HB Clinical Council Meeting

Date:	Wednesday 1 September 2021
Time:	3.00pm – 5.30pm
Venue:	Te Waiora Room, DHB Administration Building, Corner Omahu Road and McLeod Street, Hastings
Members:	Dr Robin Whyman (Co-Chair) Dr Andy Phillips Dr Russell Wills Dr Nicholas Jones Dr Mike Park Peta Rowden Dr Jessica Keepa JB Heperi-Smith Dr Umang Patel Dr Kevin Choy Chris McKenna Karyn Bousfield Emma Patel Brendan Duck Catherine Overfield
Apologies:	
In Attendance:	Keriana Brooking, Chief Executive Officer Chris Ash, Chief Operating Officer Susan Barnes, Patient Safety & Quality Manager
Minute Taker:	Gemma Newland, EA Chief Allied Health Professions Officer

Public Agenda

Item	Section 1: Routine	Time (pm)
1.	Karakia, Welcome and Apologies	3.00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review of Actions (public) - A Lesperance letter reply (10)	
5.	Annual Plan and Workplan – copy for information	
6.	HB Clinical Council Board Report – August (public) – copy for information	
7.	AGM Planning for October – nomination forms to be discussed	3.10
	Section 2: Standing Management and Committee Reports	
8.	Chief Executive Officer's Report	3.20
9.	COVID19 Vaccine and Immunisation Programme Rollout Progress Report	3.35
10.	Clinical Council Representatives and Committee Reports: - Professional Standards and Performance Committee - Credentialling Paper	3.45
11.	**Section 3: Recommendation to Exclude the Public** Under Clause 33, New Zealand Public Health & Disability Act 2000	

Public Excluded Agenda

Item	Section 4: Routine	Time
12.	Minutes of Previous Meeting (public excluded)	3.55
13.	Matters Arising – Review of Actions (public excluded)	
14.	HB Clinical Council Board Report – August (public excluded) – copy for information	
	Section: Presentations / Discussion	
15.	Chief Operating Officer Report – Chris Ash	4.00
16.	Topics of Interest – Member Issues / Updates	4.15
17.	System Performance Measures – Stubborn Reds Discussion (Action #2 PubEx) Workshop session – Emma Foster and Lisa Jones	4.20 (40 mins)
18.	HRT Dashboard Q1 2021 Data – Robin Whyman	5.00
19.	Co-Chair discussion regarding HRT Data (Action public ex #5)	
20.	Patient Safety Report – Susan Barnes	5.15
21.	DAA – Corrective Actions Report – Susan Barnes	
22.	Meeting concludes	5.30

The next Clinical Council Meeting will be held on
Wednesday 6 October 2021 commencing at 3.00pm

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

*Showing **respect** for each other, our staff, patients and consumers*

	✔	✘
Welcoming	Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles	Is closed, cold, makes people feel a nuisance Ignore 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 peoples 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

*Continuous **improvement** in everything we do*

	✔	✘
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

RARANGA TE TIRA PARTNERSHIP

*Working together in **partnership** across the community*

	✔	✘
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 whanau 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

*Delivering high quality **care** to patients and consumers*

	✔	✘
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 give 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

Karakia

Hei Aratākina te Hui (to start)

E Io i runga i te Rangi Whakarongo mai titiro iho mai E Io i runga i te Waitai, i te Wai Moana, i te Wai Maori Whakapiri mai whakatata mai E Io i runga i a Papatuānuku Nau mai haere mai Nōu e Io te aō nei Whakatakina te mauri ki runga ki tēna taura ki tēna tauira Kia eke tārewa tu ki te Rangi Haumie Hui E tāiki e.	The waters of life connect us to all nations of this world. Sharing skills of one another and an understanding that throughout the hui we are courageous in our decisions that set and implement decisions.

Karakia whakamutunga (to finish) Unuhia

Unuhia, unuhia te uru tapu nui o Tāne Kia wātea, kia māmā te ngākau, te wairua, Te tinana, te hinengaro i te ara takatū. Koia rā e rongo, whakairia ki runga Kia wātea, kia wātea, āe rā, kua wātea!	Release, release the sacred knowledge of Tāne To clear and to relieve the heart, the spirit, The body and the mind of the bustling path. Tis Rongo that suspends it up above To be cleared of obstructions, yes, tis cleared.

Interests Register
Aug-21

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
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	Forum for national midwifery and maternity issues	No	
	Current part secondment to TAS SSHW team Programme Consultant for CCDM	Team member	Implementation of CCDM programme	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	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	
	Hastings Environment Centre	Board member	Sustainable Living	No	
	Ora Taiao	Executive Board Member	Health and Climate	No	
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	
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	
Karyn Bousfield	Jonathan Black Farsight Global	Partner is Director	Organisational Psychologist/ Contractor	No	Potenital percieved - no connection on a professional level
Mike Park	College of Intensive Care Medicine (CICM)	Fellow	CPO and accreditation	No	
	ASMS	Member	Trade Union	No	
	ANZICS	Member	Professional society	No	
	Central region IHT DHB Committee	Chair	DHB network for IHT	No	
	HBDHB Medical Diirector Acute & Medical	Medical Director		Yes	Potential Pecunirary - Low level
Dr Kevin Choy	The Doctors, Hastings	GP & Director	GP	Yes	Provision of Primary Care - business
Dr Umang Patel	City Medical Ltd, Napier	GP & Medical Director	GP	Yes	Provision of Primary Care - business
	HBDHB	ED SMO/Consultant Locum	Consultant	No	
	PHO	Wife is Nursing Director		Yes	Low
Peta Rowden	Hawke's Bay DHB – Shanelle Rowden-Read	Daughter	Health Care Assistant	Yes	Low - family member
	National Directors of Mental Health Nursing (DOMHNs)	Member	Collective strategic group to positively influence nursing priorities for mental health and addiction nurses in New Zealand.	No	
	Hawke's Bay DHB Mental Health & Addictions Services – Nurse Director	Employee	Employee	No	
	Te Ao Maramatanga - College of Mental Health Nursing	Member	Professional body for practising mental health nurses in New Zealand	No	
Dr Jessica Keepa	Te Taiwhenua o Heretaunga	GP	GP	Yes	Provision of Primary Care - employee
	NZ Royal College of GPs	Member	Professional society/body	No	
	Te Ohu Rata o Aotearoa (Māori medical practitioners)	Member	Professional society		
	Hawke's Bay Faculty of GPs	Member	Professional society		
Emma Patel	Health Hawke's Bay (PHO)	Primary Care Nurse Director	Nurse Director	No	Perceived
	Dr Umang Patel - City Medical Ltd	Husband	GP & Medical Director	No	Perceived
Brendon Duck	HBDHB - Systems Lead for Medicine	Employee	Health Services	Yes	Potential
	Totara Health	Director	General Practice	Yes	Delivery of funded primary care services via back to back agreement with Health HB
	Totara Health - Pharmacist Prescriber	Employee	General Practice	No	
	Pharmaceutical Society of New Zealand	Advisor	Crown Agency	No	
	HQSC	Advisor	Crown Agency	No	
Catherine Overfield	Member of NZ College of Midwives	Professional Member	Professional guidance and indemnity cover	No	
JB Heperi-Smith					

8/25/2021

MINUTES OF THE MONTHLY HAWKE'S BAY CLINICAL COUNCIL MEETING HELD IN THE TE WAIORA MEETING ROOM, CORPORATE OFFICE ON WEDNESDAY, 4 AUGUST 2021 at 3.00 pm

PUBLIC

Present:	Dr Robin Whyman (Co Chair) Jules Arthur (Co-Chair) Dr Jessica Keepa Dr Kevin Choy Karyn Bousfield Dr Russell Wills Dr Andy Phillips Dr Nicholas Jones Brendan Duck Dr Umang Patel Emma Patel
Apologies:	Keriana Brooking, Chief Executive Officer Susan Barnes, Patient Safety & Quality Manager Dr Mike Park Chris McKenna Peta Rowden JB Heperi-Smith Chris Ash, Chief Operating Officer
In Attendance:	Gemma Newland, EA to Chief Allied Health Professions Officer (minutes)

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Jules opened the meeting with a karakia. Apologies noted.

2. INTEREST REGISTER

No conflicts of interest were noted for the meeting.

3. MINUTES OF PREVIOUS MEETING

The minutes of the Hawke's Bay Clinical Council public meeting held on 7th July 2021 were confirmed as a correct record of the meeting.

Moved: Nick Jones
Seconded: Russell Wills
Carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Clinical Council Appointments
Council welcomed Brendan Duck and JB Heperi-Smith last meeting. Recruitment is in progress for an Allied Health Director for Mental Health and an appointment will be made later this month. At that stage a decision could be made about the appointment of a Senior Allied Health Representative to Clinical Council.

Item 2: Clinical Council newsletter to wider health sector
In progress.

Item 3: Quality Framework
On hold.

Item 4: CCDM – Next presentation
On agenda today.

Item 5: Covid-19 Programme
On agenda today.

Item 6: Leadership Programme for Senior Clinicians
Request to Martin Price for information on the national leadership workshops – Gemma will contact again.

Item 7: EMedicine Management Strategy – progress update
Date to be confirmed.

Item 8: Inpatient Survey Action – progress update
Date to be confirmed.

Item 9: HealthPathways – progress update
February 2022 confirmed.

5. HB CLINICAL COUNCIL BOARD REPORT – JULY

Taken as read.

6. CEO UPDATE

Keriana was an apology – no update.

7. CLINICAL COUNCIL ANNUAL PLAN AND WORK PLAN 2020/21

Taken as read.

8. COVID-19 VACCINE AND IMMUNISATION PROGRAMME ROLLOUT PROGRESS REPORT

Nick Jones reported that the immunisation rates have increased and now 13,000 doses are provided per week – which is a big increase in the scale. DHB clinics still provide the majority but GP clinics are increasing. Clinical Advisory Group (CAG) is continuing to work through the SOPs. The programme team is looking at employing another 0.5 FTE staff member into the Covid-19 workforce.

Improving equity is a priority for the operational group. As at current date Māori rates of vaccination uptake were lower than non-Māori. Early delivery priorities were in aged care and healthcare settings. Plans for marae-based, whanau, in conjunction with Kaumatua, and large workplace vaccinations in conjunction with online bookings are being worked through.

Russell Wills reflected from a primary care view that opportunistic vaccination is a potential way of increasing rates. Emma Patel confirmed that primary care does support opportunistic vaccination and that some providers are taking this on. Vaccinators already qualified are only required to complete four hours of e-learning specific to the Covid-19 vaccine delivery. This extra training is a requirement of the Ministry of Health (MoH) and the Covid-19 vaccine is distinct. Opportunities for additional practices to come on board are there. Meanwhile, the importance of continuing to educate parents/caregivers about the importance of childhood immunisations (such as MMR) remained to ensure children were getting immunised on time, despite the COVID-19 pandemic.

9. EQUITY ACTION PLAN PRESENTATION

Nick spoke to a PowerPoint presentation – explaining Hawke's Bay Health equity action plan is now at its second step, moving from a framework, to an action plan in progress. The five core change principals that sit across the organisation are: make health equity a strategic priority, develop structure and process to support health equity work, address the multiple determinants of health, eliminate institutional racism and partner with community organisations.

A survey was issued across the organisation to Senior Leadership to create a benchmark of how the DHB is performing. The four key findings / themes were noted: more accountability is needed, poor implementation of strategy across the organisation, inadequate visibility of equity and an ad hoc vs. systematic approach. Key indicators of success addressing the issues identified will be remeasured in 18 months' time.

Council discussed the plan and the issues that may arise with implementation and effectiveness.

Karyn recognised this plan to be a great piece of work and believes this is the right path to be taking. Karyn asked the question of how will Clinical Council stay connected and govern over this? Andy Phillips agreed that we need to follow up on this.

Clinical Council will seek to maintain reporting on the progress, as well as the progress with implementation of the equity funding process.

SECTION 2: REPORTING COMMITTEES TO COUNCIL

10. CLINICAL COUNCIL REPRESENTATIVES AND COMMITTEE REPORTS

Professional Standards and Performance Committee co-chairs (Andy and Karyn) met to discuss the groups that supplied them with meeting reports / minutes. They intend on bringing a medical and midwifery credentialing paper to Council next month.

OTHER BUSINESS

Inwards Correspondence: Letter from Andrew Lesperance, Chair of Clinical Governance and Advisory Committee, Health Hawke's Bay:

Council noted this letter was requesting standing positions on Council for the Nurse Director Primary Care, Medical Director Primary Care and Maori Primary Care Nurse

Council discussed the letter and the requests noting that the Nurse Director Primary Care and Medical Director Primary Care are standing positions on the Council in the most recent Terms of Reference. It was also noted that a vacancy on Council exists for a nurse and that Council had considered the overall size of Council in developing the latest Terms of Reference. Council had recommended to the DHB and PHO CEOs that "*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, Pacifica health and rural health interests and expertise are reflected*."

It was agreed the Chairs would reply to the letter inviting a nomination for a primary care nurse consistent with the Terms of Reference.

Further changes to the Terms of Reference would need to be considered at the 2021 Annual General Meeting and recommended to the DHB and PHO CEOs.

Jules Arthur
Jules announced to the group that she has accepted a new position as National Midwifery Advisor at TAS, so this will be her last Clinical Council meeting. Jules thanked the group and noted that she felt both privileged and honoured to be a member of Clinical Council and most recently, co-Chair. Jules has been on Council for 10 years and acknowledged Robin's support as Co-Chair.

Congratulations from all members, and Robin and Nick provided their personal thanks to Jules.

SECTION 3: RECOMMENDATION TO EXCLUDE

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

12. Minutes of Previous Meeting (public excluded)
13. Matters Arising – Review Actions (public excluded)
14. HB Clinical Council Board Report – July (public excluded)
15. Topics of Interest - Member Issues/Updates
16. Presentation on Community Localities and Networks
17. System Performance Measures – stubborn reds discussion
18. HRT Dashboard – Q1 2021
19. CCDM Safe Staffing
20. Patient Safety quarterly report
21. DAA – Corrective actions report
22. Safety1st – Progress Report
23. Chief Operating Officer Report

The meeting closed at 4.10pm

Confirmed: _____ Co-Chairs

Date: _____

HAWKE'S BAY CLINICAL COUNCIL
MATTERS ARISING / ACTIONS

(Public)

As at August 2021

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1.	Jun-20	***Clinical Council Appointments*** Appointment of a Senior Allied Health Professional on Council to be confirmed	Co-Chairs/ Andy Phillips	ASAP	In progress
2.	Oct-20	***Clinical Council newsletter to wider health sector*** Co-Chairs to work with Comms Team to finalise draft for confirmation by members	Co-Chairs	Sept 2021	In progress
3.	Dec-20	***Quality Framework*** Introduce framework to DLTs Launch framework	Susan Barnes Susan Barnes	Mid 2021	On hold (viz Health Services Leadership Structure review)
4.	July-21	***Leadership Programme for Senior Clinicians*** Martin Price to provide Council with notes from the national leadership workshops.	Martin Price	Aug 2021	In progress
5.	July-21	***EMedicine Management Strategy*** Progress review	Di Vicary / Brendan Duck	TBC	
6.	July-21	***Inpatient Survey Action*** Themes to be summarised by Nancy Barlow and Council to create plan of action to address and share with appropriate groups.	Nancy Barlow	TBC	
7.	July-21	***HealthPathways*** Update from Team Leads	Tania Page and Donna Armstrong	Feb 2022	
8.	Aug-21	***HBDHB Equity Action Plan*** • Reporting progress to be fed back to Council • Request for Council to have site on the equity funding process	Nick Jones and JB Heperi-Smith	Feb 2022	
9.	Aug-21	***Professional Standards and Performance Committee*** Medical and Midwifery credentialing papers	Andy Phillips and Karyn Bousflield	Sept 2021	

Action	Date Entered	Action to be Taken	By Whom	Month	Status
10.	Aug-21	***Inwards correspondence from Health Hawke's Bay*** Letter drafted in response to addressing lack of equity and primary care representation.	Robin Whyman	Sept 2021	

Corporate Services

17 August 2021

Andrew Lesperance
Chair
Clinical Governance and Advisory Committee
Health Hawke's Bay
HASTINGS

Tēnā koe Andrew

PRIMARY CARE REPRESENTATIVES ON CLINICAL COUNCIL

Thank you for your letter dated 13 July to Clinical Council regarding the concern of Clinical Advisory Group regarding the current membership and representation.

The Terms of Reference for Clinical Council that were updated following the 2020 AGM have established the PHO Medical Director and PHO Nurse Director positions as standing positions. We are really appreciating the contribution that Emma Patel is bringing to Clinical Council and understand that Louise Haywood may make an alternative nomination. We are happy to attach a copy fo the Terms of Reference which are jointly approved by the CEOs of the DHB and PHO.

Currently positions for one Senior Nurse and one Senior Allied Health Professional remain unfilled. The Senior Nurse position has been vacant since Debs Higgins resigned from Council in February 2021. Given that the 2021 AGM of the Clinical Council is due in October we recommend that this is an opportunity for a nurse from primary care to be nominated. Following discussion of your letter at the August Clinical Council meeting I am pleased that we have already received one nomination that can be taken forward to the AGM. Of course further nominations can be received.

The 2020 chnages to the Terms of Reference also state that "*When making appointments, consideration is given to maintaining a wide range of perspectives and interests within the total membership, ensuring in particular that Māori health, Pacifica health and rural health interests and expertise are reflected*".

We will continue to ensure that meetings of the Clinical Council do demonstrate equity as a primary focus of our governance.

Ngā manaakitanga

Jules Arthur
Co-Chair
Clinical Council

Robin Whyman
Co-Chair
Clinical Council

Hawke's Bay Clinical Council
C/- Hawke's Bay District Health Board
Omahu Road, Private Bag 9014, Hastings 4156, New Zealand
Telephone: (06) 878 8109

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2020/2021

AREA OF FOCUS	ACTIVITIES	TIMEFRAME	PROGRESS
Clinical Effectiveness	1 HRT Quarterly Report 2 System Performance Measures 3 Te Ara Whakawaiora	Quarterly Quarterly TBC	1 and 2 on September agenda
Patient Safety & Quality	1 Implementation of the clinical governance framework 2 Implementation of Safety1st 3 Patient Safety and Risk Management Report	April 2021 August 2021 October 2021	On hold post structure review Reported in August 2021
Engaged & Effective Workforce	1 Safe Staffing / CCDM 2 Clinical Council Newsletter development 3 Meeting with newly appointed ED People and Culture	April 2021 Mid-year July 2021	August, November 2021 In progress Completed
Equity	1 Review of Terms of Reference 2 Revision of the HRT dashboard for ethnicity data in the indicators 3 Membership of other committees and groups	April 2021 August 2021 October 2021	Completed – consider membership AGM September
Consumer Engagement	1 Pātaka Kōrero 2 Consumer engagement framework 3 Inpatient survey	TBC August 2021 July 2021	 Completed Completed, with a request for a summary of themes for further discussion by Clinical Council

@BCL@34066037

Clinical Council Workplan 2020 / 2021

As at August 2021

Meeting	Clinical Council	Area of Focus from CC Annual Plan	FRAC	BOARD
May	HRT dashboard – Q4 2020 data System Performance Measures Patient Safety quarterly report DAA corrective actions update COVID vaccination update Clinical Committees Updates	Clinical Effectiveness Patient Safety and Quality Clinical Effectiveness Patient Safety and Quality	Dashboard (May) + Short Report (including narrative from CC)) forms part of Patient Safety Report	Summary of conversations/key topics discussed
June	DAA corrective actions update COVID vaccination update Clinical Committees Updates	Equity Consumer Engagement Clinical Effectiveness Patient Safety and Quality		**No meeting held due to lack of quorum**
July	Presentation – Inpatient survey Martin Price, ED People & Culture eMedicine Management Strategy COVID vaccination update Clinical Committees Updates	Consumer Engagement Engaged & Effective Workforce Clinical Effectiveness Patient Safety and Quality Clinical Effectiveness		Summary of conversations/key topics discussed

Clinical Council Workplan 2020 / 2021

As at August 2021

Meeting	Clinical Council	Area of Focus from CC Annual Plan	FRAC	BOARD
August	Equity action plan DAA corrective actions update CCDM Safe Staffing (core data set) Patient Safety quarterly report DAA corrective actions update COVID vaccination update Clinical Committees Updates Community/Consumer Council & Localities/Community Networks Safety1st – progress report	Equity Patient Safety and Quality Clinical Effectiveness Clinical Effectiveness Patient Safety and Quality	Report (2) Dashboard (August) + Short Report (including narrative from CC) forms part of Patient Safety Report	Summary of conversations/key topics discussed
September	HRT dashboard – Q1 2021 data System Performance Measures Discussion Risk Management Governance report DAA corrective actions update COVID vaccination update Clinical Committees Updates	Clinical Effectiveness Patient Safety and Quality Equity Engaged & Effective Workforce Consumer Engagement		Summary of conversations/key topics discussed
October and AGM	DAA corrective actions update Risk Management Governance report (next Jan 2022) COVID vaccination update Clinical Committees Updates	Clinical Effectiveness Equity Patient Safety and Quality Clinical Effectiveness Engaged & Effective Workforce		Summary of conversations/key topics discussed

Clinical Council Workplan 2020 / 2021

As at August 2021

Meeting	Clinical Council	Area of Focus from CC Annual Plan	FRAC	BOARD
November	HRT dashboard – Q2 2021 data System Performance Measures Patient Safety quarterly report COVID vaccination update Clinical Committees Updates Adverse Event Management Policy Cultural Safety discussion (workshop)	Clinical Effectiveness Equity Patient Safety and Quality Clinical Effectiveness Engaged & Effective Workforce	Dashboard (November) + Short Report (including narrative from CC) forms part of Patient Safety Report	Summary of conversations/key topics discussed
December	COVID vaccination update Clinical Committees Updates	Clinical Effectiveness Equity Patient Safety and Quality Clinical Effectiveness Engaged & Effective Workforce		Summary of conversations/key topics discussed

HAWKE'S BAY District Health Board Whakawāteatia	**REPORT FROM HB CLINICAL COUNCIL (Public) AUGUST 2021** For the attention of: **HBDHB Board**
Document Author(s) Document Owner	Gemma Newland (Executive Assistant to Chief Allied Health Professions Officer) Jules Arthur and Robin Whyman (Co-Chairs)
Date	August 2021
Purpose/Summary of the Aim of the Paper	Provide Board with an overview of matters discussed at HB Clinical Council meeting on 4 August 2021.
Health Equity Framework	The Hawke's Bay Clinical Council works in partnership with a whole of system approach to ensure Hawke's Bay health services are achieving equity in health outcomes through the provision of services that are culturally safe, appropriate in addressing inequities and accessible to Tangata Whenua.
Principles of the Treaty of Waitangi that this report addresses:	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system; committed to Te Tiriti o Waitangi and achieving equity for Tangata Whenua and other populations, in the provision of health care in the Hawkes' Bay District.
Risk Assessment	Risk associated with the issues considered by the Clinical Council included equitable delivery of the COVID vaccination programme and ongoing delivery of childhood immunisations.
Financial/Legal Impact	
Stakeholder Consultation and Impact	Stakeholder engagement is the basis of discussion of issues at the Clinical Council
Strategic Impact	None identified
Previous Consideration / Interdependent Papers	None identified
RECOMMENDATION: It is recommended that the Board: *1.* **Note** the contents of this report	

1. COVID-19 Vaccination Programme

Nick Jones discussed the increases in COVID-19 vaccination rates in Hawke's Bay. It was noted that while Hawke's Bay DHB (HBDHB) clinics were still providing the majority of vaccinations, GP clinics were increasing vaccination rates. Clinical Council noted a concern to improve equity, which is a

priority for the operational group. A whole whānau approach needed to be utilised and the ability for vaccination frameworks to be more flexible. Council supported the ongoing focus of the operational group on improving equity of delivery of the vaccination programme.

It was noted that whilst COVID vaccination remains a national priority; continued local focus on provision of childhood immunisations should remain forefront of mind.

2. Equity Action Plan Presentation

Nick Jones explained the implementation of the Hawke's Bay Health equity action plan to Clinical Council. Council discussed the plan and the issues that may arise with implementation and effectiveness.

Council agreed the priority of this plan was an important piece of work and supported the path taken

Clinical Council asked for progress reports and to provide a monitoring function including progress with the implementation of the equity funding agreed in the 2021/ 2022 HBDHB budget.

AGM PLANNING DISCUSSION

ROBIN WHYMAN

VOTING FORMS TO BE SUPPLIED SEPARATELY

CHIEF EXECUTIVE OFFICER REPORT

ANDREW BOYD (ACTING)

COVID-19 VACCINE AND IMMUNISATION PROGRAMME ROLLOUT

CHRIS MCKENNA / NICK JONES

CLINICAL COUNCIL REPRESENTATIVES AND COMMITTEE REPORTS

HAWKE'S BAY District Health Board Whakawāteatia	**Report from Professional Standards and Performance Advisory Group**
	For the attention of: Clinical Council
Document Author(s)	Karyn Bousfield-Black, Joint Chair Professional Standards and Performance Advisory Group Andy Phillips, Joint Chair Professional Standards and Performance Advisory Group
Date	1 September 2021
Purpose/Summary of the Aim of the Paper	To provide an update from the Professional Standards and Performance Advisory Group – points of escalation from sub-committees
Health Equity Framework	The Health Equity Framework guides planning and decision-making at all levels
Principles of the Treaty of Waitangi that this report addresses	Our Te Tiriti responsibilities are addressed through individual advisory groups. Advisory groups will be reminded of the requirement to address the Te Tiriti responsibilities through their work
Risk Assessment	Points of risk are escalated to Clinical Council as required
Financial/Legal Impact	None to note
Stakeholder Consultation and Impact	None to note
Strategic Impact	None to note
Previous Consideration / Interdependent Papers	Credentialing process update also provided to Clinical Council
RECOMMENDATION: *It is recommended that the Clinical Council:* 1. *Note and acknowledge this report*	

Advisory Groups

Allied Health Professions

The Allied Health Professions Advisory Group meets monthly to review progress against the HBDHB Allied Health Professionals Strategy (2018-2023) Into Action which as the following priorities:

1. Building trusting relationships
2. Building clinical capacity and capability
3. Evaluate, improve and evidence the impact of the allied health professions contribution
4. Build allied health professionals leadership capability and capacity

Drawing on these priorities alongside the DHB Values, focus on equity, response to MOH national and HBDHB priorities the agenda for each meeting allows allied health leaders to educate, update, respond and contribute, whilst also allowing clinical governance and oversight to the Chief Allied Health Professions Officer. Recent discussions included:

Building Trusting Relationships

- Supervision Framework
- Self-Care in Healthcare

Building clinical capacity and capability

- AH CCDM programme
- Capacity and demand issues generally
- TAS AHST Pay Equity
- Recruitment and retention
- Career and Salary Progression
- Programme Incubator
- Central Region Career Framework
- Central Regions Professional Practice Expectations
- Values Based Recruitment
- Vulnerable Workforces

Evaluate, improve and evidence the impact of allied health professions contribution

- AH on Our Hub
- AH CCDM programme
- Allied Health Audits
- Allied Health Grand Round
- AH Connector
- Allied Health promotion days
- AH Clinical Assurance Framework
- Performance Plans and Reviews
-

Build allied health professionals' leadership capability and capacity

- CEO Leadership Training
- Wahine Connect

Equity

- Wai 2575
- AH Equity response and Maori Workforce
- HBDHB Equity Framework
- Maori Relationship Board

Allied Health Response to MOH National Priorities

- MOH – Allied Health Strategy 2021-2023 – Martin Chadwick
- National Directors of Allied Health, Scientific and Technical Group Priorities and Relationships 2021 Planning
- Locality networks
- Ngā Paerawa Health and Disability Standards
- Health and Disability System Review
- NZNO Strikes
- Covid-19
    - Vaccination programme
    - Debrief / learnings
    - National updates
    - Workforce

Allied Health Response to HBDHB Priorities

- HBDHB Allied Health Professions Strategy
- Influenza vaccination
- HSLT Restructure
- Facilitates e.g. Te Whata Moanarua relocation, Hand Therapy relocation, surgical expansion, radiology expansion projects
- Integrated System Planning Profess – Karyn Bousfield-Black and Saskia Booiman
- Hawke's Bay Community Health Pathways – Donna Armstrong
- Surgical Services Expansion Project – Janet Heinz

Credentialing Advisory Groups

Note the separate report to Clinical Council regarding credentialing

RMO Training & Advisory Group

The RMO training & Advisory Group continue to work through a number of processes and issues to proactively support effective RMO workflow, productivity and safe practice. Three key issues of concern have been raised to the Professional Standards and Performance Advisory Group for noting and assistance in solution finding:

- Issues with emergency paging and out of hours cover, missed calls and pagers not working – DE is currently working to ensure a solution is available including an alternate to the pager system.
- Current workload and processes for managing out of hours – options are being considered for new ways of managing including improved nurse coordination and an electronic tasking system.
- Lack of effective orientation for all doctors including RMO's

These issues have been raised with the Health Services Executive Group to ensure a managed approach in addressing the issues effectively.

Research

Diana Schmid – Clinical Coordinator or CTRU, retired on 6th August.
A research strategy will be drafted for consultation

HOSPITAL SERVICES UPDATE

HAWKE'S BAY District Health Board Whakawāteatia	**CREDENTIALLING**
	For the attention of: Clinical Council
Document Author(s)	Colin Hutchison, Chair of Medical Credentialling Committee Karyn Bousfield-Black, Joint Chair Professional Standards and Performance Advisory Group Andy Phillips, Joint Chair Professional Standards and Performance Advisory Group
Date	25 August 2021
Purpose/Summary of the Aim of the Paper	To provide a summary of current secondary care credentialing processes
Health Equity Framework	Not currently embedded in credentialing – advice required on this
Principles of the Treaty of Waitangi that this report addresses	Not currently embedded in credentialing – advice required on this
Risk Assessment	Credentialing processes are required to be robust to avoid personal, clinical and organisational risk. New credentialing processes have reduced risk
Financial/Legal Impact	There is potentially significant legal impact on having either too loose or too tight credentialing processes
Stakeholder Consultation and Impact	Credentialing processes have been agreed with Medical Heads of Department and Senior Allied Health and Nursing Leaders
Strategic Impact	None to note
Previous Consideration / Interdependent Papers	None to note
RECOMMENDATION: *It is recommended that the Clinical Council:* 1. *Note and acknowledge this report*	

SITUATION

Recent clinical events have prompted a reflection and review of the secondary care credentialing processes**.**

BACKGROUND

Credentialing identifies the specific clinical responsibility a practitioner has within an organisation and monitors their ongoing competence in that respect.

Credentialing is required for staff working at expanded, advanced expert practice roles "where there are particular risks of serious harm, or a lack of direct clinical oversight" (MOH, 2010, p1). Credentialing is distinct, separate and yet linked to the performance and competence frameworks.

The *Competence Framework* relates to each profession's requirements for demonstrating ongoing competence to practice. For the professions that are governed by the HPCA Act (2003) this includes their obligation to hold an Annual Practicing Certificate.

The *Performance Framework* relates to the extent that the individual is carrying out the duties as per his or her job description and employment contract.

The *Credentialing Framework* relates to patient safety and practitioner protection in clinical situations where assurance is required to manage or prevent risks where advanced or expert scopes of practice roles are being performed.

SITUATION

MEDICAL CREDENTIALLING

Individual SMO Credentialling is the process whereby it is determined that Clinicians employed by HBDHB are working within a defined scope of practice, consistent with their qualifications, training, experience and stated expertise. Department Credentialling is a process by which the clinical department's size and scope of practice is defined and agreed between the Service Director and Head of Department

There are HBDHB policies for medical credentialling that cover short term and permanent appointments with an appeals process and for departmental credentialing on a five year cycle. The processes are shown in Appendix A. The individual credentialing is initially carried out using a self-assessment form that is reviewed by the committee. The prime focus of credentialling is patient safety. The process focuses on quality improvement and provision of excellent clinical care with active participation by professionally accountable clinicians. Within the policy there is a requirement for all HBDHB clinicians to:

- Agree to participate in credentialling as a condition of their terms of employment
- Have the appropriate qualification(s), knowledge, training, experience and resources to practice safely and competently
- Practice within a defined scope of practice, with appropriate support.

The HBDHB medical credentialing process is based on a "four-step" process, according to the Ministry of Health Credentialling Framework for Health Professionals. It requires willing and active participation in partnership between clinicians and their employers, based on trust and mutual respect. The process involves both internal peer review and external departmental review. It is non-disciplinary, but it may lead to changes in clinical responsibilities. The aim is for credentialling processes to be

unbiased, fair, transparent and robust with equal protection afforded to every clinician. The scope of practice represents the range of clinical responsibility that the clinician may exercise in the department, according to their qualification, knowledge, training and experience; the available resources, and the service provision requirements of the department. The scope of practice defines the boundaries of clinical practice within which the clinician may provide care to the patient within HBDHB facilities. Most scopes of practice will be easily drafted general statements framed permissively and positively. It may include specific restrictions on the individual's scope of practice, and may also define the range of tasks or procedures covered while undertaking relieving work or on call roster coverage of general duties.

The above relates to HBDHB's role in credentialling which is distinct and complementary to the professional bodies' role (e.g. statutory registration bodies, colleges and societies) which includes ensuring practitioners are competent and fit to practice through the practitioner registration and certification process. Certification is the formal recognition (through the professional body) that an individual clinician meets the required professional standards.

The present chair has been a member of the Committee for the past 6 years and Chair for the last 18 months. The Committee has recently more clearly defined its role in the organisation to resolve the previous situation where numerous problems were brought by the senior medical staff to the Committee that the Committee was not empowered to solve. Specifically, these were largely around operational activities within departments such as the inadequate facilities or lack of support with administration functions.

Over the past 19 months the CMDO and committee chair have worked together to provide a narrower role for the Credentialing Committee going forward. There has been partnership working with the Heads of Department and Service Directors to reinforce the role of Credentialing Committee of focussing on ensuring that new Senior Medical Officers to Hawke's Bay DHB and existing Senior Medical Officers have appropriate competencies and scope of practice to deliver defined services to the patients of the Hawke's Bay region. The committee has been clear that it doesn't have an operational role in the organisation and that concerns about departments or the support to run departments needs to be taken via the Service Directors and Line Management to the Chief Operating Officer.

The role of the Medical Credentialing Committee is to work in partnership with the recruitment team at Hawkes Bay DHB and the individual Head of Departments to ensure that new Senior Medical Officers are appropriately qualified for the positions that they are due to uptake, have approval from the Medical Council and relevant colleges to take up these roles and that robust reference checks have been undertaken by the Head of Department and Service Director. This review process occurs live in between meetings electronically. The HR Department make this a seamless process whereby once the Head of Department and Service Directors have completed the recruitment process, the relevant documents are all sent out to the Credentialing Committee and electronic replies approved and the appointment of the new SMO in a very timely manner.

Once the SMO is in the organisation, the medical credentialing committee carries out review of each individual together with the rest of their Department on a rolling two-year programme. When the time approaches for the two-year review of the Department, the Head of the Department works with their SMOs to ensure that their scope of practice is updated and signed off and that any disciplinary or competence issues are highlighted and reviewed and finally that CMA is up to date. This is then

presented by the Head of Department for their SMOs to the Credentialing Committee and the majority of these are signed off with no major issues.

In addition to these internal processes the Medical Council is responsible for ensuring that SMOs are competent and fit to practise medicine. One of the ways that it does this is by requiring SMOs to meet the requirements of recertification programmes set by Council, including satisfying any continuing professional development (CPD) requirements included in the programme. The Medical Council requires SMOs to undertake and satisfy a set of activities and processes on an on-going basis, to demonstrate that they are continuing to maintain your competence to practice. This includes participating in continuing professional development, including peer reviews, audits of medical practice, and continual medical education. The Medical Council also uses regular practice review (RPR) as part of your continuing professional development. RPR is a quality improvement process, aimed at maintaining and improving standards of the profession.

The Medical Credentialling Committee believes that this narrow scope and format for the Credentialing Committee is working well. The chair is content that there are no major barriers to undertaking medical credentialing within a wider health care credentialing for the organisation.

In the longer term, the DHB should explore a more detailed review of scope practices with individual Head of Departments. This will support the DHB to have visibility that Heads of Departments are working with individual SMOs to ensure that not only are SMOs competent at the point they arrive in the DHB, but that they are undertaking sufficient practice to remain competent in a given set of procedures or practices in the care of patients.

NURSING AND ALLIED HEALTH CREDENTIALLING

The purpose of the nursing and allied health credentialing process is to provide assurance that all staff practising in expanded, advanced and expert roles are appropriately qualified, skilled and supported to provide safe, effective care.

The principles are that:

- Credentialed activities / skills are guided by the area of clinical practice and professional suitability.
- The capability of the organisation to provide clinical practice support will determine credentialed activities.
- The scope of expanded, advanced or expert practice will be discipline and area specific with appropriate credentialing arrangements in place.
- The credentialing framework ensures service quality, reliable delivery, patient safety and practitioner protection.
- The credentialing process will be fair and transparent.

Nursing and allied health credentialing is consistent with the HBDHB responsibility to comply with the following legislations and regulations:

- The Health Practitioners Competence Assurance (HPCA) Act (2003).
- Regulatory requirements of each discipline’s regulatory authority.
- Credentialing Framework’ as detailed in the Ministry of Health Publication.

The framework ensures that there is evidence of appropriate qualifications, continuing professional development knowledge, training, experience, competency and access to required supervision and support.

For nursing, the specific competencies for working in expanded practice are integrated into practice and evidenced as part of a professional development and recognition programme (PDRP) and this credentialing process.

The Nursing and allied health credentialing Advisory Group comprises of the Chief Nursing & Midwifery Officer, Chief Allied Health Professions Officer, relevant professional leaders / advisors and co-opt others with relevant expertise. The advisory group is responsible for developing and implementing a credentialing process. The advisory group is responsible for ensuring competency criteria for each credentialed activity regarding are agreed including (but not limited to):

- Verification of threshold qualifications
- Relevant training, certification or experience required to perform the activity
- Key performance indicators (quantitative and qualitative).

The advisory group maintains a register of ratified approved activities and individuals. The advisory group can authorise a suspension of credentialed activities on a temporary or permanent basis for reasons such as:

- Changes in service needs
- Concerns about the practitioner's performance, competence or access to support
- Notification from an individual practitioner to voluntarily restrict or limit their own activities

The process for the activity to be Credentialed (step 1) is:

1 Discuss with the relevant Clinical Nurse Manager / Nurse Director / Team Leader / Professional Lead whether the proposed activity / skill can be supported by the team / service

2 Complete the application form – New Application to Register A New Advanced Credentialed Activity /
Skill

3 The credentialing advisory group will review the application to determine if the proposed service fully meets the application criteria, to ensure benefit to the patient population and minimise clinical risk to the DHB.

4 Once confirmed, the advisory group will:

5 Provide the applicant and employing manager written notification of approval and when renewal is due

6 Add to the credentialing register, the approved activity / skill

7 Advise the Professional Standards and Credentialing Committee written notification of the approved credentialed activity (by way of regular report)

8 The staff member will receive written notification of when renewal application for the activity / skill is required -

9 If the credentialing advisory group does not approve the application the specialty area will receive written notification with a right to appeal.

The process for the Individual Seeking to be Credentialed (step 2) is:

1 The individual staff member to discuss with the relevant Clinical Nurse Manager / Nurse Director / Team Leader / Professional Lead whether the activity / skill is approved and the individual can be supported
2 Complete the relevant application form – Individual Application for An Individual Clinical Applying to be Credentialed Against and Approved Activity / Skill.
3 The credentialing advisory group will review the application and determines if the individual meets the requirements.
4 Once confirmed, the advisory group will:
5 Notify the staff member and employing manager with written notification of the approved credentialed activity and a copy will be held on the employee's personnel file
6 Add the staff member to the register against the approved activity / skill
7 Notify the staff member with written notification of when renewal application is required
8 If the credentialing advisory group does not approve the application the individual has the right to appeal the decision.

There are criteria for maintaining credentialing. The credentialed activity lead and individual are responsible for ensuring that their service and individuals maintain their competency and knowledge consistent with their credentialed role, within the specified time frame of their credentialed activity.

Clinical Nurse Managers / Team leaders / Professional Lead or employing managers are responsible for ensuring that outcomes are audited to demonstrate staff performance of their credentialed role. Audits must be registered with Audit Registration.

The Credentialing Advisory Group conducts reviews of policy and processes as required to ensure consistency and process assurance.

ASSESSMENT

This paper describes current credentialling processes for clinical staff across all professions. There are robust processes in place for medical, nursing and allied health credentialing. A number of nursing and allied health advanced clinical tasks are now included in scope of practice and so do not require credentialing. A good number of advanced nursing activities continue to go through credentialling. Occasionally there are nursing credentialed activities that are curtailed on the appointment of new SMOs and this is followed up by senior nursing leadership. The lack of credentialed allied health activities is being followed up by senior allied health leadership. For midwifery there is a guidelines/policy group within maternity that reports through the Maternity Clinical Governance Group rather than a credentialling process.

HAWKE'S BAY
District Health Board
Whakawāteatia

APPENDIX A :

Credentialling Procedures Guide

(Senior Medical & Senior Dental Officers)

HBDHB Credentialling Committee (Senior Medical/ Dental Officers)
Hawke's Bay District Health Board
October 2016

Contents

Introduction

This guide was produced in accordance with the Credentialling Policy (Senior Medical/ Dental Officers) HBDHB/OPM/043, setting out the procedural steps by which the required biennial individual and departmental credentialling activities may be implemented across services.

Key documents supporting the process are highlighted and accessible via the hyperlinks provided, or via the policies and procedures page on Nettie (sitting under the associated policy).

Initial Credentialling (New Appointments)

Short term appointments (< 12 weeks)

1. The position is advertised with a current position profile. A clearly defined scope of practice is documented by the Head of Department "HoD" (or Clinical Lead as determined by the service), using the Scope of Practice form.

2. The applicant review and short listing process is followed. Once short listed, the applicant completes the Initial Credentialling (New Appointment Self-Assessment) form and returns the original signed copy to the Recruiter.

3. Interview and reference checking.

4. The appointment decision is made by the Employing Manager and HoD.

Long term appointments (≥12 weeks)

1. Follow steps 1, 2 & 3 as for short-term appointments

2. The Employing Manager notifies the Recruiter of the proposed appointee requiring Credentialling Committee review.

3. The Recruiter notifies the Credentialling Committee secretary of the proposed appointment and provides the following:

   - Appointment Review by Credentialling Committee form (section A completed);
   - Scope of Practice form completed for the position advertised;
   - *Scope of Practice Checklist form* completed by the applicant;
   - Applicant's Initial Credentialling (New Appointment Self-Assessment) form (copy of original form excluding confidential section - page 3, with applicant's signature);
   - Curriculum vitae
   - Confirmation of a plan for oversight/supervision (if applicant holds no NZ vocational registration)

4. The Credentialling Committee secretary arranges the appointment review to coincide with the next scheduled meeting.

   - The relevant HoD attends the committee meeting when the proposed appointment is reviewed.

5. The Credentialling Committee reviews the documentation and makes a recommendation regarding the appointment with respect to scope of practice. The recommendation is confirmed in writing by the committee chairperson.

   - Chairperson completes the committee sign off section ('B') of the *Credentialling Committee Appointment Review* form
   - Original copy of appointment review form is held by the Recruiter and a copy is retained by the committee

6. The Service Director and HoD make the final appointment decision.

Individual Credentialling

First biennial individual self-assessment

1. The clinician completes the Individual Credentialling (Self-Assessment) form and submits this to the Head of Department 'HoD' (or Clinical Lead, as determined by the service).
2. The HoD reviews the clinician's declaration and meets with the clinician to discuss its content.
3. The HoD makes a recommendation for credentialed status following consultation and scope of practice review with the clinician.
4. If no changes are required to the clinician's original Scope of Practice form, it is signed off by the clinician and HoD. If changes are required, a new form is completed and signed by both parties.
5. The HoD completes the Certification of Individual Credentialling form. NB: If the clinician is a 'visiting specialist' to another health care facility, a copy of this may be provided as evidence of a clinician's credentialed status.
6. Individual Credentialling documentation is retained in the clinician's personnel file.

Repeat biennial individual self-assessment

1. The clinician reviews their previous self-assessment. If there is no requirement to change the content, the clinician signs off the declaration and submits it to their HoD (or delegate).
2. The HoD reviews the clinician's declaration and meets with the clinician to discuss its content.
3. The HoD makes a recommendation for credentialed status following consultation and scope of practice review with the clinician.
4. If the scope of practice remains unchanged, the HoD and clinician sign off the Scope of Practice form.
5. Individual Credentialling documentation is retained in the clinician's personnel file.

Departmental Credentialling

1. The Departmental Credentialling form is completed by the Head of Department (or Clinical Lead, as determined by the service) and Service Director with department input biennially. This includes the following:

   1.1 The range of clinical activities provided by the department;

   1.2 The contracted services supplied by the department;

   1.3 The responsibilities of clinicians within the department;

   1.4 The availability of specific clinical support and other resources (including any resource constraints or systems deficiencies that staff believe impact significantly on their ability to deliver competent and safe care);

   1.5 Those clinical services not provided locally;

   1.6 Where specific guidelines are provided by Specialist Societies or Colleges, log records are maintained to demonstrate compliance;

   1.7 Evidence of departmental clinical audit and review activity (including mortality/ morbidity review).

2. The HoD ensures that Individual Credentialling forms are completed and reviewed biennially, and that individual scopes of practice are congruent with declared departmental scope.

3. The HoD and Service Director provides the Credentialling Committee with a biennial report on progress with credentialling activity in the department.

4. An External Reviewer audits the Departmental Credentialling activity process and content at least every five years (refer External Review section).

5. The External Reviewer completes the Certification of Departmental Credentialling form when satisfied the department adequately meets its contractual requirements.

External Review

1. The External Review timeframe and reviewer is negotiated between the Service Director, Head of Department (or Clinical Lead, as determined by the Service) and department staff within the required five yearly timeframe.

2. An internal report is completed by the Service Director in conjunction with the HoD and Clinical Director, incorporating the following:

   1.1 Introduction - description of the department, missions/values/goals, scope of practice;

   1.2 Resources – staff (clinical/admin/support), rosters, equipment, environment, information management and technology;

   1.3 Service links – relationships with internal/external providers;

   1.4 Patient population – contracted volumes, catchment area;

   1.5 Quality Improvement Activities – key performance indicators, audit/review plan, quality measurement/monitoring activities, processes for monitoring quality of service delivery/outcomes; and

   1.6 Professional Development – continuing medical education 'CME', research, conference attendance, credentialling programme.

3. The Service Director schedules a programme for the External Reviewer in conjunction with the HoD

4. The External Review incorporates review of the following:

   4.1 Internal report – considering alignment of department scope of practice with service delivery expectations and capabilities;

   4.2 Standards of practice: referral, assessment, treatment planning, documentation, discharge and follow up care (Clinical Guidelines and Protocols);

   4.3 Safety of practice including: supervision, skill mix/experience and work practices, clinical cover, staffing levels, professional caseload (volume competence), comparisons with other like services;

   4.4 Health record review: accessibility, quality, and organisation of health record;

   4.5 Staff/ consumer interviews/ focus groups as appropriate;

   4.6 Background resource information review; and

   4.7 National/ collegial/ peer comparison.

   The review process *may* include direct observation of practice.

5. The External Reviewer debriefs the Service Director, Clinical Director and HoD with a verbal summary of review findings.

6. The External Reviewer submits a draft written report to the Service Director, Clinical Director and HoD within two weeks of review – identifying areas of perceived risk and recommendations for improvement.

7. The draft report is circulated by the Service Director to key participatory staff for prompt review/comment. Comments are collated and forwarded to the External Reviewer by the Service Director within a two-week timeframe.

8. The final report is presented to the Service Director, HoD and Clinical Director within six weeks of the External Review.

9. The Service Director coordinates the completion of the action plan and forwards a copy to the Credentialling Committee.

Appeals Process

10

1. The clinician has 30 days in which to submit an appeal.

2. The appellant must set out in writing what is challenged and why.

3. A person/s is appointed to review the appeal. The appointment is made by mutual agreement between the appellant and the Head of Department (or Clinical Lead, as determined by the Service).

4. The HoD notifies the Clinical Director of the appeal. NB: Where the appellant is a HoD, the Clinical Director makes the appointment and in the event the appellant is a Clinical Director, the Chief Medical Officer makes the appointment.

5. The reviewer gathers information relevant to the appeal through interviewing the appellant and HoD (or Clinical Director/ Chief Medical Officer). External input may be sought from the relevant Registration Body/ College/ Society as required.

6. The reviewer presents a report on the appeals process and findings to the appellant, HoD, Clinical Director or Chief Medical Officer for review/comment.

7. The HoD (Clinical Director/ Chief Medical Officer) makes a recommendation based on the report findings.

8. The appellant has an opportunity to agree or disagree with the HoD /Clinical Director/ Chief Medical Officer's recommendation:
   If the appellant *agrees* with the recommendation:
   - He/she is credentialed to the agreed scope of practice.
   - The HoD (Clinical Director/ Chief Medical Officer) notifies the Clinical Director (Chief Medical Officer/ or nominated Credentialling Committee member) of the appeal's outcome or;

   If the appellant *disagrees* with the recommendation:
   - The appeal escalates to the Clinical Director or Chief Medical Officer/ nominated Credentialling Committee member. A Human Resource representative will be consulted to determine the appropriate conflict resolution process. The practice in question (if applicable) is suspended until the appeal process is worked through.

9. The Clinical Director or Chief Medical Officer/ nominated Credentialling Committee member makes a recommendation for management of the conflict which may include:
   - Re-instatement of credentialed status
   - Adjustment of credentialed status
   - Adjustment of clinical duties

- Re-training

10. The Credentialling Committee is informed of the outcome of the appeal resolution process.

Information Management

Each clinical department has the following e-folders located under the "credentialling" folder in the share ("I") drive:

Departmental Credentialling
External Reviews
HOD Reports
Individual Credentialling
Scope of Practice
Z-Mortality & Morbidity Review

Under the *Individual Credentialling* and *Scope of Practice* folders are year dated sub folders for storing information that is updated biennially (by 30 June) and a working file where e-versions of documents are kept for editing purposes.

A hard folder should be held securely to retain original paper copies of signed credentialling forms.

Process steps:

1. In preparation for the biennial individual credentialling deadline of 30 June, the Administrator emails each clinician their Individual Credentialling (Self-Assessment) form and Scope of Practice form. Depending on the size of the clinical department, this activity may involve all of the department's clinicians at the same time or may be staggered over the two years (as negotiated with the Service Director/ HoD).

   Clinicians are requested to review and return the forms (within a timeframe no greater than four weeks). Clinicians will be required to either:

   a) Complete a blank Individual Credentialling (Self-Assessment) form and review their Scope of Practice form (first individual credentialing since employed at HBDHB); or

   b) Review their pre-populated self-assessment form and *Scope of Practice* form (from 'working file'), tracking changes on the form(s); or print down forms and mark desired changes

   c) Indicate if no changes required

2. Once returned to the Administrator, the 'working file' of the form is updated (where changes required) and printed down or where no changes required, the original signed paper copy of the form is accessed. These forms are made available to the HoD in preparation for sign off.
3. The HoD meets with the clinician and together they sign off the *Individual Credentialling (Self-Assessment)* and *Scope of Practice* forms (unless further changes made – repeat step 2).
4. The Administrator saves a 'working file' version (MS Word) of documents within the designated e-folders and the original signed copy is scanned and saved (PDF) in the designated year-dated e-folder. The paper original is stored securely (as for personnel files) for a period of not less than 7 years.
5. In preparation for the biennial requirement to review/update the Departmental Credentialling form by 30 June, the Administrator emails the *Departmental Credentialling* form (MS Word 'working file' version) to the Service Director and HoD to review/ update as required. Once content confirmed, the document is signed off by both parties. Both WORD and PDF versions are saved in the designated e-folders. The original signed paper copy is securely stored in preparation for the next review.

Credentialling Checklist

Refer to Credentialling information management for acquisition/location of forms ***(refer page 9)***

Initial credentialing (new appointments)

☐ All new SMO/SDO/MO appointments comply with policy requirements ***(refer page 4)***

Individual Credentialling (credentialing review):

☐ All clinicians in the department have a clearly defined scope of practice (reviewed and signed off by clinician and clinical lead/ head of department 'HOD' within the last two years)

☐ All clinicians in the department have submitted their biennial individual Credentialling self-assessment within the last two years.

NB: Provision on the form for sign off only if content remains unchanged. A new form must be completed if content change required or after five years (whichever comes first).

☐ Subsequent to review/completion/sign off of the individual credentialing form, all clinicians' scopes of practice have been reviewed ***(refer page 5)*** by the clinician in conjunction with the clinical lead/ HOD.

NB: Provision on the form for sign off only if content remains unchanged. A new form must be completed if content change required or after five years (whichever comes first).

Departmental Credentialling:

☐ The departmental credentialing form has been reviewed/refreshed as required and signed off by the clinical lead/ HOD and service manager within the last year ***(refer page 6)***

NB: Provision on the form for sign off only if content remains unchanged. A new form must be completed if content change required or after five years (whichever comes first).

External Review:

☐ An external review of the department (distinct from certification/accreditation review) has occurred within the last five years.

Introduction of new/innovative clinical practices/procedures
(refer associated Policy - CPG/081) & Procedure Assessment Form):

☐ Any new/innovative clinical procedures/practices (as outlined in HBDHB Policy - CPG/081) have been assessed according to the policy and referred on to the Credentialling Committee where relevant criteria met.

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

11

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

12. Confirmation of Previous Minutes (Public Excluded)
13. Matters Arising – Review of Actions (Public Excluded)
14. Clinical Council Board Report (Public Excluded)
15. Chief Operating Officers Report (Public Excluded)
16. Topics of Interest (Public Excluded)
17. System Performance Measures Discussion (Public Excluded)
18. HRT Dashboard Report (Public Excluded)
19. Co-Chair Discussion on HRT Report (Public Excluded)
20. Patient Safety Report (Public Excluded)
21. DAA Corrective Actions Report (Public Excluded)

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).