



Quality Improvement Committee

Minutes

Meeting details

Date and time	1 June 2007, 9.30AM – 4.30PM
Venue	Karaka Room, 650 Great South Road, Penrose

In attendance

Committee members	Pat Snedden (Chair) (PS), Barbara Crawford (BC), Barbara Greer (BG), Barry Taylor (BT), Catherine Rae (CR), Cindy Farquhar (CF), Jean Hera (JH), Jim Vause (JV), Judi Strid (JS), Mary Seddon (MS),
Secretariat	Gillian Bohm (GB), Lote Gatland
Guests	David Galler (DG), Bruce Anderson (BA), David Meates (DM), Colin Feek, Vladimir Stevanovic
Apologies	Alan Merry (AM), Robin Youngson (RY), Kevin Hague (KH), Barbara Greer (for lateness).

Summary of discussion and decisions	Action points
<p>1. Health-life reflection</p> <ul style="list-style-type: none"> - CR reflected on the effect on health workers' strikes and its effect on the Dunedin hospital and organisational restructures and how these have a negative impact on quality improvement projects in the hospital. - CR spoke on the advantage of the existence of a quality and risk manager's group. She reported that at the last Quality and Risk Managers meeting the QIC priorities were discussed and it was agreed to ask that a quality and risk manager be a member of the Safe and Quality Use of Medicines Group (SQUM). 	
<p>2. Apologies</p> <p>Apologies received from RY, AM, KH, and BG (for being late).</p> <p><i>Moved: That the apologies be accepted.</i></p> <p><i>Proposed: BT Seconded: CR Carried.</i></p>	
<p>3. Minutes</p> <p><i>Moved: That the minutes are a true and fair record with the following amendments:</i></p> <ul style="list-style-type: none"> - Change 'adverse events' to 'medication errors' under point 3.4 points to note. - Reword 3.2 to reflect the fact that the Office of the Health and Disability Commissioner is in a supporting role not a leading role. Words supplied by JS. - Remove acronyms. Future minutes to use to use full titles/word with acronyms in brackets initially then acronym. <p><i>Proposed: BC Seconded: MS Carried.</i></p>	

<p>4. Correspondence arising</p> <p>4.1 <u>National Screening Advisory Committee</u></p> <ul style="list-style-type: none"> - Discussion ensued as to how the Committee should manage letters similar to this one from other areas of the health sector. - Principle: If it can be done well somewhere else it should be done elsewhere. - JV declared a conflict as he is a member of the National Screening Advisory Committee. His opinion was still requested. - Discussion resulted in the Committee agreeing to invite Pat Touhy to speak to the Committee about the matter raised in the letter as it is a high level issue. - Agreed that a letter be drafted to inform Alistair Woodward of the Committee's actions. <p>4.2 <u>6th Australasian Conference on Safety and Quality in Health Care in New Zealand in 2008</u></p> <ul style="list-style-type: none"> - Question as to who should attend this year's conference in Brisbane to promote next year's conference in New Zealand. - George Downward was put forward as a suggestion as he is the New Zealand representative on the Australian Association for Quality in Healthcare and is chairing the NZ organising group. - Another suggestion was for someone from the consumer forum to attend to advance the focus on consumers. - It was noted that Australia is ahead of New Zealand in relation to the focus on consumers in matters relating to quality in the healthcare sector and that the conference programme included several consumer-orientated sessions. - It was agreed that the Secretariat will organise the representation. 	<p>Secretariat to draft interim response to Alistair Woodward.</p> <p>Secretariat to invite Pat Touhy to the next QIC meeting.</p> <p>Secretariat to liaise with conference organisers.</p>
<p>5. Chair's report</p> <ul style="list-style-type: none"> - Meeting with Hon Peter Dunne Notes from this meeting were circulated to the Committee. The Committee needs a systematic approach to get all influential stakeholders on board. Invite Hon Peter Dunne to speak to the Committee. - Meeting with Chief Executive Group Kevin Hague provided feedback in a previously circulated memo. - Epidemiological representation This will be discussed with DG and BT and any other Committee member that is interested. - Funding 2007-08 Government Budget Announcement increased secretariat funding. Separate project funding will need to be found to support business case initiatives. - Committee representation with media The usual practice for statutory committees was outlined and discussed. It was agreed to follow this and that only the Chair to speak to the media on behalf of the Committee. It was also agreed that the Chair may request information from Committee members and refer media to them as individual experts. Members in this situation need to inform the media that they were not speaking on behalf of QIC and identify their role/position. 	<p>Secretariat to invite Hon Peter Dunne to the next meeting.</p> <p>Chair to follow up on the appointment of epidemiologist</p>

<ul style="list-style-type: none"> - A joint media release with the Health Information Strategy Advisory Committee (HISAC) was tabled Due to the high interest around the Budget 07 announcement on funding for the Improving Medication Safety: Bedside Verification project it was agreed that there be a joint media release between QIC and HISAC. 	<p>Secretariat to follow-up on status of joint media release with HISAC.</p>
<p>6. Quality and Risk Manager's May 2006 Paper - BC</p> <p>A paper prepared for the Minister of Health by a group of Quality and Risk Managers was previously circulated. BC spoke to the paper and the discussion noted that:</p> <ul style="list-style-type: none"> - Quality and Risk Manager's take a systems approach not an individual analysis. - QIC needs to sponsor a conversation with Directors of Nursing, Chief Medical Officers, and Quality and Risk Managers. 	
<p>7. DHB CE presentation</p> <p>David Meates, Chief Executive, Wairarapa District Health Board.</p> <p>The presentation focused on the need to think differently and transform the model of delivery as shown through the Wairarapa example. In addition, DM's advice to QIC as a CE was to focus on:</p> <ul style="list-style-type: none"> - Clinical auditor instead of mortality review. Make mortality review a subset of clinical auditor. A lot of the basics are not in place in DHBs. Run into the problem of building on shaky ground. - In terms of patient flows, it is more about the development of the tools and a repository of expertise that can be used by other DHBs. - Look at how you can pool teams together in a way that you can build support. - Use of technology is something that needs to be looked at. A lot is being spent on IT in DHBs. Much of it is not efficient. - Need an investment in change management. A lot of clinical leaders not educated in system management. Need to get them educated. 	
<p>8. Health and Disability Commissioner (HDC) presentation</p> <p>Points to note from presentation:</p> <ul style="list-style-type: none"> - HDC pleased that this committee exists with a DHB Chair as Chair and a DHB CE as a member. - Intention to shift his office from being a complaints body to an office that can provide a way to improve the quality of care in the health sector. - Calling on all DHBs to report to his office by 30 June in response to the report on Wellington hospital, was a way to have DHBs collaborate. Part of the problem is the way we 'reinvent the wheel'. - The Wanganui situation is a different set of common problems. Success is to look at how we move as a country to an electronic health record. - In relation to the Auckland hospital case, the message received from an external regulator is not directed just to the health sector but broader. Awareness from consumers that they need to ask questions. - We do not know the best way for medicine reconciliation. The SQUM group is looking at this. 	

<p>Discussion points to note:</p> <ul style="list-style-type: none"> - A recent study showed that 1 in 200 people who suffer an adverse event make a complaint to the HDC. - The HDC relies on his advisors to know the situation in the sector. - DHBs in reviewing these cases have been unable yet to give assurance that these 3 cases would not happen in their own DHBs. - What happens if there is no reaction from the sector as a result of the reports? The New Zealand model is not like the healthcare commission in the United Kingdom. In New Zealand, because of the size, you can talk to each other and get a sense of what is going on in the sector. - The HDC has not been striking resistance as a result of his reports. - The risks associated with patient transfer are a continuing concern. - Industrial action and work change processes have increased. There have been changes in professions, in the way they work. - What are we going to do about it? - Communication is a big issue and a real weakness. - Talk needs to be with the patient and also their support people. - Concern expressed that the Committee has not considered Rapid Response Teams as a national project. - There needs to be increased national standardisation (eg. a standard consent form) - Primary care has already got a policy on informed consent which is now in the quality standards programme. (Cornerstone programme). - The challenge is, 'do the Quality Health New Zealand programmes do this?' - We know what to do. The issue is how do we do it? - The Committee could be the release mechanism. Quality and Risk Managers should not be driving it. The clinical staff should be driving it. - The physiological unstable patient programme is purely clinicians. - The Committee invited the HDC to come anytime to speak to the Committee. - The Committee requested a summary of the DHB responses that were being forwarded to the HDC. 	<p>Secretariat to contact the Office of the HDC to get the DHB responses.</p>
<p>9. Clinical bench marking data – VS</p> <p>Colin Feek, Deputy Director-General, Vladamir Stevanovic, Team Leader, Ministry of Health presentation.</p> <p>Points to note from presentation:</p> <ul style="list-style-type: none"> - There is no quality control around clinical coding. Why is the auditing of clinical coding not happening any more? - Clinical coders should be sitting with clinicians. - Clinical audit was abolished 3 years ago. Responsibility has moved from the Ministry to DHBs. Ideally match the data against records. - Usually errors are from a recording error. - Question arises around the integrity of the data and how we use that data. - Information provided in the presentation is on a Ministry website for DHBs to use. 	

<p>Discussion points to note:</p> <ul style="list-style-type: none"> - Paper tabled by MS¹ (Powell et al, 2003) - Clinical bench marking data is summary data. How do we get from here to a national minimum dataset. - Capital and Coast DHB have been using Australian benchmarking data and will move to use this benchmarking tool. - The first purpose of this presentation is information sharing. - Auckland has used the New Zealand Health Information System data for a number of projects. - The question arises as to who is doing the coding? It all comes down to how people interpret the data. - Leadership is needed around this clinical benchmarking data. This is not general knowledge in the sector. - The problem is that the sector did not want to pick this up because of the diagnostic related group (DRG) format. - The choice of indicators is important. Average length of stay (ALOS) would get interest from hospital management and not from those in clinical quality. - Screening tool is to give an indication of a need for further scrutiny. 	
<p>10. Priority determination and communication with the sector</p> <p>All business plans need to focus on two things:</p> <ul style="list-style-type: none"> - What does success look like? - How will we measure it? <p>A peer group together with the secretariat will evaluate each business case so each one is ready for adoption in August 2007. We will fund members to do this.</p> <p>Peer Groups are as follows:</p> <p>Patient Flows – David Galler, Barbara Crawford, Kevin Hague, Judi Strid Incident Management – Barbara Crawford, Catherine Rae, Robin Youngson, Jean Hera, David Galler</p> <p>Mortality Review – Alan Merry, Barry Taylor</p> <p>Safe Medication Management – Alan Merry, Mary Seddon, Bruce Anderson, David Galler</p> <p>Infection Prevention and Control – Judi Strid, Mary Seddon, Barbara Crawford, Catherine Rae, Barbara Greer</p> <p>Education and Training – Barbara Crawford, Catherine Rae, Judi Strid, Jim Vause, Barry Taylor.</p> <p>Note: The safe medication management business case is ready for approval and the funds are already available. The Committee agreed to approve this business case by email before the August 2007 meeting.</p>	

¹ Powell A E, Davies H T O, Thomson, R G. (2003) Using routine comparative data to assess the quality of health care: understanding and avoiding common pitfalls. *Quality & Safety in Health Care* 12(2): 122-128

10.1 Patient Flows

Committee supports this as an important project.

Discussion points to note:

- Need a stronger consumer perspective in the paper.
- Concerns that a national project on improving patient flows will stop what DHBs are currently doing.
- Need to be clear on process deliverables.
- Suggestion that the title could be improved JS to consider an alternative.
- What is the impact on inequalities. Current inequalities as noted in the paper are not compelling.
- Should not to be restricted to the Emergency Department (ED). ED is a starting point and can move to other areas, eg. mental health.
- DHBs can choose to be involved and will be recruited to the project.

10.2 Mortality Review

Discussion points to note:

- Costs in the business case have been stretched over 3 years.
- Large DHBs are not taking up the local mortality review groups as there are too many deaths to be able to resource to review each one.
- The definition of perioperative was questioned. Definition to be discussed at a later date when a working group is set up. Could use current definition used by Scotland and Western Australia.
- Review at a local level allows changes to be almost immediate.
- Establishing a perioperative mortality review committee is a way to try and make surgical intervention safer.
- Quality framework within DHBs has the budget. Review at a local level should be funded at the DHB level not our level.

10.3 Incident Management

Discussion points to note:

- Committee agreed that no national database will be set up.
- Could have a national collection of the data in the future.
- Future direction for this project is a national system.
- The HDC should be actively involved and his office should be included as a stakeholder.
- Open disclosure is a real positive and educating the sector on this is needed.
- Open Disclosure needs to be defined in the way that clinicians are aware that it does not involve naming staff.
- This is about trust.
- There is a trust and confidence issue that the health sector is talking the same language and communication.
- There are three voices in quality – customer, staff and process. We do not want to dry up these voices.
- Success is the reporting of incidents and engagement from across the sector so that the majority of clinical practitioners are reporting/involved.
- Only 10% of incidents are recorded in some organisations.
- Need to link the quality improvement steps and include it in the project description.

- Concern raised about training as outlined in document and the approach that an independent provider will go into each DHB to train people when several DHBs have well developed programmes.

10.4 Safe Medication Management

Discussion points to note:

- Focus on bar coding and reconciliation and the continuum in between.
- Remove breakthrough series from the business case.
- This needs the support of SQUM and needs to address the use of high risk medication.
- The DHB CEs started SQUM. The Committee needs to talk to DHB CEs about the position of SQUM and whether it should be a subgroup of QIC.
- Only way medication safety will work will be if it gets 'buy in'.
- Medicine reconciliation will be developed in a clearer way.

10.5 Infection Prevention and Control

Discussion points to note:

- Initial agreement was to focus on hand hygiene only. After mid-week teleconference, there is consideration now for a national surveillance programmes for surgical site infections (SSI) and catheter- related bacteraemia
- Everyone is trying to do hand washing. Most DHBs have the anti microbial gels and the talking walls.
- More interest would be in surgical site infections and central line associated bacteraemia (CLAB)
- The reason for the interest in hand hygiene is because the World Health Organisation has identified this as a priority in the World Alliance for Patient Safety Programme and invited New Zealand to participate in the High 5's project.
- Need to have a surveillance approach.
- Currently, there is no way of measuring SSI or working out CLAB.
- There is no widespread attention to hand hygiene.
- The business case needs to address the practice issue ie. What is happening now?

10.6 Education and Training

Discussion points to note:

- major changes needed to be made to the business case
- new scope development to exclude standardised modules for undergraduate training, include comprehensive training, for multidisciplinary teams and training for quality coordinators.
- At the moment, undergraduate training is limited but increasing quite quickly. Training is happening at the DHB level, which is the most appropriate place to train people about systems.
- Singapore authority has a strategy that you can not be promoted until you have been trained in quality tools and techniques.
- Focus needs to be at a DHB level.
- We need to fund, seek, and offer training.
- Need to provide clarity to educational institutes as to areas of training in improvement tools and methods.
- Need to first gauge interest then we could move it out to tertiary

<p>educational institutions.</p> <ul style="list-style-type: none"> - There is already a large workforce where training is needed due to not being trained at the tertiary educational level. <p>10.7 Consumer Participation</p> <p>Discussion points to note:</p> <ul style="list-style-type: none"> - Reiterated from the last meeting that we still support the principles and will provide sponsorship for the “Strengthening Consumer Voices” Summit. - The Summit now has a list of 22 partners and sufficient sponsorship has been received for the next summit meeting. - The Committee has a key role to provide seeding money and establishment money. - DHBNZ has agreed to take on the project to persuade the remaining DHBs to come on board. - Results from the “Strengthening Consumer Voices Partnership” summit will be brought back to the Committee to consider how it can continue to support this consumer initiative and promote the benefits consumer participation - No business case was developed as QIC has only been asked for financial support. 	<p>Secretariat to include this in the Committee’s work programme.</p>
<p>11. Committee Work Programme</p> <p>A draft of the 07/08 Work Programme was presented. PS will work with Secretariat to finalise work programme.</p>	
<p>12. General Business</p> <p>12.1 Feedback from conferences</p> <p>Feedback from conferences was cancelled due to a lack of time.</p>	
<p>12.2 Policy for representation at conferences</p> <p>The policy had been previously circulated.</p> <p><i>Moved: That the policy is accepted.</i></p> <p><i>Proposed: PS Secoded: BT</i></p> <p><i>Carried.</i></p>	<p>Secretariat to post policy on Quickplace.</p>
<p>12.3 Email about a quality team to be established in the Ministry</p> <p>Discussion points to note:</p> <ul style="list-style-type: none"> - This extra group can link all DHBs together to work on matters that are not being pursued by the QIC. - Should this group be in the Ministry or outside the Ministry like the New Zealand Guidelines Group? - This is an enabling initiative. It would be ideal to have a national patient safety agency but we’re not there yet. - Is this group an addendum to the Secretariat or not. Need to explore this further. May be good to see where this group goes. 	
<p>12.4 Gathering of a quality crowd.</p> <p>Need to look into gathering people in the sector involved with quality improvement activities. QIC will provide financial support for this activity as it is important to gather the ‘influence brokers’.</p>	<p>Secretariat to check on having a day after the innovation awards on 11 October.</p>

<p>12.5 Links with groups <i>Safe and Quality Use of Medicines</i> PS to attend a SQUM meeting.</p> <p><i>HISAC</i> It was noted that the Committee needs to link with the Health Information Strategic Advisory Committee.</p> <p><i>Cancer Control Council</i> JS spoke of the work of the Council in setting up consumer forums and suggested that Craig Tamblyn, Manager of the secretariat be invited to a QIC meeting. It was agreed that the Secretariat talk with Craig and seek information from them that could be circulated to the Committee as a first step.</p>	<p>Invitation from SQUM for PS to attend their meeting for half an hour.</p>
<p>12.5 Invitation to speak to the College of GPs Board of Quality College of GPs invited the QIC Chair to speak to their Board of Quality on 8 June 2007. PS opened the invite to the Committee. JV as a member of the College of GPs Board of Quality removed himself as a candidate. No other members put their name forward.</p>	<p>Secretariat to liaise with the College of GPs to arrange an alternative.</p>
<p>Closure of meeting PS concluded meeting at 4.10PM after a prayer from BG.</p>	

<p>Next meeting</p>
<p>Friday, 3 August 2007, 9.30AM – 4.30PM Sunderland Room, Wellington Airport Conference Centre</p>