	# Quality Improvement Committee

Minutes & Action Points

Meeting details	
Date and time	20 June 2008, 9.30AM – 5.00PM
Venue	Counties Manukau DHB, 19 Lambie Drive, Manukau, Auckland

In attendance	
Committee members	Jean Hera (JH), Alan Merry (AM), Mary Seddon (MS), Robin Youngson (RY), Pat Snedden (PS), Barbara Crawford (BC), Judi Strid (JS), Cindy Farquhar (CF), Catherine Rae (CR) arrived 9:45am, Janice Meuller (JM)
Secretariat	Katherine Klohn (KK), Alan Spinks (AS), Kathryn Baker (KB)
Guests	David Galler (DG), Cheyne Chalmers (CC1), Anne McLean (AM1), Geriant Martin (GM), Chai Chua (CC) arrived 12:45pm, Jim Bagian (JB) arrived 11:10am, Neville Habulous (NH) arrived 2:42pm, Maureen Robinson (MR) arrived 11:10am, Stellar Ward (SW), Diane Robertson (DR) arrived 11:10am, Lynne Lane (LL1) arrived 11:10am, Anne Kolbe (AK) arrived 3:40pm.
Apologies	Kevin Hague (KH), Barbara Greer (BG), Jim Vause (JV), Nick Baker (NB).

Summary of discussion and decisions	**Action points**
1. Meeting Opening and Karakia Meeting opens at 9:32 am	
2. Apologies Kevin Hague, Barbara Greer, Jim Vause, Nick Baker	
3. Health- life Reflection – PS It is important to have professionals' who are intuitive to the populations they are servicing. Health Care Aotearoa Nursing Forum is so integrated that it has a wide impact on health services. How do we remove impediments for Pacific peoples to get into the workforce?	
4. Confirmation of minutes 4th April 2008 meeting **Moved: That the minutes are a true and fair record with amendment.** *Proposed: PS Seconded: MS carried.*	Secretariat to post minutes on website
5. Matters arising not covered in the Agenda There were no additional matters not covered in the agenda.	
6. Chair's Report – PS We need to pay attention to the Primary Care Sector and look at the issues of quality, inviting players and stakeholders into instigating improvement. Would like to get participation from the primary care sector in discussion. Ron Paterson has been involved in two cases in private hospitals. Members agreed that the engagement of private hospitals is important. Create "committee only" space at next meeting where we reflect on the	PS to work with Secretariat to prepare agenda for August meeting.

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membership of QIC – ie. there are people that attend the QIC meeting in the role of commentators but not members. Perhaps instigate a formal expansion of this committee and advise the Minister. <u>Chair asks for any comments:</u> Involving Primary Health Care is important.	
7. Quality Improvement Indicators – PS / Saving 1000 Lives Campaign – MS and GM It has been difficult to get an agreement on a set of indicators to measure DHB improvement. We should try to dove tail the quality improvement indicators in each of the national programmes. CEOs, DoNs, responded positively to implementing indicators associated with the national quality improvement programmes and wish to apply the learning they get and offer it back into the national system. A group was charged to proceed on this in the northern region. Started as Save 500 Lives campaign and as it spread it became Save 1000 Lives. GM is the chair of the working group to implement a national framework to amalgamate with our existing programmes. Proposal for the establishment of a National Patient Safety campaign for New Zealand was tabled and circulated to attendees. Saving 1000 Lives Campaign – GM How do we harness the Quality, Improvement & Innovation work and create a framework and culture that creates change and lays a foundation. Find comparable indicators in the health system and integrate this into the system we have now. This programme was originally developed in the States by having a handful of measures that workers in health centres apply. The goal was to save 100,000 lives and the result was over 122,000 Americans were identified as being saved by the implementation of these measures. This campaign is not just to look at mortality but look at episodes of harm. By the clear and focussed implementation we can forecast the amount of people we will save through this campaign. It is important to do this now as the release of Serious & Sentinel Events reporting has provided the starting point – we can now move forward to provide support and cohesion for Quality Improvement Programmes. Taking the energy and enthusiasm and building it into a systematic approach so we can deliver on our goals. Doing this on a national scale will accelerate the learning and spreading good practices. We need consistent national goals but local adaptation. Sustainability by shared learning by nationwide faculty which creates culture change. This programme has borrowed heavily from the IHI, and we have adapted their 12 measures into 6 measures: 1. Patient Observations 2. Medication Safety 3. Surgical Complication 4. Cardiac Care 5. Health Care Associated Infections 6. Clinical Government & Reporting Some of these measures are very closely linked with existing QIC programmes (ie.	

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2 and 5). The other four are not yet implemented. Saving 1000 Lives will brand the individual QIC programmes as national campaigns. <u>Chair asks for any comments:</u> It is good progress on the work we are already doing. These priorities began implementation a while ago and it's a good idea to review the framework and implementation. It is important to give DHBs an overall view of how this fits into the bigger picture. This campaign has a proven track record of success and allows us to measure our quality levels with other countries. Regional collaboration is important. It is a good time for NZ to take this kind of approach and the model is coherent from a DHB and public perspective. Indicators are desperately needed and it is good to see them being compiled. There is little information on how this will work in action. How do we translate the vision into reality? MS – pg 10 shows implementation framework. How will the other sections of the health sector be included (eg. mental health)? MS – it is an area that does not currently have good measures and we may need to look at developing specific measures. Do we have to import every aspect of this and are we being too ambitious? Suggest that 6 measures are a bit ambitious. There seems to be a lot of overlap in the measures. There will need to be an overarching framework to pull it together. We need to be careful to align what we are doing, look at some of the measures and align them more closely to the work we are already doing. I think we still need to work on the measures. MS – This is not going to be a whole lot more work for DHBs, we are already doing two measures, the sixth is philosophical. The last three were selected carefully according to morbidity. The IHI launch for their campaign engendered passion within the sector. People were visiting hospitals to see it in action. The QIP programme for CVD and Diabetes will feed very well into this. We need to decide what is important and what isn't for this campaign. We should use these six measures to start off with, and once these are successfully actioned we can apply this methodology to other health issues. This is just a starting point. It currently exists mainly in secondary care. In very few places are there processes in place to improve primary care. This will provide tools for permanent culture change. It doesn't matter which topics this campaign addresses, once people can see the change their beliefs will be shifted to support it. I think we should be pragmatic about this and just do it. From the Northern Region point of view, this campaign is an opportunity for us to engage with the public. The methodology connects to many parts of the systems – clinicians, academics, politicians. Less is better – we should be very selective about the indicators. Faced with work force shortages, we need to consider the amount of work it takes to drive this change at the bedside. It should be implemented regionally. It would be unethical not to do it. We have enough expertise in NZ to adapt it to our health system. How can we implement this in a way that makes it easy for people to do the right thing? This needs to be presented to the public in a way they can understand. We need to see how consumers are involved in it. This will set a national standard for DHBs to measure quality. The Northern Region is seeking an endorsement from QIC for a national programme. QIC have identified priorities and this looks to be slightly swaying from what we have already decided upon. Taking on too many measures that move away from our original priorities may question our credibility as a Committee.	

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We need to address issues of focus and sustainability, we are not just drawing on IHI's experience – other countries have adopted this approach. It is politically dangerous to go out and measure a whole lot of things if you don't have a strategy to change them. A staged approach is important so people can see it is achievable. We need to be able to report back to the public about what we are doing. PS – There is broad support for the principle. We need to scope the programme – does it include the right things? Implementation – how do we make sure that we have a systematic approach that fits easily with programmes already underway? Need to design strategies for solutions to these issues. The Northern Region collaboration can meet with any member of QIC regarding implementing these indicators. MS – we need to get action on this in the next month. We cannot push this through without a considerable amount of thought. The ADHB has not taken part in reviewing mortality – if they are failing in that area how can they take this on as well? PS - General response was positive. Issues around the implementation and prioritisation of the additional topics. We will create a one-day workshop where we invite the main stakeholders of each NQIP project along with people from the Northern Region Collaborative, get their input and address the issues. **8. Workshop – Robin Youngson: Leaders in Healthcare** PS invited the Committee to enter into an open dialogue with reflections over the past year. RY There has been a paradigm shift in the sector. Is compassion a value missing in the sector? How to move forward from here: 1. Focus on core values 2. Initiate collaborative processes 3. Commit funding and resources to a national strategy. See background paper Appendix 1 for further information. <u>Chair asks for any comments:</u> Robin's honest and open disclosure is recognised. The Committee needs to identify what strategies we need to implement now? We are looking at a short term medical workforce crisis (a solution will require a multi-agency approach, on which we are procrastinating) with the vacancies with junior doctors and exodus with senior clinicians. It will require action from immigration, health, treasury to come up with some people to fill those gaps. We need to make the health sector a positive environment to work in. The current issues are generating negative behaviour like bullying. Why don't we have skills assessment for senior managers? Do we need training and assessment in place for managers? Do we need to form a professional group to set standards and train so we can teach these skills to senior clinicians etc.? PS – what is the experience of the Committee relating to this? Shared frustration with the culture of (*patient*) compliance in the health and education sector. Linked to this is the habit of blaming the patient. I love the idea	

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of standing beside current workers and assisting them to find a solution. A good slogan is "making it easy to do the right thing", capturing a good idea/practice, but making it easy for workers to apply instead of imposing it on people. Agrees with every that's been said in principle. Believes NZ has a good healthcare system, and believes it has the potential to be the best in the world. You need to engage the people in the health service to do it because they actually want to do the right thing for the patients. Clinicians and senior doctors have been dis-empowered. I think it is an important issue that needs addressing. The tragedy of our existence is that we always treat difference as deficit. Management needs to have training as they indirectly treat thousands of patients in their role. We are intellectually bankrupt – our problem isn't lack of money, it is lack of people (*with the right skills*). *We are already in a workforce crisis. We need to create a 'brain' in the sector*. Health workers lack the basic knowledge base – why don't 60% of doctors wash their hands in between patients? Why has it become acceptable to leave patients in the corridor? Why does the equivalent of a plane load of people are harmed every day in Auckland and we do nothing about it? Understands the need to train managers, but if we just train them and leave them isolated things will not improve. They need a support or network in place to create forward movement. If we do get a change in that area, how do we connect up? People working for change are isolated and eventually give up. A system is designed to achieve exactly what it achieves. South West NHS is currently on a drive for leadership improvement in order to change the system. We have a system, but it is not intentionally designed – it is an amalgamation of every party. There is a clear difference between true knowledge and regurgitation. The vision needs to be clear to those in the sector. Take a systems approach, sometimes training alone is not sufficient to fix the issue. Develop a system that allows people to see what it takes to get to our goal. Not everything should be standardized. This is the same discussion that is going on in every other sector. Lack of resources, people, commitment etc. There is a silo mentality whereby people think they're different and special – therefore the rules do not apply to them. Agrees with a systems approach for solution instead of leadership approach – need to get agreement on what we collectively want to do. We have been trying to articulate the clinician/leadership partnership. More than just doctor-nurse-hospital manager. We need to consider the partnership model a bit more creatively. Referring to the Patient 'A' Case, the hospital staff are so stressed that they don't have time to be compassionate. Where was the fundamental human respect for the patient? Middle managers are so busy trying to operate in the system that they force the rushed mindset down to staff. It has been very difficult to bring about change in the DHB. Leadership can not always be taught to a manager. Any culture change needs to be enforced on doctors as well. The role of influence in leadership is hugely important. The same issues are	

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apparent across the country. We can train managers, but less than 1% will apply what is learned. We need to hold managers accountable for best practice (as is done with clinicians). First, we need to establish the criteria. We need to integrate all the knowledge bases from the different parts of the sector – working in synergy. 1pm DG takes over chair. We need an element of structure and a plan to move this forward. Feels defensive regarding the comments on lack of skill in management. The existing culture demands managers who make the hard decisions rather than be compassionate. How many of the leaders here are mentoring and coaching future leaders? Are you doing it systematically? There is a science and practice of management and of leadership. It is more helpful to speak of "management" and "leadership" rather than managers and leaders. Create a partnership between clinicians and managers with leadership skills. Clarified training as experiential learning. How many of our leaders understand systems thinking? Identify what skill sets are needed for leadership. **9. Review draft QIC Annual Report** This was deferred to a future date. QIC members to send comments through to KK. **10. National Quality Improvement Programmes: report from the Steering Committee – CC** Earlier concerns of lack of buy-in by DHB CEOs have been addressed. Craig Climo to remain on the national steering group, and John Peters from NMDHB will also attend. Launch of the Management of Healthcare Incidents on July 1st, Minister of Health to attend. Need to make infomation on the QIP programmes easily accessible to public and health sector – will use QIC website and possibly develop our own. The focus should be getting the substance of each project underway instead of writing a massive amount of reports. How do we collectively bring the 21 DHBs along? Participation does not always mean buy-in. A lot of the programmes need to be clinically led.	PS to ask the Minister to make an exception for the appoint of members.
Chair asks for any comments: Does the Steering Group take an oversight in the programmes? The Mortality project listed is being led by the MoH. There is a genuine risk that if the national peri-operative mortality review committee does not get set up very quickly during this Government it may not happen for a long time. If people want input into definition of terms for new mortality committee submit comments to AM.	Standing agenda item for QIC members to present information from the Steering Groups
Is it possible to have reports on the project deliverables on each of the original business cases? We need to be careful not to write multiple reports to multiple audiences. We need to determine who the NQIPs are accountable to. We do not want to be process/bureaucracy orientated. QIC members on steering group committees report verbally to QIC committee.	Secretariat to inform Gillian Grew.
BC – Management Healthcare Incidents report back: going well, objectives are being accomplished. MS – Medication Management report back: the proposed timeline looks very	PS to request report on data from Infection Prevention and

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ambitious. The funding does not seem to be getting down to the DHB level. CR – Infection Prevention and Control report back: looking to appoint a project manager. Wanting to identify pilot sites within ADHB. Looking to put together a technical group. JS – Patient Journey report back: the collaborative approach is looking very promising. I am anxious that the patient has become invisible in regards to the written plan. Need to reconnect with the original business case. Need to get consumers on steering groups, possibly have a workshop to consolidate the consumer's experience. QIC members should note that they need to feed through ideas/concerns to the QIC representative for each steering group. Consumer involvement on steering groups is paramount and each steering group needs to make it a priority to ensure they have consumer input. Regarding format for deliverables, does QIC need to create a template for him to report back with? Contact: Kitty Bennett at Ministry of Consumer Affairs – is this the process that QIC endorses or via participant from consumers? What about feedback from consumer reps? Remuneration for their expenses and time? Discuss QIC's stance at the National Steering Group. Should these steering groups be consumer led? **11. Conversation with Jim Bagian** PS introduced Jim Bagian, Director of the National Centre for Patient Safety, Department of Veteran's Affaires If you give people sensible tools that will allow them to achieve what THEY want to achieve then they will use them. In his implementation experience, volunteers used the tools first. Ideas spread by word of mouth. Reporting is fuel for the improvement engine – must prioritise – have services report on the issues that they want to. Severity Assessment Code (SAC) is used to exactly describe incidents – you need to define actual levels in the SAC score, eg. catastrophic, severe etc. Two percent of all events reported get a root cause analysis, 40% of only have local review. 58% of these are falls, medication events, para-suicide (out patients), AWOL patients. Distribute a model of responsibility at a hospital level. 95% of the improvement effort is done at the local level. Recommends having a full time incident person at each DHB (Patient Safety Manager) in charge of putting together the SAC and to train a full time team to do a root cause analysis, present their recommendations to the CEO with specific people assigned to deliverables. CEO then agrees/disagrees and provides reasoning, then flows up to incident management group who assigns one person to analyse the response (takes about 40 work hours). CEO needs to concur on each point. Distributed model needs to be owned at a local level where everyone takes ownership. Most reporting comes from the in-patient area, although there are a few from out-patient and regulatory agencies as well. <u>Chair asks for any comments:</u> Is your focus specifically just the hospital or does it extend to primary health care? JB – we include the whole continuum of health care. However, most of them come from the in patients. Work with regulatory agencies. Protection against disclosure – Dept HDC is supportive of open disclosure. JB -	Control Steering Group. Secretariat to write a letter on behalf of QIC to Chi Chuah reminding the steering group to ensure consumer involvement in the development of the NQIP.

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VA has been doing open disclosure since 1982. Two levels of disclosure: 1. clinical disclosure – obligation to tell patient (but does not disclose the workings of the RCA, when this is done they pledge to share the learnings from this. Will not say who did what to whom, but to apologise, show results, proceed from the learnings), usually ends here. 2. institutional disclosure – remuneration and compensation. How do you deal with individual accountability? JB – ask questions of why – differentiate between systems and peoples issues, but 'whys' can take you quite a ways back – more productive to approach from a systems level. Determine what is blameworthy: "intentionally unsafe act" etc. **12. National Quality Improvement Programme: Management of Healthcare Incidents – MR and NH** Establish a function and technical IT system to manage incidents – what an IT system needs, not picking or implementing a system. Have established project team and steering group. 5 streams: policy, education and training, information systems specifications, project management and communications. PS – reporting process in real time, circulating through the whole health system. Giving MoH the ability to report back into the sector how similar events are occurring in the system. <u>Chair asks for any comments:</u> The concept is fine, my worry is about when you look at what the DHBs control/manage, then there is the other side that the DHB do not control. Why are the different areas all gathering info and what are they going to do with it? Where should the central repository sit? We don't have in place a culture of accountability. We need to communicate why we're doing this to the skeptics. In Jim Bagian's experience, he was initially met with indifference. The majority thought we shouldn't be doing this at all. Got them to think about how they would do it – let them come up with their own ideas until they find a system that works. Concerned about there being duplication with mortality review reporting. There needs to be legal protection for people otherwise they are unlikely to report. PS – we need to have CEO input post launch – get behind them with CEO network. QIC needs to now take this up.	MR and NH to come back to the next QIC meeting to continue this discussion.
13. Approval of Consumer Participation business case – JS <u>Chair asks for any comments:</u> Committee supports it and thinks the time is right for this to go forward. This is a significant step that is well overdue. PS moves that we adopt the programme. Seconded by BC. Motion carried.	JS to make refinements so the business case is consistent and accurate.
14. Reports from the Chair of PMMRC – CF Is it useful for QIC to receive reporting, and who specifically should receive it? Issue of confidentiality. CF met with Steve Chadwick and found she was very open. PMMRC have developed a report on "late" terminations for the Abortion Supervisory Committee. <u>Chair asks for any comments:</u> We need to discuss what we want to do with the reporting.	CF to circulate recommendation and executive summary of the annual report electronically.

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Possible working group with the mortality review Chairs to discuss their relationship with QIC.	
15. General Business and Correspondence – PS Letter from the Minister of Health to QIC circulated. Not for discussion today.	PS to send the letter with a draft of the original letter. PS to give indication of his response to the minister. Secretariat to send PS a copy of draft of the sector forum programme for circulation to Committee.
Closure of Meeting PS: Closes meeting at 4:50pm	

Next meeting
01 August 2008 in Wellington

Signed ____ Date: 1 August 2008
Pat Snedden (Chair)