



Quality Improvement Committee

Minutes

Meeting details

Date and time	3 August 2007, 9.30AM – 4.00PM
Venue	Wellington Airport Conference Centre, Wellington

In attendance

Committee members	Pat Snedden (PS) Robin Youngson (RY), Jean Hera (JH), Jim Vause (JV), Barbara Crawford (BC), Kevin Hague (KH), Mary Seddon (MS), Judi Strid (JS), Alan Merry (AM), Barry Taylor (BT)
Secretariat	Gillian Bohm (GB), Lote Gatland, Rachel Monaghan
Guests	Bruce Anderson, David Galler, Jan White – ACC CEO (9.55am-10.30am), Peter Glensor - Hutt Valley Health Chair (9.30am-11.45am), Chai Chuah - Hutt Valley DHB CEO (10.30am-11.45am), Hon Peter Dunne – Associate Minister of Health (11.45am-12.35pm), Rob Eaddy – Chief of Staff(11.45am-12.35pm), Sheila Swan(11.45am-12.30pm), Karen Mitchell (11.45am-12.30pm)
Apologies	Cindy Farquhar (CF), Catherine Rae (CR), Barbara Greer (BG)

Summary of discussion and decisions	Action points
<p>1. Karakia Meeting opened at 9.30am with a karakia by JV.</p>	Secretariat to arrange tea and coffee on arrival.
<p>2. Apologies and health-life reflection Secretariat brought to the Committee's attention that apologies were received from CF, CR, and BG. <i>PS Moved: That the apologies be accepted.</i> <i>Proposed: RY Seconded: JS Carried.</i></p> <p>BC reflected on Waikato District Health Board's (DHB's) 'quality' status.</p> <ul style="list-style-type: none"> - The DHB commissioned a clinical governance review and the recommendations are currently being implemented. The review identified lack of representation and attention to "quality" at Board and Senior Management levels. Action that aligns with the programmes in the 'Scoping priorities for quality in the health and disability sector' report were also recommended. - The DHB is reviewing its incident policy, all of which is included in the incident management business case. Specifications on this will be completed by February 2008 and is currently educating all staff on this matter. - The Quality and Risk unit has been elevated to where the unit reports to the Director of Nursing and the Chief Medical Advisor. - The DHB is in the process of establishing 'quality' key performance indicators including customer focus and accountability. 	AM to reflect at the next meeting.

Summary of discussion and decisions	Action points
<ul style="list-style-type: none"> - BC described her recent visit to Addenbrookes, Cambridge UK, commenting that there was an oblivious and explicit patient centred approach, KPIs for measuring quality were used throughout the organisation and the demonstrable difference that the process of “deep” cleaning had made to hospital acquired infection rates. 	
<p>3. Minutes (1 June meeting)</p> <p><i>PS moved: That the minutes are a true and fair record with the following amendments:</i></p> <ul style="list-style-type: none"> - Addition of AM’s name to the list of apologies - Remove point 11 from section 8 - Remove date from section 12.5 <p><i>Proposed: BC Seconded: MS Carried.</i></p>	<p>Secretariat to post minutes on website.</p>
<p>4. Chair’s report</p> <p>Four themes for discussion today:</p> <ol style="list-style-type: none"> 1) Relationship and interface between QIC, DHBs, Minister and Ministry of Health. 2) Unanimity with the business cases. 3) Context and interface with primary care. 4) Ensure committee is comfortable and the process is doing what we intend it to do. <p><i>Business Cases</i></p> <ul style="list-style-type: none"> - Business cases will be discussed in terms of content to see if everyone is comfortable with the content. - These business cases mean major reforms. We need to identify the baseline to see whether we are able to improve things. This then needs to run through the business case discussion. <p><i>Safe and Quality Use of Medicines (SQUM) Group</i></p> <ul style="list-style-type: none"> - SQUM meeting 9 August 2007. - SQUM and QIC need to be intuitive with one another. - SQUM is a vital part of the systemic approach to quality. - Interaction between SQUM and QIC: <ul style="list-style-type: none"> - SQUM does not want to replicate work. They should send their agendas to QIC and vice versa - seamless. - Add SQUM report on QIC’s agenda and vice versa. - SQUM has a parallel process. - QIC needs to set a good example of collaborative activity. - QIC needs to link with other ‘like’ groups. - Need to work collaboratively with the Chief Medical Officer (CMO) group and the Director of Nursing (DON) group. PS invited to attend the next CMO group meeting to give the group a direction about this Committee. <p><i>Event at Health Innovations 10/11 October 2007</i></p> <p>There is already a comprehensive agenda for 10/11 October 2007. We should frame our (QIC) work and hold an event in February 2008.</p>	<ul style="list-style-type: none"> - PS to attend 9 August 2007 SQUM meeting. - GB to send the SQUM strategic approach to QIC. - Secretariat to identify ‘like’ groups.
<p>5. ACC CEO presentation (Dr Jan White)</p> <p>See presentation.</p>	

Summary of discussion and decisions	Action points
<p>Points to note from presentation:</p> <ul style="list-style-type: none"> - ACC has mandates. One mandate is to prevent injury. - ACC legislation allows it to contribute to other government departments that are involved with preventing injury and to be involved in other areas where there is an opportunity to reduce cost/save money. - The Ministry of Health is responsible for implementing improvements to prevent treatment injury in the health sector. - The July 2005 legislation replaced medical misadventure with treatment injury. Medical misadventure was restrictive as medical mishap/error had to be proven to have been associated with an individual practitioner. Due to its strict interpretation, 60% of claims were declined. - The new legislation requires that that a causal relationship between the treatment and the injury for compensation to be granted. - Under new treatment injury, 70% of claims are accepted. - ACC has received 10,000 claims so far and claims are rising 30% a year - ACC is accumulating an information base. However, ACC can only collect data for making a decision on a claim. - There is a limit on the information available from the claims for analysis. For groups like QIC. - There needs to be a culture change so clinicians will report. There is suspicion from clinicians as to what is going to be done with the data. <p>Discussion points to note:</p> <ul style="list-style-type: none"> - A lot of clinician ignorance restricts reporting. It is difficult to find an ACC form in a hospital ward. Treatment injuries in wards are under reported. - The ACC information is not perfect. Statistical significance of the information is dependant on the amount of claims received by ACC. It is a voluntary reporting system. If people do not report then patients are not getting what they are entitled to. - The statistics may not be perfect but it all treatment injury costs money. A lot of the claims do not receive a lot of money from ACC but there will be a cost in the health sector. - Many of the general practitioner treatment injury claims are 'mild'. ACC has been approached from the College of GPs to work with the primary care sector on treatment injury. - The definition of infection in the presentation relates to infections that are linked to the process of care. - Psychiatry and paediatric claims are not included in the graphs. - DHBs are poor in claiming for psychiatric treatment injury. - Harm reporting – ACC could start reports on key incidents that occur; similar to what the Office of the Health and Disability Commissioner does. - ACC does not feed back to the practitioner who created the injury. An opportunity is lost to rectify the source of the problem. There is an issue of natural justice. - When a claim gets to, for example, the Medical Council and it is flagged against a person's name then there is something that can be done. - ACC's primary focus is the claimant. - Harm notification is sent to the Ministry of Health from ACC. It is up to the Ministry to decide what to do with the notice. 	<p>Secretariat to get more detail on the graphs from Jan White. Need the dollars spent instead of numbers as well.</p>

Summary of discussion and decisions	Action points
<ul style="list-style-type: none"> - It should be up to the DHB who knows the details to follow through on harm notifications as some incidents could be purely coincidental and not a system failure. The Ministry needs DHBs to assist with the harm notification issued by ACC. - ACC can provide DHB specific reports. - ACC is obliged under legislation to notify where it identifies a “risk of harm to the public” to the authority responsible for patient safety – the following events are reportable: - Sentinel events : An event during care/treatment that has resulted in an <u>unanticipated death</u> or <u>major permanent loss of function</u> not related to the natural course of the consumer’s illness or underlying condition - Serious events : An event or related events that has the <u>potential</u> to result in death or major permanent loss of function, not related to the natural course of the consumer’s illness or underlying condition - Reports on claims are forwarded to registration authorities . - Systems that organisations should use for reporting needs some direction/process developed. - ACC is involved in this so entitlements are given to people that are injured. - Harm notification may be something that QIC needs to look at. - Harm notification can not be used for benchmarking because reporting differs in different areas. - Could look at data over 2 or 3 years to get a more accurate assessment of the situation. However, we need to be careful that reporting hasn’t changed over the time period used. - ACC has two purposes: - Compensation and prevention - Injury prevention: It is helpful for DHBs/providers to have good reporting from ACC. However, the kind of information that DHBs want, ACC often does not have as ACC only collects enough information to make a claim decision. - ACC is a natural supporter of some of QIC’s priorities. - When there is an advantage to ACC then ACC will get involved with QIC. - QIC needs to work closely with ACC. ACC interest could be in the education of improving quality systems. - Useful solution: give the matters back to the DHBs then they can establish if there is an issue to deal with. 	<p>PS to engage with ACC/ Dr Jan White.</p>
<p>6. Group Process Discussion</p> <p>See memo from Kevin Hague.</p> <p>Points to note from discussion:</p> <ul style="list-style-type: none"> - DHB land is a complex environment with DHBs having different priorities. - Having DHBs all work in a particular way can be difficult. - When it comes to the quality improvement priorities, we need/ the country needs the DHBs to be implementing that work and to own it. - A lot of pendulums in health. Those studying systems know a lot of the pendulums e.g. centralisation and decentralisation. Currently, we have settings that are decentralised. We have a lot of collective structures, e.g. DHBNZ, others that fall out of that group are the DON and CMO 	

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<p>groups.</p> <ul style="list-style-type: none"> - What the legislation says and what the Minister says is what DHBs going to do. - Each DHB has some level of quality improvement that interfaces with some of these projects. - Could have a structural arrangement that has DHBs responsible for implementing the projects. - Need to find a solution that incorporates the Minister's desire for a rapid result and his willingness to put resource into achieving those. Expertise and enthusiasm in the QIC is extremely important and needs to be combined with DHB responsibility. - Concern raised about the loss of a national approach. An example of a national approach is the suicide prevention project. There was commitment from CEOs, clinical directors of Māori health, and mental health. If only two or three were in agreement then they would not proceed. - The New Zealand Guidelines Group had a national project team (2 or 3 people), which had a role to assist DHBs to do it their way. There was a set of national goals which they all agreed to work towards. The DHBs were provided tools but the DHBs implemented it their own way. This is how we could approach it. - If QIC does not direct DHBs or the Ministry then QIC could lose cohesion. - The Minister directing DHBs has significantly more weight than QIC inviting DHBs to take on the priorities. - CEOs group makes a collective determination. - QIC is specifying the 'what' but not the 'how'. - Possible conflict of interest situation as DHBNZ chair (implementing group) is also the chair of QIC (the monitoring group). Conflict of interest against the recommending power and the monitoring power. - QIC is fundamentally advisory but it also needs to think of the cost that its advice may incur. The business cases are advisory and not specific. - 'Thou shalt' does not work. - CMOs bar one supported QIC's work. - Need to do what is going to work and what is going to work for consumers. We want to have confidence that it is going to be effective in DHBs and not lost down the line. - There is a serious issue around governance and the manner these projects are to be implemented. When you put 21 DHBs in a room there will be different perceptions from each person. - The strength of this committee is that it has a very broad representation. We need to find a way to bring that knowledge into the implementation. Not sure how that is going to work if seated with a group of CEOs/CMOs. - Concern that there is a lot of management focus/project focus. The Committee would need a lot more support/a bigger secretariat. Is this going to be another National Health Committee? - The structure would need to be changed when you get to primary care. <p>Comments from Peter Glensor, Chair of Hutt Valley Health, who controls the oversight of Value for Money (VFM), one of the 5 DHBNZ workstreams : There are two dimensions of VFM: 1 – some benchmarking of our provider arms. Pressing for more than half of</p>	

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<p>its money is spent in its provider arm. Huge differences from provider arm to provider arm. All DHBS are committed to this benchmarking.</p> <p>2 – sharing of innovation, of new and better ways of working. This is not a voluntary process. Everyone agrees that this is a new way of working, where every DHB will have to report back to show how they implemented it or why they didn't implement it.</p> <p>These quality improvement priorities can be part of the VFM workstream.</p> <p>The Committee noted the need to discuss general group process. Secretariat to add this to the next agenda along with reflection time.</p> <p>Points to note from discussion (continued):</p> <ul style="list-style-type: none"> - if we are not all aligned, we will fail. - What we have learned from other jurisdictions is that whole system change needs central coordination and collaboration. - A criticism of the previous iteration of this committee was that it did not articulate, drive or lead a national quality agenda. - If each DHB can implement projects in its own way, public confidence can be affected by people receiving different care from different DHBs. - If the money is coming from the Minister, he is responsible to the House for the use of the money. - Initiatives such as immunisation have been centrally guided. - Start of the process is the Minister's letter of expectation to DHBs. - Minister signs off the annual plan and the strategic plan. - The Minister should direct the DHBs to work collaboratively to implement these projects. - Function of the Committee is as per the Committee's terms of reference - advice to the Minister and report how well these are going. - Suggested model of engagement. QIC/Minister and Ministry of Health/ DHB interface. See attached model. <p>The Committee agreed to adopt the triangular diagram in draft</p>	<p>Secretariat to add group process discussion to next agenda.</p> <p>Committee to facilitate a meeting with key players focusing on quality improvement. PS and JH to work on this and circulate to the Committee.</p> <p>Secretariat to write/draw the triangular diagram.</p>
<p>7. DHB CEO presentation – Chai Chuah, Hutt Valley DHB See presentation.</p>	
<p>8. Hon Peter Dunne - Associate Minister of Health</p> <p>Points to note from speech:</p> <ul style="list-style-type: none"> - A consequence of the confidence and supply agreement was the medicines strategy. - Does not see what is being done with the medicines strategy as cutting across the work QIC has been involved in. - A consultation document on a national medication strategy was released last year. This was a descriptor of the current situation. It did not put out a blue print. It left the door open for input. - In March 2007 public submissions closed. There were then four specialist meetings. Over 90 submissions were received. Shortly, a draft report will be received to put together a policy approach. - The driving force for the Minister came out of an exchange. Given rapid technological change, what is the long term plan in terms of managing medicine availability? - There is not a shortage of information around patterns of medicine use. There is a lot of information available. However, similar interest groups 	

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<p>are not sharing their information with others. How do we better integrate what is there already.</p> <ul style="list-style-type: none"> - While we do need to address high risk medicines, there is the issue of safe and quality use of medicines. Not just the ‘best bang for our buck’ but the best use of the medicines. - There is a very natural intersection with the work we’re doing in this area. - At the end of this year a Cabinet paper on the shape of the medicines strategy will be completed. It will not be the last word. I do expect to be able to have a big picture overview. - Time is an issue. It took 15-16 years to develop a medicine strategy in Australia. While there were political imperatives (needing to get a medicine strategy in place in the current Government) the Minister is equally mindful of the fact that we need to get it right. - Current uncertainty about the medicines regulatory environment given the apparent impasse on the therapeutic medicines legislation. - Minister’s view: pass a bill that gives a joint agency. He supports the carve-out proposal that is being discussed at the moment. - The more immediate issue is, if that goal cannot be achieved what are we left with. The status quo is not satisfactory. - The rapidity of change is changing from one day to the next. This is a very fluid situation. <p>Discussion points to note:</p> <ul style="list-style-type: none"> - What about the interface with QIC? - In relation to adverse medication incident management. PHARMAC regulates what drugs are available but have not looked into how we can decrease medication incidents. - Adjustments can be made through the system. Once the decision is made to fund medicines we have a diffuse way of checking those decisions. The Pharmacy Council informed the Minister of studies on post-dispensing medicines. One person complained about taking medication ‘aurally’ but should have been taking it ‘orally’. - It is not a matter of inventing new wheels but using all the wheels on the chariot effectively. - Packaging of medicines is an important issue. Currently some medication is packed identically. Different packaging should be used for different drugs so as to create safer use. - Who is responsibility is to ensure packaging is safe? <p>JV declared a conflict of interest as he is on the Pharmaceutical and Therapeutics Advisory Committee (PTAC).</p> <ul style="list-style-type: none"> - Need to work constructively with the Minister through this medicine strategy process as it relates to primary care. - Center for Adverse Reactions Monitoring (CARM) and BPAC based in Dunedin are similar groups, however, they are not working together yet are located an arms length away. - The connecting piece is the health consumer. Elderly patients with a number of different diagnoses were taking 13 different medications. Pharmacists reviewing self medication in the elderly found a 52% error rate when they visited them in their homes. - Emphasis should be on the elderly since they have the highest volume of medication. 	

Summary of discussion and decisions	Action points
<ul style="list-style-type: none"> - There is a difference in charging to a patient for filling prescriptions. If a patient is discharged from a hospital it is \$15 but only costs \$3 getting the medicine from a general practitioner. Equitable costing to patients may need to be considered in the strategy. <p>Undertaking by both PS and the Minister to keep each other informed.</p>	
<p>9. Business Cases Discussion</p>	
<p>9.1 Safe Medication Management</p> <p>Discussion points to note:</p> <ul style="list-style-type: none"> - Need to be clear about the stages in the process. Medication chart needs to be added to the first section of the business case and the list needs to be chronologically ordered. - There needs to be a quality and risk manager on the steering group. - There needs to be a person who has expertise in the quality and use of medicines. - Need to put in the business case the types of skills that are needed on the steering group rather than positions. - The role and participation of consumers need to be included in the paper. - A consumer focus needs to be across all business cases. - How can the achievements proposed in the business case be measured? Could be covered off by adding in a statement that there needs to be an evaluative approach. - Add in a section called 'Monitor and evaluate'. - What is the scope of this project? It appears that primary care and community pharmacies are not included. - The Health Information Strategy Action Committee has community projects. We need to make sure we're aware of what is going on in the primary sector so we don't overlap. We can look into primary care later. - There is a big need in outpatients. There is no standardised way of charting medication. - Electronic prescribing in primary care already exists. - Implementing IT solutions will be difficult. - The delay will be from 'where it sits with other priorities'. If the Minister says that this is his top three priorities, then other things in DHBs will be put on the backburner. <p>AM repeated his conflict of interest. AM owns shares and is a member of the Safer Sleep LLC Board, which produces a barcode based safety system for medications in anaesthesia.</p> <p><i>PS proposed:</i> <i>The Committee recommends the progress of the Safe Medication Management Business Case inclusive of the amendments discussed and agreed by the Committee and inclusive of the relationship changes consistent with the model of DHB/QIC interface as agreed by the Committee and authorises the QIC Chair to sign this off to go to the Minister and provide a copy to all members and SQUM</i></p> <p><i>Seconded: BT</i> <i>Carried.</i> <i>Abstention: AM (due to his conflict of interest).</i></p>	<p>This business case to be reframed and sent to the Minister.</p> <p>Copies to be sent to all Committee members and SQUM.</p>

Summary of discussion and decisions	Action points
<p>9.2 Incident Management Business Case</p> <p>Discussion points to note:</p> <ul style="list-style-type: none"> - There is no commitment to the implementation of the project within the business case. - Question arose as to what the NSW system and the VA system was in the business case - Open disclosure is good but need anonymous reporting. - The scope of the project (point 3) was reiterated. - Check what it is meant by 'consultation with the sector' in the business case - All the systems in existence at the moment are not that great. - The value of the system is to the user. - It is not about data collection but about the feedback loop. - Need to educate the sector in open disclosure. - No where in the document does it say about how we're going to implement the nationally co-ordinated incident information management system. - Education and training needs to be broader. Training needs to be for everybody. - What are the primary care implications. - Need to reference who this applies to. - Need Māori in the group (see 6.4 in the business case) - Unable to see how consumers are going to be involved. Need to include consumer. PS will work out the wording to the consumer part and get back to Jean on it. - The detailed answer will come out of the policy development. <p>QIC to give authority to sign off on this business case.</p> <p><i>PS proposed:</i> <i>That the Committee adopt the management of healthcare incidents business case subject to dealing with the relationship issues inclusive of the amendments and that the authority to sign this off will be vested in the chair after thorough discussion with RY, BC, and JH.</i> <i>Seconded BC</i> <i>Carried.</i></p>	<p>PS to work out the wording to the consumer part and get back to JH.</p> <p>PS will work with JH, BC, and RY to finalise this process within the next month.</p>
<p>9.3 National Mortality Review System Business Case</p> <p>Discussion points to note:</p> <ul style="list-style-type: none"> - Question as to cost. Is this a realistic indication? - We need to get a peer review for any project over \$1million. - Ratio of fixed to variable cost will vary in this project. - How valuable is the child and youth mortality review process is to the Minister? - Proportion of money spent on child and youth is quite high. - The child and youth are more complicated than perinatal. - We have never had something that covers community deaths. - Do other countries do this? USA has a national system through every state. The Australian model is more centralised. The UK has good system for national review of deaths. <p><i>PS proposed:</i></p>	<p>Secretariat to obtain peer review on this business case.</p> <p>Secretariat to amend business case to reflect proposal by PS</p>

Summary of discussion and decisions	Action points
<p><i>The Committee recommends the progress of the National Mortality Review Systems Business Case inclusive of the amendments discussed and agreed by the Committee and inclusive of the relationship changes consistent with the model of DHB/QIC interface as agreed by the Committee and authorises the QIC Chair to sign this off to go to the Minister and provide a copy to all members.</i></p> <p><i>Seconded: JH</i> <i>Carried.</i></p>	<p>Business case to be forwarded to PS for sign off.</p>
<p>9.4 Education and Training Business Case</p> <p>Discussion points to note:</p> <ul style="list-style-type: none"> - Strong DHB focus. PHOs are not mentioned. - We will change the scope for this business case to include primary health. - It is a one-off dropping into the bucket what we really need is a capacity building and may become NZQA registered. - The business case should mention role of HRANZ (Health Regulatory Authorities of New Zealand). - Support people needed to be added throughout. - There is a sequencing issue. It is difficult to make it mandatory. - A way forward that may encompass the needs of various organisations is to assess the competencies and then provide the training accordingly. - There needs to be a national mechanism for identifying and approving this programme. - Need to identify ways to engage consumer organisations that are interested in health sector training. - Need for a greater focus on sustainability, using the train the trainer approach. - Prefer to see an emphasis on risk management. <p>New reference group formed made up of DG, JH, JS, MS, CR, and JV.</p>	<p>Secretariat to arrange meeting for new reference group</p> <p>MS to supply a paper to secretariat that provides a model job description for a quality and risk manager.</p>
<p>9.5 Infection Prevention and Control Business Case</p> <p>Discussion points to note:</p> <ul style="list-style-type: none"> - Needs to have a more comprehensive approach, which will better reflect where DHBs are at and what they're doing. - Include consumers by training them. - Remove the consumers asking practitioners whether they've washed their hands. - In our community culture, they won't challenge someone in authority. If we have to remind health practitioners to wash their hands that would undermine consumer confidence in their care. - Empowerment of the consumer where the consumer is vulnerable what tools can we provide them. - DHBs should welcome feedback. - Need to show a general interest in that family. This is what Sylvia Cartwright said in 1988. - Responsiveness to complaints. Patient satisfaction survey needs to provide useful indicators. - What are the quality measures that the Ministry of Health should be measuring? - Core of the issue: empower patients. Promote a trusting and good 	<p>Secretariat to amend the business case as per Committee discussion</p> <p>Secretariat to work with peer review group to finalise business case.</p>

Summary of discussion and decisions	Action points
<p>relationship with doctor/patient healthcare. Don't want to promote conflict between the two. What is good in NZ is a reasonably good relationship.</p> <ul style="list-style-type: none"> - Infection control person in Waikato supportive of the business cases. 15 of the 15 DHBs contacted are already using hand gel. Need to acknowledge the huge amount of work already done in this area. - Everyone is agreeing to communication, the business case needs to be rewritten to include a range of things. The biggest thing is a surveillance system. - Middlemore infection control person is excited about this business case. But there needs to be surveillance before and after. - It makes sense to have a synergy between this business case and the standard being reviewed currently. JS and CR on the steering group looking at the infection standard. - If we pick up the WHO patient safety high 5s clean hands initiative hand gel would need to be included. - Change tone to recognise what has been done. - Develop measures and then put those measures out in the world for peer review at an international level. - Where are the important gains coming from? - Public reporting is the most effective way. This needs to be included in the business case. - Could include a recommendation that the Ministry investigate a new quality-reporting requirement on XYZ. Can not publicly report unless we measure. - Need to recognise that the ICUs in the USA are different to NZ ICUs. <p>GB to redraft this business case with the help of BC, JS, and CR.</p> <p>PS proposed: <i>The Committee recommends the progress of the Infection Prevention and Control Business Case inclusive of the amendments discussed and agreed by the Committee and more specifically any amendments that arise from discussions with BC, JS, and CR, and inclusive of the relationship changes consistent with the model of DHB/QIC interface as agreed by the Committee and authorises the QIC Chair, once in receipt of the amended business case, to sign this off to go to the Minister and provide a copy to all members.</i> Seconded by JH. Carried.</p> <p>Note: Timeline of sign-off is dependant on GB, BC, JS and CR.</p>	
<p>9.6 Optimising the Patient's Journey Business Case</p> <p>Discussion points to note:</p> <ul style="list-style-type: none"> - Westcoast DHB it is at the point of incorporating primary and secondary patient journeys. So they're way ahead of this business case. - A Māori patient journey is different from a non-Māori patient journey. - The patient needs to be put first. Utilisation of resources needs to be secondary. - Support a national linkage with a collaborative. - A collaborative involving some DHBs has been done in some other areas eg. Participation in a health round table. All DHBs said they would benchmark among themselves. 	<p>Secretariat to amend business case to reflect the Committee discussion.</p>

Summary of discussion and decisions	Action points
<ul style="list-style-type: none"> - Narrative issue about how this business case is described. Need to include the value stream. - In our process when we engage with the sector we make it clear that the consumer is at the centre of everything we do. We need to articulate it right. The consumer experience of the health system needs to be edified by what we do. - Not all solutions will fit each place. - Need to recognise that not everyone will adopt this immediately. This is a trial. DHB by DHB implementation. - Need to frame this in more value terms. - The rights and responsibilities of the consumer is the underlying factor. <p>AM moved: <i>The Committee recommends the progress of the Optimising the Patient's Journey Business Case inclusive of the amendments discussed and agreed by the Committee, and inclusive of the relationship changes consistent with the model of DHB/QIC interface as agreed by the Committee and authorises the QIC Chair, to sign this off to go to the Minister and provide a copy to all members.</i> <i>Seconded: BT. Carried.</i></p>	<p>Finalised business to be forwarded to PS for sign off</p>
<p>10. General Discussion</p> <p>What does QIC do when we see that something needs to be done and it's not in the top six of our priorities? e.g. interface with primary care.</p> <ul style="list-style-type: none"> - Does QIC have overall responsibility of quality? - HDC has recommended the implementation rapid response teams/early warning systems. - We have to go down the priority line. We need to be champions to the DHBs for quality systems. - We should allow people who have a strong interest to work in that area, and empower them to do that work. - These projects are a temporary diversion. QIC needs to step back into a governance role. - Could have a QIC retreat to strategise. - Are we going to get more projects? Yes. Need a method of prioritisation. - Could encourage the Minister to ask QIC for advice. - QIC is relevant to the whole sector. Starting with DHBs is good, but need to be careful that we do not just focus on DHBs. - The message we give to people is that 'we're here for the long haul'. - We need to put people in touch with each other when issues are raised. Facilitate those connections. - Need a stock-take of quality initiatives. This could highlight people working in same topic. Could use the current DHB reporting against the IQ Goals - Would like to see a contestable fund available for quality improvement and innovation. - The national risk assessment tool could be a future focus. <p>A way forward:</p> <ul style="list-style-type: none"> - decision about QIC processes - decision about QIC strategy beyond current projects - how do we do next what we need to do? - Committee members to come with an idea to the next meeting (JV, 	<p>Secretariat to provide members with copy of unpublished "chartbook" for them to discuss at next meeting.</p>

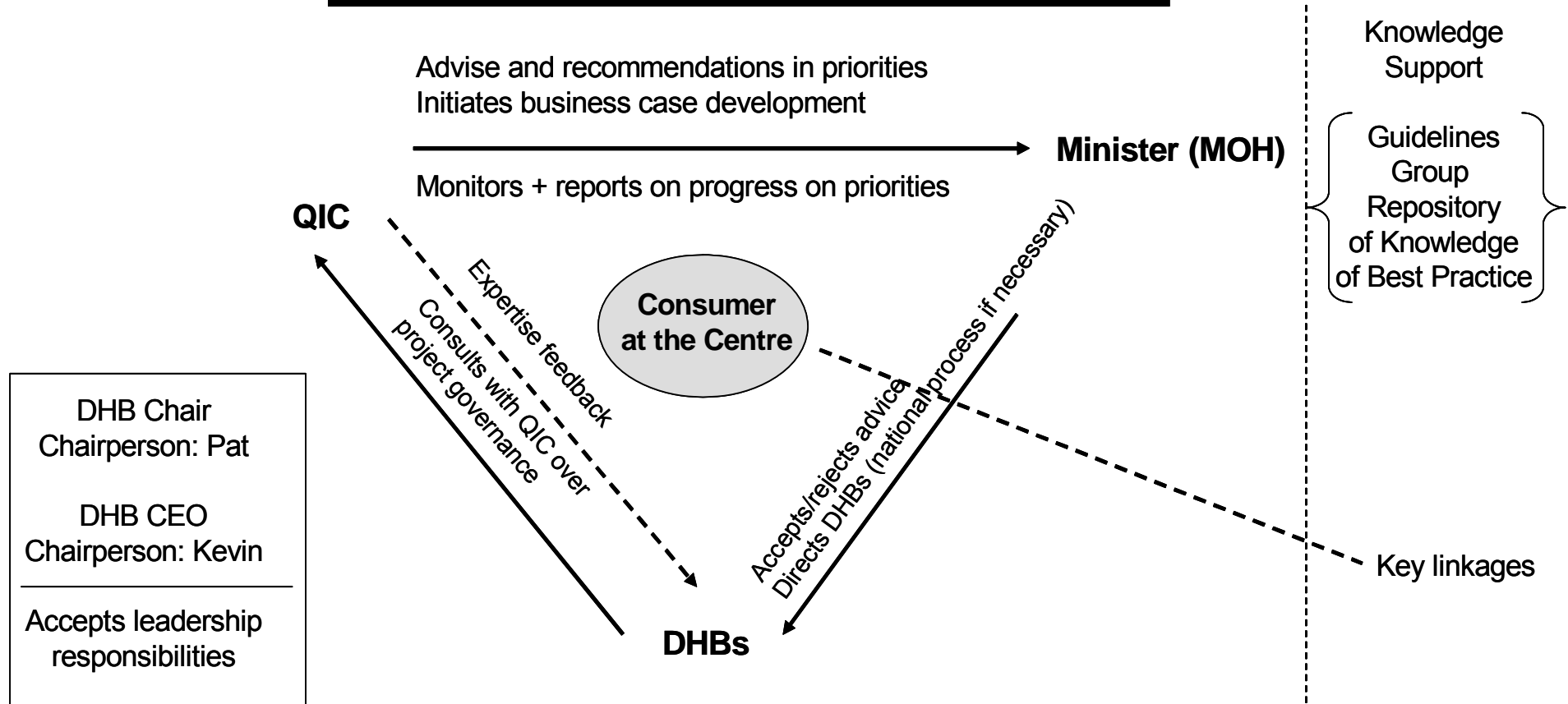
Summary of discussion and decisions	Action points
<p>DG, BT).</p> <p>BC advised she will not be at the next meeting.</p>	
<p>11. General Business</p> <p>11.1 Correspondence Committee agreed to send the letter drafted by the Secretariat, to Alistair Woodward.</p> <p>11.2 Upcoming meetings</p> <ul style="list-style-type: none"> - PS to attend SQUM - KH and PS to attend CE group - PS presenting at next DHB Chair's meeting in September. - Helpful for PS to meet with the Quality and Risk Manager's Group <p>11.3 Communication matters</p> <ul style="list-style-type: none"> - CMO group would like to be more informed. Majority of CMO group were supportive of everything that QIC was doing. - Issue about getting information to clinicians. - Question as to how to communicate quality issues in the sector. - A few media issues on particular matters. Karen Brown, Radio NZ is keen to be updated. - Could run a series with Karen Brown. Different members could talk for 20 minutes each week about the positive things working in the health sector. - Discussion ensued as to what other areas the Committee could be looking at. 	<p>Secretariat to post letter to Alistair Woodward.</p> <p>Secretariat to provide a powerpoint presentation for PS.</p>
<p>Closure of Meeting PS concluded meeting at 4pm.</p>	

Next meeting
<p>Friday, 14 September 2007, 9.30AM – 4.30PM Auckland</p>



Signed _____ Date 04 March 2008
Pat Snedden (Chair)

SUGGESTED MODEL OF QIC / MINISTER (MOH) / DHB INTERFACE



<p>DHB Chair Chairperson: Pat</p>
<p>DHB CEO Chairperson: Kevin</p>
<hr/> <p>Accepts leadership responsibilities</p>

- Accepts responsibility for project implementation/governance
- Integrates direction under VFM priority (DHB)
- Actively utilises QIC expertise
- Adopts/revises initial business case
- Delivers on final business case imperatives
- Consumer involvement across the board including the governance level