Summary notes of the 96th meeting of the Health Quality & Safety Commission Board on 24–25 November 2022 held at Chartered Accountants, 50 Customhouse Quay, Wellington.

24 November 2022

Members: Dr Dale Bramley (Chair), Mr Andrew Connolly, Prof Peter Crampton, Shenagh Gleisner, Dr Wil Harrison, Rae Lamb, Dr Collin Tukuitonga.

Staff: *In attendance:* Dr Janice Wilson, Gillian Bohm, Victoria Evans, Fritz Evile, Richard Hamblin, Kayleen Katene, Bevan Sloan, Martin Thomas, Stephanie Turner, Deon York, Paula Farrand (EA to the Board), Shelley Hanifan (minutes), Paul McBride – item 10, Pauline Gulliver – item 11, Kere Pomare – item 12, Caroline Tilah and Glen Mitchell – item 14, Catherine Gerard – item 15.

Guests: Angie Smith – Co-chair, Consumer Advisory Group, Morag McDowell – Health and Disability Commissioner, Dick Ongley – Chair, Perioperative Mortality Review Committee, Fiona Cram – Chair, Family Violence Death Review Committee.

Apologies: Russ Aiton, Ria Earp, Dr Tristram Ingham, Dr Jenny Parr.

- 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**.
- A patient story was provided by way of a video.
- The Health and Disability Commissioner update was **noted**.
- The Chief Executive report was **noted**.
- The financial report was **discussed.**

Consumer advisory group membership

The Director, Partners in Care introduced the item, reminding the board that Te kāhui mahi ngātahi | the Consumer advisory group (CAG) membership was extending from four to eight members.

The board:

- **agreed** to Te Kāhui Mahi Ngātahi | Consumer advisory group being co-chaired, modelling a partnership approach.
- **noted** the current vacancy of Te Kāhui Mahi Ngātahi | Consumer advisory group, with the expectation of appointment in January 2023.

Disability scope, what's in train and what's to come

The principal advisor, policy briefly introduced the item highlighting work across the Commission contributing to health quality for disabled people. The Director, Health Equity highlighted that he is seeking to appoint a senior advisor, disability and working to develop a more formal work programme in health quality for disabled people. The importance of ensuring visibility of work to improve health for disabled people in all reporting was emphasised.

Noting papers

It was confirmed that the information provided by consumers was helpful. There was a discussion about current pressures on the health system.

Board meeting with Te kāhui mahi ngātahi | Consumer advisory group

Te kāhui mahi ngātahi | the consumer advisory group (CAG) was welcomed to the meeting, and introductions made. CAG noted that consumers are still missing within decision making structures and organisations need support to implement the Code of expectations for health entities' engagement with consumers and whānau. More explanation is required for consumers and whānau also, about why participation is important. The value of community action during this time of change was recognised. The specific knowledge and value that consumers and whānau bring into health sector organisations is badly needed to help guide effective change.

The Director of Partners in Care and the CAG were asked to advise on how the Commission can most usefully guide effective consumer and whānau participation at locality, hospital, regional management and quality/clinical governance level.

Perioperative Mortality Review Committee (POMRC) infographic and dashboard

The Chair of POMRC was welcomed to the meeting and introduced the work being done to make POMRC information more accessible. The board asked for additional consideration of the public facing infographic messages, to ensure they are simple and positively framed.

The Senior Analyst, Health Quality Intelligence presented on the POMRC interactive dashboard work, noting that it will be released in three weeks' time to an audience of health care professionals and others who are given access. This is not a public facing tool at this stage. Making this or similar work more widely available, can be worked toward in the future. The board was interested in how the tools and information can be used to support action to improve equity.

The POMRC was thanked for their work and congratulated for making their information more widely available and accessible.

The Board:

- **agreed** to the release of the Levels 1 and 2 of the Perioperative Mortality Review Committee's workstream on 15 December 2022 which includes a public facing infographic and an interactive dashboard (Perioperative Mortality Explorer)

Family Violence Death Review Committee families of homicide survivors

The Chair of Family Violence Death Review Committee (FVDRC) introduced the draft FVDRC Report - *An ongoing duty to care: Responding to survivors of family violence homicide*, which follows up on the children who survive family violence deaths. The draft report provides what the FVDRC imagine would be the ideal scenario in terms of support for survivors. The board congratulated the team for this innovative approach. It was acknowledged that this approach may be challenging for those working in government and agencies. The skills of people in 'connector' roles, and the challenges of building and maintaining these skills in communities was recognised.

The Joint Venture Business Unit (Te Puna Aonui) has offered to work with the Commission and FVDRC to develop a framework to assist with implementation. There is likely to be a relationship agreement developed to underpin this work. The board would like to have Te Puna Aonui attend a future meeting.

The Board

- **approved** the publication of the Family Violence Death Review Committee's report 'An ongoing duty to care' on the Commission's website in February 2023.

National mortality review function change update

The Director of Strategic Initiatives updated the board on progress to date. Generally, feedback from stakeholders has been positive, and the team is working hard to ensure a well-managed transition. Staff have looked further into establishment of an interim National Mortality Review Committee (NMRC) and received expert legal advice. We can bring forward implementation of the permanent NMRC to 1 July 2023, avoiding the need for an interim MRC, allowing a cleaner change. We will have terms of reference ready and calls for nominations to allow us to have appointments made by the end of May. Induction of new members would occur in June 2023. We will develop terms of reference for an Expert Advisory Group to support the tasks of establishment from February-June 2023.

The resignation of Suicide Mortality Review Committee (SuMRC) members was discussed. A letter will be drafted for the chair to sign, thanking members for their contribution to national learning and hoping for the opportunity to work with them again in the future.

The board thanked the team for their hard work and efforts.

Supporting the new health system to use data for improvement

The Assistant director, Health quality intelligence was welcomed to the meeting and introduced the item. While a number of data ecosystems exist, the role of different agencies linking together to support quality is still emerging.

It is important that data is used to inform policy, and that a Pae Ora Act view of quality and focus leads this. It was acknowledged that there is a window of opportunity to inform and direct decisions on data for quality, within organisations, including primary care and in services. The importance of a common narrative about our shared quality data across the system was discussed. We can help specify and ensure that key contributors have the data that they want and need to undertake their quality roles, including Iwi Māori Partnership Boards and primary care.

Final national adverse events policy

The Specialist, Adverse Events introduced the item, noting that the 'Healing, learning and improving from harm: National adverse events policy 2023' is a revision of the 2017 National Adverse Event Reporting Policy. It incorporates feedback from key stakeholders, embeds and enacts Te Tiriti o Waitangi and incorporates a te ao Māori worldview. The policy accounts for changes to the regulatory framework via NZS 8134:2021 Ngā Paerewa health and disability services standard, extending the range of providers who will need to meet policy requirements.

Discussion reflected strong support for the policy. Concerns regarding the inconsistent application of the Severity Assessment Code (SAC) Criteria and sector guidance for all providers from the Commission were addressed.

The Board:

- **approved** the publication of the 'Healing, learning and improving from harm: National adverse events policy 2023' that comes into effect 1 July 2023.

25 November 2022

Members: Dr Dale Bramley (Chair), Mr Andrew Connolly, Prof Peter Crampton, Shenagh Gleisner, Dr Wil Harrison, Rae Lamb, Dr Collin Tukuitonga.

Staff: *In attendance:* Dr Janice Wilson, Gillian Bohm, Victoria Evans, Fritz Evile, Richard Hamblin, Kayleen Katene, Bevan Sloan, Martin Thomas, Stephanie Turner, Deon York, Paula Farrand (EA to the Board), Shelley Hanifan (minutes)

Guests: Morag McDowell – Health and Disability Commissioner (zoom), Ria Earp – Chair, Te Kāhui Piringa, Members of Te Kāhui Piringa

Apologies: Russ Aiton, Ria Earp, Dr Tristram Ingham, Dr Jenny Parr.

Risk appetite

The reforms have brought the opportunity and the responsibility to share views on quality when there is evidence and the Commission can make an authoritative contribution. It is important to select the right things to speak out on, based on evidence and context, and to have the right spokespeople. Timing is key. We need to highlight issues and not allocate blame.

A framework of criteria covering selection, timing, framing and process requirements to be met, would be helpful. The board agreed that there is overall support to be more outspoken, with careful decision making on topics and approaches that will be regularly discussed at each board meeting.

Board meeting with Te Kāhui Piringa

The Chair Te Kāhui Piringa highlighted that Te Rōpū Māori has decided that their new name will be Te Kāhui Piringa. The group introduced themselves and talked about how to work together well. Time will be required for new members of Te Kāhui Piringa to understand their role and how to maximise it. So far, members have been impressed with papers, and with the Te Ao Māori Framework. Te Kāhui Piringa will decide and advise the board on how often they will meet and how they would like to work with the board.

Te Ao Māori Framework implementation and socialisation update

The Director, Ahuahu Kaunuku highlighted that the final draft of the framework is being worked on. There is a need to align the framework with other tools, as a suite to drive action. There are a range of complimentary tools and thought must be given to how they work together.

The communications team is working with Ahuahu Kaunuku to prepare videos and materials to support the roll-out in the new year. The intention is to pilot phase one with organisations that have been involved with the project, and then to take the pilot wider later in the year. Ahuahu Kaunuku are also working closely with the education and training team to ensure planning for sector education as well.

The process of development and piloting is being written up and there is very good feedback about Wairuatanga being at the centre of the framework. A long-term commitment to this work is required. It will take time for the sector to change, and to build in te ao Māori as normal operating.

The Te Ao Māori Framework is to be shared with Te Aka Whai Ora for comment and feedback.

Recommendations for surgical mesh

The Medical director and executive lead (quality systems) highlighted the complex challenges presented by surgical mesh. The Health and Disability Commissioner offered to work with the Commission towards a goal of expediting the work underway to resolve the challenges, and this was welcomed.

To minimise the risk of harm to patients from surgical mesh, the board agreed to:

- strongly advise Te Whatu Ora to implement a process for all urogynaecological procedures involving mesh insertion to be discussed at a multidisciplinary meeting.
- recommend that Manatū Hauora mandate that all public and private facilities where urogynaecological mesh is inserted have processes to ensure every case has been discussed at a regional multidisciplinary meeting.
- recommend that Manatū Hauora undertake an audit of the current credentialed status of public and private surgeons and facilities and mandate that facilities must ensure surgeons have been credentialed within the previous two years.
- recommend Manatū Hauora expedite the work on establishing a mesh registry.
- request an urgent response from Manatū Hauora and Te Whatu Ora on the above actions with clear timelines for implemented.
- undertake a coordinated approach to the above with the Health and Disability Commissioner in addressing the concerns related to potential for harm for patients from mesh implantation, through the development of a join media release and joint letters to agencies.
- Andrew Connolly, as the appropriate spokesperson, and talking points will be developed to support him to speak directly to the public.
- a meeting with the Medical Council to discuss appropriate practice for urogynaecological surgical mesh implantation.