	# Quality Improvement Committee

Meeting Minutes

Meeting details	
Date and time	30 November 2007, 9.30AM – 4.30PM
Venue	Viscount Room, Wellington Airport Conference Centre, Wellington

In attendance	
Committee members	Jean Hera (JH), Kevin Hague (KH), Barry Taylor (BT), Alan Merry (AM), Jim Vause (JV), Cindy Farquhar (CF), Mary Seddon (MS)
Secretariat	Gillian Bohm (GB), David St George (DstG), Katherine Klohn (KK)
Guests	Helen Smith (HS), David Gallar (DG), Cathy Cooney (CC) and Lesley Yule (LY) Lakes DHB arrive 10:40
Apologies	Barbara Crawford (BC), Barbara Greer (BG), Judi Strid (JS), Robin Youngson (RY), Catherine Rae (CR), Pat Snedden (PS)

Summary of discussion and decisions	Action points
1. Meeting Opening Meeting opened at 9:45am.	
2. Apologies and health-life reflection Secretariat brought to the Committee's attention that apologies were received from PS, BC, BG, JS, RY, CR. DG for lateness (9:47).	
3. Items to add to the agenda KH asked if any items should be added to the agenda. It was agreed that the Committee would discuss issues concerning the Secretariat of QIC, CYMRC, and PMMRC. JV also suggested changing the order of the agenda around the planning and monitoring topics.	
4. Health-life reflection – BT BT began by stating how much he has enjoyed working on QIC (seeing as this is his last meeting with them). In regards to the health-life reflection, BT wanted to address five points: 1. Wanted to re-emphasize the importance of vulnerability of early life and that adverse episodes in early life continue to impact through out life. 2. It is important to note impact of various effects on youth vulnerability, and to recognise differing standards for provision of services to youth. Also crucial to note these differing standards for youth determine the trajectory for wellness later in life. 3. The standard of living for adults in New Zealand is generally quite good: - In NZ 2% of adults have poor living conditions, but 16% of children have poor living conditions, so more emphasis needs to be placed on getting things right for children.	

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4. Quality initiatives recommended by this group are more important for children because they may have more impact 5. Why is it so difficult to implement changes? - If you have a child with disability/development problems, they often go through at least seven different care givers. (Patient Flow project has particular relevance here.) - Otago wants to pool money together from health and social services to help create a proper flow of care for children with disability- but this is very difficult as sometimes other DHBs don't want to incorporate. Is it a problem with power influencing those who are high enough to help? A mismatch in our system? - How does this Committee make recommendations to obtain leadership that will actually lead? We need to move from power being central to a more peripheral structure- need to set up feedback loops. BT sees the three Committees (CYMRC, PMMRC, QIC) as a living organism in a series of feedback loops- thinks this is the way to go to make things work properly. JV agrees with issue of feedback loops and thinks it is a very good idea. DG: thinks they are good ideas too, but he has a comment on pooling money: when you make a peripheral organisation it is important to customise care as well, so one should pool resources with common interests to make sure you address the various interests. BT: when doing RFPs you should make sure to stipulate an integration of the information services (they will have to use a common information system across the sector). DG: on decision making: important to put into words what a new relationship might be, those principles, and what might be a way to show this - a recognition statement can help to "reset" relationships, acknowledge problems, and offer to start anew. CF: reflects on 16% of children: maybe it is like this because children just naturally have fewer resources and one becomes better off as they get older. On another note, she felt sorry for CCDHB this week because their implementation of the grocery voucher programme really reflects the shortage in midwives, and she thinks this was poorly covered in the media. MS agrees the PR concerning this could have been played better. AM thinks this is a wonderful reflection from BT. He also wants to discuss disempowerment of clinical staff - he sees there are soluble problems but people in clinical positions have given up. This is not as simple as clinical staff needing to run the system, but instead we need to get everyone to play the part, possibly through a common set of administration and help around the health care system- should there be some sort of training for this? MS: DHBs that do better have a good relationship between clinicians and directors.	

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KH: wants to acknowledge the contribution BT has made to both QIC and EpiQual (CF and JV are the only other two that go back to the very beginning), many thanks for the thought provoking contribution.	
5. Minutes (14 September 2007 Meeting) Any amendments? Yes: 10.1: remove number of perinatal and maternal deaths (since they are not public).	Secretariat to revise minutes and sign at next meeting Secretariat to post minutes on website.
6. Matters arising from Minutes not covered in agenda None **7. Chair's report** (PS apologised - KH to Chair in his absence) KH: Minister has signed off on business cases with dollars allocated; now MoH and DHB CE's are working together to structure how the programmes are implemented. MS: the Safety and Quality Use of Medicines group are asking how soon can they access this money. DG has approached new Minister with the recommendations from the Health and Disability Commissioner on Wellington Hospital and the subsequent report from MS, and he took all the info on board quite quickly. The new Minister will spread delegation quite widely across the associate health ministers and will assign DHB responsibilities as well. DG feels the Minister will give full support to national quality improvement programmes. AM: can the Committee include the Minister and associate Ministers (one at a time) in these meetings? Invite the new Minister or one of the associate Ministers to the a meeting next year? GB has put QIC on the priority list to meet the new Minister. GB will continue to work on setting up a meeting. KH: the Ministry restructure will strengthen health's positioning on key political objectives (Electives and Value for Money), and it is positive for QIC as Quality has been positioned front and centre as now there is a real need for the government to tell a story on quality. MS asks if there is a report back on Health and DHBNZ? KH: will talk about that later in the day [BREAK FOR MORNING TEA 10:33] (Introduction of Committee, Secretariat, and Guests)	
8. Cathy Cooney's Presentation on Quality Improvement on Lakes DHB (Power point presentation and handout available) Lakes DHB- what they stand for, their priority areas: 1. Service Improvement - clinical governance structure, quality assurance,	Secretariat to obtain copy presentation from Cathy Cooney's

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patient flow 2. Safe and Quality Services - infection control, medicines management, adverse event reporting, mortality review committee 3. Building a healthy workplace - a culture of success and the RMO project 4. Achieving Results w/ elective services, intersectoral collaboration – COBOP, community support and integration, mental health, acute solutions Taupo, reducing inequalities KH opens the floor to discussion: MS thanks to CC for her presentation. Wants to make a point about the patient satisfaction survey (a requirement by the MoH), this is damning and should be stopped because it doesn't measure clinical quality. Either change the indicators or get rid of it because it does not reflect well enough on clinical care nor does it give enough information for DHBs to work on. CC says Lakes DHB does their own survey, but she is also happy that their MoH one has improved and says the feedback concerning mental health was encouraging. GB: A review of the survey processes noted that individual DHBs had a problem obtaining valid response rates. Out of the 12 standard questions 10 have been standardised by the Picker Institute and are used internationally. BT wants to know how many of these programmes will actually improve quality for children, are Lakes aware of specific and different needs for children? LY: there is an outreach team to help with this and the paediatric team to help with this as well. DG: if you don't have a measure of where you are, and where you might be, then you are basically in the dark - much more than just reporting. CC: through the surveys one is able to identify issues down through the unit level, so now Lakes is able to offer support to the units that have poorer results. Their surveys are done through *Best Practice Australia* and cost about $18k in total (this price includes having the surveys all mapped out, etc). JV: how viable is this for other DHBs? CC: the tools can be picked up by any DHB because these tools are directly transferable, and there are clear recommendations out of the survey report. KH: this massive improvement has been very inspirational, relates it to BT's reflection on quality improvement cycles. [CC and LY depart 11:30] DG: On the 08 December 2007 there will be a report around sentinel events that a Dominion Post reporter requested by OIA from Capital Coast DHB. Originally the DHB contested it, and it then went to the Ombudsman who subsequently instructed that they were anonymized and released as an OIA. This incident brings up the issue of transparency - nothing should be hidden from reporting, and in a perfect	PA

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world everything should be transparent. One wants it to be transparent but needs to move people with it at the same time- is there a role that someone on this Committee can take up to make a comment on this? **9. Safety in New Zealand Hospitals: A Progress Report – MS** Out of the ten issues, two (and a half) fall under what we are already doing. We should focus on: 1. identification and management of the deteriorating patient (produce a prototype toolkit) 2. handover of care - in all areas (medical staff and nursing) 3. investigations of sentinel events and communication with Coroner The surveys tended to get a better response if the CMO did it; however, what staff reported had the possibility of being "diluted" by senior management. DG: one shouldn't read too much into the individual reports. The point was more for identifying a strategic programme, and he saw quite a significant role for the MoH and Committee helping in this regard (possibly coordinating and seconding people to help logistically). BT: some contacts at the DHB level reported that they responded broadly because the questions were broad, so note the issue of communication with people who were writing the responses, also issues relating to culture (was this a blaming culture?). CF: you could say there is quite a lot of criticism coming through to DHBs. MS: but there is a responsibility if a DHB isn't reporting, to report that. DG: remember this report is for the Health and Disability Commissioner (HDC), and he has a different role than us. KH: there is clearly a piece of work that needs to come next - is there a system response that should follow up? A policy, a reply by the MoH, a toolkit? It would be helpful to have a piece of work that looks at what the options are for a system response which is related to each of these points (for QIC, MoH, DHBs) should this go to the Secretariat? GB: before the Secretariat undertakes work on this the Committee needs to have a discussion and create some clear parameters for the wok. MS: whoever handles this should go directly to the DHBs (who have already gone through this process) and work with them. DG: The new Sector Capability and Innovation Directorate is there for that very purpose. CF thinks this is a nice approach to a sentinel event that Disability Commissioner has done, but is there a way to see who has completed the response and see if it was done properly? Was this done rigorously enough? MS: remember that this isn't a scientific study, and the rigour is in line with what was asked.	

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AM thinks the recommendations are good recommendations but done for a particular purpose – this is hypothesis generated data, not scientifically certain data. We shouldn't treat this for what it isn't. Also agrees with CF – we should do purpose designed evaluation. KH proposes that we should respond by setting up a process for developing parameters; moreover, we should use the information we have as starting points and not just as the defining characteristics. DG agrees with this. MS also points out that there are some things we shouldn't be doing (like scope of the enrolled nurse). DG: maybe we should go through these and see which ones we should do? Are there any volunteers who would do this? This needs to be quite detailed- what they have identified, what is their response, etc. HS: this list of 10 shouldn't be the only priority, and we should take other issues into account as well. JV: this is a problem we have had from the beginning with QIC. He is concerned QIC will do the action and then not know what is happening; therefore QIC needs a monitoring role as well. What we should do is build in a methodology of what should be going on, on the ground. Should also use this methodology to slot into our overall programme.	Secretariat should provide a report of QIC's response to HDC's request, which should be supplemented by expert input from QIC members.
10. Report back from DHB combined CMO, CNO, Q&RM meeting – DG This was a unique opportunity to meet with quality and risk managers, chief medical advisors, and directors of nursing from across the country and was used by PS to introduce the national quality improvement programmes (business cases). It was an "ice breaking" type of meeting, but there was some resistance on authority, prioritisation, etc. Some professional silo issues emerged in discussion as well. This meeting was important because there was a clear commitment to the programmes, even if the priorities were not the ones people necessarily wanted. (They realised that working on these will show positive work going on overall, thus allowing money to be invested. This idea helped to break through some of the resistance.) GB: there was quite a buzz throughout the meeting about the issues and collaboration. PS did a sensational speech and gained significant engagement and commitment from attendees. AM did see some reserve from responses, not as unequivocal, but PS did quite an inspirational job. HS: there was a disparity between people who knew about QIC and those who didn't. Also, for a few of the DHBs that were the first time those three people had come together to work as a group.	Secretariat to get papers from JP for next QIC meeting

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11. Report back from Consumer Summit – JH Came away feeling positive, and acknowledges this is a challenging process. Four of the Ministers did video presentations in the beginning. (CF BG GB DG JS attended as well.) Tasks on the day - principles, mission statement, name, (Aotearoa Consumers' Collaboration). Should be taking a whole approach and not just pushing sectors. Debate around the agenda of the planning group. Need to take a different approach with consumers around communication, many had not kept track of information on the website and hadn't come very prepared. Some consumers were coming from a position of anger about consumer concerns which was not constructive. Work plan discussion – good agreement on top three work plan priorities and relationship developing between consumers. Key groups made vigorous presentations on their "points of difference". It was decided that the organising group now has to go away with input and come back with a redrafted constitution and improve communication with participants. GB: there was agreement on the priorities for action and these will be able to be used as a basis for developing the Consumer Participation business case. Agreed that there needed to be a full discussion next meeting with Judi Strid present to update developments since the consumer summit. [LUNCH AT 12:18-1:03]	Secretariat to organise more vegetarian options for lunches at future meetings.
12. Reports from chairs of PMMRC and CYMRC • CYMRC – BT Last Committee meeting was a "data meeting" where they looked at the previous year's data and comments, recommendations, and issues from local review groups. Annual report is at the editor's now and should hopefully go to the Minister next week. The Committee have decided that next year's report will include two years of data and have a bit of a catch up, which will accelerate the process back to reporting data the year following collection. Therefore, the systems of coding will need to go much faster (also don't want to waste time coding things twice) - they want to start coding to a three digit level or have it that NZHIS begins to code much faster. Interested in learning new processes of gathering and compiling data for reports, and there are also issues with both the Chair and Secretariat (they need more technical experience for Secretariat members). The Committee was happy to hear about the extra funding going for local mortality review coordination. Important to also note that the quality of data will improve dramatically, Faith Roberts will be helping in collecting standardized data at the Coronial level. They	CYMRC Annual Report - Report back, should be tabled at the next meeting as a report to QIC.

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would also like to get the Coroner's office and police to collaborate on standardization of data. BT is happy with the structure that CYMRC has set up, and he is looking to where it sits and how the Secretariat fits into that, which is important for the feedback loop system. The Committee has had lots of challenges but a lot of important solutions as well, and BT is looking forward to the future of the group. • PMMRC – CF The Committee has been established now for just over two years. They prepared their Annual report in June, and it took a long time to be processed, it was released just a few weeks ago as a public document. Recommendations to highlight: 1. require DHBs to provide support to families who had a perinatal loss, 2. perinatal pathology services – are in dire need of more support because currently there are only two across the country, 3. improving information on all births – need more information to make sound conclusions on preventing death. CF reflected on lessons from her media training: 1. have three key points to talk about, 2. have one key message to continually come back to and emphasize. Second report is under preparation for the first six months of data; the whole Committee is contributing to the writing with the idea to have a timely report published. They should have it ready to go mid way next year; however, coming election will raise issues around when it will actually be published. Issues around mortality review: one way to deal with the large quantity of work involved was to create working groups/working parties. However, this creates an addition demand on committee members and the Chair, so more support would be quite helpful. Next year there will be high media around Maternal and Perinatal Reports. Also will have a workshop for local groups next year (but worried about issues of fatigue surrounding these people). MS: question around current interest of midwifery shortage, does this go into PMMRC's investigation of deaths? CF: hard to extract this information specifically out of the system, so it would be more likely to come out of a HDC report than one from PMMRC. MS: an issue is going to arise out of the lack of midwives and the amount of work they have to do to keep their licenses. GB: reflected on the recent meetings of the Maternal Mortality Review working group, people involved in these issues need to think about the fact that a full day of	

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review of maternal deaths is quite harrowing, even for very senior clinical and experienced people. We need to acknowledge this emotional stress and make sure it doesn't become a barrier against doing this type of work. BT: CYMRC is also concerned about this when setting up local groups, is there a model out there to deal with it? CYF has an international report done on how to support people who do these reviews.	CYMRC and PMMRC should together look to the CYF document to figure out ways to deal with issues around setting up local groups.
13. Chartbook KH: at the last meeting we took away draft copies to review the data and decide what to do next. JH found a few typos, and she would also like to strengthen the consumer portion. She found it hard to address the value of the total document. DG: there is a utility for it as a historical record. MS: what piece of work is this Committee planning to bring out? Do it in this light or in a different way? CF: publish this on the website so it will be a record. BT: make it a PDF. : save the chapters separately so it won't be too large of a PDF file. CF: can we have a press release as well? If it has a good reception, then maybe it cane be something we do again. BT: it will be easier to update it then have to create it from scratch. BT could provide indicators for child health. KH: full Committee is likely to endorse our actions at this time.	Secretariat to continue tidying up and editing, if members have particular comments they should raise them with secretariat
14. Implementation national quality improvements programmes – QIC's role in monitoring GB: some background – when we met with the previous Minister, he was anxious that there was rigorous monitoring on the use of public money and the progress. He requested that QIC and MoH put some thought into this and make the monitoring process explicit. The Minister indicated that he was signing the documents with the proviso that this would be put in place. MS: would this be project specific? GB need initially for an overall framework for the governance and management of all programmes, specific measures will come from the project plans.	

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DG: people will be interested in setting these up quite quickly. GB has started on a document that begins to outline implementation, but she wonders if this is the right way to go? DG is not sure either, but he hopes these issues will become clearer as the programmes work out. Should there be more liaison with DHBs? KH: two links to what the Minister seeks - QIC to Minister, DHBs to QIC – and the next stage is for implementers of these projects to say how we will achieve these things. We need time lines as well - QIC will stipulate things that need to be done within a timeline, and then QIC's report to the Minister will say whether this was achieved in the allotted time. MS doesn't want traffic lights in our indicators that check whether to see of something has effected change. AM: for each of the projects the monitorable items will be different. It will take a lot of work to look at each project and determine this – so it will probably require sub group work on each project, and we should also be aware of what level of monitoring we want to take this down to. DG: some parts of the monitoring need to occur at the local level. MS: need to be clear of which type of process we are talking about when we discuss this. BT: ask recommendation committee to look into process and outcome measures. They should ask what the implementation programme is and what the process and outcome measures are. MS: objection against traffic light systems against certain measures. We should be intelligent enough to analyse it without the help of aids. AM: we could monitor what the Committee has set up. KH: DHBs have accountability to QIC and the Minister. BT: in the initial contract we can't tell them what the measures are, but over time we should be able to set these measures up. KH: should we have quarterly reporting to the Minister since each of these projects is intended to achieve outcomes? AM: what we are asking for is quite hard, which is identifying a measurable thing that is reliable; achieving this would be a major achievement. GB: we can put higher level process measures about each programme in place, and then ask each individual project team to create more specific measures. JV: we also need to have guidelines as to the quality of measures asked for. HS: we could end up with people doing things quite differently and having too many	

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variations on the measures. AM: do we need to create a paper that generically informs the Minister on what we want to say, what we want the groups to do, etc.? MS: we need indications around : 1. implementation around the programmes 2. clinical indicators KH: we should write to the Minister but also write to the implimentators asking how this process will work and what their indicators will be. KH: we should negotiate implementation around and between DHBs and the Ministry now. Hopefully there will be more clarity in the next week.	
15. Planning for sector quality event in Wellington, Friday 22 February 2008 GB: PS requested that a decision is made at this meeting whether this is on or off. Remember, we still don't have format, shape, keynote speaker, etc. MS: it is clear that we need this day to get knowledge about QIC out to the public. AM: is the date fixed? Can we reset the dates? GB: PS is quite keen to have this in February. KH: before we try to set a date we try to see what we need to do first. DG: who is the audience? Do we ask more chairs, senior governance, senior clinical people, and make some room for the people who were at the 22 November meeting as well? AM: the purpose is getting people on board, getting some publicity, getting kudos from the Minister, all while including consumers, health care workers, and MoH. BT asks what is topical. DG: also note the election is next year, so we want to indicate that we are staying here – the value needs to be clearly articulated. JH: how do consumers get funding to get there? AM: easy to break even on a conference by charging a fee, therefore providing concessionary provisions to those who need it. CF would favour an event for all comers. MS: this conference is about the image. HS: yes it is about the image. Also, how do you combine these huge groups of people and goals? MS: we should present work streams.	

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KH: basically, culture change and orientation - broad level stuff that can add impetus to some type of environment and achieve culture change via marketing (image). If you say it often enough it will happen. KH: so are we clear that this isn't likely to happen on 22 February? AM has some speaker ideas: Atul Gawande, who is a great storyteller with wealth of stories to make key points. GB: should we aim for around April or May? Steering group: PS, KH, CF, DG, JV, RY add AM and JH to this.	AM: Find out dates that Atul Gawande could be available. Secretariat should add AM and JH to the steering group.
16. Correspondence • CARM letter from Dr Michael Tatley to PS regarding a unified approach to medicines safety in New Zealand GB: CARM is suggesting that they taking on a new activity, the receiving of reports of medication errors, which is a completely different focus from their current work. BT: we need a centre such as this to collect and do the interface with DHBs. MS: there are many areas where this could be useful. AM: college of anaesthesiologists has been trying to get traction like this for years. It is a "no brainer" to have a repository of information like this in place, but we will need additional expertise. DstG: how would this reporting happen on the ground? AM: must come from practitioners who do it primarily, but it also needs to be centrally done.	Secretariat to invite Dr Michael Tatley to the next QIC meeting.
17. What is the current status of DHBNZ – KH Two DHBs have withdrawn from this group, so DHBNZ will soft pedal the issue till the chairs change on the two groups. Hopefully the change in leadership will provide the opportunity to reengage these two. DHBNZ is meant to be a Secretariat towards DHBs on issues they need to collaborate on. There are issues around national DHB work and MoH work. They need more clarity around what is a DHB issue and what is a MoH issue. The final point is around the criteria where DHBs will collaborate: will it be when it is compulsory or when there is universal benefit? Also, it is tricky when there is overall benefit but not universal benefit - Canterbury thinks this is illegal, but most DHBs think the taxpayer money should be used towards a common good. There are many issues where this third option is the case.	

Summary of discussion and decisions	Action points
Is the organization threatened? No, it is still a good source for sustaining projects	
18. Planning for QIC programme to 30 June 2008 - including focus on primary care Areas we have touched on that relate to this: 1. The next two QIC business cases (consumer and education project) 2. The task which the HDC has asked us to do, leading a sector response around HDC decision on CCDHB 3. Some frustration around need to focus initially around secondary care, would like to extend onto primary care 4. NGO disability sector would be a good area for QIC to touch on over the life time of the Committee 5. Data and indicators (in relation to the five business cases and the chart book), development of appropriate indicators (parallel to development of health targets) 6. Broader issue of leadership and learning- process for sector learning 7. QIC summit 8. Broader issues around culture change (leadership in governance and the focus there) **Quality in Primary Care** JV: Issues we can explore here, areas that have gain for us to work on There are a number of realms in primary care that need work on, and it needs some cross over as well. Should QIC look into whether they need a separate primary care work group or turn it into a sub committee? We need to focus on disparities and QI activities. How do we do this as a group, or do we need to get another group to do it? We need to look beyond the College of GPs Quality Committee. KH: need to create a seminar to pull together primary care stake holders. AM: there is an under representation of primary care people on this Committee - a good point that we need to take seriously. BT: still disturbed by the current structure of primary care and is working to facilitate quality issues across a group of GPs. They need to link up IT systems between primary and secondary care; moreover, this linkage would seem to improve quality and decrease cost. DG: primary care seems impenetrable and a huge barrier to anything. MS: if you have a pure business model GPs don't want to do it because of the high cost. HS: some primary care problems are becoming secondary care problems. JV: lots of things done in secondary care will never work in primary care due to the business model. Also, those initiatives that have been done are being done differently throughout the country – they need an overarching systems/ national overview to help with this. BT: do we need a PHO quality group coming together? JV: we need to think of more than just PHOs. MS: we need a group where all of this input comes together. **Issue of culture change- put consumers at the centre** DG: effective use of partnership to improve outcomes. MS is keen to set up something about this early warning score initiative and would like to see this happen. Initiating this would be hands on, but it needs to be quite hands on to change the culture. DG: should we have this discussion with Margie Apa, Deputy Director-General, Sector Capability and Innovation Directorate? Should we discuss the handover programme as well?	QIC should work up this idea for the February meeting and analyse the resources and time frames we have available. Secretariat to prepare paper with recommendations for the QIC work programme for February meeting.

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MS: with each of these projects, we have some learning on cultural change that goes with them.	
19. General Business BT: Issues around Secretariat change - we need to have definition around roles in MoH. There needs to be active engagement and clinical knowledge for those providing support, especially in regards to the Mortality Review Committees. They need an expert within the MoH to advise on this and give their point of view. There also needs to be a memorandum of understanding between the each Committee and the MoH. CF: the number of changes in the Secretariat is frustrating and affects the ability of the Committee to perform. Furthermore, the information from the Mortality Committees is quite emotive (concerning deaths), so they need someone with background knowledge to help them perform. KH: if there is unsatisfactory resourcing then the chairs of these Committees should take it up with the Minister. Should QIC have an opinion on this as well? [JH left 4:03] DG would support getting clarity around the memorandum of understanding. KH: is talking to Margie Apa the best way to address the issues BT has raised? DG chairs should talk to Stephen about these issues. **Directors of Nursing representation** GB: at 22 November meeting the DHB DoNs requested that there be a representative on QIC. PS has suggested that we co-opt a DoN onto the QIC. So, we need to identify the skills and knowledge we require and then write to the requesting a representative. **Support of CCDHB** What can we do to help? DG: more general issues - encourage people to get off their backs and help them move forward. Also issues around transparency and the culture we are trying to create. KH: should PS have a conversation with the Chair of the Board? DG will have a conversation with PS about this and explore the territory informally. KH: if there is broad support for QIC to do something to help out then we should do it. If there is a spot for us to help PS should let QIC members know this by email. AM: should be cautious with how we approach this. **Last meeting for Helen Smith.** KH: thanks to HS for all of her work on the Committee in BC's absence. KH: thanks to Committee for great working day. [Meeting closed 4:15]	Invite Margie Apa to come and talk at the next meeting Secretariat to draft letter a letter of invitation to DHB Don group for PS.

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Closure of Meeting KH concluded meeting at 4:15	

Next meeting
21 February 2008 Auckland

Signed ________________________________ Date ______04 March 2007____
Pat Snedden (Chair)