



Quality Improvement Committee

Minutes

Meeting details

Date and time	14 September 2007, 9.30AM – 4.00PM
Venue	Cullinan Room, Jet Park Hotel, Auckland

In attendance

Committee members	Pat Snedden (PS), Robin Youngson (RY), Jean Hera (JH), Jim Vause (JV), Kevin Hague (KH), Mary Seddon (MS), Judi Strid (JS) joined meeting 10.10am, Barry Taylor (BT), Catherine Rae (CR), Barbara Greer (BG), Cindy Farquhar (CF)
Secretariat	Gillian Bohm (GB), David St George (DstG), Damien Cole
Guests	David Galler (DG), Helen Smith (HS), Stephen McKernan (SMcK) – Director-General of Health (10.30am – 11.50am), John Peters (JP) – CEO Nelson Marlborough DHB (10.30am – 12noon)
Apologies	Barbara Crawford (BC), Alan Merry (AM)

Summary of discussion and decisions	Action points
<p>1. Karakia Meeting opened at 9.30am with a karakia by BG.</p>	<p>Secretariat to arrange tea and coffee on arrival.</p>
<p>2. Apologies and health-life reflection Secretariat brought to the Committee's attention that apologies were received from BC and AM. <i>PS Moved: That the apologies are accepted. Carried.</i></p> <p>MS provided the health-life reflection - that in reviewing all the DHB responses to the recommendations made in the HDC report (05HDC11908) that there are three types of DHB</p> <ul style="list-style-type: none"> - Those that are bad at writing policy and implementation, those that are good at writing policy but poor at implementation, those that are good at writing policy and implementing it. - If the response was written by a clinician it was better than those written by a manager - Small DHBs seem better able to implement improved processes - DHBs had common concerns – workforce and scopes of practice, handover and the short shifts worked by doctors and nurses, open disclosure and the requirement for a national programme, care for the marginalised patient (very old, mental health, addicted) and the variable responses to serious incidents. <p>MS was preparing to speak at the NZIHM conference and her main message would be "health care quality is their business".</p>	<p>BT to reflect at the next meeting.</p>

Summary of discussion and decisions	Action points
<p>3. Minutes (3 August meeting)</p> <p>Corrections to the minutes-</p> <p>“BC described her recent visit to Addenbrookes, Cambridge UK, commenting that there was an oblivious and explicit patient centred approach,” replace oblivious with obvious.</p> <p>“Responsiveness to complaints. Patient satisfaction survey needs to provide useful indicators.” Replace provide useful indicators with be validated.</p> <p><i>PS moved: That the minutes, with the above changes, are a true and fair record.</i> <i>:Carried.</i></p> <p>4. Chair’s report</p> <p><i>DHBNZ Chairs and CE annual meeting.</i></p> <p>The major topics for discussion were:</p> <ul style="list-style-type: none"> • Plans and strategies for the year ahead • Work streams – procurement • Industrial relations, including Health Sector partnership • Value for Money stream • Information technology • Primary care strategy <p>PS had addressed QIC agenda in Value for Money work stream, and this was accepted formally.</p> <p>John Peters has responsibility for the Value for Money work stream. These are activities that get best results, described in terms of economic impact as well as performance impact.</p> <p>DHBs are committed to mutual benchmarking within NZ and Australia. How can we derive insight from the best of the best, what are the reasons for the variation?</p> <p>DHBs often argue they are special and different and they give that as an excuse for being inefficient and not meeting a benchmark.</p> <p>Counter-argument: Can something be done to get everyone to work in the same way, they should be able to.</p> <p>MS commented on the need to understand common cause variation from special cause variation.</p> <p>DG need to think of “value” in broadest term not just dollars.</p> <p>KH need to anticipate projects creating structure that that could support project.</p> <p><i>QIC business cases sign off</i></p> <p>PS Anticipating that Minister will agree – some of the work for the business cases is already underway.</p> <p>GB described usual process required to obtain approval for proposal with significant spending.</p> <p>Discussion on if the business cases should be ranked? BT noted that Minister did not require it. DG agreed.</p> <p>Cases will be discussed individually later in agenda.</p>	<p>Secretariat to post minutes on website.</p>
<p>Last edited: 20 September 2007</p>	<p>Page 2 of 9</p>

Summary of discussion and decisions	Action points
<p>Health sector partnerships</p> <p>PS Health sector engagement and collaboration. There are only four players; Ministry, Unions, DHBs, Clinicians. How can they work together?</p> <p>12 unions in provider arms. CEs want to see workforce into better work practices, appropriate wages, increased public confidence. Two Chairs and three CEs (Wairarapa, Lakes, Southland) in conversation with the MoH and CTU unions. CTU presented their view – recent nurses settlement predicated on basis of partnership. RISK: Opportunities must be maximised as the downside is a costly workforce. Unions are also taking risks. Impact on stability of workforce. Adversarial stance was not taken. ASMS haven't signed up but have no objection. Culture of interaction must be changed. DAP parameters but increased partnership opens up potential for new ways of working and maximising opportunity DG leadership can't change without change processes, need to change culture of interaction PS national collaborative growing all the time</p> <p><i>JP and SMcK arrived 10.30 am</i></p> <p>5. Stephen McKernan spoke</p> <p>Relationships inside Boards – sharing information on who is doing things well, engage at local level. Share lessons like nurses – good outcome, issues based long term settlement. There are opportunities for DHBs and unions to work constructively.</p> <p>There is no impediment in terms of resourcing for QIC to do its job.</p> <p>6. Engagement with ACC</p> <p>PS reported that ACC want to be engaged and asked if there should be a person from ACC on QIC?</p> <p>MS alarmed at ability of ACC to refer individual clinicians to Nurses Council by passing DHBs.</p> <p>GB noted that ACC are required by legislation to notify registration bodies.</p> <p>JS HDC does not receive notification now as they used to.</p> <p>JH Medical Council do not regard this notification as disciplinary matter.</p> <p>DStG: ACC Harm panel doesn't get enough information to be able to decided on individual competence. MoH contacts DHBs if it requires further information.</p> <p>DG: MoH & ACC have close relationship. PS Sensible to have ACC person on QIC. Committee agreed.</p>	

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<p>7. John Peters Presentation</p> <p>JP spoke to a power point presentation (attached). Discussion.</p> <p>MS Need to minimise Quality Assurance focus and ask the value for money of accreditation. Certification is required. Note that all recent organisations investigated by HDC were accredited organisations.</p> <p>BG Asked JP how is quality measured in the DHB and the role of the internal auditor in NMDHB</p> <p>JP: Audits, but how often do we check? On an annual basis.</p> <p>CR: Quality structure in the DHB important. Currently this may not be enabling – different structures in different DHBs mean struggling to achieve quality. Referred to JP statement “don’t tell us how to do it” and noted the potential for 21 different ways.</p> <p>JP Agreed</p> <p>DG Approves of presentation. Quality is core of Value for Money. What are the mechanisms by which quality initiatives are put into practice?</p> <p>BT: Do quality representatives have time to put into quality?</p> <p>JP: Engage with clinicians – a couple only are engaged.</p> <p>MS: How to measure non-\$ value?</p> <p>JP: Still learning to. Originally champions (CEO or direct report to CEO) would identify key initiatives that had high benefit and require their DHBs to report. What happens is that DHBs form clusters of interest around some projects. Morale is hard to quantify but can be verified.</p> <p>MS: Are they different? Is the list of projects available?</p> <p>JP: Yes, will share, including prioritisation criteria.</p>	<p>Secretariat to get papers from JP for next QIC meeting</p>
<p>8. QIC interface model</p> <p>The draft of the model had been circulated prior to the meeting. Points from the discussion include:</p> <p>RY: How are the resources brought together? Across all programs? Where is the detailed model?</p> <p>MS: did not agree with point 2 page 4 CE section</p> <p>JS: Agrees with RY about potential for lack of cohesion.</p> <p>DG: Expertise identified and accessed. Experts have done this.</p> <p>BT: Have DHB CEOs thought about how they will implement this?</p> <p>KH: Yes, they’ve planned the infrastructure. They understand that outside expertise will be required. They’ve implemented big projects before.</p> <p>JP: Agrees with KH. Awareness of resourcing issues. A commitment and interest in succeeding. It will be frustrating that different DHBs will achieve at different levels.</p> <p>JS: Is there a shared view in each DHB about where quality sits? It is known there are variations between DHBs about status of quality.</p> <p>JP: Recognised this – DHBs don’t have an option about opting in or out. Stated engagement is a requirement.</p> <p>CF: Has there been a similar model successfully implemented?</p>	

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<p>PS: Collectivity is not new. Using that experience with this project.</p> <p>CF: Only 10 out of 21 engaged with the collaborative run by the NZ Guidelines Group mental health project. Central funding but no staff supplied. Doubts the viability and realism of the interface model. Stakeholders have to really want it for the project to succeed.</p> <p>BG: How will consumers be involved in the (interface) triangular model?</p> <p>JV: Monitoring will be key aspect; don't see resources for this in interface model.</p> <p>CR: Imposing business cases will not succeed without close monitoring and accountability. QIC must have control over that.</p> <p>HS: National direction is essential. To be integrated into all DHBs plan.</p> <p>MS: Monitoring is responsibility of DHBs (pg 4), but independent monitoring is required.</p> <p>KH: QIC will do that.</p> <p>JS: Understands differences across DHBs. Project to improve quality of services to those who've attempted suicide. What happened was that each DHB put different significance on this. Some DHBs changed the protocol. Others changed the tools. Evidence –based approaches MUST be followed. Also difference in engagement with consumers.</p> <p>JH: What is going to work? It is going to be hard.</p> <p>BT: Mortality review has worked because of centralised data structure. So independent data structure is necessary and allows learning.</p> <p>PS: Everyone has experienced success and failure. Ministry mandate and money goes to DHBs but they react differently. Clear structural mandating process is provided – QIC is saying that it is not good enough if progress is not made. Agitation role is important. Make business cases attractive to stakeholders. This structure is one that different DHBs will go along with. 12 month evaluation period will allow that.</p> <p>SMcK: QIC's model is not different – take up concerns are acknowledged. No other model will work. Connect the system to drive the priorities of the system. Change in priorities through DHBs. The interface model is a good one. There is sufficient expertise and resources. The business cases are crucial. Minister wants to see traction and can and will take action about failure. Ministry has monitoring role, so must be clear about WHAT is being monitored – there must be milestones for reporting. This is important to the Minister – so the first business case gives notice.</p> <p>DG: Ministry must monitor – what will it look like in five years time? All DHBs will spend some money on this and see it as the core of the Value for Money stream.</p> <p>PS: RY asked, what about expertise, KH, can you answer this?</p> <p>KH: What is the resource that comes with it? DHBs are slow to change.</p> <p>PS: Has the money asked for been reasonable?</p> <p>JS: asked about complete take-up</p> <p>KH: This project is in a different category. Its being driven from the highest level, the Minister requires us to do something.</p> <p>CF: CEOs may sign off at the top, but this often doesn't flow through at lower levels.</p> <p>JV: How independent can QIC be?</p>	

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<p>PS: Don't want duplication – make it part of the work plan. Also consumer participation – there is deliverable.</p> <p>BT: QIC must define variables for monitoring. What are the measures?</p> <p>JS: Promote projects as making it easy to do the right thing for consumers – this makes it difficult to say no.</p> <p>PS Moved that the QIC interface model is adopted.</p> <p>BT seconded</p> <p>Carried</p>	
<p>9. Business case confirmation</p>	
<p>9.1 Incident Management</p> <p>JV: Distinguish open disclosure process from scoping the means</p> <p>Passed by Committee</p>	<p>Secretariat to produce final version of business case</p>
<p>9.2 Infection Prevention and control</p> <p>Page 11 – remove No 4</p> <p>JH: Consumer reps are missing, please add them</p> <p>Passed by Committee</p>	<p>Secretariat to produce final version of business case</p>
<p>9.3 National Mortality Review System Business Case</p> <p>JS: Add consumer representatives</p> <p>6.2 replace structure with current description of operation</p> <p>Passed by Committee</p>	<p>Secretariat to produce final version of business case</p>
<p>9.4 Optimising Patients Journey</p> <p>CF: Is there room for a pilot?</p> <p>DG: Collaborative process</p> <p>MS: Some places have their own problems that might affect how a single pilot project would run, and this wouldn't necessarily reflect anything worthwhile about the business case.</p> <p>Passed by Committee</p>	<p>Secretariat to produce final version of business case</p>
<p>9.5 Safe Medication Management</p> <p>Previously agreed by Committee</p>	
<p>10. Reports from Chairs of PMMRC and CYMRC</p>	
<p>10.1 Report from Chair of PMMRC</p> <p>CF: Two years since establishment .Collection of 100% of data for perinatal and maternal deaths. 355 perinatal deaths recorded, more than were expected. 12 maternal deaths (media attention). Many communications with different groups required. Representation from PMMRC on these groups is required. Chair of PMMRC is a difficult job. Otago data group allows analysis of the completely comprehensive information.</p> <p>JS: How does the information-collecting lead to learning?</p> <p>CF: Support for committee and learning at a DHB level.</p>	

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<p>10.2 Report from Chair of CYMRC</p> <p>BT: Congratulations to CF for collecting complete information. CYMRC not able to get such complete data. 4th Annual Report in final phase of preparation. Expressed concern on the frequent changes to the Secretariat personnel and lack of information on budget.</p>	
<p>11. Consumer participation.</p> <p>PS What is the role of the consumer in what we are doing? Role of consumer needs to be described in business cases and what are the opportunities and challenges for consumers.</p> <p>What is a consumer? What is consumer involvement? How important is a mandated community? What is wanted from a consumer representative?</p> <p>DG: need to identify consumer vs public</p> <p>JS: also consumer groups vs consumer representatives</p> <p>JV: Two reps are always better than one.</p> <p>JS: consumers need to have informed people with a mandate to a constituency. For public engagement representatives need specialist knowledge.</p> <p>JS: community representatives on HVDHB credentialing committee has been patients who have experience and knowledge of services</p> <p>MS: Consumer representatives are needed to do something about hospital visiting hours as these are set for the convenience of staff not consumers. Middlemore Hospital visiting hours are difficult for visitors.</p> <p>DG: There is evidence that open disclosure leads to clear benefits.</p> <p>JS: When looking for advice from consumers, be clear about what you want.</p> <p>DG: More open-ness is better for everybody.</p> <p>RY: most carers didn't recognise the power differential, need to change the medical profession and offer knowledge and skills in "service of consumer",</p> <p>JS: Improving networking among consumer groups will strengthen consumer voice.</p> <p>GB: New Zealand lags behind other countries in the organisation and utilisation of consumer representation in the health and disability sector.</p> <p>CF: One third of Guidelines organisations involve consumers.</p> <p>DG: Asks PS and KH whether an elected board member of DHBs helps.</p> <p>PS: Elected reps put in hard work. But there is never mass public presence at Board meetings except when wages are being discussed.</p> <p>JS: consumer organisations network amongst themselves need to "strengthen consumer voice" as well as "strengthen consumer organisations"</p>	
<p>12. Process to date</p> <p>PS</p> <ul style="list-style-type: none"> - Gather the experts - Frame the kaupapa (agenda) - Mine previous experience - Commit to <ul style="list-style-type: none"> o tasks o priority o implementation 	

Summary of discussion and decisions	Action points
<ul style="list-style-type: none"> o speed o resource - Report to Minister <p>Reflection on Committee processes</p> <p>JS: full agendas, longer time to hear other members viewpoints, lack time on business cases, too many guest speakers</p> <p>JV: problem with accessing skill sets to implement business cases, need to return to requirements in Terms of Reference, where are we at with quality?</p> <p>RY: distracted with business cases, how to bring strategic approach to quality, recommendations in EpiQual 2nd report and chartbook.</p> <p>KH: been focusing on projects, now on way to Minister, some space to return to what vision, what state we want, what need to do now in process, setting landscape, look at Terms of Reference</p> <p>CF: dislike unfinished projects, want to publish chartbook, put extensive time and energy into it.</p> <p>CR: time of learning, interfaces now clearer, what structure for future</p> <p>DG: reflect that EpiQual did not have good resources, should use existing groups like DHB Quality and Risk Managers more</p> <p>BG guest speakers have taken large meeting time, they need to link more closely to Committee work</p> <p>JV: need to include PHOs, work with Cancer Control Council next year, reflect populations in our work</p> <p>RY: meetings could be longer</p> <p>PS: thanks for the reflections</p>	
<p>13. Epiqual Chartbook</p> <p>CF wants these published by QIC</p> <p>PS: QIC could publish Chartbook as it is as background – as an Epiqual publication</p> <p>KH: Nervous about publishing as the data is now so old.</p> <p>DG: strongly supports this (data out of date)</p> <p>CF: Its all been published before.</p> <p>RY: Its better to publish imperfect than not to publish at all</p> <p>PS: All to read Chart-book before next meeting. Review it in context of QIC's terms of reference.</p>	
<p>14. Quality event in February 2008</p> <p>Hosted by QIC and Minister</p> <p>Possible Topics:</p> <ul style="list-style-type: none"> - Leadership in complex systems - Greater exposure for Quality and QIC - Consumer Involvement and what it means - Information on national projects <p>There must be clarity about outcomes</p> <p>People interested in being involved are: PS, JV, HS, KH, RY, DG, CF.</p>	<p>Secretariat to organise teleconference</p>
<p>15. Other business</p> <p>Annual report in June 2008.</p>	

Summary of discussion and decisions	Action points
Closure of Meeting BG delivered a Karakia PS concluded meeting at 4.20pm.	

Next meeting
Friday, 30 November 2007, 9.30AM – 4.30PM in Wellington



Signed _____ Date 04 March 2008
 Pat Snedden (Chair)