	# Quality Improvement Committee

DRAFT Minutes and Action Points

Meeting details	
Date and time	1 May 2009, 9.30AM – 5.00PM
Venue	Ventura Inn, 14 Airpark Drive, Airport Oaks, Auckland

In attendance	
Committee members	Pat Snedden (PS), Jean Hera (JH), Mary Seddon (MS), Judi Strid (JS) 12:50pm, Nick Baker (NB), Barbara Crawford (BC), Jim Vause (JV), Alan Merry (AM)
Secretariat	Gillian Bohm (GB), Kathryn Baker (KB), Alan Spinks (AS)
Guests	David Galler (DG), Peter Jansen (PJ) , Janice Mueller (JM), Chai Chuah (CC) 10:30am, Cheyne Chalmers (CC1), Geraint Martin (GM), Des Gorman (DG1), Allan Cumming (AC) 10:00am, Suzanne Proudfoot (SP) 10:00am, Greg Bala (GB1) 10:30am, Garry Smith (GS) 10:30am, Shelley Hanifan (SH) 10:30am, Clare Kirk (CK) 10:30am, Neville Hablous (NH) 9:30am, Maureen Robinson (MR) 12:30pm
Apologies	Barbara Greer (BG), Catherine Rae (CR), Cynthia Farquhar (CF), Anne McLean (AM1)

Summary of discussion and decisions	Action points
1. Meeting Opening and Karakia Meeting opens at 9:28am. Chair thanks those working long hours on the Swine Flu threat. Welcomes Des Gorman to QIC with round table introductions. Guests arriving throughout the day are: Chai Chuah, Allan Cumming, Suzanne Proudfoot, Greg Bala, Garry Smith, Shelley Hanifan, Clare Kirk, Neville Hablous, Maureen Robinson.	
2. Apologies Barbara Greer, Catherine Rae, Cynthia Farquhar, Anne McLean (flight cancelled). Due to absences we do not have a quorum for this meeting.	
3. Health-life Reflection - DG Recently went to Berlin for quality and safety meeting and DG wanted to make a few remarks about the trip. Reflected frustration in the slow course of change in the NZ health sector. DG has read the HDC report on Waitemata DHB over the last few days and believes that part of the systemic failure is that they lack a vision and mission for quality. On the trip DG reflected on his path in improvement. The real thing is the 'how'. NZ needs to establish a series of initiatives that join up in order to improve quality. If QIC does not have a consensus about action then it will never bring about wide spread change. There are a host of different views in health organisations across the sector so without consensus we're not going to arrive where we want to be.	

Summary of discussion and decisions	Action points
4. Minutes 20 Feb Meeting Pg 2: "finance cost of deficits" Pg 4: "staged" proposal Pg 4: business case…for the first Pg 7: typo MS moves to accept minutes, DG seconds. Motion passed.	**Secretariat to revise minutes for signing at next meeting and post minutes on website.**
5. Chair's Report – PS *Chair tables a series of emails and a letter from Murray Horn, Chair Ministerial Advisory Group* The Chair seeks Committee member's views on the letter and the Committee's view on funding issues. Emails – prelude to further discussion. Achievements were about member competency, launching the national quality improvement programmes and the implementation through DHB process. The country needs a single quality forum – focused on the whole of quality delivery, not just through DHBs. A national plan is lacking. Getting a common view on what needs to happen would vastly improve outcomes. Future programmes need to be specific and definable. DHBs need to do this out of their current baselines, and assist with workforce capacity. Should a national plan be mandatory? We need to incentivise quality improvements rather than withholding revenue from those not participating. We need to know what makes a difference to patients and be able to measure those across hospitals. Three things to discuss: 1. What constitutes a minimum level of safety? 2. How would you effectively incentivise people to do the right thing across the country that does not compel them, but inspires them? 3. How should we position where QIC would be in the new administration? Chair asks for any comments: Define what incentives are – don't assume they're financial. Helping clinicians to improve their performance can be a form of incentive. It needs to be a transformational change from the bottom up. What has changed my clinical behaviour was the transparency of measures. Knowing that others could see my performance motivated me to change. Keeping it confidential does not motivate change. Incentivise vs mandatory – DHBs respond to mandatory. If we continue to say that quality is not mandatory then we will not get top level commitment. DG1 identified a conflict of interest as he has collaborated on the national workforce initiative with Murray Horn. Key messages are reformation and imbedding – you need a hub to avoid duplication and you need the spokes to turn those ideas into action. The key element is capturing the hearts and minds. I think mandating does not work as clinicians will just do what they want anyway. Trust motivates people; the opportunity to do their job better is more appealing to clinicians. It is important to have a national consistency – why are DHBs all doing things differently? There is a severe deficit in focusing on the hearts and minds as it does not include minimum standards which are needed to ensure patient safety. There are many different ways to incentivise. There is a difference between measurement for improvement and measurement	**DG1 to send Secretariat paper for circulation on altruistic behaviour .**

Summary of discussion and decisions	Action points
for accountability. If we're measuring for accountability then we will destroy any trust. We will derail what we're trying to do. Regarding the metaphor of hub and spoke, what do we need to do with QIC to make this a legitimate hub? There are ethical issues with quality being financially incentivised. It is the ethical responsibility of DHBs to deliver on quality. Quality needs to be put first. There needs to be a sense of responsibility and openness. Making public much of the information we have (good or bad) causes improvement to happen dramatically. DHBs currently have quality units established. I'm not sure if we've done that well nationally, particularly in the smaller DHBs. There is a role for us to play in capability development. People are looking to QIC for leadership. Workforce needs a lot of formal and informal systems to help them do what they do best. PS summarises initial QIC member discussion saying it forms a base stanza to our conversation later on. Will tease this out a lot further. *Conversation continues at 11:30-12:30pm* We need to clarify incentives that aren't financial for DHBs. You can't change doctors with financial incentives. Be clear about what we're incentivising. We need an over-arching framework that quality initiatives fit into. Saving Lives Campaign ticks all the required boxes for this. We could point Murray Horn in the direction of this. In addition to Saving Lives Campaign, we need an ongoing overall strategic view of where quality is going in the future. There seems to be this same conversation occurring in a number of groups – Value For Money, Sector Capability and Innovation (MoH), NQIP Steering Group. At the moment things feel disjointed, and QIC needs to provide a central point – there is just no framework for it at the moment. The benefit of the Saving Lives Campaign is that it pulls all these projects together into one framework. At the moment there is not a clear interface with quality. It is a discussion that needs to be had with a number of people. What is the quality outcome we are looking for New Zealand? The MoH is signing an MOU or contract with the NHS. Where does QIC fit? This conversation started over a year ago, and the conversation is still happening regarding a partnership. QIC should position itself as the expertise of investment in quality. In summary, there will be a change in how QIC presents itself and there will be some writing needed around this. QIC's success has been in getting things done. Now it needs to work on a national agenda for quality.	**JM, AM, MS, JH, NB, BC, GB, JS will assist PS in drafting a quality strategy (to be revised by DG1).**
6. The National Quality Improvement Programmes first year review *Optimising the Patient's Journey – Suzanne Proudfoot, Allan Cumming* Booklets circulated. Outlined goals of programme. This programme is very much focused on methodology, a culture of continuous quality improvement embedded into health organizations. Optimising the Patient's Journey (OPJ) is much more about the 'how', which makes our outcomes a bit harder to measure. OPJ rolls out a methodology and other quality programmes come into that methodology – which can create issues in implementing it as you have resistance from people that don't want to change the way they do things. Have run three learning events. Reports and recommendations produced from each event. About to launch Phase 2 of the programme. We have a number of pilot sites around the country for the second phase. The new methodology seems to be working well, but it is early days yet.	

Summary of discussion and decisions	Action points
We do have commitment from 20 DHBs, varying levels of commitment. Each OPJ learning event has had over 100 delegates. Regional meetings are run for more practical teaching. The knowledge base and skills across DHBs varied greatly. We have seen great improvement in the last eight months. Outcomes: DHBs can produce control charts and the Davis Balestracci workshop was very beneficial. Knowledge base of DHBs has widened and skill development achieved. Implementation of tools utilisation. Increased focus on patient outcomes and satisfaction. Lowlights: Leadership engagement and uptake of Phase 2 has been less than favourable. Asking people to change the way they work is not usually met with enthusiasm. DHBs are not keen to share data – they think OPJ will use the data to have MoH penalize DHBs for under performance. <u>Chair asks for any comments:</u> The best journey is one the patient does not need to make. Define the de-evolution between secondary and primary care. This is being addressed in Phase 2. Please expand on the methodology that OPJ is using, is this conflicting with other QIC programmes. Secondly, is there a place for training people in a broader sense? OPJ has a specific approach around frontline staff, quality improvement approach rather than audit and quality control. Some of the other NQIPs have an emphasis on big development / large pilot rather than small incremental change. How did the feeling that data would be used against DHBs come about. The Health Roundtable (HRT) already collects a lot of data; DHBs were not comfortable with the quality of data they could submit. What problems were there in funding consumer involvement? There was no allocation in our budget for consumer involvement, fees and travel have accumulated. Will the changes made be sustainable? We believe it is sustainable at Counties Manukau DHB. It won't be sustained everywhere as it does require a top-down commitment to support the methodology. *Infection Prevention & Control – Greg Bala, Garry Smith* <u>Hand Hygiene</u> This project involves a focus on cultural change. Creating the tools, framework and environment so each DHB can receive a set of tools, pick up and implement. Culture change is a leadership issue, not a straight process from point of delivery. Outlines national and local workforce structure. Eight DHBs committed to Phase 2. There is a risk that the remaining DHBs will not participate. While only eight DHBs have signed up to Phase 2 (project goal is to involve at least 18 DHBs), a number of others are showing interest. Resourcing is the main issue – getting it lined up with budget cycles. The more DHBs that are participating the stronger the regional networks are – providing support with smaller DHBs. There is a barrier to the sign up, and then there are the practical components. All DHBs are engaged, but we hope to increase the number of participating DHBs. Encouraging creativity and making posters to get more buy-in at a local level has seen some success. A PDA will be provided to each DHB for submitting data. <u>Catheter-related Bloodstream Infection</u> Based on IHI central line bundle. Guidance document is complete, in the process	**SP to send primary care pilot site criteria to JV.**

Summary of discussion and decisions	Action points
of confirming three pilot sites. The introduction seminar will be held in May 2009. Surgical and Procedural Site Infections The project team has been formed and their first meeting has been held. Recommendations will be developed by the end of 2009 (calendar year). Chair asks for any comments: Getting buy-in requires modifying your message. Enlarge the issue caused by infections in order to acquire funding. You might get more buy-in if you focus less on audit. The objective is culture change – the audit component is the beginning of that culture change. This should not be seen as an add-on project – this is the basics of what every clinician should be doing. This demonstrates how far we've got to go on the quality journey. But the programme should not grind people down with huge audits. Victorian recommendation for sample size (having spent eight years on this issue). We have no limitation on when people can do any of the particular phases. What do you aim to achieve by benchmarking? The majority of data is for the benefit of the DHB itself and to demonstrate the overall success of the campaign. Why is it a guidance document and not a guideline? It will not meet the definition of an evidence based guideline. Do you have any CMOs as lead on hand hygiene? No. Will the profile be raised on hand hygiene? Yes, we are going through the procurement process on getting more products and distributing to DHBs. The hand sanitizer will make it much easier – people won't need to walk away to a basin to sanitise their hands. One DHB has been told they cannot get a PDA yet so cannot submit data. PDAs should be readily available to anyone so I'm not sure who has told them that they can't have one. Regarding the package for CVC where it recommends the use of the total body drape, I don't believe you need a total body drape – just a substantial one. People look at that requirement and think it's not sensible. We'll take that feedback to the team. It is possible that it was taken directly from the IHI recommendations. How will you address the uptake from DHBs? Even though the project is split into two phases, it won't be two succinct phases as each DHB moves individually from one phase to the next. Ideally everyone would adopt the programme by the end of 2009. This needs to extend past the hospital into primary care. No change has been made to the project scope. *Safe Medication Management – Clare Kirk and Chai Chuah* Highlight: the participation from DHBs has been great. We have representation across all DHBs, and consumer, primary care representation in working groups. Draft medication chart is waiting on sign off. Safe & Quality Use of Medicine (SQM) is to finalise the first in a series of national medicines charts for trialling. Five DHBs are now doing medicine reconciliation. Standards have been developed. Five more DHBs will start before Dec 2009. There is a potential for scope change in unit dose packaging (UDP) – the extent of UDP, interim repackaging. Need to establish governance. We have an interim clinical governance panel in place currently. Will need to work with each DHB to consider their size in how they apply the programme. We need to clearly communicate changes with clinicians and clearly communicate how it changes their work.	

Summary of discussion and decisions	Action points
<u>Chair asks for any comments:</u> Will there be a national prescribing chart for children? It is currently being looked at. Will you provide any data on the patient group populations? When we have a pilot site running there will be a baseline measurement. Will it still be an electronic record? Yes, the new chart forms the basis of what will become an e-chart. The project has come a long way. We have a commitment to a national drug chart. We still don't have a good connection between SQM and the steering group. Are we able to link in with Australia as there is a lot of traffic between the two countries? Yes. I would like to see linkages with the electronic health record. We need a national strategy around EHR. A number of us are on that agenda, so the understanding of the linkages is there. *Mortality Review – Shelley Hanifan* Everything is organised for the Peri-operative Committee, we are just waiting on the final approval from the Minister. This probably won't happen until 31st July once the Ministerial Advisory Committee has completed their review. The Family Violence Death Review Committee has been running and is on its third meeting. Still in establishment phase. There is a strong clinical buy-in for Mortality Review. <u>Chair asks for any comments:</u> How many deaths reviewed by CYMRC committee would be reviewed by the Family Violence Death Review Committee as well? About half, we are currently meeting to discuss this. To investigate death there will be a joint inquiry in larger DHBs. In smaller ones, one committee will make the inquiry and inform the other. It will be an add-on to the process that is already there. There has been discussion about workforce restrictions inhibiting the implementation – ie. the DHB FTE cap. Is quality assurance classed as administration? If not then it should not be under the FTE cap. *National Incident Management System – Neville Hablous and Maureen Robinson* We have delivered our policy, are two thirds through training DHBs and are currently working on specifications. The original scope was within DHBs but we have now extended this to the whole health and disability sector. All milestones have been met on time and within budget. There has been excellent cooperation with DHBs. <u>Chair asks for any comments:</u> How did you choose the faculty? We set out criteria and then asked many people for recommendations / suggestions. Is there any mental health expertise on the faculty? No, but we have had a lot of mental health people through with feedback. Four DHBs have asked for another round to submit feedback on the policy. It has been agreed that the policy will be a working draft for the next nine months. It is a good idea to keep the policy in draft as the system is piloted. The policy can be reviewed to a final draft once the initial issues are fixed. What is the big challenge for you now? A lot of risks were identified. Made many approaches to the Ministry to get a national process in place. This initiative cannot be run by the DHBs themselves, but needs to be managed by a national	**PS to meet with DHB Chairs/ CEOs to discuss budget for the national consortium.** **PS to facilitate a conversation between MR and**

Summary of discussion and decisions	Action points
consortium – not the Ministry. There is no budget for a national consortium. I think we need to move ourselves on this process and get the DHB Chairs to come to a view. What has happened with the SSE definitions for the Safety Act? We have been given a bit more time now so will continue to work on that. The attitude towards SSE is changing – people are not avoiding it now.	**GS before MR meets with Ashley Bloomfield**
7. Positioning of the Quality Improvement Committee PS summarises the previous discussion held at the start of meeting for those not present. The Ministerial Advisory Committee wants advice from QIC on how you get quality throughout the whole health system. Encourages CEOs to take a sector view with this. The Committee needs to agree on a direction by the end of this discussion. Chair asks for any comments: Key contextual issues. The worldwide quality improvement movement has been kicked off with events / moments of truth / as a response to massive clinical governance failure. This has led to a crisis of confidence world wide. NZ has never had that crisis stimulus that has occurred in other nations. There have been initiatives that have just faded away. We need to find a mechanism to sustain this change. We have previously talked about the Saving Lives Campaign, but it never quite got the traction. QIC should be the quality governance; the Ministry should then create the framework. There should be minimum standards (i.e. washing hands), improvements put in place. There needs to be a faculty for improvement that can make all of this happen. Quality is not an added extra – likened to breaks in a car – quality is essential. We need to be very public about our performance. Publish quality accounts to the same level we publish financial accounts. I am skeptical of financial incentives – as this does not produce cultural change. We cannot forget the importance of capturing hearts and minds. Have clinically relevant information available to you in real time, you can see your performance and this motivates a constant improvement cycle. A ministerial committee showing leadership at the highest point with a commitment to quality is needed. How we create baselines, performance is a no-brainer – we must be stronger in that. We need to bring quality to the top of the agenda. How do we link that into the heart of the organization? We need to grab the intellectual property available to help us. How it is prioritized is important and that requires marketing. Understand what can be cut when financial restraints take hold. How can a central body support or facilitate the capability of the whole country? Larger DHBs have more flexibility than smaller DHBs. Whatever we put in place needs to take into account this flexibility and work with all sizes well. How do we not lose momentum on what I see as a successful start on a quality movement? The DoNs are looking at leadership from the centre and they want to know what happens to data they send, but the do want to do it themselves. Determine what sits in the centre, and what sits with the DHBs. Support the regional approach. I agree with national leadership for quality and faculty for improvement. The sector is littered with projects that have begun. We need proper methodology which can be implemented by a faculty. How do we incentivise that? Some things should not be an option. How do you integrate the agenda of quality into current priorities? People always think that quality is the extra stuff – not the fundamentals. Be clear what quality cannot solve at this point in time. Slogans and statements do not help – they like the simplicity but that's where it ends. Not sure how to win hearts and minds. The key issue is culture. Quality does not sit prominently in our curriculum. Where will it be taught? There is reluctance in existing workforce; to what extent can QIC	

Summary of discussion and decisions	Action points
work in health education and work to educate the newcomers on quality. If we prevent even half of the incidents, the cost can be recouped. We could work much better at setting up regional nodes. We won't get the culture right when quality is seen as an add-on. Why isn't quality discussed in everything that we talk about? Quality had been confined to a little space. The change in the profile of quality over the last ten years is extraordinary. We need to celebrate organizations making great achievements. We're not only going to do the NQIPs, we're investing time, energy and money to make these "business as usual". When will we know that we have succeeded? When innovation and excellence have become contagious and sustainable. We value what we measure. We need to remove perverse incentives. Learn from existing regional nodes, eg. IMAC. From the ACC perspective, we see results of extraordinary outcomes of care. There is a large amount of cases where minimum requirements are not met. DHBs talk a lot about the cost of implementing quality programmes. The cost of poor quality is much more. We need to increase the focus on quality in training health professionals from the start. Ensure that we're utilising all health professionals. In the early days of EpiQual, we didn't have a handle on national strategic overview. We need to ensure QIC does work on that – knowing how one project fits into the big picture is essential. As a group we need internal education about the history of QIC / EpiQual in order to move forward with a strategic overview. What would be included in the business case for quality? Feedback from people about the most useful things they have been involved in – include details on the money DHBs will save in improving quality. We need to move away from DHBs competing which fosters mistrust. Move towards an ethos of collaboration and building on strengths. <u>Chair summary</u>: Quality cabinet – collective sense of mandated experts and have a capacity to identify and distinguish between important and less important things. Clinicians need the support to do their jobs well. Tensions coming through are mostly in terms of style – how quality is made a priority. Struggle at education level to induct them into a quality mindset – at a university level. Consumer apprehension – they just want to be safe through their journey, rather than experience a negative impact from the system. Minister wants to know if quality will be good for his business vs. economic analyst wanting to know how it will impact financially. This requires a very significant think piece where we outlay where we will position ourselves. <u>Further comments</u>: Needs to be strategic and high level – not from any one entity in the health sector. This needs to then be captured by leaders in health and fed through their organizations. We need to ensure all entities / organisations are connected in the family tree of quality. When quality becomes everybody's business, it becomes nobody's business. We need people that have dedicated time otherwise it may get lost. Having a faculty that can direct change is important. We don't have to invent this. There will be many other examples from large organizations that have standard products. Reducing variation on core business, and having good quality at the optimum price. Focusing on clinical leadership to lead this. Needs to be at the top of the agenda, part of the standard reporting system.	

Summary of discussion and decisions	Action points
8. Safe Surgery Checklist – AM PS speaking with an executive of the private sector next week. This is a strategic opportunity with QIC to start a conversation with the private surgical hospital association. This checklist was a result of collaboration with people from around the world, months of reviewing data. In the pilot study there was a level of surgical resistance. The display of imaging in our theatres was inadequate. Buy-in is now pretty good. I would like to endorse this checklist as it stands and suggest that the Ministry and QIC do the same. It is likely that in 18 months this checklist will be a standard across the board. <u>Chair asks for any comments:</u> Surgeons will not be keen to do this. We have a lot more power in the public sector. CCDHB had a joint project with Bowen Hospital regarding the universal surgical safety and it was very successful. This checklist sounds like a feature of the Saving Lives campaign which we had agreed would be a good framework to position projects. We need the surgeons to lead it so they don't see it as something that is done to them by an outside force. CCDHB is performing public / private interface brilliantly. This checklist may also link in with Productive Theatre. Why is MoH spending money on NHS programme when Whai Manaaki is already delivering the same results? If the MoH is not aligned with QIC then it undermines our credibility. We will need a project around this, consult with the private sector, and come back with recommendations.	
9. Reflection on release of SSE reports and follow up on action to be taken by DHBs How do we get this data to people who can do something about it? <u>Chair asks for any comments:</u> Publish case studies with the learning listed below it. This is done in an existing Australian health journal that is a must read. We need to collate the data from the last two reports and present it in a way to make it accessible for change. ACC are already doing some work on this and needs to liaise with MoH as to how to embed the learning. Under the auspice of a quality and risk group, get a direct conversation with ACC and ask how to transmit this to a learning environment. A guest editorial could look at international approach to offer advice. That might be useful in a workshop rather than a media event. Mental Health SSE began quite untidy but ended rather tidy. Thanks GB for her input as a common party to both groups.	**BC, CC1 and PJ will start a conversation with ACC to put together a one pager to discuss in June.**
10. Payment for consumer representatives – JS, JH The aim is to deal with consumers consistently and fairly. There is currently a lack of guidance on how best to involve consumers. There has not been any paper towards the payment of consumer representatives before. <u>Chair asks for any comments:</u> It is a very coherent which I support.	**Secretariat to write a covering letter and send this on to the NQIP steering group saying we**

Summary of discussion and decisions	Action points
Is there a definition of what a consumer is? Consumer Affairs has done a lot of work around definition. There is a definition in the practitioner's point of view. What are we going to do with this? Use it in the NQIPs and encourage them to circulate it to all parties involved. Acquire feedback from the NQIP steering group. This is a good opportunity to lead the DHBs in consumer relations. Send this on to the DHBs saying we think this is sensible and ask for their feedback. We will apply it to our own programmes and then offer this adopted process to be available to others. **12. General Business / Correspondence / CYMRC Chair report / Jim Bagian visit / planning for QIC annual report** *CYMRC Report* Our database needs to change as it has not been updated in six years. Needs additional search features. Will include a section on alcohol related deaths in our fifth report due out later this year. MoH sees it as a very important issue to include. Clarified relationship with the coroners in support to the mortality committees. There will be a Memorandum of Understanding developed between the Chief Coroner's Office and MoH. *HDC Report* Only released this week so will be discussed at next QIC meeting. *Jim Bagian visit to New Zealand* Jim is coming to Australia for a QHC Conference and the suggestion is that we get him back into NZ the following week (14-16 Sept). Some DHBs and Communio are having him run some sessions. Jim is a valuable resource; we need to plan how to use him across 3-4 regions. *Correspondence* Issue with correspondence log not having details after December. All relevant correspondence was still included in the reading.	**think this is sensible and ask for their feedback.** **NB to provide PS with a one pager on what he needs regarding the FTE cap.** **JS to provide copy of the report to QIC.** **Secretariat will co-ordinate visit with Communio and DHBs.** **KB to update correspondence log with letter details after Dec.**
Closure of Meeting PS: Closes meeting at 4:08pm	

Next meeting
22 June 2009 in Wellington

Signed ____ Date __________
Pat Snedden (Chair)