



Quality Improvement Committee

DRAFT Minutes and Action Points

Meeting details

Date and time	22 June 2009, 9.30AM – 4.30PM
Venue	Wellington Airport Conference Centre, Wellington Airport, Wellington

In attendance

Committee members	Pat Snedden (PS), Jean Hera (JH), Mary Seddon (MS), Cynthia Farquhar (CF), Judi Strid (JS), Anne McLean (AM1) (10am),
Secretariat	Gillian Bohm (GB), Shirley Jones (SJ),
Guests	Peter Jansen (PJ) Geraint Martin (GM), Jim Primrose (JP), Vinod Singh 1pm; David Galler (DG), 10:05; Maureen Gillon (MG), Bev O'Keefe (BO), Stephen Underwood (SU), Gavin Valentine (GV) (College of GPs / Maven), 10:30am.
Apologies	Barbara Greer (BG), Barbara Crawford (BC), Alan Merry (AM), Nick Baker (NB), Jim Vause (JV), Janice Mueller (JM), Des Gorman (DG1), Catherine Rae (CR), Chai Chuah (CC), Cheyne Chalmers (CC1),

Summary of discussion and decisions	Action points
<p>1. Meeting Opening and Karakia Meeting opens at 9:32am. Protocol / tikanga agreed and to be adopted that all mobile phones and PDA are set to silent for the meeting. Guests arriving throughout the day are: Vinod Singh (VS), Maureen Gillon (MG), Bev O'Keefe (BO), Stephen Underwood (SU), Gavin Valentine (GV).</p>	
<p>2. Apologies Barbara Greer (BG), Barbara Crawford (BC), Alan Merry (AM), Nick Baker (NB), Jim Vause (JV), Janice Mueller (JM), Des Gorman (DG1), Catherine Rae (CR), Cheyne Chalmers (CC1) Due to absences the meeting does not have a quorum.</p>	
<p>3. Health-life Reflection - CC1 Due to CC1 absence, this did not proceed</p>	
<p>4. Minutes 20 Feb Meeting Discussion about the paper prepared for the Ministerial Advisory Group. Agreement that information on the three topics of independence, sector ownership and track record needs to be more explicit. PS has agreed to send further information to Murray Horne. Minutes to be formally adopted at next meeting that has a quorum.</p>	<p>Secretariat to revise minutes for signing at next meeting and post minutes on website.</p>
<p>5. Matters arising from the minutes - ACC alerts PJ distributed and spoke to the alerts used by ACC. The ACC newsletter and case study gained general support from those present, noted the reports are similar to those released by NPSA and JAHCO. Discussion on if this was a suitable method of getting the learnings from serious and sentinel events out to people, particularly clinicians on the floor, postal dissemination hits only a few. ACC are looking to strengthen their reports and how to support institutional needs.</p>	

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<p>Questions were raised over the patient's privacy in the case study; PJ advised that the case study is a compilation of common problems, rather than one patient's incident in particular.</p> <p>Questioned about this method of transmission, does it work for clinical people? This method works as it is "personalised", rather than a random, anonymous story, it has more impact and clinicians can understand the implications of errors. It is an attempt to blend the cold hard facts and the emotional story to gain buy in from clinical people. How should the bare facts for the data collection be categorised? Incidents can be packaged, without needing to go into depth. Dissemination methods were queried: postal has cost, email alerts could be useful as it is delivered to whoever needs to see the alert and what is required. The Chair queried if it should be a QIC alert, should it be QIC and ACC and asked for direction from QIC for what is the smart thing to do here. How could this be done in New Zealand? There is concern that it may take more than alerts to achieve change.</p> <p>There is belief in the electronic system, but also dissemination through staff meetings, how to balance this against the clinical work demands of people. Postal is useful as people will respond to mailed information, whereas they may delete an email.</p> <p>PJ believes that the mixed delivery media is compulsory, that this will reach far more into the community. SQM have been putting out alerts for 2 years, often gets stuck at CEO level as the CEO's secretary stops it. Knowledge is required about how to get it out to the GPs and other people. There needs to be a designated person to receive these and to disseminate to staff.</p> <p>The Chair is very keen to transmit the learning from this process and notes dissemination the key.</p> <p>Noted that medication should be on the graph, and was not. The notification is where ACC then goes to the various council or college; often the first time the clinician/practice knows something went wrong is when they are called up to explain.</p> <p>The process of how to get clever dissemination of information down to the clinician level and how we can get this out needs assessment. Some felt that the current Serious and Sentinel event reports were ineffective and focus should be on getting alerts out. The alerts should be viewed as a signal and an indication of what the nation is doing about these.</p> <p>ACC believe that making a start on using the data that is entered hopefully will reduce the claims.</p> <p>It will be useful to get ACC in to analyse and use the claims, to get the experts in and link it into our work. What's the way of improving people at the front line from the education we have here. There is the systemic and the individual and how to blend these to get the best result.</p>	
<p>6. Chair's Report – PS</p> <p>Ministerial Advisory Group (MAG) report</p> <p>After the last meeting PS was very clear that, as a result of the kind of conversation held, we should be pitching the case for quality and in a way that would be structurally appealing for the Group, however feedback from Murray Horn was that the emphasis was wrong, and there should be a return to the original questions from the letter to QIC and we should be looking at the placing of QIC in the larger scheme of things.</p> <p>DG has looked at the original bullet points around this and is looking at the economic connection between strategy and what we are going to get out of this. PS will circulate, and GM will circulate a paper he forwarded to the MAG. PS cannot pick where this is going and needs advice from the group. This review is becoming increasingly around money and less around quality. What PS thinks</p>	

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<p>should be done is NZ needs to say we need a patient safety process that is quality driven, independently run and out of the baseline DHB funding budget and available for DHB to provide quality improvement in a systemic way.</p> <p>GM. Chai asked GM has developed a paper for MAG that reviews primary and secondary care and quality. GM has sent onto Murray Horn. The paper looks at the indices needed and how to make economic savings while increasing quality, an independent patient safety approach. Saving 1000 Lives was highlighted: patient safety was put under saving money, by being safe, there are fewer costs associated with fixing mishaps later.</p> <p>It is unclear the direction of the MAG report and recommendations. The Committee expressed a hope that there will be a decision on the greater independence of QIC and a decision for a strong on quality and safety agenda. CF attended the meeting of the Chair's of the Ministerial Committees, where concern was expressed on the future of some Committees. PS need to focus on how the agenda of QIC gets into the sector management process, but it seems it has not quite got into the mindset. PJ agrees that there is a cost to a lack of quality; we are reaping the outcomes of poor quality, saving lives etc.</p> <p>What we do not need is a sector that stagnates with lowered productivity. The concept is that both quality and innovation need to be backed. The hardest place to create innovation is from within the Ministry, it needs to come from the frontline. What are the linkages with other activities and how to create synergy.</p> <p>Be clear that it's the methodology that matters, eg Saving 1000 Lives uses a common methodology.</p> <p>What will be different for patients, what will be different?</p> <p>Needs to involve consumers in the wider PHC sector.</p> <p>Important though to make a start somewhere.</p> <p>Offer support from QIC to develop their approach, which should include principles, a concrete action plan, incorporate Government priorities and multidisciplinary terms.</p> <p>Consider QIC / primary care meeting – national workshops and clear objectives.</p> <p>Offer to work with you to get the proposal into a shape where it can be presented / work-shopped at a national meeting. End result: coherent I care market, reframe approach to ensure things can be improved for patients.</p> <p>Changes to the document were discussed.</p> <p>The key themes are this is a significant opportunity and it is important to get the tone right.</p> <p>Discussion agreed that QIC's role is to identify and systemise best evidence based practise within health and disability system that improves patient outcomes, costs less and lifts outcomes.</p> <p>Need a focussed consensus view on this, so there is no deviation from the message: increasing productivity, quality and effectiveness within the sector.</p> <p>Patient safety rings well with public and politicians, but is a key quality output.</p> <p>Ensuring quality will prevent more deaths.</p> <p>Paper should include the long term future as a quality safety agency that is arms length, virtual or real, from the MoH, and mandated by the sector. This agency will also be responsible for incident management, mortality review and leadership of quality clinical. It needs to create a statement about what the health sector is for - not what the sector cant be due to funding constraints.</p> <p>Needs more concrete ideas and concepts, which it will be outside the Ministry and will sit with the DHBs.</p> <p>We may need to stop some things and move focus to other areas.</p> <p>Top slicing is the key: there will be less money in the health system. We are sitting on reliability, we know that we harm people, however there is no single</p>	

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<p>entity accountable for quality and perhaps it's time we measure and deliver. How do we find a methodology for events, how do we get down to the system issues over individual issues.</p> <p>Electronic delivery systems. ACC case studies viewed and considered a great learning tool.</p> <p>Need a mechanism to discuss these sorts of events. This relates to the incident management conversation to have with Margie.</p> <p>Volunteers to write paper sought. DG will make changes and then circulate.</p>	
<p>7. Advancing the Primary Care Improvement agenda – business case presented by RNZCGP</p> <p>PJ declared a conflict of interest as he was recently appointed to Royal New Zealand College of General Practitioners Board.</p> <p>BO provided an overview of the work of the College in quality improvement and the relationship with this proposal. IPAC is working with them. Development would achieve. Looking for an integrated approach, not another ad hoc project. Commencing project work with e-transfer of care to promote a seamless approach. Maureen primarily responsible for quality programme. This particular business proposal is to seek endorsement of programme to take back to the Ministry; qi4gp may be represented to QIC for further funding. Looking at PMS systems across practise and wider primary care, looking for connectivity between users to ensure better access to information and access while maintaining privacy of patients. Contracted Otago University to collate and bring together initiatives in primary care. QI is happening on an ad hoc basis, time to look at the best, analyse then disseminate and bring together for the most important and effective. Challenge went out to primary care community to find the best way of doing improvement.</p> <p>This is the first significant part of the process. RNZCGP wants a coherent overarching process of doing the right thing.</p> <p>Very supportive of primary care coming on board. Asks for clarification of the strategy. There is QI and cornerstone, but no framework within the proposal and how it would add to the rest of the improvement work. What is the body of work that tells her that the frame work will add to quality of care?</p> <p>The quality framework needed evidence that the direction was the correct way to proceed. Wellington Medical School has done the literature review and have put together what a good plan should look like. The right components are required and a good plan is required. There are five work streams. Second is to the clinical developments phase, this requires many tools and process, clinical skills and getting a complete package of things that can be applied to clinical and quality assessment programmes and then put out to primary care providers.</p> <p>Engaging primary care is a good step forward and strongly welcomed. Would like clarity where they want to be that at the end of the process. What would the success of the project look like?</p> <p>BO sees this as a journey, rather than a defined destination. There has been a lot of money put into a performance programme for which the benefits have been doubtful. This is looking to engage with the entire sector. Three parts: repository of well researched indicators, implementation of project via robust clinical networks in NZ, creation of standards. Currently have a strong primary care infrastructure and good IT tools. Wants national standards, local implementation and indicators.</p> <p>BO sees primary care driving the safety and quality process. Keeping people in the community, the safety agenda as part of the quality agenda is part of the patient safety and part of primary care. Anyone who ends up in hospital that</p>	

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<p>shouldn't is a lapse on the part of primary care.</p> <p>Fragmentation of primary care is difficult. Coming together around a common agenda of safety and QI, is applaudable. Again, the framework, plan is iterative, and needs the engagement and constituency. There is concern about what will be done; GP's have said they are doing a stock take. Simple things around access are issues, flow of information, and access to appropriate diagnostics for primary care. About ensuring there is enough support and tools to prevent unnecessary hospitalisations.</p> <p>How will this go across the entire sector? PHO seem to be the logical starting point; however there are so many more that can be involved. A critical role is patients themselves. We are moving into an environment where the community is starting to take care of itself, starting to be proactive. They need easy access to their health information. Consumer involvement is important.</p> <p>How will this plan engage and impact on NGO providers working in primary care and what will the links be to the PHOs?</p> <p>BO IPAC has used PHO and IPA members, sees this as a whole of the sector approach.</p> <p>The college spoke to the primary PHO forum and the chair is very enthusiastic about this and they have indicated they would like to be involved in some way. Generally support this, needs more details on some areas. Background on the quality issues in GP, what areas are acknowledged. Serious and sentinel events should be reported. It is suggested that the other parties are asked for contribution.</p> <p>Two requests, specific endorsement of the framework, and to be invited to the next meeting to give a wider contextual overview of the project.</p> <p>Wanted clarity on adverse events and definitions not the same as QIC definitions. Is looking for patient outcome indicators, and how this information can be transmitted to people using Cornerstone to improve both practice and patient outcomes.</p> <p>Significant synergy and outcomes from the programme, not necessarily from the Ministry driving it. The indicators have come up from a process noted in the document.</p> <p>Looking for the model of comprehensive care, or a better model in the end, better building blocks. Need improvement in capability and capacity which will bring more improvements, skills, understanding of outcomes, evidence of care, need to build these areas or a true result does not occur. New standards around clinical care will be appropriate as they will match what the journey outcomes create, Professional groups involved are great, identifies lacking in the underlying principles, what are the touchstones going forward? There is a tendency to make the approach going forward to comprehensive care. What is the problem and how will we know in three years time that it's worked? Having only a framework with no improvements for, is not a good deliverable. Opportunity for world class change.</p> <p>Need to see this as an investment. Still have an information gap between primary and secondary care.</p> <p>Hugely supportive of the concept, but not for the business case as it does not say what will be done and what patient outcomes will be achieved.</p> <p>Complex to bring primary care members together and get them into the same direction. QIC is committed to getting the right direction. PS believes we should engage with it, not toss it.</p> <p>Does want to see a successful primary care programme. Business case needs more focus, and this may be from further.</p> <p>The engagement needs to look at the "big" primary care quality items, then we need to look at what the problems are and what they relate to.</p>	

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<p>PHO has created a professionalism within GPs. Interested in measurement and is data driven. Any programme needs to measure the quality problems. Are these standards going to be professional standards, like midwifery etc? General practise is now about the practise team, the scope of the team, rather than the individual. Building blocks are in place, commenced in 1999 with Aiming for Excellence, and now are we getting value for money, is this good for patients. We are now back at the drawing board and looking at what pieces are missing. What is important is that there is a sense of confidence, by people who have been doing quality for a long time. Critique is from well earned knowledge, need to take it on board and look towards a closer working relationship to create an all inclusive approach to quality. Need clarity on the business case. Endorsement will happen, however, it needs to have more work. Need to add value from QIC to sharpen up what the College wants to do. Formal offer of support to sharpen up the process and QIC will make a resolution on how to make this happen. Congratulates RNZCGP on the work so far and for getting all the major primary care players engaged. There is overarching support and we need to take the critique and include in the design of the programme. <i>RNZCGP departs QIC continue discussion</i> Business case needs work and needs dovetailing into current work. Performance management framework has changed focus. How do we include this into the wider community, how do we become more inclusive, how do we use the existing frameworks. Cannot find concrete deliverables. Is the development of clinical standards actually part of the quality framework? What is the IPA / PHOs financial commitment? Need a common methodology across the sector. The current document does not reflect the previous discussions surrounding the plan. Need to support them to develop the business plan. Need to start at multi-disciplinary approach as a key principle with a proper quality methodology sitting underneath this. Once these are in place, then we have something more robust than is currently present. PS Suggest QIC and the RNZCGP host the primary care sector for dialogue and working to create a common output. Themes coming through: common robust methodology; RNZCGP may need some clarification of what QIC expects from this statement, QIC will need to have the principles set prior to the meeting, need to get the business case into a place where the national players can all comment on it, looking for a coherent primary care programme with resource to carry it through. Proposal is to put up problems in Primary care and how they see the way to address these. PS proposes that QIC formally offer support in continuing to develop the business case and suggests a further workshop to continue the work. Agreed.</p>	<p>GM, DG, prepared to support QIC in next steps for the business case.</p> <p>QIC can help by reframing the focus, PS, JS, JH and JP will also help.</p>
<p>8. Learning from the national Serious & Sentinel Events report PS need to demonstrate that the learnings from the last two years reporting are communicated to sector. Small group developing a format for summary of learning and recommendations for changing organisational systems to reduce events occurring. PS referred to a memo to the QIC from M Apa, Deputy-Director General, Sector Capability & Innovation Directorate re Implementation of Draft Policy on Management of Healthcare Incidents Policy and Release of 08/09 Serious and Sentinel Events Report. Content of memo noted and that the current process was an interim measure. Short-term, the QIC secretariat in MoH can look after it, until it finds a permanent home, unless a permanent home can be found immediately. QIC can take lead</p>	

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<p>agency role until an independent body is established. If it goes to DHB, then needs to be funded. Costings not readily available e.g. IT system needs to be costed and finalized IT specifications required to be able to make full costing. Limited approval given for six months for it to reside with MoH, until an independent body is constructed to take it over. QIC supports this on the basis that it goes to an independent agency. QIC asked that the email address be reportableevents@qic.co.nz</p> <p>Agree that the repository will be with the QIC secretariat for a period of six months prior to its repositioning with an independent body. PS moved and carried.</p>	
<p>9. National VTE programme – MS, VS Vinod made presentation on VTE. Group formed in 2007, three DHBs have formal guidelines. The programme looking at the prevention of VTE rather than purely treatment. If VTE recognised and treated early enough deaths are prevented. If the processes outlined were used for all admissions, then this could prevent many deaths each year. There is consensus around the table that this is an important improvement programme. It really indicates the need for a national patient safety agency. Agreed: 1st instance, endorsement of Vinod going back to colleagues to generate a formal recommendation that includes a cost benefit analysis, to QIC based on a consensus on how this is to be adopted and implemented. Then support with QIC advice to Minister. The number of preventable deaths should be analysed and added to business case.</p>	
<p>10. National Mortality review - CF CF spoke to the annual report of the Perinatal and Maternal Mortality Review Committee. Although the release of the report had been delayed because of concerns on the data contained in the report there had been little media interest in report once released. National workshop with media outlets to improve media reporting is in the workplan for the next 12 months. There is a view currently that all the national mortality review committees could be amalgamated. Some conclusions: early screening will assist, increasing post-mortem examination will help, paediatric pathologist services only half the country and needs extending, community deaths often not reviewed, preparation for obstetric emergencies requires constant training particularly for blood transfusions, support for families who have had babies who have died needs increasing and improving.</p>	<p>Secretariat to prepare report for Minister endorsing recommendations and stating that linkages between QIC and mortality review Committee's important.</p>
<p>11. Review of draft QIC annual report and workplan for 2009/10 Annual report drafted and circulated for comment. PS to draft Chair's introduction. Terms of reference will be added to final document. Workplan also being drafted. GB attempted to take the key tasks and put all work under the key tasks. DG wants to know if we should put all our eggs into the Q&S basket and make the workplan match the report to MAG. It is about an indication of the work intended to do and the known costs for meetings etc. GB will update and send out to QIC.</p> <p>12. Safe Surgery – Rose Gedden New Zealand Private Hospitals Association (NZPHA) happy to work with QIC on a national initiative to implement the Safer Surgery Saves Lives and the surgical checklist. NZPHA represent 24 organisations with 36 hospitals. Full endorsement received about six weeks ago. Whole hearted endorsement to join the initiative. They would like to formally present it to their membership in September; they have invited AM and Jim Bagian to this to endorse this further.</p>	<p>Secretariat will continue to prepare annual report and workplan.</p>

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<p>Many hospitals are already doing the work and are tweaking it; some do not see any difference to what they are currently doing. This is about doing it every time for every patient, systematically.</p> <p>How does QIC get each hospital to aid and implement this process?</p> <p>How does the NZPHA Board get their hospitals implement a new initiative?</p> <p>RG this is usually a directive from the CEO down. The board has larger hospital representation.</p> <p>What inducements would assist private hospitals to take this on?</p> <p>RG the Association would be the impetus, with hospitals following.</p> <p>Benchmarking with clinical indicators will be introduced.</p> <p>Need to "NZise" the checklist and need national agreement that this is the version to be used. This may be the role of QIC to standardise.</p> <p>RG offered to help standardise the WHO checklist.</p> <p>Need for a toolkit, to identify how to ensure this is in place.</p> <p>RG this is reasonable thing for their group to instigate.</p> <p>PS leaves meeting at 1555, GM chairs rest of meeting.</p> <p>13. HDC Case Discussion</p> <p>Significant systemic issues that compromised care in the emergency department in some wards, including workforce and capacity planning and models of care at North Shore hospital.</p> <p>DHB chairs recently met and discussed difficulties of reduced funding paths, Health and Disability Commissioner (HDC) will be looking for evidence that they had been putting up flags and a case for additional funding and what did they do if they didn't get the funding.</p> <p>HDC sees QIC as being a platform able to implement national changes.</p> <p>Need to raise the issue of the North Shore problems with the national group looking at ED issues. Can get greater flow and make this a better patient and staff experience.</p> <p>Suggestion that HDC could highlight parts of reports that he would like the QIC to consider and work on a national solution.</p> <p>14. NQIP update</p> <p>Reporting on progress of NQIP programmes postponed until next meeting.</p> <p>15. General Business</p> <p>Jim Vause has emailed resigned to PS, commenting on the low attendance fees as part of reason for resignation. Needs to formally resign to Minister, GB will follow up.</p> <p>Cheyne Chambers is moving to Melbourne, new representative of the Directors of Nursing will need to be co-opted.</p>	<p>JS to report feedback to Commissioner.</p> <p>GM to make the link at the ED group.</p> <p>Secretariat to contact JV and to write to CC1 with gratitude for her services.</p>
<p>Closure of Meeting GM: Closes meeting at 4:25 pm</p>	

Next meeting
28 August 2009 in Auckland

Signed _____ Date _____
Pat Snedden (Chair)