	# Quality Improvement Committee

DRAFT Minutes

Meeting details	
Date and time	08 September 2008, 9:30AM – 5:00PM
Venue	Villa Maria Estate, 118 Montgomerie Road, Mangere, Auckland

In attendance	
Committee members	Pat Snedden (PS), Barbara Crawford (BC), Nick Baker (NB), Catherine Rae (CR), Jean Hera (JH), Jim Vause (JV), Judi Strid (JS), Mary Seddon (MS) Co-opts: Anne McLean (AM1), Janice Mueller (JM), Geraint Martin (GM), Cheyne Chalmers (CC)
Secretariat	Katherine Klohn (KK), Gillian Bohm (GB), Margie Apa (MA), David Galler (DG)
Guests	Chris Clarke (CC1) *Arriving at morning tea (present from 10:45am-2:30pm):* Martin Chadwick (MC), Kate Weston (KW), Fiona Thompson (FT), Jim Primrose (JP), Susan Dovey (SD), Peter Didsbury (PD), Victor Klap (VK), Alan Greenslade (AG), Denis Ward (DW), Paul Roseman (PR), Christina Tapu (CT), Murray Tilyard (MT), Rob Cooper (RC), Petra van den Munchoff (PvdM), Maureen Gillon (MG), John Welling (JW), Karen Thomas (KT), Harry Pert (HP) *Leaving at 2:30pm:* Greg Balla (GB1)
Apologies	Alan Merry (AM), Cindy Farquhar (CF), Kevin Hague (KH), Barbara Greer (BG)

Summary of discussion and decisions	Action points
1. Meeting Opening Meeting opens at 9:30am, greetings from PS, welcomes everyone today to this important meeting day for the primary health care sector.	
2. Apologies Apologies from Alan Merry (AM), Cindy Farquhar (CF), and Kevin Hague (KH), Barbara Greer (BG) Apologies for lateness: Judi Strid (JS) 9:49am, Barbara Crawford (BC) 9:50am, Anne McLean (AM1) 9:53am	
3. Confirm Minutes 01 August Meeting JV moves to accept minutes, MS seconds it Changes noted PS notes minutes are approved, all in favour, none opposed Motion to accept minutes passed.	**Secretariat to correct typos, get Chair's signature, and post minutes on the QIC website.**
4. Matters arising not covered in the Agenda – PS *Today's Primary Care Workshop* PS gives a brief overview of what today's workshop will consist of and asks for any comments or suggestions from the committee members. Everyone agrees with the direction- it is also suggested that there is a timeline agreed upon to implement this work. Another point to note is that today we may be	

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drawn down a GP line, but let's keep all of the contrasting priorities in mind. Volunteer facilitators for today: CR, JM, JS, JV, JH, BC <u>Questions that will be asked at today's workshop:</u> What are you here for / who are you representing? What will you bring to this conversation? What do you think QIC should do next? Who else should be in this conversation (who isn't here) for this to work? *Saving 1000 Lives Programme* This will be addressed later in the day. We need to have a common view forward on this, and the committee will have a discussion around this after we finish the primary care workshop.	
5. DHB CEO Presentation – Chris Clarke, Hawkes Bay DHB (Presentation- see Appendix 1) Opens by stating how it's important that this group has the quality agenda in the public arena and kept it in the forefront. Presentation theme: Leadership and its relation to quality in health care. <u>Chair asks for any comments:</u> It's useful to see how many problems are created by artificial constructs. Consider the time factor: a drive to 30 June stops DHBs from looking at major issues. Quality gets overlooked in favour of accountability measures because there will be a push to produce as much as you can at the lowest possible cost. Also, consider leadership: who owns DHBs? CEOs are there to help make sense, but a larger sense of leadership is needed. The *Saving 1000* Programme will give more incentive to drive quality. We shouldn't overlook the achievements that Primary Care has already achieved (for instance, look to the increase in the number of consults). We need funding mechanisms that encourage those who achieve while aiming to not under-fund those who need funding most.	
6. Primary Care Workshop (PS Presentation – See Appendix 2) PS thanks everyone for attending. Presents overview of session, and leaves the groups with four questions to answer. Participants break into six small groups to discuss the following questions posed by PS: 1. What are you here for / who are you representing? 2. What will you bring to this conversation? 3. What do you think QIC should do next? 4. Who else should be in this conversation (who isn't here) for this to work? Presentations on key messages from each group: *Group one – JS* • The things we have in common are far more than our differences, so we should keep this in mind.	

Summary of discussion and decisions	Action points

• Ideas on what QIC should do next:
  ▪ affirm the experience and expertise of Primary Health Care (PHC)
  ▪ support PHC as the core of the health service
  ▪ support a quality information strategy for PHC
  ▪ facilitate a stock-take of what is going on
  ▪ integrate PHC into existing QIC projects and the *Saving 1000 Lives* campaign.
Group two – JM
• We should use the existing framework and recognise our strengths and what is working well.
• We need to articulate the differences between quality assurance and quality improvement. This could be aided by developing a common language.
• Our work should be kept it simple while simultaneously understanding the complexity involved.
• Finally, we should focus on supporting consumer involvement and facilitating an information exchange, all while avoiding platitudes to make this more real.
Group three – MS
• QIC should continue to facilitate these types of conversations with a clear focus on action; we need to articulate a common vision.
• We should create structure but also allow for improvisation.
• Ideas on how to incentivise others to participate: use the reason they started in this field. (However- we need to keep in mind that we shouldn't be just paid to do the job we should already be doing.)
• QIC needs to stay above the fray and set universal principals- we can brand this and make it something that everyone can intuitively work out.
• We can activate a leading practice- a national strategy with pockets of excellence.
• Finally, we should have a common message with ability to interpret the "language" to different groups.
Group four – CR
• We need to have an understanding around what is part of the primary care quality process. For instance, what has already been agreed in the primary care strategy?
• We should develop principals for how primary care works with DHBs (to avoid the risk of misrepresentation and of micromanagement).
• We can review strengths of previous quality systems and re-evaluate them. If these previous systems have been discontinued, then examine why they aren't happening any longer.
• We can also help by facilitating information sharing.
• QIC should define an effective clinical governance structure- the sector needs a definition and guidance. This is very crucial, and we will need examples from those who are doing this well.
• In regards to the existing QIC programmes, we will need more promotion and to discuss programmes in length with PHC. If we facilitate this knowledge sharing, we can then work with PHC to see what the linkages are going to be.
Group five – JV
• Need a clear vision on what we're about and we need a framework. People have questions about the framework around quality. For instance, the primary health care strategy- does this include quality?
• We need coherence to define the problem of defining quality. When defining standards, we should look for cultural gaps. We can support more	

Summary of discussion and decisions	Action points

research/evaluation to define good innovation.
• Question: can QIC continue in its current form (seeing as this is a volunteer job using people who take their spare time to do this- not a full time job with a group of people dedicated to helping out)?
• When dealing with the scope of things in primary care, how wide do you go? What do you involve? Also, the question of personal vs public. Is public health in a higher realm, or is this a third tier of health?
Group six – BC
• We need resources to develop the quality improvement programmes.
• QIC should help shape/create an environment in New Zealand that supports quality improvement (ie, some sort of national ethos), and we should also support an environment where innovation can flourish. We will need strong representation from the College of GPs.
• Teamwork, as opposed to individuality, will be key. For instance, we can support primary and secondary interface conversations.
• We will also need shared responsibility in patient outcomes.
• In regards to creating national definitions- we need a conversation around this, then we can decide if we want to progress with this or not.
• At a senior level, also question- what are mechanisms that get clinical leadership involved?
• When analysing clinical governance from a whole of district point of view- what could you show if your clinical governance is effective?
• However, we have to move from vertical to horizontal thinking- process and structure isn't always the answer.
 	
PS – Summation
• The potential task for QIC in this matter- affirmation for PHC in the sector. Also, it's time for QIC to commit to making every future agenda include PHC.
• There is dynamism in the sector- a pursuit of quality that we would like to harness, so we should use a dynamic model (for example, qi4gp). We could use what is currently happening to make a good system into a great system.
• Today many people are missing- Pacific, Māori, NGOs, and the Ageing Health section. However, we should begin to accelerate this process by using the model we have in hospitals and moving forward. We need to make sure this process is inclusionary, and we need to animate the system to think this is a good thing to do. Should QIC set up a primary care leadership group and get the Crown behind us? We need as much overlap as we can get. Ultimately, we should get this big idea together, inform all parties, and push hard for these ideas.
• We need to:
    ▪ get a leadership group together
    ▪ be inclusive of all parties
    ▪ create core principals.
 	
Other comments:
NZNO- PHC is the starting and finishing point on the patient journey, so we need quality in this area.
 	
What is the alternative to this if we aren't up for it? If quality isn't our top priority for those of us in these professions, then we shouldn't be here in the first place.	

Summary of discussion and decisions	Action points
What is quality- what consists of failures in the quality agenda? It is best if we don't code this in bureaucracy- have to use plain language (for example- safe care meeting patient needs) in order to get a handle on this all. This should be an explicit policy driven by practitioners and patients working in teams- these are the people who need to drive the quality paradigm, and the policy needs to be supported by evidence. At the core of this work is how we reflect upon ourselves as unique providers of quality activity. Quality isn't just about the patient journey, for it should also aim towards a better society and better health care for New Zealanders overall. It needs to be voluntary and we need to get people to engage in this process. Moreover, various groups can come together under a general quality framework. The qi4gp quality strategy was used as an example, and their definition of clinical governance is "managing the gap between what we're currently doing and what we should be doing". The sharing of information/learning that is being suggested could be the most important action for many smaller parties concerned (i.e., optometrists, podiatrists, etc). [All guests depart] Chair asks for any comments: Committee members thought this was an excellent workshop and PHC seemed happy to run with this. But a serious question needs to be addressed- what will QIC look like in the future? Does it have the ability/capacity to perform the tasks mentioned? There will need to be much more resource for QIC if we carry forward with this. It was good to see the differing levels of development of quality and a discussion of the primary/secondary interface. Members hope they can modify and change to be more inclusive of the sector. We need to develop a framework to recognize these good quality improvement tools as well as updating our IT systems. Timing was good for this and people were very receptive- people want to work together and move forward. Also, there are many similarities between what is happening here and with the consumer sector. The main challenge with going forward- we need to get the agenda right and talk/consult with groups when moving forward. We've scratched the surface here today and still have a long way to go It was very positive to see the willingness of guests to come and the efforts they made to get here. There was a very strong sense of relief that this is finally taking place, and the announcement of this meeting stimulated many pre-conversations on the topic. The design of today's meeting was to provoke these groups into thought- are they ready to go forward with this? Now how do we design this to go through and how do we include those we didn't get in this meeting? QIC needs some help from the Ministry thinking about this- QIC would like an action plan and communications strategy.	**PS to send out thank-you to guests and**

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Should we develop a primary care faculty? What are the next steps post this discussion? What are the problems we are trying to solve? If we create this suggested faculty, why not be quite radical with the numbers of consumers we have in this (for example, make consumers constitute 50% of this group)? It would be great to have more consumers driving this change. Consumers aren't just an add on- they need to be included from the beginning. Our primary health care strategy is at a delicate stage- we need to focus on what has already been done. There is an opportunity here to link primary health care practitioners back to their core practice. **7. Report from Chair of CYMRC – NB** CYMRC's work plan has been submitted to the Minister- the Committee is improving business as usual. CYMRC is waiting for the Minister to sign off on their fourth annual report. They are looking for their report at the end of this year to publish data up to 2007 (which will catch them up date). Their report is a sobering report, and CYMRC need to find a way to convey the strong messages coming from it and increase the impact of their data. The local mortality review coordinators are picking up in other DHBs, and the Committee is looking for a national coordinator as well. There is ongoing work contracting the data group, and the family violence death review committee is being set up. (The Committee is looking not to overlap this work with the other mortality review committees.) CYMRC still has a good interface with PMMRC. Major concerns: suicide, road traffic accidents, and SIDs are the big three causes in youth deaths. In regards to shared sleeping arrangements, they need to look at New Zealand data from this. **8. *Saving 1000 Lives* Programme** Background: They have four DHBs signed up to get on with this but will need to be careful to not overburden DHBs. PS will talk to CEOs about this business case. PS has held this a bit to give it some breathing space and not overwhelm DHBs with this request on top of the NQIPs. The Committee needs to look very carefully at the burden of DHB reporting compliance- what are they reporting? What is core business and what can they drop? MS notes that the point of the *Saving 1000 Lives* programme was to makes the DHB CE's lives easier. The Minister has expressed a real sense of commitment to the process- we only get one shot at this, so we need to do this really well. This means we need to have enough milestones and note that the timing around this is critical. This programme will also provide a sense of branding and coherence around the NQIPs. Some people in the sector don't have the feeling that we will actually do this- it is a good idea, but will we really get on with it? To some of the members, it feels like they have missed the opportunity to do this in the first instance. However, there is an ethical dimension to this- we know if we do this people will be alive where they could have died- but there still seems to be something that is holding this back.	**email his presentation with this.** **PS to talk to working group about the PHC strategy / faculty issue : JV, JP, MA, JH, CC1, BC**

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The Ministry's Cabinet paper concerning this programme was signed off by the Minister- where this lies now is with QIC. However, we have to worry that if we push this too hard, then instead of galvanising DHBs we will upset people and turn them off. Members agree that we shouldn't limit this to just the Northern DHBs. Should we introduce the idea of the patient safety campaign to CEOs? Do they really understand what this comprises of? Also, this programme was intended to be linked to the next round of Serious and Sentinel Event reporting and to satiate the Minister's request for indicators. Two steps: 1. Introduce this idea to DHB CEOs and Chairs. 2. Ask the Minister to tell us weather he wants to do this. Basically we are just asking him to announce that he will be doing this in February with release of second Serious and Sentinel Events reporting (he can use this programme as an ice breaker- there will be a patient safety campaign and details to follow…). **9. National Quality Improvement Programmes: Reports Back** *Report from the National Steering Group – MA* (MA Presentation – see Appendix 3) Where will the next round of Serious and Sentinel Events be reported? This is tied up with the Ministry's Cabinet paper recommendation, which is to modify QIC's role as to avoid any conflict of interest (therefore QIC should be placed outside of the Ministry). In regards to the Safe Medication Management programme: is the funding for this only to set up the operational side of things? The $10.2m is the first part released with knowledge that further funding will be required. QIC needs some standardisation around the governance of these projects- MA can offer up a more systematic report of what the National Steering Group receives (she can create systemised reporting programme by programme about what is going on). However, members think this should be delegated to the Project Managers (who report to lead CEOs and MA anyway). They can use the standard template that is already in use. [MA and JP depart at 4:01pm] *Report from the QIC members on NQIP steering groups* BC provides a general report back from her group. One question: should the incident management DVD go out to tender? Useful for us to have a rational about the reporting process timeline. There is a mixed view around the table about this. We need to recognise accountability vs learning. QIC will also commit to making sure consumer information is in the Communio process.	**PS to talk to CEOs about this business case.** **SEC to bring draft business case of Saving 1000 Lives to the next QIC meeting.** **NQIP Project Managers to use standard template to report back to QIC.**
10. Presentation from NQIP, Infection Prevention and Control – Greg Balla *GB1 – Infection Prevention and Control* The three components of their workstream (surgical site infections, catheter related bloodstream infections, and national hand hygiene campaign) are underway. Second milestone was scheduled for February, but they are looking to review this date seeing as the other NQIPs are aiming for that month as well.	

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GB1 believes the National Steering Group is feeding back to his programme well and thinks talking to them is a helpful process. CC / GM to feedback on this process at each meeting as well.	
11. Review and commentary HDC report 07HDC09719, dated 26 June 2008 This incident could happen anywhere we haven't put in effective systems for learning. How does CARM fit in with medication safety- it is a voluntary system. CARM is on side, we need to work with CARM and other agencies to tie this up. There are a number of issues such as problems with coordination of care and the way practitioners communicate with consumers. The Committee wants a mechanism to respond to each HDC report- they will pass this on to the Medicine's group to take into consideration when they report.	
12. Correspondence – PS [NB leaves 4:51pm] 1. Letter from SQUM re changes to drug names. SQUM is asking us to take action here, what do we do? We should elevate this to Ministerial level and ask for some intervention- we need to organise this in a national way. This is not in the realms of MedSafe or Pharmac- a system change needs to happen here. Need a message from QIC to DG of health (MS to draft this letter), PS to send out to committee, and then send off to the DG. 2. Letter from RCGPS about consumer involvement. Feedback will be provided from JV, and he will let PS know if he needs to respond or not. 3. Medical mistake DVD proposal. QIC has noted it and will refer it to the Incident Management programme group.	**MS to draft a letter to DG of Health concerning SQUM's request. PS to review and send to QIC members for comment.** **JV to feedback from RCGPS letter re: consumer involvement.**
13. General Business – PS At the next meeting QIC will review legislation around Serious and Sentinel Event protection. PS to talk to AM and Ron Patterson, and any ideas from the Committee are welcome. GB informed QIC on new project starting to review the national credentialing guidance. JS- Do we need to have extra meetings for QIC? Some meeting, suggest three per annum, to concentrate on QIC "business" others to engage sector and strategic planning. This question ties in with how Committee develops, since it will be easier if we have an arm's length resource. We can bring this question up when we discuss the Cabinet paper at the next QIC meeting. JS inquired on the progess of the Strengthening Consumer Voice business case that QIC has sent to the Minister- PS will take this up.	**PS to investigate SCV with the Minister.**

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Agreed that venous thromboembolism (VTE) in hospitalised patients to be on the next agenda.	
14. Confirm dates for 2009 meetings <u>Dates for 2009:</u> • Friday 20 February in Wellington • Friday 01 May in Auckland • Monday 22 June in Wellington • Friday 28 August in Auckland • Monday 19 October in Wellington • Monday 07 December in Auckland Dates confirmed.	
Closure of Meeting PS: Closes meeting at 5:15pm and thanks everyone for attending.	

Next meeting
Friday 17 October 2008 in Wellington

20 February 2009

Signed ____ Date ___________

Pat Snedden (Chair)