



# Quality Improvement Committee

## DRAFT Minutes and Action Points

### Meeting details

Date and time	20 February 2009, 9.30AM – 5.00PM
Venue	Airport Motel, 142 Tirangi Road, Lyall Bay, Wellington

### In attendance

Committee members	Pat Snedden (PS), Jean Hera (JH), Mary Seddon (MS), Judi Strid (JS), Nick Baker (NB), Barbara Crawford (BC), Catherine Rae (CR), Alan Merry (AM), Cynthia Farquhar (CF),
Secretariat	Gillian Bohm (GB), Stacey Day (SD), Ashley Bloomfield (AB)
Guests	David Galler (DG), Anne McLean (AM1), Peter Jansen (PJ), Cheyne Chalmers (CC1), Janice Mueller (JM), John Ovretveit (JO), guests from RNZCGPs (arrive at 11.00am & depart at 1.00pm)
Apologies	Jim Vause (JV), Barbara Greer (BG), Geraint Martin (GM), Chai Chuah (CC)

Summary of discussion and decisions	Action points
<p><b>1. Meeting Opening and Karakia</b> Meeting opens at 9.33am. Guests arriving throughout the day are: David Galler (9.54am); Anne McLean (10.10am); John Ovretveit; RNZCGP group.</p>	
<p><b>2. Apologies</b> Jim Vause, Barbara Greer, Geraint Martin, Chai Chuah.</p>	
<p><b>3. Health- life Reflection - AM</b> The world has changed dramatically lately and we are seeing economic changes across the world. These changes impact on real people, making for difficult times. With the government change we are seeing a different philosophy, and different set of problems.</p> <p>There is a focus on health – we are seeing less people in the health workforce. The Serious and Sentinel Event report detail focuses your mind when reading the cases. Some mistakes are appalling and shouldn't have happened. We need to proceed with work integrity, stick to our guns and what we believe in.</p> <p><u>Chair asks for any comments:</u> ACC has a few campaigns starting, such as return to work as not having a job shortens your life, and quality of work (ACC guy) Group congratulated Alan Merry for his new year's honors.</p>	
<p><b>4. Minutes 17 October 2008 Meeting</b> True and fair record, unanimous agreement.</p> <p>Morning tea.</p>	<p><b>Secretariat to revise minutes for signing at next meeting and post minutes on website.</b></p>

Summary of discussion and decisions	Action points
<p><b>5. Matters arising not covered in the Agenda – PS</b> There were no matters not covered by the Agenda</p>	
<p><b>6. Chair’s Report – PS</b> <u>Chair’s reflections:</u> Unemployment may reach high of 7%, which we haven’t seen for at least 20 years, this means 100,000 plus, unemployed. Finance costs of deficits are rising, and we haven’t seen this in NZ since the 90s. For the incoming government one message is we will not see a surplus in their time of office (finance minister). MoH and other boards are being asked for line by line reviews of budgets. How can we put money back to the centre? This is a very large and serious problem we are facing.</p> <p>What is government doing – is the money being spent against priorities? If not on their agenda it will cease, and if on agenda it may stop when no longer required. Do the services especially in health meet the agenda? If not, we will get rid of them, e.g. HEHA in schools. Promotion of innovation is a philosophical issue; we need to see better value for money spent. Their will also be no increases in pay, which hasn’t happened in a long time.</p> <p><b>Financial situation in health</b> - DHBs have guaranteed funding for 3 years – deficits have to be funded out of the pot, so pressure to find dollars to cover this. There is an accountability mechanism built in, this government not much about whole of life view, its about direct outcomes, they want to see action. There is an accountability mechanism built in, government currently not focused on whole of life view, focused on direct outcomes, they want to see action.</p> <p><b>General vision</b> – not mapped out totally, suspect we will see marked changes in philosophy – MoH needs to take a leading role from the centre. This was previous Minister of Health’s view, now we may see a regional focus; regional priorities might be the driver. Clinical leadership will be prominent; Minister of Health’s view is that of clinicians taking a lead. Clinical networks, clinical leadership and regional view.</p> <p><b>Ministerial review group</b> – formed when Minister of Health was in opposition, he has canvassed widely. First six months is always rock and roll with any new minister. The group is looking at financial problems, infrastructure, IT, and they have targeted that the ministry has 138 committees, and what is the value added? Chair is meeting with the group to talk about QIC.</p> <p>QIC needs need to speak the language of the Government. We are now two years old, quality is fundamental, building quality and safe care is foundational. We need to gain the confidence of the Minister, not ideological, born out of evidence, carries a vision in the whole of the system and is at the core of what the Minister wants - accessible health care. SSE being released on Monday 23<sup>rd</sup>. It is a tale of sad stories, people hurt in our system, and had we been more careful they may not have been hurt.</p> <p><u>Chair asks for any comments:</u> What is the Minister’s position on retaining physicians? Need to reduce administration to have money for front line staff. Australia is starting to feel effects of economic decline, so perhaps the large salaries that attract New Zealanders wont be offered anymore. It is clear that the Minister has bits of the picture, but he doesn’t know the whole picture, the dots need to be joined together for him.</p>	<p><b>CF and NB to provide Chair with a briefing papers for Ministerial Advisory Group.</b></p>

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<p>Supports Chair's approach, still early days, and minister is approachable and seems to want to listen, we need to be positive in our relationship building.</p> <p>AB comments: MoH perspective – endorse fundamental need to get Ministers confidence, from MoH perspective that the Ministry is delivering on the new agenda.</p>	
<p><b>7. Optimising the Patient's Journey Programme - DG</b></p> <p>A paper with recommendations on system features of outpatient booking processes had been distributed to the Committee. Actively managing a standardized approach to managing referrals will see great gains for all. Health and Disability Commissioner found that there is no standardised approach across DHBs to process outpatient appointments. It was referred to QIC, who initially responded, then it was referred to Optimising the Patient Journey programme for their recommendations. They have provided us with a set of recommendations.</p> <p><u>Chair asks for any comments:</u></p> <p>This is a good example of why we were set up and delivers clear and unambiguous outcomes.</p> <p>Pg. 4 – there was disagreement during an OPJ learning laboratory, as people had different ideas as to what they wanted.</p> <p>Concern raised over who checks the referral.</p> <p>Recommendation 8 – concerns over vulnerable people without phones, people not wanting to phone – DG to make note of this.</p> <p>Recommendation 2 – believe it should be mandatory. This is supported.</p> <p>Perspective from HDC, the Commissioner will be asking for a reporting / monitoring mechanism.</p> <p>QIC endorses subject to amendments, and Secretariat will circulate recommendations to DHBs.</p>	<p><b>Secretariat will circulate recommendations to DHBs.</b></p>
<p><b>8. Planning for release of serious and sentinel events on 23 February</b></p> <p>SSE has been through a clinical and technical advisory, and the Minister has been briefed.</p> <p>How do we distribute the lessons learnt from this? QIC needs to get CEOs and CMOs on board to get widespread coverage.</p> <p>Suggestion that DHB Chairs and CEOs add national and local reports to board agendas at the next public meeting to discuss. The public need to know it is going to be on the agenda. Could add to the media release that boards have been asked to add to their agenda.</p> <p><u>Chair asks for any comments:</u></p> <p>Staff forums, QIC give a presentation to them. Should be a requirement for all clinicians to read the SSE. Send to professional associations, so they can circulate it to their members.</p> <p><b>9. Strengthening Consumer Voice proposal</b></p> <p>Concern that the proposal is losing momentum. New government wanted to halt anything that the previous government hasn't yet started. However this fits into the new government's agenda.</p> <p>There is also a link with Nationals health policy.</p> <p>Will QIC endorse the paper – Leading together, learning together?</p> <p><b>Outline:</b></p> <p>Not about duplicating what consumer groups do, but to strengthen their</p>	<p><b>Paper on definitions tabled – need an expert group to advance – BC, NB, AM, JH to teleconference.</b></p>

Summary of discussion and decisions	Action points
<p>effectiveness. Professional bodies think it is important. Clear message to Government to show it is widely supported. Supports a national entity being set up. Consequences of not proceeding are highlighted.</p> <p><u>Chair asks for any comments:</u>  Some issues with paper. We need to design systems where the patient benefits. Some issues with GPs context. The concepts need to be married together, to maintain relationships.  Still thinks it is important, needs work on how we present it.  Supports strengthening consumer voice, been a large delay already. Consumers need training, and up-skilling. Doesn't think you should replace the patient centre. One of the problems is making it more specific, need to make choices and look at different options. There are lots of papers around consumer voice, and this needs to focus on quality and safety aspect for the new Government, and where there is evidence and good practice in NZ, show what works and doesn't work. Where would you want the consumer to have a voice? In quality and safety, and there are some examples in oncology where patients have helped to redesign oncology services. Scan and list good practice and evidence, and try to take a more experiential evidence approach.  Back at step one with this Minister, so need to say how has the consumer voice made a difference, show a consumer story, there are plenty of examples.  Agree, need a story.  Consequences argument not very compelling. Needs work.  Don't make it look like its setting up a body, have a staged proposal.</p> <p>The business case will need to be revised and the funding reduced for the first.</p> <p>Process steps – re-write business case and design a new pathway forward. Reposition and then bring back to next meeting. Group asked to see paper before meeting so people can comment.  JH, JS, DG, PJ, may with the business case.</p> <p><b>10. Next steps in working with Primary Care with the Board of Quality RNZCGP</b>  <i>Refer scene setting powerpoint presentation from RNZCGP.</i></p> <p>Why is primary care important? – better health outcomes, lower costs, greater equity in health.  The College – work with everyone, to get to the destination quicker, need to understand each others business better. High volume, high turnover business where errors will happen. Figures on primary health care figures predominantly taken from the US. Our calculations show we probably have around 2,000 preventable errors per annum.  The industry is different to hospitals – general practices are small businesses.</p> <p>First draft has been worked on a 'think piece' – setting out a rationale for work streams that the College wants to undertake for the next three years. The College will send to QIC once they have had a chance to comment on.</p> <p><u>Chair asks for any comments:</u>  QIC is in support then we would try and find resources for this.  Timely, much work hospital focused, interaction with primary care has been a struggle. There are areas for improvement. Interface with OPJ.  NZCGP keen to work to build relationships, find trust levels, and make sure social</p>	

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<p>marketing, and health promotion gets noticed (what some organisations are doing).</p> <p>In old days GP was the coordinator, now there is poor coordination, with patients not knowing how to work the system. The College can partner and lead on</p> <p>The College is mindful around how we construct the primary health care fleet. There is a huge DHB sector as well, which is a challenge; we need to take it piece by piece. Need to consolidate where we go with primary health care</p> <p>We have started to identify the stakeholders, and how do you have a conversation with all the stakeholders.</p> <p>A new journal launches next month, as a significant step in not just being about GPs, but including other health professionals.</p> <p>From an academic point of view, Looking at evidence based, apply academic rigour is great. Mapping out a quality landscape is not an easy task, with many people willing to help. Knowledge and skill transfer is hard to do, this work helps build on that.</p> <p>Many risks are at the boundary areas, the incident management project met this week, and noticed it was just around DHBs, there is potential to extend this, use as a mechanism to join together.</p> <p>Significant events – highlighted difficulty with engagement with DHBs, relationships need to be built.</p> <p>The safe medication project isn't going to move forward without support from both.</p> <p>SSE, whole of systems approach. Primary and Secondary interface required. There is also a language barrier.</p> <p>GPs need to advise DHBs of adverse events, when DHBs may not be aware that it happened.</p> <p>Primary care is not an easy sector, not straight forward. Bringing them together with the symposium was well done. Need to have the relationships to get the business done.</p> <p>Shared messages and framework needed to move forward. Big challenge ACC data around the events, and injuries, there are gaps between services (primary and secondary), this is just the tip of the iceberg, and there are many problems in the system. Need to also look at the most vulnerable parts of the population.</p> <p>With limited resource environment we are going into, we need to work together. Needs to be an entire system through the whole way.</p> <p>HDC left out, but they see a lot of issues, and need to be linked into the central management system. A relationship is starting to be built.</p> <p>At last meeting a number of groups was identified as being left out, e.g. midwives and family planning, have they been engaged? Response - many are but not all yet.</p> <p><u>Chair's summation:</u></p> <p>Symposium was great, first time ever. We have the brains here to do this the right way, to get this off the ground – we will start without everyone, but involve additional others as we go along.</p> <p>We have a complex allocation issue - DHBs to support deficits have taken some funding to support their deficits.</p> <p>QIC needs to recommend that DHBs flush out any resources they have, as this is important. The group needs to design how it is going to happen. NZCGP asked to come back to next QIC meeting with the bones of where they want to go, and what they want from QIC? Response - that they want to be collaborative, their team will continue to grow.</p>	<p><b>RNZCGP to attend next meeting with proposal.</b></p>

Summary of discussion and decisions	Action points
<p><b>11. Presentation: “Saving through quality: the economics of improvement” – John Ovretveit, Director of Research and Professor of Health Innovation, the Karolinska Institutet, Stockholm.</b>  <i>Refer presentation by JO.</i></p> <p><u>Chair asks for any comments:</u>  Not much benchmarking around, and we launch into the doing.  The conversation keeps coming back to cost. Can we afford it?  A fundamental issue is we need to understand what works and doesn't work,  There is no point in investing money in things that don't work.  If quality units had to fund themselves, they would probably operate in a very different way.  In times when funding tight need to invest in innovate and quality. Strength of evidence should depend on what you're asking for.  We know there is evidence, and the savings to be had are large. Need to revisit the Saving 1000 Lives campaign.  The main point is to look at the resources we use on quality and safety and use it to the best effect. Think about implementation. How do you adapt and design at a local level looking at your organisation?</p> <p><b>12. Implementation of the National Quality Improvement Programmes - report from the National Steering Group</b></p> <p><b>Safe Medication Management update</b> – still diversions between steering committee and project teams. Progressing slowly however. Concerns over some elements of project.</p> <p><b>Incident Management update</b> – Steering Group meeting this week, in regards to policy, want to know at what stage the policy is at. Been through consultation processes, is a working draft and hasn't been ratified at the Ministry. The MoH will need to consider several things e.g. in the technical and advisory group there have been several discussions around root cause analysis, and how many should be done, the cost to the DHBs to train people, and the use of the SAC tools, and how are we going to manage central reporting.  Education and training. Five DHBs trained in 2008, and continuing until August, every two weeks. Engaging with primary health and consumers isn't as successful as hoped.  The IT plan. Do we want to develop a system that everyone can use in principle? Their needs to be a sub group formed to look into this. Make strategic decisions on scope.  Key decision needs to be based on what we want the end product to be. Then determine what system is going to holds this. Step by step process, can add things to it.</p> <p><b>Optimising the Patient Journey update</b> – Next learning event is 23-24 February, focus is emergency departments.</p>	
<p><b>13. HDC reports discussion – cases 07HDC14539 and 07HDC10316</b>  Many have interface issues, so could fit into the OPJ pathway.  A telling sign is what is the DHB response?  Are national workforce groups privy to this information?</p> <p>Next agenda – importance of communications, and understanding new communication methods to get information out.</p>	<p><b>DG to respond to HDC on the Radiology case.</b></p>

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<p><b>14. Reports from the Chairs of CYMRC and PMMRC</b></p> <p><b>CYMRC report</b>  Report tabled and circulated.  Innovative ways are being looked at. The reviews that have come before have been extremely useful and influential, e.g. SSE  The opportunities for change stem from local work which we previously haven't talked about much.  We need to look beyond the definitions.  We have lots of potential good practice points, we have own network to share learnings, and any suggestions from QIC welcomed. A regular newsletter suggested, pick a case and discuss, like Victoria do.  There are some issues with funding constraints. Also need to be working with ACC to see the mortality, but also the accidents e.g. driveway deaths low, but driveway injuries high for ACC.</p> <p><b>PMMRC report</b> - Report tabled and circulated  <u>Chair asks for any comments:</u>  Chair wants mortality review reports to be at the front of the May 1<sup>st</sup> agenda.</p>	
<p><b>16. General Business / Correspondence</b></p> <p><b>Compassion in healthcare – refer email from Robin Youngson.</b>  Not sure it would make that many changes. Hard to define compassion.  Peoples' definitions depend on person, race, sex, age etc.  It is recognisable, something we ought to be doing.  We all think compassion is a good thing. Legislation for it is tricky.  A lot of complaints still come to HDC complaining on lack of compassion. One argument is to make it more explicit in Code.  How much work is this going to create? Is it justified to go through the hassle of changing legislation?  Supports the inclusion of compassion in the Code.</p> <p><b>Surgical Checklist – AM</b>  A check before anaesthesia, then another at surgery and one after. Auckland DHB was a pilot site. Very cost effective, evidence based. Agreed to place on next agenda.  Looking through SSE when it comes to surgical problems, there is a large amount of variability. Demands a national response.</p> <p>Add to the agenda for 1 May meeting. AM to write a proposal.</p>	<p><b>Chair to take advice on this, and talk to the HDC then make a recommendation.</b></p>
<p><b>Closure of Meeting</b>  PS: Closes meeting at 4.08pm</p>	

Next meeting
1 May 2009 in Auckland

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Pat Snedden (Chair)