

**EPIDEMIOLOGY AND QUALITY ASSURANCE
ADVISORY COMMITTEE
Friday 12 August 2005**

Meeting held:	Miramar Links Conference and Function Centre
In Attendance:	Denise Hutchins (DH) (10am onwards), Jonathan Jarman (JJ) (to 2:30pm), Sharon Kletchko (SK), Barry Taylor (BT), Jim Vause (JV), Barbara Greer (BG); Nigel Dickson (ND)
Apologies	Cynthia Farquhar (CF), Robin Youngson (RY)
Guests:	Professor Tony Blakely (TB), David Waters (DW)
Secretariat:	Gillian Bohm (GB), Angie Perry (AP)

Agenda Items	Summary of discussion & decisions
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Meeting Commenced	9:30 am
1. Welcome	SK commenced meeting as Chair until DH's arrival.
2. Confirmation of notes and minutes	Notes for 1 July 2005 approved and minutes from 21/22 April confirmed. Action: Secretariat to include page numbers on the minutes.
3. Chairs report	Nothing to report that will not be discussed as agenda items.
4. Matters arising from notes	<p>1. <i>Safe and Quality Use of Medicines</i> JJ queried whether the draft document was on Quickplace.</p> <p>The group discussed the options for linkage between Safe and Quality Use of Medicines.</p> <p>Agreed: EpiQual support further exploration of the relationship between EpiQual and the Safe and Quality Use of Medicines Group.</p> <p>Action: GB to put the draft document onto Quickplace.</p> <p>2. <i>Chartbook</i> The group requested that the Secretariat follow up whether any tests (such as blood sugar level) are going to be included in the health survey. The group emphasised that any tests need to be scientifically valid.</p> <p>Action: Secretariat to ask PHI about nature of any testing.</p> <p>3. <i>Annual Report</i> GB advised the annual report was tabled at the House of Representatives on 11th August. The Minister has requested a meeting with EpiQual to discuss their workplan and recommendations in the annual report.</p> <p>Discussion by the group that some aspects of the annual report recommendations need to be more explicitly expressed in the workplan.</p>

	<p>Action: Include preparation for meeting with the Minister as an agenda item for the next meeting.</p>
<p>5. Correspondence Inward / Outward</p>	<p><i>Inward correspondence:</i> Responses to requests for feedback on the PQAA template.</p>
<p>6. Decades of Disparity 2: Discussion with Tony Blakely</p>	<p>Professor Tony Blakely presented to the group information based on the findings of Decades of Disparity 2. TB advised that all the graphs are available to download from www.otago.ac.nz/nzcmswebtable.</p> <p>TB presented graphs on all cause mortality. There was some discussion over the use of absolute ratio versus relative ratio. Discussion that there is a need to look at both absolute and relative and this is reflected in the typology of trends.</p> <p><i>Ischaemic heart disease</i> - the graphs showed that high and low socioeconomic groups had spikes in epidemics at different times, then eventual convergence. This illustrated the dynamic nature of inequalities in health.</p> <p><i>Cancer</i> – TB noted growing differences in Cancer. There was no difference between income groups until the 1980's. For colorectal cancer, there is a huge increase in mortality rates for Maori/Pacific compared to non-Maori in the 1996 – 1999 cohort, indicating that some mortality issues for Maori have changed over this time. Non-lung cancers are showing a higher contribution in cancer mortality, particularly in females.</p> <p>So how do you decide whether health inequalities are increasing or decreasing? TB introduced the typology of trends, a continuum (Reducing inequalities ↔ Widening inequalities) with four trend types that indicate whether inequalities are decreasing, stable or increasing. TB commented that income was becoming an increasingly important metric over time.</p> <p><i>Ethnic difference in cancer survival</i> – TB presented a graph of the ratio of Maori to non-Maori non-Pacific 5 year relative cancer survival. The differences could not be fully explained by stages. Possible explanations are access to primary care (affecting stage) and access through care (Eg co-morbidities may limit treatment options), however there is no 'silver bullet' that explains the differences.</p> <p>Finding the explanation will require a systems approach, as there are small differences over time in each area (detection, diagnosis, treatment) that accumulate.</p> <p><i>Tobacco</i> – TB presented information on smoking and commented that eradicating tobacco from New Zealand would do more for reducing inequalities in health than reversing the income gap.</p> <p>TB presented a scenario of a high need versus a low need PHO and looked at options for needs based funding. The group discussed the options. The group considered that access to quality services is an area where the committee can make recommendations. This area should be reflected in the chartbook.</p>

<p>7. Chartbook</p>	<p>David Waters attended to present the progress he has made with the chartbook. DW took the first draft and incorporated the indicator discussed with PHI. DW also included the new dimensions of capacity to improve and reducing risks. DW found some obvious gaps, such as under satisfaction in the 'living with chronic conditions' section. He indicated he would now like to progress discussion to get a clear idea of the criteria for what to include in the chartbook.</p> <p>Discussion over layout of the chartbook. The options are to develop a new approach or build on the international examples. The group thought they should build on past examples and liked the 'capacity to improve' area DW had included. DH highlighted that the chartbook needed to be readable and understandable to a wide audience. The group considered that capacity to improve should be included in the page for each indicator as a section, not in the table.</p> <p>The group discussed the sieve to choose the most appropriate indicators, such as: Does it demonstrate quality? Is it amenable to change? Is it valid and reliable? It was noted that the Committee had previously identified sieve components and that these should be revisited in light of today's discussion.</p> <p>Action: Committee members to individually review the current indicators using the sieve.</p> <p>Action: Secretariat to send summary of sieve to the committee.</p> <p>Action: Chartbook working group to schedule a teleconference to discuss the indicators.</p>
<p>8. Review of CYMRC annual report</p>	<p>BT provided an overview of the report. BT commented that there had already been discussion that appendix one would in future be the main body of the report.</p> <p><i>Data Collection</i> – BT highlighted some issues with variability in quality of data, which is addressed in the report. For example, coronial data is not collected in an national database, therefore there is variance in collection.</p> <p><i>Local review process</i> – BT advised the local process was to identify local systems issues which are fed back to the national group. Currently there is debate of the ability for local agents to meet. Legal opinion is being sought to help clarify and progress this.</p> <p><i>Data</i> – BT took the group through the data. There are ongoing improvements in post-neonatal mortality. Mortality rates are stable for the 1-4yr and 5-9yr age groups, with a significant drop in the 10-14yr age group. The 15-19 yr and 20-24 age groups have also shown decreases. BT noted that unintentional vehicular deaths accounted for 25% of all deaths in the 20-24 yr age group.</p> <p>BT advised that currently a project is being undertaken to look at the</p>

ethnicity data in the CYMRC database. There are some obvious areas of disparity already evident, such as suicide and SUDI deaths. Table A10 depicts SUDI risk factors, but shows the need for improvement in collection of this information. Even this limited data however shows the need for continuation of advice on safe sleeping practices. The group discussed the need to have access to the information from multiple sources, not just Plunket, as some families do not use this service. It was noted that there is sometimes a disconnect between the lead maternity carer and Plunket. This is a structural issue that could be addressed.

BT highlighted that the use of bath seats was becoming popular and that their use may affect the likelihood that children are left unattended in the bath. Analysis found that children under the age of 4 should not be left alone in a bath under any circumstances. The data showed no 'healthy/normal' children over the age of four died of drowning in the bath. BT advised the new edition of the WellChild book has better guidance on safe bathing.

BT commented that he had asked locally what guidance was given about supervision for bathing on the neonatal/postnatal ward and found there was none. The importance of anticipatory guidance (giving the right guidance at the right time) was highlighted.

BT highlighted recommendation 17, of children at risk where they were with adults under the care of mental health services. BT considered that adults who miss a mental health services appointment should be followed up, particularly if they have children.

The group discussed the recommendations as a whole. SK commented that the recommendations did not show where to go from here – Eg: who takes ownership of them? JJ commented that the recommendations around decreasing mortality were not prioritised. There is uncertainty around how many deaths are being commented about. BT advised that the recommendations were not in priority order – some would save lives, while others are important process issues.

JJ asked if DHBs had to choose one, which would be the best one to address? BT responded that it was safe sleeping environment, as it had the potential to save 40 lives a year.

JV queried the difference between recommendations 10 and 11. BT clarified that recommendation 11 was targeting care facilities, eg: foster care, women's refuge. JV commented that the recommendation needs to be made clearer so it is focussed and understandable.


Agreed: EpiQual to give the Minister advise on what recommendations they consider priorities: safe sleeping practices, safe bathing and protocol for death scene investigation. Suggestions include bringing Appendix 1 to the beginning of the report and making the report more accessible to a wider audience.

	<p>Action: Secretariat to draft advice and send to the committee for review.</p>
<p>9. IQ Action Plan</p>	<p>GB explained that a model for the new action plan was needed to allow engagement with the sector. The group went through each of the goals and the questions they had considered for each goal:</p> <p><i>The Treaty of Waitangi</i> – How do we address the issue of manuwhenua versus mātāwaka and how do we get alignment of governance with need?</p> <p><i>Leadership and shared vision</i> – Discussion over the complexities of leadership and enabling a shared vision. The group explored how to get commitment to quality. One suggestion was to require the board/governance structure to publicly report on their spending on quality (ie: on use of the 1% of budget that is allocated for quality). DH highlighted that you cannot change the system unless you allow the framework (ie: the funding) to change to allow it.</p> <p>The group considered that they needed to use the right language and suggested for the goals:</p> <ol style="list-style-type: none"> 1. Maori Governance 2. Leadership 3. Community involvement/planning 4. Culture of quality 5. Continuous Quality Improvement, Innovation 6. Open disclosure 7. Teamwork and Integration 8. Process and Tools [note: relates to 4, but is implementation] 9. Evidence and Measurement 10. Research/Study 11. Safety [Regulation] <p>JV asked about the role of professional self regulation? Discussion over clinicians taking accountability for their role and becoming involved in the quality process. JV queried how do we provide leadership for leaders? SK advised that there was an agency that provided training for senior public sector employees, but they did not accept health sector leaders (such as DHB CEOs).</p> <p><i>Community Involvement</i> – National agreement required on minimum requirements.</p> <p><i>Culture of Quality</i> – Awareness understanding and commitment needed to be applied to the Structure, Process and Culture. Each DHB should have an education programme and have tools available to enable it.</p> <p><i>Continuous Quality Improvement</i>- Questions to ask include ‘Do you have an electronic alert system?’ and ‘Do you have a quality check mechanism in the high risk areas?’ DH highlighted that we want to be clear and simple, linking questions back to the evidence (such as the Davis study).</p>

	<p><i>Innovation</i> – Discussion over taking the opportunity to change and evolutionary redesign of systems. Questions included ‘Do you have systems for recognition of quality?’ and ‘Do you empower your clinical teams?’</p> <p><i>Open disclosure</i> – Do you have a system of honesty and transparency?</p> <p><i>Teamwork</i> - Are your clinical teams physically together? Do you have multi-disciplinary quality assurance activities (HPCA)?</p> <p><i>Tools/Process</i> – Discussion over supporting the workforce to undertake quality improvement activities and review of the HPCA, encouraging adjustments to support the intent of the Act. Questions include ‘Do you use the HPCA?’ and “Are lessons applied and shared nationally?’</p> <p><i>Information/IT/Research</i> - Questions such as ‘Do you have knowledge management systems (people and information technology)?’</p> <p>Action: DH to discuss with the Secretariat how to progress this project.</p>
<p>10. HPCA</p>	<p>The group reviewed the feedback from responsible persons on the template. Positive feedback that responsible persons were pleased to have been given the opportunity to comment. Many however commented on the inability to extract useful data as the information was too broad and that the template is too onerous.</p> <p>DH highlighted that there is a difference between the intent of the legislation and the legislation itself. The group agreed that the template needed to be made simpler. BT suggested that the form be designed around the process in DHBs.</p> <p>Agreed: Working group (SK, DH, JV, BT) to continue with this project.</p> <p>Action: AP to send BT copies of the available DHB PQAA reporting forms.</p>
<p>11. Adult mortality review</p>	<p>GB tabled a first draft of the consultation paper to establish and adult mortality review committee, which would review peri-operative and medical deaths. The paper outlines the arguments of why the Ministry recommends medical deaths should be included and provides three options for consideration.</p> <p>The next step is to refine the consultation document and release it to the sector for feedback.</p>
<p>Meeting closed</p>	<p>4:30pm</p>

Next Meeting: 7 October 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: 7 October 2005
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