified as a problem due to timing of the auditor arriving in theatre. Any anaesthetic technician wanting to take on the observational auditing role will need to be trained.

11. Southern Cross update
Southern Cross is committed to aligning with Hand Hygiene and Safe Surgery programmes and using the same Safe Surgery web-based data collection tool that is available to DHB surgical teams.

The Southern Cross version of the surgical safety checklist posters for their facilities was subject to review and with further recommendations about the wording of the posters, the group agreed the Southern Cross surgical safety checklist posters will be put on the Commission's website.

Action: finalised Southern Cross posters, to be provided and placed on the Commission website.

12. Other business
The joint meeting with POMRC will be on the morning of 5 October, before the Wellington Safe Surgery NZ regional workshop with Professor Cliff Hughes presenting.

Action: the programme team to develop a discussion paper for the Safe Surgery NZ Advisory Group and Perioperative Mortality Review Committee meeting. This will be circulated to both groups' members prior to the meeting.

Gabrielle Nicholson advised the group that the 16 June meeting was her last in her capacity as Senior Portfolio Manager. The Chair wanted to acknowledge the commitment, input, drive and good work Gabrielle has contributed while managing the Safe Surgery programme.

Next meeting; 1 September 2016
Health Quality and Safety Commission, Level 9, 17-21 Whitmore Street, Wellington.