Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 14 March 2018**

Meeting: **3.00 pm to 5.30 pm**

Venue: **Te Waiora Meeting Room (Boardroom), District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Council Members:

Dr John Gommans (Co-Chair)
Dr Andy Phillips (Co-Chair)
Chris McKenna
Dr Mark Peterson
David Warrington
Dr Robin Whyman
Lee-Ora Lusis
Dr Nicholas Jones
Jules Arthur
Maurice King
Dr Tae Richardson
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Peter Culham

Apologies: Dr Tae Richardson and Anne McLeod

In Attendance:

Kate Coley, Executive Director - People & Quality (ED P&Q)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator / EA to ED P&Q
Kerri Nuku, Māori Relationship Board Representative

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and receive apologies	3:00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Workplan	
	Section 2 – For Discussion / Decision	
6.	Clinical Governance Structure – Value Assessment – Co-Chairs	3:10
7.	Clinical Governance of Investigation Results Policy – Co-Chairs	3:25
	Section 3 – Presentations / Discussion	
8.	Choosing Wisely Presentation – Andy Phillips	3:45
9.	Clinical Services Plan – Sector Update – Ken Foote	4:10
10.	HB Health Sector Leadership Forum Reflections – Co-Chairs	4:15
	Section 4 – For Information Only (no presenters)	
11.	Cardiology Review and plan of action	-
12.	Establishing Health and Social Care Localities in HB (six monthly update)	-
13.	HHB Clinical Advisory and Governance Committee	-
	Section 5 – General	
14.	Topics of Interest – Member Issues / Updates	4:35
15.	**Section 6 – Recommendation to Exclude the Public**	

Public Excluded

Item	Section 7 – Presentation	
16.	Demand / Capacity – Andy Phillips	4:50

NEXT MEETING: Wednesday, 11 April 2018 at 3.00 pm, Boardroom, HBDHB Corporate Office

Interests Register
16 February 2018

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Family member employed by HBDHB since November 2015	Daughter, RMO	Will note interest if discussions occur around RMOs.	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Primary Heatlh Alliance	Executive Member	Primary Care advocacy organisation	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Chair of NZ AMDC	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMDC representing those based in NZ	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region	No	
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chriopractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary			
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	Nature of Interest **eg Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Manager	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health		No	
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
	National Information Clinical Leadership Group	Member	Professional network	No	
Maurice King (Community Pharmacist)	Napier Balmoral Pharmacist	Shareholder and Director	Community Pharmacy	Yes	Has various contracts with HBDHB to provide pharmacy based services. Low. Ensure position declared when discussing issues in this area.
	Pharmacy Guild of NZ	Member	Representative and negotiating organisation for Pharmacy	Yes	Negotiations on behalf of Napier Phamacy with HBDHB. Low. Ensure position declared when discussing issues in this area.
	Phamaceutical Society of NZ	Member	Pharmacy advocacy, profressional standards and training.	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Independent Advisor	No	
Dr Peter Culham (GP)	Havelock North Properties Limited	Shareholder	Medical Centre owner	Yes	Low, pecuniary, hold leases with healthcare providers
	Te Mata Peak Practice	GP and Director	General Practice	Yes	Low, percuniary, provides primary care services
	C&G Healthcare	Director	Private business	No	No further exposure beyond mentioned above
	Royal NZ College of General Practitioners	Fellow		No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 14 FEBRUARY 2018 AT 3.00 PM

PUBLIC

Present:
Dr John Gommans (Chair)
Dr Andy Phillips (Co-Chair)
Chris McKenna
Dr Russell Wills
Dr Robin Whyman
Dr David Rodgers
Dr Nicholas Jones
Dr Tae Richardson
Dr Peter Culham
Debs Higgins
Jules Arthur
Anne McLeod
Lee-Ora Lusis

In Attendance:
Ken Foote, Company Secretary
Kate Coley, Executive Director – People & Quality (ED P&Q)
Tracy Fricker, Council Administrator and EA to Executive Director – People & Quality
Ana Apatu, Maori Relationship Board Representative (on behalf of Kerri Nuku)

Apologies: David Warrington and Dr Mark Peterson

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr John Gommans (Chair) welcomed everyone to the first meeting of 2018. A welcome was also extended to new member Dr Peter Culham, GP Representative. Dr Culham provided an overview of his background and roundtable introductions took place.

Dr David Rodgers introduced Dr James Newman, GP Registrar, Waipukurau who attended the meeting as an observer.

Apologies were noted as above.

2. INTEREST REGISTER

No conflicts were noted for items on the agenda. There were no additions or amendments to the Interest Register.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 6 December 2018, were confirmed as a correct record of the meeting.

The minutes of the combined meeting of the HB Clinical Council and HB Consumer Council held on 6 December 2018, were also confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 IS Roadmap Presentation
The Company Secretary advised that Anne Speden, Chief Information Officer had requested this be deferred to the March meeting.

Item #2 Clinical Governance Committees Structure
On today's agenda under item #8 for discussion.

Item #3 Clinical Council Workplan
On today's agenda under item #9 for discussion.

Verbal Update regarding Person & Whanau Centred Care

The Chair advised that following the workshop at the December meeting the Co-Chairs and Company Secretary met with the Consumer Council Chair to discuss how we take this work forward. It needs to be clear for the Board on what is meant by Person and Whanau Centred Care and how it translates into actions and the objectives we want to achieve. The key issues from the feedback were:

- Language
- Leadership
- Resourcing
- Putting it into practice

There is a lot of work going on in the DHB but there is a need to have an overarching strategy which also incorporates the people strategy. Once the strategy has been developed, resources would be required to implement. It was also acknowledged that the Nuka model of care would also strengthen and feed into this as a critical component.

The People & Quality Directorate has been requested to develop the strategy on behalf of the Clinical Council. The ED P&Q commented that a lot of engagement will occur in the development of the paper.

Actions: ***Strategy document to be prepared by ED P&Q for Clinical Council***
Summary of meeting notes to be sent out to Clinical Council members

SECTION 2: DISCUSSION / DECISION

5. QUALITY ANNUAL PLAN 2017/18

Kate Coley, Executive Director – People & Quality (ED P&Q) provided a progress report on the Quality Annual Plan.

Key points noted:

- Improvement advisors becoming embedded within Directorate Leadership Teams
- Involvement in directorates and services engagement with consumers in co-design projects
- Achievement of all HQSC safety markers and maintaining number one or second position in hand hygiene for the last 12 months
- Agreement and contract signed to proceed with the implementation of a new integrated risk management system
- Delivery of Relationship Centred Practice Development Programme

General discussion took place regarding the new integrated risk management system and the importance for the Clinical Council to see the breadth of clinical risks around the hospital; having a common platform and set of indicators for directorates; sharing data in primary care; contractual and relationship issues with sharing data widely; the balance of transparency of information and being able to make valid comparisons and information being used for quality improvement measurement and not performance management. It was noted that relationship and trust between the hospital and primary will build overtime.

The ED P&Q advised that the timeframe for implementation of the system is end of September.

6. CLINICAL PORTAL PROJECT (FOR BOARD APPROVAL)

The Chair welcomed Anne Speden, Chief Information Officer, Michael Sheehan, Project Manager RHIP and Dr Matt Bailey, Intensivist and Clinical Lead to the meeting.

Key points noted:

- Clinical Portal will replace ECA inside the DHB only at this stage (primary care interface is a separate project), the DHB needs a stable platform that it can build on first
- It will be a consistent inference, shared solution for patient information across the region
- Orion Health has developed the software and the project is using the internal IS team, clinician engagement, and sets of skills from others as needed
- Capital and operational expenditure spans over two financial years 2017/18 $258k and 2018/19 $262k, which is already budgeted
- The project reports regularly to the IS Leadership Group and FRAC
- Timeline is on track to deliver in April ability to view all regional clinical information. In June it will deliver ability to view all our own clinical patient information and external/regional data
- Learnings have been gained from Wanganui and MidCentral DHBs experience and there will be a progressive implementation across HBDHB for the various features and functions of the system
- HBDHB has taken a lead role in the region and it is now a clinically driven system, it will be a platform for the future and the technology will be developed to support the “people process” not IT driven
- An external review was undertaken and the resilience of the initial system proposed was not robust enough. Changes have been made to the base platform so we will not inherit any instability
- CTAS will bulk fund Orion for a whole stream of work so we will see outcomes more quickly
- HBDHB has developed a strategic partnership with Orion and they have offered us a prototype shop at HBDHB so we can see new functions and will be able to test and adopt them if we wish
- Objective is for the project to be completed by December 2018

The Chair complimented Anne Speden and her team for the turnaround from a position where Hawke’s Bay was seen regionally to be dragging the chain to now leading the process. The purpose of this project is for the DHB to have a fit for purpose base platform that we can build on in the future, which will include access for primary care. Anne confirmed discussions are already underway with primary care.

General discussion took place regarding the view, functionality, features, reporting and access to the system.

The Clinical Council noted the contents of the report and **endorsed** the implementation of the Clinical Portal Business Case.

SECTION 3: INFORMATION / DISCUSSION

7. CLINICAL SERVICES PLANNING UPDATE

The Company Secretary provided a verbal update on the project.

Key points noted:

- Work began last year with meetings and data collection to get a clear picture of the current state of clinical service delivery for Hawke's Bay - demand issues and supply
- A baseline document was prepared by Sapere to form the basis of all future planning
- Future planning was due to commence at beginning of February to March, with a draft CSP completed by the end of March. Due to other activities going on and pressure on staff a decision has been made to push the timeline for the project out
- Sapere have analysed the current state document and identified the key issues for the Hawke's Bay health system to be addressed within the CSP. These documents will be loaded on the Our Health website
- In April, four, three-hour future state option workshops will be held on frailty and elderly; vulnerable population; hospital and primary and community care. An integrated workshop will also be held including participants from the four workshops in May
- Sapere will take all the information from the workshops and come back with a draft CSP by end of June. During July this document will have a limited circulation internally, including all the governance groups to give feedback with the ability to make changes. The next step will be for wider consultation internally and externally during August-September. This is important as it sets the scene for the future and need to ensure that all groups are able to provide feedback. All comments will be collated and feedback to Sapere for them to produce a final CSP which will come through all governance groups for endorsement and then to the Board for sign-off in October
- It is important that the CSP is in place by the end of the year as it feeds in to a Hawke's Bay Health Sector Strategy. Transform and Sustain is due to end on 31 December 2018 so its replacement needs to be in the early stages of development by then. The CSP will form a core component of this.

The Chair commented on the need to get the right clinicians and the right mix of people to the workshops. The CSP is a roadmap and longer term view of the Hawke's Bay Health Sector for the next 10-15 years.

8. CLINICAL GOVERNANCE STRUCTURE – VALUE ASSESSMENT

Dr Andy Phillips (Co-Chair) provided a summary of the work taken to date for the clinical governance structure and value assessment, which will be reported to the Board in March.

The paper includes eight recommendations for the Clinical Council to discuss:

1. Changes to structure following December meeting

Changes made to the structure with further decisions regarding CAGC and Equity and Integration advisory groups discussed below.

2. Increase primary care representation on clinical advisory groups

Agree more engagement and ownership by primary care is needed. We need whole of sector engagement if we are to meet our obligations and the needs of the Hawke's Bay health system and to value their input.

Need to look at other ways for meeting e.g. video conferencing, working online, meeting in evenings, emails. Remuneration and help from DHB/PHO to find backfill. This need applies to all professions including LMCs and community pharmacists. Working on these committees/advisory groups is seen as a good learning experience. It is important to invite people from the inception, hold people accountable and look at what competencies are required around the table and choose from the quality improvement core competencies. A governance training programme also needs to be developed.

3. Equity in the governance structure and reporting line

Equity in particular the outcomes for difference between Maori and non-Maori is an issue in our health system, therefore there is a need for all groups have a focus on equity. Under the Health & Disability Act we also have a statutory responsibility to reduce, with a view to eliminating health outcome disparities. Inequities also relate to age, gender, economic status and geography.

Agree that equity is an important part of clinical governance and needs to be reflected in our structures and reporting.

Agree that equity should be included in the terms of reference for all committees and advisory groups. One way of doing that would be to reference the New Zealand healthcare triple aim (the simultaneous pursuit of Improved quality, safety and experience of care for individuals; improved health and equity for all populations; and best value for public health system)

Agree that there needs to be a technical group advising Clinical Council on equity

The Clinical Council believe equity is important and is part of everything we do and there is a gap in the clinical governance of equity. It did not come to a firm view that it should be an equity committee reporting to the Clinical Council or be part of a bigger solution across the health sector. Agreed that a discussion needs to be had with other governance bodies, especially the Board on the place of equity and the clinical governance of equity.

4. Reporting Line for PHO Clinical Advisory & Governance Group (CAGC)

CAGC is the equivalent to the PHO as the Clinical Council is for the DHB Board. It is appropriate that it sits on the top level as a clinical committee. All other five committees should have a relationship to CAGC and vice versa.

5. Reporting Line for Maternity Governance Advisory Group

Agreement had previously been achieved that this group should report up to the Patient Safety & Risk Management Committee.

6. Integration within the governance structure

On hold pending agreement of the Alliance Structure.

7. Develop a business case for the additional management and administration support

Agreed that this is important and also taking into account resourcing for enabling participation by community and primary health colleagues (appendix 4).

8. Clinical governance structure be implemented with appropriate supports by 1 July 2018

Agreed.

The Chair advised that the recommendations will be discussed at EMT next week. Following this a final paper will be presented to Clinical Council for ratification at its meeting in March and then a report will go to the Board in March.

9. CLINICAL COUNCIL'S ANNUAL PLAN 2017/18 AND 2018/19

The Annual Plan was provided in the meeting papers. It was agreed that the Annual Plan from last year be rolled over for 2017/18. Clinical Council needs to be proactive rather than reactive and have goals that can be achieved over a 12 month period.

Action: ***Annual Plan and goals to be discussed at the next half day meeting.***

10. ADVERSE EVENTS UPDATE

The Chair provided an update on the adverse event report which is reported annually by the Health Quality & Safety Commission on hospital serious adverse events. In past years HBDHB has reported between 11-13 events, this year 21 were reported. The Board Chair was concerned at this increase and requested a six-month update.

Discussion held regarding need to encourage more reporting and ensure clinicians do not feel a risk to their livelihoods from reporting events; to look at the moderate and near miss events; quality improvements from these events and safety of the hospital when it is under pressure.

The report was **noted** by the Clinical Council.

11. CLINICAL GOVERNANCE OF RESULTS

The Chair provided an update on the current issues around the clinical governance of results. Eight main issues identified:

1. No clear policy around clinical governance of and responsibility for results
2. Large volume of historic unsigned results in the DHB system
3. >260,000 open referrals in DHB system and results to cc all
4. Multiple DHB clinicians getting the same result
5. Incorrect ID of requestor, event, patient
6. Incorrect or unknown GP and some GP Practices now requesting the practice rather than GP be used
7. ECA is cumbersome for results sign-off and no ability to transfer responsibility
8. Issues of inconsistently transferring results from external providers into ECA

This is a whole of sector problem. A draft policy Clinical Governance of Investigation Results has been developed. The Chair requested feedback on the draft policy.

Action: ***Draft policy to be sent to members in word format to enable changes/comments to be tracked.***

SECTION 4: MONITORING (for information only)

12. NGATAHI VULNERABLE CHILDREN'S WORKFORCE DEVELOPMENT PROGRESS REPORT

The report was included in the meeting papers for information only. The Co-Chair congratulated Dr Russell Wills and Bernice Gabriel, Programme Manager on the work undertaken to date which has gone exceedingly well.

13. SUICIDE PREVENTION UPDATE

The report was included in the meeting papers for information. No issues discussed.

14. TE ARA WHAKAWAIORA - ACCESS 0-4 / 45-65 YRS (LOCAL INDICATOR)

The report was included in the meeting papers for information. No issues discussed.

15. HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS DASHBOARD Q2 (OCT-DEC 2017)

A copy of the report was provided in the meeting papers. No issues discussed.

SECTION 5: GENERAL

16. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

Nil.

The meeting closed at 5.45 pm.

Confirmed: _____
Chair

Date: _____

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/10/17	***Laboratory Services Committee*** Invitation for Anne Speden to present "IS Roadmap" – extend to include misdirected results and governance of results	Co-Chairs	Deferred to April	Included on Workplan
2	14/02/18	***Person & Whanau Cented Care*** • Strategy document to be prepared • Meeting notes from meeting held on 1 February to be sent to Council Members	ED P&Q Admin	? Feb	Timing to be advised Actioned
3	14/02/18	***Clinical Council Annual Plan*** • 2016/17 annual plan to be rolled over for 2017/18 • 2018/19 annual plan and goals to be workshopped at next half day meeting	Admin Co-Chairs	Mar May	Actioned Included on Workplan

HB CLINICAL COUNCIL WORKPLAN 2018

Meeting Dates	Papers and Topics	Lead(s)
11 Apr 18	***For Discussion - Decision***	
	Annual Plan 2018/19 first draft	Chris Ash
	Building Culture	Kate Coley
	Quality Dashboard – *Quarterly reporting commencing in early 2018*	Kate Coley
	Oncology Model of Care	Sharon Mason
	Planned MRI and Fluroscopy Equipment Replacement Programme	Sharon Mason
	IS Roadmap	Anne Speden
	Mobility Action Plan update	Andy and Tae
	First 1000 Days of Life	Andy and Tae
	Alcohol statement	Sharon Mason
	Budget Prioritisation Process Update tbc	Tim Evans
	Monitoring and for Information	
	Collaborative Clinical Pathways Update	Mark Peterson
	Clinical Services Plan Update	Ken Foote
	Legislative Compliance (6 monthly)	Kate Coley / K Lafferty
	Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations	Kate Coley
	Te Ara Whakawaiora – Culturally Competent Workforce (local indicator) - Building a Diverse Workforce and Engaging Effectively with Maori	Kate Coley
	Te Ara Whakawaiora / Did not Attend (local indicator)	Sharon Mason / Carleine
	Te Ara Whakawaiora – Healthy Weight (National Indicator)	Sharon Mason / Shari
	Te Ara Whakawaiora – Breastfeeding (National Indicator)	Chris McKenna
	Te Ara Whakawaiora – Cardiovascular (National Indicator)	John Gommans
	Committee Reports	
	HB Nursing Midwifery Leadership Council Update incl. Dashboard	Chris McKenna
	Clinical Advisory & Governance Group Report	Tae Richardson
9 May ***(Half Day Meeting including Consumer Council)***	***For Discussion - Decision***	
	Consumer Experience results – where to from here	Kate Coley
	Maternal Wellbeing Model of Health Presentation	Chris McKenna / Jules
	Monitoring and for Information	
	Clinical Services Plan Update	Ken Foote
	Best Start Healthy Eating & Activity Plan update	Sharon Mason
	Smokefree Update (6 monthly) include board action detail	Sharon Mason
	HBDHB Performance Framework Exception Dashboard Q3	Tim Evans
	Committee Reports	
	HB Clinical Research Committee Update	John Gommans
	Infection Prevention Control Committee	Chris McKenna

Meeting Dates	Papers and Topics	Lead(s)
13 Jun	***For Discussion - Decision***	
	Youth Health Strategy (board action June 2017)	Chris Ash
	Building Culture – People Strategy Final	Kate Coley
	Urgent Care Service Update (6 monthly update)	Wayne Woolrich/ David R
	Annual Plan 2018/19 2nd draft	Chris Ash
	Monitoring and for Information	
	Clinical Services Plan Update	Ken Foote
	Consumer Experience Feedback Q2	Kate Coley
	Collaborative Pathways (6 monthly updates for here forth)	Mark Peterson
	Committee Reports	
	Clinical Advisory & Governance Group Report	Tae Richardson (final report as Chair -tbc)
	Lab and Radiology Reports dependant on Governance Structure	

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Clinical Governance Structure – Value Assessment**
	For the attention of: **HB Clinical Council**
Document Owner	John Gommans and Andy Phillips, Co-Chairs
Document Author(s)	John Gommans and Andy Phillips, Co-Chairs
Reviewed by	Executive Management Team
Month/Year	March, 2018
Purpose	For Approval
Previous Consideration Discussions	Clinical Council (December 2017 and February 2018)
Summary	• At the request of the HBDHB Board. Clinical Council were asked to review the structure, value and workloads of Council's proposed clinical committees and advisory groups. • EMT has discussed clinical council recommendations and the following incorporates EMT feedback • A governance structure is proposed with - Four Clinical Committees reporting to Council, which align with the four pillars of clinical governance. - An information management committee will not be set up to report to clinical council since there is already an IS Governance committee in existence with strong clinical representation - A range of advisory groups that already exist within the DHB but these will expand their scope over time to fulfil sector wide clinical governance needs and obligations • Primary & community care representation will be strengthened within the clinical committee structure • Equity is reflected in the governance structure and reporting lines. To help achieve this, achieving the triple aim will be part of the terms of reference for each committee and advisory group - the simultaneous pursuit of Improved quality, safety and experience of care for individuals; improved health and equity for all populations; and best value for public health system resource • Clinical Council agreed the requirement for equity in the health sector's governance structure(s) but that how this is best achieved while also meeting clinical governance needs requires further discussion with other governance bodies • A technical clinical advisory group on equity will be formed once a new Executive Director with this in their portfolio is recruited.

	• The issue of integration within the governance structure will be on hold pending agreement of the updated Alliance structure • Primary Care (PHO) Clinical Advisory and Governance Group will report directly to council as well as the PHO • The final recommendations of clinical council will be presented to the March 2018 HBDHB Board meeting • It will be necessary to develop a business case for the costs of supporting the clinical governance structure. This will include estimated admin support costs of $95K plus costs for enabling primary & community care clinicians participation on Advisory Groups • The intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018.
Contribution to Goals and Strategic Implications	• Improving Value from public health system resources through the prudent use of clinicians within clinical governance structures • Improving quality, safety and experience of care through effective clinical governance • Improving Health and Equity for all populations through establishing equity with clinical governance structures
Impact on Reducing Inequities/Disparities	The intention of embedding equity within the clinical governance structure is to ensure that staff at all levels are aware of their responsibility to abolish health inequity
Consumer Engagement	Nil to date
Other Consultation /Involvement	Nil to date
Financial/Budget Impact	Additional cost for supporting the clinical governance structure and backfilling for primary care representation
Timing Issues	• March Clinical Council meeting for final recommendation • Recommendation to March 2018 Board meeting • Implement new structure by 1 July 2018
Announcements/ Communications	Communication to HB health system following March 2018 Board meeting

RECOMMENDATION:

It is recommended that HB Clinical Council

1. **Approve** the proposed clinical committees and advisory group structure
2. **Note** the intention to present clinical council's recommendations to the March 2018 HBDHB Board meeting
3. **Note** the intention for phased increase in primary & community care representation on Clinical Committees to ensure a whole of sector approach
4. **Note** the intent for clinical governance training to be provided for all members of Advisory Groups and Clinical Committees
5. **Note** the incorporation of triple aim in Terms of Reference for all elements of the governance structure and the intent to set up a technical advisory group on equity pending recruitment of an Executive Director
6. **Note** that an overarching governance committee on equity will be subject to further discussion with other governance bodies.
7. **Note** the reporting line for the Primary Care (PHO) Clinical Advisory and Governance Group

8. **Note** that the issue of integration within the governance structure is on hold pending agreement of the Alliance structure
9. **Note** that it will be necessary to develop a business case for the costs of supporting the clinical governance structure
10. **Note** that the intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018

HAWKE'S BAY
District Health Board
Whakawāteatia

Ensuring Best Value From the Hawkes Bay Health System Clinical Governance Committee Structures

Author(s):	**John Gommans and Andy Phillips, Co-Chairs of HB Clinical Council**
Date:	**7 March 2018**

PURPOSE

At the request of the HBDHB Board, Clinical Council were asked to review the structure, value and workloads of Council's proposed clinical committees and advisory groups. The intention is that these can be implemented with appropriate supports by 1 July 2018. Clinical Council has reviewed the implications of this structure in terms of their value, the function of and need for each separate advisory group in terms of the Councils role in 'clinical governance', ensuring that their purpose did not conflict with other governance structures or processes, and resource implications including clinician and management time plus administrative support.

A panel undertook an initial review. At its December and February meetings Clinical Council identified and endorsed a number of proposed changes and these are presented for ratification by council in this paper

CLINICAL GOVERNANCE

Clinical Governance is defined as "*the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks and fostering an environment of excellence in care for consumers, patients, community*"

Good clinical governance is essential to ensure continuous improvement in the safety and quality of care; and makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement i.e. key functions of clinical governance include monitoring of quality and safety, and provision of clinical advice.

In 2001, the Institute of Medicine described quality health care as safe, effective, patient-centred, timely, efficient, and equitable. Delivering good clinical governance requires attention to each of these domains.

CLINICAL COUNCIL

Clinical Council is the principal clinical governance, leadership and advisory group for the Hawkes Bay health system. The structure agreed by clinical council in June 2017 is show in Appendix 2. Its functions are to:

- Provide clinical advice and assurance to the HB health system management and governance structures
- Work in partnership with the HB Health Consumer Council to ensure the HB health system is organised around the needs of people
- Provide oversight of clinical quality and patient safety
- Provide clinical leadership to the HB health system workforce
- Co-ordinate and manage this clinical governance structure

CLINICAL COMMITTEES

There will be the four clinical committees aligned to the domains of safety and quality. These are:

- Professional Standards and Performance Committee – to provide assurance that all essential requirements relating to credentialing, professional standards, clinical training and research are actively promoted and maintained
- Clinical Effectiveness & Audit Committee – to provide advice and guidance to ensure that quality clinical practice is delivered by all publicly funded health service, diagnostic, pharmaceutical and therapeutic providers.
- Patient Safety & Risk Management – to provide assurance that all matters relating to patient safety and clinical risk are effectively monitored and managed
- Patient Experience – to jointly develop and recommend strategies, systems, policies, processes and actions that will contribute to the continuous improvement of patient's experience within the HB health system

The PHO Clinical Advisory and Governance Committee reports directly to the PHO Board with a reporting line to Clinical Council

CLINICAL ADVISORY GROUPS

Supporting the governance work of and reporting to the five clinical committees there will be 19 Clinical Advisory Groups (AGs). Most of these already exist to some extent within the DHB but have not been well aligned with clinical council and/or are not well integrated across the sector. Hospital services are currently well represented within the AGs which will be expanded to include cross sector representation and particularly from community and primary care. This will demonstrate that primary care contribution is valued by the sector. This will require additional resource to enable primary care clinician's engagement e.g. so that backfill can be provided. This remuneration will be at a level not less than the cost of providing backfill. There is currently variable expertise in governance within clinical committees and advisory groups, and training is required.

THE PLACE OF EQUITY IN CLINICAL GOVERNANCE

Although there are inequities related to age, gender, and income the most consistent and compelling inequities in NZ are between Māori and non-Māori. The causes of this are multifactorial including

- Differential access to the determinants of health and exposures leading to differences in disease incidence
- Differential access to health care
- Differences in quality of care received.

Under the New Zealand Public Health and Disability Act 2000, DHBs have a statutory responsibility to "reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders":

The NZ healthcare triple aim explicitly acknowledges this with the simultaneous pursuit of iimproved quality, safety and experience of care for individuals, improved health and equity for all populations and best value for public health system resource.

To deliver on this, equity is a sector wide responsibility with several other groups already working in this space, including Population and Public Health Services, Maori Relationship Board and Pacifica working groups. Clinical Council debated and agreed a recommendation for the position of equity within the clinical governance structure.

Council agreed that equity is an important element of service quality and that health equity should be everyone's business. In recognition of this, the triple aim will be explicitly part of each Terms of Reference. It is proposed that a technical equity advisory group reporting to Clinical Effectiveness and Audit Committee is set up once a new Executive Director is appointed. The function of this Advisory Group is the provision of advice to clinical researchers and clinical services to support equitable outcomes from health services and systems. The Equity Technical Advisory Group will support services to deliver equitable, value for money, sustainable services and systems which are person and whānau centered, effective, safe, timely, accessible and efficient.

Appropriate Governance of equity at a high level is required for the Hawkes Bay Health System and how this is best addressed requires engagement with other governance bodies. Clinical Council believes that a high level governance committee is required which will need to include clinical governance of equity as an important element of delivering clinical quality within its remit.

ADMINISTRATIVE SUPPORT

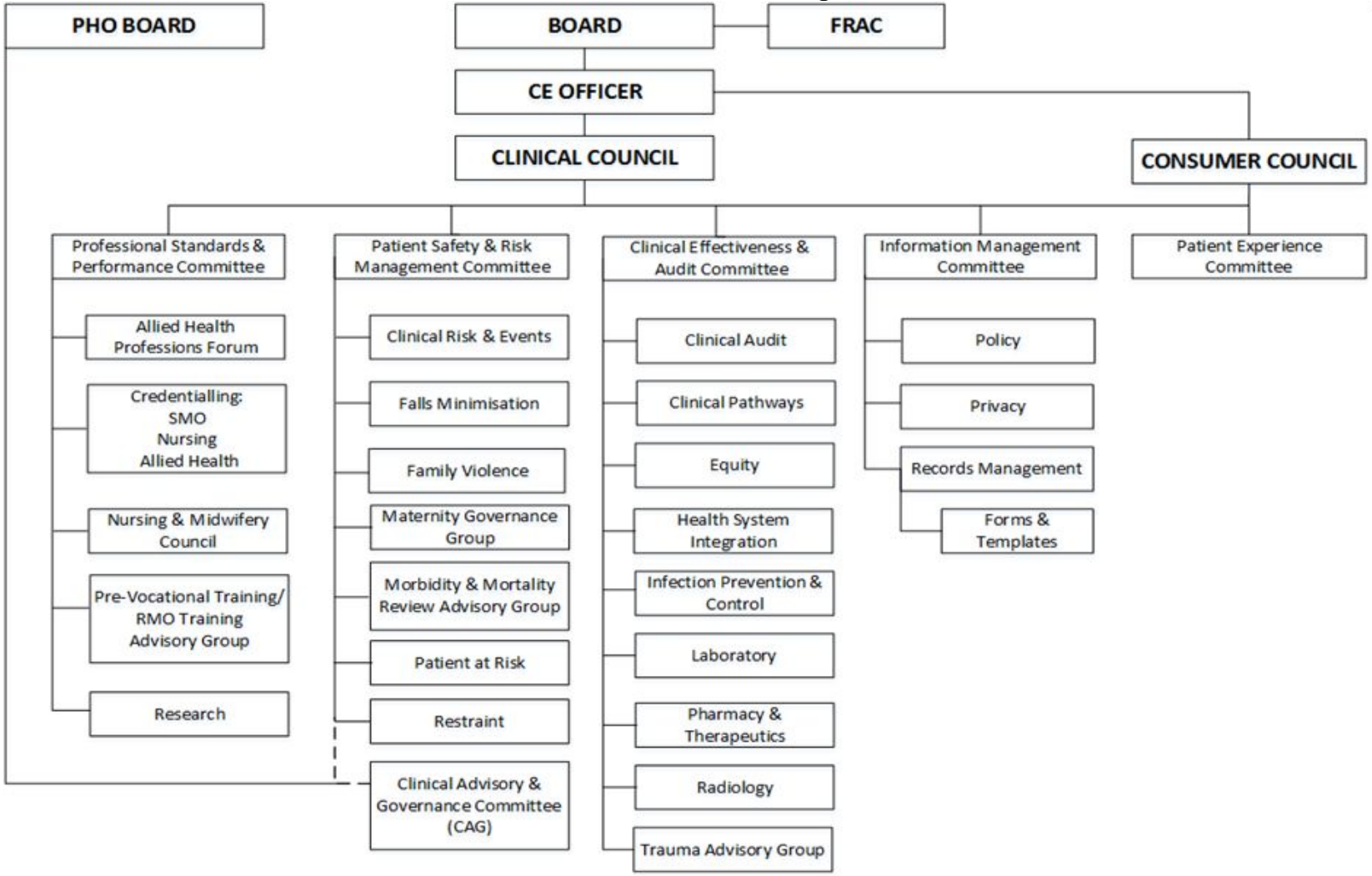
The company secretary reviewed the administrative support required for effective operation of the governance structure. This is shown in appendix 3. It is noted that a business case will need to be constructed to request funding.

RECOMMENDATION:

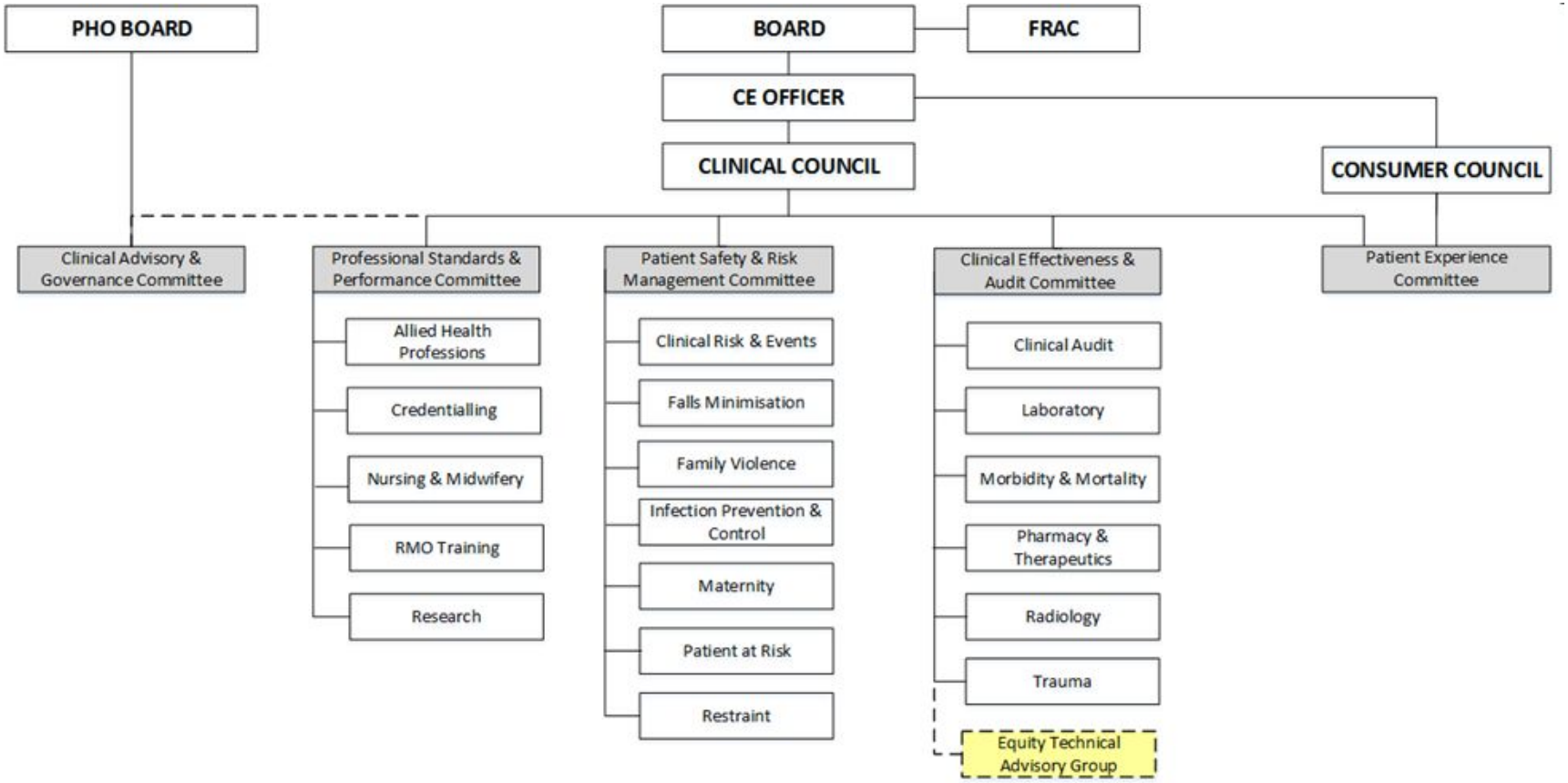
It is recommended that HB Clinical Council

1. **Approve** the proposed clinical committees and advisory group structure
2. **Note** the intention to present clinical council's recommendations to the March 2018 HBDHB Board meeting
3. **Note** the intention for phased increase in primary & community care representation on Clinical Committees to ensure a whole of sector approach
4. **Note** the intent for clinical governance training to be provided for all members of Advisory Groups and Clinical Committees
5. **Note** the incorporation of triple aim in Terms of Reference for all elements of the governance structure and the intent to set up a technical advisory group on equity pending recruitment of an Executive Director
6. **Note** that an overarching governance committee on equity will be subject to further discussion with other governance bodies.
7. **Note** the reporting line for the Primary Care (PHO) Clinical Advisory and Governance Group
8. **Note** that the issue of integration within the governance structure is on hold pending agreement of the Alliance structure
9. **Note** that it will be necessary to develop a business case for the costs of supporting the clinical governance structure
10. **Note** that the intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018

APPENDIX 1 – CLINICAL GOVERNANCE COMMITTEE STRUCTURE – Original version as at June 2017



APPENDIX 2 – CLINICAL GOVERNANCE COMMITTEE STRUCTURE – Proposed revised version March 2018



Pending appointment of new Executive Director

APPENDIX 3: CLINICAL GOVERNANCE STRUCTURE - MANAGEMENT & ADMINISTRATION REQUIREMENTS

1. CURRENT SUPPORT FOR CLINICAL AND CONSUMER COUNCILS

1.1 Management

- Ken Foote (Company Secretary)
  Governance and administration, including maintenance of ToR, work plans, membership, tenure, payments, cost centre, ensuring appropriate agendas, minutes and reports are prepared etc.
- Kate Coley (ED People & Quality)
  Operational support and guidance, including submission of reports, actioning outcomes, coordinating activities, responding to request etc.
- Consumer Engagement Manager key contact / support for Consumer Council

1.2 Administration

- Brenda Crene – Board Administrator and PA
- Maintenance of ToRs, membership schedules, contacts, interests, coordination of workflow (linked to Corporate governance), payment of fees and expenses, Diligent Boardbooks, filing of agendas and minutes etc
- Tracy Fricker – EA to ED People & Quality
- Preparation of agendas, Diligent Boardbooks, minutes and board reports.

1.3 Other

Current support for existing committees is provided by some members of the quality team, EAs and PAs of current chairs/members, and other service based administrative resources.

2. SUPPORT FOR THE AGREED CLINICAL GOVERNANCE STRUCTURE

The clinical governance structure will require administrative support to ensure that it is both effective and delivering good “value”.
Good governance practice requires the following:

2.1 Management Leadership Responsibility

- Structures and processes to be appropriately designed, implemented, monitored and adequately resourced
- An environment is created such that clinical governance is visible and valued by all key stakeholders.
- Roles, responsibilities, accountabilities and expectations are clear and well understood.
- Trust and mutual respect is developed, with Clinical, Consumer and Management leaders working in partnership to ensure the “structure” achieves the desired outcomes.
- Develop outcome measures / measures of success.

2.2 Management Responsibility / Resources (Whole structure)

- Terms of reference to be maintained, updated and amended as necessary
- New appointments/reappointments to be appropriately approved and membership schedules maintained
- Chairs appointed/briefed and ‘trained’ as necessary
- Details of any payments to members and approval processes to be agreed, documented and actioned
- Management of budget and cost centre
- Workplans to be coordinated and maintained
- Ensure appropriate reports are prepared, submitted, distributed and filed as appropriate
- Committee/Advisory group secretaries to be appointed, coordinated and ‘trained’ as necessary

- Standard templates developed for minutes/actions plans/reports etc.
- Overall coordination/management of structure.

2.3 Administration Responsibility/Resources ((Individual advisory groups/committees)

- Meetings to be set up/rooms booked etc
- Agendas prepared and distributed
- Attendance registers completed
- Any payments to members to be actioned
- Minutes to be taken, approved and distributed
- Action plans to be recorded, followed up and completed actions noted.
- Liaison with Advisory group/Committee Chair maintained
- Reports to be written/presented as required.

2.4 Minutes

- 'Action Minutes' templates to be developed/distributed
- Training for minute taking to achieve standardisation, efficiency and effectiveness

2.5 Communication Plans

- How to advise health sector that this is happening
- Encourage nominations/participation/ownership/confidence
- Ensure effective flow of information and sharing of learnings.

3. SECTOR WIDE RESPONSIBILITY

Two of the principal strategic changes to be embedded into this updated clinical governance structure are:

- Expanding the mandate of each committee and advisory group to be sector wide (where appropriate).
- Including consumer representation on all committees and relevant advisory groups.

These changes will have implications as follows:

- The timings and venues for meetings will need to take account of primary care clinician and consumer involvement
- Relevant policies will need to be updated/developed to recognise this involvement with appropriate payments/compensation.

4. RESOURCE REQUIREMENTS

To implement appropriate 'good governance practice' to ensure the new structure is both effective and efficient, it has been identified that the following support / resources will be required.

- Company Secretary and ED People & Quality continue to provide management leadership
- Board Administrator continues with overall responsibility for Administrative issues
- A new positon is created (Clinical Governance Administrator) to assume responsibility for directly supporting Clinical and Consumer Councils and Whole of Structure' management and administration (estimated $50k per annum)
- Members of the quality team EA & PAs and other service based administrative resources continue to provide secretarial support to individual committees and advisory groups with 'system' support guidance and coordination from the Board and Clinical Governance Administrators.
- Budget allowance for fees and expenses of 'primary care' (non-HBDHB/HHB staff) and consumers (on approval of new policy) will need to be provided (estimated $45k per annum.

A business case will need to be developed to seek approval for this additional $95k per annum budget.

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CLINICAL GOVERNANCE OF INVESTIGATION RESULTS POLICY

Clinical Governance of Investigation Results

Draft v3~~2~~.1 ~~16 January~~6 March 2018

"As … HDC cases indicate, patients do suffer harm as a result of mismanagement of clinical investigations. The number of doctors being reported to MCNZ because of these errors is high and would appear to be rising."

"The Medical Protection Society article 'Handling test results' looks at the issue of doctors' responsibility for tests they did not order and notes the primary responsibility for following up abnormal results rests with the clinician who ordered the tests. ***However, the HDC has an expectation that an abnormal result will be followed up by a treating doctor regardless of who ordered the test to avoid patients falling through the cracks. This makes sense****."*

From Coles Medical Practice in New Zealand, Medical Council of NZ, 2017

Purpose: the purpose of this guidance document is to ensure safe and effective patient care by providing clarity around clinical responsibility for investigation results and reports of patients cared for by clinicians working for Hawkes Bay DHB, including electronic acknowledgment.

Responsible Clinician:
While it is generally considered that the requestor of a test should take responsibility for acknowledgment of results and any actions required, in a hospital setting many tests are requested on behalf of teams and results may only be available after the ordering clinician has completed their duties.

Therefore, ultimate responsibility rests with the 'responsible clinician' who is accountable for results/reports of all investigations requested either by them or by those acting under delegated authority such as registered medical officers (RMOs), allied health staff, ~~or~~ nurses and midwives.

If services allocate patient care to a team such as 'Emergency Department' (ED), 'Acute Medical' or 'AAU'; initial responsibility rests with the duty or admitting senior medical officer but there must be clear arrangements ensuring either transfer of responsibility to a named SMO or that a designated responsible clinician reviews outstanding team results daily. Ensuring this is a clinical Head of Department (HoD) responsibility.

Definition:
Responsible clinicians are vocationally registered clinicians capable of autonomous practice without supervision. Currently this includes

- Senior Medical Officers (SMO)
- General Practitioners (GP)
- Advanced Practice Allied Health staff (AHP)
- Nurse Practitioners (NP) and Nurse Prescribers
- Lead Maternity Carers (LMC) and DHB Midwives

Accountability:

- There can only be one responsible clinician during any episode of care

- Laboratory and radiology systems must ensure results are only allocated to responsible clinicians
- Every responsible clinician must have a 'results inbox' available to them when they sign in to their clinical portal that includes all outstanding unacknowledged results
- Electronic results should only appear in the 'results inbox' of one responsible clinician
- Registrar clinics must be associated with a named SMO who assumes responsibility for results
- Responsibility may be delegated to another person (see below)
- Responsibility will be transferred when a patient's care transfers to another team such as when patients are admitted from ED
- By acknowledging a result a clinician is also taking responsibility for any action required. ~~Simply reviewing a result without ensuring appropriate action occurs is not acceptable.~~
- Through acknowledging a result, that result will also disappear off any outstanding results work list, therefore, clinicians must not acknowledge important results that should be viewed and actioned by others.
- Simply reviewing a significantly abnormal result without ensuring appropriate action occurs or that it is brought to the attention of an appropriate responsible clinician is not acceptable.

Locums:

- Locum SMOs or Responsible Clinicians are responsible for investigation results while they work at the DHB and should sign off all results prior to departure
- Responsibility for any outstanding results will transfer to a relevant responsible clinician at the end of the locum's employment. Ensuring this is a Head of Department responsibility.

Role of the responsible clinician:
Is to ensure investigation results/reports are reviewed and acknowledged (signed off), and where required that appropriate action is taken. This may be achieved by either personally acknowledging results or appropriately delegating this responsibility to others.

Delegation:
Responsibility for results acknowledgment may be delegated to other team members such as the responsible clinician's team RMOs and credentialed Clinical Nurse Specialists, Allied Health, Midwives or support staff following appropriate training and if clear protocols are in place.

It is the responsibility of SMOs to instruct their RMOs or others with delegated authority regarding expectations and indicate

- When they can and should independently acknowledge results
- What results they should not acknowledge; for example histology
- What results they should inform the SMO about before or after acknowledging.

RMOs and others have a responsibility to remain within their area of competence and scope of practice, and to seek guidance when required.

Results not finalized or available before discharge:

It cannot be assumed that GPs will follow up on outstanding test results. This requires either a discussion with the GP to ensure they are prepared to accept responsibility or that explicitly agreed delegation for the responsibility is documented in the discharge summary.

- GPs and LMC cannot 'acknowledge' results in the hospital system – a hospital clinician will still need to do this
- It is inappropriate to expect GPs or other clinicians to be responsible for results that require specialist knowledge or intervention.

Automatic sign off:
The following results may be automatically electronically signed off in the hospital laboratory system and not appear in any clinician's results inbox – the results will still be available for viewing

- GP ordered investigations
- Outstanding haematology and biochemistry results greater than 12 weeks old
- Proforma reports that are solely for system documentation and contain no clinically relevant information.

Explicitly excluded are all radiology, echocardiography, histology and cytology reports.

Updated results/reports:

- If a result or report is amended or otherwise updated this should result in cancellation of any prior acknowledgment or signoff but the initial report and signoff should remain available in records
- Notification of the new amended or updated report should appear in the responsible clinician's results inbox

Timeframes and monitoring:

- All results should be acknowledged within 5 working days of being finalized.
- Any results not acknowledged within 15 working days of being finalized will be considered non compliant with acceptable practice.
- If an SMO is on leave explicit arrangements should be made regarding acknowledgement of outstanding results.
- Reports of compliance will be shared with responsible clinicians and their HoD, and will be a performance indicator discussed at professional development reviews.

John Gommans
Chief Medical & Dental Officer – Hospital

Mark Peterson
Chief Medical Officer – Primary Care

Chris McKenna
Chief Nursing and Midwifery Officer

Andy Phillips
Chief Allied Health Professions Officer

CHOOSING WISELY

Presentation

Clinical Services Plan
Sector Update March 2018

BACKGROUND
The Clinical Services Plan (CSP) process has been underway for some months now, with progress reports and relevant documents delivered and posted to the Our Health website.

An initial draft of the CSP was planned for late March 2018. However, with general workload pressures, and to ensure feedback from workshops were well reflected within the initial draft, a decision was made late last year to dedicate more time to this crucial stage of the project, to make sure we "get it right".
In late January, a revised plan and timeline was agreed between Hawke's Bay District Health Board's Executive Management Team, Consultant group Sapere and the CSP project team, to complete the first draft by 30 June 2018 ready for extensive sector and community consultation with the final CSP tabled to Hawke's Bay District Health Board for approval at its October 2018 meeting.

REVISED PLAN
A summary of the revised plan includes:

- Baseline document and summary statement approved 28 February 2018
- Documentation for future options workshops distributed mid-March 2018
- Future options workshops to be held early April 2018
- Integrated workshop held early May 2018
- First draft completed 30 June 2018
- Draft CSP reviewed and updated July 2018
- Wide sector and community engagement on draft CSP – August / September 2018
- Final CSP completed early October 2018
- Final CSP adopted by HBDHB Board 31 October 2018

BASELINE DOCUMENT & SUMMARY STATEMENT
Two background development documents have recently been completed.

The *Baseline Document* provides a summary of the current state of services delivered across general practice and other community providers, as well as district health board health services provided both in the community and hospital.

The *Summary Statemen*t summarises findings from the *Baseline Document*. It also integrates findings from the patient journey workshops held in September 2017.

Both these documents will be used to inform the next part of the process and will be incorporated as appropriate into the final CSP.

FUTURE OPTIONS WORKSHOPS
Four key themes have been identified for workshops in April, that will have health professionals and consumers working together to produce a long list of options for the future design and delivery of relevant services. These themes are:

- Looking after frail people in our care
- Supporting our people in vulnerable situations
- Reorganising primary care for the challenge
- What is the character of our hospital in 10 years' time?

These workshops will be led by our senior clinicians and will be limited to 30 participants each. Discussions will be informed by the above documents, along with other reference material and personal experience.

The output from these workshops will feed into the Integrative Workshop, to be held in May 2018.

SECTOR AND COMMUNITY ENGAGEMENT

There will be comprehensive engagement both within the health sector and with the wider Hawke's Bay community once we have a draft CSP. Consultation will take place throughout August and September 2018 and details of how this will occur will be extensively promoted once we are closer to a finalised draft CSP.

CLINICAL SERVICES PLAN (CSP)

Just a reminder, the CSP will:

- Describe the current capability and capacity of services (Baseline)
- Describe the challenges and opportunities facing service provision now and in the future.
- Describe high-level options that will help meet those challenges and take advantage of those opportunities.
- Provide an indication of strategic direction and important areas for investment.
- Inform Hawke's Bay District Health Board's five year strategic plan

The CSP will not:

- Address details of implementation
- Provide detailed financial modelling
- Provide a workforce strategy and plan
- Include a facilities master plan

FURTHER INFORMATION

For further information, please visit: http://ourhealthhb.nz/news-and-events/clinical-services-plan-transforming-our-health-services/
Alternatively you can email:
clinicalservicesplan@hbdhb.govt.nz

HB HEALTH SECTOR LEADERSHIP FORUM

Reflections

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CARDIOLOGY REVIEW AND PLAN OF ACTION

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Update on Establishing Health and Social Care Localities in Hawke's Bay**
	For the attention of: **Clinical and Consumer Council; HBDHB Board** **Māori Relationship Board (April), Pasifika Health Leadership Group** (May)
Document Owner	Chris Ash – Executive Director Primary Care
Document Author(s)	Jill Garrett – Strategic Services Manager – Primary Care Te Pare Meihana - Manager, Wairoa Hospital and Health Centre
Reviewed by	Executive Management Team
Month/Year	February, 2018
Purpose	For Information
Previous Consideration Discussions	Regular update for monitoring
Summary	This paper outlines: • Progress in the two existing localities over the last 6 months • Planned activities over the coming 6 month period • Commentary on how the Health & Social Care Localities programme is being aligned with broader work relating to Primary Care Development
Contribution to Goals and Strategic Implications	Improving Health and Equity for all populations Improving value from public health system resources
Impact on Reducing Inequities/Disparities	Focus of the work in localities is on eliminating and preventing the inequity gap within health outcomes – whole of population
Consumer Engagement	Consumer representation within both locality groups
Other Consultation /Involvement	Not applicable
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION

It is recommended that the Clinical and Consumer Council:

1. **Note** the content of this report**.**

HAWKE'S BAY
District Health Board
Whakawāteatia

Update on Establishing Health and Social Care Localities in Hawke's Bay

Author(s):	**Jill Garrett – Strategic Services Manager – Primary Care** **Te Pare Meihana - Manager, Wairoa Hospital and Health Centre**
Date:	**February, 2018**

1.0 Locality Development in the Context of Primary Healthcare Development

1.1 A commitment has been made to reinvigorate the Alliance Agreement for Hawke's Bay by means of a Primary Care Development Partnership ('PCDP'). The need for this development has been identified on the back of longstanding and widely-held frustrations about the inability to secure care integration and modernisation at pace in primary healthcare.

1.2 As the draft working plan for the PCDP has become clearer, it is increasingly evident that there are a number of crucial intersects with the Localities programme. The PCDP will rely on a strong, and increasingly stronger and more coordinated local voice to drive prioritisation, community leadership, and the adoption and spread of best practice. At the same time, there are a number of themes common to development in a number of localities (such as the development of sustainable service delivery models for rural communities) that will benefit from a more centrally-sponsored approach.

1.3 At present, the programme has focused solely on the establishment of a 'localities approach' in the rural areas of Wairoa and Central Hawke's Bay. In two relatively self-defining rural communities, this approach has generated significant benefits. Work on the proposed 'Hastings' and 'Napier' localities has not, to date, been initiated. The approach will be reviewed in consultation with stakeholders, and in line with the establishment of the PCDP.

1.4 In both existing locality areas, however, the breadth and depth of the work undertaken has been markedly different. This has largely fallen into the domain of three core activities, those being:

- Integration of local provider management arrangements, supported by devolved decision rights for DHB services, with the goal of transformation in the delivery of clinical services
- Progressing and supporting local innovation in support of community health and wellbeing priorities, particularly in the intersectoral sphere
- Promoting an enhanced local dimension to health planning, funding and market development

1.5 Collective impact modelling has been used in both localities, Wairoa and Central Hawke's Bay (CHB) to build form and function into the task of preparing localities to drive local developments, and as a framework to evaluate progress to date. Implementing collective impact focuses on four key areas, namely, governance and infrastructure, strategic planning, community involvement and evaluation and improvement. However, in the context of 1.4 (above), collective impact does not define the breadth of the endeavor to which it is applied.

1.6 Under the framework, there are five stages on the road to achieving full collaboration.

The Five Levels of **Collaboration**

	1	2	3	4	5
	Networking	**Cooperation**	**Coordination**	**Coalition**	**Collaboration**
Relationship Characteristics	• Aware of organisation loosely defined roles. • Little communication. • All decisions are made independently.	• Provide information to each other. • Somewhat defined roles. • Formal communication. • All decisions are made independently.	• Share information and resources. • Defined roles. • Frequent communication. • Shared decision making.	• Share ideas. • Share resources. • Frequent and prioritised communication. • All members have a vote in decision making.	• Members belong to one system. • Frequent communication is characterised by mutual trust. • Consensus is reached on all decisions.

Source: Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. American Journal of Evaluation, 27, 3, 383-392

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1.7 In Wairoa, the emergence of the Community Partnerships Committee (He Reo Ngātahi: One Voice, Our Voice) pushes the overall assessment of progress towards Level 3 of the model, with some evidence of function at Level 4. Particularly important has been the definition of the community vision that 'All whānau in Wairoa are thriving', and the solid commitment of leadership from iwi, government agencies, and local community organisations to the work of the committee. In the primary healthcare service integration space, intensive activity is taking place to secure rapid progression from Level 2.

1.8 In CHB, assessment across all four areas of the model places overall progress at Level 2 of the model, with some aspects of Level 3 exhibited. CHB is growing its governance function, using strategic planning to create direction and vision, has strong community involvement, and now with greater emphasis on data sharing will be better positioned to plan health improvement initiatives.

2.0 Wairoa

2.1 Activity Completed (Last 6 months)

- Established senior nursing roles – The Rural Nurse Specialist and Clinical Nurse Specialist (Long Term Conditions) roles will support innovation in primary healthcare model development.
- Health of Older Persons stakeholder meetings – These support identification of local service gaps and guide development and resourcing of the care pathway.
- Case management and governance – Work is progressing with sector partners to join up approaches to supporting local whānau who are most in need of services and support.
- Integrated renal service model – Planning is underway to relocate the existing renal chairs.
- General Practice alliance agreements – These continue to evolve, and have supported project work to deliver free under 18 care, diabetes support and Cornerstone accreditation.

2.2 Activity in Progress (Next 6 months)

- Progress towards a single integrated general practice model for Wairoa
- Continued focus on more integrated primary and secondary care patient pathway
- Extension of EngAGE to include Wairoa, as part of strategy for rural provision of this service
- Further develop senior nursing opportunities, including establishment of a shared care model across providers, and a nursing workforce development approach for Wairoa.

- Achieve a "go live" date for Oranga Whānau single case management and governance within services for vulnerable tamariki and whānau
- Join up health projects and strengthen rangatahi leadership, in support of the wellbeing of young people in Wairoa
- Project to reduce the incidence of diabetes through a collaborative initiative between general practice and Kahungunu Executive.

3.0 Central Hawke's Bay

3.1 Activity Completed (Last 6 months)

- Choose Well
  - Signage and local materials now developed and in use in Waipawa and Waipukurau
  - Flyers and fridge magnets advertising Health Services have been developed by the Health Liaison Group and distributed to households, schools and services within CHB
- Whānau Wellness – The first programme in CHB is now in place with 58 individuals signed up in December 2017. Of those registered, 15% live in Porangahau, 15% in Waipawa, and the remaining 70% in Waipukurau.
- Workplace Wellness – A population health-based programme of support has been developed and provided to the largest employer in CHB (Silver Fern Farms).
- Shared electronic health record – This is now available to support collaborative patient management across general practice, pharmacy and the hospital services

3.2 Activity in Progress (Next 6 months)

- In-depth analysis of the CHB Health Status review to inform priorities for 2018-19 and potential operational partnerships to achieve improved health outcomes.
- VMR network enabling virtual health clinics to be provided in outreach settings.
- Extension of EngAGE to include CHB, as part of strategy for rural provision of this service
- Creation of an Lead Maternity Carer (LMC) Hub in CHB.
- Extending workplace wellness programme to support five major local employers.
- Supporting the Ministry of Education Communities of Learning (COLs) with their local achievement of health and wellbeing-related objectives (linked to readiness for learning).

RECOMMENDATION

It is recommended that the Clinical and Consumer Council:

Note the content of this report**.**

OURHEALTH
HAWKE'S BAY
Whakawateatia

CLINICAL ADVISORY & GOVERNANCE COMMITTEE

13

Draft Minutes 13 February Meeting
Agenda for 20 March Meeting

Minutes

Clinical Advisory and Governance Committee

Date	13 February 2018	**Start Time:**	5.30pm
Venue	Tukituki Meeting Room, 2nd Floor, GJ Gardner Building		
Present	Chris McKenna (Chair), Julia Ebbett, Maurice King, Mark Peterson, Andrew Phillips, Tae Richardson		
In Attendance	HHB: Wayne Woolrich, GM; Linda Dubbeldam, Manager Innovation & Development; Sara Salman, Clinical Advisory Pharmacist; Fiona Gray (minutes)		
Guests	Trish Freer, Manager Health Programmes, HHB; Michele McCarthy, Health and Social Care IT Liaison, HHB; Val Shirley, Improvement Advisory | People & Quality, HBDHB		
Apologies	Bayden Barber, Catrina Riley		

Item	Minute
1. Administration	**1.1 Apologies** Catrina Riley, Bayden Barber. **1.2 Interest Register** Amendments/additions received from Julia Ebbett, Maurice King and Andrew Phillips. **1.3 Conflicts with today's Agenda** None. **1.4 Draft Minutes** The minutes as circulated were accepted as a true and accurate record of the meeting. **1.5 Action Items** The action register had one action: CAG 01 0917. The Quality Scorecard discussion paper will be presented at the March CAG meeting. **1.6 Committee Work plan** Not available at the meeting. Workplan emailed to the Committee on 23 February. **1.7 Items approved since last meeting** None. **1.8 Additional Agenda Item** The Flexible Funding Pool Evaluation Project (see Items for Information).
2. Items for Approval	None.
3. Items for Discussion	**3.1 Primary Mental Health – Model of Care** Trish Freer, Manager Health Programmes, Health Hawke's Bay, presented to the meeting on Primary Mental Health. Trish tabled Youth Mental Health handout packs. There followed discussion around (1) the credentialed nurse charge-out rate; (2) the full spectrum of services and provider network; and (3) quality improvement and accountability.

	Management response 1. The rates set for credentialed nurses was the general practice idea of an acceptable level of remuneration. 2. All services are available to all patients and there are clear reporting requirements for each session. An end of care summary report is required which will go back to the GP and will also provide management with an opportunity to review the outcomes. The new claims system will be able to help with collecting pre- and post-intervention data. Discussions are underway with Māori providers asking how they think this programme can best support their population. 3. The evaluation forms have been developed with a clinical eye and have been through the Steering Group. Service change based on outcome information will enable the service to better meet the needs of under-served populations. **3.2 Misdirected Patient Information** This paper was written for the November 2017 CAG meeting; significant improvements since then were reported on by Michele McCarthy, Health and Social Care IT Liaison Health Hawke's Bay. <u>Updates</u> Continued use of the Age/Sex register: in the process of ensuring the accuracy of the age/sex register to be uploaded onto ECA, and confirming this is okay to be uploaded onto the ECA. **ACTION** – Andy Phillips to invite Anne Speden, Chief Information Officer, to present to CAG on the Clinical Portal and what is happening with Primary Care around that. **ACTION**: Michele McCarthy to provide Misdirected Results Action Register to future CAG meetings. The Chair congratulated Michele on the work done to date and confirmed Michele will attend each CAG meeting to give a verbal update. **3.3 BPAC^{NZ} Report** Sara Salman, Clinical Advisory Pharmacist, asked the Committee for feedback on change of consent, to be able to share the pharmaceutical utilisation data more widely. **ACTION**: The Committee agreed that the BPAC^{NZ} pharmaceutical utilisation data should be made available for this Committee, including Clinical Council, and that this information should be shared with the Clinical Pharmacist Facilitators in order to enable them to decipher the variation and act on it as necessary, and for the utilisation data to be shared throughout the region. The Committee further agreed to request from BPAC^{NZ} additional data that reflects Hawke's Bay's population demographics with the view to ensuring the elimination of inequity.
4 Business Performance Reports for Information	None.

5 Other Items for Information	**5.1 Health Literacy – Project Update** Taken as read. **5.2 Clinical Services Plan Update** Taken as read. **5.3 Integrated Primary Care Workforce Strategy Update** Taken as read. **5.4 Collaborative Pathways Updates** Taken as read. **5.5 Foundation Standards/Cornerstone Update** Taken as read. **5.6 Diabetes Care Improvement Plan Refresh** Taken as read. Linda Dubbeldam, Manager Innovation and Development, queried whether diabetes information should come to this Committee in the same way it has been requested for mental health? The Committee recommended exploring a dashboard around diabetes. Linda to provide a verbal update at next meeting. **5.7 Additional Agenda item - Flexible Funding Pool Evaluation Project** This paper was tabled by Linda Dubbeldam, Manager Innovation & Development Health Hawke's Bay. A copy of the Project Start-Up document will be discussed the March CAG meeting.		
6 Any other Business	The Chair noted that Val Shirley will be attending the next, and future, CAG meetings as a full Committee member.		
Meeting closed	7.36pm	**Next meeting**	20 March 2018

13.1

Agenda

Health Hawke's Bay Clinical Advisory and Governance Committee

Date:	20 March 2018	**Time:**	5.30 – 7.30pm
Venue:	Tukituki Meeting Room, Second Floor, GJ Gardner Building		
Invitees:	Chris McKenna (Chair), Bayden Barber, Julia Ebbett, Maurice King, Mark Peterson, Andrew Phillips, Tae Richardson, Catrina Riley; Val Shirley		
In Attendance:	HHB: Wayne Woolrich, General Manager; Linda Dubbeldam, Manager Innovation & Development; Sara Salman, Clinical Advisory Pharmacist; Stephanie Maggin (minutes)		
Guests:	Anne Speden, HBDHB; Michael Sheehan (Clinical Portal PM)		

	Paper	Action	Lead
1. Administration			
1.1 Apologies	Verbal	Acknowledge	Chair
1.2 Interest Register	Paper	Noting	Chair
1.3 Conflicts with today's Agenda	Paper	Noting	Chair
1.4 Draft Minutes – 13 February 2018	Paper	Confirm	Chair
1.5 Action Items	Paper	Noting	Chair
1.6 Committee Work Plan	Paper	Acknowledge	Linda Dubbeldam
1.7 Items approved since last meeting	Verbal	Verbal	Chair
1.8 Additional Agenda items	Verbal	Verbal	Chair
2. Items for Approval None.			
3. Presentation (20 mins)			
3.1 Clinical Portal and Impacts on Primary Care including lab and radiology	Presentation	Acknowledge	Anne Speden and Michael Sheehan
4. Strategic Discussion (45 mins)			
4.1 Strategic Plan Discussion	Paper		Wayne Woolrich
5. Items for Discussion			
5.1 Clinical Services Plan update (10 mins)	Presentation		Ken Foote
5.2 External reporting of Professional Misconduct	Paper	Acknowledge	Linda Dubbeldam
5.3 Flexible Funding Pool Project Start-up - Draft	Paper	Acknowledge	Linda Dubbeldam
6. Business Performance Reports for Information None.			
7. Other Items for Information			
7.1 Integrated Primary Care Workforce Strategy Update	Paper	Acknowledge	Linda Dubbeldam
7.2 Annual Seasonal Influenza Campaign – Plan (2017 data – plan for 2018)	Paper	Acknowledge	Linda Dubbeldam
7.3 High Needs Enrolment Programme – Q2	Paper	Acknowledge	Linda Dubbeldam
Any other business			
Next Meeting	15 May 2018	5.30pm	

TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

16. Demand / Capacity presentation

15

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).