HB Clinical Council
Monthly Meeting

Date: **Wednesday, 13 November 2019**

Meeting: **3.00 pm to 5:30 pm**

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

Council Members:

Jules Arthur (Co-Chair)
Dr Andy Phillips
Chris McKenna
Dr Mark Peterson
Karyn Bousfield
Peta Rowden
Di Vicary
Dr Mike Park
Debs Higgins
Dr Robin Whyman (Co-Chair)
Dr Kevin Choy
Dr Russell Wills
Debs Higgins
Dr Peter Culham
Dr Nicholas Jones
Anne McLeod
Dr Umang Patel

Apology:

In Attendance:

Kate Coley, ED People and Quality & Susan Barnes, Patient Safety & Quality Manager
Ken Foote, Company Secretary
Ana Apatu, Māori Relationship Board Representative
Les Cunningham, Consumer Council Representative

MONTHLY MEETING

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and apologies	3pm
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions / ToR	
5.	Clinical Council Workplan/Annual Plan - Assign coordinators	
6.	HB Clinical Council Board Report (Oct)	
7.	Co-Chairs Report	
	Section 2 – For Decision	3.20
8.	Clinical Governance Structure - Appointments	
	Section 3 – For Discussion	
9.	Community Nurse Prescribing Terms of Reference – Chris McKenna & Karyn Bousfield	3.30
10.	Collaborative Pathways verbal upate – Karyn Bousfield	3.45
11.	Steriliser event report –Dr Robin Whyman	3.55
	Section 4 - Committee Reports	
12.	Clinical Advisory & Governance Group meeting update – Dr Mark Peterson & Dr Kevin Choy	4.15
13.	Clinical Council Committee Reports- verbal updates	4.20
14.	Te Pitau Health Alliance Governance Group report – provided for information	4.35
15.	**Recommendation to Exclude the Public**	

Public Excluded

Item	Section 5 – Routine	4.35
16.	Minutes of Previous Meeting	
17.	Matters Arising - Review Actions	
18.	HB Clinical Council Board Report (Oct) – public excluded	
19.	Clinical Council Workplan – **Community, Women & Children Directorate report**	4.40
20.	Patient Safety & Clinical Quality	5.15

Next Meeting: Wednesday,11 December 2019 at 3.00 pm, Boardroom, HBDHB Corporate Office

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

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

Interests Register
Nov-19

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
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	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
	General Practice New Zealand	Executive Member			
	General Practice Leaders Forum	Member			
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	
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	
Debs Higgins (Senior Nurse)	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	Health HB	Employee	Role: Clinical Performance Support Lead	Yes	Low
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	
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	

6/11/2019

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**
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	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	
Di Vicary	Vicary Pharmacy Services Ltd	Director	Pharmacy Contracts	No	
	Pharmaceutical Society of New Zealand	Committee Member HB brnach	Supporting pharmacists in HB	Yes	Perceived personal
	HPDT	Pharmacist member	Discplinary tribunals for pharmacists	Yes	Will not sit in hearings for HB pharmacists
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	
	TAS	Wife works for TAS	Services to HBDHB & MoH	Yes	Perceived personal

MINUTES OF THE MONTHLY HAWKE'S BAY CLINICAL COUNCIL MEETING HELD IN THE TE WAIORA MEETING ROOM, CORPORATE OFFICE ON WEDNESDAY, 9 OCTOBER 2019 at 3pm

PUBLIC

Present:
Jules Arthur (Co-Chair)
Dr Robin Whyman (Co-Chair)
Chris McKenna
Dr Russell Wills
Peta Rowden
Karyn Bousfield
Di Vicary
Dr Peter Culham
Dr Mark Peterson

Anne McLeod
Dr Andy Phillips

Apologies: Debs Higgins, Dr Kevin Choy, Dr Nicholas Jones, Dr Mike Park

In Attendance:
Ken Foote (Company Secretary)
Kate Coley (Executive Director of People & Quality)
Jacqui Sanders-Jones (Board Administrator)
Les Cunningham (HB Health Consumer Council)

WELCOME AND APOLOGIES

Due to logistics for the presenter from Health Round Table, the Public Excluded section of the meeting took place before the Public section, at which welcomes and apologies were addressed.

INTEREST REGISTER

No changes noted.

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the quarterly meeting held on 11 September 2019 were confirmed as a correct record of the meeting.

Moved: Dr Russell Wills

Seconded: Dr Peter Culham

Carried

MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: **New Clinical Governance Structure/Terms of Reference–** remains ongoing action

Item 2: **Screening for Harms** – this piece of work sits with the Health Improvement & equity team and should cover wider issues than just VIP focus– **Kate Coley will take forward as an ACTION.**

Item 3: **Tò Waha** – addressed and complete.

Item 4: Health certification Findings - Complete

Item 5: Clinical Advisory and Governance Group Meeting update – item in agenda. Complete

MONTHLY WORKPLAN

Clinical Council's Workplan was agreed with the following amendments:

- November meeting will not be a shared meeting with consumer council.
- Mark Peterson chairs CAG (not Chris McKenna) – update workplan
- IS updates need to be specific to clinical council, not just a general IS update i.e. clinical portal

HB CLINICAL COUNCIL BOARD REPORT

Agreed with no further comment noted

SECTION 2: FOR DISCUSSION

- **TERMS OF REFERENCE**

Members agreed to amendment to Delegated Authority in the Clinical Council terms of reference.

- **ANNUAL OBJECTIVES 19/20**

Chairs led discussion in the review of the proposed objectives for 19/20, noting that it is essential that everyone takes a role in order to achieve these objectives and that clear allocated support of delivery should be determined. The objectives proposed try to ensure we have a tight group of realistic goals, recognising that the bulk of work would sit with the following key areas:

'Ensure the Clinical Governance Structure is fully implemented and integrated with appropriate reporting, management and administration process in place by 31 March 2020, and to

Ensure the development and implementation of a sector wide process for monitoring, reporting and effectively managing clinical risk, clinical quality and patient safety by 30 June 2020.'

Clinical Council's role is to provide advice on prioritisation and effective use of resource.

Member raised concern about capacity of the current system to deal with demand. Conversation followed on the governance pathway to Board and constraints which can develop along the way, supporting the expectation that Clinical Council unpick each risk and then decide on a plan to address.

The role of Te Pitau Health Alliance Governance Group was considered from a clinical council perspective, the connections and how the two committees work together. In response, the Alliance agreement builds in the Consumer Council, Clinical Council and MRB as advisory groups. All papers should go through advisory groups before going through Te Pitau (not the other way around) so there is timely opportunity to give feedback and input from these key stakeholders.

Practically, expectation would be that each SLA/redesign group would have timeframes set by Te Pitau. These timeframes perhaps should be captured into the workplan of Clinical Council and Consumer Council so that advice/input can be given at an earlier stage of planning process.

Tracked changes to rewording of objectives was agreed by committee members.

- **WORKPLAN 2019/20**

A draft Workplan was presented for the year, with items for the agenda which align with key objectives set in Annual Plan 19/20. Shows the flow of items to FRAC/Board.

Points 1 – 4 provide detail on what the report looks like and how the directorates should report to Clinical Council with the expected content of the presentation. Members were reminded that Clinical Council do not serve to hold Directorates to account but these presentations are sharing of clinical risks, mitigations, ongoing concerns and any new/emerging risks with a plan to elevate risks to Board in monthly reporting . Question (the comments box was miniscule for some reason) – how are we going to objectively decide the risks that require elevation to Board?

Member felt strongly that Surgical (specifically Electives access) is a high risk and should be addressed earlier in the year as it's a current issue, especially in the community. Clinical risk is reviewed each month at Clinical Council and this is where relevant concerns (such as electives) will be reviewed, however it was agreed to re-order the work programme as below;

- Surgical in February

- Mental Health in May

- Older persons and Ops in July

- Medical Directorate in April

It was recognised that there is a need for responsiveness to emerging issues and these will be addressed as required. We need to articulate how this will happen – I don't feel there is clarity in the process which I would like to suggest we work up and then discuss with our directorate colleagues at our November meeting perhaps?

ACTION – the reports of these Directorates to be brought up to Board as part of the Co-Chair's monthly board report.

Request raised for HR/Workforce risk to be brought to Clinical Council regularly every 6 months. **ACTION for inclusion Kate Coley/Workplan**

Overall, the revised Workplan felt to be a positive piece of work which allows for greater accountability.

- **COMMUNICATIONS & INCREASING OUR VISIBILITY**

Part of the communication plan in place is the update to the Clinical Council webpage on the Corporate HBDHB site, which is currently underway. This should enable greater health sector and community understanding of the Clinical Council and its role.

ACTION: Bios required from members. A short piece identifying your role, relationship with HBDHB, role in Clinical Council etc, to send through to Co-Chairs.

SECTION 3: COMMITTEE REPORTS

CLINICAL ADVISORY & GOVERNANCE GROUP MEETING UPDATE

Di Vicary, Chief Pharmacist, explained that she had met with PHO advisors as to how pharmacists were getting hold of prescribers. Guidance from PHO was to approach each prescriber through case-by-case management. There are appointments being set up with each practice however time required to do this is essential and challenging at present. This is affecting not just GPs, but also LMC and other community health professionals. Felt to be a wider issue than CAG & PHO. There is a plan in place to take this forward and address key specifics raised.

Laboratory Committee has mis-directed lab results on their radar. Working to a resolution of this.

IS continue to prove an issue with addressing misplaced lab results – THIS DOESN'T MAKE SENSE?. This has been referred to the Laboratory Advisory group (reporting through to CAG)

TE PITAU HEALTH ALLIANCE GOVERNANCE GROUP REPORT

Provided for information.

CLINICAL GOVERNANCE COMMITTEE STRUCTURE APPOINTMENTS

- **Committee Chairs review/appointments:**

  Professional Standards & Performance Committee **– Members agreed Dr Andy Phillips as Co-Chair, with other position TBC**

  Clinical Effectiveness & Audit committee **– Co Chair required TBC**

- **Clinical Council rep on IS governance group:**

  Clinician required for IS governance group **(secondary sector clinician preferred)**

  TBC – Suggestion to approach HODs.

- **Amendment to Terms of Reference for Consumer Experience Committee membership:**

  Members endorsed proposal of change to Terms of Reference of Clinical Governance Consumer Experience Committee as outlined in the report.

  Members agreed that Dr Russell Wills to be representative for Clinical Council on this committee.

GENERAL BUSINESS

- Dr Andy Phillips gave an update on strike action from Laboratory workers and Radiographers.
- Anne McLeod highlighted that CAFS & Mental Health waiting lists all severely affected by psychologists' strike.
- Steriliser incident – final report to come to committee as this was an assurance from previous Chair.

Co-Chair reported that the Ministry of Health have requested HBDHB (and other DHBs) to undertake actions, including recommendation to track critical instruments but this is recognised as being quite a massive undertaking and this is being reviewed by Business Intelligence.

All patients involved have been followed up and no one identified with ongoing issues from incident. All patients have been personally advised.

ACTION: Bring the Steriliser report back to Clinical Council (Co-Chairs) as agenda item - Workplan

4

RECOMMENDATION TO EXCLUDE

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:

11. **Topics of Interest – Member Issues / Updates**
12. **Minutes of Previous Meeting (Public Excluded)**
13. **Matters Arising – Review Actions (Public Excluded)**
14. **HB Clinical Council report to Board- August (Public Excluded)**
15. **Health Roundtable Workshop**

Karyn Bousfield closed the meeting with a karakia.

There being no further business, the meeting closed at 5.42pm

Confirmed: _____

Chair

Date: _____

4

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	12/09/18	***New Clinical Governance Structure / Terms of References***			
		• CAG TOR to be provided	Mark Peterson	TBC	Pending approval
		• Committee Chairs to provide Advisory Group (AG) TOR to Company Secretary for consistency/format review	Committee Co-Chairs	Ongoing	Ongoing
		• Committee Chairs to approve TOR for respective AGs	"	Ongoing	Ongoing
		• Clinical Council to endorse AG TOR	All	Aug AGM	
2	09/10/19	***Screening for Harms*** Small working group to prepare starter for 10 paper for discussion. Update October: This piece of work sits with the Health Improvement & equity team and should cover wider issues than just VIP focus	Kate Coley (Bernard Te Paa)	November	Ongoing
4	09/10/19	**HR/Workforce risk** Report to be brought to Clinical Council every 6 months	Kate Coley	April 2020	Every six months – onto Workplan
5	09/10/19	**Bios for Clinical Council webpage** Short word document on your role, relationship with HBDHB and role within Clinical Council to be sent Co-Chair, Julie Arthur	All	November	
6	09/10/19	**Steriliser report** **To be provided to Clinical Council for discussion item at next meeting**	Robin Whyman	November	Agenda item

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2019/20

ACTION/PROGRESS REPORT – updated monthly

OBJECTIVE	Coordination lead	PROGRESS TO xxxx
1. Provide a clinical perspective on the Implementation Plan for Whanau Ora Hapori Ora(the new 5 Year Strategic Plan for the HB health sector) and the Annual Plan for 2020/21 by 31 March 2020		
2. Co-design with Consumer Council and support the initial implementation of a detailed plan for Person and Whanau Centred Care in HB by 30 Jun 2020	**Debs Higgins & Russell Wills**	
3. Ensure the Clinical Governance Structure is fully implemented and integrated, with appropriate reporting, management and administration processes in place, by 31 March 2020	**Robin Whyman & Jules Arthur**	
4. Ensure the development and implemention of a sector wide process for monitoring, reporting and effectively managing clinical risk, clinical quality and patient safety by 30 Jun 2020		
5. Ensure the development of a HB Clinical Workforce Plan to support Whanau Ora Hapori Ora (the new 5 Year Strategic Plan), by 30 Jun 20		

@BCL@38043AB8

Clinical Council Workplan 2019/20

Meeting	Clinical Council	Current Clinical Council Workplan	FRAC	BOARD
October	HRT Dashboard Workshop – HRT	Clinical Committees Update	Dashboard (Sept) + Short report (including narrative from CC & HRT Workshop)	Summary of conversations/key topics discussed
November	Communities, Women & Children Directorate (4)	Clinical Committees Updates Collaborative pathways After Hours Urgent Care update		Summary of conversations/key topics discussed
December	HRT Dashboard	Clinical Committees Updates IS Update	Report (2) plus summary of Clinical Council dashboard	Summary of conversations/key topics discussed
January		**NO MEETINGS**		
February	Surgical Directorate	Clinical Committees Updates	Dashboard (from December CC) + Short Report (including narrative from CC)	Summary of conversations/key topics discussed
March	HRT Dashboard	Clinical Committees Updates	Report (2)	Summary of conversations/key topics discussed
April	Medical Directorate (4) Primary Care	Clinical Committees Updates	Dashboard (March) + Short Report (including narrative from CC)	Summary of conversations/key topics discussed
May	Mental Health Directorate (4)	Clinical Committees Updates Clinical Workforce Development Governance		Summary of conversations/key topics discussed

Meeting	Clinical Council	Current Clinical Council Workplan	FRAC	BOARD
June	HRT Dashboard	Clinical Committees Updates	Report (2)	Summary of conversations/key topics discussed
July	Older Persons Directorate (4) Operations Directorate (4)	Clinical Committees Updates	Dashboard (June) + Short Report (including narrative from CC)	Summary of conversations/key topics discussed
August	AGM	Clinical Council – Objectives & Workplan 2020-21	Report (2)	Summary of conversations/key topics discussed

(1) Short report – emerging issues and anything urgent
(2) Report – update on adverse events, themes and trends from patient events, update on certification, general updates, patient experience statistics, complaints, national survey etc.
(3) HQSM – to come as an when reported
(4) **Brief to Directorates** –Need to ensure that the directorate team is present (SD, ND, AH and MD). There is an expectation that the whole DLT attends please.
Provided with 30 minutes for presentation (10mins), questions and discussion (20mins).

Your brief for the presentation is:

- Describe the services within your directorate
- What is the data/indicators that you use to monitor patient safety and quality
- Share your top clinical risks
- What actions and activities are implemented to monitor and mitigate the risks
- What would you like from Clinical Council?

Please find a template for your presentation attached 

	Hawke's Bay Clinical Council
	For the attention of: **HBDHB Board**
Document Owners:	Robin Whyman & Jules Arthur (Co-Chairs)
Month:	October 2019
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board:

1. **Notes** the contents of this report

HB Clinical Council met on 9 October 2019. A summary of matters discussed is provided below:

ANNUAL OBJECTIVES

Council members discussed and confirmed a limited number of objectives for 2019/20:

1. Provide a clinical perspective on the Implementation Plan for Whanau Ora Hapori Ora (the new 5 Year Strategic Plan for the HB health sector) and the Annual Plan for 2020/21 by 31 March 2020

2. Co-design with Consumer Council and support the initial implementation of a detailed plan for Person and Whanau Centred Care in HB by 30 Jun 2020

3. Ensure the Clinical Governance Structure is fully implemented and integrated, with appropriate reporting, management and administration processes in place, by 31 March 2020

4. Ensure the development and implemention of a sector wide process for monitoring, reporting and effectively managing clinical risk, clinical quality and patient safety by 30 Jun 2020

5. Ensure the development of a HB Clinical Workforce Plan to support Whanau Ora Hapori Ora (the new 5 Year Strategic Plan), by 30 Jun 2020

It was agreed that the initial focus needs to be on Objective 4, and ensuring that effective systems and reporting is in place for Clinical Council to meet it's clinical governance responsibilities to FRAC and the Board.

The role of Clinical Council in supporting the work of the Te Pitau Health Alliance Governance Group was discussed, and the requirement for this relationship to be clarified was agreed.

WORKPLAN 2019/20

A monthly workplan for Council was discussed and agreed. This plan provides for a combination of:

- Discussion/progress on the above objectives
- Presentations on clinical issues direct from Directorates & Primary Care
- Receive/monitor clinical governance structure reports
- Clinical quality, patient safety and risk reports, workshops and performance management
- HBDHB Governance Workplan issues requiring Clinical Council input
- Review/confirm appropriate reports to FRAC/Board

COMMUNICATIONS & CLINICAL COUNCIL VISIBILITY

Agreement reached on updating the Clinical Council web page and implementing other communications to enhance the level of knowledge and understanding about Council's role.

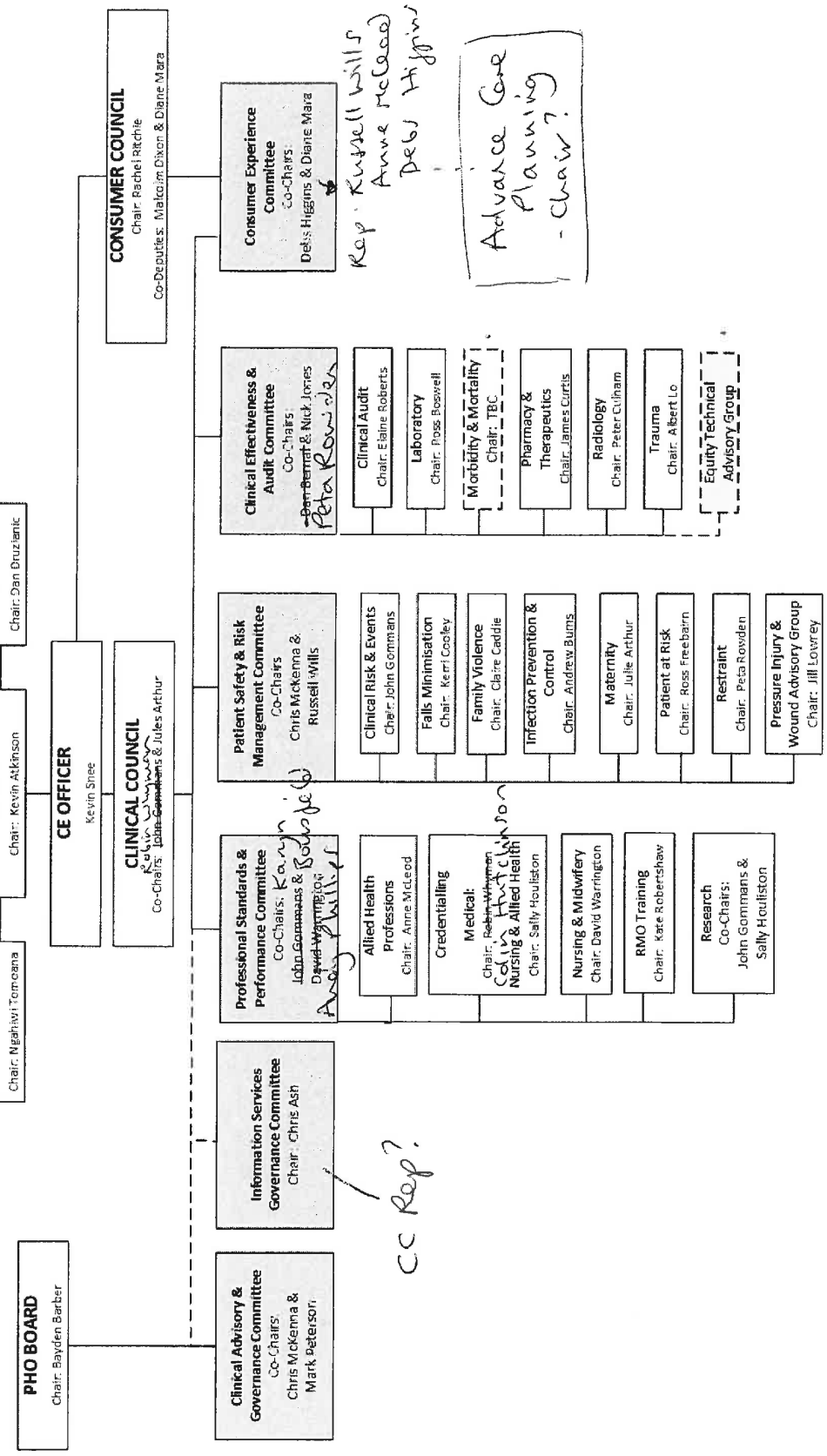
GENERAL ISSUES

Other issues discussed and/or agreed included:

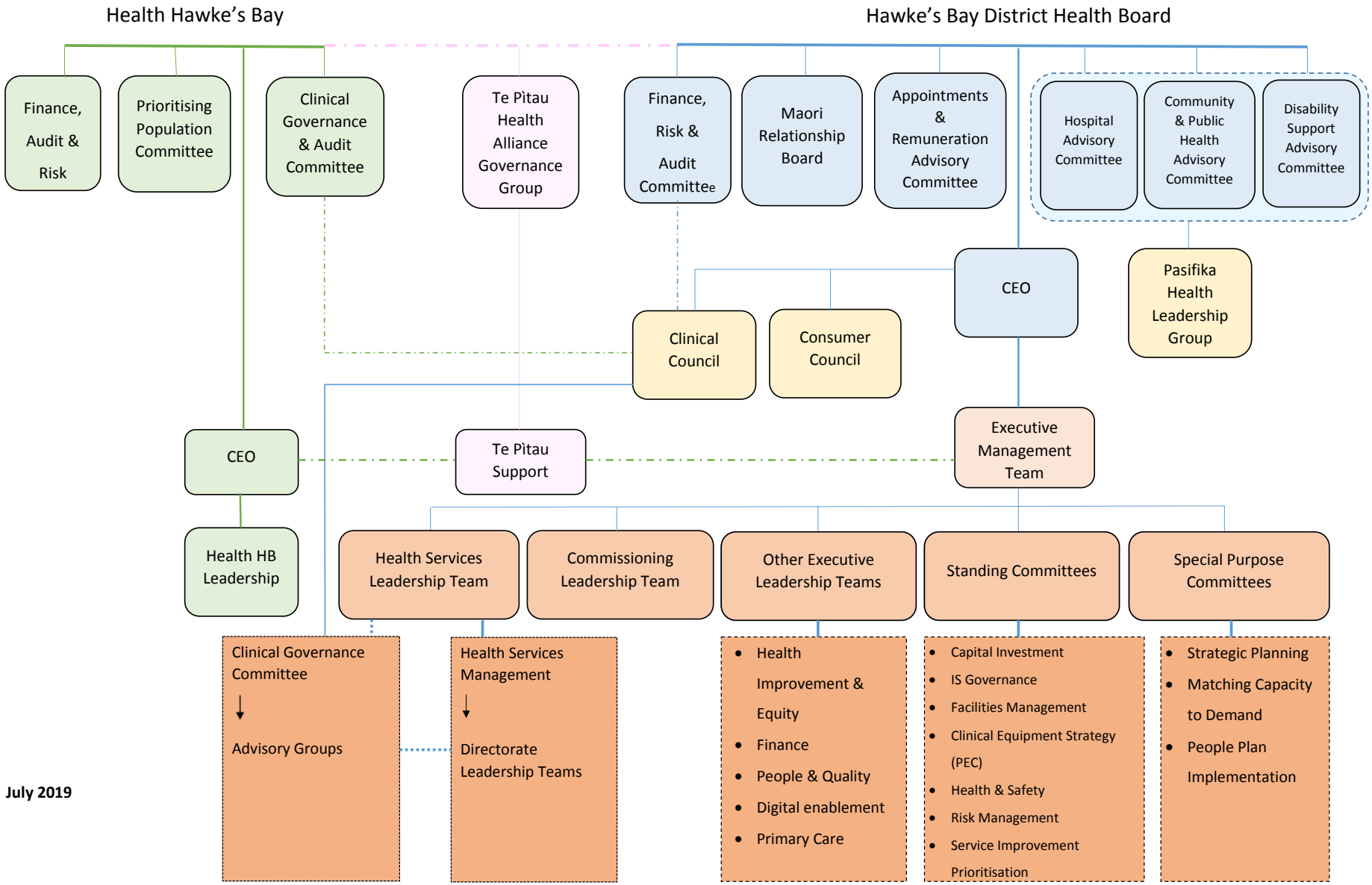
- Improving communications between prescribers and pharmacists
- Processes around minimising/managing mis-directed lab results
- Appointments of replacement Chairs to some Clinical Governance Committees
- Amending the membership provisions of the Terms of reference for the Consumer Experience Committee, from four to three members from each Council
- Clinical/patient impacts of recent strikes

CO- CHAIR'S REPORT

Verbal


CLINICAL GOVERNANCE COMMITTEE STRUCTURE
PHO BOARD
Chair: Bayden Barber
MRB
Chair: Ngahiwi Tomoana
BOARD
Chair: Kevin Atkinson
FRAC
Chair: Dan Bruzzanic
CE OFFICER
Kevin Snee
CLINICAL COUNCIL
Co-Chairs: John Gommans & Jules Arthur
CONSUMER COUNCIL
Chair: Rachel Ritchie
Co-Deputies: Malcolm Dixon & Diane Mara
Clinical Advisory & Governance Committee
Co-Chairs:
Chris McKenna & Mark Peterson
Information Services Governance Committee
Chair: Chris Ash
Professional Standards & Performance Committee
Co-Chairs: John Gommans & David Warrington
Patient Safety & Risk Management Committee
Co-Chairs
Chris McKenna & Russell Wills
Clinical Effectiveness & Audit Committee
Co-Chairs
Dan Bernat & Nick Jones
Consumer Experience Committee
Co-Chairs:
Debs Higgins & Diane Mara
Allied Health Professions
Chair: Anne McLeod
Credentialling
Medical:
Chair: Robin Wyllie
Nursing & Allied Health
Chair: Sally Houliston
Nursing & Midwifery
Chair: David Warrington
RMO Training
Chair: Kate Robertshaw
Research
Co-Chairs:
John Gommans & Sally Houliston
Clinical Risk & Events
Chair: John Gommans
Falls Minimisation
Chair: Kerri Cooley
Family Violence
Chair: Claire Caddie
Infection Prevention & Control
Chair: Andrew Burns
Maternity
Chair: Julie Arthur
Patient at Risk
Chair: Ross Freebairn
Restraint
Chair: Peta Rowden
Pressure Injury & Wound Advisory Group
Chair: Jill Lowrey
Clinical Audit
Chair: Elaine Roberts
Laboratory
Chair: Ross Boswell
Morbidity & Mortality
Chair: TBC
Pharmacy & Therapeutics
Chair: James Curtis
Radiology
Chair: Peter Culham
Trauma
Chair: Albert Lo
Equity Technical Advisory Group
Pending any changes to Executive Management Team
Version 16 (Nov 2018)

HEALTH GOVERNANCE & LEADERSHIP DECISION-MAKING STRUCTURE



July 2019

OURHEALTH HAWKE'S BAY Whakawateatia

TERMS OF REFERENCE

Nurse Prescribing Governing Group

Purpose	To advise, facilitate, and support the ongoing development of nurse prescribers and their mentors within the Hawkes Bay Health System and District Health Board (HBDHB).
Functions	**The Governing Group will explore the Nurse Prescribing role delineation and endorse how this fits within the Hawkes Bay Health System. It will ensure that the skills of nurse prescribers are aligned to this, and determine how this is overseen.** **Scope** The scope of the Nurse Prescribing Governing Group is to facilitate safe nurse prescribing within the Hawkes Bay Health System and HBDHB by ensuring that organisational and professional support is in place for nurse prescribers and their mentors. Therefore this group manages issues relating to: • Clinical and organisational processes, policies, and procedures related to safe nurse prescribing • Access to, and support for, authorised prescriber mentors • Access to ongoing professional development required for nurse prescribers to maintain competency, including access to a regularly occurring Nurse Prescribing Case Review/Peer Support Group • Supportive, collaborative, and collegial team relationships and work culture aimed at optimising patient outcomes The Nurse Prescribing Governing Group shall maintain, foster, and develop collaborative relationships with the following: • Pharmacy and Therapeutics Advisory Group • Executive Clinical Leads • Medication Event Committee • Nursing & Midwifery Leadership Advisory Group **Actions** The Nurse Prescribing Governing Group seeks to: • Ensure policies and procedures developed are appropriate to the Hawkes Bay Health System • Ensure HBDHB and Health Hawkes Bay processes, policies, and procedures enable safe nurse prescribing within the Hawkes Bay Health System • Review the findings of issues and incidents related to nurse prescribing, and ensure learnings are disseminated • Oversee the activities undertaken by the Nurse Prescribing Case Review Group
Membership	The Nurse Prescribing Governing Group shall consist of the following members: • Nurse Director x 2 • Nurse Consultant - Workforce Development

	• Chief Medical Officer (Ex-officio) • Chief Nursing and Midwifery Officer (Ex-officio) • Nurse Educator • Nurse Practitioner • Chief Pharmacist • Laboratory • Maori Nurse • Primary Health Care Nurse x 2 • Rural Nurse Specialist • Authorised Prescriber x 2 • Workforce Development Health Hawkes Bay • Chair of the Pharmacy and Therapeutics Advisory Group • Nurse Manager x 3 Additional representatives/groups may be consulted as required.
Chair	Meetings shall be chaired by the Chief Nursing and Midwifery Officer or delegated representative
Quorum	A quorum of seven for each meeting is required
Meetings	Meetings will be held every 2 months
Reporting	The Nurse Prescribing Governing Group reports to the Pharmacy and Therapeutics Advisory Group and the HBDHB Executive Clinical Leads.
Minutes	An electronic agenda and any previous draft meting minutes will be circulated to the group approximately one week before the proposed meeting

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Collaborative Pathways

External Review of Recent Event at Hawkes Bay District Health Board

Reviewers

Shelagh Thomas
RN, BN
CSSD Manager, Hutt Valley DHB
President New Zealand Sterile Sciences Association

Monette Johnston
RN, BN
Nurse Manager, Perioperative District Wide RN, Nelson Marlborough DHB

Jo Stodart
RN, MPH
Charge Nurse IPC, Southern DHB

OVERVIEW

Purpose of a Sterile Service Unit

The purpose of a Sterile Service Unit (SSU) is to provide the reprocessing of surgical equipment and to ensure that these items are free from bacteria and pathogens to prevent Surgical Site Infection (SSI) occurring through cross-infection. The effect of incorrect reprocessing of equipment has the potential to cause SSIs in patients which prolongs hospital stay, increases cost to the organisation and has a direct effect on the patient.

"SSIs can cause emotional and financial stress, serious illness, longer hospital stays, long-term disabilities, and can result in loss of life."

(Health Quality Safety Commission (HQSC), 2019)

The consequences for patients, as well as health services, means that the prevention of SSIs is extremely important, therefore following strict reprocessing and sterilising standards are essential in order to minimize risk to both patients and the organisation.

Australia and New Zealand have adopted a recognised registered set of standards by which organisations can mitigate and reduce risk to patients by following set procedures using a systematic approach. These are Australian and New Zealand standard AS/NZS4187:2014 and normative references contained therein. Contained within the standards are details of each process with an end process of tracking items sterilised to enable recall of items which have been through the process or patients as a result of post-identification of possible autoclave faults.

The SSU is a complex area where the main purpose of the unit is to process equipment through a systemic process of decontamination, appropriate packaging, sterilisation, and contain a tracking label, then stored in an appropriately designed area where staff are able to locate and retrieve as necessary. A SSU is also required to have appropriately educated / trained personnel who have completed a course of study in sterilisation techniques and processes, and shall include resources such as policies, procedures and guidelines which are easily accessed and also maintain records of prior sterilisation processes for follow-up and audit.

BACKGROUND TO EXTERNAL REVIEW

Following the events that occurred at Hawkes Bay District Health Board (HBDHB) between the periods of 1 - 11 February 2019 an internal review was undertaken by HBDHB. The purpose of the review was to demonstrate HBDHB's ongoing commitment to improve and protect the health and safety of the patients and public.

The review covered all aspects of the sterilisation failure and subsequent use of unsterile instruments on patients, risk mitigation and recall of potentially affected patients. The review was extremely thorough and is attached. The internal review documents were sent to the external reviewers on the 12 March 2019 for consideration prior to a site visit.

The Ministry of Health and HBDHB senior management team agreed that an external review of their findings was warranted in order to assure the general population of Hawkes Bay that they were not at any major risk going forward from the event and that all practical steps have been taken to prevent a recurrence in the future.

QUESTIONS FOR EXTERNAL REVIEWERS FROM HBDHB

Prior to the external review HBDHB issued a set of questions for the reviewers:

- Are the external reviewers satisfied with the three root causes identified?
- The internal review teams Terms of Reference restrict the investigation from individual staff blame. Are the external reviewers satisfied that this area was not defined within the report?
- Do the external reviewers consider that the tracking slips and scans used in the Dental clinic should be recommended for use in all departments for invasive procedures?

The identified roots causes were:

1 Full confirmation of sterilisation was not confirmed before instruments were removed from Autoclave 3.
2 Staff failed to follow HBDHB sterilisation policy and protocol checks prior to equipment dispatch from the Sterile Services Department.
3 There was a system wide failure to follow HBDHB sterilisation policy and protocol checks of sterilisation code strips on pouches and packs prior to their use in clinical department.

PROCESS UNDERTAKEN BY EXTERNAL REVIEWERS

External reviewers were invited to HBDHB to meet with the HBDHB internal review steering group personnel involved in the management of the event. The externals reviewers met with those involved to discuss the report and findings and to ask further relevant questions.

The external reviewers then took the opportunity to visit SSU as well as the Villas, District Nursing and Dental Environments. The aim of the visit to the various areas was to put the event into context as well as talk with staff who work first hand in those areas, enabling the external reviewers to answer the questions above and to offer recommendations to HBDHB to implement as well as recommendations that can be put into place as soon as possible on a national scale and supported by the Ministry of Health to prevent this occurring elsewhere.

FINDINGS FROM EXTERNAL REVIEW

FINDING ONE

The external review highlighted that on the evening of 1 February 2019 when the load was put into the autoclave there were three main factors that contributed to the event occurring. These were:

1) The technician did not recall hearing the steriliser begin its cycle after pressing the start button.

2) The printer on the autoclave had not been working for some months and this would have signalled the commencement of the cycle and would have identified at the conclusion of the cycle as to whether all sterilising parameters had been met. The review team were concerned that other loads may have potentially been unsterile due to this printer being out of action for a lengthy period of time. However further detailed discussion with members of the SSU staff and the HBDHB Internal review team allayed this concern. HBDHB were able to fully demonstrate that no other steriliser load had failed to sterilise and there was not an increased risk to the patients or the public.

3) The SSU technicians finished their shift for the night and passed responsibility for the unloading of the autoclaves to nursing staff who are not trained in sterilising technology.

Recommendations:

1) After loading the autoclave the technician does not leave the area until such time as there is evidence that the cycle has commenced. As per HBDHB CSSD policy, the technician shall identify on the autoclave printout where the cycle commences and at the end of the cycle, the technician shall sign that the load has passed and sign off on the printout.

Recommendation

It is recommended that there is regular auditing of this process.

2) It is noted that the printer on the autoclave has now been replaced and the start button inspected for function. In accordance with AS/NZS4187:2014 S8.7.1:

"Sterilising equipment shall be checked to ensure that it is functioning as intended each day, prior to being used for sterilisation of reusable medical devices. The process record shall be checked at the completion of each sterilisation cycle to verify that the process was delivered in accordance with the validated specification."

With a non-functioning printer on the autoclave for some time, the standard was not being followed. Additionally section 9.1 of the standard states:

"Prior to the release of an RMD from each process e.g. sterilisation, the process record cycle shall be checked to ensure the process has been delivered in accordance with its specifications."

Recommendation

It is recommended that all washer decontaminator and sterilising equipment is repaired immediately when a fault is detected, in order to ensure that the end product is delivered by a validated process and meets the requirements of the standard.

3) It is noted that the last load was placed into the autoclave at 22:45 PM and then the sterilising technician completed their duty at 23:00 PM after handing over responsibility for the autoclave load to the nurses on duty in theatre. It is the role of the sterilising technician to be accountable for all loads that are undergoing sterilisation. The scope of practice for sterile technicians outlines in section 8.3 and 8.4 the competencies required for operating the sterilisers and for the completion of the sterilisation procedure. This includes safe handling, traceability, monitoring, documentation and recording. The scope of practice for registered nurses does not include sterilising technology but is rather based on nursing skills.

Recommendation

It is recommended that no load be placed into the autoclaves any later than one hour prior to the conclusion of the rostered evening shift in the SSU e.g.10:00pm for an 11pm shift finishing time. This will allow for processing and release of the load to cooling prior to the sterilising technician completing their allocated shift. Recommended practice and sterilisation standards state no loads are to be left in the steriliser overnight.

It is further recommended that nursing staff do not undertake the duties of the sterilising technician as it is not within their scope of practice.

FINDING TWO

There was no clearly marked areas where items were waiting to be loaded into the autoclaves as opposed to items which had been removed from the autoclaves and awaiting release for use. AS/NZS4187:2014 S6.5.2d states that:

"Unloading the steriliser-The area in which sterilised items are unloaded shall be controlled. The environmental conditions in this area shall not adversely affect the quality of the processed RMD. RMD's sterilised by moist heat or dry heat process shall be allowed to cool prior to handling."

Recommendation

It is recommended that clearly marked out zones are identified for storage of unsterile items prior to sterilisation and sterile items that are cooling. Additionally only those staff employed as sterile technicians shall enter this area and remove sterile items to the place of storage in the sterile store.
Note: The HBDHB SSU have already drawn up plans to modify this area and it would be encouraged that HVDHB re review these in light of these findings.

FINDING THREE

The issue of fast tracking instruments sets throughout the day was cited as a reason why loads were placed in the autoclave at a late hour. SSU staff felt there was a requirement to rush everything through in case the equipment was required overnight. While SSU received a copy of the next day's elective lists they were unsure what was required as a priority.

Recommendation

It is recommended that it is communicated clearly from theatre as to which sets are a priority for the following morning lists. This could be on a whiteboard whereby theatre staff document what is required.

Repeated fast tracking of instrument sets is not best practice nor best utilisation of SSU time. It highlights that there may be a potential deficit of essential instrument sets.

Recommendation

It is recommended that there is an urgent review of the trays that are being consistently fast tracked on a daily basis and that there is consideration for an increase in the number of these sets.

FINDING FOUR

As identified in Finding One, the printer on the autoclave had not been operational and the start button on the autoclave was dysfunctional. It is noted that this has now been corrected. The external review team noted that there was no preventative maintenance contract in situ for the quarterly maintenance and annual validation processes for the autoclaves and washer disinfectors. Rather this is undertaken on an irregular basis. Had there been a contract in operation then the contractor would have this scheduled at regular intervals and the printer incident would not or should not have occurred.

Recommendation

It is recommended that there are maintenance contracts for regular scheduled maintenance of sterile services equipment as directed by the standard AS/NZS4187:2014

FINDING FIVE

HBDHB operate the MAQS tracking system to identify and report on all aspects process of reprocessing a reusable medical device (RMD). It is understood that this system is to be upgraded in early April 2019.

The standard AS/NZS 4187:2014:2.4.3.2 (b) states that traceability / tracking system shows:

(i) Sterilising process cycle number and date of sterilisation.
(ii) Identification of the steriliser, e.g. steriliser identification number or code.
(iii) Identification of the person responsible for sterilising the RMD and the date of sterilisation.
(iv) Identification of the person responsible for release of the RMD (sterilisation load) documented evidence of attainment of process parameters e.g. process/record printout. This can be electronic or manual. Where an electronic system is in place, procedures should be in place to verify attainment of process parameters at the conclusion of every cycle.

HBDHB protocols clearly define the actions to be undertaken by the sterile technicians when loading and unloading the autoclaves. On the day of the event the steriliser concerned was not identified by number or bar code for tracking. There was not documented evidence available that the process parameters had been met. The sterile technician is responsible for the loading and unloading of the autoclave however deferred the responsibility for unloading to a third party.

Recommendation

It is recommended that the tracking system upgrade includes lock outs on each step of the process of tracking, e.g. unloading cannot occur until there is evidence of sterilisation.

Instrument sets which are processed by SSU are tracked through to the patient in theatre and this meets the requirements of best practice. This event highlighted that not all RMD were able to be traced back to the patient particularly in wards and clinics which were out of the perioperative environment. The dental services at HBDHB were doing an excellent job of trying to manage tracking their sterile instruments to patients. However the manual tracking of RMD to patients and all the relevant documentation required is time consuming and could be more effectively managed if tracking were available to all users of RMD.

Recommendation

HBDHB gives consideration to expanding the scope of the tracking system to include tracking of RMD to all wards and clinics who utilise sterilised RMD. This will require access to a PC and scanner loaded with access to the tracking system similar to the programme used in theatre. The long term benefits of risk mitigation and patient safety and staff education will far outweigh the capital cost of installing the system to these areas.

FINDING SIX

In order to adhere to and excel in best practice in sterilising technology it is vital that all sterile technicians who are employed by HBDHB achieve the minimum qualification of old Level 3 or current Level 4 Certificate of Sterilising Technology. It is noted that not all sterile technicians hold this qualification. Furthermore, as a professional group under the umbrella of the Allied Health

Directorate, sterile technicians should be encouraged to have completed professional portfolios for registration with their professional body. This practice encourages continuing professional development of the sterile technician.

It is noted that there is currently no educator specifically dedicated to the training and education of sterile technicians. Professional development is by the technicians own volition, by visiting company representatives and when the sterile services manager has time. Sterile Services is a recognised profession in its own right and therefore requires specific speciality knowledge and skills.

Although the dental services had good knowledge and processed in place the other villas were unable to identify if items had been sterilised as they were unaware of the changes to the indicators on the packs, rather they took it on trust that if the item was supplied by CSSD then it 'must be sterile.' On further investigation external customers could not show they understood the importance of checking integrity of sterile items prior to opening and the correct storage of the RMD's. This has been partially addressed since the events on 1st February by ensuring all departments have visual aids to show changes in indicators on packages.

The standard AS/NZS 4187:2014:9.5 states that *"a reprocessed critical / semi-critical RMD shall be handled, transported and stored in a manner which minimizes the risk of contamination"*. Maintaining sterility of RMDs and items purchased sterile by the HSO is dependent on maintaining a suitable storage environment, education of staff and the implementation of transport systems which protect package integrity until the point of use.

Recommendation

HBDHB appoints to an educator role specifically focused on Sterile Technicians training and professional development. This role could include allocated hours dedicated to the education of external customers who use the SSD service. This was include education and auditing as per the recommended standards and audit tool AS/NZS4187:2014. The educator role would be best suited would be best suited to a senior sterile technician who has completed the advanced certificate in sterile technology or the diploma in sterile technology or working towards this. It is envisaged that the role would require a minimum 0.5to 1.0FTE.

SUMMARY

On the day of the reportable event and potentially on other days leading up to the event:

- Sterilisation processes did not conform to the standard AS/NZS4187:2014.
- There was no traceability or sterilisation records for follow up or audit process.
- Loads were not correctly checked or verified as having completed the full sterilisation cycle ensuring correct pressure and heat had been reached and maintained for the correct period of time.
- Sterilisation identifiers were not visible therefore staff not able to verify sterility.
- Flow for reprocessing of equipment from dirty to clean in SSU needs amending. Unit does not meet the current requirements for a SSU and is not conducive to best practice and the direct health and wellbeing of those personnel initiating the processes.
- There needs to be maintenance contracts in place for quarterly maintenance and annual validation of washers and autoclaves.
- Patients will receive a high standard of care through use of sterile RMD that has followed a process which is able to be tracked, audited and does not compromise on the health and safety of patients. (Health and Disability Commission 2019)
- The external reviewers were presented with three questions prior to the review.

- The review team believe that the questions have been answered without blame being placed to any one HBDHB staff member. Rather there were several failures that led to this event.

CONCLUSION

Hawkes Bay District Health Board and staff are to be commended for making open disclosure on this event. The work that the Hawkes Bay District Health Board review team undertook, in particular, the identification and follow up clinics for the potentially affected patients was completed in a timely, professional and systematic process, ensuring that all patients were informed and supported. There are lessons to be learnt not only for HBDHB but for every DHB in New Zealand as well as for the Ministry of Health.

The reprocessing of RMDs and sterile services within our health care environments has for too long been ignored by the health service management due to it not being a source of revenue, but rather requiring high cost investment. However, patient safety within New Zealand should be the number one priority.

It is recommended that going forward that the Ministry of Health should note that for all DHB's in New Zealand the following should occur immediately to prevent further incidents occurring:

- Electronic tracking and traceability systems should be installed in all sterile service units and operating theatres as soon as possible, tracking down to individual instrument level.
- Within 18 months tracking should be extended out to include all RMD used in wards and outpatient clinics.
- Annual auditing of CSSD/SSU departments against the standard AS/NZS4187:2014 is performed by an external auditor. This should be in conjunction with a robust internal auditing programme as detailed in the standard.
  Note: A document for auditing against the standard is available. The tool was specifically commissioned and developed by the New Zealand Sterile Sciences Association.

REFERENCES

Australia and New Zealand Sterilisation Standards. (2014). AS/NZS4187:2014 *"Reprocessing of Reusable Medical Devices in Health Care Service Organisations". Australia and New Zealand Sterile Sciences Association. www.nzssa.org (Retrieved March, 2019).*

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CLINICAL ADVISORY & GOVERNANCE GROUP

Verbal update

Clinical Council
Committee Representative Reports

Verbal updates

13

	Te Pītau Health Alliance (Hawke's Bay) Governance Group
	For the attention of: **HBDHB and Health Hawke's Bay Ltd Boards**
Document Owner:	Bayden Barber, Chair
Author:	Chris Ash, Executive Director Primary Care
Month:	October, 2019
Consideration:	For Information

Recommendation

That the Boards:

Note the contents of this report.

The Te Pītau Health Alliance (Hawke's Bay) Governance Group met on Wednesday 9 October 2019.

Significant issues discussed and agreed (including resolutions) are noted below.

Te Pītau Health Alliance (Hawke's Bay) Agreement

Ken Foote (Company Secretary) referred to the Te Pītau Health Alliance (Hawke's Bay) Agreement, and reaffirmed to members Te Pītau's scope and purpose, with HBDHB/PHO Board delegated authority, to improve health outcomes for the Hawke's Bay population through transforming, evolving and integrating primary and community healthcare. The effectiveness of operating arrangements to enable this will be considered in a review of the Te Pītau Health Alliance, which will take place in December.

The technical considerations associated with remunerating members of the public for involvement in redesign, including tax implications, were relayed by Ken. The issue will be considered further by management as part of the implementation plan for the Health Strategy.

Ken reminded members that Clinical Council and Consumer Council stakeholder groups are available to Te Pītau Health Alliance for support and advice.

Communications Plan

A Communications strategy, presented by Wayne Woolrich (CEO, Health Hawke's Bay) in the absence of Anna Kirk (Communications Manager), was noted by members.

Anna is to undertake a workshop with the Te Pītau Governance Group to coincide with the December review of Alliance arrangements.

Mental Health & Addiction (MH&A) Redesign Update

Resolution
The Te Pītau Health Alliance (Hawke's Bay) Governance Group:
1. **Accepted** the co-design and co-decision-making frameworks and approach as depicted in report appendices.

Janine Jensen (Senior Commissioning Manager) and Shirley Lammas (Planning & Commissioning Manager) provided a formal summary on project progress since November 2018, which covered framework (co-design/co-decision-making), design (consultation) and approach (six stages).

Following consultation with local Māori, the MH&A redesign project is to be known as Oranga Hinengaro: Well-Being of the Mind. A communications plan is being compiled.

The Government's other primary care interventions were noted, e.g. MH&A Request For Proposal (RFP), Alcohol and Other Drug (AOD) and, Crisis work (not funded within the redesign budget).

Noting the sheer volume of work in the MH&A field at present, it is important to ensure that project progression does not become frustrated by an unclear or moving scope. It was agreed that the Chair would discuss with Chris Ash and Wayne Woolrich how to resolve concerns about workload feasibility in this important area.

System Level Measure (SLM) Reporting Requirements

Resolution
The Te Pītau Health Alliance (Hawke's Bay) Governance Group:
1. **Acknowledged** the draft template for the SLM dashboard (noting potential amendments over 2019/20), and agreed to provide feedback on any changes.

Kate Rawstron (Head of Planning & Strategic Projects) and Louise Pattison (Project Manager) provided explanation on the SLM 2019/20 Quarter 3 Dashboard (example only), and the six listed MoH SLM milestones.

Suggested measurement of 'wait time to see GP' and 'improved access to primary care' were noted as future potential SLM milestones. A quarterly monitoring return was raised.

For example only purposes, Dr Peter Culham will present the Dashboard via Clinical Council.

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

16. **Minutes of Previous Meeting (Public Excluded)**
17. **Matters Arising – Review Actions (Public Excluded)**
18. **HB Clinical Council report to Board (Public Excluded)**
19. **Clinical Council Workplan- Community, Women & Children Directorate report**
20. **Patient Safety & Clinical Quality report**

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).