

From the Acting Chief Medical Officer  
Dr Elizabeth Mitchell



Department of  
**Health, Social Services  
and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydënter Heisin  
an Fowk Siccar**

**HSS(MD)18/2009**

**For action:**

Chief Executives HSC Trusts

Medical Directors HSC Trusts for cascade to:

*Associate Medical Directors, Clinical Directors,*

*Heads of Governance*

*Consultant surgeons*

*Consultant anaesthetists*

Directors of Nursing HSC Trusts

Chief Executive, Regulation & Quality Improvement

Authority for cascade to:

*Independent hospitals and clinics*

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**For information:**

General Medical Practitioners

Chief Executive, HSC Board

Chief Executive, Public Health Agency

Director Public Health, Public Health Agency

Director of Nursing, Public Health Agency

Professor David Woolfson, Head of School of  
Pharmacy, QUB

Professor Linda Johnston, Head of Nursing &  
Midwifery, QUB

Professor Hugh McKenna, Head of Life and Health  
Sciences, UU

Dr Owen Barr, Head of School of Nursing, UU

Staff Tutor of Nursing, Open University.

Director, Safety Forum

Your Ref:

Our Ref: HSS(MD)18/2009

Date: 13 May 2009

Dear Colleagues

**SAFE SURGERY SAVES LIVES**

Hospitals in eight cities around the globe have successfully demonstrated that during major operations the use of a simple surgical checklist, developed by the World Health Organization (WHO), can lower the incidence of surgery-related deaths and complications by one third.

The checklist (see copy attached) was launched in 2008 by the WHO as a second Global Patient Safety Challenge, '[Safe Surgery Saves Lives](#)' to reduce the number of surgical deaths across the world.

It identifies a core set of surgical safety standards that can be applied in all healthcare settings. It requires only a few minutes to complete at three critical points during operative care – before anaesthesia is administered, before skin incision and before the patient leaves the operating room. It is intended to ensure the safe delivery of anaesthesia, appropriate prophylaxis against infection, effective teamwork by the operating room staff and other essential practices in perioperative care.

A study of the use of the checklist in nearly 8,000 surgical patients, published in the [New England Journal of Medicine](#), (21/1/09) showed a reduction in deaths and complications. In industrialised countries, major complications are reported to occur in 3–16% of inpatient surgical procedures, with death rates of approximately 0.4–0.8%.

The WHO checklist contains the core set of safety checks but can be adapted locally or for specific specialties through Trust clinical governance procedures. Clinicians may find this particular tool helpful and we strongly commend the use of the WHO checklist.

The Safety Forum has expressed willingness to provide support to this initiative. Recognising that work is already underway in some Trusts to implement the principles of the WHO Surgical Safety Checklist, it was discussed at a meeting on 4 March 2009 of the Safety Forum with Trust representatives (patient safety officers and others). It was therefore agreed that Trusts would:

- review their baseline position;
- nominate a clinical lead or leads for taking the work forward; and
- provide the Safety Forum with an update by 1 June 2009.

Later in June the Safety Forum will facilitate further discussion with Trusts about the use of surgical checklists as a tool to address safety issues within surgical settings in Northern Ireland.

Yours sincerely

**DR ELIZABETH MITCHELL**  
Acting Chief Medical Officer

**MR MARTIN BRADLEY**  
Chief Nursing Officer

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