

**NATIONAL HEALTH EPIDEMIOLOGY AND QUALITY ASSURANCE
ADVISORY COMMITTEE (EPIQUAL)
Friday 9 December 2005**

Meeting held:	Miramar Links Conference and Function Centre
In Attendance:	Denise Hutchins (DH), Sharon Kletchko (SK), Barry Taylor (BT), Jim Vause (JV), Robin Youngson (RY), Nigel Dickson (ND)
Apologies	Barbara Greer (BG), Cynthia Farquhar (CF), Jonathan Jarman (JJ)
Guests:	Nick Baker (NB) and Elizabeth Craig (EC): Paediatric Society of New Zealand, Karen Poutasi (KP): Director-General of Health
Secretariat:	Gillian Bohm (GB), Angie Perry (AP)

Agenda Items	Summary of discussion & decisions
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Meeting Commenced	9:30 am
1. Welcome and apologies	
2. Confirmation of minutes	Proposed: DH Seconded: RY Minutes confirmed.
3. Chairs report	<p>DH had a brief meeting with KP in November to discuss what EpiQual were doing, where EpiQual want to go and what EpiQual need to get there.</p> <p>The Health and Disability Commissioner met with Select Committee and the Minister recently, with a focus on the availability of information for consumers about health outcomes. DH also had a conversation with the Commissioner regarding this and other topics. The Commissioner was clear in his discussions with the Director-General and the Select Committee that EpiQual needs to be adequately resourced.</p> <p>DH presented to the National Mental Health Quality Managers on EpiQual, ie: who EpiQual are, where EpiQual want to go and what is on the work programme. DH also advised about the recommendation in the annual report for representation from Mental Health on EpiQual.</p> <p>DH had a discussion with Dwayne Crombie regarding Safe and Quality Use of Medicines (SQUM). The SQUM National Strategy is due for release on 13 December 2005. DH received a pre-release copy of the strategy. Although the report does not directly mention EpiQual, there is some indication of how EpiQual could be involved with SQUM.</p>
4. Correspondence	<p>Incoming – none</p> <p>Outgoing – letter of response sent to the responsible person for protected quality assurance activities, following receipt of feedback from the proposed reporting template.</p>

<p>5. Matters arising from minutes</p>	<p><u>Conceptual framework</u> SK had contacted PHI about the conceptual framework following the last meeting. A PHI publication including a conceptual framework approach is due for release next week. The release had been delayed as the new Minister had to see the publication before release. SK highlighted that this is the first time a different lens has been used to look at the quality of the health and disability services throughout New Zealand. The framework uses a health inequality index, with the measurement the gradient between worst and best (rather than reporting against the national average). Some of the results are surprising.</p> <p>This framework has the potential to alter many aspects of health and disability services, such as PBFF and the way mortality review is conducted. SK highlighted that as this framework is due to be published it will be easier to utilise this for the Chartbook, adding another perspective to the information.</p> <p><u>Future meeting dates</u> ND gave his apologies for 30th March. It is possible he may not be available for the meeting on 11th October as well.</p>
<p>6. Chartbook</p>	<p>GB advised that a new version of the Chartbook was not brought to the meeting as she was awaiting the information from PHI and NZHIS. An updated copy will be provided at the next meeting.</p> <p>DH brought colour copies of some of the more complete pages of the Chartbook to give the Committee an indication of the layout.</p> <p>DH asked about the expert opinions. GB advised expert opinion could not be sought until all the data is collected.</p>
<p>7. Presentation from the Paediatric Society of New Zealand (PSNZ)</p>	<p><u>The New Zealand Child and Youth Epidemiology Service</u> NB gave an overview of why there is a need for this service, what the PSNZ have been doing and the future directions for the service. NB highlighted that the key driver for this work was the NZ Public Health and Disability Act, which moved thinking towards care for communities.</p> <p>To begin with PSNZ asked DHBs what process they were using to inform their district annual plan. The results were variable, with few DHBs using a detailed child and youth health needs assessment. The aim is for all DHBs to have a quality child and youth epidemiological report that includes national and sub-regional benchmarking, regular updates, and collects information from many sources.</p> <p>The health needs assessment is important as it guides any change in direction. Good epidemiology needs to inform the health needs assessment.</p> <p>PSNZ consider it is sensible to have a national collection of Child and Youth epidemiology data, as it is more efficient and comparable to have all the information in one place.</p> <p>LC advised that it was evident that different groups were doing similar things and that integration at a national level would be useful. PSNZ had received some funding from the Population Health Charitable Trust</p>

to scope a Child and Youth Epidemiology Service. In 2004 LC spoke to all DHBs about their health information needs.

The PSNZ Epidemiological Service is solely funded by contract from DHBs. Half of the DHBs have taken up the service. The service provided has a three year plan:

- Year one – Summary data
- Year two – Determinants data
- Year three – information on an area of interest for the DHB.

LC highlighted the constraints of the national datasets, including that the numerator is provided in electronic format and denominator in hard copy. This makes analysis complex, resulting in information at a basic level. Adjusting for ethnicity, age and gender is also problematic. The Epidemiological Service has chosen to provide a broad range of information instead of adjusting and therefore only reporting on a small amount of information.

Summary data reports

The goal of the DHB reports is to help DHBs understand why their statistics are the way they are. The reports include a first section with the DHB region information on ethnic split, age structure and deprivation profile. The remainder of the report looks at the relative risks of the DHB against each indicator. The appendix of the report discusses the limitations of each of the data sources.

The purpose of the report structure is to provide DHBs with an understanding their region's profile to provide some context when looking at the data. The reports are aimed at the funding and planning level.

The group discussed the report information. JV asked how variability in risks over time was presented. LC advised this was in the report commentary.

The aim for the next 18 months

Annette King signed off funds to scope the development of a Child and Youth health indicator framework. This project will be managed by PHI.

PSNZ will be looking at a conceptual framework for monitoring indicators and investigating what needs to be done in this area, eg: whether the indicators reported to the Ministry are relevant/ appropriate. Are they indicators that DHBs have control or influence over?

Discussion over the complementary nature of EpiQual's and PSNZ's goals. PSNZ advised that they could provide information on a limited number of indicators for inclusion in the Chartbook now, or alternatively in 18 months time would be able to provide more information.

Agreed: EpiQual to discuss further the options for collaboration and will advise PSNZ at a later date.

<p>8. Discussion following the PSNZ presentation</p>	<p>The group were impressed with the work of the Child and Youth Epidemiological Service and considered that this, and similar initiatives, should be encouraged and supported.</p> <p>EpiQual considered however that their primary relationship was with the national data gatherers such as PHI and NZHIS. The group discussed the nature of EpiQual's involvement with projects such as PSNZs and considered what EpiQual should be supporting is the relationships between local initiatives and national groups.</p> <p>The group discussed developing a framework for these relationships to foster a move towards an integrative approach. The framework should provide organisation at a national level but allow innovation at the service delivery level.</p> <p>Action: Invite Jason Whakaari (NZHIS) to next EpiQual meeting to discuss data sources.</p>
<p>9. Meeting with Karen Poutasi</p>	<p>KP advised she was taking the opportunity to catch up with all the Ministerial Committees. She particularly wanted to speak with EpiQual about where we were at in New Zealand with various quality initiatives and how did this compare with other countries?</p> <p>The new Minister accompanied KP to Washington for the Commonwealth Fund Symposium. Quality was big on the agenda, as was patient responsiveness. This provided the Minister with a good introduction to quality in health.</p> <p>KP explained that there had been some discussion in the Ministry recently on quality and how to gain traction in the sector. The Ministry are 'gearing up' the quality agenda, as the time is right. We need to identify where the gaps are and what do we need to drive them?</p> <p>KP suggested that having a DHB CEO on EpiQual would assist in gaining this traction and connecting with what was happening 'on the ground'. KP has put this suggestion forward to the Minister for his consideration.</p> <p>BT highlighted an area of concern for mortality review. In his and GB's recent visit to Auckland DHBs regarding local mortality review, the DHB considered the structure was good but questioned who pays for it. The concern is that when you ask what you can do as a major drive, until you get DHB commitment to take up national structures you are not achieving what you could.</p> <p>KP advised that EpiQual needed to focus on one aspect that would get widespread endorsement, something that you are able to modify in the short term to achieve gains.</p> <p>SK commented that it was the method of using a sharp edge with a wedge following. The key is to ensure the wedge follows. DH highlighted that if EpiQual is to take the learning engine approach, then we must ensure the systems we talk about are there (the wedge).</p>

RY spoke about Ron Heifetz, who defined two types of problems:

1. Technical – Solutions, authority, “management”
Eg: medication errors: solution of one universal electronic medication file that all practitioners can access.
2. Adaptive – values, beliefs, behaviours, conflict and loss, “leadership”
Eg: When everyone has a different version of the problem. You need to build collaboration and trust across professionals.

RY highlighted that the real danger is focussing on the technical problems. KP considered that we needed to do a bit of both. For example, people know that to get to X you need to do Y (technical approach), but people still don't do Y (adaptive approach).

BT advised that if we are trying to decide on a driver, we need to consult with the DHBs.

JV thought that there is a deficit of understanding of what quality is. He appreciated the need for traction, but queried if policy gaps were evident whether the Ministry would be receptive to this being highlighted. KP responded that the Ministry are always interested in learning of areas that could be improved.

ND queried whether any money could be earmarked for quality. KP responded that it would be difficult in the short term as this money is devolved to DHBs. RY commented that money for central resources, such as common toolkits, should not be devolved to DHBs.

SK suggested that EpiQual need to create the want within DHBs to improve quality - EpiQual could make the benefits more real to DHBs (Eg: by demonstrating the opportunity cost).

RY highlighted the need to invest in our senior leadership: targeting training on leadership for change for CEOs.

Where to from here?

KP considered that the discussion reinforced the usefulness of a DHB CEO on EpiQual. The Ministry is also trying to shift some resources to have a secondment from the sector working at the Ministry on quality.

The group discussed how EpiQual's work programme could achieve the goal. The 'Engagement and partnership' section includes resources for a workshop. The group considered the workshop could be utilised to consult with the sector to agree on the first quality aspect to start with.


The group considered it was extremely important to get the right people to attend the workshop and that support from the Director-General, the Health and Disability Commissioner and the Minister would assist in this.

<p>10. Discussion from meeting with Karen Poutasi</p>	<p>The group debriefed on the discussion topics and agreed a follow up letter to KP would be appropriate. Key points to include are:</p> <ul style="list-style-type: none"> • A workshop to engage the sector • Leadership development • Development of a central mechanism for supporting mortality review • Quality: its importance and placement in the Ministry <p>Action: Secretariat to draft the letter to KP based on the discussion. Letter to be sent to KP as soon as possible.</p> <p>Action: RY to provide the group with a summary of Ron Heifetz's model for inclusion in this letter.</p>
<p>11. HPCA – Protected Quality Assurance Activities (PQAA)</p>	<p>BT provided the group with a mock up of a web enabled form for use in PQAA reporting. The website database would allow various users to utilise the site to enter and report on their own protected quality assurance activities and would enable the Ministry and EpiQual to access information at a national level.</p> <p>Action: Secretariat to ask the Ministry's IT department to give an estimate of the cost of development of the web enabled form/database and produce an electronic mock up of the web enabled form (in consultation with BT).</p>
<p>12. Adult Mortality review</p>	<p>The group reviewed the latest version of the proposal, which has been modified for distribution as a consultation document. The group suggested some changes to the document before distribution.</p> <p>The group discussed the long term vision for national mortality review in New Zealand. DH suggested that this long term vision could be alluded to in the covering letter to the consultation document.</p> <p>Suggestions for who should be consulted included: relevant colleges, Director's of Nursing, Chief Operating Officers, dentists and registration bodies.</p> <p>Action: Secretariat to make the suggested changes to the consultation document.</p> <p>Action: Secretariat to compile distribution list.</p> <p>Action: Secretariat to draft cover letter to accompany consultation document.</p>
<p>13. Consumer representation</p>	<p>DH and BG attended the NZGG Consumer Summit as representatives of EpiQual. GB also attended as a Ministry representative. DH gave a summary of the content of the day.</p> <p>DH commented that it was an interesting day, with huge variation in the types of consumer groups represented. There was much discussion and it was evident that there is a lot more work to do before a national consumer group could be set up in New Zealand.</p> <p>The discussion highlighted the range of understanding of health issues by the diverse consumer groups. JV suggested that some lack of understanding of the issues could be because individuals haven't had</p>

	the experience of the health setting. The group discussed the need for improved health literacy in New Zealand.
14. Other business	SK suggested that EpiQual should provide input into the proposed guidance for community based assessment centres being suggested as required in pandemic planning, as it is very much a quality related issue (broaching many dimensions of quality such as access, timeliness and people centeredness). Action: Secretariat to circulate a copy of the guidelines to EpiQual.
Meeting closed	4:30pm

Next Meeting: 14 February 2006

Venue: De Havilland Room, Wellington Airport Conference Centre.

Minutes approved	<p>Signature: </p> <p>Date: 14 February 2006</p>
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