

The Quality Improvement Committee

First Report to the Minister of Health
February 2007 to June 2008

Disclaimer

The Quality Improvement Committee prepared this report.

This report does not necessarily represent the views or policy decisions of the Ministry of Health.

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Chair's Introduction

This is the Quality Improvement Committee's first report to the Minister of Health. The report records some significant initiatives that signal a real sea change in New Zealand's progress in the quality improvement arena, and highlights key activities and initiatives that have been achieved since our establishment in February 2007.

There is increasing recognition and acknowledgement (both in New Zealand and internationally) about the need to have a focused and co-ordinated approach to quality improvement. The nature of health care delivery is changing rapidly. We are facing challenges such as increasing complexity of care, an aging population with long-term chronic conditions and a demand for skills that we are having difficulty meeting. It seems that these factors along with determined support from successive Ministers of Health have come together to provide the right environment to create pressure for real quality gains here in New Zealand.

The Committee has adopted a broad definition of quality that is systems wide and takes in elements of safety, best practice and value for money. This approach requires commitment from the entire health community to make it happen. That's why we have been actively partnering with key leaders, clinicians and managers in District Health Boards (DHBs) while our oversight extends outside the doors of the hospital into the primary health care sector.

More than ever quality is the effective tikanga base of the New Zealand health system. What's important is the outcome for the person being served and the effective management of that service in a way that protects them. The health consumer is central to our focus.


I am proud of the achievements of the last 18 months. In February 2008, the Committee released the *Sentinel and Serious Events* report. This report by DHBs in the 2006/07 year provides the first consolidated report about serious and sentinel events across New Zealand's 21 DHBs. It required collaboration and linkages across DHBs. We intend to release these reports annually, and over time we expect that reporting will improve and, therefore, our ability to learn from these events will also improve. The Committee has started work to establish a nationally consistent reporting framework that will provide impetus in this area.

The Committee has chosen to focus attention on areas that will provide the most benefit to improving quality care to consumers. We have established six national quality improvement programmes in partnership with the DHBs. These initiatives will be rolled out over the next two years.

We hope that these initiatives provide an impetus for DHBs to invest in other areas of quality improvement over the coming years. The Committee intends to partner with colleagues in the private and primary health sectors to support quality improvement initiatives in these areas too.

I would like to acknowledge and thank the members of the Quality Improvement Committee and the secretariat for their commitment and enthusiasm. The Committee has been able to build on the valuable work of our predecessors, the National Health Epidemiology and Quality Assurance Advisory Committee (EpiQual).

I look forward to continuing our work to improve the quality and safety of New Zealand's health and disability services.

A handwritten signature in black ink, appearing to read 'Pat Snedden', with a horizontal line underneath.

Pat Snedden

Chair

Quality Improvement Committee

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1 Background Information

1.1 Establishment of the QIC

The National Health Epidemiology and Quality Assurance Advisory Committee (EpiQual) was established under section 17 of the New Zealand Public Health and Disability Act 2000. It was appointed by, and accountable to, the Minister of Health.

In its second report to the Minister of Health in November 2006, EpiQual put forward two goals for 2007/08 to achieve its strategic objective of repositioning itself to provide sector leadership on quality improvement. These goals were to:

1. reconvene a newly appointed Committee and Chair under revised terms of reference; and
2. agree upon a new work plan with the Minister.

On 1 February 2007 the Minister of Health, Hon Pete Hodgson, announced new members and a new name for the Committee – the Quality Improvement Committee (QIC). The number of members increased from 10 to 13 and the specified composition of the membership changed to reflect the skills and experience required, including knowledge of consumer participation and advocacy.

The new Committee's role is to work across the health and disability sector (with a particular focus on hospital care) as both an advisor and a facilitator. The members of the QIC (the Committee) are listed in Appendix 1. A new work plan (largely based on EpiQual's recommendations to the Minister of Health) for the Committee was agreed in October 2007.

1.2 The QIC's terms of reference

The new terms of reference for the Committee are different from those of EpiQual. They apply a broad definition of 'quality' that is strongly associated with safety, value for money, people-centred care, high performance and best practice. Improving quality in health care is seen as a continuous process that must be supported by professionalism, technology, experience and a pervasive ethos of care.

The role of the Committee is to provide advice to the Minister on any health, epidemiology or quality assurance matter, as well as sponsoring, monitoring and evaluating programmes within the Improving Quality (IQ) action plan. The Committee must specifically deal with perinatal, maternal, infant, child and adolescent morbidity and mortality issues. The full terms of reference are attached as Appendix 2.

1.3 Key tasks

The key tasks for the Committee were also changed to reflect the new terms of reference for the Committee. The emphasis is on collaboration, and providing advice on priorities for education and research to support quality improvement. These activities will assist in the rapid implementation of innovation. The key tasks for the Committee are listed in Appendix 2.

1.4 Consumer focus

The Committee has adopted as a base principle that consumers will be central to all the processes, outcomes, relationships and linkages in their quality improvement projects.

2 Recommendations from EpiQual

The precursor to the Committee, EpiQual, made nine recommendations to the Minister of Health.¹ These recommendations formed the basis for the Committee's work programme and are summarised below.

1. Six priorities for quality in the health and disability sector were to be funded and implemented. These were:
 - the development and implementation of a nationally consistent approach to the management of healthcare incidents
 - the implementation of a national programme for the improved management of medications across health and disability organisations
 - the implementation of a national programme that is designed to improve the patient-centredness and flow of patients in the inpatient setting
 - the development and implementation of a national programme of infection protection and control
 - the provision of education and training in quality improvement methods for all health professionals
 - the implementation of a strategy for improving consumer participation in the health and disability sector.
2. Systems for reporting should continue to be improved so that reports on the breadth and depth of quality assurance activities could be directed to EpiQual for review and analysis.
3. EpiQual's membership was to include two Māori members.
4. The Ministry of Health should ensure arrangements were in place to provide appropriate support at the DHB level for the local mortality review process specified by the Child and Youth Mortality Review Committee (CYMRC).
5. All ongoing Ministry of Health strategies to prevent sudden unexpected death in infancy were to work in partnership with Māori and Pacific communities.
6. The Minister of Health should discuss with the Ministers of Police and Justice the need to encourage and support the collaboration between their respective government departments in order to advance the development of the health-trained assessor role.

¹ National Health Epidemiology and Quality Assurance Advisory Committee (EpiQual). *Second Report to the Minister of Health: May 2005 to November 2006.*

7. In 2007/08 the Minister should establish a New Zealand Adult Mortality Review Committee with a mandate to review deaths relating to anaesthesia and surgery.
8. The following activities should be included in the IQ action plan for 2007–2010 (in addition to the priorities listed in recommendation 1):
 - mortality review
 - chronic disease management (Leading for Outcomes)
 - enhancement of the processes for the management and maintenance of clinician competence (credentialling)
 - advances in information technology to improve patient safety.
9. EpiQual’s terms of reference were to be extended to:
 - providing independent advice to the Minister on quality improvement by analysing information and evidence on systemic quality and safety issues from a national perspective, and recommending system improvements
 - developing whole-system frameworks and integrative approaches to quality improvement that support and develop leadership, shared learning, culture change and trust, thereby quickening the implementation of proven innovation and practice
 - being active in building collaboration among national organisations to facilitate an integrated approach to quality and safety and to promote the dissemination of proven innovations
 - recommending data sets to better inform and monitor quality improvement, including the setting of targets and performance objectives for DHBs
 - collaborating with the Health and Disability Commissioner (HDC) in promoting the Code of Health and Disability Services Consumers’ Rights as a basis for continuous quality improvement and ensuring complaints processes link with systems improvement
 - providing advice to the Tertiary Education Commission and the Health Research Council on priorities for education and research in support of improvements in the health and disability sector.

3 Activities and Highlights

3.1 Sector leadership

Engagement and partnership

The Committee has a key role in facilitating and promoting quality improvement alongside others in the health and disability sector. The Committee links with the Office of the HDC and looks at ways areas identified by the Commissioner can be incorporated into the Committee's work programme. The Committee has also developed a good working relationship with District Health Board New Zealand's (DHBNZ) Safety and Quality Use of Medicines (SQUM) group. They have assisted SQUM in their initiatives, incorporating this expertise into the deliberations of the Committee.

At each of the Committee meetings a DHB Chief Executive Officer (CEO) has been invited to speak about quality issues, activities, systems and plans across the DHB, and to participate in a more general conversation on their views of the "quality" issues for the sector. Ministers and Ministry officials, including the Director-General of Health, have also attended committee meetings. A list of all guests and other attendees at the Committee meetings is included in Appendix 1.

The Committee is also well linked with international quality initiatives, such as those being run by the World Health Organisation (WHO), the United Kingdom's National Health Service and the United States' Institute of Healthcare Improvement. A good example of this is the Committee's involvement in the WHO Safe Surgery Saves Lives study, and other WHO patient safety initiatives.

Promoting quality improvement

The challenge of implementing processes across DHBs is evident to most who work in the sector. However, what is often under-estimated is the challenge of aligning the thinking within single organisations. Successful implementation will require parallel movement and commitment across the disciplines.

The Committee has hosted two meetings with the Chief Medical Officers, Directors of Nursing and quality and risk managers from all the DHBs. These meetings have provided an opportunity for this group to reach a common understanding of the goals set by the Committee and, more importantly, agree on the weight of focus that needs to be brought to these initiatives. This convergence in thinking will form a base from which the Committee initiatives will be advanced within DHBs.

As a result of these meetings, new levels of collaboration are occurring. For example, the Auckland-based DHBs have set up an informal group to undertake Auckland-wide initiatives.

Members of the Committee have also worked to promote quality improvement through speaking at numerous national and regional events. For example, the Committee's work has been promoted at Waikato DHB's Quality and Risk (Q&R) forums for staff, and at the Midland Q&R forum that Waikato DHB hosts in partnership with Pinnacle Group. Information about the Committee is also included in Waikato DHB's quarterly *Quality and Risk* newsletter.

The members of Committee have actively contributed to quality improvement initiatives in the areas of quality indicators, primary care and rapid reporting teams.

Sentinel and Serious Events report

In February 2008, the Committee released the *Sentinel and Serious Events* report. This report by DHBs in the 2006/07 year provides the first consolidated report about serious and sentinel events across New Zealand's 21 DHBs. It required collaboration and linkages across DHBs and with the HDC and Office of the Ombudsmen.

A serious or sentinel event has resulted in, or has the potential to result in, serious lasting disability or death not related to the natural course of the patient's illness or underlying condition.

Although hospitals have always collected data about these events, this is the first time the data have been compiled into one report with detailed summaries of each serious and sentinel event. The aim is to improve safety by encouraging open and transparent reporting of incidents when something goes wrong.

The report shows that in 2006/07, 182 people treated in New Zealand hospitals were involved in actual or potentially preventable clinical incidents that resulted – or could have resulted – in serious harm or death. Of these, 40 died as a result of the incident. Over that same period, more than 800,000 people were treated and discharged by competent and professional carers working very hard to save and improve lives. The full report is available from the website <http://www.qic.health.govt.nz>

In response to the *Sentinel and Serious Events* report, members of the Committee made presentations to a wide range of organisations and individuals. The Committee will also oversee the annual release of a sentinel and serious events report, and part of their work programme will see the development of a more streamlined approach to collecting and recording information for the report.

4 The Work Programme

The Committee have a focused and co-ordinated approach to quality improvement, recognising that health care has become increasingly complex and a strategic approach to quality improvement at all levels is vital.

In the first instance, the Committee's programme has focused on addressing the quality and safety issues within public hospitals because the greatest risks are in this part of the health care system.

4.1 Developing a set of quality indicators for DHBs

The Committee has established a working group to determine an initial set of quality improvement indicators to form part of a nationally consistent reporting framework. The data are to be collected nationally in order to monitor the quality of care in publicly funded hospitals. The end result will be a set of indicators showing national progress in quality improvement, which will be part of the wider report card on progress within the health and disability sector.

A review of evidence-based quality indicators that are internationally recognised was completed as a first step. A preliminary list drawn from various international programmes such as the Institute for Healthcare Improvement's "Save 100,000 lives" campaign was considered by the Committee. In the first instance they agreed that it would make practical sense for the initial set of measures to relate to the work being undertaken in the Committee's national quality improvement programmes.

The four Northern/Auckland DHBs have adopted a very similar set of indicators that will be collected from July 2008. The Committee intend to work with these DHBs to further refine the indicators so that a nationally consistent set is implemented. Priority will be given to those indicators that relate to the National Quality Improvement Programmes described later in this report.

4.2 Use of funding and accountability levers to support quality objectives

The Committee is promoting the use of multiple levers to support visible and measurable quality improvement. The Committee has recommended that the Minister support rapid diffusion and adoption of proven quality improvements by including reference to quality objectives in the following documents:

- Minister's Letter of Expectations to DHBs
- Monitoring Intervention Framework
- DHB Chief Executive Performance Agreements.

4.3 National quality improvement programmes

Six priorities recommended by EpiQual formed the basis of the Committee's national quality improvement programmes. These are:

- optimising the patient's journey
- management of healthcare incidents
- infection prevention and control
- national mortality review systems
- safe medication management
- improving consumer participation.

Funding of \$19 million has been allocated, and the Committee has chosen an ambitious approach to implement these programmes. Funding for running each of the national programmes has been devolved to a "lead" DHB, who holds full responsibility for project implementation and governance. It is hoped that this collaborative approach will demonstrate that working together provides an effective means of achieving quality improvement. This approach is different from past nationally organised projects that tended to be sponsored or implemented by the Ministry of Health. Consequently, there will be a formal evaluation of progress 12 months from the adoption of the improvement programmes.

A national steering group of CEOs from four DHBs and a general manager from the Ministry of Health provide governance and oversight for all of the improvement programmes. There is a member from the Committee on each of the programme steering groups.

These improvement programmes or "business cases" are described in more detail below.

Optimising the patient's journey

A key mechanism for improving the quality of patient care is to look at the patient's journey through the system from their perspective. This helps ensure that the patient's experience and the use of resources is both effective and efficient.

This project has established a national collaborative approach that is anticipated to take three years to complete. It will be conducted in two phases:

1. improving the patient's journey from attendance at the emergency department or outpatient service to discharge from that episode of care
2. improving the management of patients with chronic illnesses such as diabetes, asthma or depression who either present at the hospital for treatment or come from a community or primary care setting to the hospital.

In keeping with the Committee's approach to work with DHBs, this project is being led by Counties Manukau DHB.

The project plan for this work programme has been developed and was signed off by DHB chief executives on 29 April. The launch of the national programme is planned for 1 July 2008.

Management of health care incidents

Incident management is a key strategy being used by health services for managing the risks of clinical care, as well as corporate risks. When implemented correctly, it is an effective mechanism for systematically identifying and managing problems and failures in the system, and assisting with learning to prevent them happening again. It also guides the immediate response to incidents, thereby minimising further harm for patients and their families and health practitioners.

A vital component of this environment is that it is one in which "open disclosure" of an event happens in an open and truthful way. This can only occur if health practitioners and their patients believe that the culture is both caring and compassionate.

The national programme set up by the Committee has three components, described below. Funding and responsibility for this programme rests with the Waikato DHB.

1. Reviewing national policy and guidelines related to managing reportable events, including the principles and practices around the open disclosure of adverse events.

2. Providing a comprehensive education programme for health and disability providers on incident management. This will have a particular focus on investigating and managing serious events, for the purpose of identifying system improvements, reducing future patient risk, open disclosure of the results to patients and families and developing the confidence and communication techniques required for effective open disclosure.
3. Scoping of the business and technical requirements for a nationally co-ordinated incident information management system that meet the information requirements of all key stakeholders, including health providers, DHBs, the Ministry of Health, ACC, the Office of the HDC and the coroners.

This programme is under way, with terms of reference agreed and the steering group in place. The national launch of the programme took place on 23 June 2008.

Infection prevention and control

Infections that have been contracted in the health care system are a significant problem worldwide. Reducing these infections has been identified as a priority because of the disease burden and economic burden that these infections create.

At any one time, over 1.4 million people worldwide suffer from infections acquired in hospital and up to 10% of patients admitted to modern hospitals in the developed world acquire one or more infections. A New Zealand study in the late 1990s showed an estimated prevalence of 9.5%.

This aim of this project is to reduce the rate of hospital-acquired infections. It builds on existing DHB hospital hand hygiene programmes to implement a comprehensive hand hygiene programme nationally. A comprehensive approach is needed, and as a first step, the components of this national programme are:

- adoption of the WHO guidelines on hand hygiene, participation in the WHP High 5s Action on Patient Safety programme and implementation of a national hand hygiene campaign
- development of guidance on the prevention of catheter-related bloodstream infections, including piloting the guidance and finalising and publishing the guidance document
- review of current systems for surveillance of procedural and surgical site infections and recommendations for implementing a national surveillance system.

Auckland DHB has responsibility for this project. The project plan for this work programme has been developed and was signed off by DHB chief executives on 29 April. The project teams, steering group and technical advisory group are currently being confirmed, with work expected to be under way very soon.

National mortality review systems

The importance of systematic analysis of mortality is well recognised both nationally and internationally, and many countries have long-established mortality review processes.

Currently in New Zealand there is a national Perinatal and Maternal Mortality Review Committee (PMMRC) and a Child and Youth Mortality Review Committee (CYMRC). New Zealand lags behind other countries, notably Australia, in not having a national adult mortality review process.

Clinicians and professional colleges, societies and associations have identified the need for an adult mortality review committee and consider that the greatest priority should be to review peri-operative and anaesthetic related deaths.

This national programme has two components:

1. establishment of a national adult mortality review committee to look at peri-operative deaths
2. extension of the local Child and Youth Mortality Review Groups (CYMRGs) to cover all DHBs and to include appropriate review of peri-operative deaths in this age group.

The Ministry of Health is currently overseeing the appointments process for the National Adult Mortality Review Committee. The second component addresses one of EpiQual's recommendations, and the Ministry of Health is currently working with the Crown Funding Committee to confirm funding for the establishment of nationwide CYMRGs.

Safe medication management

Medication is one of the most common therapeutic interventions used in the health care system, and medication errors are common. Approximately 1.6% of people admitted to hospital may experience an adverse medication event. Of these events, the majority are preventable and occur inside hospitals. Preventable adverse events have a significant impact on consumers and their families, with about 3% resulting in death and 8% in permanent disability.

Several strategies have been proven to be effective for reducing the rate of errors in medication management. They include:

- the use of standardised medication charts across the whole organisation or sector
- continually and effectively reconciling a patient's medication list, particularly when the patient is being transferred from one part of the health system to another part
- the introduction of some safety mechanisms around the use of high-risk drugs
- verifying medications at the bedside, using bar-coded point-of-care systems
- using an electronic prescribing system.

This national programme is being run by Hutt Valley DHB and will implement strategies that have already proven to be effective in reducing the rate of errors in medication management. These strategies are described below.

1. **Medication chart:** This component will standardise medication prescribing in hospitals, and with built in safety features has the potential to decrease medication errors by up to 25%. It will form the basis for an electronic medication chart.
2. **Medicine reconciliation:** This component requires accurate collection of a consumer's medication history, which can then be accessed by health practitioners involved in their care.
3. **Introduce e-medication chart or e-prescribing or a clinician point-of-entry system:** Building on the significant progress made by the SQUM group, this component allows for the standardised chart to be put into an electronic form. There are other possible additions that build on the national medication chart and may involve e-prescribing or a clinician point-of-entry system.
4. **Standardised hospital medicine information systems:** Emphasis and effort will primarily go into implementing a consistent electronic prescribing system and ensuring that all information systems dealing with medicines use a consistent dataset of medicines.
5. **Package pharmaceuticals at unit of doses with barcodes or wrappers or labels:** In the short to medium term, this is likely to involve the purchase and operation of unit dose repackaging machines. The medium to long term may see the development of regulation for globally standardised barcodes to be printed on pharmaceutical packaging.

6. **Link all information systems connected with medicine management:** This component aims to link up patient management systems, electronic prescribing systems, barcode point-of-care (BPOC) systems and pharmacy dispensing systems using a common consistent dataset of medicines.
7. **Introduce bedside verification using BPOC systems:** Many of the other components will need to be completed before this can happen. Once it is in place, electronic medication administration records will be possible.
8. **Train and support DHB staff:** The features outlined in this business case will involve staff changing current work patterns. Attention will need to be paid to the associated change management process.

The project plan for this work programme has been developed and was signed off by DHB chief executives on 26 April. The project teams and steering group have been appointed. The launch of the national programme is planned for 1 July 2008.

Strengthening the consumer voice

As mentioned earlier in this report, the Committee has adopted as a base principle that the consumer will be central to all the processes, outcomes, relationships and linkages necessary for successful achievement of its quality improvement projects.

This improvement programme came about because of the increasing body of evidence that indicated health outcome benefits with consumer participation. It also reflects the priorities and aspirations of consumer representatives who participated in the Strengthening Consumer Voice summit. A first step is to establish a national consumer collaborative that will operate at a strategic level to co-ordinate and strengthen health and disability consumer organisations in their ability to provide a strong and collective consumer voice and provide a national access point for seeking consumer representation.

A consumer planning group has been established to assist the development of this national group whilst the Committee national programme is being finalised.

5 Future Challenges and Strategic Objectives

The Committee has set themselves an ambitious programme of work, and now has the challenge of ensuring that in among the myriad of activity, focus on the key objectives of the programmes is maintained. Specific challenges for the Committee are:

- continuing to engage with DHB CEOs to remain in touch with what is happening in DHBs, and the CEOs' views about the quality challenges their organisations face
- ensuring the original intent and focus for work programmes remain as they are rolled out
- monitoring the progress of the national quality improvement programmes so that the Committee can continue to provide appropriate advice and guidance to DHBs that are leading the work programmes
- engaging DHB boards to encourage their support of the national quality improvement programmes.

Key themes for the 2008/09 work plan build on the work programmes currently under way. These include:

- making the Committee's work more inclusive of, and relevant to, the primary sector
- linking with the private sector
- education and training in quality improvement
- establishment of rapid response teams.

The Committee is also interested in finding practical strategies that assist senior managers and clinicians to provide leadership for quality improvement and innovation in their organisations.

Appendix 1: Quality Improvement Committee Membership and Meetings

Membership

Pat Snedden (Chair)
Alan Merry
Barbara Crawford
Barbara Greer
Barry Taylor
Catherine Rae
Cynthia Farquhar
Jean Hera
Jim Vause
Judi Strid
Kevin Hague
Mary Seddon
Robin Youngson

For more information about the Quality Improvement Committee and its membership, see its website (<http://www.qic.health.govt.nz>).

Meetings

From February 2006 to June 2008 the Quality Improvement Committee met seven times in either Auckland or Wellington:

4 February 2007
30 March 2007
1 June 2007
3 August 2007
4 September 2007
30 November 2007
21 February 2008
4 April 2008
20 June 2008

Guests

At all meetings there were one or more invited guests who either listened or presented to the Committee. Guests and other attendees are listed in the following table.

Date of meeting	Name	Organisation
4 February 2007	Stephan McKernan Hon Pete Hodgson David Galler Grant Hawke	Teleconference Teleconference Ministry of Health Ngati Whatua
30 March 2007	David Galler Geraint Martin Bruce Anderson Nigel Miller Mary Gordon Sue Ineson Neil Chave Clare Kirk	Ministry of Health CEO Counties Manukau Ministry of Health Chief Medical Advisor Canterbury DHB Director of Nursing Canterbury DHB Healthcare NZ Healthcare NZ Healthcare NZ
1 June 2007	David Galler Bruce Anderson David Meates Colin Feek Vladimir Stevanovic	Ministry of Health Ministry of Health CEO Wairarapa DHB Ministry of Health Ministry of Health
3 August 2007	Bruce Anderson David Galler Jan White Peter Glensor Chai Chuah Hon Peter Dunne Rob Eaddy Sheila Swan Karen Mitchell	Ministry of Health Ministry of Health ACC CEO Chair Hutt Valley Health CEO Hutt Valley Health DHB Associate Minister of Health Chief of Staff Ministry of Health Ministry of Health
4 September 2007	David Galler Stephan McKernan John Peters	Ministry of Health Director-General of Health CEO Nelson Marlborough DHB
30 November 2007	David Galler Cathy Cooney Lesley Yule	Ministry of Health CEO Lakes DHB Quality and Risk Manager Lakes DHB

Date of meeting	Name	Organisation
21 February 2008	David Galler Lindsey Bartlett Spiro Anastasiou Geoff Annals Nigel Millar Janice Mueller Michael Tatley Desiree Kunac Maureen Gillon John Wellingham	Ministry of Health Director of Nursing Tairāwhiti Communications consultant NZ Nurses Organisation Chief Medical Advisor Canterbury DHB General Manager, Auckland DHB University of Otago University of Otago Royal NZ College of General Practitioners Royal NZ College of General Practitioners
4 April 2008	David Galler Murray Georgel Margie Apa David Waters Chai Chuah Paul Cressey Michael Buist Dougal McKechnie	Ministry of Health CEO Wairarapa DHB Ministry of Health Independent consultant CEO Hutt Valley Health DHB Health Information Strategic Advisory Committee Australian expert in rapid response teams Health Information Strategic Advisory Committee
20 June	David Galler Chai Chuah Jim Bagain Neville Habulous Maureen Robinson Stellar Ward Diane Robertson Lynne Lane Anne Kolbe	Ministry of Health CEO Hutt Valley Health DHB Director of the National Centre for Patient Safety of the Department of Veteran's Affairs USA Waikato DHB Director Communio Ltd Counties Manukau DHB Auckland City Mission Independent consultant

Appendix 2: Terms of Reference

Accountability

The National Health Epidemiology and Quality Assurance Advisory Committee, operating under the name 'Quality Improvement Committee', is established under section 11 of the New Zealand Public Health and Disability Act 2000 (the 'Act'). It is appointed by, and accountable to, the Minister of Health.

Purpose of the Committee

The role of the Quality Improvement Committee is to provide advice to the Minister on any health, epidemiology and quality assurance matters, including sponsoring, monitoring and evaluating programmes within the Improving Quality (IQ) Action Plan. It must specifically deal with perinatal, maternal, infant, child and adolescent morbidity and mortality issues.

The Quality Improvement Committee will work across the health and disability sector (with a particular focus on hospital care) as both an advisor and a facilitator. In providing its advice it must:

- ensure that there is a capacity to improve health outcomes through quality improvement programmes, including those directed to clinical providers
- seek to develop a shared learning environment in the health sector, thereby quickening the implementation of innovation and the continual achievement of best practice
- provide a national perspective on the variety of accountability mechanisms in the health and disability sector, including ethics, negotiated targets, societal demands, investigative and disciplinary systems and other formal accountability mechanisms
- ensure, to the maximum extent practicable, that there is national co-ordination in the reporting of relevant health, epidemiology and quality assurance matters
- identify that quality in healthcare and disability support is always everyone's business, and that improving quality is continuous and is supported by professionalism, technology, experience, a pervasive ethos of care and by the quest for better value for money
- apply a broad definition of 'quality' that is strongly associated with safety, value for money, people-centred care, high performance and best practice.

The advice given to the Minister is to be formulated after consultation by the Committee with District Health Boards and other persons involved in the provision of services, and any other persons that the Committee considers appropriate.

Key tasks

- To provide independent advice to the Minister on quality improvement by analysing information and evidence on systemic quality and safety issues from a national perspective, and recommending system improvements.
- To develop whole system frameworks and integrative approaches to quality improvement that support and develop leadership, shared learning, trust and culture change, thereby quickening the implementation of innovation and best practice.
- To be active in building collaboration with national organisations to facilitate an integrated approach to quality and safety and to promote the dissemination of proven innovations.
- To identify examples of innovation or best practice (globally and nationally) that can be adapted for implementation in New Zealand.
- To collect and document evidence and information to assist the spread of innovation and best practice, including the findings and recommendations from mortality review committees, the Health and Disability Commissioner, the Service Planning and New Health Intervention Assessment (SPNIA) Framework and other work streams of relevance.
- To organise and facilitate fora for the discussion and understanding of documented examples of innovation and best practice.
- To recommend data sets to better inform and monitor quality improvement, including the setting of targets and performance objectives for DHBs.
- To collaborate with the Office of the HDC in promoting the Code of Health and Disability Service Consumers' Rights as a basis for continuous improvement, engaging consumers in quality improvement and ensuring complaints processes link with system improvement.
- To review the annual reports of the national mortality review committees and provide the Minister with independent commentary.
- To provide advice to the Tertiary Education Commission and the Health Research Council on priorities for education and research in support of improvements in the health and disability sector.

In developing its advice, the Committee must consider reports from the Perinatal and Maternal Mortality Review Committee and the Child and Youth Mortality Review Committee, and any other mortality review committee appointed under section 18 of the Act. It may also consider relevant reports, including the following:

- New Zealand health sector quality improvement strategy
- health professionals competence
- audit information related to implementation of the Health and Disability Services (Safety) Act 2001
- relevant opinions of the Health and Disability Commissioner, under section 45 of the Health and Disability Commissioner Act 1994
- information relating to treatment injury provided for in section 284 of the Injury Prevention, Rehabilitation, and Compensation Act 2001.

It will also:

- identify data quality and analysis issues, identify information gaps and make recommendations on how to learn from, and prevent, system failures
- consider such matters as the Minister specifies by notice to the Committee
- advise the Minister on clinical epidemiological matters that will improve clinical practice quality and support other quality assurance initiatives.

Composition of the Committee

The Committee will have a maximum of 13 members appointed by the Minister.

The Minister will appoint a Chairperson for the Committee, and the Minister may from among Committee membership appoint a Deputy Chair or delegate to the Committee the appointment of a Deputy Chair.

The Chair of any national mortality review Committee appointed under section 11 of the New Zealand Health and Disability Act (2000) will be a member for the duration of their term of office.

Desired skills and knowledge of the collective Committee membership

Members will have the ability to work strategically and co-operatively, and will have credibility in relevant communities.

Collectively the Committee will reflect the following:

- expertise in quality improvement and clinical risk management in the health and disability sector
- knowledge of best practice and/or implementation of innovation in the health and disability sector
- knowledge of health services research and measurement
- knowledge of mortality review systems
- knowledge of clinical epidemiology
- experience of DHB service provision and management at a senior level
- health professionals with extensive and recent clinical experience
- an understanding of the diverse cultural context of the New Zealand health and disability sector
- knowledge of consumer participation and representation.

The Committee may appoint sub-groups or establish working parties relevant to its agreed work plan. It may also co-opt expertise as necessary to assist both the main Committee and any sub-groups it may establish.

Nomination process

The nomination process will comply with the requirements of the State Services Commission.

Term and conditions of appointment

The Minister of Health appoints members of the Quality Improvement Committee for a term of office of up to three years; members will be eligible to serve a second consecutive term to allow for continuity and the full use of increased experience and knowledge. The terms of office of members will be staggered to ensure continuity of membership. No member may hold office for more than six consecutive years. Unless a person sooner vacates their office, every appointed member of the Quality Improvement Committee shall continue in office until a successor comes into office.

Any member of the Quality Improvement Committee may at any time resign as a member by advising the Minister of Health in writing.

Any member of the Quality Improvement Committee may at any time be removed from office by the Minister of Health for inability to perform the functions of office, bankruptcy, neglect of duty, or misconduct, proved to the satisfaction of the Minister.

The Minister may from time to time alter or reconstitute the Quality Improvement Committee, or discharge any member of the Quality Improvement Committee, or appoint new members to the Quality Improvement Committee for the purpose of decreasing or increasing the membership or filling any vacancies.

The Chair will provide advice to the Minister on Committee appointments.

Reporting requirements

The Quality Improvement Committee is required to:

- report as necessary, but at least once a year, to the Minister on its advice on the matters referred to in section 17(3) of the Act
- keep a record of all Committee meetings, which outlines the matters discussed and includes a clear note of all decisions taken or recommendations made.

Frequency of meetings

The timing and frequency of meetings will be determined by the tasks the Committee is required to fulfil and as part of its work programme to be agreed with the Minister. All meetings of the Committee will be convened by the Chair (or Deputy Chair) as appropriate.

Attendance fees

Members of the Quality Improvement Committee are entitled to be paid fees for attendance at meetings of both the Committee and its sub-groups. The level of fees is set in accordance with the State Services Commission's framework for fees for statutory bodies. The Chair will receive \$450 (GST exclusive) per meeting day for the Committee (plus half a day's preparation fee per meeting). In addition the Chair is entitled to claim additional fees up to two days per month Committee-related activities. The Chair will preside at every meeting of the Committee at which the Chair is present.

The attendance fee for members is set at \$320 (GST exclusive) per day working for the Committee (plus half a day's preparation fee for Committee meetings or teleconferences). The attendance fee for teleconferences will be calculated on a pro rata basis (the hourly rate will be calculated at one seventh of the daily rate).

Meetings of the Committee

Meetings will be held in Auckland unless the Chair decides otherwise. Actual and reasonable expenses for activities required by the Committee of its members (e.g. travel, accommodation and meals) will be met from the Committee's budget provided prior approval is received.

At any meeting, a quorum shall consist of nine members. A quorum must include either the Chair or Deputy Chair.

Every question before any meeting shall generally be determined by consensus decision-making. Where a consensus cannot be reached a majority vote will apply. Where a decision cannot be reached through consensus and a majority vote is made, the Chair shall have the casting vote.

Duties and responsibilities of members

As an independent statutory body, the Quality Improvement Committee has an obligation to conduct its activities in an open and ethical manner. The Committee has a duty to operate in an effective manner within the parameters of its functions as set out in its Terms of Reference.

Committee members are expected to:

- have a commitment to work for the greater good of the Committee. They are accountable to the Minister of Health
- attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole
- make every effort to attend all Committee meetings and devote sufficient time to become familiar with the affairs of the Committee and the wider environment within which it operates
- declare any conflict of interest (as defined in the Ministry of Health conflict of interest protocol for statutory bodies) which may prevent them from impartially and fairly carrying out their Committee duties

- make every effort to attend all the Committee meetings and devote sufficient time to become familiar with the affairs of the Committee and the wider environment within which it operates
- act responsibly with regard to the effective and efficient administration of the Committee and the use of Committee funds.

Conflicts of interest

Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest. Proper observation of these principles will help protect the Quality Improvement Committee and its members and will ensure it retains public confidence.

Members attend meetings and undertake Committee activities as independent persons responsible to the Committee as a whole. Members are not appointed as representatives of professional organisations and groups. The Quality Improvement Committee should not, therefore, assume that a particular group's interests have been taken into account because a member is associated with a particular group.

When members believe they have a conflict of interest on a subject that will prevent them from reaching an impartial decision or undertaking an activity consistent with the Committee's functions, they must declare that conflict of interest and withdraw themselves from the discussion and/or activity.

Performance measures

The Quality Improvement Committee will be effectively meeting its tasks when it provides relevant and timely advice to the Minister of Health based in research, analysis and consultation with appropriate groups and organisations.

The Quality Improvement Committee must:

- agree in advance to a work programme with the Minister of Health
- achieve its agreed work programme
- stay within its allocated budget.

The Committee will agree a work programme in advance with the Minister that fulfils its functions and can be achieved within a sufficient, allocated budget.

In carrying out its functions the Committee must ensure that:

- appropriate consultation has occurred when developing a methodology and subsequently disseminating findings
- any recommendations are developed in the context of available evidence
- any advice and recommendations comply with the laws of New Zealand
- its recommendations are published and widely available.

The secretariat

A secretariat to the Quality Improvement Committee will be based in the Ministry of Health, funded out of the Committee's allocated budget.

The Secretariat will provide advice and guidance on governmental and ministerial processes and support the Committee to meet its statutory requirements.

The Secretariat will be responsive to requests from Committee members, members of the public and other stakeholders.

This document was authorised by

Hon Pete Hodgson
Minister of Health

17 April 2007