



# Quality Improvement Committee

## Minutes

### Meeting details

Date and time	04 April 2008, 9.30AM – 5.00PM
Venue	Wellington Airport Conference Centre, Wellington

### In attendance

Committee members	Jean Hera (JH), Nick Baker (NB), Alan Merry (AM), Mary Seddon (MS), Robin Youngson (RY), Pat Snedden (PS), Barbara Crawford (BC), Judi Strid (JS)
Secretariat	Gillian Bohm (GB), Katherine Klohn (KK)
Guests	David Gallar (DG), Muarry Gorgell (MG), Margie Apa (MA) arrived 11:03, David Waters (DW) arrived 11:25, Chai Chuah (CC) and Paul Cressey (PC) arrived 11:40, Michael Buist (MB) arrived 12:55, Dougal McKechnie (DM) arrived 3:18
Apologies	Cindy Farquhar (CF), Kevin Hague (KH), Jim Vause (JV), Barbara Greer (BG), Catherine Rae (CR), Cheyne Chalmers (CC1)

Summary of discussion and decisions	Action points
<p><b>1. Meeting Opening</b> Meeting opens at 9:33am PS opens by thanking everyone in the health sector for all of the work they are involved in - all the care they administer and all of the people they treat.</p>	
<p><b>2. Apologies</b> Cindy Farquhar, Catherine Rae, Kevin Hague, Barbara Greer, Jim Vause, and Cheyne Chalmers</p>	
<p><b>3. Health- life Reflection – JS</b> Current events feel like a water shed for the consumer sector, and QIC is providing a window of opportunity for consumers to achieve what they've wanted to achieve for decades- this is a real turning point. She has the utmost confidence that great things will be achieved through QIC seeking funding and supporting the establishment of a national consumer entity and the activities described in the proposed business case.</p> <p>Satisfying to see that consumer perspectives are being taken seriously. This reassures consumers and shows there is common ground amongst consumers and health and disability providers in taking steps to strengthen consumer voice.</p> <p>There has been a burst of enthusiasm around evidence based approaches that consumers have been asking about for decades. It is satisfying to see consumer desire for information about effectiveness is finally being taken into account</p> <p>So far the consumer sector has taken great strides, and with further support from QIC she thinks great things will happen.</p> <p><u>Chair asks for any comments:</u></p> <ul style="list-style-type: none"> <li>JS is thanked and members are in agreement with her assessment.</li> </ul>	

Summary of discussion and decisions	Action points
<ul style="list-style-type: none"> <li>▪ Can remember back to when the consumer voice was “hard to hear”, and it’s impressive to see how far we’ve come.</li> <li>▪ Paper by Atul Gwande is good example of how the consumer voice changed obstetric care.</li> </ul> <p>PS thanks JS for her health-life reflection.</p>	
<p><b>4. Matters arising not covered in the Agenda – PS</b></p> <p>Members noted: When are we going to think about doing more beyond the five business cases?</p> <p>Activities around the primary care need greater definition and engagement of people in quality and improvement programmes.</p> <p>KH is on long term leave and has been given permission by the Minister not to attend QIC in the meantime. KH was also CEO representative on Safe and Quality Use Medicines Group and this role will also need a replacement. Possibility of creating a video around training people to deal with serious and sentinel events. Committee agreed this was a good idea. We also need to seek views of the College of Anaesthetists re incident reporting.</p>	<p>Chair to co-opt CE to QIC</p> <p>Chair to advise film company of committee approval</p>
<p><b>5. Chair’s Report – PS</b></p> <p>1. Activities following the release of the DHB Serious and sentinel event reports</p> <p>Feedback from sector that the process went well. The event has built a coalition of interest, people came together and worked together well. The DHB Chief Medical Advisors, Directors of Nursing and Quality and Risk Managers are beginning to know one another and coming together and becoming champions for one another. QIC hosted a meeting to plan actions for release of DHB reports of serious and sentinel events occurring in 2007/08 BC and GB to report on this later in agenda.</p> <p>2. Whanganui DHB Board meeting</p> <p>PS and DG were invited to attended and provide a presentation on the role of the Board in leading quality initiatives. PS commenced the session speaking about Quality leadership - comes from personal commitment and coherence of the Board to push and promote it; the Board needs to have coherent views on how to manage its quality process in order to drive this to others; the difficulty of holding others to account for quality outcomes if the Board doesn’t hold itself accountable for quality outcomes. PS sees his responsibility as chair of QIC to promote leadership (and coherence) of the Boards. This meeting experience helped to ensure this is at the top of his priority list. We should be promoting quality governance processes in the sector more e.g. the interaction between CEO (management) and Board (governance).</p> <p><u>Summary of discussion:</u> Could we offer training to CEOs and Boards? DHBs, particularly small DHBs, need to look beyond their geographical constituency to provide quality services, but elected members may not have this focus, so there is potential for a lack of public accountability. We need to provide</p>	

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<p>leadership to help DHBs - is this Committee in the appropriate place to have an overview and provide advice?</p> <p>3. Minister's aspirations for QIC The Minister is very keen to see rapid process on all fronts around the Quality agenda.</p>	
<p><b>6. Meeting minutes format – PS</b> The Committee would like to see the minutes in a more narrative style. They would like a brief set of minutes that summarise the key points and reference points and highlight the actions to do. However, the Committee recognizes that the minutes need to be transparent enough for public to know the Committees discussions and decisions and the risk of briefer minutes giving rise to perceptions of “hidden agendas”. The Committee should summarise key points at the end of each section to include specifically in the minutes.</p> <p><b>7. DHB CEO Presentation – MG</b> What Quality looks like in MG's DHB- (MidCentral DHB) from a DHB perspective: Quality &amp; Improvement is alive and well at Mid Central DHB. MidCentral DHB's approach is that quality should be an everyday integrated approach, and therefore MG has no formal presentation to emphasise that quality shouldn't be on a pedestal- it needs to be a conversation.</p> <p>MidCentral is an average size DHB with a general population distribution and pockets of population. Over the past few years it has taken a very strategic perspective on what's required in a for long term health and disability services.</p> <p>What does Quality mean to MidCentral DHB: There aren't separate programmes, separate regimes. The services need to be safe for patients and staff, and there is a coherence of this approach amongst everyone involved. Also, they need to view this from the responsibility of a funder.</p> <p>Their achievements:</p> <ul style="list-style-type: none"> <li>▪ Clinical governance- they have clinical boards with cross membership and all aspects you would expect to have (peer reviews, credentialing, audit, professional standards like accreditation). They also have a structure of partnership between group managers and services (which embraces professional clinical leadership).</li> <li>▪ A number of initiatives- one could even term them 'quality' initiatives because they are making things better for patients and consumers. They have taken a transparent approach to reporting every quarter (the recent sentinel events weren't such an issue because they deal with them every quarter).</li> </ul> <p>Their challenges:</p> <ul style="list-style-type: none"> <li>▪ Tensions between being open and avoiding repercussions, especially by the media.</li> <li>▪ Continuous, that is small steps, improvement is great, but is often not recognized in the short term.</li> <li>▪ Tension between local, regional, and national objectives.</li> <li>▪ Issues around workforce and workforce numbers (which is bad because they may be tempted to take shortcuts).</li> <li>▪ Ranking/Rating- We live in a small country, so when ranking occurs many</li> </ul>	<p><b>PS to work with the Secretariat on minutes format.</b></p>

Summary of discussion and decisions	Action points
<p>will be thrown below the average (which may spur people on to improve), but everyone can't be above average.</p> <p><u>What culture does MidCentral promote:</u> Quality is a part of everything they do. They are primarily patient focused, followed by a 'service improvement' philosophy Everyone needs to be held accountable for professional responsibilities. Quality is a part of everything they do every day. If the DHB is doing something that doesn't contribute to this, then they should re evaluate what they're doing.</p> <p><u>Chair asks for any comments:</u> Likes the notion of quality as being a part of the "life-blood", but do you have some sort of Quality framework since there is no "definition" of quality?</p> <p>MG: Yes, there is a quality plan and framework, but he still doesn't allow quality to rest on a pedestal, this definition helps simply in regards to reporting to the Ministry about quality.</p> <p>Quality should be special though or it may get swept under the rug. Have you educated your staff about Quality &amp; Improvement tools?</p> <p>MG: There has not been enough training, and there have been issues at various levels over the past years, this is something that needs to be worked on.</p> <p>It is impressive that every three weeks MG meets the employees that come into the organisation and that he reviews all of the HDC complaints that come through. RY worked in a highly successful clinical management partnership during the development of a new acute hospital where there was no separate "Quality" infrastructure. It was just a transforming principle of everyday business. He knows that a beneficial partnership is possible, so it is frustrating to see when it is torn apart and not working.</p> <p>Do clinical partners have financial authority and responsibility?</p> <p>MG: Yes</p> <p>This could lead to problems because many doctors argue that the financial matters are not their responsibility. Some clinicians feel disempowered and disaffected- it is asking too much of them to take a stand on important quality issues as well as financial issues. Very few services have strong leadership that can receive funding without a "cap in hand" approach to management, and clinicians get frustrated because they have their eye on the outcome of improvement but managers have their eye on the outcome of the bottom line.</p> <p>CMDHB is testing a combined management and clinical committee that puts everyone around the same table and avoids splitting them up. It's time that many clinicians step up and help improve the systems.</p> <p>MG: As a CEO he would prefer to deal with this at a more distributed level, a shared responsibility (ie, how you want to employ people has resource consequences).</p> <p>How does MG monitor quality outcomes? How does he know that quality has improved?</p> <p>MG: Everything they do needs to be improved upon. In the DAP there is a list of</p>	

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<p>things that need to be done, and every one of these has a quality aspect to it that is reported on back to the Committee and Board.</p> <p>However, in personal experiences there has been a wall of silence around particular adverse outcomes. Where does the blame fall? He does appreciate the work that is going towards this, but one also must realise there are still problems evident. Things aren't always rosy, but we must learn from these experiences.</p> <p>PS: Thanks to MG for joining us.</p> <p>PS: Welcomes Margie Apa (MA)</p> <p><b>8. Draft Consumer Participation Business Case</b></p> <p>JS's tabled and circulated a diagram of the interface between work that QIC is supporting through the consumer business case and other web-based initiatives. [appendix 1]</p> <p>The business plan needs to achieve sufficient resourcing for the Consumer Collaboration to be established, to provide funding for the 3 priority workplans a Consumer summit, and to achieve the development of a National Consumer policy. This will not be handed to a lead DHB as with the other business cases. In this case the National Consumer Collaboration will be responsible (once it has been formally established as a legal entity) to move these actions forward. JS is looking for someone from QIC to be involved with the Strengthening Consumers' Voice Partners Group which has been set up to work alongside the interim Planning Group to ensure the interest amongst partner groups is maintained.</p> <p><u>Chair asks for any comments:</u>  There are comments and questions around the detail in the business case, but definitely not in the "direction of travel". Good proposal but some review of costing needed.  The business case needs to have more detail on costs listed such as what is the "connecting effectively" workplan and what exactly this funding will be spent on?  The proposal needs to show how the Collaboration links with other consumer work in the sector to avoid crossing over other groups' responsibilities.  There are existing consumer organizations that hold National contracts so need to show the linkages and how the Collaboration focus and activities are complementary to other consumer initiatives.</p> <p><b>9. Quality Improvement Indicators – DW</b>  [MS to Chair while PS is in a meeting]  Report circulated with agenda.  A working group of the QIC has been meeting via teleconference since the last meeting. The group had hoped that there would be a nice meshing of indicators currently collected in NZ with sets of indicators recommended and/ or collected in other countries, but this did not occur. Group have spent most time reviewing "clinical indicators" but surveys or assessments of safety cultures are also a way of measuring quality improvement. QIC were asked to consider :</p> <ul style="list-style-type: none"> <li>▪ Do we invent a new set of Quality &amp; Improvement indicators for NZ DHBs?</li> <li>▪ Do we adopt an international set that has been tried and tested? (ie, OECD [and NZ already reports on a number of these indicators], AHRQ [which also works well with Management of Health Care Incidents], and WHO Statistical information system) Can an international set be applied to the NZ</li> </ul>	<p><b>Secretariat to review and update costing in the business case with JS.</b></p> <p><b>Update business case to be circulated to QIC .</b></p>

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<p>DHB environment?</p> <ul style="list-style-type: none"> <li>▪ Do we consider a different approach (along the lines of NHS Star ratings)?</li> </ul> <p><u>Chair asks for any comments:</u></p> <p>We need to be getting this right and respond to the request of Health and Disability Commissioner Ron Paterson. We should use the expertise of QIC to help make determinations on the way forward. If this process is to take a longer, we must offer an explanation.</p> <p>QIC must be clear what the purpose of collecting the indicators is- and if it is quality improvement, then ensure the indicators measure this. The following indicators are recommended:</p> <ol style="list-style-type: none"> <li>1. Surgical site infection</li> <li>2. Central line associated bacteraemia</li> <li>3. MRO cross-infection: MRSA Infection Rate</li> <li>4. Mental Health</li> <li>5. AMI 30 day mortality</li> <li>6. AMI bundle</li> <li>7. Stroke bundle</li> <li>8. Medication errors</li> <li>9. Lung Ca % of patients receiving treatment within 8 weeks of first referral to specialist clinic</li> </ol> <p><u>Reasons these indicators were chosen:</u></p> <ul style="list-style-type: none"> <li>▪ Some of these indicators link process to outcomes.</li> <li>▪ Wanted to pick one with long wait times in NZ (like Ca lung).</li> <li>▪ Picked one of the surgical site indicators.</li> <li>▪ Picked one to compare to the Australian indicators.</li> <li>▪ Wanted some sort of mental health reference, which is a large cause of morbidity and mortality.</li> <li>▪ Included a more refined mortality indicator (This measure is important for a National level, but is it important for quality?)</li> </ul> <p>NB: [Declares conflict of interest since he is the Chair of the Steering Committee of the NZ Child and Youth Health Epidemiology Service.]</p> <p>We have 21 different DHBs with 21 different definitions, but this group can help find the right indicators and make it uniform around the DHBs. They could set Quality &amp; Improvement indicators against the child and youth health indicators to compare, but CYH doesn't work on process indicators.</p> <p>If we try to get an indicator for every service this would overwhelm providers. The Minister has asked for a short list of indicators that are comparable across DHBs.</p> <p>Do we need Primary Care's input as well? These indicator definitions need a workshop with the right people representing and some face to face work. Also, what are we currently collecting that we can stop collecting?</p> <p>Note that the Minister has asked for indicators on QUALITY IMPROVEMENT and indicators that drive quality improvement. Are we getting the right mix?</p> <p><u>Points to consider:</u></p> <ul style="list-style-type: none"> <li>▪ We should create indicators that reflect QIC's work priority areas, and then we can add on other important indicators later. We should take a staged approach and look at indicators for each of our programmes (the QIC business cases).</li> </ul>	

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<ul style="list-style-type: none"> <li>▪ We need to take into account indicators that are of interest to the public.</li> <li>▪ We should look at linkages as well. We need to consider what's currently being collected and what we can stop collecting.</li> <li>▪ We can provide a workshop and survey for DHBs. We will also need a measure that will give us a handle on whether DHBs are working on what they should (and making sure they are doing what we have intended).</li> </ul> <p>QIC needs to get together and figure these indicators out. These indicators need to be formally communicated to the Minister who has asked for them.</p> <p>NB The NZ Child and Youth Epidemiology Service has a meeting with all DHBs over indicators and prioritization on 29 May, should he bring GB and DG along and add the topic of Quality &amp; Improvement to the agenda?</p> <p>DW to talk to Colin Feek about what the Ministry is already collecting, collaborate with him, and add a QIC perspective to what he's collecting.</p> <p>The HDC has indicated concern on the lack of measurement and monitoring of surgical site infection, and although this is a challenge, this indicator will be a part of the infection prevention and control programme. The aim will be to have indicators ready for operational impact post 01 July 2008.</p>	<p><b>Further work on developing indicators for the national quality improvement programmes required.</b></p> <p><b>Create a small sub group from QIC to develop indicators.</b></p>
<p><b>10. Rapid Response Teams – MB</b>  MB introduced by DG and MB delivered a presentation on rapid response teams.</p> <p>MB is the founder of Patientrack software 2003, which focuses on issues of delay and handover in patient care. They aim for a reduction in incidents; however, this is only a tool and not a solution.</p> <p>Patientrack provides automated clinical communication and real time clinical governance. It is a research tool that enables a better understanding of the complex relationship between patients and clinicians. MB's presentation addressed the universality of this problem and showed a way in which to solve this problem.</p> <p><u>Chair asks for any comments:</u></p> <p>This is a useful tool for QIC to consider.  When considering electronic data, we need to look to issues of politics/culture. Do we necessarily need an electronic solution? Most members agree it is good to have electronic access to data that can facilitate learning.  Suggestion made that QIC may progress discussion on an Early Warning System (EWS) and issues of MET failure in QIC this year.</p> <p>PS: Thanks to MB for the presentation.</p>	
<p><b>11. Implementation of the National Quality Improvement Programmes, report from the National Steering Group – CC</b>  [Powerpoint presentation appendix 2]  Five QIC projects (the QIC National Quality Improvement Programmes)</p> <p><u>Presentation covered:</u></p> <ul style="list-style-type: none"> <li>▪ Governance and Accountability (A National Steering Group has responsibility for oversight of programmes, and SQUM needs to be a default member.)</li> </ul>	<p><b>Secretariat to obtain copy of CC's presentation and email or post to QIC members.</b></p>

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<ul style="list-style-type: none"> <li>▪ CFA variations – process on track for May update</li> <li>▪ Development of the project plans for each programme.</li> <li>▪ General issues: <ul style="list-style-type: none"> <li>○ The set up of structures is to be completed by end of April.</li> <li>○ From May onwards the focus will be on implementation.</li> <li>○ There will be ongoing communication on the priority of these programmes to the sector</li> <li>○ There will be linkages with national information archives.</li> <li>○ Each project’s steering group will be broadly based.</li> <li>○ They will offer pilot site opportunities to all DHBs.</li> <li>○ Each programme will have a different approach. For instance, Safe Medication Management will have a “programme approach”.</li> </ul> </li> </ul> <p><u>Chair asks for any comments:</u> Are there any issues around expectations, problems, control, etc?</p> <p>It was noted that Waikato DHB had contracted Communio to manage the Incident Management Project. When QIC programmes are contracted out to a third party, there needs to be clarity re responsibility for programme leadership and communication. (There must also be clarity of communication between the national and project steering groups.) Work is being done, but CC needs to push it to make it more visible for CEOs. He would like to see alignment of QIC and CE expectations and make sure both are heading in the same direction. Currently there is a challenge with communication. We are in the set up phase so we should give a bit of lenience with the communication. However, when things get started up there should be no excuse. There is also a challenge for CEs to keep the programmes as a priority. QIC needs to be informed on the project plans, future developments, etc. The project plans need to reflect the original intent of the QIC business cases. It was agreed that a member of QIC be on each of the programme steering groups:</p> <ul style="list-style-type: none"> <li>▪ Incident Management- BC (invited to be on steering group in place of MS)</li> <li>▪ Patient’s Journey- DG</li> <li>▪ Safer Medication- MS</li> <li>▪ Mortality Review- NB</li> <li>▪ Infection Control- CR (will need to ask her since she is not present to discuss)</li> </ul> <p>PS: thanks CC for his presentation.</p>	<p><b>The national quality improvement programmes to be a standing agenda item with an update from the National Steering Group at each QIC meeting.</b></p> <p><b>The project plans to be forwarded to QIC for circulation to QIC members.</b></p> <p><b>A member of QIC to be on each of the programme steering groups</b></p>
<p><b>12. Introduction of Margie Apa, DDG</b> MA spoke about the structure and workplan of the Sector Capability and Innovation Directorate. The Quality Improvement &amp; Innovation Team within this Directorate provides the QIC Secretariat. A new manager, Alan Spinx, has been appointed. MA is keen to collaborate with QIC on the Quality Work Programme and obtain guidance on areas that need focus. The Minister is providing sense of urgency and requesting “traction” in this work. MA wants to invest in leadership development within the sector and test the idea of “innovation hubs” with the sector. Colin Feek is the director of clinical benchmarking in the MOH and encourages QIC to obtain an update on his work.</p>	<p><b>Colin Feek and Vladimir Stevanovic to present to the next meeting.</b></p>
<p><b>13. Accountability Mechanisms – DG</b> Paper tabled and circulated [appendix 3] The Ministry is preparing a paper for the Minister to present at Cabinet regarding</p>	

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<p>accountability mechanisms. It is a structural issue which needs a mitigation plan. There should be a local responsiveness to population needs. DG is happy this includes public reporting and that quality is finally on the agenda.</p> <p>We are looking for levers to drive greater collaboration between DHBs [see DG's handout]</p> <ul style="list-style-type: none"> <li>▪ No one approach to performance improvement is likely to be sufficient; rather, several interventions will be needed, including Ministerial leadership and direction.</li> <li>▪ The paper identifies “arrows that the Minister has in his quiver, and how and when should he choose to fire those”.</li> <li>▪ Challenge: given the diversity of 21 DHBs and 82 PHOs, we will need a range of mechanisms that will fit all of these given where they are at developmentally.</li> </ul> <p><u>What do the levers and accountability mean for CEOs and Boards?</u></p> <ul style="list-style-type: none"> <li>▪ There need to be different types of levers that are developed for different organisational cultures.</li> <li>▪ With a financial incentive, there is always the risk that they are only doing it for the money.</li> <li>▪ Organisations that are further away from total quality integration will need more rigid incentives, and as they develop we can move further away from these more controlled options.</li> </ul> <p>We need to focus on the context and provide advice to the Minister on levers and targets that match the underlying culture of the organization.</p>	
<p><b>14. HIS-NZ ePharmacy (HISAC) – PC and DM</b></p> <p><u>HISAC's approach to information management in New Zealand</u></p> <ul style="list-style-type: none"> <li>▪ There are two different international approaches, and NZ's point to point approach is more successful than the UK's centralized approach.</li> <li>▪ We should utilise a universal ePharmacy message, which will tie in closely with Safe Medication Management, and it will be used across the sector.</li> <li>▪ Part of their agenda is to get international outreach, which means ONE universal medication list. Working at senior levels of government is the most effective way to work this.</li> </ul> <p><u>Resolution by PS:</u> QIC will endorse the universal medicines list presented by HISAC and HISAC should come back to QIC with a business model for ePharmacy. QIC will make it a mandatory requirement of the Safe Medication Management programme to adopt this universal medicines list as a foundation.</p> <p>PS: thanks to PC and DM for their work.</p>	<p><b>PC to send PS an email about eMedicines.</b></p> <p><b>HISAC will inform QIC on progress of eMedicines and ePharmacy.</b></p>
<p><b>15. Reports from the Chairs of CYMRC and PMMRC – NB</b></p> <p><u>CYMRC report</u> <u>NB tabled and circulate a report [appendix 4]</u></p> <ul style="list-style-type: none"> <li>▪ There is a need to set up processes to ensure national consistency and quality with local review groups so we don't get 21 different styles of local mortality review.</li> <li>▪ NB and the Data Group are working very hard to report to the Minister on 2006 and 2007 deaths at the end of 2008, a two year report, to catch up and ensure timely reporting in future years.</li> </ul>	

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<ul style="list-style-type: none"> <li>▪ CYMRC wishes to further the Committee's goals with the release of non personal data around issues of public health importance, to support good practice and systems change.</li> <li>▪ There will be a roll out of local mortality groups to all DHBs as currently only 11 have groups. CYMRC will need to assist in their mentoring and training, or will they need a lead DHB for this? Or is the business case funding for local coordinators only?</li> </ul> <p><u>PMMRC report</u>  <u>NB tabled and circulated a report on behalf of PMMRC [appendix 5]:</u></p> <ul style="list-style-type: none"> <li>▪ The PMMRC local review groups and network was easier to establish because there was already a ground swell of support.</li> <li>▪ A major issue: there is only one paediatric pathologist in the country, resulting in problems of cover and continuity.</li> <li>▪ MA has had meetings over the paediatric pathology issue. PS encourages a conversation between MOH and PMMRC/CYMRC to discuss this.</li> <li>▪ PMMRC is concerned about the lack of clinical support for CYMRC and PMMRC secretariat - MA will bring this up to Janice Wilson.</li> </ul> <p>PS acknowledges the receipt of both PMMRC and CYMRC reports.</p> <p>In regards to CYMRC, PS endorses the request of NB to support a National Standards of Implementation of the collection of Mortality data. This needs to be DHB wide throughout the country, and size doesn't matter. Whatever training and support infrastructure is needed should be included in the workplan. NB has full support from QIC in regards to nationally consistent forms of data and getting coherence amongst the 21 DHBs. QIC supported the request for CYMRC to be able to become responsive and informative to the public on issues of public health importance.</p> <p>In regards to PMMRC, PS endorses that the Committee secretariat support will be inclusive of clinical support.</p> <p>With regard to both PMMRC and CYMRC the maintenance and development of an appropriate paediatric pathology workforce to allow timely access to appropriate post mortems in every part of the country, especially for infants and complex cases, was seen as a very important issue. QIC needs to make sure that steps are taken to develop a sustainable service for the whole country.</p>	
<p><b>16. Combined meeting 27 March 2008 report back – BC and GB</b>  Report of meeting tabled and distributed [appendix 6]</p> <p>This was held in order to obtain agreement on the definitions of serious and sentinel events and the processes to be used by DHBs to report these centrally for the next twelve months. The format for the next report on serious and sentinel events occurring in 2007/08 was agreed.</p>	
<p><b>17. Planning for the sector quality event, report from the sub-group – RY</b>  A draft programme was tabled and circulated [appendix 7]</p> <p>The morning of this event will be used to set out information on the major programmes. Should there be a presentation for regional chairs and CEO groups?</p> <p>Since there will be a large number of groups present there is a risk of divergent</p>	

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<p>viewpoints not being heard. QIC could contract Synergia to help facilitate the dialogue to strengthen engagement with the many parties who will need to support national quality improvement programmes. We will also need to talk about critical elements for success.</p> <p>Moreover, we should note the number of "Quality" events that are coming up and take these into account and try to avoid an overlap. [see handout "Planned Quality Related Events in 2008"]</p>	
<p><b>18. QIC Annual Report – GB</b>  A draft Table of Contents was tabled and circulated [appendix 8]  Work has commenced on the drafting of the QIC report from February 2007 to June 2008, a first will be circulated to members by email.</p>	<p><b>Feedback on proposed Table of Contents to Secretariat</b></p>
<p><b>19. Further Items for Discussion – PS</b>  PS had received a proposal from a company to develop resources to teach people about responding to quality improvement and adverse events. PS will ask the company to develop a proposal around the key ideas for QIC.</p> <p>It was agreed that an allied health representative should be co-opted. Janice Mueller from ADHB is suggested.  It was recommended that QIC co-opt someone with expertise in Mental Health as well.  PS attended a meeting with the College of Anesthetists and discussed their approach to dealing with incident management. Including the need for standardisation.</p> <p>RY has been participating in activities to implement clinical governance frameworks work in Australia. QIC would like RY to feedback from that around what they are doing.</p> <p>PS suggests asking additional people to subsequent QIC meetings, they would attend the general meeting and Committee only matters would be dealt with after their departure.</p>	<p><b>QIC to co-opt an allied health representative and consider co-opting someone with expertise in mental health.</b></p> <p><b>RY to provide a presentation on clinical governance frameworks in Australia at the next meeting.</b></p>
<p><b>Closure of Meeting</b>  PS: Closes meeting at 4:41pm</p>	

<b>Next meeting</b>
20 June 2008 in Auckland



Signed \_\_\_\_\_ Date 20 June 2008  
Pat Snedden (Chair)

