HB Clinical Council
Monthly & Annual Meeting

Date: **Wednesday, 12 September 2018**

Lunch: **12.30 pm**

Meeting: **1.00 pm to 5:00 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 Daniel Bernal
Jules Arthur
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Peter Culham
Dr Nicholas Jones

Apology: Dr Mark Peterson

In Attendance:

Kate Coley, ED People and Quality
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator / EA to ED P&Q
Ana Apatu, Māori Relationship Board Representative

MONTHLY MEETING

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and apologies	1:00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
	Section 2 – For Discussion	
5.	After Hours Urgent Care Update (6 mthly) – Wayne Woolrich / David Rodgers	1:10
	Section 2 – For Information only (no presenter)	
6.	Matariki Regional Development Strategy and Social Inclusion update (6 mthly)	-
	Section 3 - Committee Reports	
7.	Clinical Advisory & Governance Group	1:30
8.	**Recommendation to Exclude the Public**	

Public Excluded

Item	Section 4– Routine	Time (pm)
9.	Member Topics of Interest	1:35
10.	Minutes of Previous Meeting	
11.	Matters Arising - Review Actions	
12.	Mid-point Health Cert Surveillance Audit – corrective actions – Kate Coley	1:50

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATE TIRA PARTNERSHIP
TAUWHIRO CARE

Next Meeting: Wednesday, 10 October 2018 at 3.00 pm, Boardroom, HBDHB Corporate Office

ANNUAL MEETING

Public

Item	Section 6 – Annual Meeting	Time (pm)
13.	Welcome and apologies	2:00
14.	Minutes of Previous Annual Meeting held 9 August 2017	
15.	Matters Arising from Annual Meeting - nil	-
16.	**Annual Information**: 16.1 Attendance over the prior 12 months 16.2 Tenure	2:03
17.	**Clinical Services Plan and Person & Whanau Centred Care**: 17.1 CSP Presentation and Video – Ken Foote 17.2 Commitment to Person & Whanau Centred Care – Debs & Rachel 17.3 Working with Consumers – Debs Higgins & Rachel RItchie	2:05
18.	**Quality Indicators & Dashboard – verbal update** 18.1 Progress & Options– Kate Coley 18.2 Roles & Responsibilities – Russell Wills & Andy Phillips	2:35
	AFTERNOON TEA (10 minutes)	3:05
19.	**Clinical Risk Management**: Chris McKenna / Kate Coley 19.1 Monitoring / Reporting 19.2 Roles & Responsibilities (verbal)	3:15
20.	**Clinical Governance**: 20.1 Draft Clinical Governance Manual – John Gommans / Ken Foote 20.2 New Structures – John Gommans/ Andy Phillips • Terms of Reference(s) 20.3 Committee Reporting Schedule – Kate Coley	3:45
21.	**Review Council Role & Terms of Reference**	4:15
22.	**Review of Clinical Council's Annual Workplan 2017/18 (past year)**	4:30
23.	**Clinical Council's Annual Workplan** 23.1 Development of Clinical Council's Annual Workplan for 2018/19 23.2 Council's Workplan as at 5 September 2018 (for information)	4:50
24.	**Election of Chair / Co-Chairs 2018/19**	5:00

Next Meeting: Wednesday, 10 October 2018 at 3.00 pm, Boardroom, HBDHB Corporate Office

Interests Register
Aug-18

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest e.g. Organisation / Close Family Member	Nature of Interest e.g. 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 agrees the contract.	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 Health 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 for patient quality and safety.	No	
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic 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 & Governance Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Clinical Advisory & Governance Committee (CAG) for Health HB (Tenure ends 27/06/18)	Member	Report on CAG meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	
	Locum General Practitioner			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
	National Advisory Committee of the RNZCGPs	Member and CP Teacher	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.

5/09/2018

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. 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**
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 Director	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			
	Kidney Health Australia - Caring for Australasians with Renal Impairment	Member		No	Guidelines group - involved with the group "Management of chronic kidney disease among Aboriginal, Torres Strait Islander Peoples and Maori".
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	
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, pecuniary, 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	
Daniel Bernal	New Zealand Hospital Pharmacists Association	Member	Discussion	No	
	Pharmaceutical Society of New Zealand	Member	Access their resources, record my CPD on their website.	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, 8 AUGUST 2018 3.00 PM

PUBLIC

Present:	Dr Andy Phillips (Chair) Dr Robin Whyman Dr Nicholas Jones Dr David Rodgers Dr Mark Peterson Dr Russell Wills Dr Peter Culham Dr Daniel Bernal Debs Higgins Chris McKenna Lee-Ora Lusis Anne McLeod Jules Arthur (until 3.45 pm)
In Attendance:	Ken Foote, Company Secretary Tracy Fricker, Council Administrator and EA to Executive Director – People & Quality Ana Apatu, Māori Relationship Board Representative Dr Kevin Snee, Chief Executive Officer (from 4.20 pm)
Apologies:	Dr John Gommans, David Warrington

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Andy Phillips (Chair) welcomed everyone to the meeting, including Jess Radcliffe, GP Registrar who attended the meeting as an observer.

Apologies were noted as above.

2. INTEREST REGISTER

No conflicts of interests were noted for agenda items. Dr David Rodgers advised that he is no longer a Police Medical Officer and that this can be removed from his interests.

Action: Interest register to be amended to note the change for Dr Rodgers.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 13 June 2018, were confirmed as a correct record of the meeting.

The minutes of the HB Clinical Council meeting held on 11 July 2018, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 Investments Update (Outcomes of Budget Prioritisation)
The Chair explained the two stage prioritisation process, the first stage being a technical assessment based on the Triple Aim with recommendations being made and the second stage coming back to governance groups to look at a values based assessment to make recommendations to the Board. This will be brought to a future meeting for a more detailed discussion.

5. WORKPLAN

The workplan was included in the meeting papers.

A discussion on the workplan will take place at the AGM in September. Question posed does the workplan meet our needs as governors? The Council would like to see a greater connection between the Clinical Council workplan and the Annual Plan.

Action: All members to consider the workplan prior to the AGM.

SECTION 2: PRESENTATIONS

6. VIOLENCE INTERVENTION PROGRAMME (VIP)

The Chair welcomed Cheryl Newman, Family Violence Intervention Co-ordinator, Claire Caddie, Acting Executive Director Provider Services, Jeanette Frechtling, Clinical Team Leader, Child Development Unit and Wietske Cloo, Acting Service Director, Community Women & Children to the meeting.

Cheryl Newman provided a presentation. The key points noted:

- Case studies were presented of victims of assault who were not screened for intimate partner violence, child abuse or neglect
- The importance of screening
- Our community – children want to be with their families; women want choices about the services they receive, how and when
- Men and women frequently carry trauma from childhood which can impact across the lifespan
- Families want services that are culturally responsive and to work with people who are respectful and listen to their needs
- Violence Intervention Programme Quality and Improvement actions
- Evaluation of training – between 1 March 2016 and 28 February 2018, 466 staff attended a VIP training programme, screening rates during that same time stagnated to an average of only 36%
- Influences for change and effective change in other organisations due to investment in leadership and dedicated specialist teams, IT systems to support data collection for improvement and culture change

Dr Wills advised that there are some areas that do screening well like the Child Development Unit, Special Care Baby Unit and areas of Maternity, but generally we do poorly with screening. It is a clinical leadership issue not a resource issue and VIP would like to hear from Council how, in our clinical leadership roles can we improve the care we provide to women and children at risk of family violence.

General discussion took place, feedback provided:

- Screening needs to be meaningful, not a tick-box exercise

- Need more emphasis in the community at general practice level and work in conjunction with the VIP programme at the DHB. It is a whole of sector responsibility
- Relationship building is important, look at a holistic view. It is not a task, it is looking at wellness
- Screening is part of an overall clinical assessment and the whole clinical team are responsible
- Staff can also be affected by family violence and we need to ensure that there is support for this and respond as an employer
- Training is it generally focused on RNs and Allied Health staff with a small number of RMOs/SMOs. The more staff that are trained to offer some level of support/response the better
- What we don't do well is learn collectively from each other
- VIP has limited resource (fte) which cannot sustain supporting the whole sector. Should the shift of resource be made to primary care?
- Time has to be valued, time and ability to be responsive to a disclosure. Responsiveness 24/7 needs to be looked at to support staff who get a "yes" disclosure

The Chair summarised that this is an important issue and we recognise that we need to improve actions to prevent family harm across the sector. Council would like to see the response pathways for when a disclosure is made. Clinical leadership and the need to support DHB and primary care staff resilience is important. This is an important issue for our community and other government agencies including the Police, MSD and ACC.

The Clinical Council supports and noted the work being done by the VIP Programme.

Actions: ***Cheryl Newman to provide details of pathways to guide clinicians on who to contact and pathways of interventions when people disclose family harm.***

Clinical Leaders (CMDO, CNMO, CAHPO and CMO (Primary) to discuss how to influence clinicians to screen for family violence.

7. HBDHB ANNUAL PLAN 2018/19

Paul Malan, Head of Planning & Strategic Services provided a verbal update on the Annual Plan for 2018/19. The Annual Plan is a compliance document to meet the Ministry of Health's expectations. The Annual Plan will align to other plans including the People Plan; Clinical Services Plan and Korero Mai in the future. 2018/19 is the final year of the 5-year transform and sustain strategy. The replacement 5-year strategy will inform the delivery of future Annual Plans.

Key points noted:

- The Annual Plan is a compliance document, written to articulate the DHB's response to national planning guidance
- The planning guidance is issued with the Letter of Expectations - this year it was released, with the financial envelope in May
- The Annual Plan must align to, but will not precisely mirror the more comprehensive content of, the DHB's various delivery plans
- 2018/19 is the final year of the 5-year Transform & Sustain Strategy. The CSP is one of a number of inputs to inform the refreshed Strategy
- The replacement 5-year Strategy will inform the annual delivery plans from 2019/20 – 2024/25. Annual Plans will remain, but the Ministry of Health wants to work with DHBs to increase value within the process.
- Timeline – draft annual plan submitted on 27 July; final annual plan due end of September
- Priority areas for 2018/19, including new focus on:
  - Population Mental Health – Significant focus under this priority relates to collaborative redesign of community mental health & addictions services via PCDP

  - Addictions – While Annual Plan focus is narrow, introductory narrative explains the wider focus (especially in respect of methamphetamine) the DHB will place on this area in 2018/19
  - Primary Care Access – Linked to ongoing work nationally to finalise the initiatives introduced in the 2018 budget
  - School Services – Both stock-take work and specific work on extending the service into secondary schools
  - Strengthening Public Health Service Delivery – CSP is a major focus
  - Sustainability Priorities – Focus included on alignment with Kaitiakitanga
  - Regional Services Plan – Priority in 2018/19 is the PCI business case
- Next steps:
  - Plan to include financial templates
  - Clarification of any Hawke's Bay-specific expectations arising from the June meeting with the Ministry of Health will be made, and incorporated
  - During August, ongoing refinement of priorities will be undertaken in liaison between MOH and the DHB
  - A process to finalise and sign off the 2018/19 Annual Plan ahead of the September deadline for the final document will be agreed and enacted

General discussion took place including the Independent Health Review, issues with the regional cardiac plan and our local priorities; endocardiography results and other results not being shared with primary care.

The Chair thanked Paul Malan for the update on the Annual Plan.

SECTION 3: DISCUSSION

8. PEOPLE & QUALITY DASHBOARD

The Chair provided a verbal update on progress with the dashboard. A copy was also provided in the papers. The Chair asked whether there were other items members would like included in the dashboard. Brief discussion took place, members would like to see family violence interventions and also along with the graphs commentary included around what is being done / actions undertaken.

Action ***All to provide feedback on the dashboard to*** andy.phillips@hbdhb.govt.nz.

9. PREPARATION FOR AGM DISCUSSIONS

The Company Secretary provided a brief summary on what is to be discussed in more detail at the AGM:

- Review Clinical Council's Annual Plan 2017/18
- Review Strategic Context (tabled)
- Review Terms of Reference

At governance level agendas are being looked at and there is a feeling that things are being drilled down too far and there is a need to be brought back to a strategic level.

A high level strategic scan of strategic goals against the Triple Aim plus one (Health & Equity for all Populations; Quality, Safety and Experience of Care and Best Value from Health System Resources; plus one: Growing our People) provided by the Company Secretary was provided as a starting point for the discussion.

Issues raised by members included:

- Joined up meetings with Consumer Council are useful, but with having a shortened Clinical Council meeting beforehand there is not enough time for discussion. This structure needs to be looked at for future joint meetings
- Need to look more at governance and measuring ourselves against the triple aim, our annual plan is busy and we are not achieving it
- Need to look at our rules of business and how we engage with and get issues from the sector
- Overwhelmed by the volume of writing in the papers
- Would like to see agenda items being linked to the TOR
- We provide advice for the CEO and Board but still don't have a feel for the risks we are sitting on as a DHB and health system. Having some refection on this would be useful
- Having a dashboard/snapshot on how were are doing on the major pieces of work we are governing over. Clinical indicator set, HRT and other data e.g. falls, hand hygiene, pressure injuries. Also making it relevant for primary care colleagues, cornerstone accreditation rates etc.
- Clinical governance structure has not yet been fully implemented. With the Committees and Advisory Groups the intention was to have reports coming to Clinical Council, based on the activities of the groups, actions that are identified, risk mitigation strategies etc. This need to be a high priority
- Isolate the items that have been home grown as opposed to what the ministry has dictated
- Have the Alliance Agreement as an appendix on the TOR
- Identification of risk, stories of what you know to be true from what you see in practice and the data. Council has not had visibility on some important things
- Need to engage with the sector on how clinicians in secondary and primary care can report issues to the Clinical Council
- Having an MRB observer at Clinical Council is good and is a two way process.

The Chair thanked everyone for the feedback. Further discussion will be held at the AGM.

10. CLINICAL SERVICES PLAN (CSP)

The Company Secretary provided a verbal update:

- Following feedback last month the draft CSP was approved by the Board on 27 July with some minor modifications
- The next phase is the engagement process with the community including information packs and brochures that are easy to read and understand with the key themes
- The CSP document and a summary will be available on the website
- There is an email address on the website for people to provide comment and also a tear off form on the brochure, also any feedback provided at meetings can be emailed to the CSP email address
- All feedback will be collated and whether the plan needs to be modified or it is an operational issue that needs to be flagged
- At the end of the engagement process the feedback will be summarised and people advised what we have done with it

Sapere will have the final draft completed by end of September and it will come back to all governance groups in October for endorsement and then to the Board at end of October for approval.

In the early part of next year the 5 year strategic plan will evolve and will have more detail in it on what we will be doing over the next 5 years. From the 5 year plan, year one will be extracted and developed into an operational plan for 2019/20.

SECTION 4: REPORTING COMMITTEES

11. CLINICAL ADVISORY & GOVERNANCE GROUP (CAG) UPDATE

Chris McKenna provided an update from CAG:

- CAG has been re-framed and there will be three new GP members starting in September from Totara Health, Hastings Health Centre and Te Taiwhenua
- The PHO has developed their strategic plan and is now looking at the annual plan and work plan. Moving to 6 meetings per year
- Nuka presentation provided by Mark Peterson and Linda Dubbeldam was well received
- Branding around Health Care Home was endorsed
- Cornerstone Accreditation update

CAG are working hard to get good proactive clinical advice and having GPs at the forefront. The issues for CAG are the same as Clinical Council, getting proper clinical input and making it meaningful.

SECTION 5: INFORMATION ONLY (No Presenters)

12. TE ARA WHAKAPIRI NEXT STEPS (LAST DAYS OF LIFE)

Paper provided for information only. No issues discussed.

13. TE ARA WHAKAWAIORA - ACCESS RATES 0-4 / 45-65 YRS

Paper was provided for information only. However, the paper asked for council to endorse some aspects. Brief discussion took place regarding inequities for 45-65; concern re: process around recommendations on cardiac disease, clinical pathways and the CPO.

The Clinical Council **noted** the recommendations in the paper. As there was not time allocated to discuss this paper in detail, members were asked to identify key issues and time will be allocated at a future meeting for discussion.

Actions: ***Members to send key issues for discussion to Jill Garrett.***
Paper to be brought back for discussion in October (noting there is a quarterly update scheduled for November 2018).

14. SECTION 6: RECOMMENDATION TO EXCLUDE THE PUBLIC

The Chair moved that the public be excluded from the following parts of the meeting:

15. Minutes of Previous Meetings (13 June and 11 July)
16. Matters Arising – Review Actions
17. Patient Safety and Clinical Compliance Update including Adverse Events 2017/18
18. Topics of Interest – Member Issues / Updates

The meeting closed at 5.05 pm.

Confirmed: _____
Chair

Date: _____

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/04/18	***Investments Update (Outcomes of Budget Prioritisation)*** • Process for presentation, discussion and decision making on innovative service models and funding to be worked up and brought back to a future meeting	A Phillips	TBC	In progress
2	08/08/18	***Interest Register*** • Change of interest for Dr David Rodgers	Admin	Sep	Actioned
3	08/08/18	***Workplan*** • Members to consider workplan in preparation for discussion at AGM	All Members	Sep	
4	08/08/18	***Violence Intervention Programme*** • Pathway details to be provided to guide clinicians • Clinical Leaders (CMDO, CNMO, CAHPO and CMO (Primary) to discuss how to influence clinicians to screen for family violence	C Newman Co-Chairs	? ?	
5	08/08/18	***Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs*** • Key issues to be sent to Jill Garrett • Paper to be dicussed further at a future meeting (Quarterly update due in November)	All members All members	Aug/Sep Oct/Nov	

HAWKE'S BAY District Health Board Whakawāteatia	**After Hours Urgent Care**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner	Wayne Woolrich, CEO Health Hawke's Bay
Document Author(s)	Dr David Rodgers (Health Hawke's Bay, Medical Advisor)
Reviewed by	Wayne Woolrich, CEO Health Hawke's Bay; Dr Mark Peterson, CMO Primary HBDHB, and the Executive Management Team
Month/Year	August 2018
Purpose	For Information
Previous Consideration Discussions	Following the District Health Board (DHB) notice to Health Hawke's Bay (HHB) to cease the Emergency Department's (ED) contracted after hours provision for Hastings practices, a new model to deliver after hours urgent care in Hawke's Bay was initiated (effective 1 December 2017). HHB the Primary Health Organisation (PHO) led this significant work in collaboration with General Practice providers to secure an agreement and to operationalise this model, within a short space of time.
Summary	This review provides a high level update on the first six months of operations of the new model and highlights areas of focus. The intent is to make comment on areas of focus acknowledging it is too early to make significant change. A comprehensive 12-month review will be completed where recommendations will be made to improve how care is provided to our community.
Contribution to Goals and Strategic Implications	The redesign and implementation has resulted in a new model that: • Consistency of service for patients in Hastings and Napier • Minimises primary care provision by ED • Meets the PHO's contractual requirements with the DHB
Impact on Reducing Inequities/Disparities	We have no baseline data for the equity gaps in the previous model for after hours' care. This six-month review highlights aspects of the service model that could improve equity, that being the mobile in home care and the next day appointments. The twelve-month review will focus on equity and recommendations for improvement.
Consumer Engagement	No engagement as this was a desk top review. Consumer engagement will be undertaken for the comprehensive twelve-month review.
Other Consultation /Involvement	N/A

Financial/Budget Impact	The business case provided for an operating deficit of $76k in year one, to be underwritten equally by the DHB and HHB. At the time of the review the model is forecasted to operate in line with the business case projection. A major financial concern was the low utilisation rates of the overnight paramedic. This service was projected to make a budget contribution of up to $70K p.a. but has to date only realised less than $1K in revenue (identified early on as a significant risk). HHB worked with St John with both parties agreeing (in good faith) to a renegotiated and rationalised service level agreement, with similar service specifications now being delivered to a smaller number of clients for a lower cost than originally agreed. This variation has significantly reduced the financial risk to the model.
Timing Issues	N/A
Announcements/ Communications	N/A

RECOMMENDATION:

That HB Clinical Council, HB Health Consumer Council, Māori Relationship Board and HBDHB Board:

1. **Note** the six month review of the Urgent Care After Hours service.

To	Health Hawke's Bay Board of Directors	From	Dr David Rodgers
Title	After Hours Urgent Care	Date	August 2018

FOR INFORMATION

Purpose

To provide Health Hawke's Bay Board of Directors and Hawke's Bay District Health Board with a six-month review of the Urgent Care After Hours service.

Context

Following the District Health Board (DHB) notice to Health Hawke's Bay (HHB) to cease the Emergency Department's (ED) contracted after hours provision for Hastings practices, a new model to deliver after hours urgent care in Hawke's Bay was initiated (effective 1 December 2017). HHB the Primary Health Organisation (PHO) led this significant work in collaboration with General Practice providers to secure an agreement and to operationalise this model, within a short space of time. The redesign represents a step forward in consistency of service, and is understood by all parties to be an early step in a wider process that will see further collaboration to improve and enhance the urgent care model (in partnership with patients, consumers and their whānau).

The redesign and implementation has resulted in a new model that:

- Provides an appropriate level of care for all patients
- Greater use of multidisciplinary skills
- Consistency of service for patients in Hastings and Napier
- Minimises primary care provision by ED
- Sustainability within available financial resources
- Meets the PHO's contractual requirements with the DHB
- Provides a firm foundation for the further development of integrated primary care solutions to ensure that the patient remains connected with their own GP

PRIOR TO THE NEW MODEL

In Hastings, general practice provided primary care from 8.00am to 8.00pm seven days a week (as agreed with the DHB) utilising the health line phone triage service and ED for those patients who needed be seen.

In Napier, general practice had an after hours roster, whereby most GPs serviced their afterhours via City Medical.

This model was problematic due to:

- Recruitment challenges as Napier practices required GP's to work on the afterhours roster
- Widespread concern that servicing the onerous afterhours roster was impacting on quality of care in hours
- Accessing care overnight was expensive for some patients
- Perception that the Hastings model was encouraging inappropriate use of ED

REVIEW OF MODEL

Aspects of the Napier model (noted below) were extended in the redesign, to provide benefits to all within Napier and Hastings.

- Accident and Medical centres and co located pharmacies in both Napier and Hastings to remain open until 9.00pm
- Nurse triage and treatment (free of charge) from 9.00pm to 8.00am at City Medical (Napier)
- The Urgent Care nurse service (based in Napier) extended its scope to provide phone support and walk-in triage for all Napier and Hastings patients (between the hours of 9.00pm and 8.00am), with the ability to utilise the provider portal enabling direct access to GP notes
- Professional development support provided for the overnight nurses who work in City Medical
- Service model includes access to telephone support from an on-call GP until 3.00am
- Mobile paramedic offering an advanced face to face service at patients' own homes (available across Napier and Hastings 9.00pm to 3.00am
- Ability for GPs to ring fence next-day urgent care appointments with the patient's own GP
- ED contracted to provide face-to-face support for a small number of patients requiring urgent primary care need between the hours of 3.00am and 8.00am

Challenges

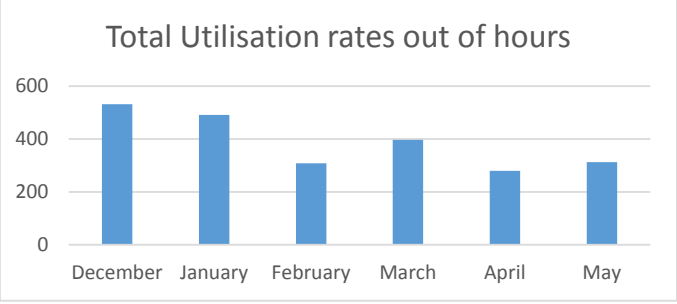
The redesigned service was a new contractual arrangement between multiple providers and required a significant investment of time to contract and establish the service. This resulted in a lack of focus on the need to communicate the changes to consumers. To remedy this, a fairly generic (and expensive) PR campaign shared the message that 'calling your usual GP number out of hours would connect you to an urgent care service' but communicating the detail of the plan remained challenging. A social media campaign communicating the service and personalising the urgent care paramedic helped to clarify the services available, but it is still unclear how well consumers understand the changes.

In the first few months it became evident that the utilisation rates for the urgent care paramedic were below those that were expected (and despite PR activities) the urgent care paramedic service remained underutilised. This presented an immediate financial and workforce concern. The PHO and St John worked together to review and agree a new model, whereby the urgent care paramedic skill set would be deployed across the ambulance fleet overnight rather than one paramedic dedicated to the service being on call.

The Shared Electronic Health Record has been difficult and utilisation has been slow, due to operational issues with the software vendor and logistical issues training staff to use the software (this has now been remedied).

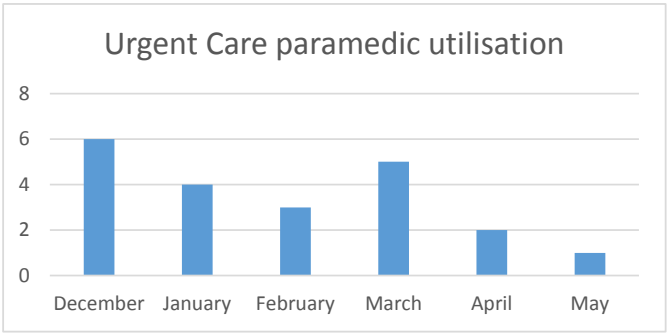
Utilisation rates and audit of subset of cases

Total utilisation rates across the new service (all components):



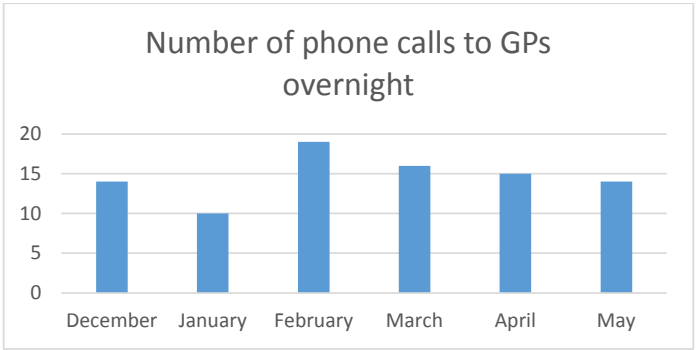
Total service utilisation across Hastings and Napier which includes presentations at City Medical (Napier), phone calls out of hours and paramedic call outs. December and January were months of high utilisation across the health sector in the province as our local economy is heavily tourist dependent. The drop in February is also likely related to the fact it's a shorter month. Overall though there is a definite decline in overall utilisation, this is also apparent at an individual service level.

Paramedic utilisation rates:



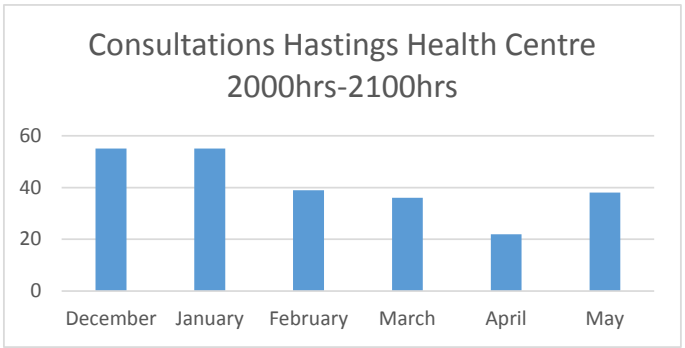
Urgent care paramedic visit rates per month started at a low point, which has continued to decline. The redesigned service allowed for three urgent care paramedic visits per night not being realised. The Paramedic utilisation rate is an area that requires additional focus.

GP phone support utilisation rates



The number of phone calls to GPs overnight has remained fairly static. A positive contributor to a manageable call level has been implementing more effective standing orders at the start of the redesign and available to the nurses who work overnight at City Medical.

Hastings Health Centre utilisation rates



Utilisation rates for Hastings Health centre have remained low with an average of 1.35 presentations per hour between 2000hrs and 2100hrs. With no change over the past six months this is an area that requires additional focus.

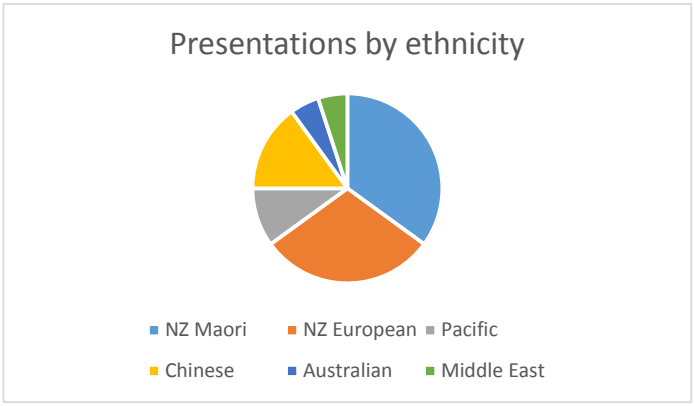
Next day GP appointments

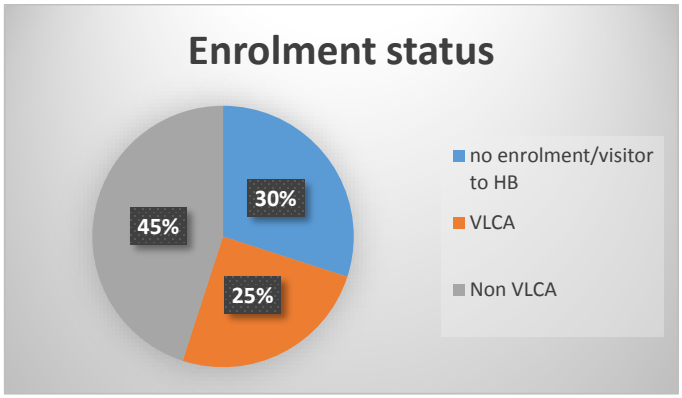
The next day GP appointments were only formally (recorded from April) ash resulted in thirty seven next day requests made in eighty four nights of on call duty. As some of these nights are weekends, this equates to thirty seven next day appointments across seventy working days, representing one appointment per workday across Napier and Hastings. At this point in time there is no way to determine whether these next day GP review appointments actually took place. This is an area to focus on to understand whether barriers such as cost or transport were relevant to non-attendance.

Patient Case Audit

Twenty random cases (across the six months from the contact records kept by the overnight City Medical nursing team) were used as a sample for the audit.

Ethnicity and Enrolment status





Points to highlight:

- The majority were NZ Māori (35%), followed by NZ European (30%)
- A significant minority were not enrolled in a practice locally, although this may be confounded by overseas visitors

- There was poor correlation between VLCA enrolment and ethnicity – less than half of NZ Māori consumers and none of the Pasifika consumers (identified in the audit) were enrolled at a VLCA practice

Clinical disposition:

- No one utilised the urgent care paramedic service. This isn't surprising as the total number of paramedic visits across six months was twenty one. While the total number of consumer contacts with the after hours model was two thousand, three hundred and twenty, twenty one urgent care paramedic patient contacts represents less than 1% of total patient contacts. The audit identified one clinical case appropriate for the paramedic service as it fit within their scope of practice and it was for a patient for whom transport was an issue. In this case the patient couldn't afford the paramedic service ($65 fee), so the paramedic was not dispatched.
- One of the twenty contacts resulted in transfer to ED. On review of the clinical notes this appears entirely appropriate, and a case that would almost certainly have been transferred to ED under the previous model
- Nine of the twenty contacts were treated using standing orders by the City Medical based nurse
- Ten of the twenty contacts were referred to next day GP services
- Seventeen of the twenty contacts were attendances onsite to the nurse at City Medical

<u>Intangible benefits not captured in audit/utilisation analysis</u>

The working relationship between HHB and St John (both regionally and nationally) has been immeasurably strengthened through the development of this new service model. This was highlighted by being able to negotiate an entire new service level agreement and renegotiate the contract quickly as the model developed throughout the months of implementation. This changed the service from one dedicated paramedic on shift waiting for calls for six hours per night, to using the paramedics that were already on duty in ambulances to deliver the same scope of practice as the dedicated urgent care paramedic. This significantly reduced the financial risk to those parties funding the model.

One of the benefits of training a larger cohort of paramedics (in the urgent care skill set) is that these skills are then deployed across their rosters and the St John network in Hawke's Bay. As one paramedic put it, "Once you've learnt this stuff you can't really unlearn it." This means patients are being treated in their homes by St John using the urgent care skill set and equipment which then prevents hospitalisation or GP review. Anecdotally this is happening several times per day, and is apparent in Central Hawke's Bay (CHB). CHB was outside the remit of this model, so it's great that some benefit is being felt in what remains a difficult to service part of Hawke's Bay.

General Practice has benefited from the alignment and consistency of Napier and Hastings resulting in reduced recruitment barriers. As one GP stated "you are fresher in your day job because you haven't been up the night before. Even if you're not called out, when you're on call you don't really sleep well."

While the shared health electronic record is still not being fully utilised, we have been able to hit a major milestone and significant step forward whereby GPs are comfortable with sharing information by engaging in a Hawke's Bay wide model. It has been identified that approaching general practice early on to ask for better information sharing was a key to success. General practice had a good understanding of what the information would be used for and how it would be accessed. The ability to have all general practice agree to this demonstrates the continued strength of the growing relationship of trust between general practice and Health Hawke's Bay.

Financial Analysis

The business case provided for an operating deficit of $76k in year one, to be underwritten equally by the DHB and HHB. At the time of the review the model is forecasted to operate in line with the business case projection.

A major financial concern was the low utilisation rates of the overnight paramedic. This service was projected to make a budget contribution of up to $70K p.a. but has to date only realised less than $1K in revenue (identified early on as a significant risk). HHB worked with St John with both parties agreeing (in good faith) to a renegotiated and rationalised service level agreement, with similar service specifications now being delivered to a smaller number of clients for a lower cost than originally agreed. This variation has significantly reduced the financial risk to the model.

There are other parts of the model which also have significant costs, with very low utilisation rates. While it was reasonable to underwrite these costs during the initial phase of the model, given that there has been no increase in utilisation across six (6) months it is timely to look at these costs.

Other areas of focus is the provision of the extra hour of care at Hastings Health Centre. The total cost for this service is $144K p.a. comprising of $93K p.a. for GP services and $51K p.a. for Community Pharmacy services. The utilisation rates for the extra hour of Community Pharmacy are not available, but it reasonable to infer it will be similar to the GP utilisation rate. The investment equates to $395 per hour to keep the Hastings GP and pharmacy service open. At the current utilisation rates this equates to approximately $294 per consumer which is difficult to justify long term if utilisation does not increase.

ED is contracted for $30k p.a. to see consumers between 0300 and 0800. This is an area of focus to explore as to whether this investment could be better used elsewhere to improve consumer care options.

Equity Assessment

We have no baseline data for the equity gaps in the previous model for after hours care. Anecdotally, utilisation of the after hours service overnight at City Medical has tended to include significant numbers of high needs consumers. This has been supported in the results shown in this audit.

The numbers utilising the new elements of the service (the urgent care paramedic and the Hastings Health Centre 8.00pm – 9.00pm) have been so low that there is limited scope for an adequate equity assessment of utilisation.

It is worth noting (that in the audit of a small subset of clinical cases) the one case that would have been really appropriate for the urgent care paramedic could not afford the service.

Two aspects of this model have significant potential to have an impact on equity. These are mobile treatment in a consumer's own home and next day general practice review. Each of these has potential to improve consumer's ability to access care, but each have cost implications which has likely impacted their use for those who most need them. This will be an area of focus for the twelve month review.

Potential Changes to the Model

There is scope to make several changes to the model, either individually or as a suite of changes to try to make it more cost efficient and have impact on the equity gap in provision of primary and urgent care in Hawke's Bay.

Areas identified:

Efficiencies

- Pulling back from the extended service in Hastings, this the between 8.00pm and 9.00pm. This would represent considerable financial savings with little impact in terms of clinical risk. The service is underutilised and is a poor use of both financial resource, and more importantly, of clinical resources (GP, practice nurse and pharmacist).
- Reduce the level of contracted support from ED services for the care of patients between 0300hrs and 0800 hrs.
- Reduce the level of GP phone support service. Whilst not used very often, the City Medical overnight nurses feel it is a valuable support service for their clinical safety and their confidence. The nurses have expressed a preference for this service to be extended throughout the night i.e. extending past the 0300hrs current cut off time.
- Professional development fund for the overnight nurses is currently under-utilised. However, it is an area that is important to ensure the nurses providing overnight care feel supported and have access further education or professional development. This not an area we would consider reducing.

Investments from efficiencies

- Used to offset the current projected service deficit
- Extend the GP phone support service to cover 0300hrs to 0800hrs. There is appetite from the City Medical nurses who work overnight to extend the GP call support.
- Extend the hours of urgent care paramedic service. The model has moved from one dedicated paramedic, to using the network of paramedics. This service could be extended to cover 0300hrs to 0800hrs.
- Reduce / remove the co-payment for the St John's service. The utilisation rates are low and there is capacity to increase consumer care utilisation. On review, it seems that there aren't many clinically relevant cases, and where there are, cost can be a barrier. Reducing the co-payment to the consumer would address one of these problems
- Reduce / remove the co-payment for next day GP review that impacts consumers not being able to see their GP the next day because they cannot afford to. The recommended next day appointment is not only good for the consumer, it provides the overnight nurse a degree of safety in discharging someone overnight.

With the service being operational for six months, there has not been the operational time to justify making recommendations for material change. The twelve-month review will present an opportunity to consider redesigning the service model to improve its equity impact and to address its current deficit. If certain aspects of the current model were to be withdrawn from, funding could be repurposed to improve access for those who most need.

A future focus identified during the review is whether Central Hawkes Bay (CHB) could join this service model. This would require engagement with local model stakeholders, CHB stakeholders and St John. This would require a further piece of work from HHB to investigate the practicalities and appetite for this in CHB.

Conclusion and Next Steps

This review provides a high level update on the first six months of operations of the new model and highlights areas of focus. The intent is to make comment on areas of focus acknowledging it is too early to make significant change. A comprehensive 12-month review will be completed where recommendations will be made to improve how care is provided to our community.

HAWKE'S BAY District Health Board Whakawāteatia	**Matariki Hawke's Bay Regional Economic Development and Social Inclusion Strategy Six Monthly Update**
	For the attention of: **Māori Relationship Board, Pasifika Health, HB Clinical Council,HB Health Consumer Council and HBDHB Board**
Document Owner	Andy Phillips, Te Tumuaki O Te Puni Tūmatawhānui
Document Author(s)	Shari Tidswell, Equity and Intersector Development Manager
Reviewed by	Kevin Snee, Chief Executive Officer
Month/Year	August 2018
Purpose	This report provides and update on progress for the Matariki Strategies and HBDHB's contribution to these.
Previous Consideration Discussions	This is reported six monthly: - Initial presentation 29 November 2017
Summary	Matariki has established a new two tiered leadership structure – Governance and an Executive Leadership Group, this has supported greater sharing of information. National funding is now coordinated via Matariki including Provincial Development Fund. Projects have been integrated which starts the process to combining both strategic documents by the end of the year.
Contribution to Goals and Strategic Implications	Improving health and equity Contributing to an intersectoral approach
Impact on Reducing Inequities/Disparities	Matariki is a Treaty based strategy and the vision for both Strategies is increased equity.
Consumer Engagement	Completed in the development of both Strategies, including community consulation hui in each local authority.
Other Consultation /Involvement	Not applicable for this report
Financial/Budget Impact	Not applicable for this report
Timing Issues	Not applicable
Announcements/ Communications	Provided via Matariki website.

RECOMMENDATION:

That Māori Relationship Board, HB Clinical Council, HB Health Consumer Council & Pasifika Health:

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

HAWKE'S BAY
District Health Board
Whakawāteatia

Board Six Monthly Update: Matariki Hawke's Bay Regional Economic Development and Social Inclusion Strategy

Author(s):	Shari Tidswell, Equity and Intersector Development Manager
Date:	**August 2018**

OVERVIEW

Matariki includes two regional strategies designed to achieve regional development via economic development and social inclusion. Through the delivery of actions, these complementary strategies will support the Regional Economic vision:

> *"Every household and every whānau is actively engaged in, contributing to and benefiting from a thriving Hawke's Bay economy."*

and Social Inclusion vision:

> *"Hawke's Bay is a vibrant, cohesive, diverse and safe community, where every child is given the best start in life and everyone has the opportunities that result in equity of outcomes."*

Underpinning this is the understanding that regional economic growth and equitable opportunities for individuals, whānau and community go hand in hand.

An intersectoral approach is being used to deliver actions and support the strategies. Intersectoral partners include community, Iwi, hapū, business, local government and government partners.

PROGRESS ON ACTIONS LED OR CONTRIBUTED TO BY HBDHB

Progress on the governance structure has been achieved with the adoption of a two tiered model. This group includes; five Councils (Mayors and a Chair), five Maori leadership representatives and five business leaders. The Governance Group provides leadership and overall direction for Matariki.

The Executive Leadership Group comprises of CEOs (senior officials and managers) from all stakeholder groups including government agencies, this includes the HBDHB CEO Kevin Snee and/or his delegate. This group provides operational and direct project support including monitoring the progress of the Strategy's actions. Administrative support is to be provided via the Business Hawke's Bay.

The Regional Growth Fund now has criteria and a process for applications. The Executive Leadership Group will review funding applications for endorsement – this will require proposals to illustrate how they will contribute to Matariki actions. Most funding to date is focused on youth employment.

The HBDHB continues to provide in-kind support for the Social Inclusion Working Group with the following recently completed:

- A communications plan for Social Inclusion
- An integrated actions table for both Strategies
- A joining statement to link the Strategies
- Supporting documents for the activity leads to deliver their roles

The HBDHB's current activity has potential to link with Matariki in the following actions:

- "Investigating whānau centric places, connected to local communities, where people access a wide range of support services…" HBDHB localities, community hubs and whānau centric programmes link to this work.
- The HBDHB's Clinical Services Plan being a good example of "Develop a new sustainable operating system for government agencies and NGOs delivering social support services".
- Supporting the development of community investment panels in Wairoa and Central Hawke's Bay. These "Establish representative groups in locations across Hawke's Bay to enable community and whānau voice and leadership in social and economic development".

HBDHB are contributing to Matariki actions as follows:

- Partnering with MSD, TPK and EIT to deliver "Project 1,000 linking 1,000 local people on benefits with new jobs". Our role includes membership on the Rangatahi Kia Eke advisory group. This project has placed 25 youth previously on health and disability benefits, into work experience placements. Have also contributed to design of the evaluation which is a collaboration with EIT.
- "Support the employment of people with challenges that may impact on their capacity to obtain or retain employment" - the DHB Annual Plan has included this work under "Work Ready" action. This is a Transform and Sustain project and a full project plan is under development. Initial activity will address barriers to employment including supporting youth to pass employer drug tests and access to support for driver licensing.

CHALLENGES

Some challenges had earlier hindered progress, notably:

- Changes in key staff, the project support role changed twice in eight months
- Delay in establishing the Governance and Executive Leadership structures which impacted the monitoring of projects to deliver actions
- Resourcing uncertainties via the change in Government and establishment of a new fund

These issues have been addressed over the previous two months. The project is now back on track with actions being accelerated and funding opportunities available to support new projects.

CONCLUSION

The work linked to Matariki is included in the HBDHB's Annual Plan, primarily under the actions in "Ready for Work". As stated above, there are also links with other key areas of work.

HBDHB benefits from cross-sector relationships developed via the membership of Matariki and these relationships will continue to offer opportunities. An example of this was the opportunity to use the Executive Leadership Group meeting to engage these key stakeholders in the Clinical Service Plan process.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
HBDHB continues to contribute to Executive Leadership Group	• Attend monthly meetings and contribute to actions	Kevin Snee/ Andrew Phillips	Ongoing
Continue to support actions areas with in-kind support	• Support the ready for work actions • Contribute to the work delivering whānau centric approaches • Complete the housing actions via Housing Coalition	Shari Tidswell	1 July 2019

RECOMMENDATION:

That Māori Relationship Board, HB Clinical Council, HB Health Consumer Council & Pasifika Health:

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

Minutes

Clinical Advisory and Governance Committee

Date	24 July 2018	**Start Time:**	5.30pm
Venue	Tukituki Meeting Room, 2nd Floor, GJ Gardner Building		
Present	Chris McKenna (Chair), Julia Ebbett, Mark Peterson, Andrew Phillips, Catrina Riley		
In Attendance	HHB: Wayne Woolrich, CEO; Linda Dubbeldam, Manager Innovation & Development; Stephanie Maggin (minutes)		
Apologies	Bayden Barber, Maurice King		

Before the meeting began, the Chair, on behalf of CAG, thanked Catrina Riley warmly for many years of tenure on the Committee; this is Catrina's last meeting.
The Chair congratulated Andy Phillips on his two new roles as Health Improvement and Equity and Quality Improvement and Patient Safety; Andy will be in these roles for a period of six months.

Item	Minute
1. Administration	**1.1 Apologies** Bayden Barber, Maurice King. **1.2 Interest Register** The Interest Register was not seen but the Committee was invited to email Stephanie with any amendments/changes. **1.3 Conflicts with today's Agenda** None. **1.4 Draft Minutes – 19 June 2018** The Minutes as circulated were accepted as a true and accurate record of the meeting. **1.5 Action Items** The Action Register was worked through: CAG 01 0318. Work in progress. CAG 02 0318. Work in progress. CAG 02 0518. Work in progress. CAG 03 0518. Work in progress. CAG 06 0618. Work in progress. CAG 07 0618. Work in progress. CAG 09 0618. Work in progress. **1.6 Committee Work plan** See 3.2 below. **1.7 Items approved since last meeting** None. **1.8 Correspondence** 1.8.1 Letter to Tae Richardson 1.8.2 Letter from Catrina Riley
2. Presentation	**Health Care Home and Nuka** Linda Dubbeldam, Manager Innovation and Development, presented on Health Care Homes.

	Health Care Homes (HCH) is a system of care developed in New Zealand. A total of 128 practices in New Zealand are involved in Health Care Homes. The HCH Core Concepts are: proactive care, routine/preventative care, business efficiency, timely unplanned care and are supported by hospital care, self-care, and community care. With NUKA, it was great to see the health system owned by the people and to see the benefits and to hear about the benefits.		
3. Items for Discussion	**3.1 Health Hawke's Bay Governance Committees** This paper was taken as read. Wayne Woolrich updated the Committee on the recent Expression of Interest. Three GPs have expressed an interest to join the Committee. From an operational point of view the PHO wishes to link one of the PHO Medical Advisors onto the Committee, in addition to the three other GPs. <u>Committee comments</u> • We need to reconsider what this Committee is for as there have been changes over time. • This is an Advisory committee for both the Board and the CEO and it needs a strong clinical input. • Rural health representation is also needed on the Committee. <u>Management response</u> We want to move away from bringing reports to this table that reflect what we have done and to justify what we've been doing; we need to think about future. We have an opportunity to work closer and better as a Committee and move away from spreading ourselves too thinly. <u>Summary</u> CAG supports the approach for the new committee structure. **Action:** Send Committee Terms of Reference to the Chair. **3.2 Committee Workplan 2018/19** The 2018-19 draft work plan will be bought to the September meeting, once Chris McKenna and Linda Dubbeldam will draft the work plan for the September meeting. 3.3 **Strategic Focus** Wayne Woolrich, CEO, informed the Committee that the Strategy document was about to be published and spoke briefly about desired outcomes: • Establish foundations and commit to equity in health outcomes • Commit to working better as a health system • Play a lead role in the evolution of general practice across the network • Redesign our services		
4. Other items for Information	**4.1 Quality Review – Cornerstone** This paper was taken as read. **4.2 Bowel Screening comms to general practice** This paper was taken as read.		
5 Any other business	The Chair complimented the PHO in supporting the HBDHB with the recent nurses' action and in particular, Lizzy Mackenzie, who was wonderful. **Action:** A letter for Lizzy Mackenzie, from CAG.		
Meeting closed:	7.15pm	**Next meeting:**	18 September 2018

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:

9. Topics of Interest – Member Issues / Updates

10. Minutes of Previous Meeting (Public Excluded)

11. Matters Arising – Review of Actions

12. Mid-point Health Cert Surveillance Audit – corrective actions

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).

HAWKE'S BAY CLINICAL COUNCIL

ANNUAL GENERAL MEETING 2018

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL ANNUAL GENERAL MEETING HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 9 AUGUST 2017 AT 3.40 PM

PUBLIC

Present:	Dr Mark Peterson (Co-Chair) Chris McKenna (Co-Chair) Dr Russell Wills Dr Robin Whyman Dr David Rodgers Dr Kiri Bird Dr Tae Richardson Debs Higgins David Warrington Maurice King Anne McLeod Lee-Ora Lusis Andy Phillips
In Attendance:	Kate Coley, Executive Director – People & Quality (EDP&Q) Tracy Fricker, Council Administrator and EA to EDP&Q Graeme Norton, Chair - HB Health Consumer Council Sharon Mason, Acting Chief Executive Officer
Apologies:	Dr Nicholas Jones, Dr John Gommans and Jules Arthur

SECTION 6: ANNUAL MEETING

18. WELCOME AND OPENING

Dr Mark Peterson (Chair) welcomed everyone to the Annual General Meeting.

Graeme Norton, Chair of the Consumer Council took the opportunity to advise the Clinical Council that as of 1 September there will be a new chair of the Consumer Council. Graeme will still be a member of the Consumer Council for six months to ease in the transition. This will be announced at the Consumer Council meeting tomorrow and will be confirmed by the Board at the end of the month. The new chair will only be chairing the Consumer Council meetings and going to the Board meetings. Graeme will still attend the Clinical Council meetings as the Consumer Council representative.

Kate Coley acknowledged Graeme Norton's role as Consumer Council Chair and all the work he has done and will continue to do at a local and national level and is supportive of Graeme remaining on the Clinical Council. Debs Higgins also acknowledged the work she has witnessed in her role as the Clinical Council representative on the Consumer Council and the progressive nature of the work that Graeme has done for the Clinical and Consumer Councils.

19. APOLOGIES

Apologies were noted as above.

20. MINUTES OF PREVIOUS ANNUAL MEETING

The minutes from the previous Annual General Meeting held on 10 August 2016 were confirmed as a correct record of the meeting.

Move and carried.

21. MATTERS ARISING FROM PREVIOUS ANNUAL MEETING

There were no matters arising from the Annual General Meeting in 2016.

22. ANNUAL INFORMATION

Review of the Last 12 Months (2016/17) Year in Summary

The Chair commented that a summary of work that the Clinical Council has looked at over the past 12 months was provided in the meeting papers. It is an extensive list. One of the challenges we may want to talk about in regard to the work plan is that too much and are we doing justice to what we do? This needs to be taken into consideration when the work plan for next year is discussed.

Attendance over the prior 12 months

The attendance rate for Clinical Council meetings are very good which reflects that it has value for the people coming.

Changes from attendance list provided in the meeting papers:

- Tae Richardson attended the December, February and April meetings
- Anne McLeod attended the February meeting

Tenure

Dr Kiri Bird is reaching the end of her term. Kiri advised that she will be stepping down to allow some refresh of the Clinical Council. The Chair thanked Kiri for her time on Clinical Council her input and work has been valued. The Chair advised that Kiri's last meeting will be September.

23. REVIEW OF HB CLINICAL COUNCIL TERMS OF REFERENCE

The Chair asked if there was any feedback on the Terms of Reference (TOR).

Feedback:

- The TOR may look different once the clinical council committees' structure is up and running, should the review of the TOR be parked for 2-3 months. Rather than the Clinical Council becoming the clinical "tick box" for some of the papers that go through to the Board, there is an opportunity for this Council to focus on some key challenges in terms of patient safety and clinical quality and other matters.
- Look at the longstanding issues we have from a clinical quality and safety perspective and doing work on those instead of business as usual.
- Are we spending our time proportionate to the big issues e.g. the mortality rate and looking at the drivers for that. Where we direct our influence needs to be related to the big issues.
- Need to be more proactive on having workshops on the topics.
- Clinical Council needs to have a dashboard which can be monitored and can take action when there is some variance and be front footing as clinical leaders. Kate Coley advised that next month we are due to bring a draft concept dashboard to Clinical Council from a patient safety perspective which will be a good starter for ten in terms of a robust discussion is the hospital and primary care safe.

- We need to be circumspect on what comes to Clinical Council, our time is valuable and are we focusing on the right things.
- The agendas are overwhelming when they arrive, trying to read the information in a few days can be difficult. What we should focus on are things that have the greatest clinical importance
- It is also about making sure that we have the right subject expertise around the table and if there are knowledge gaps that we have the right people here.
- The Hawke's Bay Health Alliance will also be around to help the committees address some of the health inequity issues and social deficits if we do it right
- Identify the gnarly issues and put them on the work plan for the next 12 months.
- Would like to look at safety, there are real concerns about patient safety. A conversation on our priorities are would be valuable

Graeme Norton commented that the Consumer Council have a sub-group which meets before the meeting and looks at what needs to go to the Board and requires endorsement and then they look at what is important and what they can make a difference with and the rest is included for information. If people want to initiate something there is a process. They focus on 3-4 key things and that works well. An example is that at tomorrow's meeting there is a session on whether or not the Consumer Council should initiate work on a disability strategy for HBDHB. Information has been gathered and will be talked about and it will assist to shape a paper which will be shared with the Clinical Council. This is working proactively on something the Consumer Council thinks is important.

Chris McKenna commented that one of the challenges as chair is getting people to speak out and contribute, it can be a challenge to set that scene. We all have a responsibility to bring these issues to the table and start the discussion especially when we have papers that clinical leaders and wise heads around the Clinical Council don't agree with. We need be more articulate and deal with that at these meetings. That has been a difficulty sometimes.

Mark Peterson reflected on his time on the Clinical Council and felt that we have regressed somewhat and that these meetings started off much better than now looking at clinical safety issues. We have become monitors with all of these monitoring papers and are doing too much. Reporting papers do not need to come to Clinical Council. Hopefully this discussion will help to reduce the size of the agendas and make them more relevant. There is an element of monitoring that a Clinical Council needs to do and the dashboard will assist with that.

Chris McKenna commented that hopefully the committees will do the monitoring and that the Clinical Council can act as true governors and lead to solutions.

The TOR do not need changing it is all in the document, the Clinical Council just need to work to the TOR.

The Chair thanked everyone for their feedback which will hopefully implement change for future agendas.

24. QUALITY ANNUAL PLAN REVIEW 2016-17

Kate Coley advised that Quality Plan last year was endorsed by Clinical Council and FRAC. There has been a significant amount of work achieved over the last 12 months:

Key points:

- We have moved on with consumer engagement in the services and making improvements there, where services are coming to us at the start and not at the end
- The Improvement Advisors are working well with the teams across the sector
- We have attained all the health quality safety markers and have retained our number one position with hand hygiene

- The Clinical Committees governance structure is now in place
- There has been a significant amount of work around relationship centred practice
- An integrated risk management system will be implemented by the end of this year and this will be will shared this with primary care and community providers in the future.
- Next year the Quality Plan will not include the day to day business as usual information, it will be the big pieces of work and projects like health literacy, clinical governance structure, consumer engagement including the local patient experience survey, which are key priorities for 2017/18
- The dashboard will be come to clinical council in September as a draft concept. It will evolve overtime and will bring a greater visibility from a quality and safety perspective for Clinical Council. There is a lot of work locally and nationally looking at data quality which will help with our dashboard to give us a clear picture of safety.

Discussion held regarding the difficulty of accessing data and it being integrated. Graeme Norton used the example of the system used in Canterbury that works well in the South Island.

The Clinical Council **noted** the contents of the report.

25. CLINICAL GOVERNANCE STRUCTURE

David Warrington advised that the structure has been completed and the TOR for each committee has been drafted by Ken Foote, Company Secretary. The Chairs of each of the committees were to feedback. The next step is to ensure that the TOR for all the advisory groups were reviewed, including structure and membership.

Graeme Norton advised that a group came together around the Patient Experience Committee and they have drafted up a plan for it.

David Warrington advised that with the Nursing and Midwifery Council TOR, they have looked at the percentage of Maori within the committee. If we are working in true partnership 25% of the positions on the committee should be dedicated to Maori, not just having representation of Maori, but also focusing on Maori in terms of having a Karakia and introducing new members. A challenge needs to be sent to other committees like the capital committee who are not part of this process.

Andy Phillips proposed that that the Clinical Council ratify the structure included in the meeting papers as the approved version of the clinical committees' structure. This was **approved** by Clinical Council members.

General updates provided below:

Clinical Effectiveness & Audit Committee

- Clinical Audit – there hasn't been a clinical Audit group that has met regularly. There is clinical audit done in the organisation but it is ad-hoc, sporadic and the results don't come back anywhere to close the audit cycle so there is significant work to do
- Clinical pathways – this work is going well
- Equity & Health System Integration – both are new groups and it has been a challenge as to whether we have these advisory groups. Reflection on discussion today is that we clearly do need some focused attention on both these. Work is to be completed on the TOR for these groups and any issues of health system integration and equity will be reported to clinical council on a regular basis
- Laboratory Committee – has been ably chaired by Dr Kiri Bird, but will need to find a new chair
- Pharmacy & Therapeutics – have been doing reasonably well
- Radiology Services – was blind to a number of the issues in the radiology department which was an issue.

Patient Safety & Risk Management Committee

- This is the largest committee with 10 advisory groups, most of which are working well and get exceptional results. We are looking to refresh membership and looking at where we can recruit more talent because these are all groups where there is an opportunity to recruit talented young clinical leaders and support their development
- Patient at Risk Advisory Group - will be re-purposed to meet the HQSC guidelines and chaired by Dr James Curtis, the Head of Department - Medicine
- Morbidity &Mortality Review Advisory Group – this is a new group. There are mandated groups which report nationally and then there are other ad-hoc groups that have no guidelines or standardisation. M&M reviews are not MDT and are not shared. This will be a big piece of work

Professional Standards & Performance Committee

- Allied Health Professions Forum – continues to meet monthly. Most recently has been occupied with designing the Allied Health Strategy
- Nursing & Allied Health Credentialling Committee – met in April to progress credentialling in various areas. The committee has concerns about Maori representation within credentialed activities and will address this at future meetings
- SMO Credentialling – has received/endorsed two biennial credentialling reports (Anaesthesia and Orthopaedics), has approved five new long term SMO appointments and is reviewing another four new SMO appointments
- Research – TOR and membership to be updated and presented to Clinical Council in October; a new consumer representative is to be sourced; next research forum is scheduled for 9 October, the theme s PHD with three key speakers, August meeting will include a workshop around research opportunities and how to tie in to existing strategies and initiatives in the DHB
- Pre-vocational Training / RMO Training – Community based attachments are progressing; PES are continuing to encourage clinical supervisors to participate in timely and engaged feedback with the PG1/2; documentation relating to training issues including medical education leave for RMOs and guidance for supporting struggling interns is almost complete; with increasing numbers of PG1/2 from November, a fifth PES is needed, once funding is assured an expression of interest will be circulated.

26. REVIEW OF CLINICAL COUNCIL'S ANNUAL WORKPLAN 2016/17

Information included in the meeting papers.

27. DEVELOPMENT OF COUNCIL'S ANNUAL WORKPLAN FOR 2017/18

Discussion took place under item #23.

28. ELECTION OF CHAIR / CO-CHAIRS 2017/18

Dr Mark Peterson advised that both he and Chris McKenna were stepping down as Co-Chairs.

Dr Mark Peterson nominated Dr John Gommans as Chair. This was seconded by Chris McKenna.

Dr Robin Whyman nominated Andy Phillips for Co-Chair/Deputy Chair and this was seconded by Dr Russell Wills.

Dr David Rodgers commented that should the role of Co-Chair be someone who sits outside of the Executive Membership Team.

As no other nominations were forthcoming, the Clinical Council endorsed the nominations.

Sharon Mason, Acting CEO advised that these nominations needed to be approved by Dr Kevin Snee as the Clinical Council reports to the Chief Executive Officer.

Action: Nominations to be presented to the CEO for approval.

The meeting closed at 4.40 pm.

Confirmed: _____
Chair

Date: _____

ANNUAL INFORMATION

CLINICAL COUNCIL ATTENDANCE RECORD

2017-18

Council members	Aug	Sept	Oct	Nov	Dec	Feb	Mar	Apr	May	Jun	Jul	Mtgs attended	# of Mtgs
Chris McKenna	1	1	1	1	1	1	1	1	1	1	A	10	of 11
Dr Mark Peterson	1	1	1	1	1	A	A	1	1	A	A	7	of 11
Dr John Gommans	A	A	1	1	1	1	1	1	1	1	1	9	of 11
Jules Arthur	1	1	1	1	1	1	1	A	1	A	A	8	of 11
Dr Kiri Bird	1	1										2	of 2
David Warrington	1	1	1	1	A	A	1	1	1	1	A	8	of 11
Dr Tae Richardson	1	1	1	1	1	1	A	1	1	1		9	of 10
Dr Andy Phillips	1	1	1	A	1	1	1	1	1	1	1	10	of 11
Dr David Rodgers	1	1	1	1	1	1	1	1	A	1	1	10	of 11
Debs Higgins	1	1	1	1	1	1	1	1	1	1	1	11	of 11
Robin Whyman	1	1	A	1	1	1	1	1	1	1	A	9	of 11
Anne McLeod	1	1	A	1	1	1	A	1	A	1	A	7	of 11
Dr Russell Wills	1	1	A	1	1	1	1	1	1	A	1	9	of 11
Lee-Ora Lusis	1	1	A	1	1	1	A	1	A	1	A	7	of 11
Dr Nicolas Jones	A	1	1	1	1	1	1	1	1	1	A	9	of 11
Maurice King	1	1	1	1	1	1	1	1	1	1		10	of 10
Dr Peter Culham						1	1	A	1	A	A	3	of 6
Dr Daniel Bernal											1	1	of 1
	14	15	11	14	14	14	12	14	13	12	6		

16.1

Hawke's Bay Clinical Council

Tenure as at 10 July 2018

Tenure		Term	Expiry
Peter Culham	General Practitioner	1st	Sep 20
Debs Higgins	Senior Nurse	1st	Sep 18
Robin Whyman	Senior Medical / Dental Officer	1st	Sep 18
David Rodgers	General Practitioner	1st	Sep 18
Anne McLeod	Senior Allied Health Professional	1st	Sep 18
Russell Wills	Senior Medical / Dental Officer	1st	Sep 19
Lee-Ora Lusis	Senior Nurse	1st	Sep 19
David Warrington	Senior Nurse	2nd	Sep 19
John Gommans	Chief Medical Officer - Hospital		N/A
Mark Peterson	Chief Medical Officer - Primary Care		N/A
Chris McKenna	Chief Nursing Officer		N/A
Tae Richardson	Clinical Lead Clinical Advisory Governance Committee		N/A
Nicholas Jones	Acting Director Population Health		N/A
Jules Arthur	Director of Midwifery		N/A
Andy Phillips	Chief Allied Health Professions Officer		N/A
Daniel Bernal	Pharmacist		Temp

Terms of Reference - Tenure

- Normally appointed for 3 years
- Ideal for one third retire by rotation each year (ie 2-3)
- Members may be reappointed but for no more than 3 terms.

Note

Members appointed by role/position do not have a finite term.

CLINICAL SERVICES PLAN AND PERSON & WHANAU CENTRED CARE

17.1 Presentation (and video)

Draft Clinical Services Plan

the next 10 years

17.1

CSP – What is it?

- Informs the **priorities for future investment** in the HB health system
- Sets out the **potential demand** for services in the future and a range of service and model of care options for how the DHB and its health and social system partners will **respond to that demand**.
- Takes a view of the **health system as a whole**, encompassing primary, community, and hospital level care; and acknowledging the important influence of **socioeconomic determinants**
- The planning horizon is long term and considers options for the HB health system over a **10 year time frame**.
- Will inform our next **five year strategic plan**.

How has it been developed?

- Started with understanding the **current state** of service provision and **challenges** for the future
- Mapped **healthcare journeys** through patient journey workshops and explored **options for service and model of care** development
- Expanded these possibilities and **brought it all together**
- Retested through the **equity/values & behaviours** lens
- All done over the past **12 months** through data gathering, analysis, and a series of **co-design meetings and workshops** with health professionals, consumers, community and governance groups

Major Challenges

- Looking across the HB health system, **inequities, unmet need and delayed access to services persist**
- **Demographic changes will increase pressure** on our already stretched health services – both primary care & hospital
- Increasing **complexity, co-morbidities and frailty** will add further pressures
- Current models of care are **unsustainable**
- We have **pockets of service excellence** already and will build on these in our new system

Commitments

- Our bold goal is to achieve **equity** with a particular focus on those with **unmet needs**
- We will create a culture that is **person and whānau centred,** requiring a fundamental shift in behaviours, systems, processes and services for all people working across the HB health system
- This CSP establishes a firm commitment to **co-designing and prioritising services to meet the needs of populations with the poorest health and social outcomes**
- We will support people to make good choices by **making health easy to understand**

17.1

The Plan

'The plan sets out a **range of options for service and model of care development**, organised around key themes developed with stakeholders in the Hawke's Bay health system. **It does not explicitly address every area of the health system**. In the future, we will keep doing many of the things we do currently, and continue to develop new models of care we have already started. **As well as that we will change our system in the areas described in this Plan**.'

Nine Themes

- **Place based planning** will provide us with a strong platform to work collaboratively with communities
- Evolving **primary health care** is the lynchpin of our plan, with expanded teams offering a wider range of culturally relevant services that meet the needs and expectations of whanau
- **Meaningful collaboration with whanau to design the services they need** is crucial if we are to eliminate inequities and ensure children have the best start in life. **People and whanau will be equal partners** in the design of health services and in decisions about their own care

Themes (Cont…)

- Care for mental health and addictions is a priority for our health system. We will develop ground up **timely, relevant and holistic responses to support mental health & wellbeing**
- We recognise our population is aging so we will step up our response to **keep older people well at home and in their communities**
- We expect the prevalence of long term conditions to increase so will base **the management of long term conditions firmly in primary care**. The emphasis will be on prevention and proactive self management

Themes (Cont…)

- Consumers, their whanau, other support people and community providers will be engaged in **planning for well supported transitions from hospital**, from day one. Community services will need to be there for them
- The **hospital will take a narrower focus** in future, being a place providing specialist assessments and appropriate care for patients with critical illnesses or injury, and delivering services that require specialist teams or equipment that isn't feasible to replicate in multiple settings
- We will focus on prevention and non-operative management, but the requirement for surgery will inevitably increase as the population ages and **surgical services will continue to be refined**

Support Structures

- Growing our **workforce** is critical to the delivery of new models of care
- Better **information and communication technology** will enable us to work smarter
- We will need **fit for purpose** primary care and hospital **facilities**
- Effective coordinated **leadership and governance** will be necessary, across the health system, our wider communities and central government agencies
- **Health and business intelligence** will be strengthened at strategic and operational levels.
- We will need to create a **learning and innovative culture**

So What Happens Next?

- CSP first part of the overall journey to develop the **next 5 year strategy** – set direction and prioritise developments
- Build on and replace **Transform & Sustain**
- **Integrate with other strategic initiatives** such as the People Plan, Health Equity Report, Quality Framework and Matariki – Social Inclusion strategy
- **'Get on and do'** what can be done now
- **Develop and implement road maps and operational (annual) plans**, including long term investments, facilities, ICT and workforce plans
- **Monitor our progress** over time to make sure we are on track.

Questions/Feedback

- Have we got it right?
- Is anything significant missing?
- Any other feedback?
- To review the full Draft CSP and/or provide additional comments, go to:

www.ourhealthhb.nz/news-and-events/clinical-services-plan

- Feedback/comments will be received up to 31 October 2018
- Final CSP to go to HBDHB Board 28 November 2018

CLINICAL SERVICES PLAN AND PERSON & WHANAU CENTRED CARE

17.2 Commitment to Person & Whanau Centred Care (verbal)

CLINICAL SERVICES PLAN AND PERSON & WHANAU CENTRED CARE

17.3 Working with Consumers (Verbal)

HAWKE'S BAY HEALTH CONSUMER COUNCIL
ANNUAL PLAN 2018/19

Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
FUNCTIONS	• Identify and advise on and promote, a 'Partners in care' approach to the implementation of 'Person and Whānau Centred Care' into the Hawkes Bay health system, including input into: - Development of health service priorities - Strategic direction - The reduction of inequities • Participate, review and advise on reports, developments and initiatives relating to health service planning and delivery. • Seek to ensure that services are organised around the needs of all consumers	• Identify and advise on issues that will improve clinical quality, patient safety and making health easy to understand. • Seek to enhance consumer experience and service integration across the sector. • Promote equity of access/treatment • .Seek to ensure that services are responsive to individual and collective consumer needs.	• Oversee implementation of the Consumer Engagement Strategy for the Hawkes bay health system • Ensure, coordinate and enable appropriate consumer engagement within the health system - across Hawke's Bay - within the Central region - at National level • Receive, consider and disseminate information from and to HBDHB, Health Hawke's Bay, Consumer groups and communities. • Ensure regular communication and networking with the community and relevant consumer groups. • Link with special interest groups as required for specific issues and problems solving.
STRATEGIES	• Proactively raise and promote issues of importance and/or concern to consumers generally, for consideration and/or resolution by relevant organisations within the health system. • Engage early with project and planning teams, and standing committees, to ensure the consumer perspective is included in all outcomes and recommendations. • Review and comment on all relevant reports, papers, initiatives to the Board.	• Work with Clinical Council to develop and maintain an environment that promotes and improves: - Putting patients / consumers at the centre - Patient safety - Consumer experience - Clinical quality - Health literacy - Equity • Promote initiatives that empower communities and consumers to take more responsibility for their own health and wellness.	• Raise the profile and community awareness of Consumer Council and the opportunities / options for enhanced consumer engagement in decision making. • Ensure good attendance and robust discussions at monthly Consumer Council meetings • Co-ordinate consumer representation on appropriate committees and project teams: - Within Hawke's Bay - At Central Region and National levels

Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
Strategies cont..	• Ensure robust complaint/feedback systems are in place and that consumers are well informed and easily able to access these • Consumer Council members to be allocated portfolio/areas of responsibility.	• Promote a clinical culture which actively engages with patients / consumers at all levels, as 'partners in care'. • Advocate / promote for Intersectoral action on key determinants of health.	• Engage with HQSC programmes around consumer engagement and 'partners in care'. • Maintain current database and regular communications with all Hawke's Bay health consumer groups/organisations. • Provide regular updates on both the HBDHB and Health Hawke's Bay websites • Ensure Consumer Council members continue to be well connected and engaged with relevant consumer groups and communities
OBJECTIVES 2018/19	• Actively promote and participate in' co-design processes for: - Mental Health, Youth • Participate in the evolution of primary care and the work of the Primary Care Development Partnership. • Promote and support work on the development of a Disability Strategy for the HB Health sector. • Hold active membership in Clinical Council committees including Consumer Experience Committee. • Actively participate in the People Strategy and Clinical Services Plan development and implementation.	• Promote and assist initiatives that make health easy to understand within the sector and community. • Facilitate and promote the implementation of a 'person and whānau centred care" approach and culture to the delivery of health services, in partnership with the Clinical Council. • Oversee the provision of consumer feedback and the use of 'consumer stories'. • Require regular provision of and monitor all 'Consumer Experience' performance measures/indicators as co-sponsor of the 'Consumer Experience Committee' within the clinical governance structure. • Facilitate a focus on disability issues	• Support the implementation of the Consumer Engagement Strategy and principles in Hawkes Bay • Further develop and maintain connections with Youth within the community. • Influence the establishment and then participate in regional and national Consumer Advisory Networks.

QUALITY INDICATORS & DASHBOARD - UPDATE

18.1 Progress & Options (Kate Coley)

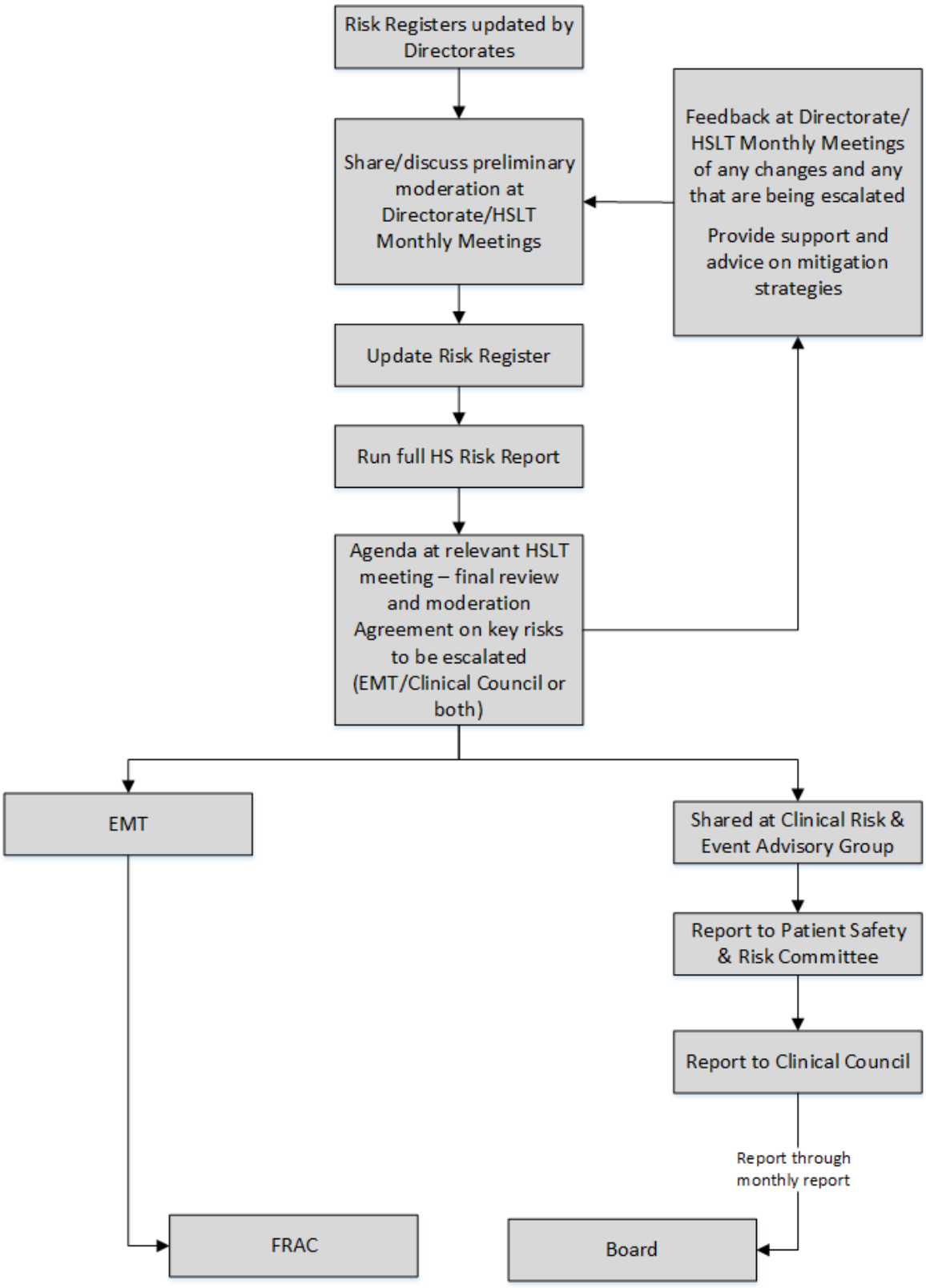
QUALITY INDICATORS & DASHBOARD - UPDATE

18.2 Roles & Responsibilities (verbal)

CLINICAL RISK MANAGEMENT

19.1 Monitoring / Reporting – (Flow Chart)

Health Services Risk Management Flow Process



19.1

CLINICAL RISK MANAGEMENT

19.2 Roles / Responsibilities (verbal)

Draft

Clinical Governance Manual

Hawke's Bay Health Sector

20.1

Author:	**Ken Foote**
Designation:	**Company Secretary**
Date:	**June 2018**

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Preface

Introduction

1.0 Introduction to clinical governance

1.1 Background and history of clinical governance

Clinical governance was first introduced in the United Kingdom (UK) in the late 1990s in response to major failures in the standard and delivery of patient care. The National Health Service (NHS) identified an imbalance between the priorities of managers and those of clinicians (fiscal, target-driven versus patient-centred, clinically focused) as central to these failures. Clinical governance was seen as a key vehicle for developing a shared commitment to high-quality care in everyday clinical practice.

Definitions of clinical governance have continued to evolve over time as the concept of clinical governance has been implemented in different health jurisdictions, and new initiatives and practices have emerged (Brennan and Flynn 2013). The drivers of clinical governance have also changed in response to developments in the culture and quality and safety and an increasing focus on patient-centred care (Ham et al 2012).

Use and application of the term 'clinical governance' has varied, in part because it is a composite mix of activities and relationships that link governance, management and practice that have been operationalised within different health systems (Flynn et al 2015).

Despite the variation there are some common approaches to clinical governance. These include:

- Consumer/patient engagement and co-design
- Open, transparent and learning culture
- Prioritising quality improvement and patient safety
- Clinical leadership for quality and safety
- An emphasis on partnerships and involvement of all staff
- Effective multidisciplinary teamwork
- Measuring clinical processes and outcomes
- Use of data to identify variation
- Effective management of clinical risks. (Flynn et al 2015).

The importance of consumer/patient involvement in improving the quality and safety of health care services is well recognised by New Zealand health professionals (Gauld and Horsburgh 2014a). New Zealand has yet to develop a formal definition for clinical governance. Variations of the Australian Council on Healthcare Standards' (2004) definition of clinical governance have been widely adopted with its strong emphasis on consumers being at the centre of continuous improvement of health care:

> *….. the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.*

A recent report by the New Zealand Treasury (2016) found that quality improvement programmes with effective clinical governance and leadership 'can lead to quantifiable savings and/or efficiency gains … and achieve better outcomes for patients'. The report identified common success factors across the four DHBs studied as 'alignment to strategic goals, executive and clinical leadership, culture and capability, measurement and results, and consumer engagement and patient experience'.

The focus of this manual is to explain the framework implemented in the HBDHB (for the sector) that will bring individual elements together and in doing so strengthen and sustain ongoing improvement across the five dimensions of quality defined by the Ministry of Health (2003): people-centred; access and equity; safety; effectiveness; and efficiency.

The Ministry of Health's five key dimensions of quality rest on the foundations of partnership, participation and protection principles of the Treaty of Waitangi.

- **People-centred** is the extent to which a service involves people, including consumers, their families and whanau, and is receptive to their needs and values. It includes participation, appropriateness, adherence to the Code of Health and Disability Services Consumers' Rights 1996 and other consumer protections such as the Health Information Privacy Code 1994.
- **Access and equity** is the extent to which people are able to receive a service on the basis of need and likely benefit, irrespective of factors such as ethnicity, age, impairment or gender. It includes the physical environment, and the extent to which this is a barrier to accessing health and disability support services. Being able to physically access health and disability support service facilities can be a significant issue for people with disabilities.
- **Safety** is the extent to which harm is kept to a minimum.
- **Effectiveness** is the extent to which a service achieves an expected and measurable benefit.
- **Efficiency** is the extent to which a service gives the greatest possible benefit for the resources used.

1.2 What is clinical governance?

Clinical governance is an organisation-wide approach to the continuous quality improvement of clinical services. It is larger in scope than any single quality improvement initiative, committee or service. It involves the systematic joining-up of all patient safety and quality improvement initiatives within a health organisation. In practice, it requires clinicians to be engaged in both the clinical and management structure of their health organisation to contribute to the mission, goals and values of that organisation. It is also about managers engaging more with clinicians and enabling them to be involved.

One way to describe clinical governance is to look at it in terms of:

> *… 'the culture, the values, the processes and the procedures that must be put in place in order to achieve sustained quality of care in healthcare organisations. Clinical governance means moving towards a culture where safe, high quality patient-centred care is ensured by all those involved in the patient's journey. (Department of Health and Children 2008)"*

Another way is to approach it from the role and responsibilities you hold and how these align with the aims and goals of your organisation. A hospital project manager in Ireland explained how clinical governance works in more personal terms:

> *'People struggle with the phrase clinical governance, but really it's about having a framework in place throughout the organisation, that supports you to be explicit about the standard of care delivered, about how you protect patients from harm, about how you listen to patients, and about how you plan and measure improvement.' (Flynn et al 2015)*

Clinical governance is achieved through a strategy that describes how the necessary components, activities and supporting structures come together and align with the organisation's overall quality strategy.

Managers and clinicians are aware of their roles and responsibilities, and have the appropriate arrangements in place to manage and monitor the quality of the clinical services they deliver. Clinical governance supports consumer engagement and participation in decisions about the treatment, services and care they need and receive. When implemented well, clinical governance also gives assurance to the governing body of the organisation that the health and disability services they provide are safe and of a high quality (Braithwaite and Travaglia 2008).

Put simply, clinical governance is a collaborative venture between clinicians, managers and consumers that aims to 'create a culture where quality and safety is everybody's primary goal' (Flynn et al 2015).

1.3 What are the key principles of clinical governance?

The key principles for clinical governance to be effective are:

- consumer-/patient-centred care
- open and transparent culture
- all staff actively participate (and partner) in clinical governance
- continuous quality improvement focus.

To fully realise the building and sustaining of high-quality services focused on consumers/patients, their needs and their experience of care in an environment that fosters trust and openness requires an organisation-wide commitment. That commitment needs to engage all staff (Ministerial Task Group on Clinical Leadership 2009).

1.4 Roles and responsibilities – the part everyone plays in clinical governance

Clinical governance operates throughout organisations at different levels and in specific contexts. To be effective, clinical governance will be evident at all levels of the organisation so staff who are providing frontline patient care or working directly with consumers are aware of the part they play. Clinical governance needs to be as meaningful and accessible to frontline clinical staff as it is to managers and senior leaders.

Using HBDHB as an example, clinicians are responsible for critically reviewing the quality of care they provide, both individually and as part of their wider team; for introducing changes that will improve quality; and for raising issues that require a wider system response than they are able to provide.

Clinical directors and service directors have joint responsibility for leading and overseeing the quality activities of clinical teams, and for planning and implementing appropriate service improvements.

Those funding services have a crucial role in articulating quality improvement from a community and whole-of-system view and in relating service design and development to improvements in population health status and outcomes.

The Chief Executive Officer (CEO) and the Executive Management Team (EMT) provide organisation-wide leadership for quality improvement.

The Consumer Council seeks to ensure the design quality and safety of services meet the needs of the people.

The Clinical Council provides the Board with appropriate assurance and advice on design, delivery, quality and safety of services delivered.

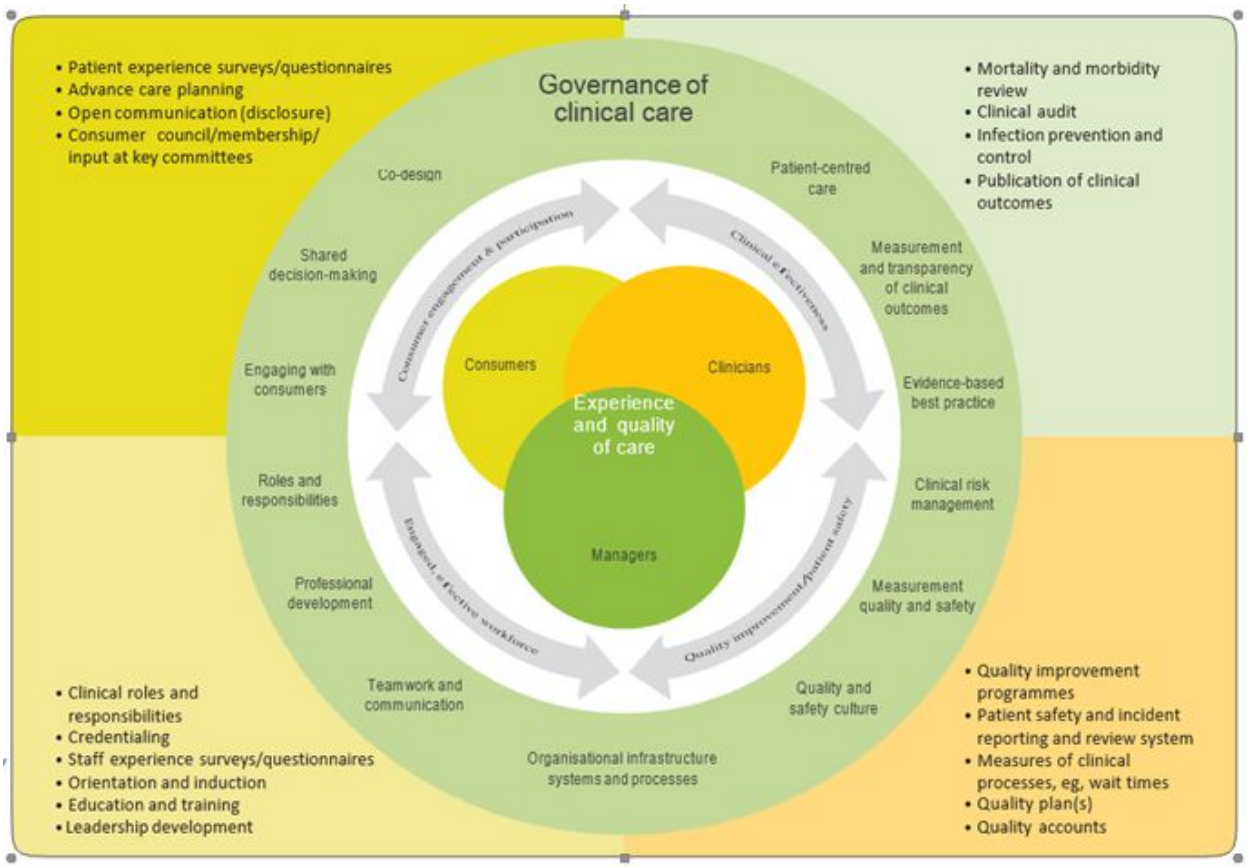
The DHB board provides governance and oversight of all quality improvement activities (Ministry of Health 2013).

2.0 A framework for clinical governance

An effective clinical governance framework has four components or 'building blocks' (Figure 1). These provide a structure for strategies to improve and enhance the quality of care, and include:

- consumer engagement and participation: making decisions about their own care and taking part in the design, delivery and evaluation of the services they use
- clinical effectiveness: the application of knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients
- a commitment to working on quality improvement and patient safety
- an engaged, effective workforce.

Figure 1: The key components of the clinical governance framework



2.1 The four framework components

2.1.1 Consumer Engagement and Participation

Enabling consumer/patients and their families/whānau as members of the health team

❖ **Strategic Approach**

- The concepts of consumer/patient engagement and consumer/patient partnership across the spectrum of health care are a key strategy for improving health outcomes.

- We as health providers encourage and enable consumer/patients and their families/whānau to engage in ways that empower them to achieve their desired outcomes to the degree they are able or wish to.

❖ **Capabilities and Structure**

- We have in place systems to support consumer-/patient-centred care, health literacy and cultural safety.
- All our clinicians practise consumer-/patient-centred care
- Consumers/patients and their families/whānau are involved at all levels in improving the design and delivery of care.
- All our staff understand and act upon the rights of consumer/patients and their families/whānau to receive information

❖ **Principles**

- Partnership with patients
- Patient experience surveys/questionnaires
- Advance care planning
- Open communication
- Health Literacy (Making Health Easy to Understand)
- Consumer/patient participation
- Shared decision-making
- Co-design
- Patient stories

2.1.2 Clinical Effectiveness

The application of best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients' (NHS Executive 1996)

❖ **Strategic Approach**

- We use evidence-based, effective interventions and treatments based on the principles of good practice.
- Evidence and data drive improvement and innovation, minimising harm, waste and variation.
- We include consumers/patients in the process of determining which outcome measures are reported and how the information is presented.

❖ **Capabilities and Structure**

- We have systems in place for giving all health care workers access to up-to-date evidence and data.
- We make available appropriate education and training, resources and information to support best practice.
- We have in place systems to allow the multidisciplinary team to review their own practice, so it is consistent with current knowledge and evidence, and the results are used for learning and to improve care and minimise harm for patients.
- Transparency and openness are core values of our organisation.
- We have systems in place for sharing improvements.

❖ **Principles**

- Measurement and transparency of clinical outcomes
- Evidence-based best practice

- Mortality and morbidity reviews
- Clinical audit
- Infection prevention and control
- Open publication of clinical outcomes

2.1.3 Quality Improvement and Patient Safety

Increasing the capabilities of everyone participating in the health workforce in quality and safety improvement appropriate to their role and sphere of work.

❖ **Strategic Approach**

- Patient safety and quality of care are our top priorities.
- Increasing organisational capability and capacity in quality improvement and patient safety is essential to having safer and better quality care.
- We identify and manage clinical risks within a just culture.

❖ **Capabilities and Structure**

- We have a coherent and effective quality and safety framework.
- The health and disability sector has in place effective governance and leadership, both clinical and managerial, across all levels to support improved quality and safety.
- All health care workers have a foundation-level understanding of quality improvement and patient safety knowledge, methods and the actions they need to take to achieve better quality and safety.
- Appropriate tools, methods and techniques are used to improve the quality and safety of care.
- Expertise in quality and safety is available to influence strategy and policy, and translate organisational goals into actions at the front line of care.
- We have in place an appropriate infrastructure to support the identification, recognition and review of patient safety incidents and/or adverse events and near misses.

❖ **Principles**

- Quality and safety culture
- Data for monitoring clinical care
- Clinical risk management
- Patient safety and incident reporting systems
- Measures of clinical processes
- Quality accounts (DHBs)
- Quality plans

2.1.4 Engaged, effective workforce

An engaged, effective workforce that works in partnership with consumers/patients and their families/whānau and actively participates in an ongoing process of self and peer review

❖ **Strategic Approach**

- Everyone in our organisation clearly communicates and role-models expectations and standards of performance.
- We foster and support multidisciplinary teamwork.
- We plan and provide professional development for a health workforce with appropriate knowledge and skills
- Education, training, development and mentoring support for the workforce

- We encourage proven innovative practice (Victorian Government Department of Human Services 2009).

❖ **Capabilities and Structure**

- We provide support so clinical staff and managers have the skills, knowledge, training and organisational resources to perform the tasks required of them, and they understand the concepts of quality and safety and continuous improvement.
- We include contracted and locum staff in these processes.

❖ **Principles**

- Orientation and induction
- Education and training
- Roles and responsibilities
- Professional development
- Teamwork and communication
- Leadership development
- Individual and service credentialing
- Clinical supervision

2.2 In Summary

Clinical governance is an organisation-wide approach to the continuous quality improvement of clinical services. It is larger in scope than any single quality improvement initiative, committee or service. It involves the systematic joining-up of all patient safety and quality improvement initiatives within a health organisation.

For further details and references to this Introduction, please refer to the publication:

- Clinical Governance - Guidance for Health and Disability Providers

  Produced by: Health Quality and Safety Commission New Zealand on www.hqsc.govt.nz

3.0 Clinical Governance in Hawke's Bay

3.1 HB Health Sector Governance Structure

Given the Hawke's Bay District Health Board (HBDHB) Board provides governance and oversight of all quality improvement activities, it is appropriate to view the full Hawke's Bay (HB) health sector governance structure within the context of clinical governance.

This structure is attached as **Appendix A**.

Whilst both the Boards and Chief Executive Officers (CEOs) of HBDHB and Health Hawke's Bay (HHB) Ltd, the Primary Health Organisation (PHO) have significant 'general' roles and responsibilities, those with very specific roles include:

- Hawke's Bay Clinical Council
- Hawke's Bay Health Consumer Council
- HHB Ltd Clinical Advisory Governance Committee

3.2 Clinical Council

Clinical governance was formally introduced into the overall governance structures of the HB health sector in September 2010, with the establishment of the HB Clinical Council. The purpose of this Council is:

- The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system.

Full Terms of Reference for this Council are attached as **Appendix B**.

Whilst this Council was initially for HBDHB only, it has subsequently been 'adopted' by HHB Ltd, so is now sector wide.

Council is directly accountable for HBDHB CEO (and HHB Ltd, CEO), but practically the Chair / co-Chairs report directly to the HBDHB Board and attend all DHB Board meetings.

3.3 Consumer Council

The HB Health Consumer Council was established in June 2013, to effectively mirror and partner the Clinical Council.

The purpose of this Council is:

- "The HB Health Consumer Council works collaboratively with the HBDHB and Health HB governance and management teams, and the HB Clinical Council to develop effective partnerships in the design and function of an effective health system in Hawke's Bay that meets the needs of the people.

  Through true partnership, the Council provides a strong and viable voice for the community and consumers, on health service planning and delivery. The Council seeks to enhance consumer engagement and experience through service integration across the secotr, the promotion of equity and ensuring that services are organised and provided to meet the needs of all consumers.

  Through effective processes and communications, the Council receives, considers and disseminates information from and to HBDHB, Health HB, consumer groups and committees.

  The Council also has a quality improvement role to advise and encourage best practice and innovation.

Full Terms of Reference for this Council are attached as **Appendix C**.

The accountability and practical reporting processes for the Consumer Council are exactly the same as the Clinical Council.

3.4 Clinical Advisory and Governance Committee

The purpose of the Clinical Advisory and Governance Committee of Health Hawke's Bay Ltd is to "support the Board of HHB in its responsibility for clinical governance through:

- Leadership that delivers sound strategic and policy advice.
- Recommending appropriate system and processes.
- Ensuring organisational accountability for clinical safety and quality improvement that will ensure that the HB population receives the right care, at the right time from the right person in a safe, honest open and caring environment.

3.5 Clinical Governance Committee Structure

Attached as **Appendix D** is a diagrammatic representation of the Clinical Governance Committee Structure of the HB health system. Key points to note are:

- There are three Committees reporting directly and solely to Clinical Council:
  - Professional Standards and Performance Committee – to provide assurance that all essential requirements relating to credentialing, professional standards, clinical training and research ae 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 and Risk management Committee – to provide assurance that all matters relating to patient safety and clinical risk are effectively monitored, managed and enhanced.
- Eighteen Advisory Groups in total have been either adapted or established, reporting directly to these three Committees.
- The Patient Experience Committee reports to both the Clinical and Consumer Council's 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 HBDHB Information Services Governance Committee (on which clinical interests are represented) is part of the HBDHB management structure, but indirectly reports to Clinical Council.
- The HHB Clinical Advisory and Governance Committee is formally a committee of HHB Board, but is represented on, and indirectly reports to Clinical Council.

3.6 Terms of Reference

A summary of the Terms of Reference of all the above Committees and Advisory Groups is attached as **Appendix E.**

3.7 Membership Principles

3.7.1 Committees

General principles applying to Committees include:

- Chairs / co-Chairs to be members of Clinical Council
- At least one consumer representative
- At least one management representative
- To include all chairs of advisory groups reporting to the Committee
- To include a representative from the Māori Health Service where appropriate
- Where appropriate membership to reflect the scope and stakeholders covered by the Committee mandate.

3.7.2 Advisory Groups

General principles applying to Advisory Groups (AG) include:

❖ Chair to be selected and appointed by the Committee to which the AG reports, taking into account

- Relevant skills, knowledge and experience
- Leadership experience / potential
- Time availability to commit to the role
- Should not already be Chair of any committee or other AG

❖ Members need to:

- Possess relevant knowledge, skills, experience and interest in being involved.
- Be drawn from across the sector
- Reflect the profile of the key stakeholders covered by the relevant purpose, scope and mandate.

3.7.3 General

- It is anticipated that in time, the mandate and therefore membership of all clinical governance groups will be sector wide.
- Representation / membership on groups needs to be shared across all teams, directorate and professional groups to ensure that the burden does not fall on a few individuals.
- Until equity becomes a reality and or a cultural norm, representation from Māori Health should be invited to ensure this issue is addressed (where appropriate).

4.0 Expectation of council, committee and advisory group chairs and members

4.1 Values and Behaviours

As with all other participants in Hawke's Bay health sector activities, all members of clinical governance councils, committees and advisory groups will be expected to 'live and reflect' the sectors shared values and behaviours. The values are:

He Kauanuanu	Respect
Ākina	Improvement
Rāranga Te Tira	Partnership
Tauwhiro	Care

Descriptions of these values and the associated behavioural expectations are attached as **Appendix F.**

4.2 Specific Expectations of all members

In addition it is expected that all members of clinical governance councils, committees and advisory groups will specifically:

- Act in accordance with good clinical governance principles and practice
- Actively promote clinical governance, patient safety and quality clinical care to other clinicians
- Be familiar with the Terms of Reference for the Committee or Advisory Group
- Acknowledge that committees and advisory groups are 'governance' groups and not 'management' teams.
- Attend all relevant meetings when available, having prepared appropriately
- Apologise for unavoidable non-attendance and/or send an alternate where applicable
- Actively participate and contribute to discussions and decisions
- Be bound by collective decision making
- Maintain confidentiality as required.
- Engage with relevant stakeholders as and when necessary, and provide 'two way' communications and feedback.
- Ensure all learnings and opportunities for service wide improvements are shared.
- Complete assigned actions as required.

4.3 Expectations of Chairs

It is expected that all chairs of clinical governance councils committees and advisory groups will:

- Provide effective leadership to the members
- Positively 'role model' relevant values, behaviours and expectations of members
- Call meetings as required.
- Effectively chair meetings of the group (Refer to **Appendix G** – the Chair's Guide to Meetings)
- Ensure all reports and actions from meetings are appropriately completed, followed up and communicated

- Be the "sector champion" for the issues covered by the purpose and functions within the Terms of Reference
- Ensure a full and competent membership is maintained.
- Maintain active engagement and communications with members between meetings.
- Maintain liaison with the Chair of the committee / council to which the group reports.
- Develop and maintain a 'Plan' for the group for at least the next 12 months.
- Conduct an annual review of the activities and performance of the group.

4.4 Decision Making

❖ All decisions made by any group must:

- Be consistent with and within the Terms of Reference
- Acknowledge that all groups are "clinical governance" groups and not "management committees", note most decisions will require "management" support to implement.
- Be well considered and supported by appropriate evidence
- Be consistent with the 'triple aim' approach and have considered resourcing and HR implications.

❖ Where possible all decisions should be by consensus:

- When consensus cannot be achieved however, a majority decision should have a minimum of 75% support from the membership.
- Decisions can be taken at meetings, by video or telephone conferencing, or by email, provided they are minuted and confirmed as true and correct at the next 'formal' meeting.

20.1

4.5 Declarations of Interest

All Chairs and Members will be required to comply with the HBDHB Policy on "Conflicts of Interest Policy – HBDHB/PPM/070"

A copy of this policy may be found on HBDHB Our Hub.

Non DHB staff may request a copy of this policy.

"The Purpose of this Policy is to set out HBDHB's expectations in relation to conflicts of interest that will ensure decisions made are not influenced by the personal or private interests of its staff or agents HBDHB acknowledges that conflicts may exist from time to time. These can be managed positively with openness and transparency."

Enquiries about Conflicts of Interest may be directed to the HBDHB Board Administrator or Company Secretary.

5.0 Reporting

To be completed

5.1 Committees Reporting to Council

- Dates
- Formats

5.2 Advisory Group Reporting to Committees

- Frequency / dates
- Formats

5.3 Clinical Governance Formal Reports

- External
- HBDHB Board
- HBDHB / HHB CEOs / EMT
- Nature / Dates /Purpose etc
- Templates

5.4 Stakeholder reporting / communication

6.0 Administration

To be completed

6.1 Management and Administration

- Roles and Responsibilities

6.2 Appointments / Reappointments

- Processes

6.3 Payments

- Fees
- Expenses
- Process / Attendance Registers

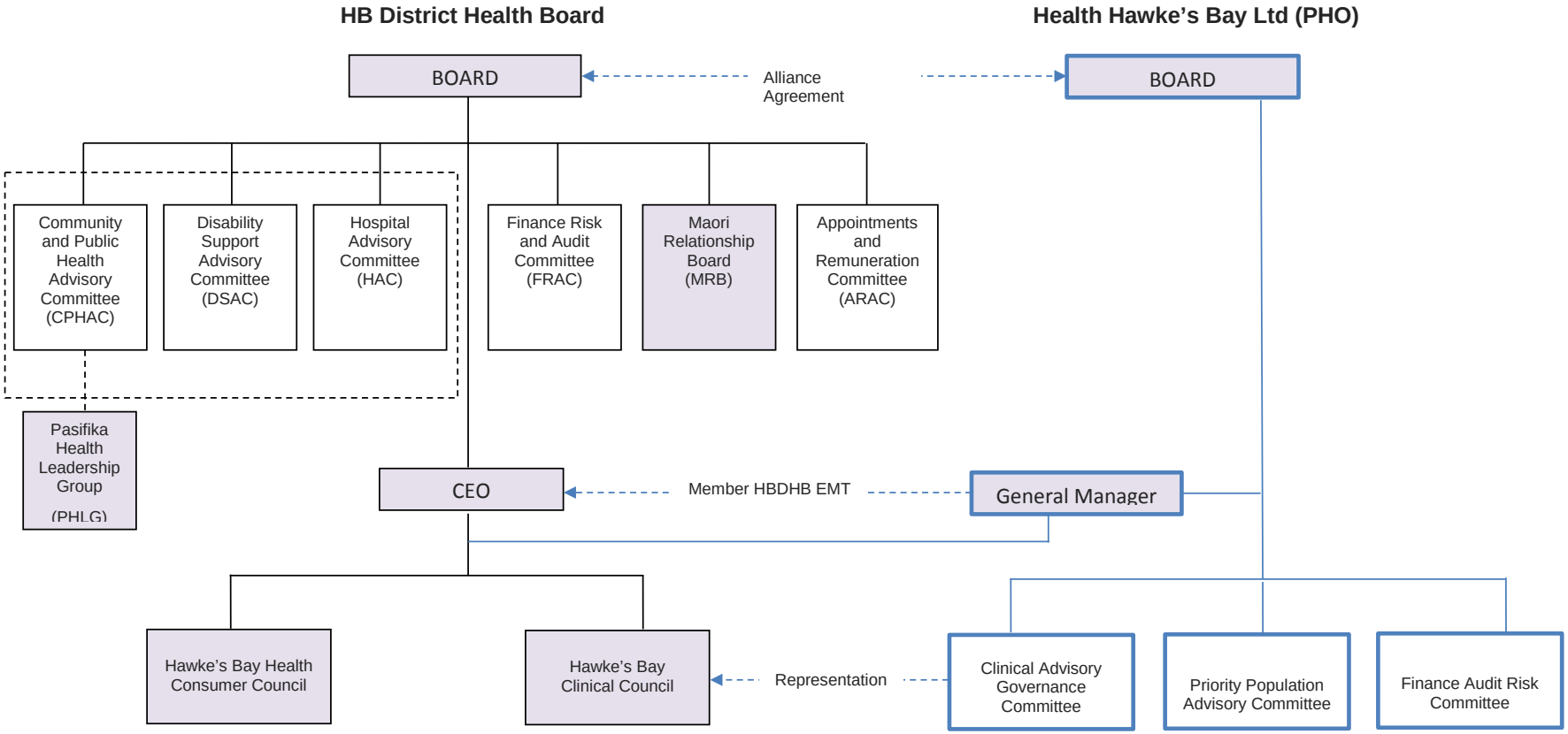
6.4 Induction and Training

6.5 Secretarial Support

- Agendas and Minutes
- Templates

Appendices

Appendix A – Hawke's Bay Health Sector Governance Structure



- Hawke's Bay Health Sector Leadership Forum
- Representation on Alliance Leadership Team (other than Pasifika Health Leadership Group)

20.1

Appendix B – Hawke's Bay Clinical Council Terms of Reference

OURHEALTH HAWKE'S BAY Whakawateatia

TERMS OF REFERENCE

Hawke's Bay Clinical Council

September 2015

Purpose	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system.
Functions	The Hawke's Bay Clinical Council (Council) • Provides clinical advice and assurance to the Hawke's Bay health system management and governance structures. • Works in partnership with the Hawke's Bay Health Consumer Council to ensure Hawke's Bay health services are organised around the needs of people. • Provides oversight of clinical quality and patient safety. • Provides clinical leadership to the Hawke's Bay health system workforce.
Level of Authority	The Council has the authority to make decisions and/or provide advice and recommendations, to the Boards of HBDHB and Health Hawke's Bay Limited (as appropriate). To assist it in this function the Council may: • Request reports and presentations from particular groups • Establish sub-groups to investigate and report back on particular matters • Commission audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Council's role is one of governance, not operational or line management. **Delegated Authority** The Council has delegated authority from the CEOs and Boards to: • Make decisions within the mandate and scope set out in the Hawke's Bay Health Alliance – Alliance Agreement • Make decisions and issue directives on quality clinical practice and patient safety issues that: ▪ Relate directly to the function and aims of the Council as set out in the Terms of Reference; and ▪ Relate directly to the provision of, or access to, HBDHB publicly funded health services; and ▪ Are clinically and financially sustainable; and ▪ Are affordable within HBDHB's current budgets.

	All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the HBDHB.
Membership	Members appointed by tenure shall normally be appointed for three years whilst ensuring that approximately one third of such members 'retire by rotation' each year. Such members may be reappointed but for no more than three terms. Members appointed by role/position do not have a finite term. *By role/position:* • CMO Primary Health Care • CMO Hospital • Chief Nursing Officer • Midwifery Director • Director of Allied Health • Chief Pharmacist • Director Population Health • Clinical Lead PHO Clinical Advisory and Governance Committee *By Appointment (tenure):* • General Practitioner x 2 • Senior Medical / Dental Officer x 2 • Senior Nurse x 3 • Senior Allied Health Professional When making appointments, consideration must be given to maintaining a wide range of perspectives and interests within the total membership, ensuring in particular that Māori health and rural health interests and expertise are reflected.
Chair	The Council will annually elect a chair and deputy, or co-chairs.
Quorum	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
Meetings	Meetings will be held monthly at least ten times per year, or more frequently at the request of the chair/co-chairs. Meetings will generally be open to the public, but may move into "public excluded" where appropriate and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee. A standing reciprocal invitation has been extended to the Hawke's Bay Health Consumer Council for a representative to be in attendance at all meetings. Matters may be dealt with between meetings through discussion with the chair/co-chairs and other relevant members of the Council.
Reporting	The Council will report through HBDHB and Health Hawke's Bay Limited Chief Executives to the respective Boards. A monthly report of Council activities/decisions will be placed on the DHB website when approved.
Minutes	Minutes will be circulated to all members of the council within one week of the meeting taking place.

Appendix C – Hawke's Bay Health Consumer Council Terms of Reference

TERMS OF REFERENCE

Hawke's Bay Health Consumer Council

September 2015

Purpose	The Hawke's Bay Health Consumer Council (Council) works collaboratively with the Hawke's Bay District Health Board (HBDHB) and Health Hawke's Bay governance and management teams, and the Hawke's Bay Clinical Council to develop effective partnerships in the design and function of an effective health system in Hawkes Bay that meets the needs of the people. Through true partnership, the Council provides a strong and viable voice for the community and consumers, on health service planning and delivery. The Council seeks to enhance consumer engagement and experience through service integration across the sector, the promotion of equity and ensuring that services are organised and provided to meet the needs of all consumers. Through effective processes and communications, the Council receives, considers and disseminates information from and to HBDHB, Health Hawke's Bay, consumer groups and communities. The Council also has a quality improvement role to advise and encourage best practice and innovation.
Functions	The functions of the Council are to: • Ensure, coordinate and enable appropriate consumer engagement across the Hawke's Bay, Central Region and national health systems. • Identify, advise on and promote a 'Partners in Care' approach to the implementation of 'Person and Whanau Centred Care into the Hawkes Bay health system, including input into the development of health service priorities and strategic direction, the reduction of inequities, and the enhancement of consumer engagement, patient safety, health literacy and clinical quality. • Participate, review and advise on reports, developments and initiatives relating to Hawkes Bay health services and the availability and/or dissemination of health related information. • Ensure regular communication and networking with the community and relevant consumer groups. • Link with special interest groups, as required for specific issues and problem solving. For the avoidance of doubt, the Council will not: • Provide clinical evaluation of health services • Discuss or review issues that are (or should be) processed as formal complaints, for which full and robust processes exists. • Be involved in the HBDHB or Health Hawke's Bay contracting processes.

Level of Authority	The Council has the authority to give advice and make recommendations to HBDHB and Health Hawke's Bay senior management and Board.
Membership	There shall be fifteen (15) members on the Council, plus an independent Chair. Members will have diverse backgrounds, contacts, knowledge and skills, and must be passionate about consumers being able to access the best possible services and care from the Hawke's Bay health sector. Although appointed to reflect the consumer voice in a particular area of interest, they will not be regarded as representatives of any specific organisation or community. Members will be appointed to reflect the following areas of interest: • Women's health • Child health • Youth health • Older persons health • Chronic conditions • Mental health • Alcohol and other drugs • Sensory and Physical disability • Intellectual and Neurological disability • Rural health • Maori health • Pacific health • Primary health • High deprivation populations When making appointments, consideration must be given to maintaining a demographic balance that generally reflects that of the population. Members shall be appointed by the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the respective boards), following consultation with the consumer and community groups in each of the areas of interest, as appropriate. Members shall be appointed for terms of two years. Members may be reappointed but for no more than three terms. Remuneration shall be paid based on the Cabinet Fees Framework applicable to HBDHB Statutory Committees.
Chair	The Chair shall be appointed by the HBDHB Board on the recommendation of the CEOs of HBDHB and Health Hawke's Bay (with endorsement by the Health Hawke's Bay Board) following consultation with Council members. Appointments shall be for terms ending no later than four months after the end of the term of the HBDHB Board that appointed them (Note: The full term of a Board is three years). The Chair may be paid additional fees and allowances, depending on the level of commitment involved in addition to Council meetings.

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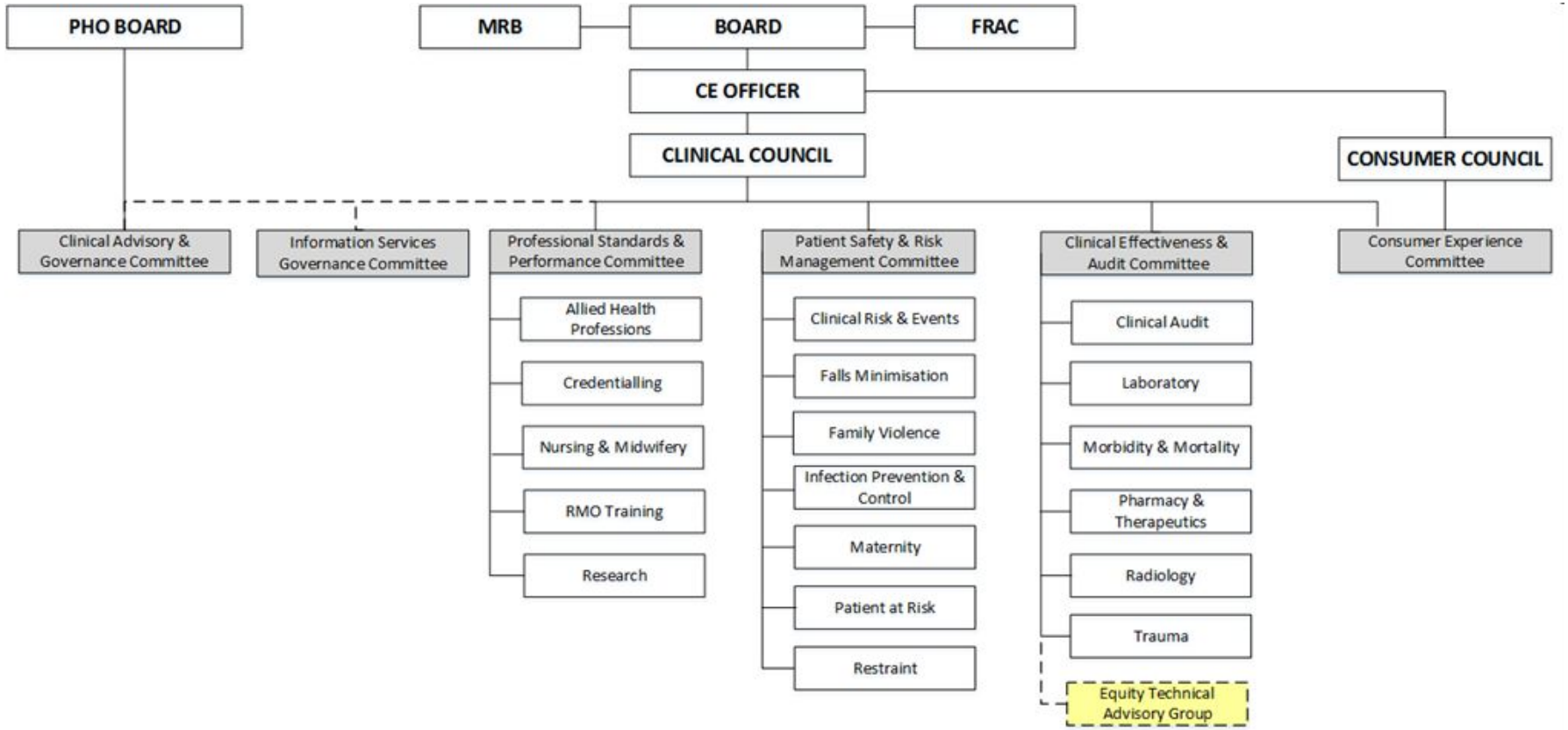
Meetings	Meetings will be held monthly, excluding January, or more frequently at the request of the Chair. Meetings will generally be open to the public but may move into "public excluded" where appropriate, and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee. A standing reciprocal invitation has been extended to the Hawke's Bay Clinical Council for a representative to be in attendance at all meetings.
Reporting	The Council will report to the CEOs of HBDHB and Health Hawke's Bay, and through the CEOs to the respective HBDHB and Health Hawke's Bay boards. A monthly report of Council activities and recommendations will be placed on HBDHB and Health Hawke's Bay websites once approved.
Minutes	Minutes will be circulated to all members and Chair of the Council, within one week of the meeting taking place. Minutes of those parts of any meeting held in "public" shall be made available to any member of the public, consumer group, community etc, on request.

Appendix D – Clinical Governance Committee Structure



Pending any changes to Executive Management Team

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Appendix E – Terms of Reference Summary for Governance Committees (including Advisory Groups)

Body	Purpose	Functions	Authority	Membership	Tenure	Chair	Quorum	Meetings	Reporting	Minutes
Clinical Council	**Principal clinical governance, leadership and advisory group for the Hawkes bay health system**	**Provide clinical advice and assurance to the HB health system management and governance structures Work in partnership with the Consumer Council to ensure HB health services are organised around the needs of people Provide oversight of clinical quality and patient safety Provide clinical leadership to the HB health system workforce Coordinate and manage clinical governance structure**	**Provide advice & recommendations to HBDHB and HHB mgmt and boards Delegated authority to commission reports, investigations and audits and to co-opt resources as necessary for a specific purpose Delegated authority to make decisions within mandate of HB Health Alliance & issue directives on quality clinical practice & patient safety issues**	**CMO Hospital; CMO Primary Care; CNO; CAHPO; Midwifery Director; Chief Pharmacist; Director Public Health; Clinical Lead CAGC; 2xGP; 2xSMO; 3xSenior Nurse; Senior Allied Health Professional**	**Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms Must ensure wide range of perspectives & interests viz Maori & rural**	**Chair & deputy or Co-Chairs elected annually**	**Half (if even) or majority (if odd)**	**Monthly Open to Public Consumer Council liaison**	**Through HBDHB and HHB CEOs to Boards Monthly report on HBDHB website**	**Council Administrator Circulated within 1 week of meeting**
COMMITTEES										
Professional Standards & Performance Cttee	Provide assurance that all essential requirements relating to credentialling, professional standards, clinical training and research are actively promoted and maintained	Ensure that all health professionals are approriately credentialled, professional standards are upheld and clinical competence is maintained. Provide oversight and forums for discussion on clinical innovation, best practice, professional training and workforce development To govern and promote a research culture, clinical research activities and implementation of appropriate research findings Oversee and monitor activities and delegated responsibilities of relevant AGs	Provide advice and recommendations to Clinical Council on strategy, processes and policy Delegated authority from Clinical Council to run forums/workshops and make decisions on individual cases relating to professional standards or research	Chairs of Credentialling AGs - Medical, Nursing, Allied Health; Chair RMO Training AG; Chair Research AG; Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Appointed by CC CC Member or Executive Clinical Leader	7	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	HR Administrator Circulated within 1 week of meeting
Patient Safety & Risk Management Cttee	Provide assurance that all matters relating to patient safety and clinical risk are effectively monitored and managed	Lead and promote a culture of continuous quality improvement and patient safety Ensure effective systems are in place and used to appropriately capture, analyse, manage and report issues associated with patient safety and clinical risk Recommend approriate strategies, policies and actions that will enhance patient safety and reduce/remove areas of clinical risk Initiate improvement projects and/or training programmes as appropriate Oversee and monitor activities and delegated responsibilities of relevant AGs	Provide advice and recommendations to Clinical Council on strategy, systems, processes and policy Delegated authority from Clinical Council to run training/workshops and make decisions on individual events/issues relating to patient safety or clinical risk	Chairs of AGs - Infection Prevention and Control; Falls; Clinical Events; Restraint; Clinical Risk; Patient at Risk; Family Violence; Trauma; Morbidity & Mortality Review Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Appointed by CC CC Member or Executive Clinical Leader	Two thirds of the appointed members	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	QIPS Patient Safety Administrator Circulated within 1 week of meeting
Clinical Effectiveness & Audit Cttee	Provide advice and guidance to ensure that quality clinical practice is delivered by all publicly funded health service, diagnostic, pharmaceutical and therapeutic providers.	Ensure an appropriate clinical audit programme is developed, implemented, monitored and managed, with associated learnings and quality improvements shared and implemented as appropriate Provide advice and guidance of what constitutes 'best practice' within HB health system Oversee clinical practice integration initiatives, including clinical pathways Endorse and/or recommend guidelines and directives relating to referrals and delivery of diagnostic services, and presribing and delivery of pharmaceutical and therapeutic services. Oversee and monitor activities and delegated responsibilities of relevant AGs	Provide advice and recommendations to Clinical Council on strategy, systems, processes, policy and major changes to clinical practice Delegated authority from Clinical Council to require minor quality improvement changes to clinical practice	Chairs of AGs - Audit; Clinical Pathways; Laboratory; Radiology; Pharmacy & Therapeudtics; Trauma Exec Dir People & Quality; Medical Director QIPS; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Appointed by CC CC Member or Executive Clinical Leader	Two thirds of the appointed members	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	QIPS Patient Safety Administrator Circulated within 1 week of meeting

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Body	Purpose	Functions	Authority	Membership	Tenure	Chair	Quorum	Meetings	Reporting	Minutes
Information Management Cttee	Provide advice and clinical advocacy for the provision of appropriate ICT systems, processes and data, to aid effective clinical decision making and the provision of quality care	Identify & document the clinical and patient care benefits of appropriate ICT systems, processes and data. Liaise as necessary and advocate for the provision of such identified systems, processes and data Ensure all data used for clinical decision making and the provision of care is current and accurate, with one single 'source of the truth'.	Provide advice and recommendations to Clinical Council on strategy, systems, processes and policy Delegated authority from Clinical Council to liaise internally as required and advocate for the provision of appropriate systems, processes and data.	Chairs of AGs - Forms & Documents; Policy; Privacy; Clinical Records Management; CIO; Consumer Council Rep; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Appointed by CC CC Member or Executive Clinical Leader	Two thirds of the appointed members	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	QIPS Patient Safety Administrator Circulated within 1 week of meeting
Patient Experience Cttee	Jointly develop and recommend strategies, systems, policies, processes and actions that will contibute to the continuous improvement of patient's experience within the HB health system.	Develop/enhance/confirm appropriate systems and surveys to be used to gather indicators of patient experience Agree targets, monitor and analyse performance Report on performance and recommend performance improvement initiatives and actions	Provide advice and recommendations to Clinical and Consumer Councils on strategy, systems, processes, policy, clinical practice and customer service	Four members from each of Clinical Council and Consumer Council Executive Director of People and Quality; Health Services Directors - Service, Nursing Medical/Surgical	Non specific appointment holders - 3 years One third retire by rotation each year May be reappointed for up to 3 terms	Jointly agreed between Clinical and Consumer Councils	Minimum of two members from each Council	Quarterly (or as required by the Chair)	Following each meeting Formal Annual report	Consumer Engagement Administrator Circulated within 1 week of meeting

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Appendix F – Health Sector Values and Behaviours

Our Shared Values and Behaviours

HE KAUANUANU RESPECT

Show ***respect*** for each other, our staff, patients and consumers.

	✔ Does	✖ Doesn't
Welcoming	*Is polite, welcoming, friendly, smiles, introduce themself* *Acknowledges people, makes eye contact, smiles*	*Is closed, cold, makes people feel a nuisance* *Ignores people, doesn't look up, rolls their eyes*
Respectful	*Values people as individuals; is culturally aware / safe* *Respects and protects privacy and dignity*	*Lacks respect or discriminates against people* *Lacks privacy, gossips, talks behind other people's backs*
Kind	*Shows kindness, empathy and compassion for others* *Enhances people's mana*	*Is rude, aggressive, shouts, snaps, intimidates, bullies* *Is abrupt, belittling, or creates stress and anxiety*
Helpful	*Attentive to people's needs, will go the extra mile* *Reliable, keeps their promises; advocates for others*	*Unhelpful, begrudging, lazy, 'not my job' attitude* *Doesn't keep promises, unresponsive*

ĀKINA IMPROVEMENT

Continually ***improve*** in everything we do.

	✔ Does	✖ Doesn't
Positive	*Has a positive attitude, optimistic, happy* *Encourages and enables others; looks for solutions*	*Grumpy, moaning, moody, has a negative attitude* *Complains but doesn't act to change things*
Learning	*Always learning and developing themselves or others* *Seeks out training and development; 'growth mindset'*	*Not interested in learning or development; apathy* *Fixed mindset, 'that's just how I am', OK with just OK*
Innovating	*Always looking for better ways to do things* *Is curious and courageous, embracing change*	*Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done*
Appreciative	*Shares and celebrates success and achievements* *Says 'thank you', recognises people's contributions*	*Nit picks, criticises, undermines or passes blame* *Makes people feel undervalued or inadequate*

Growing Our People by Living Our Values

OUR HEALTH HAWKE'S BAY | OUR PEOPLE He tāngata, He tāngata, He tāngata.

RARANGA TE TIRA PARTNERSHIP

Work together in ***partnership*** across the community.

	✔ Does	✖ Doesn't
Listens	*Listens to people, hears and values their views* *Takes time to answer questions and to clarify*	*'Tells', dictates to others and dismisses their views* *Judgmental, assumes, ignores people's views*
Communicates	*Explains clearly in ways people can understand* *Shares information, is open, honest and transparent*	*Uses language / jargon people don't understand* *Leaves people in the dark*
Involves	*Involves colleagues, partners, patients and whānau* *Trusts people; helps people play an active part*	*Excludes people, withholds info, micromanages* *Makes people feel excluded or isolated*
Connects	*Pro-actively joins up services, teams, communities* *Builds understanding and teamwork*	*Promotes or maintains silo-working* *'Us and them' attitude, shows favouritism*

TAUWHIRO CARE

Deliver high quality ***care*** to patients and consumers.

	✔ Does	✖ Doesn't
Professional	*Calm, patient, reassuring, makes people feel safe* *Has high standards, takes responsibility, is accountable*	*Rushes, 'too busy', looks / sounds unprofessional* *Unrealistic expectations, takes on too much*
Safe	*Consistently follows agreed safe practice* *Knows the safest care is supporting people to stay well*	*Inconsistent practice, slow to follow latest evidence* *Not thinking about health of our whole community*
Efficient	*Makes best use of resources and time* *Respects the value of other people's time, prompt*	*Not interested in effective user of resources* *Keeps people waiting unnecessarily, often late*
Speaks up	*Seeks out, welcomes and gives feedback to others* *Speaks up whenever they have a concern*	*Rejects feedback from others, give a 'telling off'* *'Walks past' safety concerns or poor behaviour*

Appendix G – How to Effectively Chair Meetings

	How to Prepare for a meeting	How to compile a meeting agenda that really works	How to conduct a successful meeting	How to get the most out of meetings you chair	How to make a valuable contribution to a meeting	How to deal with disruptive individuals at meetings	How to reduce the number of time-consuming meetings
1.	Make sure you've called the meeting for a reason	Be aware of the need for an agenda	Start on time	Create a member centred meeting	Understand why you have been asked to participate	Create a smaller audience for them	Be fully aware of the cost of your meetings
2.	Prepare a benchmark of productivity	Decide on the degree of formality required	Get the meeting off to a business-like start	Encourage participation by all	Know the other participants	Get the disruptive person to confront the issue	Consider why you hold so many meetings
3.	Select the participants wisely	List the items	Preview and confirm the agenda	Stimulate discussion and ideas	Arrive prepared	Attack the content	Establish a workable review process
4.	Select the right time and place for the meeting	Place the items in sequence	Focus continually on your objectives	Ban those killer comments	Arrive early and use the time wisely	Pre-plan the meeting to diffuse the disruption	Consolidate your meeting procedures
5.	Prepare and distribute an agenda that will work	Structure the agenda	End on a positive note – and on time	Keep the meeting on course	Talk up, get involved	Suggest a role reversal	Limit the number of meeting participants
6.	Despatch agenda and background papers	Assemble any background papers	Review and analyse the success of your meeting	Vary your style	Make your presence felt	Listen – just in case	Define clearly the purpose of every meeting
7.	Do homework on the participants	Distribute the agenda in advance	Follow –up promptly	Focus on the process	Be an active listener	Pull the plug	Consider an alternative to calling a meeting
8.	Gather appropriate tools for the meeting	Use the agenda to monitor the meeting		Be a good role model	Be willing to learn	Remain calm and in control	Occasionally cancel a regular meeting
9.	Be prepared psychologically			Start and finish on time	Volunteer to wrap-up the meeting		Question every item on the agenda
10				Thank members for their contribution	Adhere to the rules of meeting etiquette		Meet only when necessary

Appendix H – Glossary of key concepts and definitions

Capability	The extent to which individuals can adapt to change, generate new knowledge and continue to improve their performance (Fraser and Greenhalgh 2001).
Clinical audit	'A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change' (National Institute for Clinical Excellence 2002).
Clinical risk management	Clinical risk management is concerned with improving the quality and safety of health care services by identifying the circumstances and opportunities that put patients at risk of harm and then acting to prevent or control those risks (Reason 2001).
Clinician	Medical practitioner, nurse, midwife or allied health professional.
Co-design	Brings consumers/patients, families/whānau and staff together to share the role of improving care through the re-design of services. It is a proven methodology, which provides tools for effectively increasing the engagement of consumers in decision-making and design of health and disability services.
Consumer	A person who has accessed or is currently using a health or disability service or is likely to do so in the future (Health Quality & Safety Commission 2015b).
Consumer engagement	Consumers/patients, families/whānau, their representatives and health professionals working in active partnership at various levels across the health care system – direct care, organisational design and governance, and policy-making – to improve health and health care (Carman et al 2013). 'A process whereby consumers of health and disability services are encouraged and empowered to actively participate in decisions about the treatment, services and care they need and receive. It is most successful when consumers and clinicians demonstrate mutual respect, active listening and have confidence to participate in full and frank conversation. Systems that support consumer engagement actively seek input from consumers and staff at all levels of an organisation' (Health Quality & Safety Commission 2015a).
Culture	A system of shared values, assumptions, beliefs, behaviours and norms that represent the expectations and image of a particular people, organisation or system (adapted from Wikipedia).
Evidence-based medicine	The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients (Sackett et al 1996).
Governance	Encompasses the systems, processes and relationships through which an entity is directed or controlled (Institute of Directors (nd)).
Leadership	In health, leadership has been described as 'a mechanism for effecting change and enhancing quality... it requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients' (Department of Health 2008).

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Open communication	The timely and transparent approach to communicating with, engaging with, and supporting consumers/patients and their families/whānau when things go wrong (Health Quality & Safety Commission 2012).
Openness and transparency	Being honest, easy to understand and completely free from concealment (www.merriam-webster.com).
Patient safety	The management of risk over time in order to maximise benefit and minimise harm to patients in the health care system (Vincent and Amalberti 2016).
Risk	In the context of risk management, risk is defined as the chance of something happening that will have an impact upon objectives. Risk may have a positive or negative effect.

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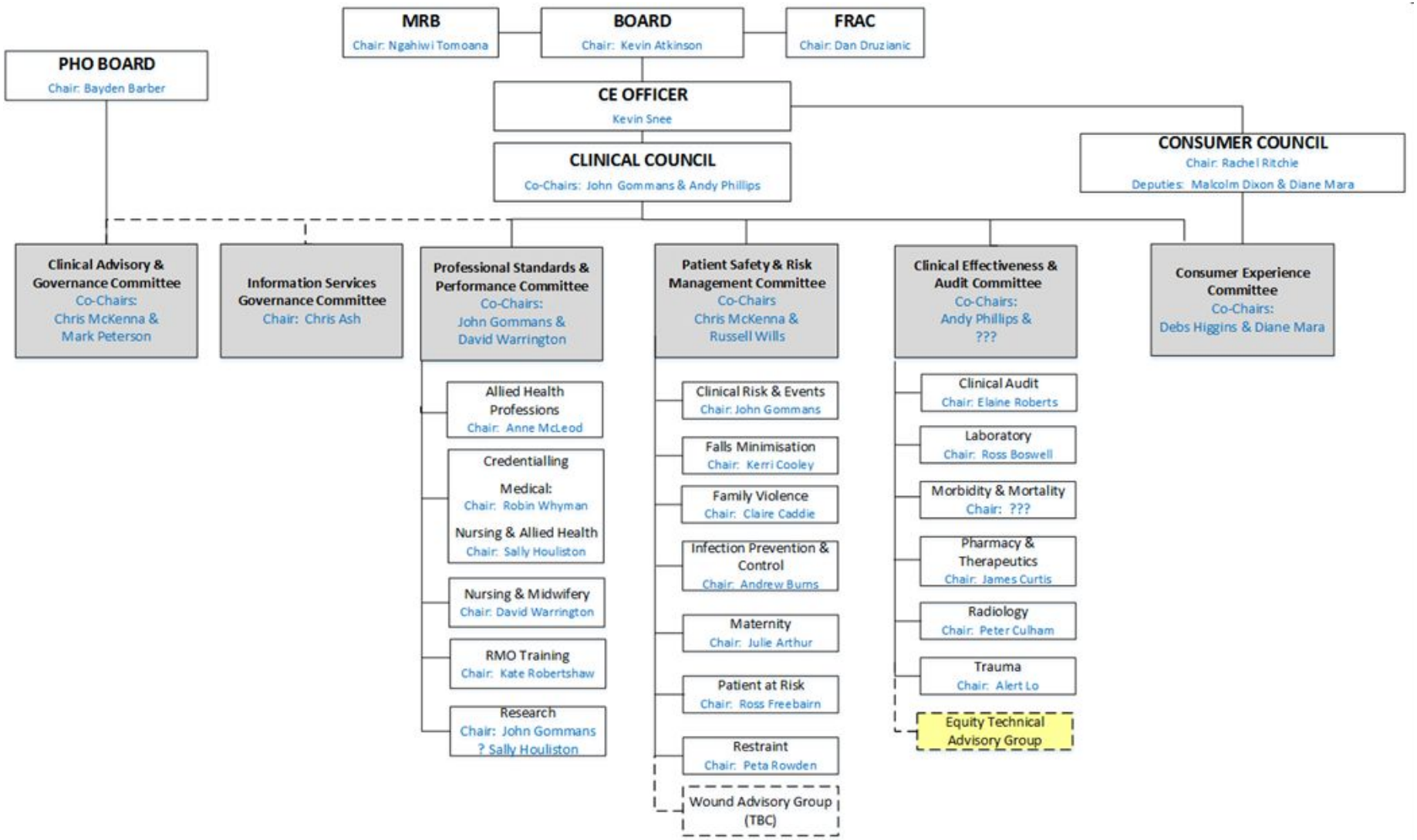
CLINICAL GOVERNANCE COMMITTEE STRUCTURE



Pending any changes to Executive Management Team

Version 14 (Sep-2018)

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TERMS OF REFERENCE

CLINICAL GOVERNANCE

PROFESSIONAL STANDARDS & PERFORMANCE COMMITTEE

May 2018

Purpose	To provide assurance to the Hawkes Bay Clinical Council that all essential requirements relating to credentialing, accreditation, professional standards, clinical training and research are actively promoted and maintained.
Functions	• Ensure decisions and recommendations are consistent with 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) • Lead and promote a culture of clinical professionalism, ensuring that all health professionals are appropriately credentialed, professional standards are upheld, and clinical competence is maintained • Ensure that the appropriate capability and capacity exists to maintain relevant professional training accreditations. • Provide oversight and forums for discussion on clinical innovation, best practice, professional training and workforce development • Govern and promote a research culture, clinical research activities and implementation of appropriate research findings • Ensure all relevant information, innovations, research findings and professional standards are well communicated throughout the sector • Oversee, monitor and govern the activities and delegated responsibilities of Committee Advisory Groups
Level of Authority	The Committee has the authority to make decisions and/or provide advice and recommendations, to the Clinical Council (as appropriate). To assist it in this function the Committee may: • Request reports and presentations from particular groups • Require Committee Advisory Groups (and/or establish other sub-groups) to investigate and report back on particular matters • Request the commissioning of audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders. **Delegated Authority** The Committee has delegated authority to: • Make decisions and issue directives/guidelines on professional standards, clinical competence and research issues that: ▪ Relate directly to the function of the Committee as set out in the Terms of Reference; and ▪ Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and ▪ Are clinically and financially sustainable; and ▪ Are affordable within current budgets.

	All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the Hawke's Bay District Health Board or Health Hawke's Bay Ltd.

Membership	**Membership**
	• Chief Medical & Dental Officer - Hospital (CMDO)
	• Chief Medical Officer - Primary Care
	• Chief Nursing & Midwifery Officer (CNMO)
	• Chief Allied Health Professions Officer
	• Executive Director People & Quality (or delegate)
	• Chairs (or delegate) of Relevant Advisory Groups:
	  ▪ SMO Credentialing
	  ▪ Nursing & Allied Health Credentialing
	  ▪ Allied Health Professions
	  ▪ Hawke's Bay Nursing & Midwifery
	  ▪ Resident Medical Officer Training
	  ▪ Hawke's Bay Clinical Research
	• Consumer Council representative
	• Senior Advisor Cultural Competency
	
	Tenure
	Whilst holding a named appointment or role, or until replaced by the group being represented.

Chair	Co-Chairs – Must be members of Clinical Council - Appointed by Clinical Council
Quorum	A quorum will be a majority of the members.
Meetings	1 hour meetings will be held quarterly at least 4 times per year, or more frequently at the request of the chair/co-chairs. Meetings shall be held at times and in locations that suit the membership. Decision making at meetings shall ideally be based on consensus
Reporting	Advisory Groups reporting to the PS&PC will provide their previous meeting minutes (to be included on the quarterly agenda) along with a verbal update from each chair at the quarterly meeting. A report shall be submitted to the Clinical council following each meeting of the Committee. A formal annual report shall be submitted within 3 months of the end of each financial year (30 June) A precis of the annual report shall be communicated to the sector, once received by Clinical Council
Minutes	The minute secretary shall be EA to the CNMO and CMDO-Hospital. Minutes and action plans will be circulated to all members within one week of the meeting taking place.

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TERMS OF REFERENCE

CLINICAL GOVERNANCE

PATIENT SAFETY & RISK MANAGEMENT COMMITTEE

August 2018

Purpose	To provide assurance to the Hawkes Bay Clinical Council that all matters relating to patient safety and clinical risk within the Hawkes Bay health system, are effectively monitored and appropriately managed and enhanced.
Functions	• Ensure decisions and recommendations are consistent with 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) • Lead and promote a culture of continuous quality improvement, patient safety, cultural competence and clinical risk management • Initiate improvement projects and/or training programmes as appropriate • Ensure all patient safety, cultural competence and clinical risk compliance requirements, standards and processes are met, and any corrective actions are appropriately addressed • Ensure effective systems, strategies, policies, resources and procedures are in place to support quality patient safety, cultural competence and clinical risk management • Ensure all relevant information, lessons learned and improvement actions are well communicated throughout the sector • Oversee, monitor and govern the activities and delegated responsibilities of Committee Advisory Groups
Level of Authority	The Committee has the authority to make decisions and/or provide advice and recommendations, to the Clinical Council (as appropriate). To assist it in this function the Committee may: • Request reports and presentations from particular groups • Require Committee Advisory Groups (and/or establish other sub-groups) to investigate and report back on particular matters • Request the commissioning of audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders. **Delegated Authority** The Committee has delegated authority to: • Make decisions and issue directives/guidelines on patient safety, cultural competence and clinical risk management issues that: - Relate directly to the function of the Committee as set out in the Terms of Reference; and

	- Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and - Are clinically and financially sustainable; and - Are affordable within current budgets. All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the HBDHB or HHB Ltd.
Membership	**Membership** • Medical Director QIPS • Chief Nursing & Midwifery Officer (CNMO) • Chairs (or nominee) of Committee Advisory Groups: - Clinical Risk & Events - Falls Minimisation - Family Violence Intervention - Maternity Governance - Infection Prevention & Control - Patient at Risk - Restraint • Consumer Council representative • Health Services Directorates representative • PHO Clinical Advisory & Governance Committee representative **Tenure** Whilst holding a named appointment or role, or until replaced by the group being represented
Chair	Co-Chairs – Medical Director QIPS & CNMO
Quorum	A quorum will be a majority of the members.
Meetings	Meetings will be held quarterly at least 4 times per year, or more frequently at the request of the chair/co-chairs. Meetings shall be held at times and in locations that suit the membership Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical council following each meeting of the Committee. A formal annual report shall be submitted within 3 months of the end of each financial year (30 June) A precis of the annual report shall be communicated to the sector, once received by Clinical Council
Minutes	The minute secretary shall be the Patient Safety Administrator. Minutes and action plans will be circulated to all members within one week of the meeting taking place.

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TERMS OF REFERENCE

CLINICAL GOVERNANCE

CLINICAL EFFECTIVENESS & AUDIT COMMITTEE

September 2018

Purpose	To provide assurance to the Hawkes Bay Clinical Council (and advice and guidance to the Hawkes Bay health system) that quality clinical practice is delivered by all publicly funded health services, including diagnostic, pharmaceutical and therapeutic providers.
Functions	• Ensure decisions and recommendations are consistent with 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) • Lead and promote a culture of quality clinical practice • Ensure an appropriate clinical audit programme is developed, implemented, monitored and managed, to provide an appropriate level of assurance across the sector • Provide advice and guidance on what constitutes 'best clinical practice' within the HB health system • Oversee clinical practice integration and equity initiatives, including clinical pathways • Endorse and/or recommend guidelines and directives relating to access to and delivery of diagnostic and therapeutic services, and prescribing and delivery of pharmaceutical services • Ensure all relevant information, lessons learned and improvement actions are well communicated throughout the sector • Oversee, monitor and govern the activities and delegated responsibilities of Committee Advisory Groups
Level of Authority	The Committee has the authority to make decisions and/or provide advice and recommendations, to the Clinical Council (as appropriate). To assist it in this function the Committee may: • Request reports and presentations from particular groups • Require Committee Advisory Groups (and/or establish other sub-groups) to investigate and report back on particular matters • Request the commissioning of audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders. **Delegated Authority** The Committee has delegated authority to: • Make decisions and issue directives/guidelines on quality clinical practice issues that:

	▪ Relate directly to the function of the Committee as set out in the Terms of Reference; and ▪ Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and ▪ Are clinically and financially sustainable; and ▪ Are affordable within current budgets. All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the HBDHB or HHB Ltd.
Membership	**Membership** • Two nominated members of Clinical Council • Chairs (or nominee) of Committee Advisory Groups: - Clinical Audit - Laboratory - Pharmacy & Therapeutics - Radiology - Trauma - Morbidity and Mortality • Consumer Council representative • Health Services Directorates representative • Primary Care representative **Tenure** At the discretion of the body/person appointing any nominee or representative
Chair	Co-Chairs – Must be members of Clinical Council – Appointed by Clinical Council
Quorum	A quorum will be a majority of the members.
Meetings	Meetings will be held quarterly at least 4 times per calendar year, or more frequently at the request of the chair/co-chairs. Meetings shall be held at times and in locations that suit the membership Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical Council following each meeting of the Committee. A formal annual report shall be submitted within 3 months of the end of each financial year (30 June) A precis of the annual report shall be communicated to the sector, once received by Clinical Council
Minutes	The minute secretary shall be the QIPS Patient Safety Administrator Minutes and action plans will be circulated to all members within one week of the meeting taking place.

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TERMS OF REFERENCE

CLINICAL GOVERNANCE

CONSUMER EXPERIENCE COMMITTEE

July 2018

Purpose	Oversee the development and implementation of strategies, systems, policies, processes and actions that will contribute to the continuous improvement of consumer experience within the HB health system.
Functions	• Ensure decisions and recommendations are consistent with 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) • Lead and promote a culture of continuous improvement of consumer experience within the HB health system • Consult as necessary to develop and recommend an overall integrated strategy for improving consumer experience • Develop, enhance and confirm appropriate systems and surveys to be used to gather indicators of consumer experience • Agree targets, monitor and analyse consumer experience performance indicators • Report on performance and recommend and/or initiate improvement actions • Ensure all relevant information, requests for feedback and improvement actions are well communicated throughout the sector, and implemented as appropriate
Level of Authority	The Committee has the authority to make decisions and/or provide advice and recommendations to the Clinical Council and Consumer Council (as appropriate). To assist it in this function the Committee may: • Request reports and presentations from particular groups • Establish sub-groups as necessary to investigate and report back on particular matters • Request the commissioning of audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders. **Delegated Authority** The Committee has delegated authority to: • Make decisions and issue directives/guidelines on consumer experience issues (other than strategy) that:

	▪ Relate directly to the function of the Committee as set out in the Terms of Reference; and ▪ Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and ▪ Are clinically and financially sustainable; and ▪ Are affordable within current budgets. All such decisions and/or directives will be binding on all clinicians or other staff who provide and/or refer to public health services funded (in whole or part) by the HBDHB or HHB Ltd.
Membership	**Membership** • Four (4) Clinical Council representatives • Four (4) Consumer Council representatives • Health Services Directorates representative • PHO representative **Tenure** Until replaced by the group being represented
Chair	Co-Chairs • One appointed by Clinical Council from the four Clinical Council representatives • One appointed by Consumer Council from the four Consumer Council representatives Co-Chairs of the Committee shall not be a Chair or Co-Chair of either of the two Councils
Quorum	A quorum will be a minimum of two members from each of the two Councils plus one other member.
Meetings	Meetings will be held quarterly at least 4 times per year, or more frequently at the request of the chair/co-chairs. Meetings shall be held at times and in locations that suit the membership, and the availability of relevant consumer experience survey information Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical Council and Consumer Council following each meeting of the Committee. A formal annual report shall be submitted within 3 months of the end of each financial year (30 June) A precis of the annual report shall be communicated to the sector, once received by both Councils.
Minutes	The minute secretary shall be a Consumer Engagement Facilitator. Minutes and action plans will be circulated to all members within one week of the meeting taking place.

CLINICAL GOVERNANCE

20.3 Committee Reporting Schedule (verbal)

REVIEW OF CLINICAL COUNCIL'S TERMS OF REFERENCE

Discussion

TERMS OF REFERENCE

Hawke's Bay Clinical Council

September 2015

Purpose	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system.
Functions	The Hawke's Bay Clinical Council (Council) • Provides clinical advice and assurance to the Hawke's Bay health system management and governance structures. • Works in partnership with the Hawke's Bay Health Consumer Council to ensure Hawke's Bay health services are organised around the needs of people. • Provides oversight of clinical quality and patient safety. • Provides clinical leadership to the Hawke's Bay health system workforce.
Level of Authority	The Council has the authority to make decisions and/or provide advice and recommendations, to the Boards of HBDHB and Health Hawke's Bay Limited (as appropriate). To assist it in this function the Council may: • Request reports and presentations from particular groups • Establish sub-groups to investigate and report back on particular matters • Commission audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Council's role is one of governance, not operational or line management. **Delegated Authority** The Council has delegated authority from the CEOs and Boards to: • Make decisions within the mandate and scope set out in the Hawke's Bay Health Alliance – Alliance Agreement • Make decisions and issue directives on quality clinical practice and patient safety issues that: ▪ Relate directly to the function and aims of the Council as set out in the Terms of Reference; and ▪ Relate directly to the provision of, or access to, HBDHB publicly funded health services; and ▪ Are clinically and financially sustainable; and ▪ Are affordable within HBDHB's current budgets. All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the HBDHB.
Membership	Members appointed by tenure shall normally be appointed for three years whilst ensuring that approximately one third of such members 'retire by

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	rotation' each year. Such members may be reappointed but for no more than three terms. Members appointed by role/position do not have a finite term. *By role/position:* • CMO Primary Health Care • CMO Hospital • Chief Nursing Officer • Midwifery Director • Director of Allied Health • Chief Pharmacist • Director Population Health • Clinical Lead PHO Clinical Advisory and Governance Committee *By Appointment (tenure):* • General Practitioner x 2 • Senior Medical / Dental Officer x 2 • Senior Nurse x 3 • Senior Allied Health Professional When making appointments, consideration must be given to maintaining a wide range of perspectives and interests within the total membership, ensuring in particular that Māori health and rural health interests and expertise are reflected.
Chair	The Council will annually elect a chair and deputy, or co-chairs.
Quorum	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
Meetings	Meetings will be held monthly at least ten times per year, or more frequently at the request of the chair/co-chairs. Meetings will generally be open to the public, but may move into "public excluded" where appropriate and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee. A standing reciprocal invitation has been extended to the Hawke's Bay Health Consumer Council for a representative to be in attendance at all meetings. Matters may be dealt with between meetings through discussion with the chair/co-chairs and other relevant members of the Council.
Reporting	The Council will report through HBDHB and Health Hawke's Bay Limited Chief Executives to the respective Boards. A monthly report of Council activities/decisions will be placed on the DHB website when approved.
Minutes	Minutes will be circulated to all members of the council within one week of the meeting taking place.

REVIEW OF CLINICAL COUNCIL'S ANNUAL WORKPLAN FOR 2017/18

Discussion

HAWKE'S BAY CLINICAL COUNCIL - ANNUAL PLAN 2017/18

FUNCTIONS	Provide Clinical advice and assurance to the Hawke's Bay health system senior management and governance structures	Work in partnership with the Hawke's Bay Health Consmer Council to ensure that Hawke's Bay health services are organised around the needs of people.	Provide oversight of clinical quality and patient safety	Provide clinical leadership to Hawke's Bay health system workforce
ROLES	Provide advice and/or assurance on: • Clinical implications of proposed services changes. • Prioritisation of health resources. • Measures that will address health inequities. • Integration of health care provision across the sector. • The effective and efficient clinical use of resources.	• Develop and promote a "Person and Whanau Centred Care" approach to health care delivery. • Facilitate service integrations across / within the sector. • Ensure systems support the effective transition of consumers between/within services. • Promote and facilitate effective consumer engagement and patient feedback at all levels. • Ensure consumers are readily able to access and navigate through the health system.	• Focus strongly on reducing preventable errors or harm. • Monitor effectiveness of current practice. • Ensure effective clinical risk management processes are in place and systems are developed that minimise risk • Provide information, analysis and advice to clinical, management and consumer groups as appropriate. • Ensure everyone in the HB health sector are aware of their responsibility for quality improvement and patient safety.	• Communicate and engage with clinicians and other stakeholders within HB Health Sector, providing clinical leadership when/where appropriate. • Oversee clinical education, training and research. • Ensure clinical accountability is in place at all levels.
STRATEGIES	• Review and comment on all reports, papers, initiatives prior to completion and submission to the Board. • Proactively develop, promote and recommend changes to improve health outcomes, patient experience and value from health resources. • Develop, promote and advise on strategies and actions that could assist with the reduction in health inequities. • Develop and promote initiatives and communications that will enhance clinical integration of services.	• Work collaboratively with the Consumer Council to design and implement a Person and Whanau Centred Care approach. • Understand what consumers need. • Understand what constitutes effective consumer engagement. • Promote clinical workforce education and training and role model desired culture. • Promote and implement effective health literacy practice. • Promote the development and implementation of appropriate systems and shared clinical records to facilitate a 'smooth patient	• Develop and maintain relevant and effective Clinical Indicator reporting and performance management processes. • Establish and maintain effective clinical governance structures and reporting processes. • Ensure safety and quality risks are proactively identified and managed through effective systems, delegation of accountabilities and properly trained and credentialed staff. • Ensure the "quality and safety" message and culture is spread and applied in all areas of HB health sector.	• Ensure all HB clinicians and other stakeholders are aware of the role, membership and activities of the Clinical Council. • Oversee the development, maintenance and implementation of a HB Clinical Workforce Sustainability Plan. • Promote clinical governance at all levels within the HB heatlh system. • Ensure appropriate attendance/input into National/Regional/ Local

	• Provide input through representation on EMT, Alliance Leadership Team and through attendance at HB Health Sector Leadership Forum.	experience' through the health system.	• Promote "value-based decision-making" at all levels. This involves improving the processes by which decisions are made, so they take into consideration all three Triple Aim objectives: o Enhanced patient experience o Improved health outcomes o Better value for money • Ensure attendance at appropriate meetings/forums to provide appropriate assurance and confidence.	meetings/events to reflect HB clinical perspective. • Promote ongoing clinical professional development including leadership and "business" training for clinical leaders. • Facilitate co-ordination of clinical education, training and research. • Role model and promote clinical accountability at all levels.
FUNCTIONS	**Provide Clinical advice and assurance to the Hawke's Bay health system senior management and governance structures**	**Work in partnership with the Hawke's Bay Health Consmer Council to ensure that Hawke's Bay health services are organised around the needs of people.**	**Provide oversight of clinical quality and patient safety**	**Provide clinical leadership to Hawke's Bay health system workforce**
OBJECTIVES 2017/18	• Prioritise meeting time to focus on papers with significant clinical issues. • Encourage proactive presentations / discussions on innovative issues / ideas. • Ensure risk management processes provide for early Clinical Council visibility (and input) of all significant clinical issues. • Align portfolio areas of responsibility to clinical governance structure memberships (once confirmed).	• Work in partnership with Consumer Council to develop an appropriate "Person & Whanau Centred Care" approach and culture. • Monitor "Quality Dashboard" and support performance improvement initiatives as appropriate. • Promote and support ongoing enhancements to information systems relating to clinical process and consumer records. • Support a review of the "Primary Heatlh Care" model of care. • Support and champion the development of a health literacy framework, policies, procedures, practices and action plan.	• Implement and progressively develop the proposed new Clinical Governance Committee / Advisory Group structures. • Monitor and report on the implementation of the action plan for "Governing for Quality. • Oversee and monitor the achievement of objectives within the QIPS Annual Plan.	• Enhance the profile and perceived value of Clinical Council within the sector, through improved effective two way communications. • Facilitate the development of a HB Clinical Workforce Sustainability Plan • Promote Strategies to enable the HB Clinical Workforce to adapt to meet the challenges of the future. • Support and promote the ongoing implementation of clinical leadership training and developments.

DEVELOPMENT OF CLINICAL COUNCIL'S ANNUAL WORKPLAN FOR 2018/19

Discussion

23.1

Clinical Council Workplan as at 5 September 2018 (subject to change)	**EMT Member**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**F R A C Meeting date**	**BOARD Meeting date**
Planned MRI and Fluoroscopy Equipment Replacement Programme **Detailed Business Case'**	Colin Hutchinson/Claire Caddie	10-Oct-18			31-Oct-18
Model of Care for Haematology and Oncology Presentation and paper (**Public Excluded)**	Colin Hutchinson/Claire Caddie	10-Oct-18			31-Oct-18
Cardiology Review and plan of action (6 monthly update requested by EMT 6 March)	Colin Hutchinson/Claire Caddie	10-Oct-18			
Using Consumer Stories Revised ... (not considered in July by governance groups - pulled at the last minute)	Kate Coley / John Gommans	10-Oct-18	11-Oct-18		31-Oct-18
Conception to Five Years, including first 1000 days (**Clinical Action Dec 17**)	Andy Phillips	10-Oct-18			
Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations 6 monthly **(Oct,** Apr, Oct**)**	Kate Coley	10-Oct-18		31-Oct-18	
Clinical Advisory & Governance Group Report (July Aug **Oct** Nov Dec Feb Mar 19)	Chris McKenna	10-Oct-18			
Maternal Wellbeing Programme Update (Board update action 25/7)	Patrick LeGeyt	10-Oct-18	11-Oct-18		31-Oct-18
Quality Dashboard Quarterly Report (July none received - now **Oct**, jan for Feb19 mtg, Apr, July)	Kate Coley	10-Oct-18		31-Oct-18	
Clinical Portal Project update - monthly + Clinical Council	Anne Speden	10-Oct-18		31-Oct-18	
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	10-Oct-18	11-Oct-18		31-Oct-18
Collaborative Pathways update (July - **Oct** - Feb - June)	Chris Ash & Mark Peterson	10-Oct-18	11-Oct-18		31-Oct-18
Annual Plan 2018/19 final - **by email TBC**	Chris Ash	10-Oct-18	11-Oct-18		31-Oct-18
Clinical Research Committee Update - issue annual report **via email TBC**	John Gommans	10-Oct-18			31-Oct-18
National Mental Health Inquiry detail released TBC	Colin Hutchinson/Claire Caddie	10-Oct-18	11-Oct-18		31-Oct-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Colin Hutchinson / Claire Caddie	10-Oct-18	11-Oct-18		31-Oct-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)	Colin Hutchinson/Claire Caddie	10-Oct-18	11-Oct-18		31-Oct-18
Te Ara Whakawaiora - Improving Access Indicator	Colin Hutchinson/Claire Caddie	10-Oct-18	11-Oct-18		31-Oct-18
Health Equity Report	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Alcohol Harm Reduction Strategy (6 monthly update) **Nov**-May-Nov-May	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
IS **Presentation** and Discussion (informed by CSP) moved to Nov - see where tracking at that time.	Anne Speden	14-Nov-18	15-Nov-18		
Quality Annual Plan - 2017/18 - Annual review against objectives (was Aug moved to **Nov (3/9)**)	Kate Coley	14-Nov-18		28-Nov-18	
Quality Annual Plan 2018/19 (new with 6 monthly reviews) TBD yearly cycle from to	Kate Coley	14-Nov-18		28-Nov-18	
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May**-Nov18**)	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Clinical Services Plan **in final form**	Ken Foote	14-Nov-18	15-Nov-18		28-Nov-18
Clinical Advisory & Governance Group Report (July Aug Sept Oct **Nov** Dec Feb Mar 19)	Chris McKenna	14-Nov-18			
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-**Nov**-Feb-May	Chris Ash	14-Nov-18	15-Nov-18		28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year Board action Nov 17	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Mobility action plan implementation - progress update on the phases	Andy Phillips	5-Dec-18	6-Dec-18		19-Dec-18
People Plan (6 monthly - **Dec**, Jun)	Kate Coley	5-Dec-18	6-Dec-18		19-Dec-18
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov **Dec** Feb Mar 19) VERBAL	Chris McKenna	5-Dec-18			
Collaborative Pathways update **(July** - Oct - **Feb**- Jun)	Chris Ash & Mark Peterson	13-Feb-19	14-Feb-19		27-Feb-19
Mid-Point Heatlh Cert Surveillance Audit - Corrective Actions (June - **Feb**)	Kate Coley	13-Feb-19		27-Feb-19	
Ngatahi Vulnerable Children's Workforce Development - annual progress **Feb 19**	Colin Hutchinson/Claire Caddie	13-Feb-19	14-Feb-19		27-Feb-19
Quality Dashboard Quarterly Report (July, Oct, jan for **Feb19** mtg, Apr, July)	Kate Coley	13-Feb-19		27-Feb-19	
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-**Feb**-May	Chris Ash	13-Feb-19	14-Feb-19		27-Feb-19
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov Dec **Feb** Mar 19)	Chris McKenna	13-Feb-19			
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-**Mar**	Andy Phillips	13-Mar-19	14-Mar-19		27-Mar-19
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Chris McKenna	13-Mar-19	14-Mar-19		27-Mar-19
Urgent Care (After Hours) Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	13-Mar-19	13-Mar-19		27-Mar-19
Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations 6 monthly (Oct**, Mar 19**, Oct**)**	Kate Coley	13-Mar-19		27-Mar-19	
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov Dec Feb **Mar 19**) WRITTEN OR VERBAL TBC	Chris McKenna	13-Mar-19			

ELECTION OF CHAIR / CO-CHAIRS