

Notes of the 81st meeting of the Health Quality & Safety Commission Board on 26-27 November 2020 at Rydges Hotel Wellington, 75 Featherston Street, Wellington.

- Members: Dr Dale Bramley (Chair), Mr Andrew Connolly, Dr Jenny Parr, Mena Antonio, Rae Lamb, Prof Peter Crampton, Shenagh Gleisner, Dr Tristram Ingham, Dr Collin Tukuitonga.
- Staff: *In attendance:* Dr Janice Wilson, Dr Iwona Stolarek, Richard Hamblin, Chris Walsh, Gillian Bohm, Kere Pomare, Tina Simcock (Minutes) Paula Farrand (EA to the Board), Shelley Hanifan, Caroline Tilah (item 5 and 15).
- Guests: Morag McDowell, Health & Disability Commissioner, members of Te Rōpū Māori (item 8).
- Apologies: Rowena Lewis – Chair, Consumer Advisory Group, Ria Earp – Chair, Te Rōpū and Stephanie Turner (26 November only).

- The minutes of the previous meeting were **approved**.
- The actions of the previous meeting were **updated** and **noted**.
- The interests register, and special register of interests were **updated**.
- Members board related activities were **noted**.
- The Health and Disability Commissioner update was **noted**.
- The chief executive report was **noted**.
- The financial report and risk register were **discussed**.
- A **patient story** was provided by way of a video.

Key decisions – the Board:

- a) **Approved** the revised mortality review committee's terms of reference template, to be customised for each of the five mortality review committees, with final approval by the board chair.
- b) **Approved** the mortality review committee's conflicts of interest guide to provide a best practice approach to identifying and managing conflicts of interest for the committees and Commission.
- c) **Agreed** in principle to the plan for a sustainability phase of any quality safety markers (QSM), which includes:
 - i. evidence of review of the progress of the QSM process measures against the original target
 - ii. a monitoring plan to ensure ongoing oversight
 - iii. a plan for acknowledgement of improvement, or intervention, if the outcome measure(s) decline
 - iv. a stakeholder management and communication plan to ensure a successful outcome.
- d) **Agreed** QSM sustainability management plans, will be provided to the board for final approval, prior to initiating.
- e) **Agreed** staff proceed with moving to a sustainability plan for the falls QSM process measure by 31 March 2021.
- f) **Agreed** staff proceed with moving to a sustainability plan for the safe surgery QSM process measures by 30 June 2021.
- g) **Agreed** staff proceed with developing new safe surgery outcome measures for monitoring as part of the DHB quality alerts.

Adverse events data 2019-20 publications

The national summary of the 2019/2020 data will be published on the Commission's website on 10 December 2020, and a media release circulated. In the future, an annual summary of adverse events will be featured in the Commission's annual report.

The board discussed the value that would be gained if more non-DHB health providers reported adverse events; in particular, general practice and aged residential care providers.

Mortality review committee terms of reference

The mortality review committee sought board approval of a revised terms of reference template and approval of the conflicts of interest guide. Following independent review, the terms of reference have been consolidated and simplified.

Te Rōpū Māori

Members of Te Rōpū Māori joined the board meeting. Discussion included:

- the best ways Te Rōpū can work with the board in relation to partnership, concepts of Te Tiriti and two-way discussion and advice.
- the Commission is 'walking the talk' in its commitment to Te Tiriti and Māori, and it has been really pleasing to see how things have grown in terms of responsiveness to Māori over the years.
- the health system is going through a redesign and this is an opportunity for Te Rōpū to help advise the board about the Commission's future position. This includes how we work with the new Māori health authority (MHA).

Refreshed Commission in the new reformed health system

The chief executive introduced the paper on the refreshed Commission in the new reformed health system, and provided a brief presentation. Suggestions for extending the Commission's core role as a national quality and safety agency were provided for the board's consideration and discussion.

Discussion with Stephen McKernan – Transition Unit

Mr McKernan gave an update on the health sector reforms, and the establishment of the Transition Unit. He outlined upcoming 'big policy choices' which include how meaningful Te Tiriti partnerships are reflected through all levels of the system, and options related to a Māori Health Authority; the overall system operating model; financial sustainability; disability; wider social sector integration; and pace of change.

Mr McKernan noted that a fresh approach to commissioning for tier one was needed, one that reduces inequity. There was also a need for strengthened performance monitoring.

Consumer advisory group

Members of the consumer advisory group joined the meeting. Discussion included:

- the importance of consumers being involved at every level of the planning and implementation of the new health reforms
- the need for a much stronger consumer voice at every level. The Commission and the consumer advisory group will work together on this
- the consumer voice on DHB consumer panels is variable, and the need for greater consistency.

Quality and safety markers sustainability plan

A plan was presented for the 'retirement' of Commission quality and safety markers (QSMs) for falls and safe surgery New Zealand (SSNZ), and the development of new safe surgery outcome measures that will be embedded in the quarterly quality alert.

There was lack of support for the use of the term 'retirement' and the term 'QSM sustainability plan' will be used instead.

It was suggested that a threshold is set for the outcome measure, so DHBs under that threshold would be required to address this. This would facilitate a formal approach the Commission could take to responding to deteriorating performance on outcomes.

There should also be a 'stretch' outcome measure over time to recognise improvement in care that would mean the threshold could be lowered.

Mortality review committee appointments

The Board considered a range of appointments and reappointments to mortality review committees (MRCs).

The board:

- **agreed** to recommended appointment of one committee member to Child and Youth Mortality Review Committee.
- **agreed** to recommended reappointment of one committee member to Family violence Death Review Committee for three years.
- **agreed** to recommended reappointment of one committee member to Suicide Mortality Review Committee.