Quality Improvement Committee

Minutes

Meeting details	
Date and time	Wednesday 14 February 2007, 9.30AM – 5.00PM
Venue	Unisys House, 650 Great South Road, Penrose

In attendance	
Committee members	Pat Snedden (Chair) (PS), Alan Merry (AM), Barbara Crawford (BC), Barbara Greer (BG), Barry Taylor (BT), Catherine Rae (CR), Judi Strid (JS), Mary Seddon (MS), Robin Youngson (RY)
Secretariat	Gillian Bohm (GB), Lote Gatland
Guests	Stephen McKernan, Director General of Health (teleconference 11.30am-12.00pm), Hon Pete Hodgson, Minister of Health (teleconference 11.30am-12.00pm), David Galler, Principal Medical Advisor to the Minister, Grant Hawke of Ngati Whatua (left 11.15am)
Apologies	Kevin Hague, Jean Hera, Cindy Farquhar, Jim Vause

Summary of discussion and decisions	Action points
1. Powhiri The Committee was welcomed by Grant Hawke of Ngati Whatua.	
2. Apologies *Moved: that the apologies be accepted.* *Proposed: BT Seconded: CR. Carried.*	
3. Chair's report PS outlined the principles he operates under in governance matters: - whakawhanaungatanga: first concentrate on the relationships between the people, what do people bring to the process, what are their aspirations, what do you want to see achieved in this process - kaupapa: what is the agenda we are trying to run here - putea: identify clearly resources needed to do the job. The clear principle is that when the Committee is clear about what it wants to achieve, the business case for the resources will be advocated.	
4. Whakawhanaungatanga/Introductions Each person was invited to introduce themselves and talk about their background, personal drivers, expertise and what they would like to see achieved within twelve months. **Some of the key themes to emerge were as follows:** - Incentives on CEOs are fundamentally driven around production and budget and not driven around quality and safety. We need to give incentives to people who can influence what happens on a day-to-day basis so they concentrate on quality and safety.	

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- A major emphasis might be on importance of cross-cultural and whole systems approaches, leadership for quality and consumer participation. - The Committee needs to score some “runs” on a particular quality initiative to see a change in the workplace that relates to the work of the Committee. We need to include the sector through a journey of learning so that solutions to complex problems emerge, this is shared learning. - Quality and safety have had a lack of leadership at the Ministry level and therefore at a DHB level. The Committee needs to make strong relationships with the DHBs to get them to lead and take responsibility for quality. The health sector should know that this committee exists and leads quality. - The Treaty needs to be incorporated in what the Committee will do and not just be represented as a tick box compliance exercise. - Quality has a lot to do with research. - We need something that will work at a local level especially to progress the mortality review. It is difficult to engage DHBs. Every DHB could have the same system of mortality review in a year’s time. - The Committee should work closely with the Safety and Quality Use of Medicines Group. The Committee needs to give leadership and make DHBs accountable for their quality. It is of concern that hospitals do not have systems to measure surgical site infection rate. This is not done at Counties Manukau DHB as there is no system. We need to put this as a major quality matter that DHBs should do. Not only check if there is a system but also check the effectiveness of the system. - Work that is currently being done in terms of clinical quality should be pulled together. There needs to be a change in the views of DHB and Ministry leaders. - The Committee needs to be bold and transparent. It needs to align itself with the current consumer initiatives. There needs to be a clear action that reflects practical steps that takes action in improvement in a systematic way. The Committee needs a high profile communication strategy. - Consumers are central to quality and safety as are those that provide services. It would be good to see every provider’s senior management team have quality on their agenda. It is not just about the accreditation/ certification but about knowing who they’re providing services for and what the quality of those services are. - The Committee needs a broad and systematic approach. One of the important issues is the policy approach around population health. There is a practical issue that in our rush towards population health goals we lose sight of the individual and family. There is a need to put a focus back on compassion on the individual/family. The public sees the health system as lacking compassion. The greatest lever for change is through patient stories and involving consumers in every aspect of health care planning. - The Committee needs to agree on what it wants to do, do it and have tangible results. The Committee needs “runs on the board”. - Commitment is needed from DHBs. The key to progress here is that improving quality is directly linked to reducing inequalities. If we get it right for the hardest to serve then we improve it for everybody.	

Summary of discussion and decisions	Action points
We need to get CEOs and CMOs involved in this process. We need to make incentives for those leading the process. The communication strategy is critical..	
5. Teleconference with the Minister of Health and Director-General of Health The Minister paid his respects to the work of the previous Committee and especially to RY for his work as the Acting Chair. He further commented: - The 'Scoping report' is a gift rather than an instruction. The Committee can decide on its priorities. - That there should be measurable progress in a few areas, not glacial progress in many areas. - That there should be a "secondary" focus initially - As to putea, there is a place holder in the budget for quality and safety. Business cases from the Committee will be assessed and then an amount will be allocated. - There is a need for consumer focus. JS is on the Committee for this purpose (to link back to the HDC). - As to reporting (apart from the statutory obligation), the Committee will be informed if there is not enough information coming through. - Reporting will come from the Committee Secretariat in the Ministry to the Minister's office. - He had nothing further to add to the terms of reference. - He would like to meet with the Committee for an hour in one of its future meetings this year. The Director-General commented: - He was excited about today and the increased emphasis on quality and safety. - We need to connect people within the sector particularly CMOs, DONs, and Quality and Risk Managers. - Some money has been put aside for quality initiatives. - As the committee quantifies benefits that will accrue, they will need to be addressed in the sector. - He was supportive of suggestions put forward by PS.	QIC/Secretariat to organise a meeting with the Minister and QIC.
6. Identified Materials for use by QIC PS facilitated a session that identified documents that would underpin the Committee's approach; - Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector and the accompanying IQ Action Plan - Seven articles published in the NZMJ on Quality Improvement - Scoping the Priorities for Quality in the Health and Disability Sector Report - The second EpiQual Annual Report - WHO's World Alliance for Patient Safety Global Action Plan - Treaty Relationships - Code of Health and Disability Services Consumers' Rights - The Mortality Review Committee's Reports - Safe and Quality Use of Medicines National Strategy 2005 - New Zealand Health and Disability Strategies - IHI save 100,000 lives strategy - Certification/Accreditation Standards - Clinical Quality Indicators	Secretariat to compile a succinct summary of each document listed to post on QIC's website.

Summary of discussion and decisions	Action points
7. Terms of Reference Recommendations to the Minister on the terms of reference were deferred by the chair as there were no major concerns raised by Committee members.	Secretariat to add this to 30 March agenda.
8. Quality and Safety Agenda **8.1 Initial Strategic Thinking** **8.1.1 Scoping Report** Committee members' comments on the report: - General overall satisfaction with the report. - Mechanisms and systems from the IHI priorities are not included in the report. - The effectiveness of AMI (acute myocardial infarction) care has not been included. The report is lacking in review structure eg. life change, evidence gained. - There is the underlying assumption that information will be readily available. It was acknowledged that the focus is on action but the Committee needs to have the right information - The priorities in the report can be done; need the local level buy-in and action. Noted: - This report was for the Minister - Quality and Risk Managers and other interested individuals and groups have been briefed on the report - There is no problem if other people are informed about the contents of this report.	
8.1.2 Marketing Tools PS introduced the concept of wrapping some key messages around the quality initiative we are set to promote: - Make quality aspirational so DHBs are keen to be "best of the best" - Quality enables you to do more with the same resource - To improve quality everybody's actions count - Examine what is working, evaluate and advocate Quality Celebration suggestion put forward by PS. Suggested initiatives for further consideration: - Map the quality initiatives by DHB - Identify all the quality champions, honour their service & commitment	PS to formulate the Quality Celebration idea and report back to the Committee.
8.2 Review of the Scoping Report Priorities Each chapter of the Report was discussed by the Committee. Summary points from discussion: **8.2.1** *A standardised approach to incident management* Each hospital has its own system. The current voluntary reporting means there is an inability to determine trends. There are advantages and disadvantages in both voluntary and mandatory reporting systems. DHBs have undertaken a small project in benchmarking some incidents. BC reported on this work. It was agreed that there are no clear definitions used nationally. There is difficulty with national comparisons because of the lack of agreed denominators. There is the	Secretariat to draw up a template outlining the decisions made by QIC in relation to these priorities and timeframes.

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need for learning organisations, RCA (root cause analysis) education and training and a nationally consistent IT system. ***QIC agreed to action in the first year:*** - development of information and processes associated with a “Just culture and open disclosure” - nationally agreed definitions of incidents.	
8.2.2 *A national programme for the improved management of medications* AM declared a conflict of interest as he owns shares and is a member of the Safer Sleep LLC Board, which produces a barcode based safety system for medications in anaesthesia. The Committee is to determine at a future meeting what links/formal relationship (if any) QIC should have with the Safety and Quality Use of Medicines Group (SQUM). SQUM could advise QIC who in turn advises the Minister. Eg. advice on bar-coding, implementation of a medication chart nationally in secondary/tertiary care. Bruce Anderson, MoH, had met recently with SQUM and presented the draft consultation document on bedside verification. SQUM believed the initial actions in improving medication safety should be on implementing an electronic medication record and the development of processes for medicine reconciliation. A business case for a national programme to implement bedside verification (bar-coding) has been presented to the Minister. There has been significant work in other countries in improving medication safety and QIC should refer to this work. QIC will further explore the potential for a national programme for medicine reconciliation There is the potential for confusion between the 2 strategic documents: Peter Dunne’s *Towards a New Zealand Medicines Strategy* and the *Safe and Quality Use of Medicines National Strategy.* The Chair will deal with this conflict. As a basic principle QIC will pay for activity-based advice asked of other groups, like SQUM. ***QIC agreed to action in the first year:*** The Committee will approach SQUM for specific advice around the bar-coding of medicines and it applicability on a trial basis in New Zealand. It will request direct involvement in this process prior to providing any Ministerial advice on the matter.	MS will communicate with SQUM group and provide a report including recommendations to QIC. The Chair will identify the commonalities with Peter Dunne between his initiatives and QIC’s own efforts
8.2.3 *Infection Control and prevention* The WHO international programme (hand hygiene) was discussed. It was unclear as to whether this should be at a national level or focused on hospitals and residential care facilities. The Committee agreed that the Minister should sign up to the WHO. The Committee would like further advice on the matter of hand hygiene. The activities undertaken by IHI including CLAB (central line associated bacteremia), SSI (surgical site infection), VAP (ventilator-associated pneumonia) were presented in some detail to QIC. BT did not believe that hand hygiene was an issue that needed to be addressed. The concept of ‘the revenge effect, that is, an unexpected bad consequence of a well-	Seek information from the National Infection Control Practitioners Group. Locate people who can provide further advice. Pat Mead a possibility. QIC to advise the Minister to sign up

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intended idea' was presented by AM. JS believed that hand hygiene programmes in schools were good. ***QIC agreed to action in the first year:*** The Committee will advise the Minister to sign on to the WHO programme on Infection Control. The Committee also decided to seek information from the National Infection Control Practitioners Group on their recommendations for national infection prevention and control improvement programmes.	to the WHO.
8.2.4 *A national programme for education and training in health care improvement* Need to have a national curriculum for quality to ensure consistency. Need to train the workforce (CEOs, CMOs, Clinicians, Managers - Quality and Risk Managers), undergraduates (nurses, doctors, pharmacists, allied health), and the general public. The information used for education and training could include approved programmes, quality tools (7 tools), clinical audit, systems thinking, RCA (root cause analysis) and breakthrough collaboratives (PDSA – plan, do, study, act) ***QIC agreed to action in the first year and second year:*** - Gather information from DHBs, other health care providers and educational institutions on their current programmes for health care improvement. - Assess the applicability of these programmes and other programmes for widespread use in New Zealand from year 2 onwards.	Secretariat to liaise with AM and MS to assess the applicability of their 'tool kit' material nationally.
8.2.5 *A national programme for improving patient flows* Discussion on the applicability for all providers and the need for improvements to be demonstrated. Canterbury DHB is an example of this. We need to involve large metropolitan hospitals. The Committee needs to make an informed decision whether to pursue this priority.	Secretariat to organise Canterbury DHB to give a presentation on patient flows to QIC.
8.2.6 *A national programme for improving consumer participation* Due to time constraints the chair deferred the discussion of this priority.	Secretariat to add this to 30 March agenda.
8.3 Mortality Review The Committee needs to know what to focus on in relation to mortality review.	Barry Taylor to provide mortality review information highlighting to the Committee what it should focus on.
8.4 No final decision made on priorities The Committee determined that NO final decision would be made on priorities until all priorities (8.2.5, 8.2.6 and 8.3) had been thoroughly considered.	
9. Appointment of a Deputy Chair Deferred by the chair until members get an understanding of one another.	Secretariat to add this to a later agenda.

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10. Update on Projects **10.1 Chartbook** Due to technical difficulties, the Chartbook presentation was postponed until the next meeting.	Secretariat to add this to 30 March agenda.
11. New Business **11.1 Representation at Conferences** Chair deferred a discussion on representation until the next meeting.	Secretariat to add this to 30 March agenda.
12. Administration **12.1 EpiQual Annual Report** *Moved: that the report be received.* *Proposed: AM. Seconded: CR. Carried.* **12.2 Confirmation of minutes** *Moved: that the minutes of 30 November 2006 be ratified.* *Proposed: RY. Seconded: BT. Carried* **12.3 Confirmation of meeting dates** No concerns raised as to the meeting dates, however, meetings will now alternate between Auckland and Wellington. Wellington meetings to be at the airport. Auckland meetings to remain at the Ministry of Health building. 30 March, 3 August, 30 November – Wellington 1 June, 14 September – Auckland **12.4 Travel** The Chair advised that Committee members have the option of booking their own flights and billing the Ministry or using the Ministry to organise and book flights. The meeting concluded at 5:00PM	Secretariat to book room at the Wellington airport for all Wellington meetings.

Next meeting
Friday, 30 March 2007, 9.30AM – 4.30PM Sunderland Room, Wellington Airport Conference Centre