HB Clinical Council
Monthly Meeting

Date: **Wednesday, 2 December 2020**

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

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

Council Members:

Dr Robin Whyman (Co-Chair)	Dr Andy Phillips
Jules Arthur (Co-Chair)	Dr Russell Wills
Dr Umang Patel	Dr Nicholas Jones
Dr Kevin Choy	Dr Mike Park
Chris McKenna	Peta Rowden
Karyn Bousfield	Dr Jessica Keepa
Debs Higgins	

Apologies: Keriana Brooking, Chief Executive Officer

In Attendance:

Chris Ash, Chief Operating Officer

Susan Barnes, Patient Safety & Quality Manager

TBC, Consumer Council Representative

Sue Sowerby, Patient Safety & Quality Administrator (minutes)

MONTHLY MEETING

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and Apologies	3.00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	HB Clinical Council Board Report – November (public) – *copy for information*	
6.	Clinical Council Annual Plan Dec 2020-Dec 2021 – review draft	3.10
7.	Terms of Reference – Review terms and membership	3.20
8.	System Performance Measures – Emma Foster and Lisa Jones	3.30
9.	Quality Framework – Karyn Bousfield and Susan Barnes	3.45
	Section 2 – Reporting Committees to Council	
10.	Clinical Council Representatives and Committee Reports: - Patient Safety & Risk Management Committee	3.55
11.	**Section 3 - Recommendation to Exclude the Public**	

Public Excluded

Item	Section 4 – Routine	
12.	Minutes of Previous Meeting (public excluded)	4.00
13.	Matters Arising - Review Actions (public excluded)	
14.	HB Clinical Council Board Report – November (public excluded) *- copy for information*	
	Section 5 – Presentations / Discussion	
15.	Risk Management Report – Carriann Hall	4.10
16.	National Antimicrobial Resistance Action Plan – Implementation Process – Di Vicary	4.25
17.	Health Roundtable – Review of April-June results – Aaron Turpin	4.40
18.	Topics of Interest - Member Issues / Updates	

Item	Section 4 – Routine	
19.	Meeting Close	5.30
ENDS		

Next Meeting:

Wednesday, 3 February 2021, 3.00-5.30 pm
Te Waiora Meeting Room (Boardroom), HBDHB Corporate Office
Cnr Omahu Road & McLeod Street, Hastings

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

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HAWKE'S BAY
Whakawāteatia

Interests Register
Jul-20

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	
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	
	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	
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

11/25/2020

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	ED SMO/Consultant Locum	Consultant	No	
	TAS	Wife works for TAS	Services to HBDHB & MoH	Yes	Perceived personal
Peta Rowden	Hawke's Bay DHB – Shanelle Rowden-Read National Directors of Mental Health Nursing (DOMHNs)	Daughter Member	Health Care Assistant Collective strategic group to positively influence nursing priorities for mental health and addiction nurses in New Zealand.	Yes No	Low - family member
	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	

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**MINUTES OF THE MONTHLY HAWKE'S BAY CLINICAL COUNCIL MEETING
HELD IN THE TE WAIORA MEETING ROOM, CORPORATE OFFICE
ON WEDNESDAY, 4 NOVEMBER 2020 at 3.00 pm**

PUBLIC

Present:	Dr Robin Whyman (Co-Chair)
	Jules Arthur (Co-Chair)
	Dr Russell Wills
	Dr Andy Phillips
	Dr Nicholas Jones
	Dr Umang Patel
	Karyn Bousfield
	Dr Kevin Choy
	Dr Mike Park
	Chris McKenna
	Debs Higgins *(from 4pm)*
Apologies:	None
In Attendance:	Keriana Brooking, Chief Executive Officer
	Susan Barnes, Patient Safety & Quality Manager
	Sue Sowerby, Patient Safety & Quality Administrator (Minutes)

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Jules Arthur (Co-Chair) welcomed everyone to the meeting with a karakia.

She took the opportunity to formally acknowledge Dr Nick Jones on being awarded a New Zealand Public Service Medal for his outstanding commitment to public health. Clinical Council members joined in congratulating Dr Jones for the award which recognises the tremendous amount he has contributed as a leader in public health in Hawke's Bay.

2. INTEREST REGISTER

No conflicts of interest were noted for the meeting. Robin Whyman asked members to ensure they remember to update the register if they take on a new role which may be perceived to be a conflict.

3. MINUTES OF PREVIOUS MEETING

The minutes of the Hawke's Bay Clinical Council meeting held on 7 October 2020 were confirmed as a correct record of the meeting.

Moved: Dr Kevin Choy
Seconded: Dr Umang Patel
Carried.

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4.   MATTERS ARISING, ACTIONS AND PROGRESS

Item 1:   Clinical Council Appointments
Robin Whyman advised that the appointment of Dr Jessica Keepa had been approved by the CEs of the DHB and Health HB and that he had a phone meeting scheduled with Dr Keepa on Friday. He expected she would commence at the December meeting.

Andy Phillips reported that an appointment to the Chief Pharmacist appointment was imminent and he expected the appointee would fill the Allied Health position on Council.

Item 2:   Clinical Council newsletter
Due in March 2021

Item 3:   Review Terms of Reference and Membership
Item 4:   Develop 2020/21 Annual Plan
On agenda.

5.   CHIEF EXECUTIVE'S UPDATE

Robin Whyman advised that he and Jules Arthur had met with the CE and that Keriana Brooking would provide an update at each meeting. Ms Brooking noted the appointment of Hon Andrew Little as Minister of Health and noted the Prime Minister's up-coming speech the following day outlining the government's early term priorities. Particular interest for the health sector will include thought beyond COVID. She commented that health is not alone on issues of infrastructure and workforce.

Keriana noted she was pleased to have a regular opportunity to provide an update on the national political landscape and engage with Clinical Council members, adding there are four areas she has identified that she would like to see progress on:
- What is our narrative – multiple documents that have been produced over the past 3-5 years lack an action focus
- The six domains of quality and their relationship with Patient Quality and Safety
- The infrastructure of our system
- The development of Models of Care.

Robin thanked Keriana, noting the themes she has raised will be woven into Clinical Council's workplan.

6.   CLINICAL COUNCIL WORK PLAN 2020/21

A workshop discussion was held which captured goals and themes Clinical Council members wish to focus on over the next 12 months. It was agreed to measure the goals against the HQSC governance framework. The Co-Chairs will formulate the work plan from the discussion for confirmation at the December meeting.

7.   TERMS OF REFERENCE - REVIEW

The Council noted the feedback from Board regarding the need to review the Terms of Reference for equity, Treaty compliance and membership. Robin Whyman noted he and Jules Arthur would meet with Patrick Le Geyt before this work is progressed at the December meeting.

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8. QUALITY FRAMEWORK

Susan Barnes, Manager Patient Safety & Quality, introduced a draft Patient Safety and Quality Framework paper which identifies what is expected at each level of governance within the organisation. The Framework and an implementation plan will be further developed following this discussion.

SECTION 2: REPORTING COMMITTEES TO COUNCIL

9. CLINICAL COUNCIL REPRESENTATIVES AND COMMITTEE REPORTS

None.

10. SECTION 3: RECOMMENDATION TO EXCLUDE

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

11. Minutes of Previous Meeting (public excluded)
12. Matters Arising – Review Actions (public excluded)
13. HB Clinical Council Board Report – July (public excluded)
14. Health Round Table – quarterly report
15. Patient Safety – quarterly report
16. Topics of Interest - Member Issues/Updates

The meeting closed at 4.30 pm

Confirmed: _____

            Co-Chairs

Date: _____

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**HAWKE'S BAY CLINICAL COUNCIL
MATTERS ARISING / ACTIONS**

**(Public)
As at November 2020**

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1.	03/06/20	***Clinical Council Appointments*** Appointment of a Senior Allied Health Professional on Council to be confirmed.	Co-Chairs/ Andy Phillips		**In progress**
2.	Oct-20	***Clinical Council newsletter to wider health sector*** (from 2019 AGM) • Develop a regular (monthly?) newsletter with key messages for distribution across the sector	Co-Chairs	Mar 2021	
3.	Oct-20	***Review Terms of Reference and Membership*** Meet with Patrick Le Geyt Provide input to Co-Chairs to be compiled for discussion at the December meeting	Co-Chairs All	Nov Nov	
4.	Nov-20	***Develop 2020/21 Work Plan/Annual Plan*** Develop documents for December meeting	Co-Chairs	Oct	

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OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council (Public)**
	For the attention of: **HBDHB Board**
Document Owner:	Jules Arthur (Co-Chair) Dr Robin Whyman (Co-Chair)
Month:	November 2020
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board:

- **Note** the contents of this report

Council met on 4 November 2020. An overview of matters discussed is provided below:

1. Chief Executive update

Robin Whyman advised that he and Jules Arthur had met with the CE and that Keriana Brooking would provide an update at each meeting. Ms Brooking noted the appointment of Hon Andrew Little as Minister of Health and noted the Prime Minister's up-coming speech the following day outlining the government's early term priorities. Particular interest for the health sector will include thought beyond COVID. She commented that health is not alone on issues of infrastructure, models of care and workforce.

2. Clinical Council Work Plan for 2020/21

A workshop discussion was held which captured goals and themes Clinical Council members wish to focus on over the next 12 months. The Co-Chairs will formulate the work plan from the discussion for confirmation at the December meeting. The Annual Plan objectives will also be finalised at the December meeting.

The Council noted the feedback from Board regarding the need to review the Terms of Reference for equity, Treaty compliance and membership. The Clinical Council agreed and intends to progress this work at the December meeting.

3. Quality Framework

Susan Barnes, Manager Patient Safety & Quality, introduced a draft Patient Safety and Quality Framework paper which identifies what is expected at each level of governance within the organisation. This paper was discussed at Clinical Council and how the framework would shape the Council's workplan. The Framework and an implementation plan will be further developed following this discussion.

4.   Next meeting

The next meeting of the Hawke's Bay Clinical Council is on 2 December 2020.

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2020/21

AREA OF FOCUS	ACTIVITIES	TIMEFRAME	PROGRESS
Clinical Effectiveness	1 HRT Quarterly Report 2 System Performance Measures 3 Te Ara Whakawaiora		
Patient Safety & Quality	1 Implementation of the clinical governance framework 2 Implementation of Safety1st		
Engaged & Effective Workforce	1 CCDM		
Equity	1 Review of Terms of Reference		
Consumer Engagement	1 Potaka Korero 2 Consumer engagement framework 3 Inpatient survey		

TERMS OF REFERENCE

Hawke's Bay Clinical Council

September 2019

Purpose	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system.
Functions	The Hawke's Bay Clinical Council (Council) • Provides clinical advice and assurance to the Hawke's Bay health system management and governance structures. • Works in partnership with the Hawke's Bay Health Consumer Council to ensure Hawke's Bay health services are organised around the needs of people. • Provides oversight of clinical quality and patient safety. • Provides clinical leadership to the Hawke's Bay health system workforce. • Ensures decisions and recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety and experience of care for individuals; improved health and equity for all populations; best value for public health system; and improved experience of providing care).

Level of Authority	The Council is appointed by, and is accountable to, the CEO of HBDHB.
	
	The Council has the authority to provide advice and make recommendations, to the CEOs and Boards of HBDHB and Health Hawke's Bay Limited (as appropriate).
	
	To assist it in this function the Council may:
	• Request reports and presentations from particular groups
	• Establish sub-groups to investigate and report back on particular matters
	• Commission audits or investigations on particular issues
	• Co-opt people from time to time as required for a specific purpose.
	
	The Council's role is one of governance, not operational or line management.
	
	Delegated Authority
	
	The Council has delegated authority from the CEOs and Boards to:
	
	• Make decisions and issue directives on quality clinical practice and patient safety issues that:
	  ▪ Relate directly to the function and aims of the Council as set out in the Terms of Reference; and
	  ▪ Relate directly to the provision of, or access to, HBDHB publicly funded health services; and
	  ▪ Are clinically and financially sustainable
	
	All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the HBDHB.

Membership	Members appointed by tenure shall normally be appointed for three years, whilst ensuring that approximately one third of such members 'retire by rotation' each

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

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	Hawke's Bay DHB Quarter 1 2020/21 Health System Performance Dashboard	
	For the attention of: **HBDHB Clinical Council**	
Document Owner	Emma Foster, Executive Director of Planning & Funding (Acting)	
Author	Lisa Jones, Portfolio Manager	
Month/Year	November 2020	
Purpose	For noting and feedback	

RECOMMENDATION:

That the HBDHB Clinical Council:

1. Note the contents of the report and provide feedback on the refreshed dashboard.

EXECUTIVE SUMMARY / INTRODUCTION

A refreshed Corporate Performance Dashboard renamed the "Health System Performance Dashboard" has been developed to focus on the performance of Hawke's Bay DHB Health System Priorities:

- First 1000 days
- Mental Health and Addictions
- Long Term Conditions
- Frail and Older People
- Responsive Health system

A set of Ministry of Health Statement of Performance Expectations (SPE) and System Level performance measures (SLM) have been aligned to the system priorities. This set does not cover all metrics available, but highlights key measures that should be the focus if we want to improve outcomes in key priority areas.

Indicators in areas of Human Resources and Finance, which were in the previous corporate dashboard, are now excluded and available via existing reporting to the Board. The inclusion of a Quality and Patient Safety Dashboard in this suite of reporting is under development. This is the first time this new format has been used and we would like feedback from the Board.

Overview
The dashboard report is split in two parts:

Part 1:   Performance Highlights of Strategic Priorities in Q1 2020/21

This part of the report highlights where we have good performance and where we have deterioration or persistent poor performance.

The *Equity Top 5* are our "Top five indicators" where we have good performance and "Top five indicators" where we are performing poorly on equity in performance. The *Trend Movements* provide an indication on where we are seeing improvement and deterioration in performance in the current reporting quarter compared to the previous quarter. *Trend Endures* is where we are seeing "consistent green" (good performance) in the last four quarters and "stubborn red" (poor performance) in the last four quarters.

Part 2:   Health Systems Priorities Dashboard

In this part of the report we review our performance against targets we have agreed with the MOH and in our Statement of Performance Expectations (SPE) in each of our strategic priority areas. We also look at equity in our performance. Equity is how well are we doing for Māori and Pacific to meet the overall target. Goal direction indicates which direction we want the indicator to go i.e. increase or decrease.

Depending on the direction of the indicator the "Additional # (Number) to meet target" can be:
- How many less people are needed to meet target if the Goal direction is a down arrow e.g. the number of patients admitted for Ambulatory Sensitive Hospitalisation's in a 12-month period to meet target. We want less people hospitalised.
- How many more people we need to access service to meet target (Goal direction arrow up) e.g. the additional number of women having a breast screening in last 2 years to meet target. We want more people screened.
- Some indicators are focused on Maori performance only and the "Additional # (Number) to meet target "are for Maori only".

An exception report covering areas of concern will also accompany the dashboard in the future.

Appendices:

Attachment A........Highlights of Strategic Priorities as at 2020/2021 Q1
Attachment B........Health System Performance Dashboard as at 2020/2021 Q1
Attachment C........Quality and Patient Safety Dashboard (under development)

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HIGHLIGHTS of Strategic Priorities as at 2020/2021 Q1

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EQUITY - TOP 5

Top Performance

% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (Service provision 24/7)
Acute bed days per 1000 population (in the last 12 months) 65 years + (Māori and Pacific) and 75 years + (Other)
Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years (Māori)
% of Māori population enrolled in the PHO
% of 65+ year olds immunised - flu vaccine

Under Performance

Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000
% of zero-19 year olds seen within 3 weeks of referral Mental health provider arm
% of zero-19 year olds seen within 8 weeks of referral Mental health provider arm
% of the eligible population will have had a CVD risk assessment in the last five years
% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice

TREND MOVEMENTS

Leaving Red for Amber

% reduction in the rate of Māori under s29 orders per 100,000 population

Leaving Green for Amber

Newly Green

% of new-borns enrolled in general practice by 3 months of age
Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years (Māori)
% of zero-19 year olds seen within 3 weeks of referral Addictions (provider arm and non-government organisation(NGO))
% of older patients assessed as at risk of falling receive an individualised care plan
% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)

Newly Red

% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.
Acute rheumatic fever initial hospitalisation rate per 100,000
Acute readmissions to hospital
% of zero-19 year olds seen within 8 weeks of referral Addictions (provider arm and NGO)
% of women aged 50-69 years receiving breast screening in the last 2 years

TREND ENDURES (last 4 Quarters)

Consistent Green

% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan
% of Māori population enrolled in the PHO
% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.

Stubborn Red

% of women booked with an LMC by week 12 of their pregnancy (Māori)
% of the eligible population will have had a CVD risk assessment in the last five years
Ambulatory sensitive hospitalisations (ASH) rate per 100,000 45-64 years
% of zero-19 year olds seen within 3 weeks of referral Mental health provider arm
Community services transition (discharge) plans: % of clients discharged from community MH&A will have a transition (discharge) plan
% of clients discharged will have a quality transition or wellness plan
% of women aged 25-69 years who have had a cervical screening event in the past 36 months
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)
% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date
% of patients waiting over four months for FSA (ESPI 2)
% of patients waiting over 120 days for treatment (ESPI 5)
% of Ophthalmology patients that wait more than or equal to 50% longer than the intended time for their appointment.
% of ACS patients undergoing coronary angiogram - door to cath within 3 days

Key

🟥 Stubborn Red: In Red for the last 4 periods

🟧 Newly Red: the current period is Red

🟨 Leaving Green for Amber: Moved from Green (previous period) to Amber (current period)

🟨 Leaving Red for Amber: Moved from Red (previous period) to Amber (current period)

🟩 Newly Green: the current period is in Green

🟩 Consistent Green: In Green for the last 4 periods

HB Clinical Council 2 December 2020 - System Performance Measures

Health System Performance Dashboard as at 2020/2021 Q1

First 1000 days

Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
% of women booked with an LMC by week 12 of their pregnancy (Māori)	≥ 80%	N/A	43.0%	N/A	↑	61
% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	≥ 90%	72.0%	78.3%	-	↑	5
SLM Number of Māori babies who live in a smoke-free household at 6 weeks post-natal	≥ 68%	N/A	31.5%	N/A	↑	230
% of new-borns enrolled in general practice by 3 months of age	≥ 85.00%	85.5%	71.7%	101.4%	↑	-
% of infants exclusively breastfed at 3 months	≥ 70%	70.0%	68.0%	58.0%	↑	-
% of eight-month-olds fully immunised	≥ 95%	89.9%	80.7%	100.0%	↑	25
% of two-year-olds have completed all age-appropriate immunisations due between birth and age two years	≥ 95%	92.6%	91.9%	94.9%	↑	13
% of preschool children (aged 0-4 years of age) enrolled in and accessing community oral health services (Yr1)	≥ 95%	DSA	DSA	DSA	↑	530
Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years (Māori)	≤ 8,205	N/A	7,323	N/A	↓	-

Mental Health and Addictions

Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
% of zero-19 year olds seen within 3 weeks of referral Mental health provider arm	≥ 80%	75%	75%	74%	↑	30
% of zero-19 year olds seen within 3 weeks of referral Addictions (provider arm and non-government organisation(NGO))	≥ 80%	83%	77%	100%	↑	-
% of zero-19 year olds seen within 8 weeks of referral Mental health provider arm	≥ 95%	91%	89%	100%	↑	-
% of zero-19 year olds seen within 8 weeks of referral Addictions (provider arm and NGO)	≥ 95%	90%	82%	100%	↑	2
Community services transition (discharge) plans: % of clients discharged from community MH&A will have a transition (discharge) plan	≥ 95%	78.1%	-	-	↑	67
% of clients discharged will have a quality transition or wellness plan	≥ 95%	65%	-	-	↑	109
% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan	≥ 95%	99%	-	-	↑	-
% reduction in the rate of Māori under s29 orders per 100,000 population	≤ 395	N/A	397	N/A	↓	3
Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	≤ 64	54.5	67.3	21.7	↓	-

Responsive Health System

Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
% of Māori population enrolled in the PHO	≥ 95%	N/A	99%	N/A	↑	-
% of children (aged 0-12 years of age) overdue for their scheduled examinations with Community Oral health service (Yr1)	≤ 10%	24.3%	22.9%	22.6%	↓	4,446
% utilisation of DHB funded dental services by adolescents for school Year 9 up to and including 17 years (Yr1)	≥ 85%	DSA	DSA	DSA	↑	DSA
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	65.0%	55.8%	62.1%	↑	1,155
% of women aged 25-69 years who have had a cervical screening event in the past 36 months	≥ 80%	68.1%	63.6%	63.8%	↑	5,078
% of people who returned a positive FIT have a first offered diagnostic date that is within 45 working days or less of their FIT result being recorded in the NBSP information system.	≥ 95%	DNA	DNA	DNA	↑	DNA
% of patients with accepted referrals for Computed Tomography (CT) scans who receive their scan, and scan results are reported, within 6 weeks (42 days)	≥ 95%	DNA	-	-	↑	DNA
% of patients with accepted referrals for MRI scans who receive their scan, and the scan results are reported, within 6 weeks (42 days).	≥ 90%	DNA	-	-	↑	DNA
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),	≥ 90%	93.4%	-	-	↑	-
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 calendar days)	≥ 70%	37.9%	-	-	↑	144
% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	≥ 70%	44.0%	-	-	↑	100
% of patients waiting over four months for FSA (ESPI 2)	0%	23.6%	29.3%	24.3%	↓	1,227
% of patients waiting over 120 days for treatment (ESPI 5)	0%	22.1%	23.1%	24.1%	↓	422
% of Ophthalmology patients that wait more than or equal to 50% longer than the intended time for their appointment.	0%	31.9%	-	-	↓	1,107
Did not attend (DNA) rate across first specialist assessments	≤ 6%	5.1%	9.6%	11.3%	↓	-
Planned care interventions for people living within the HBDHB region.	≥ 10,529	DNO	DNO	DNO	↑	DNO
% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)	≥ 95%	100%	-	-	↑	-
% of ACS patients undergoing coronary angiogram - door to cath within 3 days	≥ 70%	54.7%	56.3%	66.7%	↑	10
% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval (Service provision 24/7)	≥ 12%	9.0%	20.0%	-	↑	1
% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	≥ 85%	88.2%	-	-	↑	0
% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	≥ 90%	75.9%	-	-	↑	8

Long term conditions

Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	≥ 90%	DNA	DNA	DNA	↑	DNA
Acute rheumatic fever initial hospitalisation rate per 100,000	≤ 1.5	1.7	N/A	N/A	↓	0
% of the eligible population will have had a CVD risk assessment in the last five years	≥ 90%	82%	79%	76%	↑	4,475
% of people with diabetes who have good or acceptable glycaemic control (HbA1c<64mmols)	≥ 60%	DSA	DSA	DSA	↑	DSA
Ambulatory sensitive hospitalisations (ASH) rate per 100,000 45-64 years	≤ 3,510	4,277	7,938	7,642	↓	382
% of patients admitted with acute stroke are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	DNO	DNO	DNO	↑	DNO
% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	≥ 60%	DNO	DNO	DNO	↑	DNO
Acute readmissions to hospital	≤ 11.80%	12.50%	13.99%	13.87%	↓	-

Frail and Older people

Performance Measures	Target	Current performance	Māori	Pacific	The Goal	Additional # to reach target
% of 65+ year olds immunised - flu vaccine	≥ 75%	73%	77%	66%	↑	605
% of older patients given a falls risk assessment	≥ 90%	90%	-	-	↑	-
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 90%	93%	-	-	↑	-
Number of Needs Assessment and Service Coordination (NASC) completed assessments (first assessment, reassessments and 3 year routine assessments).		DNO	DNO	DNO		DNO
Acute bed days per 1000 population (in the last 12 months) 65 years + (Māori and Pacific) and 75 years + (Other)	≤ 2,002	1,799	1,689	1,371	↓	-
The average number of subsidised permanent Health of Older People (HOP) and Long Term Support - Chronic Health Conditios (LTS-CHC) residential beds per night per 1,000 of the 65+ population.	≤ 35	DSA	DSA	DSA	↓	DSA
Acute readmission rate: 75 years +	≤ 12.0%	12.3%	14.5%	22.1%	↓	-

Key

Green	Target achieved or exceeded
Amber	Within 0-5% of target
Red	More than 5% below target
N/A	Not relevant for the target
DNP	Data not Provided (data not from internal sources, not released to us)
DNO	Data not Obtainable (does not exist)
DNA	Data not Available (data from external sources, not released to us yet)
DSA	Bi-Yearly/Seasonal/Annual (data NOT captured every quarter)

Quality and Patient Safety						
Performance Measures	Target	Current performance	Māori	Pasific	The Goal	Additional # to reach target

NOTE: "Quality and Patient Safety" is under development.

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Hawke's Bay DHB

Clinical Governance Framework

Introduction

Good clinical governance is described as *'the system by which the governing body, managers, clinicians and staff **share responsibility and accountability** for the **quality of care, continuously improving, minimising risks** and fostering an environment of excellence in care for consumers, patients, and community''*.

An ***effective clinical governance mechanism*** that ***is integrated within all levels*** of the health system is essential to ensure improvement in:

- Patient outcomes
- Patient experience
- Quality of care
- Staff wellbeing
- Equity.

Our quality commitment:

Hawke's Bay DHB is committed to promoting and supporting a robust and integrated clinical governance framework that strengthens and sustains ongoing improvement to deliver health outcomes that are:

- Patient (and whānau) centred
- Equitable
- Safe
- Clinically effective
- Timely
- Efficient (good value for resource)

The Institute for Healthcare Improvement (IHI) has identified that **all** of the above dimensions or characteristics **must be present and integrated within** the system to establish and maintain quality healthcare.

If not, the message is simple; you can have health services that are: safe, but don't deliver equitable outcomes, timely, but not clinically effective, Patient and whānau centred, but not efficient.

The dimensions are also consistent with the NZ Quadruple Aim and are the foundation for *'A collaborative venture between clinicians, managers and consumers, to create a culture where quality and safety is everybody's primary goal'*.

The Victorian **Clinical Governance Framework** Figure.1 (Victorian Clinical Governance Policy Framework, 2009) aligns both quality and safety domains and provides the key principles, components or 'building blocks' on which good clinical governance is based. These 'building blocks' provide a structure for strategies and plans that improve and enhance the quality of care.
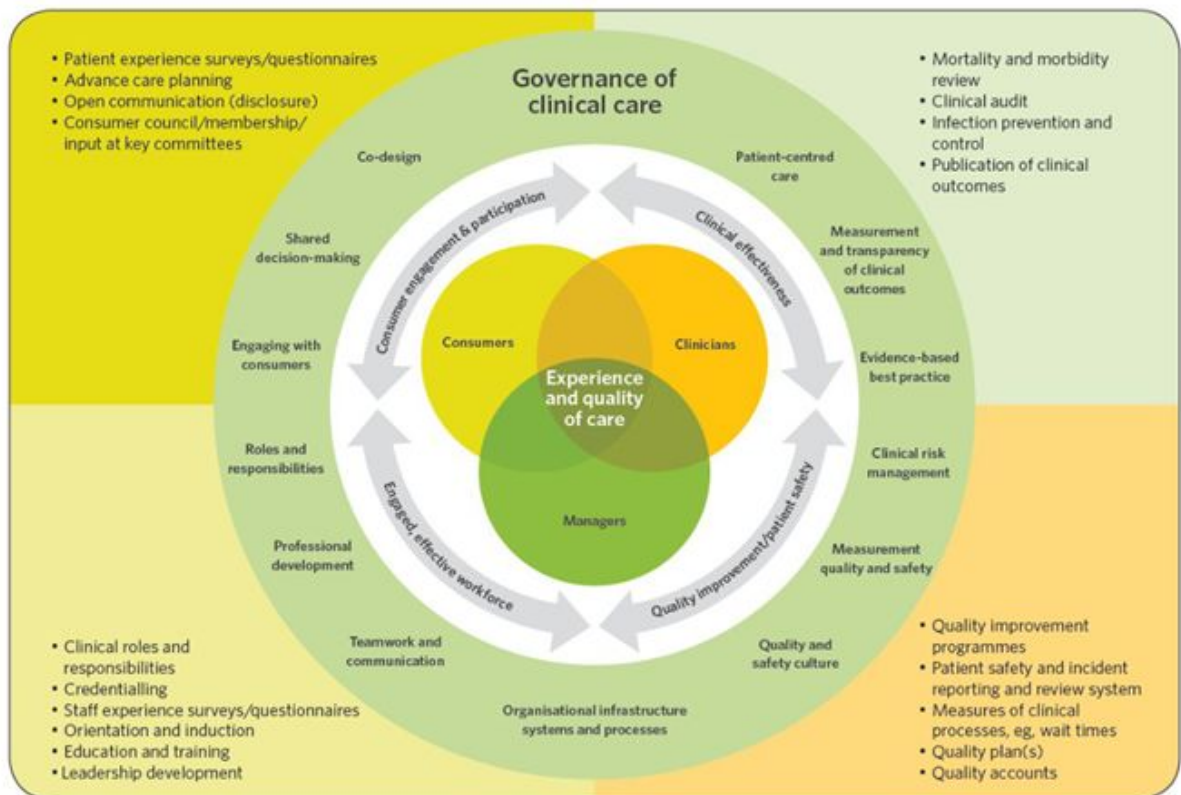
Hawke's Bay DHB

Clinical Governance Framework

The key components of the framework include:

• Consumer engagement and participation: able to find, understand and use health information. Improved equity as they are empowered to make informed decisions about their own care in partnership with clinical staff and take part to co-design, deliver and evaluate the services they use.

• Clinical effectiveness: apply knowledge, derived from research, clinical experience and consumer preferences to improve equity and achieve optimum patient care processes and outcomes

• A commitment to work on quality improvement and patient safety

• An engaged, effective workforce

Figure 1: The key components of the clinical governance framework

Hawke's Bay DHB

Clinical Governance Framework

Here at HB DHB we are committed to adopting this framework and using it as the mechanism to drive high quality safe patient care. It should be incorporated into service and care planning and delivery at all levels across the organisation and based on the following principles.

- Priorities & strategic direction are clear, communicated, & understood
- Roles & Responsibilities clearly defined & understood by all
- Strong clinical leadership & ownership
- Rigorous performance & progress measurements, including reporting and review
- Continuous quality & safety improvement; co-designed with consumers/whānau
- Compliance with legislation, certification requirements & relevant standards
- Culture, systems, processes & structures e.g. committees to support safety & quality improvement initiatives
- Consumer experience focus throughout the care continuum
- Integrated processes where the six quality dimensions (characteristics) are 'just the way we do things round here'

The roles, expectation and accountabilities of the Hawke's Bay DHB structures in the clinical governance framework are outlined in the table below.

Roles, expectation and accountability:

Role	Expectation and accountability
HBDHB Board	- Provide governance & oversight of all quality improvement activities - Set the organisation's strategic quality direction, along with clear & measurable improvement goals - Set & champion a culture where the quality & safety of consumer care is at the heart of everything we do - Each board meeting has a focus on clinical quality & patient safety (CQPS) - Hold management to account for compliance with key CQPS domains (as per Figure 1.). - Set clear quality & safety expectations of staff - Communicate compellingly about quality and safety - Hold the CEO accountable for quality and safety goals.
Chief Executive Officer	- Overall quality & safety accountability - Ensure appropriate resource is available to create the right environment for organisational learning.
Clinical Council	- Provide clinical advice & assurance to the Hawke's Bay health system management & governance structures. - Work in partnership with the Consumer Council to ensure Hawke's Bay health services are organised around the needs of people. - Provide oversight of clinical quality & patient safety. - Provide clinical leadership to Hawke's Bay health system workforce.

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Clinical Governance Framework

	• Ensure decisions & recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety & experience of care for individuals; improved health & equity for all populations; best value for public health system; & improved experience of providing care).
Consumer Council	• Ensure, coordinate & enable appropriate consumer engagement across the Hawke's Bay, Central Region & national health systems. • Champion 'Person & Whanau Centred Care' • Provide input into health service priority & strategic direction development, the reduction of inequities, & the enhancement of consumer engagement, patient safety, clinical quality & making health easy to understand. • Participate, review and advise on reports, developments and initiatives relating to Hawkes Bay health services and the availability and/or dissemination of health related information. • Ensure regular communication and networking with the community and relevant consumer groups. • Link with special interest groups, as required for specific issues & problem solving.
Health Services Leadership Team (HSLT)	• Hold Directorate Leadership Teams (DLT) accountable for the indicators above • Assist leaders to improve.
Planning and Funding	• Ensure system response & services meet the requirements set out by governing structures, which lead to improved population health status & equitable outcomes. • Ensure from a planning perspective, quality improvement from a whole of system view is prioritised
Directorate Leadership Teams (DLT)	• Implement the strategic direction, manage operations, & report on safety & quality. • Utilise & implement the clinical governance framework to supports & encourage high quality care & safety culture throughout the directorate • Lead & oversee the quality activities of clinical teams • Engage with support services to analyse performance data to enable effective planning for service improvement • Plan & implement service improvements.
Patient Safety and Quality Service	• Expert patient safety & quality advice • Provide leadership & support to enable directorates to develop & implement robust clinical governance frameworks

Hawke's Bay DHB

Clinical Governance Framework

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	• Provide leadership & support to enable directorate teams & Executive Leads to demonstrate compliance* in all aspects of quality, safety & clinical risk to:
	   ○ regulators
	   ○ stakeholders
	   ○ the public
	Compliance may be demonstrated via Clinical Governance Frameworks, directorate quality & safety plans & clinical dashboards.
	• Promote a positive & just patient safety & quality improvement culture.
	• Assist directorates to identify & analyse data* to inform & enable improvement initiatives.
	*Data includes: incident, complaint, serious event, investigation outcomes &/or themes; mortality reviews; consumer feedback, Health Round Table (HRT) data
	• Provide training to support optimal care delivery
	• Assist directorates to understand their role within clinical governance & take ownership of that role

Staff / Workers	• Critically review the quality of care provided; individually & as part of the wider team • Implement changes that will improve quality • Raise issues that require a wider system response

<mark>It needs a short closing paragraph</mark>

Quality Framework (IHI Dimensions) Hawke's Bay DHB

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	Patient and Whanau Centered	Equity in health and wellness	Safe	Efficient (value for resource)	Timely	Clinically Effective
WHAT GOOD LOOKS LIKE	Patient & whanau centered care is evident across the whole health care spectrum.	Policies, systems & processes enable proactive & responsive service delivery. I.e. takes account of the complex health, cultural, economic & social conditions that contribute to health inequities in our community.	Culture – noticing mistakes, bringing them to the fore, & learning from them is acceptable & expected i.e. it is the norm	The relationship between efficiency & effectiveness is understood. Waste is reduced, efficiency is increased, effectiveness is improved or maintained so that patients & whānau are better served	Consistent service provision review that takes into account efficiency & effectiveness to ensure care is available when needed.	Best knowledge, derived from research, clinical experience & patient/whānau feedback is used to achieve optimal processes & care outcomes.

SUCCESS ELEMENTS

Clinical & Cultural Leaders within the Senior Management Team
Clear responsibility & accountability for Clinical Governance at all levels.
Clinical Governance is defined, clear, integrated, & understood.

Patient and Whanau Centered	Equity in health and wellness	Safe	Efficient (value for resource)	Timely	Clinically Effective
Systems support consumer/patient centered care & cultural safety.	Governance is consistent with Te Tiriti o Waitangi structure to ensure cultural safety.	Quality & patient safety is a strategic priority for the Board/organisation.	Quality improvement & change management methodology - act quick, fail quick, change quick		Data & information is relevant, accurate, consistent & useable. I.e. has veracity to drive & support innovation, improvement, minimization of harm & waste.
Health care & health information is easy to access, understand & use i.e. health literate.	Equity Framework that aligns with our goals, other relevant frameworks & informs decision making.	Staff/workers have the skills, knowledge, information & resources to realise accountability	The links between proposed improvements, the organisation's Clinical Governance framework & it's goals is clearly defined.	A high trust culture exists system-wide that recognises the importance of, & implements good customer service.	Appropriate education, training & resources are available to support best practice, leadership development & clinical supervision.
Staff/workers understand the rights of consumers/patients & their families/whānau & act in support of those.	Quality embedded in planning & contracting processes & used to drive investment decisions that will benefit Māori, Pasifika & those with unmet need.	Effective induction & orientation shared across the system – backed up by behaviour & actions that are consistent with HBDHB values.	Rigorous performance & progress measurements, including reporting & review.	Information/support is available for Patients/whānau when it is needed, in a form that is useful to them	Quality markers across all quality dimensions are transparent.
Consumer engagement framework that informs & supports decision making.	Quality improvement culture driven through distributed leadership; everyone understands its importance & takes an active role to drive quality improvement to achieve patient safety & equity	A high trust culture exists system-wide where incidents & complaints are reported, reviewed & learning is shared	Performance measures include those that relate to HBDHB values, & person & whānau centred care	Appointment scheduling takes account of Patient/whānau circumstances	Information Governance Framework to share information safely.
Consumers/patients & their families/whanau are involved at all levels in co-design to improve care design & delivery.	Strong Cultural and clinical leadership across the organisation.	Organisation structure & composition enables a quality improvement change culture	A high trust culture exists system-wide that recognises the inherent opportunity to socialise & leverage positive feedback or compliments, & does so.		Knowledge, derived from research, clinical experience & consumer feedback is applied to achieve optimum patient care processes, outcomes, & improve equity
A consumer feedback repository. Feedback is available & useable to inform service improvement & change.					

Clinical Council Governance Sub Committee Report

Committee Name	**Patient Safety and Risk Management Committee report for Clinical Council**
Chair/Vice Chair	Chris McKenna/Russell Wills
Date	25/11/2020 – covering September – November 2020
Report author	Susan Barnes, Patient Safety and Quality Manager
Committee Purpose	To provide assurance to the Hawkes Bay Clinical Council that all matters relating to patient safety and clinical risk within the Hawkes Bay health system enhanced
Functions	• Lead and promote a culture of continuous quality improvement, patient safety, cultural competence and clinical risk management • Initiate improvement projects and/or training programmes as appropriate • Ensure all patient safety, cultural competence and clinical risk compliance requirements, standards and processes are met, and any corrective actions are appropriately addressed • Ensure effective systems, strategies, policies, resources and procedures are in place to support quality patient safety, cultural competence and clinical risk management • Ensure all relevant information, lessons learned and improvement actions are well communicated throughout the sector • Oversee, monitor and govern the activities and delegated responsibilities of Committee Advisory Groups • Ensure decisions and recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety and experience of care for individuals; improved health and equity for all populations; best value for public health system; and improved experience of providing care
Overview of Advisory Group activities	**Clinical Risk and Events** Safety1st Event Reporting System being scoped and implementation plan under development. Backfill and Administrator resource no longer available (originally in 2016 business case); discussions in place to resolve. Inability to undertake AE reviews in timely way due to staff redeployment to Safety1st project. Resource proposal developed and escalated. ToR and membership of CREAG under review.
	Falls Minimisation Close monitoring of falls where harm has occurred continues. Intervention ongoing (risk assessments, hand rails). Need to compare data accuracy between event reporting and HRT data.
	Family Violence No report received. Lead back from Maternity leave and fresh focus evident.
	Infection Protection and Control First stages of implementation of ICNet Hand hygiene training /auditing re-ignited post COVID. Case for ongoing IPC resource escalated. AMR action plan shared with group.
	Maternity Governance Ongoing implementation of national patient safety and quality initiatives MEWS, NEWS, Antenatal anti D prophylaxis pathway, Assisted Birth and Premature Birth Information pack for women, Early Engagement with a midwife initiative, Sepsis and GAP bundles. CCDM implementation progressing.

	Patient at Risk Verbal. Group continues to meet regularly. Need identified to ensure training records are shared at meeting. Business case completed for resource to fund ACT training.
	Restraint Reconfigured post COVID. For the period July-Sept 48 restraint events were recorded. Mental Health continues to facilitate SPEC training; refreshers have commenced. De-escalation/ Breakaway training is available to all staff. MHAS Directorate are awaiting MOH funding / contract for 0.5 FTE Nurse Educator for ED / urgent care. Aggressive presentations to DHB services remains a risk.
	Pressure Injury Data discrepancy review continues. Combined risk assessment now available on Trendcare.
Risks Key risks that require escalation to clinical council. Wherever possible include mitigations.	• Cardiology Cluster – progression of action plan/ recommendations; open disclosure of adverse events. • Uncertainty of continuation of In Home Strength and Balance Programme. Business case pending. • Family Violence – need to re-establish advisory group to give oversight to Family Harm, Child Protection and Suicide. • Current IPC Resource does not allow for effective surge response in outbreaks within DHB or community - escalated. • Maternity Governance – Full implementation of CCDM will not be achieved by June 2021 – ongoing workplan to support core data requirements for FTE calculations. Inability to provide 24/7 co-ordinator within current funding (pilot underway). Lack of US capacity, increasing surcharges by community providers – increasing inequity of access – on going discussions underway. • Theatre capacity for caesarean sections – discussions underway • Patient at Risk – ACT training not resourced. Business case developed. • Restraint - Increase in aggressive presentations. Increased use of restrictive practice, possibly driven by current status of ward (MH); increase in seclusion hours and also in restraint use.
Equity assessment Ensure ethnicity is included in data collection, analysis and interventions. Highlight areas for improvement to address inequity based on findings.	Progressively ethnicity is becoming a key part of data collection. Advisory groups are all encouraged to explore this going forward and take time to consider how the work that the group is undertaking is impacting on any inequity.
Alliance with Patient and Whanau Centred Care Principles "Working **with** consumers and families/whanau, rather than **doing to** or **for** them."	Consumer representation exists on many of the governance sub-committee groups/Advisory groups. Within the reporting framework there are examples where consumer input has contributed very positively to the shaping of services using co-design methodology. There are many opportunities for consumer involvement going forward as we establish clinical governance frameworks across our clinical directorates.

11

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:

12.	Minutes of Previous Meeting (public excluded)
13.	Matters Arising – Review Actions (public excluded)
14.	HB Clinical Council Board Report – November (public excluded)
15.	Risk Management Report
16.	National Antimicrobial Resistance Action Plan – Implementation Process
17.	Health Roundtable – Review of April-June results
18.	Topics of Interest - Member Issues/Updates

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).