Notes of the 54th meeting of the Health Quality & Safety Commission Board held on 21 July 2016 in Auckland

Present:	Prof Alan Merry (Chair), Dr Dale Bramley, Shelley Frost, Robert Henderson, Dr Bev O'Keefe, Dame Alison Paterson, Gwen Tepania-Palmer
In attendance:	Dr Janice Wilson (Chief Executive), Karen Orsborn, Richard Hamblin, Chris Walsh, Iwona Stolarek, Gabrielle Nicholson & Gary Tonkin (both via teleconference, items 10-11), Ethan Tucker (minutes)
Guests:	Dr Sally Roberts (items 10-11), Nicola Owen (item 2)
Apologies:	Heather Shotter

Key points and decisions are summarised below.

- A **patient story** was provided by a patient around several stays she had at Middlemore Hospital in 2014 and 2015.

- 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 finance report and risk register were presented and **noted**:
  - o WAP2 accommodation project

  The Board:
  - o **noted** the financial results for the year ending 30 June 2016
  - o **noted** the July Audit NZ visit, and that an interim audit report will go to the Audit Committee at the end of July
  - o **noted** the status of the WAP2 process, and that there is no longer the need to consider signing an MOU by the end of July 2016
  - o amended to focus only on audit and risk, and its name be changed to the Audit Committee

- The Board discussed the Q4 quarterly report, the final report on the 2015/16 SPE deliverables until the Annual Report. Nearly all deliverables have been achieved on schedule, with one listed as 'substantially achieved' due to a delay of one month in providing a survey of DHB safety culture, and one listed as 'partially achieved' due to a revised approach to delivering national guidance on clinical governance for quality and safety.

  The Board:
  - o **agreed** that the fourth quarter report be sent to the Ministry of Health subject to the inclusion of any Board feedback

The Board agreed to appoint Dr Jacqueline Short for an initial one-year term to the Family Violence Death Review Committee, on the recommendation of chair Assoc Prof Julia Tolmie. Dr Short has been serving as a co-opted FVDRC member filling a vacancy created by the departure of Miranda Ritchie.

  The Board:
  - o **noted** that Dr Jacqueline Short has been serving as a co-opted member on a one-year term since January 2016
  - o **agreed**, on the recommendation of FVDRC chair Assoc Prof Julia Tolmie, to appoint Dr Jacqueline Short to FVDRC as a full member for one year initially from 1 August 2016, subject to background checks

- The balanced scorecard and exception report were presented and **noted**.

- Richard Hamblin described the technical details of his paper outlining how the Commission intends to measure the value of its work. This has emerged from NZIER's recommendations, and involves using avoided costs of harm, effective expenditure, associated value of quality adjusted life years (QALYs) gained, and value of statistical lives for avoided deaths.

  The Board:

  - **noted** progress in developing the Commission's ability to measure the value it provides, informed by NZIER's recommendations

- The chief executive presented a report which included the following topics:
  - updates on implementing POMRC and PMMRC recommendations
  - summary of the Commission's cooperation with ACC
  - updates on the Ombudsman's 'transparency of information' provisional decision implementation of Te Whai Oranga, the Commission's Māori advancement programme.

- Sally Roberts presented the Hand Hygiene and *Staph aureus* bloodstream infections paper, which sets out measurement options for the Commission's hand hygiene programme, as requested by the Board on 13 April. The issues raised in April were discussed by the IPC governance and advisory group (SIPCAG) in May, which informed the development of these options.

The Board:

- **noted** the advice from the Strategic Infection Prevention & Control Advisory Group (SIPCAG) to focus on increasing the range of wards that are audited for hand hygiene compliance, along with other activities, rather than increasing the hand hygiene target above 80 percent

- **agreed** that the Commission should develop proposals to ensure auditing for hand hygiene compliance occurs across a full range of clinical areas

- **agreed** that the Commission should continue the hand hygiene programme as proposed by SIPCAG, but should develop a new structure marker (aimed at reporting on areas audited) to be reported alongside the current process marker and the current outcome marker

- **agreed** that *Staphylococcus aureus* bloodstream (SAB) rates should not be decoupled from the hand hygiene programme at this time, but should continue to be reported as an important indicator of the quality of IPC practice generally

- **noted** that further work is required to understand how SAB should continue to be reported within the Commission's measurement framework

- **agreed** that the Commission should consider processes to ensure stronger and more effective auditing of the outcome marker and process marker for hand hygiene

  - The Board considered the surgical site infection expert recommendations to retire the skin antisepsis process quality and safety marker from 30 June 2016. As compliance with the marker has been high and stable, the programme's expert faculty group and advisory group both recommend the marker be retired, to ease the compliance burden on providers. Every procedure is captured through ICNET, which provides comprehensive data on every patient. There is also likely to be some value in extending monitoring to private providers, given the wide range of elective procedures they carry out.

The Board:

- **agreed** to retire the current surgical skin antisepsis preparation process QSM from 30 June 2016

- Karen Orsborn presented the paper summarising the conclusion of the *Open for better care* national patient safety campaign, which ran from May 2013 to June 2016. Some valuable legacies of the campaign will continue after *Open*'s conclusion, and the Board acknowledged the positive results and the hard work that has gone into the campaign. *Open* has been a valuable tool for engaging the sector, and will inform our future efforts of this kind. Developing primary care topics may provide an opportunity to reuse these skills and the *Open* approach of a strong focus on simple changes informed by strong evidence.

  The Board:

  - **noted** that the *Open for better care* campaign formally concluded on 30 June 2016

  - **noted** the legacy items of the campaign, including:

    a. new regional quality and safety alliances
    b. the *Open* brand
    c. Patient Safety Week
    d. Patient safety resources for specific interventions
    e. Links with the quality and safety markers

  - **noted** that DHBs and other providers have been thanked officially for supporting the campaign.

- The correspondence file was **noted**