Te Hononga Whētuki ā-Motu
National Trauma Network

Health Quality & Safety
Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Meeting Minutes

Meeting:	**Critical haemorrhage project expert reference group meeting**
Location:	Kahurangi room and via Zoom.
Date:	16 March 2020
Time:	10.30am - 12.30pm
Attendees:	Kerry Gunn (Chair), Dominic Fleischer, James Moore, Richard Charlewood, Susan Mercer, Ian Civil, David Drower, Tony Smith, Andy Swain, Gabrielle Nicholson, Paul McBride, David Lang, Sandy Ngov (Minutes)
Apologies:	Siobhan Isles, David O'Byrne

Discussion	**Actions/ Follow up**
Welcome, introductions and brief background Kerry opened the meeting and the group introduced themselves. Ian provided an overview of the National Network, the Commission contract with ACC and the quality improvement programme, of which the haemorrhage project is one of the three focus areas. Kerry spoke briefly about the work that's been done in the haemorrhage space over the last decade or so and talked about how this project needs to build on what's been done, not replicate or replace it.	
Project plan, TOR and group admin The draft project plan and draft terms of reference (TOR) were shared with the group in advance of the meeting. Update on project work to date: - The team have worked up a draft project plan that includes potential measures we could use to evaluate improvements. - We are working on a one-page infographic outlining the case for change as an external communications tool; a draft will be brought back to ERG for sign off before sharing publicly. - Paul updated the group about the NZ Trauma Registry and said that he and Kerry are working to align different data sets in order to get a bigger/ better picture, e.g.: we are working with Monash University, who run the Aus/NZ Massive Transfusion Registry (ANZ-MTR), which collects info on massive transfusion protocol (MTP) activation and other useful data. We need to be mindful that this registry holds information from only 8 NZ sites and requires a minimum amount of blood given in a certain timeframe to be included (so a portion of the patients we are interested in will not be captured here). And we are having discussions with Bridget Dicker (St John) to get pre-hospital mortality data. We expect this to be a reasonably straightforward variation to our existing data sharing agreement with St John.	1. Each member to go through the project plan and provide any feedback before the next meeting. 2. David/ Gabrielle/ Kerry to bring draft of one-page infographic back to this group for next meeting. 3. Paul to update the group re: ANZMTR and pre hospital data from St John at the next meeting. 4. Paul to provide the group with information about what the registry tells us about haemorrhage, e.g.

Discussion	Actions/ Follow up
- A member of the group queried whether or not the registry holds information about time of arrival vs. time to theatre and Paul confirmed that this information is collected, and he can share summaries of this data with the group. Discussion/ feedback on draft project plan: - Aspirational goal: The fact that the aspirational goal is most likely unachievable was discussed and the group agreed that its intended to be a stretch goal and provide inspiration – aspirational goals are just that (aspirational) and they are set that way in order to help drive step change. Part of the role of this group is to define what we want to change and how we will measure this; including how we define a haemorrhage death. - Scope: The group recommended that the scope be amended to include preventable deaths **pre-hospital** not just in-hospital. - Measures: The group was advised that, because of upcoming changes to the trauma registry (change of host), it will be difficult to add datapoints into the trauma registry in the short term, so this is not really an option at this stage. Instead we're looking for existing data to inform the measures or using proxies. An output from this group may be recommendations for new datapoints in future. In the meantime, we can link the trauma registry to other datasets as per the earlier discussion. The group discussed the fact that the New Zealand Blood Service holds transfusion data for the whole country and collects data on diagnostic workup (i.e., blood count, blood gases, lactate levels), so this could also be a useful dataset. The group was asked to advise if they know of other datasets or can think of proxy measures that could be suitable. Discussion regarding key aspirations/key areas of improvement for the group and project: - As is often the case for QI projects, achieving outcome (death) improvements may not be feasible given the small numbers and short, 12-month project period. Instead we will focus on demonstrating process change by measuring the system's move to using best practice, e.g.: measures that demonstrate adherence to the new national guidance, MTP and critical bleeding bundle of care. - One area of focus might be to develop a nationally coordinated approach to delivery of blood to pre-hospital teams. Currently Helicopter Emergency Medical Service (HEMS) teams in Auckland receive blood, while other HEMS teams around the country do not. - Another area of focus will be to ensure that a system is in place for access and availability of whole blood for pre-hospital and hospitals. - The group described what they think the project should/ will help with: 1. Improving the identification of patients with critical haemorrhage 2. Standardisation (simplification, clarification) of processes, such as code crimson 3. Improving education on first aid haemorrhage control prior to ambulance arrival – i.e.: ensure that our work supports and	time of arrival vs. time to theatre, etc. 5. David and Kerry to find out more about the Northern region's deep dive review of haemorrhage deaths and investigate if similar projects could be done in other regions. 6. Richard to share MTP audit information. 7. David to follow up re chain of survival idea and explore its feasibility for this project. 8. Gabrielle to take ERG recs to the internal SG for consideration (e.g.: scope change) 9. Gabrielle to update project plan and TOR for next meeting.

Discussion	Actions/ Follow up
builds on the public-facing ‘stop the bleed’ campaign 4. Embedding critical haemorrhage control into destination policies to ensure notification to receiving hospitals and teams, and ensuring patients are sent to hospitals with necessary capabilities (e.g.: tertiary centres are likely to receive better access to interventions like angiographies) 5. Developing a national, standardised, best practice process for critical haemorrhage rapid decision-making that hospitals then modify for their own size and context 6. Requiring data collection for this cohort of patients, so knowledge can grow and, building on that, doing work to define acceptable and non-acceptable variance (i.e.: give consideration to how different teams/ hospitals are determining haemorrhagic death and considering whether there are opportunities to minimise variation for grey areas like older patients or MOF death vs haemorrhage death) 7. Platelet availability to smaller hospitals, whole blood availability and ensuring national, standardised, best practice MTP that hospitals then modify for their own size and context. It was agreed that the national guidance and associated protocol and bundle need to inform regional and local policies and documentation – i.e. there will need to be allowances made for regional and local variation because of the different capabilities and contexts within each hospital and region. The possibility of doing a ‘deep dive’ review to understand haemorrhage deaths over the last few years was raised. The Northern region has already done a project like this. This type of investigatory work could help us to understand patient characteristics, which could in turn inform system change. Richard advised that he did a review/ audit of MTR activations across all NZ hospitals two years ago. He will share this with the group. David raised the possibility of doing a ‘chain of survival’ type flow chart as part of the comms material and to show how this project fits in with others like ‘stop the bleed’. He will follow this up with Kerry and others offline. TOR/Governance/membership/responsibilities: This ERG will work within existing governance structures across the trauma programme. The Commission has an internal steering group and a contract governance group for the Commission programme, and a network governance group across the whole work programme. Acceptance forms and admin: Once the TOR have been agreed at the next meeting, this will be sent out with standard committee forms for everyone to sign – acceptance to the group and declaration of any conflict of interest. This group agreed to review the draft project plan and TOR and provide feedback, so this can be finalised at the next meeting. Kerry is available to discuss feedback on this offline.	

Wider reference group Suggestions on members: - This wider group should cover the various points of managing a critical haemorrhage patient and be representative of NZ hospitals (location and size). - Gabrielle will circulate the list of wider reference group members. We are open to suggestions for this group – there is no size limit per se. - Kerry has reached out to Jack Hill (anaesthetist in obstetrics) to join as the Māori health rep on the core ERG - Gabrielle has reached out to a consumer rep to join the core ERG. May need assistance from this group for suggestions for possible consumer rep if no luck. - NZ Resuscitation Council are important in raising public awareness of controlling severe haemorrhage before ambulance arriving. The group is in favour of having them engaged as they are interested, and Tony Smith would be willing to represent their body on this group if NZRC agrees to this. Gabrielle will follow up with NZRC on this. Engagement plan with the wider group: - We will engage with the wider group via email, with updates on the project as they progress, and share outputs agreed by this group for their feedback.	10. Gabrielle to circulate mailing list for this core group and send list of current members on the wider reference group. 11. Everyone advise on members who should be in the wider reference group. 12. Gabrielle to follow up on whether NZRC would support Tony as representative on this group.
Schedule of meetings In-person meeting for 23rd April in Wellington: - In view of COVID-19, the team acknowledges the members in this group will be increasingly involved in the care of patients. - While waiting for further policy guidance from the Commission, Plan A will be to proceed as an in-person meeting in Wellington as everyone agrees to do so. Plan B will be a shorter zoom (~2 hours). We will send out another doodle poll with dates post-April to schedule the Zoom meetings for remaining year (3-4 meetings). Emailing (using the mailing list) is the best way to communicate with this core group. Members may also send info directly to Sandy or Gabrielle to circulate to other members.	13. Sandy to send out doodle poll for zoom meetings following April.
Close – Next meeting for this group scheduled for 23 April 2020.	