

**EPIDEMIOLOGY AND QUALITY ASSURANCE
ADVISORY COMMITTEE
Thursday 21 and Friday 22 April 2005**

Meeting held:	Brentwood Hotel, 16 Kemp Street, Kilburnie
In Attendance:	Denise Hutchins (DH) Chair; Cynthia Farquhar (CF); Jonathan Jarman (JJ); Sharon Kletchko (SK); Barry Taylor (BT); Robin Youngson (RY); Jim Vause (JV);
Apologies	Barbara Greer (BG); Nigel Dickson (ND)
Guests (21 April only):	Barry Borman (BB), Manager (Epidemiologist), PHI Helen Walls (HW), Advisor (Epidemiology), PHI Vladimir Stevanovic (VS), Clinical Advisor/Team Leader, NZHIS Di Best (DB), Team Leader, Cancer Registry, NZHIS Professor Tony Dowell (TD), Wellington School of Medicine John O'Brien (JO), Ian Axford Fellow in Public Policy
MoH attendees:	Gillian Bohm (GB)
Secretariat:	Angie Perry (AP)

Thursday 21 April 2005

Agenda Items	Summary of discussion & decisions
Meeting Commenced	9:30 am
1. Welcome	
2. Confirmation of minutes for meeting held 16th February 2005	Minutes confirmed, with one amendment noted - Section 6, Annual report: Action: SK and RY to work with GB on developing a section on 'Complexity in healthcare'
3. Chairs report	DH highlighted the main focus of activity since the last meeting has been on the annual report.
4. Matters arising from minutes	
4.1 Service Level Agreement	The final draft of the Service Level Agreement (SLA) was tabled. Once finalised, the SLA will be standard for all Statutory Committees. Action: Secretariat to customise the SLA for the Committee and send to DH for signature.
5. Correspondence Inward / Outward	<i>Inward correspondence:</i> Letter from DHB NZ advising that the health sector conferences are currently running nationwide. RY noted concerns that some actions make it difficult for small organisations to participate fully in the conferences, such as sending emails of a large size that are unable to be opened. Discussion over content and purpose of conferences, comment

	<p>that EpiQual may wish to participate in future conferences.</p> <p>Action: DH to provide feedback to DHBNZ regarding large sized emails.</p> <p><i>Outward correspondence:</i> None</p>
<p>6. Monitoring and Measuring Quality – the use of epidemiology and national data</p>	<p>a) <i>Presentation on Cancer Survival by Vladimir Stevanovic, NZHIS</i></p> <p>VS provided an overview of the components and measures for cancer control, how the data is collected nationally and the New Zealand Cancer registry. VS explained the survival standard and how the data can be broken down and analysed; such as survival by stage, socio-economic status and ethnicity. VS advised the Committee of the current cancer related projects being undertaken by NZHIS.</p> <p>b) <i>Presentation on the New Zealand Cancer Registry by Di Best, NZHIS</i></p> <p>DB provided an overview of the Cancer Registry including what data is collected and from where, how the data is coded and the current protocols for registration of cancers. Discussion took place over data collection. DB clarified that for particular cancers additional information is collected and that not all cancers have data collected by stage of cancer. The data is considered to be reasonably complete and reliable, with audits finding very few cases that were not on the register.</p> <p>The Committee queried the extent of data collected from private hospitals. DB advised that currently the data received from private hospitals is minimal, although new legislation coming into force soon will further encourage reporting. GB clarified that data was supplied for public procedures done in private hospitals. The private hospital data from the last ten years is available through NZHIS, but has not been published. DB suggested contacting the NZHIS team leader for private hospitals if the Committee require further information/clarification on private hospital data.</p> <p>c) <i>Summary from Helen Walls and Barry Borman, PHI</i></p> <p>HW and BB tabled a summary of current health indicators collected by Public Health Intelligence. Data is collected in a variety of ways, such as through census data, Statistics New Zealand, ACC, LTSA etc. Some data is collected more regularly than others.</p> <p>The committee and presenters reviewed and discussed each indicator and decided on which indicators should be included in the Chartbook.</p>

	<p>Action: BB and HW to compile the relevant indicators and return to the committee to further discuss this work.</p>
<p>7. Performance Indicators- monitoring performance in the sector</p>	<p>a) <i>Presentation on Performance Indicators for Primary Care by Professor Tony Dowell, Wellington School of Medicine</i></p> <p>TD outlined the project to develop performance indicators for primary care and how Wellington Scholl of Medicine came to be involved in the project. TD identified some of the lessons learnt from the project.</p> <p>An important point to learn from this process is that you need to be clear in defining the purpose of the indicator and what it is going to be used for. TD highlighted that indicators were set up to assess <u>health</u> performance, but were most often used to assess <u>clinician</u> performance. It is important then to note that the sector support performance indicators that have a continuous quality improvement focus.</p> <p>TD cautioned that there is a tendency to measure the measurable, and that there is a need to distinguish between quality, performance and monitoring.</p> <p>TD identified that a good indicator is teamwork. There are well validated measurements for teamwork, however they attract compliance costs at an organisational level.</p> <p>b) <i>Presentation on Performance Measurement by John O'Brien, Ian Axford Fellow in Public Policy</i></p> <p>JO provided comparisons between the American Medicaid system and the New Zealand health system overall, and between Managed Care Organisations (MCOs) and Primary Healthcare Organisations (PHOs) specifically.</p> <p>JO summarised some examples of work internationally on performance measures and highlighted that there were some commonalities in the measures used in NZ, UK, USA and Australia.</p> <p>JO stated that it is important for an indicator for performance measurement be unambiguous. JO also advised that performance measures should, after initial set-up, have a low marginal cost.</p>
<p>8. Summary of key measures from the Australian workshop on 'Review of Future governance arrangements for safety and quality in healthcare'</p>	<p><i>Presentation by Gillian Bohm, MoH</i></p> <p>GB outlined the key themes from the review submissions and highlighted the main areas of discussion; such as the core functions of a national body, what will determine the effectiveness of national action and the vision for national action. GB identified some of the areas were Australia differed in philosophy and structure from the approach that New</p>

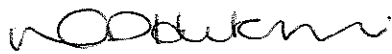
	<p>Zealand takes. The federated system provides different constraints for Australia in structuring a national body. It was noted also that the Australian system remains focussed on safety as opposed to quality.</p>
<p>9. First draft of workplan</p>	<p>The Committee discussed the draft of the workplan. Discussion included that the annual report identifies that complexity and new ways of thinking are important, but this is not reflected in the workplan.</p> <p>The Committee discussed the importance of translating knowledge (the "learning engine") into quality and engaging with the sector on local initiatives.</p> <p>It was suggested that the Committee could arrange in future to meet the DHB and primary care quality managers.</p>
<p>Meeting closed</p>	<p>4:30pm</p>

Friday 22 April 2005

Agenda Items	Summary of discussion & decisions
Meeting commenced 1. General discussion	8:30 am <i>1. Structure of the Chartbook</i> <p>BT proposed a structure for the chartbook; Identify one measure for the whole country (such as 'Healthy at 70') with the three categories of 'Prevention and Public Health', 'Getting treatment' and 'Living with chronic illness/disability'. Each of the categories could be divided with subcategories taken from the IQ strategy – Safety, Effectiveness, Efficiency, Equity, Access and People-centred – with 1 or 2 measures identified within each of the sub-categories. Behind this would be the indicators discussed with PHI.</p> <p>The Committee reiterated that the important themes from the discussions regarding indicators on the previous day was that:</p> <ul style="list-style-type: none">• interpretation is unambiguous• there is low marginal cost• new measures don't have resources diverted to them if they were going to detract from key existing measures. <p>JJ highlighted that the concept of health should look beyond just physical health, for example cultural health should be considered.</p> <i>2. Positive change in complex adaptive systems</i> <p>RY summarised discussion held within an informal forum of health leaders he has been involved with. This forum has concluded that to achieve positive change, managers/clinicians need to have the following skills: systems thinking, dialogue, learning, enabling, values, facilitation, powersharing (in a real world). Achievement of the personal mastery, knowledge, insight and skills will take 5-10 years, therefore the best long term strategy to achieve this leadership is to change the current framework.</p> <p>Thoughts on how this could be achieved included developing a Fellowship in Health System Leadership and providing a three dimensional training approach across leaders, professionals and undergraduates. The Committee discussed the training options and identified that a number of training programmes already exist around the world that could be utilised.</p>

	<p>The Committee discussed EpiQual's role. DH highlighted that the HPCA was expected to enable new ways of thinking and working. BT suggested that EpiQual's role could be to provide a base of information for people on training/resources available.</p> <p>GB commented that professional development for non-medical staff was not included in DHB contracts, which could constrain access to training for non-clinical staff.</p>
<p>2. IQ Action plan</p>	<p>GB identified that the first IQ action plan gathered together the actions that were currently occurring nationally. The second action plan is an opportunity to look forward at what actions need doing.</p> <p>The group discussed possible structures for the action plan. GB clarified that the goals cannot be changed as they are linked to the IQ Strategy, however they can be grouped.</p> <p>The Committee considered the options and drafted a framework. The areas in the framework are Leadership, Data and Evidence, and Tools and Knowledge for Improvement. At the core of these areas are people (populations and individuals). Overarching the framework is the Treaty of Waitangi, underpinned by Regulation and Protection. This framework was drafted as a Venn diagram.</p> <p>The committee considered this framework could also be utilised for EpiQual's workplan and wished to include the framework diagram in the annual report.</p> <p>Action: SK to draft the framework and send to the committee. The final version will be agreed and sent to the Secretariat by Thursday 28th April for inclusion in the final draft of the annual report.</p>
<p>3. Workplan</p>	<p>The Committee drafted the workplan project area, objectives (short and long term), actions, milestones and resources required.</p> <p>The Committee agreed on portfolio interests for each project:</p> <ul style="list-style-type: none"> • Chartbook: JJ, SK, ND, JV • Sector Engagement: RY, DH • Regulation and Protection: SK, DH, JV (standards), BT • Mortality Review Committees and Sentinel Events: BT, CF, RY <p>Action: Secretariat to incorporate draft workplan into existing workplan document and circulate to the Committee for comment.</p> <p>Action: Secretariat to consult with absent members on their preferences for project participation.</p>

4. Mortality Review Manual	GB and BT summarised for the Committee the proposed process for mortality review at the National, Local and Service Level. A manual is currently being developed to provide a universal structure for mortality review nationwide. Action: CF to provide GB with a copy of the standard template used for perinatal mortality review meetings in her organisation.
Meeting closed	3:15pm

Minutes approved	Signature:  Date: 1 July 2005
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Next Meeting: Friday 1 July 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).