

**EPIDEMIOLOGY AND QUALITY ASSURANCE  
ADVISORY COMMITTEE  
Friday 7 October 2005**

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| <b>Meeting held:</b>  | <b>Miramar Links Conference and Function Centre</b>   |
| <b>In Attendance:</b> | Denise Hutchins (DH), Jonathan Jarman (JJ), Sharon Kletchko (SK) (to 2.45pm), Barry Taylor (BT), Jim Vause (JV), Barbara Greer (BG), Cynthia Farquhar (CF), Robin Youngson (RY) (10:45 onwards) |
| <b>Apologies</b>      | Nigel Dickson (ND)  |
| <b>Guests:</b>        | Gina Lomax (GL), David Waters (DW), Jit Cheung (JC), Ted Cizadlo (TC),  |
| <b>Secretariat:</b>   | Gillian Bohm (GB), Angie Perry (AP), Ricarda Vandervorst (RV)   |

| <b>Agenda Items</b> | <b>Summary of discussion &amp; decisions</b> |
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| <b>Meeting Commenced</b>          | <b>9:30 am</b>   |
| <b>1. Welcome and apologies</b>   |  |
| <b>2. Confirmation of minutes</b> | One correction to minutes: pg 5 (paragraph 2), corrected spelling (mātāwaka).<br>Minutes confirmed.<br><b>Action:</b> Include a copy of the minutes in the agenda papers for each meeting.   |
| <b>3. Chairs report</b>           | DH advised that herself, BG, BT and CF's terms of appointment were due to expire in November 2005 and they have been reappointed by the Minister for a second term of three years.   |
| <b>4. Administration</b>          | <p>a) <i>Agree meeting dates for 2006</i></p> <p>The agreed dates for 2006 are:</p> <ul style="list-style-type: none"> <li>• Tuesday 14<sup>th</sup> February</li> <li>• Wednesday 29<sup>th</sup> and Thursday 30<sup>th</sup> March (planning meeting)</li> <li>• Friday 26<sup>th</sup> May</li> <li>• Tuesday 1<sup>st</sup> August</li> <li>• Wednesday 11<sup>th</sup> October</li> <li>• Thursday 30<sup>th</sup> November.</li> </ul> <p>b) <i>Updated handbook</i></p> <p>The Committee handbook was reviewed to ensure consistency with State Services Commission Guidelines on Boards and Committees. AP highlighted the updated sections (item numbers 3, 32, 33 and 34)</p> |

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| <p><b>5. Correspondence</b></p>  | <p><i>a) Inward</i></p> <p>Letter from the Paediatric Society of New Zealand regarding their proposal for the development of a set of Child and Youth Health Indicators for New Zealand.</p> <p><b>Action:</b> Invite the Paediatric Society of New Zealand to the EpiQual meeting 9 December.</p> <p><i>b) Outward</i></p> <p>None</p>   |
| <p><b>6. Matters arising from minutes</b></p>                                  | <p>Any matters arising from the minutes were covered in the agenda items.</p> <p>DH introduced the next section by advising the group that the Secretariat had moved to the Quality and Safety Team in the Ministry of Health. The purpose of the next section was to meet the manager of the Quality and Safety Team.</p>  |
| <p><b>7. Introduction of Gina Lomax, Manager – Quality and Safety Team</b></p> | <p>Introductions were made. GL considered she could bring her of information management experience to the Committee, to help develop better co-ordinated information systems.</p> <p>GL described the composition of the Quality and Safety Team and explained how this fitted into the overall structure of Clinical Services Directorate (CSD).</p> <p>SK requested a copy of the letter Colin Feek sent to DHB CEOs advising them of the new CSD structure.</p> <p>BT emphasised that it was strategically important to form links with other committees and commented that the regular meeting of Statutory/Ministerial committee chairs should be reactivated.</p> <p>The group commented that there are critical connections between EpiQual and policy within the Ministry. These connections are not clear from the description of the Quality and Safety team.</p> <p>GL stated that there was some work to do. It was important that the Quality and Safety team service the committees effectively.</p> <p><b>Action:</b> Secretariat to provide EpiQual with a copy of Colin Feek's letter to DHB CEOs.</p> |
| <p><b>8. NZGG Consumer Summit</b></p>  | <p>DH highlighted that the work programme has resources for two members to attend. DH proposed she attend as Chair and BG as the consumer representative member of EpiQual.</p> <p>The group agreed this was appropriate, with provision for RY to attend if either DH or BG were unable to.</p> <p>GB advised she would be attending as a Ministry of Health representative, to respond to any questions regarding the Ministry's stance on the proposal to establish a consumer focus in the Ministry (as a dedicated office/portfolio or division).</p>  |

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| <p><b>9. Presentation by Peter Jansen: Research on Maori use and experiences of healthcare services and the 'experiences of care' survey tool</b></p> | <p>PJ explained traditional measures of healthcare experiences have focussed on performance measures and satisfaction (the comparison of what <u>should have</u> happened versus what <u>did</u> happen). A better measure is to look at expectation (patient expectation of what should have happened versus what did happen).</p> <p>PJ highlighted that patients are interested in providers who they trust, who are understanding and are understandable. There are evident differences in communication approaches between provider and patient, which can be related to concordance in the relationship (ie: concordant relationships result in higher patient satisfaction).</p> <p>Studies of Maori patient satisfaction have shown that there are ethnic difference in communication, which can impact on Maori satisfaction as well as the patient <u>and</u> provider's approach to the patient's care.</p> <p><i>Maori consumer use and experiences of care</i></p> <p>PJ outlined that 10 hui had taken place. The key findings of the hui were that cost was a major barrier, regardless of income and that the barriers to care varied (based on type of provider, age, region etc...). Costs barriers included: prescriptions, visit and house call costs, time off work, value for money and travel. Barriers discussed included: cost, communication, structural (eg: distance to travel, appointment at a suitable time), disability and cultural fit.</p> <p><i>The proposed model</i></p> <p>PJ explained that the tool being developed would look at experiences of care. The methodology used is predominantly interview via telephone. Participants receive a letter prior to the interview to explain who the researchers are, what they will ask and why. The size of the pilot is 600 participants, with each interview taking approximately 30 minutes (30 questions). Preliminary results are expected by the end of the year.</p> <p>The group discussed how the tool could be utilised for EpiQual. EpiQual are interested in the response of health and disability services to user satisfaction. The group considered some of the results could inform the Chartbook.</p> <p>The group discussed communication skills. If this is what patients primarily value, there is a need to understand, measure and improve performance in communication by health and disability service providers.</p> |
| <p><b>10. Chartbook</b></p>   | <p>DW updated the group on progress with the Chartbook. Following the teleconferences with the sub-group members, DW and the secretariat have met with PHO and NZHIS to scope further indicators. Both NZHIS and PHO have been excited by the concept of the Chartbook.</p> <p>DW tabled an updated draft of the Chartbook. DW commented that he required help with the technical interpretation and commentary on</p>  |

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|   | <p>charts, particularly the 'capacity to improve' section.</p> <p>The group discussed the issue of interpretation. DW highlighted that other Chartbooks left it up to the reader to interpret the information, however it may be useful to offer some explanation as to how to interpret the information in EpiQual's Chartbook.</p> <p>The group considered that the interpretation needed careful thought and specialist advice was required. The group considered it would be useful to include the neighbourhoods analysis produced by PHI to explain the DHB regional context.</p> <p>JC suggested using a contextual framework to help readers relate conceptually to the indicators and cross-reference related indicators in the Chartbook.</p> <p>TC highlighted that the national minimum dataset was not designed to answer the questions that EpiQual wants to ask. Due to this, only five of the proposed process measures got through the sieve. There is some room for creativity in utilising and linking the existing datasets, which is being explored now. CF suggested including all the indicators EpiQual wanted (but were unable to get data on) in an appendix.</p> <p>The group discussed commentary and suggested approaching specialists to provide independent commentaries on each of the indicator sets. Some committee members would also like to provide commentary in their specialist area.</p> <p><b>Action:</b> SK to approach Martin Tobias and Barry Borman (PHI) regarding a conceptual framework.</p> <p><b>Action:</b> EpiQual committee members to identify which specialists to approach for commentary.</p> |
| <p><b>11. Renewing the IQ Action Plan</b></p> | <p>GB opened the discussion by advising that the sector would be consulted on the Action Plan, however it wasn't advisable to go to them with a blank page.</p> <p>The timeframe is set out in the legislation, which requires a new action plan by September 2006. This means a draft is required in February, consultation in March – May and a final draft completed before the IQ forum in June.</p> <p>GB advised she is holding a workshop at the next DHB Quality and Risk Managers meeting to ascertain what they think are the priorities over the next three years.</p> <p>The group brainstormed the two priority areas for each committee member (Appendix A). This process identified some priorities that could be clustered, such as HPCA, competency and teamwork.</p> <p><b>Action:</b> GB to provide EpiQual with a draft document at the February meeting that could be used as the basis for consulting with the sector.</p>  |

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| <p><b>12. HPCA – PQAA template</b></p>                      | <p>BT highlighted that responsible persons had put a large amount of time into compiling the reports and suggested that an electronic process be developed to allow them to log internal reports and produce a collated report to send to the Ministry annually. BT also suggested reviewing PQAA reports should be included as a standing item on the EpiQual meeting agenda.</p> <p>The group discussed the template responses and the current reports.</p> <p><b>Agreed:</b> Send a response letter to organisations who provided feedback advising:</p> <ul style="list-style-type: none"> <li>• We have listened to what you have to say</li> <li>• We are going to keep to the criteria in the legislation and provide further guidance on reporting</li> <li>• We are looking to systematise the process in future.</li> </ul> <p><b>Action:</b> Secretariat to draft response letter.</p> <p><b>Action:</b> Secretariat to develop interim guidance and suggested template by the December meeting.</p> <p><b>Action:</b> Barry to request Otago web developers mock up an electronic system for reporting.</p> |
| <p><b>13. Advice to Minister on CYMRC annual report</b></p> | <p>AP tabled an updated version of the draft health report, which includes commentary on actions CYMRC are taking in the priority areas.</p> <p>The group requested including a recommendation that EpiQual agree and endorse the recommendations made by CYMRC in its annual report. The report should also highlight that the New Zealand Public Health and Disability Act does not allow case conferencing and that some DHBs are having difficulty funding the mortality review process.</p>  |
| <p><b>14. Adult mortality review</b></p>                    | <p>GB advised the background paper on an adult mortality review committee was prepared for consultation with the sector. This cannot be progressed until a government has been formed.</p> <p>CF commented that the diagram should be amended to include maternal deaths.</p> <p>Suggestions included adding information/ evidence on the benefits of mortality review committees and including information from the Davis study.</p> <p><b>Action:</b> AP to amend mortality review diagram.</p>   |
| <p><b>Meeting closed</b></p>                                | <p><b>4:30pm</b></p>  |

**Next Meeting: 9 December 2005**

**Venue: Miramar Links Conference and Function Centre (Ph: 04 801 7649)**

**Location is adjacent to Wellington Airport Car Park & directly opposite exit closest to baggage retrieval area).**

**Minutes approved**

**Signature:** 

**Date:** 9-12-05

## Appendix A: Summary of Brainstorm of priority areas for the IQ Action Plan

- Patient centred healthcare providers, measured by an annual performance survey of patients and process
- Review/audit committees for mortality and morbidity (eg; return to theatre, blood transfusion, near misses)
- Overall system – utilisation of health/social impact assessment for everyday policy (equity lens)
- Keystone
  - DHBs working with local communities for shared outcomes (joint collaborative),
  - integration between primary/secondary/tertiary/public health from a patient perspective
  - enabling consumers to get the best of the health system
  - partnership between DHBs/local agencies/communities/NGOs/iwi providers
- Move the mortality review reporting documents towards a five year plan
- Electronic clinical records
- Look for quality issues when contracting for RFP – value for purchasing
- Reporting against actual performance → outcomes
- Recognition by the DHBs of being an accredited provider
  - DHB accountability for contracting with NGOs
- Improve contractual reporting
- By 2007, no deaths from patients who develop unrecognised and untreated physiological instability
- By 2007, no deaths from medication error
- Invest in leadership capacity (eg: Peter Sang to design a leadership and performance framework for DHB CEOs.
- Include training on interpersonal and communication skills as mandatory part of MOTS/ other accreditation programmes (every 3 years)
- Address inappropriate use of power and control
- Review the health management workforce
- Public Health and Disability Act DHB Needs Assessments
  - three yearly independent health assessments
  - design programmes in relation to assessments
  - able to demonstrate progress
- Making the HPCA work and teamwork
- Prioritisation of services (tool to aid this).