PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD INFORMATION**
	Date: 4 July 2018

Authors	Catherine Epps, Executive Director, Allied Health, Scientific and Technical Andrea McCance, Executive Director, Nursing and Midwifery John Tait, Chief Medical Officer
Endorsed by	Julie Patterson, Interim Chief Executive
Subject	**REVIEW OF CLINICAL GOVERNANCE AT CAPTIAL & COAST DISTRICT HEALTH BOARD**

RECOMMENDATIONS

It is **recommended** that the Board:

(a) **Notes** the contents of the Review of Clinical Governance at Capital and Coast District Health Board;

(b) **Notes** the range of recommendations will now be considered by CCDHB, and an implementation plan constructed;

(c) **Notes** first steps towards implementing any of the recommendations is the appointment of a General Manager, Quality, Improvement and Patient Safety for an interim period.

APPENDIX

1. Review of Clinical Governance at Capital and Coast District Health Board.

1. BACKGROUND

The previous interim CEO, Dr Ashley Bloomfield indicated to the Board on 28 March 2018, his intent to review Clinical Governance across CCDHB. The purpose of this review was to:

- Increase visibility of Clinical Governance to both the Executive Leadership Team and the Board.
- Consider the leadership model of the Quality Improvement and Patient Safety Directorate including consideration of a DHB-wide span.
- Evaluate the current state of Clinical Governance systems using the Health Quality and Safety Commission's (HQSC's) clinical governance framework.

1.1 Scope of the Review

The review was carried out by Dr Mary Seddon, of Seddon Healthcare Quality Ltd, during April. The scope of the review was across all of CCDHB, and the HQSC clinical governance framework was used as the tool against which the organisation was evaluated. The process consisted of reviewing numerous documents and interviewing fifty four people across the organisation, all of whom had a role in clinical governance. The review documents interviews, including feedback from the chairs of the clinical governance committees, as well as leaders from across the organisation who have a role in relation to clinical governance.

1.2 Outcome

The report has been received by CCDHB and endorsed. Numerous recommendations have been made throughout the report. A process is being undertaken to identify which recommendations to prioritise, and a plan to achieve them. It is anticipated that there will be some need to consider additional resource to deliver some of the key recommendations.

PUBLIC

As a first response to the report findings, the interim CEO has established a new executive position with a specific focus on Clinical Governance, and a mandate to work alongside the professional heads to deliver the findings of the report. The interim appointee is Sandy Blake, who commences on 9 July. Once Sandy starts in the role, further updates on this work will be provided to the Board.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**BOARD DECISION**
	Date: 28 June 2018
Author	Andrew Blair, Capital & Coast District Health Board Chair
Subject	**RESOLUTION TO EXCLUDE THE PUBLIC**

RECOMMENDATION

It is **recommended** that the Board:

a) **Agrees** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the respective public excluded papers.	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in respective public excluded papers.	
Chair's report CEO's report FRAC Recommendations Children's Hospital Update Update on Facilities and Infrastructure Risks Proposal to Retender Home and Community Support Services Declaration of 201 Warspite Avenue as Surplus to CCDHB Requirements	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)
Central Regional Services Plan 2018/19 Prioritisation and Investment Update Draft CCDHB Annual Plan 2018/19 Budget Plan 2018/19 Capital Expenditure Plan 2018/19	Subject to Ministerial approval	9(2)(f)(v)
Litigation and Legal Risk Update	Maintain legal professional privilege	9(2)(h)

* Official Information Act 1982.

THE TREASURY
Kaitohutohu Kaupapa Rawa

20 June 2018

Thomas Davis

General Manager, Corporate Services

Capital & Coast District Health Board

Wellington Regional Hospital

Dear Thomas

Re: ICR Outlook Discussion

Thank you for your sponsor letter and for the subsequent discussion with the Treasury, the Ministry of Health and functional leads, on the progress Capital & Coast DHB is making towards lifting its investment management and asset performance since its Investor Confidence Rating (ICR) assessment last year.

We appreciate the time you and your team have taken to provide us with an update on progress so that we can understand the improvement work underway ahead of the next ICR assessment in 2019.

Overall Feedback

Representatives from the Treasury, the Ministry of Health and functional leads agreed that the letter succinctly outlined the progress underway under each element. This was reinforced in the discussion which revealed the breadth and depth of the activity underway that was otherwise more modestly articulated in the letter.

Through the letter and the discussion, CCDHB demonstrated its commitment to lifting investment and asset management maturity and performance, and outlined the approach it's taking to achieve this by focusing on the highest value activities. We are supportive of this approach, particularly given the resource constraints and competing priorities currently facing the DHB.

Some of the positive improvements we acknowledge include CCDHB:

- Using the EBHC programme as a vehicle for developing, implementing and piloting project management tools and methodology
- Ensuring new methodologies and tools are practical and scalable and projects are aware of what to apply and when

- Taking a whole-of-system approach to investment and ensuring focus is on benefits / value e.g. through BBC, irrespective of capital or operating funding, and with FTE changes
- Focusing on building capability and foundational activities that will support longer term uplift e.g. developing the asset management policy and plan, ensuring asset performance data is of good quality, gaining leadership buy-in for the importance of good Organisational Change Management and piloting Project Management tools and methodology
- Developing a clinical equipment database and asset criticality framework as part of the National Clinical Engineering Group work
- Working to identify critical property assets, define minimum requirements for those assets and conduct a field exercise to inspect and confirm the current state of those assets
- Creating an improvement plan to bring together separate management systems to enable a portfolio view of ICT assets across the DHB

From a system performance perspective, CCDHB demonstrates compliance and respect for system rules and requirements. Approval thresholds are met and annual procurement plans and significant service contracts are submitted. Engagement is generally light-touch. Where appropriate, CCDHB is encouraged to engage more proactively with the Ministry. For example, with the new children's hospital (which is acknowledged as being a very unique investment), timelier reporting on ICT systems and with the changes to the leaky pipes business case (which are positive for the reduced cost and interruption to services). This will allow the Ministry to provide early and meaningful feedback and contributes to the Ministry's portfolio view of current spend and upcoming pressures across the sector. In turn, the Ministry will be more proactive in its engagement and support of CCDHB.

Overall, your letter and the discussion indicates to us that CCDHB is creating a good foundation on which to uplift investment and asset management capability and performance. CCDHB is demonstrating maturity in this space in its recognition that this uplift will help with its financially challenging position, and to enable it to be more sustainable in the long term. We affirm CCDHB's approach in being selective in its improvement activity, ensuring that the fundamentals are met and taking the most efficient and effective means to build capability e.g. by leveraging the work in the ECHB programme. We affirm this approach and encourage CCDHB to ensure this improvement momentum continues. CCDHB should also ensure that individuals in the organisation have the understanding, support and capability needed to adopt and embed these changes. For example, when the project management framework is rolled out more widely, how this will be supported and governed, and how the role of the ECHB programme team will be replicated organisationally.

We acknowledge that the Treasury, the Ministry, and functional leads have a role to play in supporting CCDHB to uplift its capability and are open to requests for support. We also acknowledge CCDHB's request for the Ministry to provide greater standardisation, coordination and support across the health sector. This includes the need to ensure the development of any centre-led national asset performance standards and frameworks (for clinical, property and ICT assets) recognises what is already in place in DHBs, and is done in the near term to avoid duplication of effort or rework. We are committed to supporting

CCDHB and the health sector to lift its investment and asset management maturity and performance and look forward to working with you to achieve this.

Yours sincerely,

Grant Petherick (on behalf of central agencies, the Ministry of Health and functional leads)

Senior Advisor, Investment Management and Asset Performance team

Treasury:3972315v1

CAPITAL & COAST DHB STAFF NEWS

Health Matters

ISSUE 38 • JUNE 2018

Thumbs up!
All Blacks visit the Children's Hospital

In this issue

Mass casualty response put to the test

Showcasing our Improvements at CCDHB

Win movie tickets!

See page 5 for details

CARE CAPACITY DEMAND MANAGEMENT UPDATE

BACK IN THE COLD - COLD CHAIN MANAGEMENT

BRUSHING UP ON ORAL CARE RESOURCES

Compliments

DISTRICT NURSES - KAPITI HEALTH CENTRE

I thank our district nurses. I haven't had to have them before. So calm and caring. Nothing was any trouble. I had to call for a weekend visit and there were no worries. It was so comforting to know if I really need help they were just a phone call away.

PARAPARAUMU MATERNITY - KAPITI HEALTH CENTRE

What a fantastic supportive group of midwives I had to guide, support and care for me and my baby during our three day stay. Every midwife I had was wonderfully supportive, gave consistent practical advice, offered help, was passionate, genuine and informative. We are very lucky to have such a great group of women working in this facility.

EYE OUTPATIENTS – WELLINGTON REGIONAL HOSPITAL

I had to avail myself of the hospital services last week because of some acute and alarming eye symptoms. The Eye Department staff were friendly and efficient and accommodated extra acute patients such as myself along with a steady stream of booked clinic appointments. The waits were long but I felt very grateful for the services provided to me and the kindness and professionalism of the staff.

EMERGENCY DEPARTMENT & WARD 1 – WELLINGTON REGIONAL HOSPITAL

Two incredible nurses took care of my daughter in ED while we were waiting for the orthopaedic doctors to see us. While my daughter was extremely difficult they remained positive and were so nice, efficient and did everything they could to help us. We stayed one night in the childrens ward where our nurse was so lovely and tended to my daughter's every need. The other nurses were also amazing. Being a young mum with a young daughter staying in hospital for the first time, the nurses made everything so much easier and smoother for us. A very unpleasant situation was made easier for us as a family and we are so grateful for the care our daughter received.

WARD 7 - KENEPURU COMMUNITY HOSPITAL

I was not expecting to stay overnight after surgery so was not at all prepared. The ward staff were fantastic, finding me everything I needed to be comfortable and happy. The nurses were also very attentive, picking up a drop in blood pressure quickly, identifying likely causes and taking effective remedial action.

COVER PHOTO: All Black prop Jeff Toomaga-Allen, and loose forwards Liam Squire and Sam Cane at the children's hospital meeting parents and brightening the kids' day.

From the interim CE

Firstly my thanks to everyone who has made me feel so welcome and supported. I'm enjoying meeting you in your workplaces and seeing the great work you are doing for our communities. I look forward to meeting many more of you over the next few weeks, when I visit services beyond the Wellington Regional Hospital campus.

I want every staff member to enjoy coming to work, and to go home feeling stimulated, challenged and professionally rewarded. I also want you all to feel physically and emotionally safe at work.

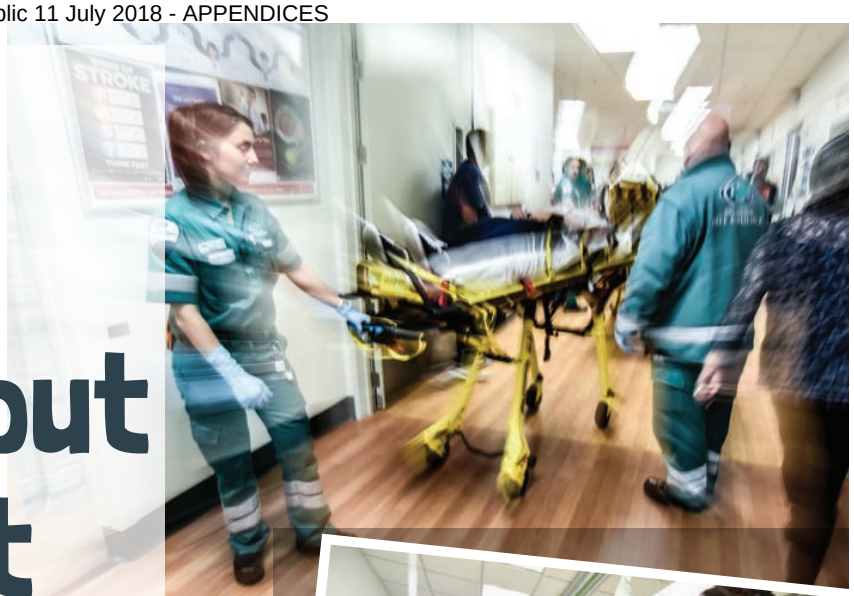
Our new People Strategy is geared towards helping us achieve this. It's the result of a lot of hard work and thoughtful input from people across the DHB over the last 12 months. The strategy's key principles and themes will act as a framework to guide the development of our organisational planning. We have the building blocks in place, and in the last two weeks, I have seen first-hand how focused the board and the executive leadership team are on ensuring that we now bring the strategy to life. You can learn more about the strategy on page 17.

I can see already that our organisation is very good at what it does but we are all human, our work is highly complex and our environment is very dynamic. We will make mistakes; it's what happens next that defines us as an organisation, and frankly you as an individual.

How we trust each other, how we view the people we are here to serve and how we accept and encourage difference impacts considerably on our ability to achieve equitable health outcomes across our population. With this in mind I invite you to read the "Gardener's Tale" which is included in this publication. I urge you to take the time to reflect on the attitudes and behaviours you would bring to the gardener's role.

Julie Patterson
Interim chief executive

Mass casualty response put to the test



A training exercise undertaken at Wellington Regional Hospital late last month provided an opportunity to test and hone our emergency response procedures in the immediate aftermath of a mass casualty incident.

The joint CCDHB and Wellington Free Ambulance exercise saw ambulances transporting 42 'casualties' – with Whitireia Polytechnic students posing as injured patients – to the hospital's Emergency Department for triage and treatment.

The scenarios called on a number of departments, support services and management teams to respond and work together, including the Intensive Care Unit, surgical services, theatres, wards, and outpatient services. The mental health team ran the reconciliation centre.

"The exercise is designed to test our emergency procedures during a mass casualty situation," says emergency management service leader Greg Phillips.

"We need to ensure we have the right coordinated response measures in place to treat, triage and find enough beds for a large number of injured patients. It also allows us to test our communication and alert systems and ensure we are able to provide updates as quickly as possible and respond to calls from concerned families."

The last mass casualty training exercise conducted at Wellington Hospital was in 2015. The last real-life mass casualty event the hospital experienced was back in 1980 when a suburban multiple unit train crashed head-on into a diesel shunter, killing two and injuring around 77.

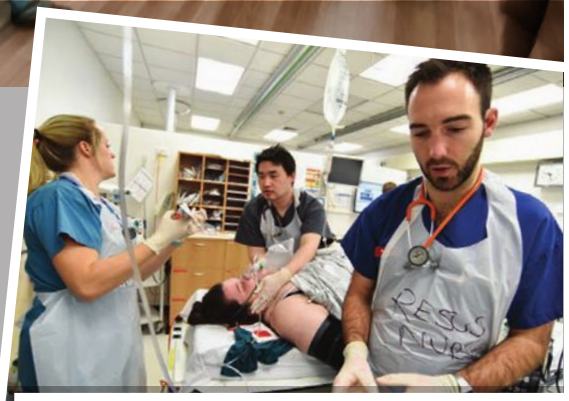
But Greg says the Christchurch and Kaikoura earthquakes served as a timely reminder that we should always be prepared.

"The more complex scenarios we set up provided big challenges for our trauma services and tested procedures that we don't use very often."

They included patients with severe burns (to test out national severe burns plan), and a critically injured pregnant woman who delivered her baby via caesarean section soon after arriving in ED.

Emergency physician Vicki Vertongen, who helped create the scenarios, says the coordinated response by all the teams involved was really strong.

"The exercise showed that the mass casualty plans we have in place do work and our teams are well-placed to respond a surge in patient numbers requiring trauma treatment," Vicki says.



SHOWCASING OUR IMPROVEMENT AT CCDHB

Trainees at the recent Improvement Showcase

We recently celebrated the success of 13 staff who took part in the fourth CCDHB Improvement Movement 12 week course. The course aims to grow our people through building improvement capability into everyday projects.

Throughout the course the trainees learn how to run their improvement project using the Model for Improvement and were supported by an improvement advisor.

The trainees from clinical and non-clinical areas all made improvements in their areas of work. They presented their improvement work at an Improvement Showcase. You can view their work outside the Boardroom on level 11, Grace Neill Building.

There have been a wide range of projects, all helping achieve CCDHB's goal of doing things better across a range of services.

"I found the course very helpful as it not only explained the theory behind the model but also provided the opportunity to work through it with much needed one-to-one support." – trainee.

This training is available to all staff including those working in primary care and is incorporated into the frontline leadership programme service management module.

Clinical nurse specialist Robyn Telfer speaking at the Improvement Showcase

OVERALL WINNER

Clinical nurse specialist Janice Tijsen, overall winner for 'Keeping dry in wet conditions'. Pictured below with Chris Lowry, chief operating officer and Caroline Tilah, former executive director operations for quality improvement and patient safety.

PEOPLE'S CHOICE WINNER

Emma Lange, nurse educator for ward 6 North, was voted the People's Choice for her work reducing pressure injuries in ward 6 North with patients who have had hip surgery.

Most recent Improvement Projects

- Improving the timeliness of seeing Triage 2 patients at Kenepuru Accident and Medical Centre.
- Improving the timeliness of reviewing ICU discharges to the wards.
- Improving fentanyl patch administration and documentation on medication charts.
- Improving confidence in the 777 call activation process.
- Decrease pressure injuries on ward 6 North in patients who have hip surgery.
- Reduce the appointment DNA (did not attend) rate in the Eye Outpatient Department.
- Provide a pharmacist discharge service to one medical team.
- Improving the visibility of the frailty assessment score and reflecting the score in the nursing care plans on Kenepuru wards 4 and 5.
- Reducing the time it takes to place child protection alerts.
- Improving access to front fastening pads for bedbound, frail and incontinent palliative patients on ward 5 South.
- Increasing the percentage of Porirua Community Mental Health Team clients discussed at a multidisciplinary team meeting.
- Reducing the number of inappropriate referrals to the Podiatry service.

Register now

The next 12 week course starts 5 September. You can register for the course through ConnectMe or contact Improvement@ccdhb.org.nz for more information.

Get in quick! We recommend booking early as places are limited.

Be part of the improvement movement

The improvement team also run **one hour improvement taster sessions** across CCDHB where participants learn how to use the Model for Improvement by running their own small improvement project using a Mr Potato Head.

"A fun activity with Mr Potato Head. It made you stop and think of your objective, how to implement and improve." – District nurse

So far we have run 36 sessions with over 400 staff from across CCDHB, receiving incredible feedback.

Get in touch with the improvement team if you want us to run this session with your team.

Answer three questions correctly and go into the draw to win two Embassy Theatre tickets donated by the Wellington Hospital's Foundation. This months questions are:

1. How many staff took part in the fourth CCDHB Improvement Movement 12 week course?
2. What is Cold Chain management?
3. Who now recieves patient letters electronically?

Email your answers to us at: healthmatters@ccdhb.org.nz with the subject line "Health Matters Competition" before 18 July. We'll announce the winner each month in Health Matters and in Daily Dose.

Congratulations to last month's winner - Alice Hanify, patient flow coordinator, Emergency Department.

CCDM UPDATE

May has been a busy month with lots going on to support the implementation of Care Capacity Demand Management (CCDM) across CCDHB. The CCDM programme, once fully operational, will help us better match the capacity to care with patient demand and workload.

TrendCare - the software which provides validated patient acuity data to support CCDM - is already operating in most of our wards and inpatient areas, however it's only one part of the CCDM process.

Local Data Councils

At the heart of CCDM is the establishment of Local Data Councils (LDCs) across all the inpatient areas which are using TrendCare. These councils will be introduced as part of a phased approach from next month to December to ensure the new LDCs are well supported. This is an exciting progression for the CCDM program which you can be involved in to make positive changes at our DHB.

A local data council is a group of frontline unit or ward staff who meet regularly to review their ward information and data to identify issues, develop improvement plans, set goals and monitor measures and improvements to the core data set. Over time local data councils will work to improve collaboration between front line staff, managers and union partners, while involving people close to the issue with problem solving.

CCDM is for our staff and our patients care: Following our CCDM Education Day in April we have established CCDM 'champions'. Now we need our staff to get involved by joining and supporting our local data councils.

Please contact your charge nurse/midwife manager or email CCDM programme manager Emma.Williams2@ccdhb.org.nz for more information.

High level plan agreed

A three-year high level plan was agreed by the CCDM Council this month which maps out how we will implement CCDM by 2021. The plan agrees key deliverables in five standards - governance, patient acuity, core data set, staffing methodology and variance response management.

CCDM website goes live

The Safe Staffing Healthy Workplaces unit have launched an excellent new CCDM resource. A range of supporting material can be found on the new website www.ccdm.health.nz

Meanwhile the CCDHB website now has an information page on our CCDM programme including the new high level plan. Check it out under 'working with us'.

PSA | NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA | MERAS Midwifery Employee Representation & Advisory Services | CCDM | Capital & Coast District Health Board Ūpoko ki te Uru Hauora

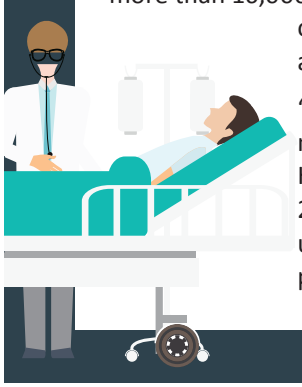
RESEARCH

TOO MUCH OXYGEN CAN KILL

Research findings published in the prestigious Lancet medical journal have shown that administering excessive oxygen increases the risk of death for seriously ill patients.

The study was carried out by the Medical Research Institute of New Zealand (MRINZ) and co-authored by Wellington Regional Hospital intensive care specialist Dr Paul Young.

It involved analysing the results of oxygen therapy for more than 16,000 patients and found that too much oxygen increases the risk of death by around 21 percent.



"The message is clear that too much oxygen can be harmful. Humans have adapted to breathe 21 percent oxygen in the air around us – anything more represents a physiological stress," Paul says.

Internationally, patients generally receive oxygen if levels drop below 90 percent and it has long been thought that administering oxygen can't harm patients. However the findings suggest a slightly lower oxygen level could be better for patients.

"There are millions of people around the world who receive oxygen for acute illnesses every day, which gives an idea of the potential global health importance of the findings of this study."

While more research is underway to try to determine exactly what level of oxygen is dangerous, MRINZ believes the strength of the current evidence is now strong enough that it will now mandate changes in clinical practice not only in New Zealand but also around the world.

A study looking at 1,000 intensive care patients in New Zealand and Australia is also being completed, with results expected early next year.

Back in the cold
a new improvement project

An improvement project focused on ensuring vaccines and refrigerated pharmaceuticals maintain their potency by being continuously stored at specific temperatures, will be launched on 1 September across our hospitals.

'Back in the Cold' is focused on cold chain management – the process that ensures vaccines and refrigerated pharmaceuticals maintain their potency by being continuously stored at temperatures between +2°C to +8°C from the time of manufacture to the point of administration.

"It establishes sustainable processes to ensure patients receive vaccines and medicines that have been stored at the required temperature range and are therefore fit for purpose," says Caroline Tilah, foremer executive director of quality improvement and patient safety.

The project sees the introduction of a cold record booklet and updated policy for all areas with pharmaceutical refrigerators storing medicines and or vaccines. The booklet and policy comply with the 2017 Ministry of Health standards and cold chain accreditation requirements.

"The booklet is a tool for providers of vaccine and other refrigerated medicines designed to keep daily minimum and maximum temperatures recordings and a record of their cold chain actions, equipment checks and services in one place. It's essentially a one stop shop for cold chain management, bringing together all of the information and templates clinical staff need to confidently manage their cold chain processes and meet the new Ministry of Health standards," Caroline says.

In addition to ensuring that our refrigerators are 100 percent compliant with all elements of the Ministry's cold chain standards, the project could also reduce medication and vaccine wastage. Every month, around $4,000 worth of vaccines and medicines are discarded because they were stored outside the required temperature range.

The project team has had representation from nursing, pharmacy, facilities, ICT as well as our new resident expert Lynette Collis from the Immunisation Advisory Centre who will also be assisting us with our cold chain accreditation.

"As I leave the organisation I am heartened to see this patient safety project come to fruition. It has been a true pleasure working with such a dedicated team," Caroline says.

Some of the team working on the Cold Chain management project.

Staff Profile

Cindy Quinnel

registered nurse, perioperative services

What's your role here?

I am a registered nurse working in the Anaesthetic pre assessment Clinic at Wellington Hospital. My role centres on the assessment, education and co-ordination of patients undergoing elective procedures at both Wellington and Kenepuru Hospitals. As part of my position, I screen patient health questionnaires to assess what type of anaesthetic assessment is required, I complete phone assessments on patients prior to their procedures, as well as working alongside the anaesthetists in our outpatient clinics.

Who's in your team?

I am very lucky to work with a small team of very knowledgeable and dedicated nurses. One of our nurses works solely out at Kenepuru, and we also have three clinical nurse specialists who undertake a variety of roles, including running nurse led anaesthetic clinics. We obviously also work very closely with our anaesthetists, as well as regularly engaging with the surgical and wider multi-disciplinary teams. A special mention also to our clinic administrator who we couldn't do without!

What's the best part of your job?

Working to educate and to optimise patients prior to having their procedures is the most rewarding aspect of my job. As we work with both paediatric and adult patients undergoing a variety of different procedures from a wide variety of specialties this can be challenging at times. The required knowledge base can sometimes seem overwhelming. However the learning opportunities are endless, and it is a role that can make a real difference to a patient and their families. I feel very privileged to do what I do.

Tell us something most staff wouldn't know about you

That I come from quite a sizable family, and are lucky enough to already have a great niece and great nephew!

Thanks

Special thanks and recognition to the following staff

5 Years

Finau Leau, health care assistant
Michael Lees, mental health support worker
Rebecca James, associate charge nurse manager
Tracy McKee, associate charge nurse manager
Alister Neill, senior medical offier - respiratory
Michael Tweed, clinical leader respiratory
Sherry Champion, 3DHB manager - service assurance
Anna Ross, registered nurse
Seni Paese, security orderly
Margaret Turner, administrator
Deborah Mather, registered nurse
Ana Paongo, registered nurse
Maria van de Putte, health care assistant - casual
Deborah Paul, physiotherapist
Penieli Ah Hoi, security orderly - Kenepuru
Maryanne Rangi, mental health support worker
Sarah Gilbertson, midwife - casual
Rodette Saril, registered nurse
Shaun White, registered nurse
Clare Odell, registered nurse (casual)
Terrance McLean, mental health support worker
Misael Mendoza, medical records clerk
Sukhwinder Kaur, registered nurse

10 Years

Cherie Watts, registered nurse
Linda Williams, dietitian
Catherine Boulton, team leader
Gayle Tristram, associate charge nurse manager
Ian Middleton, telephony support engineer
Jane Bilik, charge nurse manager
Alain Marcuse, consultant psychiatrist
Robin Perks, analyst programmer
Adrianne Mason, youth justice liaison officer
Kamala Rupasinghe, senior medical officer
Richard Gray, medical records clerk
Bernadette Goulden, registered nurse
Veena Pillay, team support administrator
Marilou Cebreros, registered nurse
Malcolm Abernethy, cardiologist – cardiology

15 Years

Anne O'Donnell, clinical leader
Marion Elliott, secretary - intensive care
Kylie Hawes, receptionist
Carmel Gillman, scientific officer
Christopher Lampard, occupational therapy support worker
Christine Remfrey, registered nurse
Scott Harding, cardiologist

20 Years

Timothy O'Meeghan, cardiologist
Jacqui Grannetia, nurse educator
Debbie Bean, nurse care manager
Joy de Villiers, team leader
Patricia Kingi, allied health assistant
Annette Ladbrook, health care assistant

25 Years

Beatrix Treuren, specialist

Cultivating Cultural Harmony

The Gardener's Tale

By Camara Jones

Camara Jones is a senior fellow at Satcher Health Leadership Institute, Morehouse School of Medicine. In 1999 she was in New Zealand for nine months as the Ian Axford Fellow in Public Policy, based in the Ministry of Health.

This article is adapted from The Gardener's Tale, published in her report, "Māori-Pakeha Health Disparities: Can treaty settlements reverse the impacts of racism?" for the Ian Axford Fellowships Office.

This version was published in 2001 in Kai Tiaki Nursing New Zealand. The original version was published in the American Journal of Public Health August 2000, Vol. 90, No. 8.

In The Gardener's Tale, Camara Jones presents an allegory that can be used to guide our thinking on racial factors that can influence health outcomes. She also presents a theoretic framework for understanding racism on three levels: institutionalised, personally mediated and internalised.

Cultivating Cultural Harmony

By Camara Jones

A gardener's simple tale can teach a great deal about the conditions which are needed to nurture cultural equality.

When my husband and I bought a house in Baltimore, we had two large flower boxes on the front porch. When the spring came we decided to grow flowers in these boxes.

One of the flower boxes was empty so we bought potting soil to fill it. We did nothing to the soil in the other flower box, assuming it was fine. Then we planted seeds from a single seed packet into the two boxes. The seeds sown into the new potting soil quickly sprang up and flourished! All the seeds sprouted, the most vital among them towering strong and tall, while even the weak seeds among them made it to a middling height.

However, the flowers planted into the old soil did not fare so well. Fewer seeds sprouted, with the strong among them only making it to a middling height, while the weak among them died. It turns out the old soil was poor and rocky in contrast to the new potting soil that was rich and fertile. The difference in yield and appearance in the two flower boxes was a vivid, real-life illustration of the importance of environment.

This image of the two flower boxes can be used to illustrate the three levels of racism: institutionalised, personally-mediated and internalised. (See boxes opposite.)

Let's imagine a gardener with two flower boxes, one filled with rich and fertile soil and the other filled with poor and rocky soil. This gardener has two packets of seed for the same kind of flower, except that one packet produces pink flowers and the other packet produces red flowers. The gardener prefers red over pink so she plants the red seed in the rich and fertile soil and the pink seed in the poor and rocky soil. And sure enough, what we described above happens. All the red flowers grow and flourish, with the fittest growing tall and strong and even the weakest making it to a middling height. But in the box with the poor and rocky soil, things look different, scrawnier. The weak among the pink seeds don't even make it, and the strongest among them only make it to a middling height. The flowers in these two boxes go to seed, dropping their seed into the same soil in which they are growing. And year after year, the same thing happens.

This story illustrates that once institutonalised racism is addressed, the other levels of racism will cure themselves.

Ten years later, the gardener comes to survey his garden. He compares the two boxes and thinks: "I was right to prefer red over pink! Look how beautiful the red flower box looks and how poor and pitiful the pink box looks."

The first part of this story illustrates some important aspects of institutionalised racism. There is the initial historical insult of separating the seed into the two different types of soil, followed by the act of omission in not recognising the difference in the soil or in not addressing that difference, if it is recognised. Indeed, the normative aspects of institutionalised racism, illustrated by the initial preference of the gardener for red over pink, and his assumption that red was better than pink, may have contributed to his blindness about the difference between the soils.

So where is personally-mediated racism in this gardener's tale? That is when the gardener, disdaining the pink flowers because they look poor and scraggly, plucks the pink blossoms off before they can even go to seed, or when he plucks out a pink seed that has been blown over into the rich soil before it can establish itself.

And where is the internalised racism in this tale? That is when a bee comes along and the pink flowers say: "Stop! Don't bring me any of that pink pollen - I prefer the red!" The pink flowers have internalised that red is better than pink, because they look across at the other flower box and see the red flowers strong and flourishing.

So what are we to do if we want to put things right in this garden? Well, we could start with the internalised racism and tell the pink flowers that "pink is beautiful!" That might make them feel a bit better, but it will do little to change the conditions in which they live.

Or we could address personally-mediated racism by conducting workshops with the gardener to convince him not to pluck the pink blossoms before they have had a chance to seed. Yet even if he is convinced to stop plucking the pink flowers, we have still done little to address the poor and rocky condition of the soil in which they live.

What we really have to do to set things right in this garden is to address the institutionalised racism. We have to break down the boxes and mix up the soil, or even leave the two boxes separate but fertilise the poor and rocky soil until it is as rich as the other soil.

When we do that, the pink flowers will grow up at least as strong as the red and perhaps stronger, as they have been selected for survival. When they do, the pink flowers will no longer think red pollen is better than pink because they will look over at red and see they are equally strong and beautiful.

And although the original gardener may have to go to his grave preferring red over pink, the gardener's children who grow up seeing that pink and red are equally beautiful will be unlikely to develop the same prejudicial attitudes as the previous generation.

This story illustrates the relationship between the three levels of racism, and the fact that institutionalised racism is the most fundamental of the three levels. It also illustrates that once institutionalised racism is addressed, the other levels of racism will cure themselves.

1) Institutionalised racism

Here you see the effects of institutionalised racism, with half as many flowers in the poor soil as in the rich, and those flowers only half as high as the flowers in the rich soil. The story illustrated the role of the initial historical insult (separation of the flowers into different types of soil), perpetuated by contemporary structural factors (the boxes). In this case, there is inaction in the face of need, supported by societal norms (the preference for red). Indeed, ideas of biological determinism (pink were inherently inferior to red) may have prevented the gardener from even questioning why the pink flowers were doing more poorly than the red. Another aspect of institutionalised racism is taking for granted unearned privilege--ie, the red flowers are feeling fine and deserving in their splendour without realising they are benefiting from richer soil.

2) Personally-mediated racism

With regard to personally-mediated racism, you will notice the pink blossoms have been plucked and discarded. Personally-mediated racism can be intentional (as in the plucking of the blossoms) or unintentional (as in picking up pink seed that has fallen to the concrete and putting it back in the poor soil). It includes acts of commission as well as acts of omission.

Indeed sometimes the interface between personally-mediated and institutionalised racism is blurred. People maintain the structural barriers or fail to act, thereby supporting institutionalised racism. Their personally-mediated acts of racism are allowed to continue because they are supported by institutions and condoned by societal norms.

3) Internalised racism

Look at the pink flower shrinking back from the pollinating buzzy bee. Internalised racism is not something intrinsic, but reflects systems of privilege (the difference in soils) and reflects societal values (the preference for red).

Internalised racism erodes individual sense of value and undermines collective action, because the pink flowers are so busy wanting to be red that they don't come together to create pink solutions.

4) Who is the gardener?

There is a very important question I have not raised so far. Who is the gardener? It is the one with agency and the control of resources, and, in this country, that is the government.

It is particularly dangerous when the gardener is allied with one group over others (you see I have coloured the gardener red, explaining the preference for red flowers). It is also dangerous when the gardener is not concerned with equity. If he had been, he would have asked the question why the pink flowers were not faring so well. Just asking the question would have led him to seek solutions.

Illustrations by Phil Reane

Patient and visitor behaviour charter

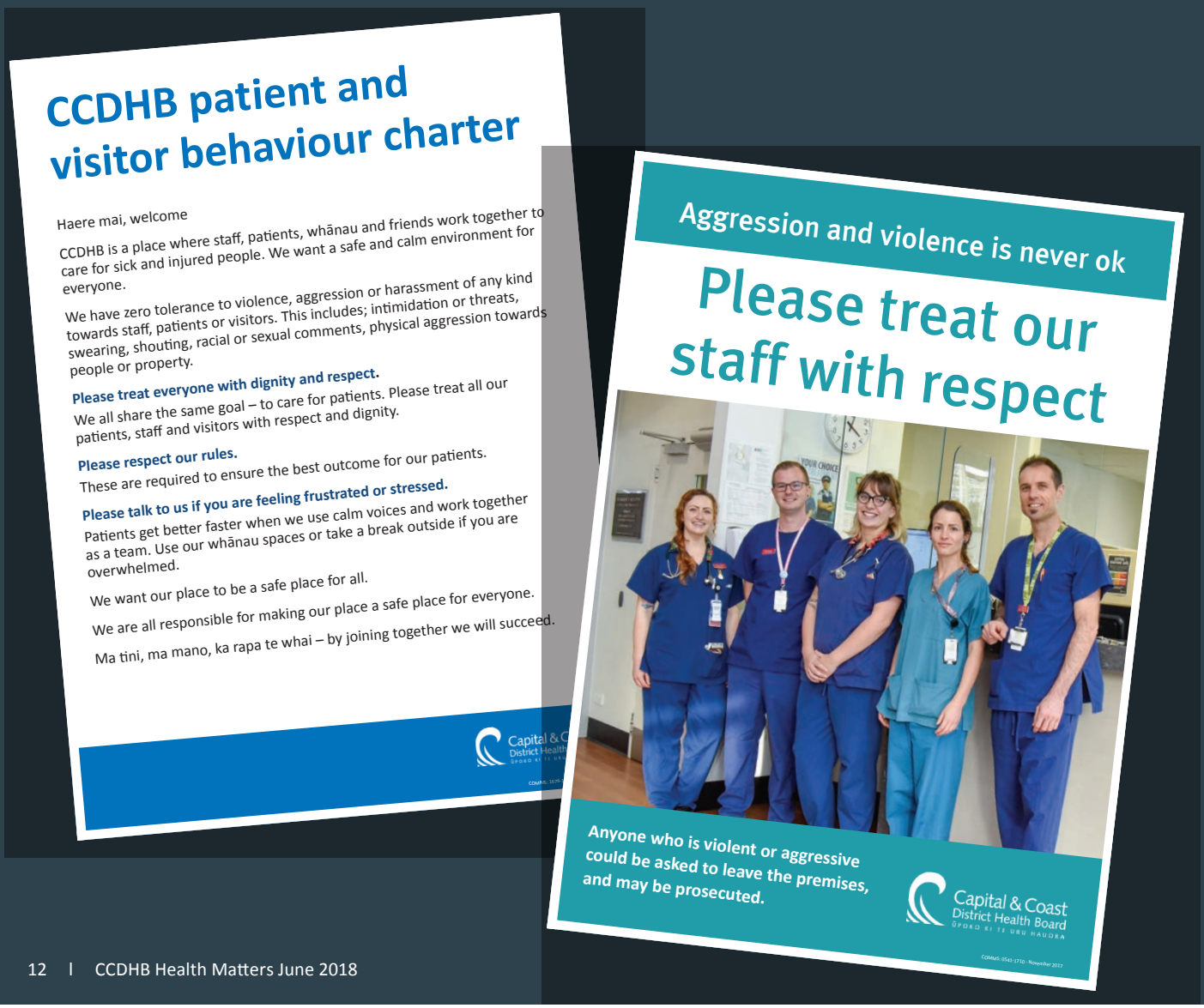
Safety across the DHB is a shared responsibility. We have a number of initiatives in place and underway to protect the safety of our staff and patients. As part of this, we have developed a patient and visitor behaviour charter. The aim of the charter is to ensure that patients and visitors are aware of what is expected of them and what they can expect of us whilst visiting our hospitals.

We know that caring for sick and injured people can sometimes be very difficult and distressing for all those involved – patients, whānau and staff. But we all share the same goal to care for patients.

It's important that patients, staff and visitors all treat one another with respect and dignity. The charter makes it clear that the DHB has zero tolerance to violence, aggression or harassment of any kind towards staff, patients or visitors. This includes intimidation or threats, swearing, shouting, racial or sexual comments, or physical aggression towards people or things.

The charter also encourages visitors to talk to staff if they're feeling frustrated or stressed.

We have created a series of posters that outline our expectations as part of our patient and visitor charter. These posters, and the charter, are available on the staff intranet under 'Quick Links'.



FIONA POPERT, PODIATRIST

DAY IN THE LIFE

As CCDHB's sole podiatrist, Fiona Popert has an important role to play in preventing and managing foot complications for patients with diabetes.

Fiona's role involves assessing and managing high risk diabetes and vascular patients with active foot wounds. These patients often present with complex injuries, and because of the disease, can end up with serious complications. Her aim is to treat foot wounds as soon as possible, to prevent further problems and support patients on the road to recovery.

Fiona originally trained in the UK, and has been a podiatrist for 30 years. She is very passionate about her work, helping people with high risk foot problems.

Fiona single-handedly covers inpatients/outpatients at both Wellington Regional Hospital and Kenepuru Community Hospital, Kapiti Health Centre and the Multi-Disciplinary Team (MDT) Diabetic Foot Clinic. She also works with other DHB podiatrists to improve podiatry services across New Zealand and to educate patients about footcare.

Her role also includes providing treatment advice to health practitioners in primary, secondary and tertiary care. She's provided clinical advice for the Health Pathways Tool which will help general practices manage and refer patients to the appropriate service and is involved in the development of a Foot Protection Service for Wellington.

She was recently part of the DHB's Improvement Movement Showcase with a project that looked at prioritising and improving referrals, and getting patients back into the community. Apart from her clinical input, Fiona is also responsible for the service's operational and strategic development which is challenging with limited resources. Despite being incredibly busy, Fiona gets a huge amount of satisfaction from her role.

"Being able to treat active foot wounds, prevent limb amputations and get people mobile again is incredibly rewarding. I have also enjoyed meeting new people from other services, especially when they show interest in what I do. I'm passionate about educating and engaging staff, and teaching nursing and podiatry students about the importance of high-risk foot care."

Brushing up on oral care

Oral care is essential nursing care in a hospital setting. However, recent research undertaken by ward 7 south nurse educator Caroline Woon, identified that there has been a lack of clear standards and guidelines for nurses about best oral care practice for patients.

Caroline wanted to change this.

"I think it's been widely assumed that health care assistants and nurses know how to clean peoples' teeth and dentures. Minimal education has been given to nurses during their nursing training but many have worked for many years without evidence based education.

"I wanted to create resources that can assist nursing staff to deliver effective oral care."

Caroline worked closely with senior dentist Liz Hitchings to develop hospital-wide resources which have been launched across both Wellington Regional and Kenepuru Community Hospitals. They include a new guideline and accompanying flow chart, as well as an online eLearning module for all nursing staff and education for health care assistants.

The resources provide additional care guidelines for cancer and ICU patients, and encourage the early identification of patients with dentures.

"The new guideline and flow chart helps to ensure a minimum standard of care is provided for all patients, which is twice daily brushing of teeth or dentures, and soaking of dentures overnight. It also encourages an oral assessment for all patients to ensure any oral complications are identified early and effective care is provided," Caroline says.

Registered nurse Nikki Acosta says the guideline and eLearning module have made it much easier to understand which products are appropriate to use for patients who have specific oral care requirements.

Oral 7 gel and toothpaste are additional resources that have been introduced for dry mouth or patients with dysphagia, as well as denture cleaning tablets and pots for patients with dentures.

Ward 7 south nurse Sia Tevaga says the Oral 7 gel has proven to be very effective for patients.

"I had a patient with halitosis and after applying the Oral 7 gel, her halitosis disappeared and her mouth appeared in a much better condition, making cleaning much easier."

Nurse educators will be helping roll out the resources to nurses across all wards and units throughout June.

"The long-term plan is to allow sharing of these resources with other DHBs so we can improve the oral care of patients around the country, standardising our approach," Caroline says.

If you have any queries about the new oral care resources, contact caroline.woon@ccdhb.org.nz

FASTER COMMUNICATION WITH NEW ELECTRONIC PATIENT LETTER SYSTEM

General practices can now receive patient letters from CCDHB electronically, significantly reducing the amount of staff time for paper handling and providing faster communication with practices on patient outcomes.

"The DHB has been working with our primary care partners around ways we can streamline the information we provide on our patients. One of the outcomes of this work has been the implementation of a system that allows us to email clinical letters from the hospital directly to the Primary Health Organisations and GPs within the DHB's catchment," says chief medical officer John Tait.

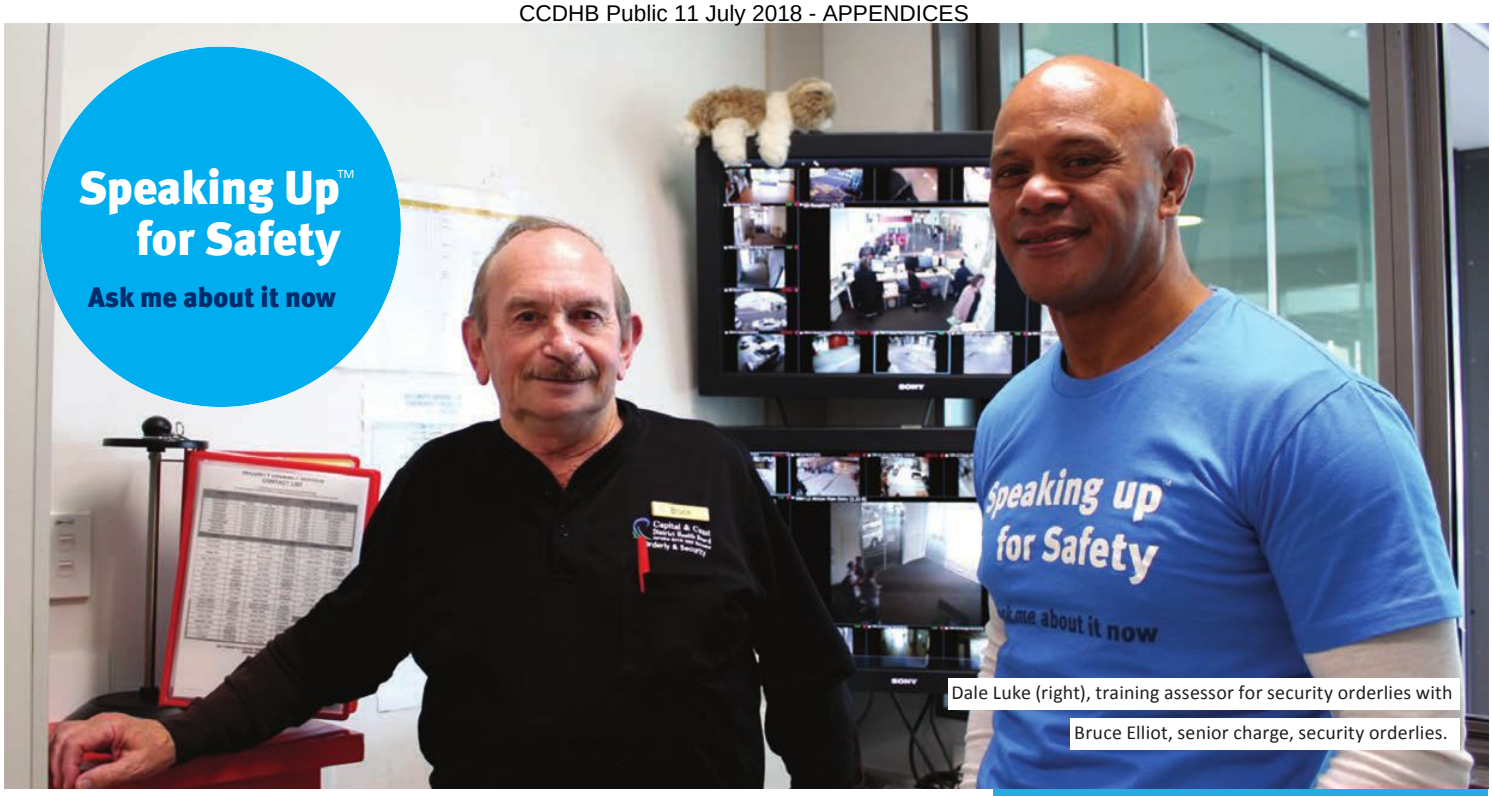
From the start of June, practices have had the option of signing up to the new system where patient letters are sent directly into Practice Management System inbox using the secure Healthlink network. All 92 of the DHB's partner practices have now signed up to the new system, and around 4,000 letters are sent to their inboxes each week.

"The service represents a more secure, faster and convenient means of providing GPs with correspondence on patients that have been seen in our outpatient clinics," John says.

Not only that, it also saves practices a large amount of time scanning letters into their system – approximately four hours a day according to practices that have already signed up.

Island Bay Medical Centre has been our testing partner in the project, and practice manager Darlene Natoli says the new system has made things much easier for the team. "The new system has lessened our administrative workload considerably and created costs savings through greater efficiency. It has been a great tool for improving productivity at our practice.

"It's also nice for patients to know that we receive their hospital letters on the same day – providing them with more certainty that we have their information and that it's secure," Darlene says.



Dale Luke (right), training assessor for security orderlies with Bruce Elliot, senior charge, security orderlies.

It's all about communication

Dale Luke has worked as an orderly for ten years at Wellington Hospital and has recently led his first Speaking up for Safety session, as part of our three-year Supporting Safety Culture programme.

He is passionate about the role of Speaking up for Safety (SUFs) in supporting staff to communicate with one another about any concerns, questions, or ideas they have.

As an orderly - and now an assessor trainer - Dale knows the importance of communication in helping to diffuse potentially aggressive situations. "What I like about Speaking up for Safety is it gives orderlies, and all our staff, the confidence to speak up."

"SUFs is all about communication and when it comes to deescalating a situation, communication is at the heart.

Dale has huge respect for doctors, nurses and staff dealing with agitated patients as it can be very challenging. "In our job we often get to a situation when things are at their worst." Dale says.

He aims to act as a bridge between patients and staff, working to create common ground when there are challenging circumstances. This includes sensitive situations requiring cultural awareness, such as dealing with bereavement and family.

By the end of this year, all CCDHB and Mental Health, Addictions and Intellectual Disability Service (MHAIDS) staff should have completed the one-hour SUFs training session, developed with the Cognitive Institute for healthcare settings.

Future focus areas of our wider Supporting Safety Culture programme later this year, include personal wellbeing and resilience as well as developing a culture of appreciation.

Every person in CCDHB, regardless of role or position, has an equal right and responsibility to speak up. "SUFs is an important tool to support this,"

Why this programme?

The purpose of Speaking up for Safety is to make it easier for you to speak up by:

- teaching everyone the skills to raise concerns about patient safety or staff conduct, assertively and with respect
- introducing a shared language and framework for how to raise concerns
- involving everyone; the board, executive leadership team, clinicians, managers and our whole DHB workforce
- promoting a safe and supportive environment by nurturing a positive safety culture

Training support:

Go to ConnectMe to book your Speaking up for Safety training, or email RES-ItsAboutOurPlace@ccdhb.org.nz to arrange a team training session.

For training in dealing with challenging incidents search 'Te Roopu Whakatau' on ConnectMe. This includes workshops focused on conflict resolution and managing aggression.

IT'S ABOUT OUR PLACE

PEOPLE STRATEGY

We were very proud to present the People Strategy to the Executive Leadership Team (ELT) and the CCDHB Board this month. The People Strategy, which is now on the intranet, provides a framework that will help to better develop our people and make CCDHB a great place to work. It brings together the observations, reflections and ideas that you have shared with us over the past 12 months about how you experience working here and how you imagine working here could be.

Our goal is for you to be excited to come to work, able to do your best work and proud to say you work here. To do that we have taken time to listen, learn and understand what is important to you.

The 2017 Staff Engagement Survey gave us a clear message as to what we should focus on improving, to make work 'as imagined', a reality. You identified eight key areas of focus, which are outlined in the diagram (above) and provide the platform for our People Strategy and upcoming plan of action.

ELT is now looking at developing this plan, which will include a work programme for the shorter and longer term. There are examples of projects already underway that support the strategy's key areas of focus. Our Workforce Systems Improvement Programme is an example of our focus on smart and simple ways of working with the project bringing together payroll, HR, finance and ICT to make our systems work better and smarter. Next month we will share some more examples as part of our 'You Said - We Did' People Strategy action update.

As part of the strategy's development we also wanted to understand how we should work together. Through our workshops, panels and discussion groups, four core principles consistently emerged (centre).

The principles give us compass points for when we are making decisions or planning our actions focused on developing CCDHB - do our choices fit with the principles our people have identified as key?

Together our key principles and themes will act as a framework to guide the development of our organisational planning.

TELL US WHAT YOU THINK: Take a look at the People Strategy on the intranet and let us know what you think. We're particularly keen on feedback around our eight key themes and four key principles.
Please email RES-ItsAboutOurPlace@ccdhb.org.nz or call Rachel Prebble on 027 685 2319.

VIEW FROM THE BOARD

Earlier this year the Board of CCDHB decided to put additional focus on the core of what we do – providing health services to the population we care for. To support this approach we set up the Health Systems Committee to take a strategic view of our services.

The committee is led by CCDHB Deputy Chair Fran Wilde and has a focus on health system investment and prioritisation, system and service planning and provider reporting and performance.

Open to the public, the committee meets monthly to consider a range of priority areas including implementing the Health System Plan, CCDHB's wider work plan and progress on Even Better Health Care initiatives. The committee then advises the Board on the needs of the health population and priorities for funding. Its advice is consistent with the Minister of Health's priorities, the New Zealand Health Strategy and the CCDHB Health System Plan.

Andrew Blair, Board Chair

• • •

At our 13 June Board meeting, we had a busy agenda which sustainability. Board members were very eager to learn about progress that's being made to reduce our environmental footprint which you can read in the sustainability update in the meeting papers for 13 June on our website. Our focus includes more sustainable management of material and waste flows, water and energy management, along with carbon reduction. We also approved the People Strategy, which you can read about on page 17. As a Board we agreed to also get involved in the future work in this space including developing our organisation's core values.

• • •

Finally, I'd like to thank you all for your patience as we work on the recruitment process around a new chief executive. I know for many of you the time since Debbie Chin's departure and the appointment of a permanent chief executive is frustrating, however the recruitment process is a key priority for the board. In the meantime we have been very fortunate to have had Ashley Bloomfield, on secondment from Hutt Valley DHB, lead our organisation, and now Julie Patterson, formerly Whanganui DHB chief executive. Like Ashley, Julie also brings a deep knowledge and understanding of how the health system operates and the importance of working together. I look forward to our continued momentum together.

WELLINGTON HOSPITALS FOUNDATION UPDATE

Wellington HOSPITALS FOUNDATION
"Getting well takes more than medicine"

Hospi's pyjamas for winter

We are delighted to announce over 2,500 pairs of pyjamas have been donated, along with some very generous online donations. These pyjamas are currently being distributed by Wellington Children's Hospital.

Thank you to all those who have made a donation so far. Help us reach our goal of 5,000 pairs of pyjamas this winter by dropping off new pyjamas at the receptions of Wellington Regional Hospital, Kenepuru Community Hospital or Kapiti Health Centre. Or donate at the WHF website and we'll buy a pair on your behalf.

National Volunteer Week - 17-23 June

To celebrate the work of Wellington Hospitals Foundation's 450 volunteers, we shared a number of volunteer stories during National Volunteer Week.

Here are two of our featured stories. You can read more about the work of our volunteers on the Wellington Hospitals Foundation website.

Bhargavi Rayakota volunteers at the weekends in the Emergency Department (ED), MAPU and ED Observation Unit. When she's not volunteering, she works in the lab at Wellington Regional Hospital. Bhargavi says volunteering is the best way to get to know the people in Wellington. It also gave her the opportunity to build up her English.

Margaret Lucas-Margaret has been a volunteer for over 15 years. She was a Pink Lady (ward volunteer) for many years, and now she is a knitter.

"This gave me a reason to get out of bed on a Monday morning! One of the best things on the ward was talking to the patients," she said of her time as a Pink Lady.

Unleashing the power of Allied Health

IPads like the one Fiona Gamble, community physiotherapist is using, helps her to provide a better service for patients in the community.

Numerous Allied Health professionals are embarking on a project focused on identifying how its services can contribute to the DHB's new Health System Plan.

The plan, which sets out a vision for how these Allied Health professions deliver services across the DHB is based around three settings of care – home, community and hospital – and looks at how these settings can contribute to building a system that improves people's outcomes and experiences of health services.

"Allied Health which included physiotherapists, social workers, occupational therapists and a range of other health professionals, plays an important part within our health system now. This project gives us an opportunity to develop options that will enable us to play a key role in improving health outcomes for our communities, and achieve the vision laid out in the Health System Plan," says allied health, technical and scientific executive director Catherine Epps.

The first step in the project involves information gathering to inform the work.

"This includes learning about the needs of people who access Allied Health already, and the needs of those who don't. At the same time, we will learn more about how our services work and what our services need in order to provide the care that our people need.

"We are talking to Allied Health staff and the services where we work with to find out what is working well and what could work better," Catherine says.

The project team is working closely with the various Allied Health leaders involved in the project within CCDHB, as well as with other Allied Health services working in primary care and in community organisations.

Catherine says that they next steps will involve a series of staff workshops being held later in August.

Anyone, wherever they work in CCDHB, who would like to have their say, are being invited to answer the following questions:

Q. What is working well for people and their whānau who need/use Allied Health services?

Q. What could work better?

You can email your thoughts to the project at RES-AlliedHP@ccdhb.org.nz.

NEWS in BRIEF

All Blacks in the house

On 15 June the patients and families at the Wellington Children's Hospital got a special treat when three members of the All Blacks squad popped in for a visit.

Prop Jeff Toomaga-Allen, and loose forwards Liam Squire and Sam Cane spent some time at the children's hospital meeting parents and brightening the kids' day. Go the All Blacks!

Major review of health system launched

Health Minister Dr David Clark has announced a review to look at how health and disability services will be structured, resourced and delivered in the coming decades.

Heather Simpson – former Chief of Staff to Helen Clark – will chair the review. An interim report is expected by the end of July 2019, and a final report by 31 January 2020.

Global plan to improve fitness

The World Health Organisation (WHO) has announced a new 'Global Action Plan on Physical Activity', aiming to have 15 percent more people internationally undertaking regular physical activity by 2030.

The plan coincides with the Ministry of Health and Sport New Zealand's work to develop a framework to increase New Zealanders' levels of physical activities.

New Director-General of Health

In June, interim chief executive Dr Ashley Bloomfield took up his new role as Director-General of Health and chief executive of the Ministry of Health.

Ashley has previously held various leadership roles at the Ministry, including Acting Deputy Director-General. Former Whanganui DHB chief executive Julie Patterson has stepped into the role of interim CE at Capital & Coast DHB.

Mental health inquiry

The Government Inquiry for Mental Health and Addictions visited our region last month. It was an opportunity to understand what's driving increased demand for services, and look at opportunities to improve mental health outcomes.

This month, the 3 DHBs submitted a formal response outlining the need to invest in a strong, capable and committed mental health sector. Recommendations from the inquiry are expected later this year.

Delegates Day

On 15 June, New Zealand Nurses Organisation (NZNO) delegates had an opportunity to meet with, and ask questions of, executive leadership team members.

'Delegates Day' was also an opportunity to network and plan how they can work together in the DHB. At least 20 DHB management staff participated, along with 31 delegates, and it was felt that the day was a success.

STATE SERVICES COMMISSION
Te Komihana O Ngā Tari Kāwanatanga

29 June 2018

Ms Julie Patterson
Acting Chief Executive
Capital and Coast District Health Board
PO Box 7902
Wellington 6242

for inclusion in Board Papers please Public Cb's report.

Dear Julie

NEW GIFTS, BENEFITS AND EXPENSES MODEL STANDARDS

I am issuing the enclosed *Chief Executive Gifts, Benefits and Expenses model standards* for State service chief executives using my powers under Section 57(4) of the State Sector Act 1988. These model standards will be effective from 1 July 2018.

The new standards outline my expectations for chief executives when accepting gifts and benefits, and incurring expenses while carrying out their duties. We developed the standards in consultation with chief executives from the Public Service and a number of Crown Entities. Thank you to those of you who provided feedback to us.

Key changes from existing guidance issued by the State Services Commission include expectations in relation to meeting nominal expenses and a requirement to disclose gifts and benefits that have been declined. The standards also clarify expectations in relation to accepting hospitality.

As an example, we were recently asked for advice regarding an invitation from Air New Zealand to attend the World of Wearable Art awards and a networking function. The new model standards state that the opportunity to 'network' is not a sufficient reason for accepting hospitality that is unrelated to a chief executive's core role.

My expectation is that you discuss the new model standards with your Risk and Audit Committee, Chief Financial Officer, and/or your Board Chair to ensure the standards are integrated into your agency's policies and processes.

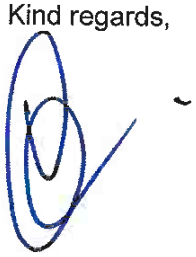
SSC has published a Guide for Agency Staff and a workbook for staff. Agencies are expected to use the workbook when preparing disclosures, as a standardised disclosure format supports greater transparency. You can find this guidance at http://www.ssc.govt.nz/ce-expenses-disclosure.

Failure to publish your disclosure on time will result in a reminder letter from the State Services Commission. Failure to publish your disclosure in accordance with the deadline set in the reminder letter will result in formal action being taken by the State Services Commissioner.

3 The Terrace
PO Box 329 Wellington 6140
New Zealand
Phone +64-4-495 6600
Fax +64-4-495 6686
www.ssc.govt.nz

Any questions about the new model standards should be directed to your respective SSC Assistant Commissioner or the team on CEexpenses@ssc.govt.nz.

Kind regards,



Peter Hughes
State Services Commissioner

ACTING IN THE SPIRIT OF SERVICE

Chief Executive Gifts, Benefits and Expenses

> New Zealanders need to be able to have trust and confidence in Public Servants and the Public Service. The Code of Conduct for the State Services makes it clear that it is unacceptable for any State Servant to use their role to advance private business interests or seek any sort of personal benefit.
>
> — **Peter Hughes, State Services Commissioner**

Chief executives hold privileged positions as stewards of the New Zealand Public Service. They make a commitment to serve in the best interests of New Zealand and New Zealanders - to act in the spirit of service at all times.

The positions chief executives hold come with very high expectations for standards of integrity and conduct. Chief executives must always put the interests of the Public Service and their organisation before their own personal interests to maintain the trust and confidence of New Zealanders.

Chief executives will, as is right, incur expenses as they carry out their role and they will be offered gifts and benefits, including hospitality. The decisions they make about these matters carry significant weight as they are subject to higher levels of public scrutiny than other public servants. Because of this, chief executives are expected to exercise the highest standard of judgement when accepting gifts and benefits or incurring expenses.

Chief executives are expected to use these standards when deciding whether to incur expenses or accept gifts and benefits, including hospitality.

SCOPE OF THE STANDARDS

While each chief executive must follow their own agency policies in deciding whether to incur expenses or accept gifts and benefits, these standards set out a higher expectation of Public Service chief executives.

There are four key elements to these standards:

1. **Getting the foundations right from the start:** ensuring chief executives are aware of the different policies and guidance which govern gifts, benefits and expenses.
2. **Decision making is robust:** taking an active approach to the consideration of where public money is spent and the perceived benefits or consequences of accepting or declining gifts and benefits.
3. **Processes are in place:** ensuring a central record of decisions regarding expenses, gifts and benefits is kept and is up-to-date.
4. **Disclosures are consistent:** ensuring chief executives comply with the expense disclosure guidance by SSC including the publishing of disclosures online within the specified timeframes.

GETTING THE FOUNDATIONS RIGHT FROM THE START

Policies

There are a range of policies and guidance which all public servants, including chief executives, need to be aware of and comply with.

Each agency will have policies to cover such situations. These model standards set out the higher expectations of chief executives.

Model standards:

Chief Executives comply with the following guidance and policies to inform how they exercise their judgement when making decisions:

- State Services Standards of Integrity and Conduct
- Auditor-General's guidance on sensitive expenditure
- Conflicts of Interest model standards
- Individual agency policies.

DECISION MAKING IS ROBUST

Gifts and benefits

Chief executives must exercise the highest judgement when deciding to accept any gifts and benefits, including hospitality from third parties. It is not acceptable for chief executives to use their position for personal gain, or be perceived to be doing so.

There will always be a public perception of influence or personal benefit if chief executives accept gifts, benefits, or hospitality. It is critical to maintaining public confidence that the integrity and motivations of chief executives are not called into question.

The opportunity to 'network' is not a sufficient reason for accepting hospitality that is unrelated to a chief executive's core role. For example, and regardless of who is in attendance, any offers that are not directly related to fulfilling the obligations of their role should be declined. This could include tickets to sports matches or concerts.

If gifts, benefits or hospitality are accepted, they must be publicly disclosed through the annual chief executive disclosure process. This process promotes transparency and ensures we are being open with New Zealanders about exactly what we are accepting from who.

Model standards:

- It is expected that when gifts and benefits are accepted there will be a transparent process of registration and declaration.
- All gifts and benefits with a value greater than $50 that are accepted must be disclosed through the annual chief executive expense disclosure process. Chief executives may choose to share gifts under this value with their staff or donate it to charity.
- Chief executives should decline gifts or benefits from a third party that places them under any obligation or influence, both real and perceived.
- Gifts and benefits that are declined should be disclosed.
- When presented with ceremonial gifts, these are expected to remain the property of the organisation rather than the chief executive. This reflects the relationship that gave rise to the gift.
- The disclosure must specify what was done with the gift or benefit.

Expenses

Expenses, including domestic and international travel, are part of the role chief executives hold.

Chief executive expenses should be modest as they have an obligation to use public resources prudently.

Chief executives may choose to meet some costs personally, such as lunch when travelling for the day or hospitality provided at staff functions, rather than claim them.

Chief executives give consideration to how claims may be perceived, for example the public would expect chief executives cover nominal expenses such as coffee, bus fares or short taxi rides.

Model standards:

- Nominal expenses are met by the chief executives themselves.
- Travel costs are kept to a minimum at all times and opportunities are taken to reduce costs where practicable.
- Hospitality costs are appropriate for the guest(s) and the occasion.
- Chief Executives ensure their expenses are reviewed by an appropriate person, such as a Risk and Audit Committee member, Board Chair (for Crown Entities) or the Chief Financial Officer.

Involvement of other agencies

While chief executives are ultimately responsible for their own decisions, there are some circumstances where it is expected that they will consult and/or advise other agencies in order to make an informed decision.

Training and Development

There is a requirement that chief executives consult with the State Services Commission (or their Board Chair) on any training and development expenses they wish to incur to ensure it is relevant to their role.

Diplomatic Events

Chief executives should advise the Ministry of Foreign Affairs and Trade on any international or diplomatic invitations - whether they are for an event held in New Zealand or overseas. MFAT is best placed to provide advice on any relevant protocols, as well as on New Zealand's diplomatic relationships with other nations.

Invitation to Partners

In the rare circumstance where it could be justifiable for a partner to incur expense (for example, where non-attendance of the partner risks causing offense, a breach of protocol or etiquette, or embarrassment), chief executives should consult the State Services Commission.

Unsure?

In any situation where a decision is unclear, chief executives are expected to consult the State Services Commission for advice.

PROCESSES ARE IN PLACE

Documentation

Centralised record keeping by chief executives will support them to disclose gifts, benefits and expenses accurately, on time and in full. This will be particularly helpful where different aspects are dealt with by different people.

Centralised record keeping requires chief executives to be able to log and provide auditable details.

There may also be valid national security reasons that result in some gifts, benefits and expenses not being disclosed, however these should still be recorded internally by the agency.

Model standards:

- Chief executives maintain a central, up-to-date record of all gifts, benefits and expenses.
- Chief executives must record the rationale behind all decisions made.
- Chief executives must record a clear monetary value against all records. Where the monetary value is unknown, an estimated value should be provided.
- For gifts and benefits:
  - Chief executives must also record how any gifts have been used
  - Chief executives must record any gifts or benefits declined and the rationale for this.
- Chief executives should include documentation of who reviewed their expenses.

DISCLOSURES ARE CONSISTENT

Disclosing expenses, gifts and benefits

Chief executives publicly disclose all items experienced or used or declined in performing their role. Guidance on making these disclosures is separate and is available at http://www.ssc.govt.nz/ce-expenses-disclosure

Publishing clear and detailed disclosures is integral in building and maintaining the public's trust and confidence in the State services.

Model standards:

- Disclosures should be reviewed by an appropriate person, such as a Risk and Audit Committee member, Board Chair (for Crown Entities) or the Chief Financial Officer.
- Disclosures must be formally approved by the chief executive personally.
- Gifts, benefits and expense disclosures are published in full and on time as per the State Services Commission's disclosure guidance.
- Chief executives will publish both accepted and declined gifts and benefits as part of their yearly disclosures.

Review of Clinical Governance at Capital & Coast DHB.

Prepared for Dr. A Bloomfield

Interim CEO CCDHB

Review conducted by:

Dr. Mary Seddon MBChB, FRACP, FAFPHM, FRACMA

Seddon Healthcare Quality Ltd

Email: mzseddon@gmail.com

Mobile: 027 576969669

Glossary of terms.

ACP	Advance Care Planning
ADETT Tool	Adverse Drug Event Trigger
ALT	Alliance Leadership Team
CCDHB	Capital & Coast DHB
CCDM Management	Care Capacity and Demand
CPHAC-HAC Committee	Community & Public Health Advisory Committee – Hospital Advisory
CYMR Review	Child and Youth Mortality
DSAC Committee	Disability Services Advisory
ED	Emergency Department
ELT	Executive Leadership Team
ERAS Surgery	Enhanced Recovery After
FRAC Management Committee	Finance, Risk and Audit
GTT	Global trigger Tool
HDC Commission	Health & Disability
HHS Services	Hospital and Healthcare
HQSC Commission	Health Quality & Safety
HRT	Health Roundtable
IA	Improvement Advisory
ICC	Integrated Care Collaborative
IHI Improvement	Institute for Healthcare
MCC Community	Medicine, Cancer and
MET	Medical Emergency Team
MFI	Model for Improvement
MHAIDS Intellectual Disability	Mental Health, Addiction and
M&M meeting	Mortality & Morbidity
MoH	Ministry of Health
MOS System	Management Operating
PMMR Morbidity Review	Perinatal Mortality and
PGY1	Post Graduate Year 1
PSCG Governance Committee	Primary/Secondary Clinical
SIP Performance	Strategy, Innovation and
SMO	Senior Medical Officer
SSE	Serious and Sentinel Events
SWC Children	Surgical, Women and
RMO	Resident Medical Officer
RCA	Root Cause Analysis
ToR	Terms of Reference
QI	Quality Improvement
QA	Quality Assurance
QIPS Patient Safety	Quality Improvement and
QSM	Quality Safety Measure

Contents

Table of Figures

Table of Tables

Tables of Appendices

Executive Summary

This review was requested by Dr. Ashley Bloomfield, acting CEO of Capital and Coast District Health Board (CCDHB).

It was commissioned as there was concern that the ELT and the Board were not receiving adequate information on the quality of care provided in CCDHB. The scope of this work was DHB-wide, encompassing, the 3 DHB Mental Health, Addiction, and Intellectual Disability Services (MHAIDS), the integrated care collaborative, the Primary/Secondary Clinical Governance Committee and the Hospital and Healthcare Services (HHS).

CCDHB serves an ethnically diverse population, and while there are pockets of high deprivation, on the whole, the population is better educated, with higher incomes and less deprivation than the New Zealand population. CCDHB is the sixth largest DHB and serves approximately 300,000 people in the Wellington area. It is also a tertiary hospital of the lower North Island for medical, surgical and psychiatric specialist conditions.

The draft Health System Plan (Working together for better lives, 2018) presents a roadmap for the future of health service delivery for CCDHB – one built on partnerships with the community and other healthcare providers, with five strategic areas that cover stages of health and ill health – from "promoting health and wellbeing" to "supporting the end of life with dignity." It proposes splitting the region into eight localities with the health needs of each locality assessed and health services designed to meet these needs. This approach, along with strong hospital-based care is likely to be an effective way to face the current and future pressures on the health service.

This review has examined CCDHB's clinical governance structures (which are unnecessarily complex and siloed), and each of the four quadrants of the Health Quality & Safety Commission's clinical governance framework: Quality Improvement/Patient Safety; Consumer Engagement and Participation; Clinical Effectiveness; and an Engaged, Effective Workforce.

CCDHB is doing a lot of things well across these quadrants with the best work seen in the Engaged, Effective Workforce. Consumer participation is not well developed though there are some exemplar units. The Quality Improvement/Patient Safety quadrant again has some areas of excellent work however it is not yet reaching its potential. There is not a culture of measuring clinical effectiveness, an area that requires development.

Summary of Clinical Governance Structure

There is no one at executive level with accountability for the quality of care delivered across the DHB. The ELT do not appear to be getting regular reports, and the Board only receives reports quarterly.

The Clinical Governance structure is not coordinated and is complex with three different directorates involved (HHS, MHAIDS and Strategy, Innovation and Performance), each taking a different approach to quality. The Quality Improvement and Patient Safety (QIPS) Directorate reports through to the HHS Clinical Governance committee, and their reports are part of the GM HHS reports. SIPs on the other hand has direct ELT visibility and the funding and autonomy to make large scale changes.

The provider arm clinical governance committees all sit under the HHS and at the moment, are of variable quality – many have out-dated terms of reference and are unclear of their reporting. The QIPS Directorate also sits under HHS rather than DHB-wide

MHAIDS has its own challenges operating as it does across 3 DHBs. As the DHBs do not have a common vision for MHAIDS, let alone common organisational processes, there are serious structural impediments to good clinical governance. There is not a clear line of sight from the CE and Executive Team as to the issues in MHAIDS and there is a perception that clinical leaders and the clinical voice is not currently heard effectively. The draft consultation document is a move in the right direction to clarify the future role of the 3 DHB MHAIDS.

Most DHBs have an Infection Prevention and Control Committee, however, CCDHB does not. There is good clinical engagement, however it will be important to ensure that infection prevention and control matters are visible to the ELT.

There is overlap between the ALT ICC and the Primary/Secondary Clinical Governance Committee, which needs to be looked at. The Clinical Council should also refine its scope.

The current structure is overly complex and does not support the flow of information on quality of care to be reported to the ELT and the Board.

Recommendations

1. ELT position accountable for clinical governance/quality improvement and patient safety. This could either be a new Executive Director for Clinical Governance or split amongst the three Professional Heads
2. Reinstate the Strategic Clinical Governance Committee as the Peak Quality Committee. All clinical governance committees would report here (rather than HHS or MHAIDS), and would link with ALT ICC, the Primary Secondary Clinical Governance Committee and Clinical Council
3. Simplify clinical governance committees
    - Amalgamate Death Review Committee and Clinical Recognition and Response Committee
    - The Clinical Practice committee – may become a role for the Clinical Council, but would require funding. Alternatively make it a regional committee.
    - Up-date ToR and reporting lines
4. Quality Improvement and Patient Safety (QIPS) Directorate to move out of the HHS and be a DHB-wide unit. This could either be a stand-alone unit reporting to an Executive Director of Clinical Governance, or it could combine with the Strategy, Innovation, and Performance Directorate
5. QIPS to have a dedicated leadership team – Manager, Medical, Nursing and Allied Health leaders.
6. Ensure that the clinical voice is heard at all levels and that there is reporting through from the MHAIDS clinical governance committee to the Strategic Clinical Governance Committee.
7. Progress with the consultation phase with MHAIDS staff as to the future organisation of the 3 DHB model, with the aim of greater integration and seamless care across the region.
8. Mission statement, Vision, and Values - recommend starting again, simplifying, and co-designing with staff and consumers

Summary of CCDHB Quality Improvement and Patient Safety.

There is a good deal of good work going on in this area, though the structure is not supportive of a DHB-wide approach. The reporting to the ELT and the Board is insufficient for them to discharge their duties in this respect.

The DHB has not defined its overall QI methodology – QIPS use the Model for Improvement, whilst SIPS use project management – and middle and upper level managers and leaders are not trained in QI.

Not everyone with a QI job title has received the appropriate training – and this includes in the conduct of Root Cause Analyses (RCA).

There are specific concerns regarding the resourcing of the Child, Youth Mortality Review (CYMR) and the delays in completing RCAs (in both HHS and MHAIDS).

Recommendations

1. Decide on a DHB QI methodology. The Model for Improvement is already being rolled out and there are three improvement advisors trained in its use, so it would seem sensible to continue with this. Train middle and senior leaders in this approach so that they can sponsor others as they complete their projects.

2. Rationalise QI reports. Produce a monthly report for ELT and the Board. This should cover the HHS, MHAIDS and the ICC, with separate sections for each. The reports should cover the 6 dimensions of Quality, and be presented in such a way that Board members can be alerted to areas of concern. The report should be presented to the Board by the person accountable for clinical governance.
3. Ensure that people appointed to Quality Manager and Quality Facilitator roles have the appropriate training in QI and RCA
4. Investigate why the Global Trigger Tool (GTT) and the Adverse Drug Event Trigger Tool (ADETT) reports are no longer available
5. Review current RCA model – consider cluster analysis or shorter investigation templates for common conditions. Ensure that recommendations are sense-checked with the clinical teams and that they are robust and acted on.
6. Use the Strategic Clinical Governance Committee to ensure that all projects are visible
7. Increase resourcing for the CYMR and ensure that there is a channel for concerns raised by this and the Perinatal Mortality and Morbidity Review (PMMR) group.

Summary of CCDHB Consumer Engagement and Participation

There are patches of excellent patient/consumer engagement and participation, however, it is not embedded in the CCDHB fabric at this time. Patient feedback is in the form of the Patient Experience Surveys, but it may be time to augment this approach.

The Board has been keen on a consumer council, however, it did not eventuate and instead a Citizen's Council has been proposed with the first meeting due in July. It will be important that the council has a clear scope and that it has direct responsibility for some projects.

That being said, there may be better ways to get patient and consumer feedback and participation in co-design. Several other DHBs collect real-time feedback from patients and establish virtual groups that can be called on for co-design projects. The Kenepuru example is useful, as is the consumer co-design in the build of the new Children's Hospital. In each case, a smaller clinical area built its own consumer representation, facilitated feedback and worked together with staff. Building on this work CCDHB has partnered with the HQSC to progress patient and family co-design.

Recommendations

1. Encourage and support (with training and tools), service specific consumer engagement and progress the HQSC training in co-design
2. Review the Patient Experience Survey – possibly stop the monthly surveys and look at other ways to secure real-time feedback. Investigate alternative methods to gather patient feedback to allow for low response rates for patient experience surveys – e.g. i-pads available during admission/outpatient appointment asking the Net Promoter Question of patients. Ensure consumers and Maori and Pacific health teams are involved in the design.
3. Develop capacity to video patient stories so that a bank of stories about common issues can be used for staff engagement and education.
4. Ensure that consumer representatives on committees are given training and support
5. Review the Advance Care Planning programme with a view to extending it.

Summary of Clinical Effectiveness

This element requires some work at CCDHB, to ensure that the clinical care delivered is effective and that data on its effectiveness is available for front line clinicians (to encourage improvement), and in summary format for the Executive and Board. There appears to be no organizational view of clinical performance with some units not measuring clinical indicators, and others participating in Australasian registries, but the data is delayed and is not generally viewed locally.

CCDHB does contribute to the Health Roundtable, which allows benchmarking with peers, however the data appears to be underutilized.

The governance of research and clinical audit work could be improved and more could be done to build useful clinical databases to support audit.

A recurring theme from the interviews is that there is good clinical engagement at CCDHB and that staff are resilient because of years of fiscal constraint – "austerity means that people stick to their knitting." It maybe that this is the reason for the lack of obvious measurement and energy in the Clinical Effectiveness domain.

Recommendations

Mortality & Morbidity Meetings:

1. CMO to discuss with clinical leaders, seen as core expectation, should involve whole multi-disciplinary team
2. CMO to review the NSW M&M process, and if suitable, to introduce it
3. Annual report to Strategic Clinical Governance Committee on themes from each meeting

Clinical Audit

4. Summary of clinical audits undertaken and results reported to the Strategic Clinical Governance Committee

Clinical Indicators

5. Scan of each department to document clinical indicators currently collected and assess barriers to greater engagement in this activity
6. Clinical Council to consider whether the Management Operating System (MOS) would assist in embedding key clinical effective measures

Summary of CCDHB Engaged Effective Workforce.

There is a good deal going on in this space and there is good clinical engagement. The main areas in the staff survey were around 'communication' and 'staff not feeling safe and supported.' The People and Capability Directorate have engaged staff in workshops and the draft People Strategy looks very good.

There is good access to training and development (including leadership training), though there is the question of whether rosters are robust enough to release people for training.

Likewise, the time allocated for clinicians in leadership roles needs to be reviewed, especially for the smaller units where it is only a couple of hours per week.

Credentialing and professional appraisal for senior medical staff needs to be strengthened.

Recommendations.

1. Continue with the Speaking up for Safety programme and ensure that staff safety and patient safety are both emphasized
2. Review the current number of, the expectations of, and time allotted to, Medical leaders
3. Perform exit reviews for the two Executive Directors Medical (MCC) that have resigned
4. Develop a standardised credentialing process with an electronic register of each SMO's individual Scope of Practice

Way Forward.

This is a review of the current state of clinical governance at CCDHB with selected recommendations.

I think that the major pieces of work are to simplify the structure and the reporting of quality performance, so that those at the front line and at the Executive and Board level can act to improve the quality of care delivered by CCDHB.

As an external reviewer, I cannot know the organisation like those who work in it; I have listened to what people have said and have tried to learn as much as I could. I would like to thank those who took the time to meet with me, and to the office of the CE for organising my time.

Review methods.

Subject of Review

The review was focussed on Clinical Governance at CCDHB. Clinical governance is an organisation-wide approach to continuously improve the quality of care provided. In practice it requires managers and clinicians to be involved in not only the day-to-day work, but also on how to make that process of work better.

The New Zealand Health Quality & Safety Commission (HQSC) have produced a guide for DHBs on clinical governance, and they outline four domains of clinical governance:

1. Consumer/patient engagement & participation
2. Clinical effectiveness
3. An engaged, effective workforce
4. Quality Improvement and Patient Safety

Scope of Review

The scope was the DHB, rather than just the hospital/provider arm. To this end the primary/secondary interface was in scope, notably the longstanding 'Primary-Secondary Clinical Governance Committee, and the 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS). The recently commenced initiatives to promote a safety culture, e.g. 'Speaking up for Safety', were also in scope. The review was to give due consideration to ways to ensuring equity, as a key dimension of quality, which is integral to the organisation's clinical governance arrangements.

Methodology

Review to be based on the Health Quality & Safety Commission's (HQSC) Clinical Governance framework.

The process of review consisted of reviewing internal and external documentation (appendix 1) and analysis of information provided by Key stakeholder interviews (appendix 2).

Limitations

The assessment and analysis conducted for this Review was limited to the time, information & data that was available.

Reports and information were accepted as provided; every effort was made to corroborate the information however, time did not permit validation of all the information. The report has not reviewed the IT strategic plan, though it is acknowledged that this is an important area for CCDHB to develop.

CCDHB Context.

Capital & Coast DHB serves a diverse community of approximately 300,000 people in Wellington, extending to Porirua and the Kapiti Coast. The population is younger than the national average with a large proportion aged between 20 and 49.

Capital and Coast is an ethnically diverse population 11.5% identify as Maori and 7% as Pacific (higher than the national average) and 15% Asian. The ethnic make-up of each area is also quite different. Porirua has a larger proportion of Maori (20%) and Pacific people (21%). The Maori and Pacific population also tended to be younger with 31 % of Maori and 27% of Pacific people aged under 15.

While it has pockets of deprivation, overall Wellington has a high proportion of people in the least deprived section of the population. (1) The Wellington region has a relatively slow population growth of only about 2% per year.

CCDHB provides tertiary services to the Central region – this includes Hutt Valley, Wairarapa, Mid Central, Hawkes Bay and Whanganui DHBs. It also works closely with Hutt Valley and Wairarapa DHBs, and is part of the 3DHB Mental Health, Addiction and Intellectual Disability Service (MHAIDS).

CCDHB provides services through the Kapiti Health centre and three hospitals – Wellington Regional Hospital in the central city, Kenepuru Hospital in Porirua and Ratonga Rua Hospital (mental health and intellectually disability) also in Porirua.

CCDHB has the equivalent of around 4,300 full time staff, making it a major employer in the Wellington region.

The DHB is the sixth largest in New Zealand and has an annual budget of more than $1 billion. Despite this there is a recurring theme amongst interviewees that there has been a long history of underfunding, which has had a detrimental effect on the culture.

The other context is that CCDHB is a training institution for medical students (part of the Otago University Clinical School), Nurses and the Allied Health, scientific and Technical workforces. There appears to be little obvious communication/collaboration between the CCDHB leadership and the leadership of the academic institutions.

New Zealand Health Strategy: Future Direction

CCDHB operates in the New Zealand public health system and is guided by the New Zealand Health Strategy (2) – see Figure 1.

Figure 1. New Zealand Health Strategy

CCDHB Health System Plan: Working together for better lives, 2018

The Plan sets out the direction for the CCDHB health system from 2016 through to 2030, and is in line with the New Zealand Health Strategy. The Plan emphasises the whole patient journey, particularly a focus on keeping patients well, "enabling patients to be their own leaders in healthcare," and working across the healthcare system. Five strategic focus areas underpin the Plan (see figure 2).

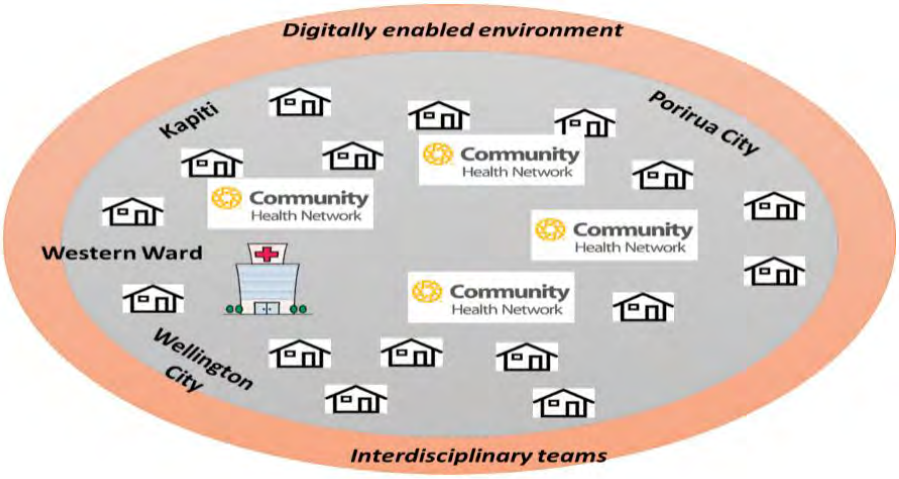
Figure 2. Five strategic Focus Areas

The strategy aims to be people and whanau led and within this identifies three groups vulnerable to inequalities – the socially vulnerable, those with a mental illness or addiction, and those with a disability. It is interesting that this does not explicitly include Maori and Pacific peoples, though they do make up the major groups in the socially vulnerable category.

The Plan also brings the concept of locality planning and healthcare delivery, with 4 localities defined (see figure 3), and three settings of care – people's homes and residential care, Community Health Networks and Hospitals (Kenepuru, Wellington Hospital). This system relies on interdisciplinary teams and a "digitally enabled environment" (see Figure 4)

Figure 3. Structure of the Health System Plan

Figure 4. Settings for care delivery



Overall the strategy challenges the traditional hospital-focused healthcare system and is likely to produce better health outcomes, reduce the acute demand on the hospital sector and inequities.

CCDHB Vision and values.

CCDHB Vision:

Better health and independence for people, families and communities (September 2017)

Best possible quality of life throughout life for all, through keeping people well including focussed action to eliminate inequitable differences of the health of our population (Draft Health Services Plan 2018).

The recent iteration of the DHB vision from the draft Health Services Plan, is rather long and could be improved. However, it does state the aim of eliminating inequities

CCDHB Mission:

Together, improve the health and independence of the people of the district.

This is very similar to the original vision. Not sure of the value of having both a vision and a mission statement.

CCDHB Core values:

- *Innovation*
- *Action*
- *A focus on people and patients*
- *Living the treaty*
- *Professionalism through leadership, honesty, integrity and collaboration*
- *Excellence through effectiveness and efficiency*

There is considerable overlap between the vision, mission, and the core values. This list goes out on all Job Descriptions, and while all the sentiments are sound, they are hardly inspiring. Recommend starting again, simplifying, and co-designing with staff and consumers.

Triple Aim:

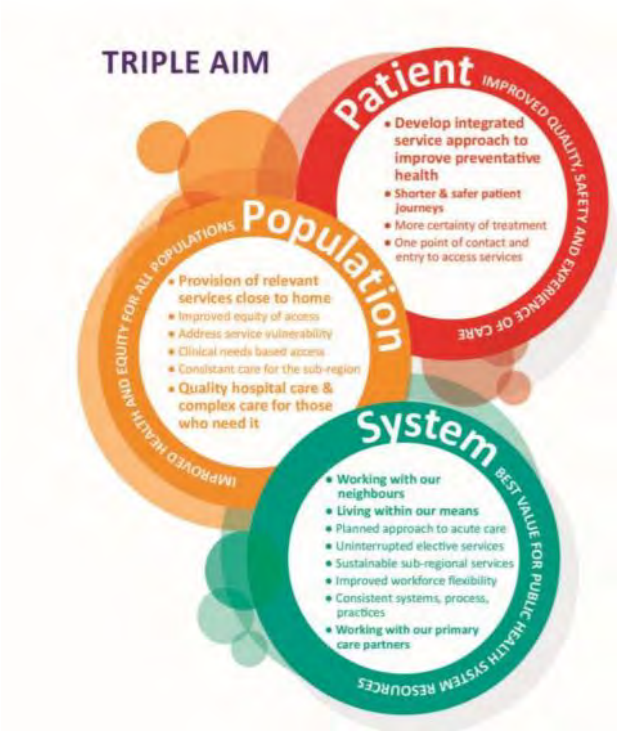
The HQSC developed a NZ version of the triple aim (see Figure 5). The original came from the Institute for Healthcare Improvement's (IHI) which stressed 3 bottom lines to deliver value in healthcare:

1. Improving the individual patient experience,
2. Improving Population Health and
3. Improving cost per capita

Figure 5. HQSC Triple Aim

CCDHB has added some detail to the triple aim (see Figure 6) changed the triple aim, emphasising integrated services, provision of services closer to home, and working with the primary care partners.

Figure 6. CCDHB Triple Aim



Clinical Governance

The term Clinical Governance was first proposed in the UK where it was defined as:

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (3)

This definition is intended to embody three key attributes: recognizably high standards of care, transparent responsibility and accountability for those standards, and a constant dynamic of improvement.

More recent definitions have tried to explain the central role of clinicians.

“Clinical Governance is an umbrella term which encompasses a range of activities in which clinicians should become involved in order to maintain and improve the quality of the care they provide to patients and to ensure full accountability of the system to patients.” (4)

The New Zealand Health Quality & Safety Commission (HQSC) have recently published their Clinical Governance Guide, (5) which build on these principles to identify four key domains of clinical governance:

1. Consumer engagement and participation - with a strong patient-centred ethos
2. An engaged/effective workforce – to participate in clinical governance
3. Clinical Effectiveness – including an open and transparent culture
4. Quality Improvement/Patient safety to continuously improve the care provided

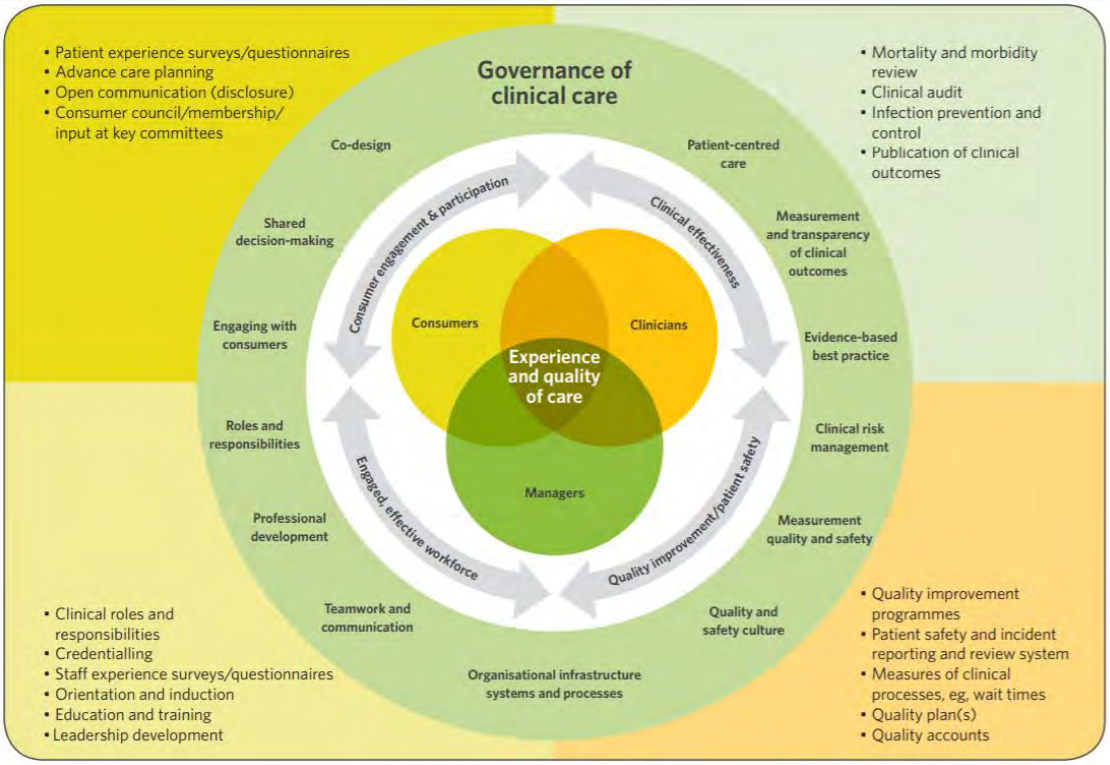
The HQSC identify structures and processes under each of these four domains as demonstrated in Figure 7. At the centre they have the primary outcome as the “experience and quality of care” with clinicians, managers and consumers working together to achieve this. Principles for each of the four

components form the next ring (e.g. evidence-based best practice), and the four quadrants list activities for each component (e.g. mortality & morbidity reviews).

It is this HQSC document that guides this review of CCDHB clinical governance.

Definitions of clinical governance have evolved over time, with greater emphasis on patient and consumer involvement and defining quality of care as outcomes that matter to patients.

Figure 7. HQSC Clinical Governance Framework



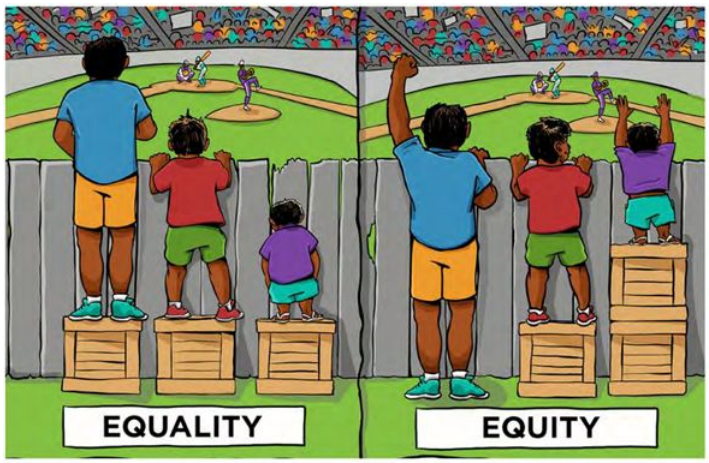
Definition of Healthcare Quality

The essential components of a high-quality healthcare organisation were defined by the Institute of Medicine in their seminal book – Crossing the Quality Chasm in 2001. (6) They highlighted six key dimensions (the STEEEP dimensions) of healthcare quality. These dimensions define quality and allow a focus for measurement and improvement of that quality:

1. *Safe*—avoiding injuries to patients from the care that is intended to help them.
2. *Timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care.
3. *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status
4. *Effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
5. *Efficient*—avoiding waste, including waste of equipment, supplies, ideas, and energy.
6. *Patient-centred*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

The definition of equitable care in the original IOM list - basically treating everyone the same - is really a definition of equality, and therefore does not satisfy the aim of equitable access to care and equity of health outcomes. This requires those disadvantaged or facing unique barriers to be provided with 'different care' to achieve the same outcomes (see figure 8).

Figure 8. Equality versus equity



There are two main philosophies about how to improve healthcare quality - Quality Assurance (QA) and continuous Quality Improvement(QI).

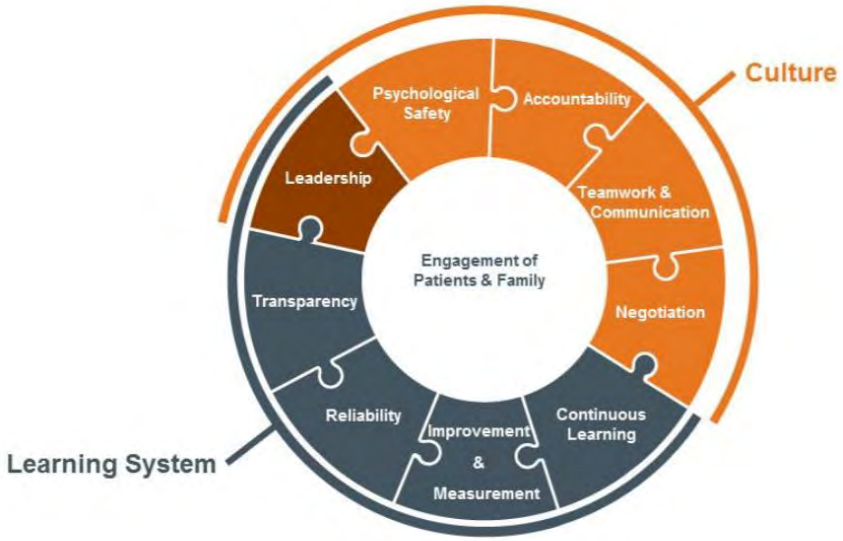
Whilst QA is important, over time the importance of continuously improving quality (rather than meeting minimum standards) has been recognised as the philosophy for excellence in healthcare. QA is necessary but not sufficient to transform healthcare quality. The table below details the distinctions between QA and QI.

Table 1. QA versus QI

	Quality Assurance	Quality Improvement
Motivation	Measuring compliance against standards	Continuously improving processes to meet and exceed standards
Means	Inspection	Small test of change
Attitude	Required, defensive	Chosen, Proactive
Focus	Outliers: "bad apples" Individuals	Processes, Systems
Scope	Clinicians	Patient care
Responsibility	Few	All

More recently the importance of organisational culture and staff engagement/learning have emerged as critical factors. They are the two umbrella principles in the framework below (figure 9), which depicts the components required for safe, reliable and effective care, from the 2017 Institute for Healthcare Improvement (IHI) White paper. (7)

Figure 9. Framework for safe, reliable and effective care



There are a number of well-known methodologies that can be employed to continuously improve quality. The three commonly used are: The Model for Improvement, Lean thinking, and Six Sigma. They share some characteristics – particularly in the time spent defining the problem and its causes, rather than rushing to solutions. Other principles, such as observing actual work processes (rather than work as imagined) and valuing front-line clinical input are also common to all three.

While it can be useful to have one methodology that staff understand, many of the tools within the different models can be used depending on the problem definition. For instance, if it is a problem with a poorly performing process (e.g. acute admissions), then a value stream map (to highlight blockages and low value steps) using lean thinking might be the most appropriate tool. If it is a problem in which the solution is not known, then using the Model for Improvement and PDSA cycles will likely lead to the best result.

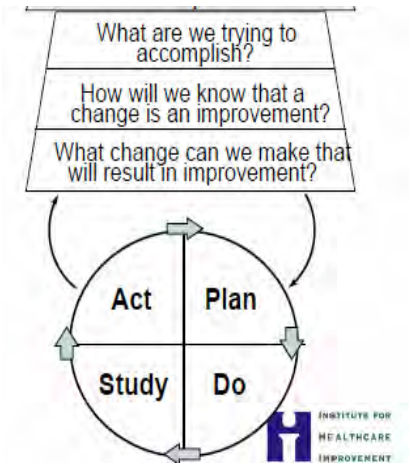
The Model for Improvement (MFI).

This model (8) asks three important questions:

1. What are we trying to achieve? This requires a clear statement of aim and evidence of a problem.
2. How will we know that a change is an improvement? This requires measures to assess the change.
3. What changes can we make? Uses small changes to trial and learn from (Plan, Do, Study, Act cycles).

This MFI has been used by Counties-Manukau DHB for over a decade and is the basis for the CCDHB Quality plan.

Figure 10. Model for Improvement



Lean thinking

Lean was born out of the study of the Toyota production system and aims to decrease waste. In healthcare this means identifying waste (e.g. patients waiting, excessive storage of consumables etc) and designing processes to maximise value. One of the central tenants of lean thinking is the value of observing the frontline work (Gemba) and valuing frontline workers input into improvement. Canterbury DHB has used lean thinking methods for a number of years.

Six-sigma.

This has also come out of a manufactory base (Motorola and General Electric) and its overriding aim is to decrease defects in outputs.

Six sigma seeks to improve the quality of the output of a process by identifying and removing the causes of defects and minimizing variability in manufacturing and business processes.

Key features of Six Sigma include:

- A clear focus on achieving measurable and quantifiable financial returns from any Six Sigma project.
- An increased emphasis on strong and passionate management leadership and support.
- A clear commitment to making decisions based on verifiable data and statistical methods, rather than assumptions and guesswork.

Auckland District Health Board (ADHB) has an organisational commitment to using both lean and six sigma methodologies for its QI and patient safety work. All managers are trained in the theory and practical application and this provides a common language around improvement.

Review of Clinical Governance Structure at CCDHB.

The Clinical Governance structure includes the Board and Executive Leadership team, the organisation of the major clinical units and the clinical governance subcommittees. At a DHB-wide level it also includes the structures that bridge the primary/secondary divide and that work at a population level.

DHB Board and Executive Leadership Team

The DHB is governed by a Board (seven elected and three appointed members), that has three sub-committees. These are the Finance, Risk and Audit Management Committee (FRAC), the recently merged Community & Public Health Advisory-Hospital Advisory Committee (CPHAC-HAC) and the 3 DHB Hospital Disability Services Advisory Committee (DSAC).

There is also a 3 DHB Maori Partnership Board that includes representatives from the four local iwi, a sub-regional Pacific Island Advisory Forum and a sub-regional Disability Advisory Group. They all take a strategic approach and are aligned with the CCDHB Board.

James Conway (9) from the Institute for Healthcare Improvement in his paper 'Getting Boards on Board' has outlined the six things that all Boards should do to improve the quality of care and reduce patient harm:

(1) setting aims—set a specific aim to reduce harm this year; make an explicit, public commitment to measurable quality improvement;

(2) getting data and hearing stories— select and review progress toward safer care as the first agenda item at every board meeting, grounded in transparency—and putting a "human face" on harm data;

(3) establishing and monitoring system-level measures—identify a small group of organization-wide "roll-up" measures of patient safety that are continually updated and are made transparent to the entire organization and its customers;

(4) changing the environment, policies, and culture— commit to establish and maintain an environment that is respectful, fair, and just for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error;

(5) learning, starting with the board— develop the board's capability and learn about how "best-in-the-world" boards work with executive and medical staff leaders to reduce harm;

(6) establishing executive accountability—oversee the effective execution of a plan to achieve aims to reduce harm, including executive team accountability for clear quality improvement targets.

This has been up-dated more recently by Pronovost and colleagues in their paper "Taking Healthcare Governance to the Next Level" (10) with an emphasis on how Boards can drive patient harm prevention and align quality improvement work (see Figure 11).

"If healthcare is to improve, it will need to ensure [that] the board takes a more systematic and disciplined approach to ensuring quality and patient safety."

Figure 11. Strategies for Boards to Govern Quality

Strategy	How To
Organization-wide agreement on purpose	Leaders commit to elimination of preventable harm and excellence of patient care.
Map delivery system from Board to bedside	Draw an organization chart of your health system care delivery areas (e.g., inpatient hospital, ambulatory care). Assign a leader to oversee quality for each area.
Align quality work with common framework	Develop a common framework to drive quality work and communicate it to all quality leaders. Johns Hopkins Medicine framework: • Internal risks to patient safety (e.g., culture of blame) • Externally reported measures • Patient experience • Value • Health care equity
Map your quality metrics to remove islands of quality	Examine every place where care is delivered. Ensure standard quality metrics are collected and data reported up through the organization (see Figure).
Ensure integrity of quality data	Ensure that someone is monitoring data accuracy and submitting quarterly audit reports. Expand the role of the financial audit committee to include auditing of quality data.
Make performance transparent	Share quality performance internally with those doing the work and externally with other stakeholders. Report methods used for measures.
Create shared accountability	Higher level leaders give lower level leaders tools to succeed: • Communicate goals and role • Provide resources • Ensure they have quality-related skills • Feedback performance Explicitly define escalating levels of oversight for longer time periods when an area misses its quality goals. After three reporting periods, area is audited and presented to the quality board committee.
Maintain focus on operations	Establish a patient safety and quality subcommittee to handle the operational details. Have representation from board to bedside on subcommittee.

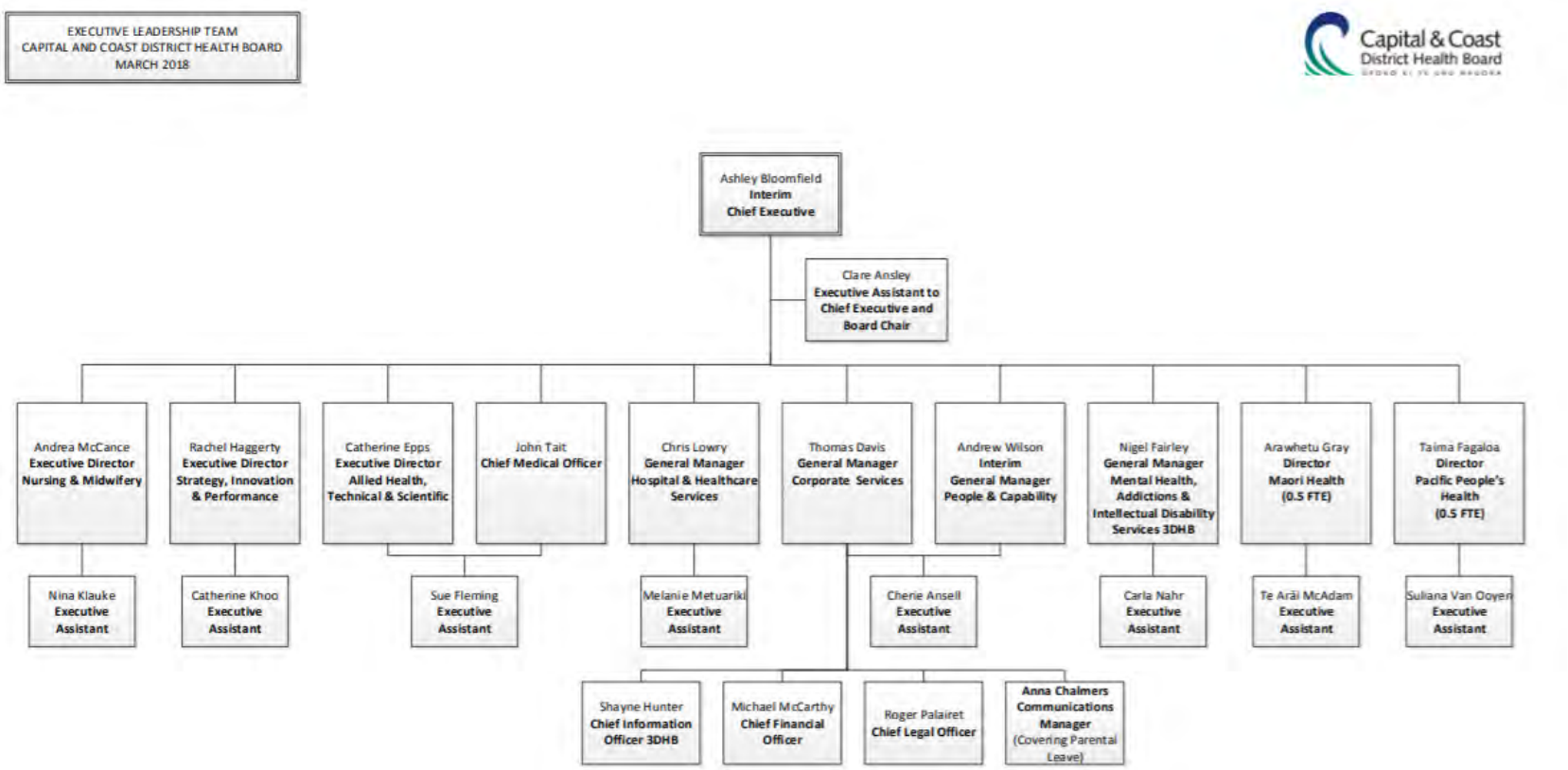
The CEO reports to the Board and is supported by the executive team (see Figure 12). There are currently 10 members of the ELT:

- Three professional Leads (Executive Director of Allied Health & Technical, Executive Director Nursing & Midwifery, and the Chief Medical Office)
- Four General Managers (GM for Hospital and Health Services (HHS), GM Corporate Services (Chief Financial Officer and Chief Information Officer are in this grouping and attend ELT meetings), GM Mental Health, Addictions & Intellectual Disability Services, and GM People and Capability
- A Director of Maori and a Director of Pacific health services
- An Executive Director of Strategy, Innovation and Performance

From a clinical governance perspective, it is noteworthy that no one is responsible for reporting on the quality of care for the organisation. Additionally, the ELT members themselves did not think that reports on the quality of care were very visible or discussed at length. Many were unclear what reports on quality were presented to the Board. The ELT structure is relatively new (end of 2016) and it would be fair to say that the actual portfolios of each executive leader are still developing – this is

especially the case for the three professional leads. There has also been instability in CE, with 8 different CEs in the last 9 years

Figure 12. Executive Leadership Team



Directorate Structure

The overall structure of the organisation is seen in Figure 13. It was updated in February 2017 and there are already some changes (e.g. Occupational Health & Safety now sits in the Corporate Services Directorate).

There are two large clinical directorates.

1. The HHS – this covers Wellington and Kenepuru Hospitals, and community sites. The HHS has two large clinical sub-groupings: Medicine, Cancer and Community (MCC), and Surgery Women's and Children's health (SWC).

2. The Mental Health, Addictions & Intellectual Disability Directorate covers the 3 DHBs in the sub-region (CCDHB, Hutt Valley DHB and Wairarapa DHB), and provides regional forensic services for the lower north island as well as serving the regional prisons.

There are also six supporting Directorates:

1. Strategy, Innovation and Performance Directorate.

This directorate includes the strategy, whole of system performance, planning and funding functions, and they are developing a focus on the different localities (and their needs) in the CCDHB region, and how services might be delivered to ensure equity. They also report on service performance and are implementing a framework of activity and infrastructure, system performance, service impact and outcomes.

SIP also supports the Health System Committee, DSAC, Integrated Care Collaborative and Citizens Health Council. It also works with the Director of Maori, Director of Pacific and Director of Disability, to bring the activities of the Advisory Groups and Board Committees into alignment.

SIP also leads the Investment and Prioritisation process engaging the ELT, Clinical Council and Integrated Care Collaborative.

SIP also provides support to "Even Better Healthcare", these programmes are not only in the community, where there is good collaboration with primary care and NGOs, but also in the HHS area. Recent programmes in the HHS have included work on a 'optimal ward', the 'frail elderly' programme and work on acute flow.

2. People and Capability Directorate

There is now a realisation that an engaged and happy workforce is important for clinical governance and this directorate has been active in this area. With the recent staff survey, staff engagement in prioritising the work plan and the Standing up for Safety work.

3. Clinical Support Services is an large sub-grouping with a mix of clinical (e.g. Pharmacy, Radiology, Medical Photography) and non-clinical (e.g. Security Orderly, Patient Admin Services)

4. Corporate Services

Occupational Health and Safety now report to Corporate Services and has become more active. The CIO also works in this directorate and digital processes are an important enabler for clinical governance. It is noted that CCDHB is behind other DHBs in term of IT investment, however, a roadmap is being drawn up.

5. Maori Health Directorate

The Maori Health Directorate did not have a director for over 2 years and until recently the director also had a separate, large funding and planning role (which has now been split from the

Maori Health Directorate's role). The Maori Health Strategy is in draft form with three priority areas identified:

i. Equity – which the group identify as a key clinical governance priority. Equity KPIs are reported to the Board twice a year, and the strategy is likely to advocate an equity lens at all levels
ii. Workforce – currently 3% of CCDHB identify as Maori, while the aim is to more accurately reflect the population level of 7%.
iii. Commissioning – this starts with identifying the current gaps in Maori Health then procuring the services using best practice.

The Maori Health Directorate's workforce includes whanau care services – meeting patients in ED, ICU and MAPU and helping them navigate CCDHB services. There are also specialist roles e.g. a social worker and a cardiac nurse. Overall 19FTE.

6. Pacific Health Directorate

CCDHB is one of 8 Pacific priority DHBs in New Zealand, reflecting the substantial Pacific Population. The Pacific Directorate is guided by the MoH 'Ala Mo'ui Strategy and has developed a CCDHB strategy – Toe Timata Le Upega.
The 'Ala Mo'ui Strategy has 4 priority outcome areas:

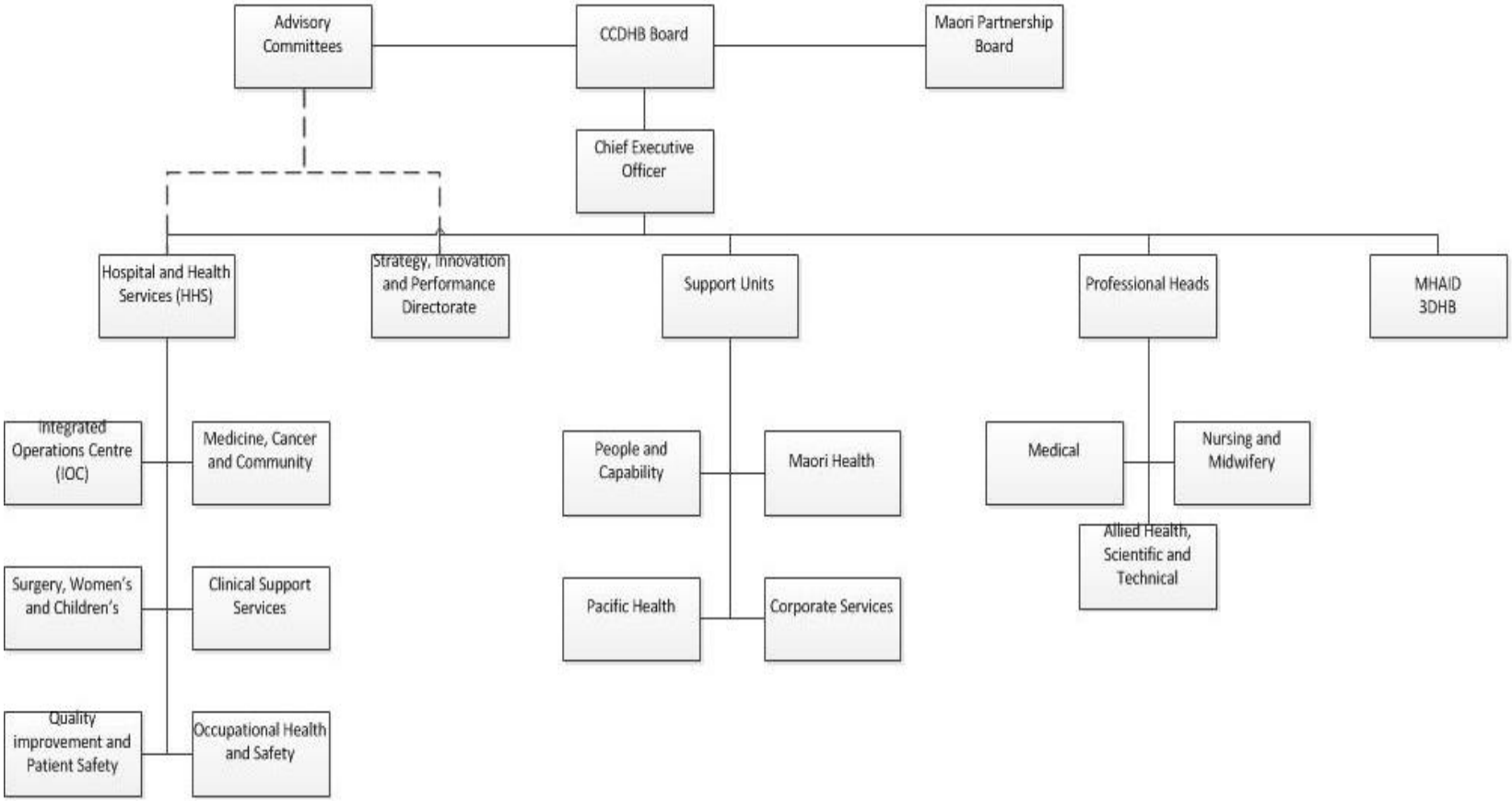
1. Systems and services meet the needs of Pacific peoples.
2. More services are delivered locally in the community and in primary care.
3. Pacific peoples are better supported to be healthy.
4. Pacific peoples experience improved broader determinants of health.

For the Pacific priority DHBs there are 21 indicators that are monitored by the MoH – these include childhood immunization rates, the percentage of 4-year olds who have a before school check and smokers offered advice to quit.
There is also a sub-regional Pacific strategic group with 10 pacific leaders. CCDHB is also responsible for Tokelau referrals (through CMO).
Approximately 5% of nurses identify as Pacific.
The current focus areas are:

- Meeting MoH KPIs
- Identifying pacific patients and providing support and navigation
- Did Not Attend (DNA) outpatient clinic rates – interviews to understand barriers, text and phone calls before clinic dates
- Healthy housing
- Coordination with Whanau Ora providers
- Alliance with Compass Health: Respiratory – 'breathe easy' and cervical cancer

The Pacific Directorate reports to the Board twice a year

Figure 13. CCDHB Organisational Structure



The Clinical Governance structure is shown in Figure 14. There are basically 5 major components to the structure

The first two operate in Primary Care and across the Primary/Secondary divide:

i. The Alliance Leadership Team (ALT) and the Integrated Care Collaborative (ICC)
ii. The Primary Secondary Clinical Governance Committee

The third is relatively new clinical council

iii. The Clinical Council reporting directly to the CEO

Then there are the Clinical Governance arrangements in the major clinical areas:

iv. HHS – all clinical governance subcommittees report here
v. The MHAIDS 3DHB
vi.

Alliance Leadership Team (ALT) and Integrated Care Collaborative (ICC)

The ALT is the strategic group comprising members from Capital & Coast DHB and local PHOs – Compass Health, Cosine, Ora Toa and Well Health – that is charged with ensuring that people in the Wellington region have better healthcare with primary and secondary health services that work well together. It is run out of the SIP directorate, chaired by a GP and has good representation from General Practice leaders, DHB clinical leaders and DHB ELT. The ALT ICC reviews the MoH Health Targets. The ICC is also working towards a locality approach for healthcare provision with four localities proposed. ICC has also adopted a pro-equity approach, providing leadership to the development of Community Health Networks.

The current focus areas are:

i. Enhanced Community care – which includes the Health Care Home model. A Health Care Home General Practice offers a strengthened care team, built around the needs of patients and their family, making it easier to get a wider range of services locally, without having to go to hospital. Health Care Home General Practices offer extended hours, access to a health portal (the patient portal had 59,945 patients registered as of April 2018) and wrap around services from district nurses and allied health professionals. See figure 15 for locations of health care homes.
ii. Child health and Youth Health
iii. Health Pathways, with 368 live pathways.

Also under the governance of the ALT There are 3 long-term condition networks:

i. Diabetes – Diabetes Clinical Network
ii. Advance Care Plan
iii. Falls – there is a Falls Prevention and Management Steering Group and a community based Fracture Liaison Service,

Sub committees/groups:

There are several governance and steering groups reporting up to the ALT.

- The long-term condition networks all each have a governance groups
- A new Enhanced Community Care Steering Group has been proposed to combine the HCH and Acute Demand efforts.
- There is also a newly established Mental Health ICC Steering Group.

Primary Secondary Clinical Governance (PSCG) Committee

According to its ToR, its purpose is to "ensure patient outcomes are maximised by improving quality and safety and reducing risk across the patient journey through the health system." It reports directly to the CE of CCDHB, and includes members of the ELT, representatives from NGOs and PHOs. It has a broader primary care membership than the ALT ICC. At the meeting of the 15th February 2018, there was a discussion around the future of the PSCG, given the changes being made at the ALT.

The ALT ICC group seems to be the real driver in transformational change in this space, and the PSCG needs to be re-defined. It may make sense that the PSCG committee takes over some of the functions of the ALT ICC (e.g. review of system level performance and communication across the primary secondary interface) and formally reports through to the ALT ICC.

Clinical Council

The Clinical Council was established to provide the Board with explicit advice from clinical leaders. The council is not a decision-making body, and its remit is really to provide advice to the Board on service improvement rather than operational matters. The specific functions of the Clinical Council (as written in the ToR) are to:

- Provide advice on key proposed service changes and measures to use resources more effectively and equitably
- Provide a forum for formal clinical engagement in decision-making
- To communicate these decisions openly to clinicians and Board members

The Clinical Council did a review of its first 6 months in October 2017. In this it noted that CCDHB already had a distributed clinical governance model, a medical leaders reference forum and clinicians involved in the ALT ICC committee. The Clinical Council reviewed papers before they are submitted to the Board – however they noted that "by the time papers and issues reach the Clinical Council they have been thoroughly researched and debated in the relevant local services." So, the Clinical Council were only providing a 'rubber stamp' to decisions.

It was felt that it would be more useful to pick up a couple of large strategic pieces and be involved from the start, rather than at the end when the paper has been written. The minutes of the meetings (14th December 2017 and 1st March 2018) show that there were discussions on two important issues: (1) on the design of the new children's hospital (and the fact that it didn't have a dedicated children's ED) and (2) the proposed rollout of the national bowel screening programme, and the implications of this for the current service. If the Clinical Council is to remain and be more relevant, it needs to take a more strategic direction, rather than focussing on papers going to the Board.

The other option is to disband the council and rely on the distributive clinical governance model, which has clinicians involved in both their individual services and in key strategic committee.

Figure 14.CCDHB Clinical Governance Structure

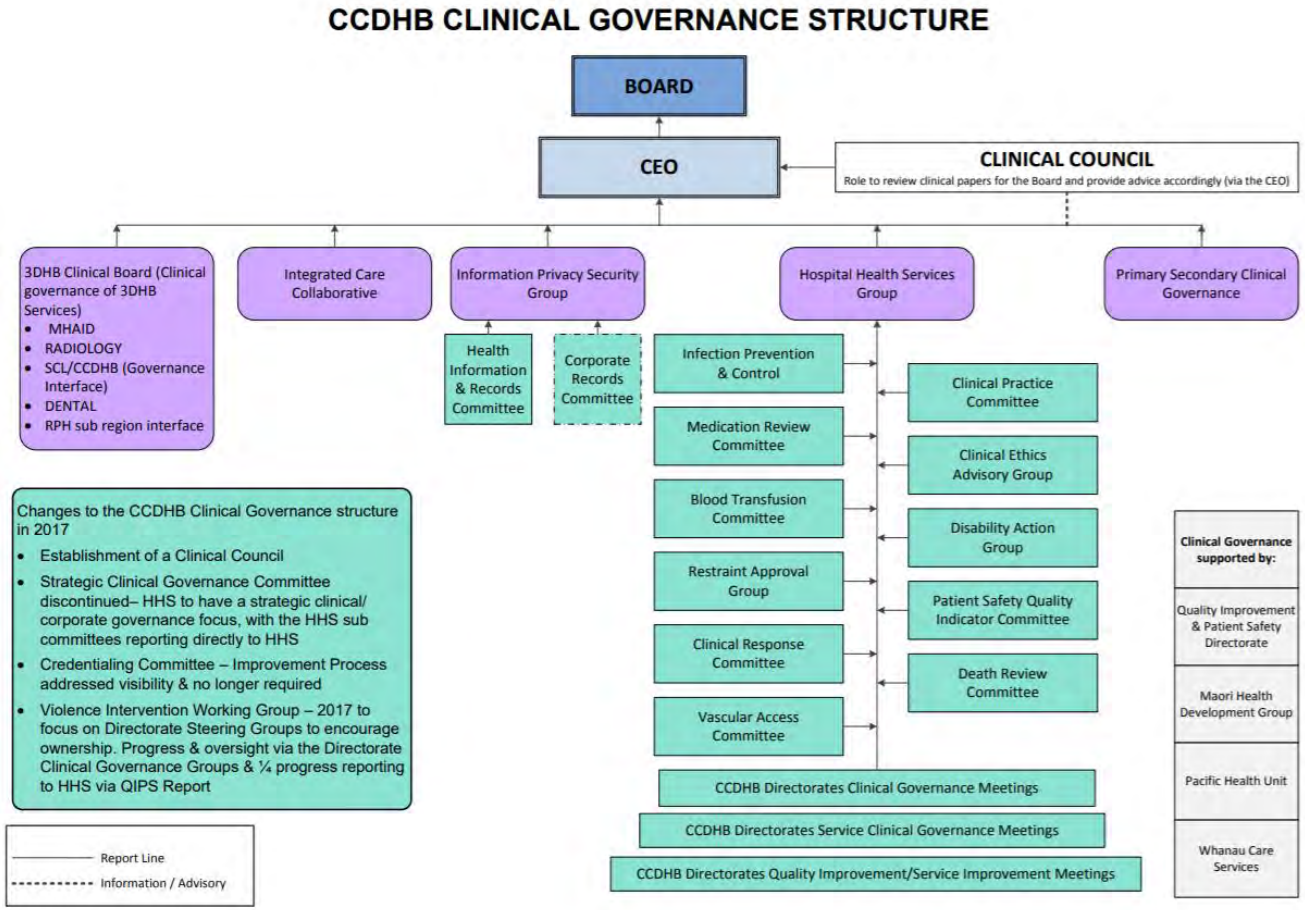
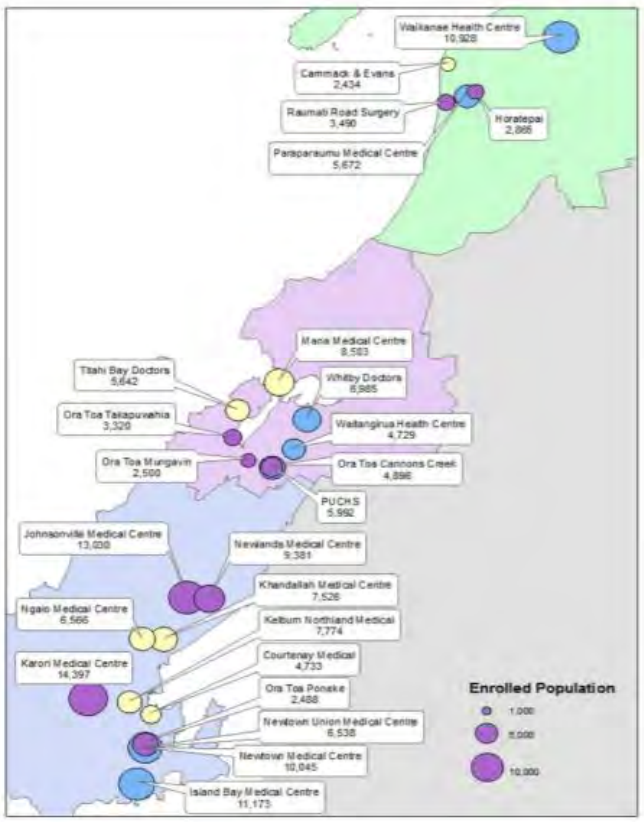


Figure 15. Distribution of Health Care Homes



Clinical Governance implications of this structure.

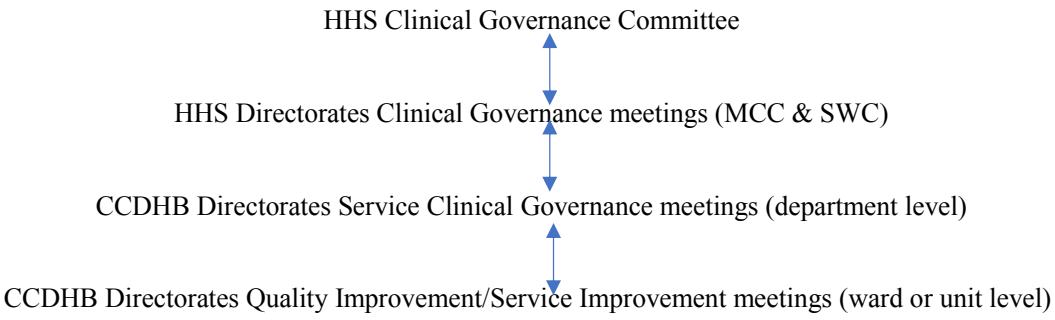
1. Hospital and Healthcare Services Clinical Governance.

Within the HHS, each group (MCC and SWC) has an Executive Director Operations and two Executive Directors Clinical (medical). The Associate Directors of Nursing & Midwifery report through to the respective Executive Director Operations and so the leadership is a dyad of managerial and medical leaders and not a triad of Management, Medical and Nursing.

Although most of the Executive Director Operations are ex nurses, this leadership structure sends a message that nursing input into clinical governance are not necessarily valued. The reporting line to the Executive Director Operations also underpowers the professional line to the Executive Director of Nursing and Midwifery.

The HHS Clinical Governance system cascades from the front-line units up to the HHS Clinical Governance Committee as below.

Figure 16. HHS Information flow.

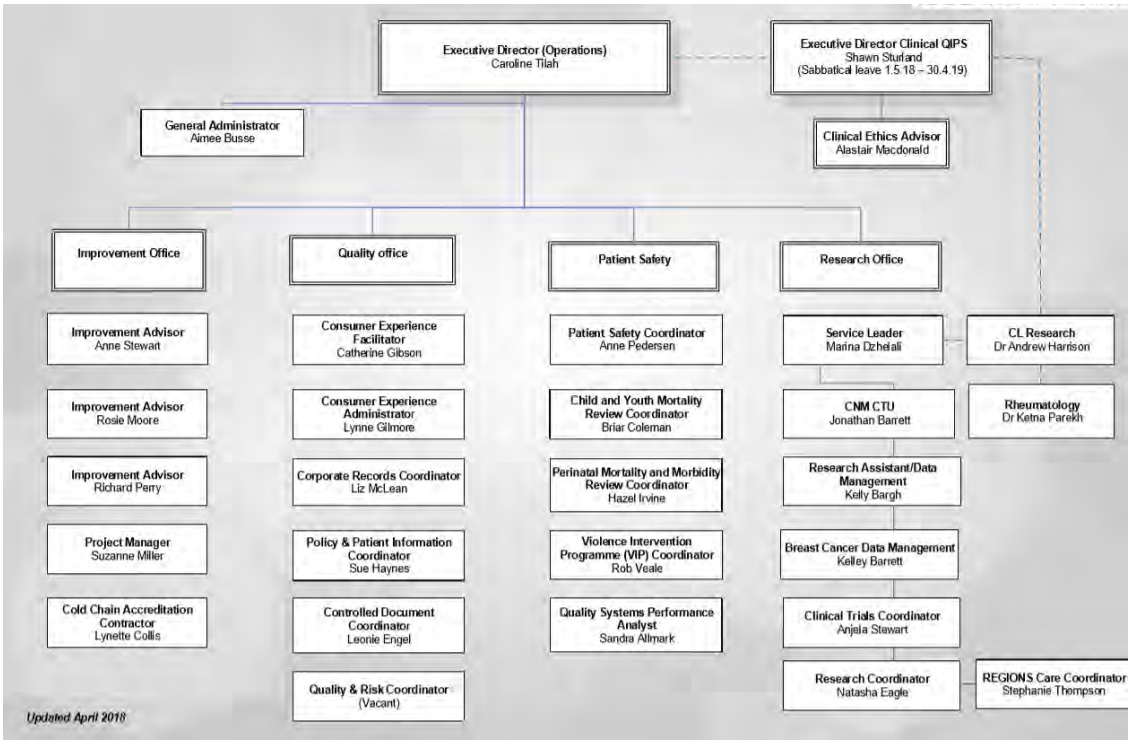


The HHS also houses the Quality Improvement & Patient Safety (QIPS) Directorate (see Figure 17). The Directorate is led by an Executive Director Operations and a part-time Executive Director Clinical (medical). The latter role did not have protected time and was frequently called back in to the substantive roster of the Intensive Care Unit (ICU). There has been a very recent change in this position with the new Executive Director Clinical providing 12 hours/week to the role. Furthermore, the workload for the QIPS Director of Operations has been onerous with 18 direct reports and multiple different written reports produced.

The QIPS unit has four siloes (as per the figure) however, they are loose groupings and do not actually work within or across the siloes. They do however, cover the major clinical governance functions:

i. Consumer experience/feedback
ii. Quality improvement expertise – with three well trained Improvement Advisors (IA),
iii. Patient safety
iv. Quality & Risk coordination
v. National Mortality and Morbidity reviews – Child & Youth and Perinatal.
vi. Research and clinical audit

Figure 17 Quality Improvement and Patient Safety unit



There used to be a Strategic Clinical Governance Committee (SCGC), that received reports from the clinical governance subcommittees, however, it was felt that as most of the staff that attended SCGC also attended HHS, that it did not add value. Instead it was agreed that there would be HHS Clinical Governance Meetings alternating with HHS Corporate Governance meetings.

HHS Clinical Governance is not proving to be as effective as envisaged; the professional leads and Clinical Heads do not all attend regularly, the agendas are not necessarily clearly defined as HHS Clinical or Corporate, and the last two Clinical Governance meetings have been cancelled and not rescheduled (last month staff on leave, and this month coincided with a mass casualty exercise). The meeting papers can be onerous (more than 100- 200 pages), which means that it is more of an information sharing exercise (if people have read the papers) rather than allowing time for discussion and decision-making.

There are nine clinical governance subcommittees that report through to the HHS Clinical Governance committee:

i. Medicines Committee – this is a well-run committee that reports quarterly to the HHS Executive Committee. The chair was unsure whether the report was presented to ELT or whether the Board saw it. The chair has ensured that the prime focus is on medication safety, and the committee has an annual work plan with one or two major medication safety projects per year. In 2017 the focus was on insulin prescribing with four standardised new insulin charts introduced across the region. The focus in 2018 is on oxygen prescribing following four deaths from hypercapnia and respiratory arrest after high flow oxygen was delivered.

ii. Blood Transfusion Committee – this committee meets quarterly and receives monthly reports on blood products and their usage. The committee's minutes are sent onto the HHS executive, but the chair was not sure if they were looked at. Several areas of concern: consent rates for transfusion are low and there is no programme to measure these; problems with transport of blood units to theatre via the pneumatic tubes; blood fridge in theatre leads to wastage. Total DHB wastage costs ~$130,000/year.

iii. Restraint Approval Committee – the ToR for this committee are out-of-date, it has been years since they were last reviewed. They are meant to report to the HHS Clinical Executive meeting but last year at least this was not a common occurrence with long gaps in reporting. It would perhaps make more sense for it to report to the MHAIDS clinical governance committee.

iv. Clinical Recognition and Response Committee – this committee meets every month and is chaired by a senior ICU/anaesthetic registrar. It reviews the cardiac arrest and Medical Emergency Team (MET) callout rates. It reports infrequently to the HHS Clinical Governance Committee – once in the last 18 months.

v. Patient Safety Quality Indicator Committee – this committee was set up to report on Quality Safety Measures (QSM) set up as part of HQSC's 'Open' patient safety programme. It is chaired by the Patient Safety Coordinator out of QIPS. It reports through to the HHS Clinical Governance Committee. The committee reviews the compliance audits and the data on the quality safety markers. However, there seems little capacity to actually improve the performance against the QSMs.

vi. Vascular Access Committee – this committee reports to the Clinical Practice Committee (see below), and according to its ToR it is "responsible for ensuring that practice surrounding the insertion and use of all vascular access devices is evidence based and minimises the risk of associated adverse patient outcomes." Currently the committee is focusing on infections associated with peripheral line insertion.

vii. Clinical Ethics Advisory Group – this group meets monthly and on an as needed basis. It focusses on clinical ethical questions as opposed to research ethics. It sits under the HHS, but considers itself to be an organisation-wide group, independent of the organisational structure. It previously reported to the SSCGC, however currently it does not formerly report anywhere. It provides advice on ~13 cases/year; opinions are not binding however, they do explore the risk versus harm of responses to complex issues. Membership includes a clinical ethics advisor, legal advisor, clinical staff and a consumer. It is active in raising awareness of the ethical and legal complexities in healthcare decisions and members present at grand rounds, orientation and there is also a blog. This committee is an asset to CCDHB, a resource not always found in other DHBs.

viii. Death Review Committee – This committee does not review deaths, but does look at processes around death – e.g. documentation, policies, checklists to ensure that everything is done correctly after a death. They have tried to engage with the chairs of the Mortality & Morbidity meetings, but with very limited success. They report that very little organisation-wide learning is currently coming from M&Ms.

ix. Clinical Practice Committee – this committee is supposed to review new medical equipment and devices; however, it has suffered from a lack of resources to carry out this function and the recent departure of its chair. It is unclear whether it is still functioning. If such a group is to continue, it would make sense for it to be regional and well resourced.

Overall the reporting from these committees is less than ideal, some ToR still have reporting lines to the now defunct SCGC committee, some report infrequently and all are unclear whether they are reported above the HHS executive committee level.

There are two committees that usually form part of any clinical governance structure, but are missing here.

(1) Credentialing Committee.

The first is a credentialing committee, which reviews the qualifications and references of all new Senior Medical Officers (SMOs) and delineates their Scope of Practice (SoP). From interviews it appears that this function is devolved to those on the interview panel for new appointments, however there is no oversight of this process, nor any transparency as to the SoP of new recruits (this information should be readily available to all staff). This may not need a formal committee, but someone needs to have visibility and be accountable for this function.

(2) Infection Prevention & Control Committee

The second committee that is missing is an Infection Prevention & Control Committee. There was a 3 DHB Infection Control Governance Group. It was not considered useful and so was disbanded. It was recommended that a CCDHB-specific Infection Prevention & Control Governance Committee was established but after discussion at HHS and it was decided this was not required.

The Infection Prevention and Control team fulfil this function and report directly to the GM of the HHS. They provide a monthly report (as part of the MCC report) and report in person every three months. They also provide an annual report to the HHS. It is unclear whether the information in any of these reports are presented to the ELT or Board. They appear to have very good relationships with their clinical colleagues and staff engagement is good. Although this group appears to be working well, the fact that there is not a multidisciplinary committee to discuss trends and issues is less than ideal.

2. Mental Health, Addictions and Intellectual Disability Services (MHAIDS) Clinical Governance

In 2014, the three DHBs set up MHAIDS with the aim of building an integrated service for people with mental health, addictions and intellectual disability needs.

MHAIDS has a wide scope providing national, regional, specialist, community and management and support services (see figure 18). There are 1,400 staff working for MHAIDS in 44 clinical teams (specialist inpatient and specialist community services), and an overall operating revenue of $142.5 million. There are 217 inpatient beds across the region. The GM MHAIDS currently has 11 direct reports (see figure 19) with the Directors of Allied Health, Medical and Operations also having a large number of direct reports.

MHAIDS is a 3 DHB service, however, it would be fair to say that it tries to operate across 3 DHBS, rather than as a seamless, integrated service for the region. From a clinical governance point of view, this means that it is accountable to the 3 different DHB Boards. Some frontline clinicians saw this as a problem with fragmented accountability and no line of sight for the CEs.

Furthermore, the key functions such as employment, planning, funding, continue to operate at an individual DHB level. This means MHAIDS management and staff work across three different systems for each of these functions, with duplication of effort and a lack of a systematic strategic vision.

In 2017 and early 2018 a draft consultation document was put together to improve MHAIDS integration[1] and to link it better with the DHB's vision (especially locality planning). Three service options were proposed:

1. Enhancing the current system (services stay the same and focus on administrative changes).
2. Enhancing the current system together with locality planning and funding.
3. Partial devolution of local community mental health teams.

And two entity options were suggested:

1. Lead DHB model.
2. Internal three-DHB business unit model.

Work is this area appears to have stalled in the wake of CE instability in two of the DHBs, and the National Mental Health Inquiry (due to be completed in October 2018).

Whilst structural changes are important in improving efficiency, whichever option is chosen must ensure that there are good linkages between management and clinical staff at all levels.

[1] Mental Health, Addictions and Intellectual Disability Service (MHAIDS) Integration. (draft) Staff and Stakeholder Consultation Document Version 5, Feb 2018

Figure 18. Scope of MHAIDS services

MHAIDS Current Services and Support Operations

NATIONAL SERVICES

National Intellectual Disability Care Agency (NIDCA); Youth Forensic Secure Service; Adult Forensic Inpatient Intellectual Disability; Youth Forensic Inpatient Intellectual Disability; Behavioural Support Service (Explore).

REGIONAL SERVICES (Provides services to Central Region, plus Tairawhiti)

Regional Forensic Services
Central Regional Forensic Service; Central Regional Youth Forensic Service

Regional Rehabilitation Services
Regional Rehabilitation & Extended Care.

Regional Rangatahi Services
Regional Rangatahi Acute Inpatient Service

Regional Speciality Services
Personality Disorder Service; Central Region Eating Disorder Service; Maternal Mental Health Services; Early Intervention Service; Co-existing mental health & addictions; Youth Alcohol and Other Drug; Co-existing Mental Health and Intellectual Disability

THREE DHB (SUB-REGIONAL) AND SPECIALIST LOCAL SERVICES

Intensive Recovery Sector
Acute Adult Inpatient Units: (Te Whare O Matairangi; Te Whare Ra Uta; Te Whare Ahuru); Acute Adult Day Services; Crisis Resolution Service; Consultation Liaison Teams; Team for Assertive Community Treatment (CCDHB only); Te Roopu Aramuka Wharoaroa (CCDHB only); Wairarapa Respite House

Operations
Te Haika; MHAIDS Casual Pool

Needs Assessment & Service Coordination
Mental Health Needs Assessment and Service Coordination

Adult: community specialist services
Opioid Treatment Service [HVDHB & CCDHB], Community Detox

LOCAL COMMUNITY SERVICES

Adult: community mental health & addictions
Community mental health teams: WDHB (x 1); HVDHB (x 2, includes Detox nurse & integrated cultural services); CCDHB (x 4), MH services for Older People (CCDHB only). Community Alcohol & Drug Service; Maori Adult [CCDHB only], Pasifika Adult [CCDHB only]

Younger persons: community mental health & addictions
Children and Adolescent Mental Health Services teams: WDHB (x 1); HVDHB (x 1) – [called Infant, Child, Adolescent Family Services]; CCDHB (x 3); Maori CAMHS [CCDHB only], Pasifika CAMHS [CCDHB only]; Paediatric Consultation and Liaison

MANAGEMENT AND SUPPORT SERVICES

Learning and Development Centre; Quality and Risk Team; Clinical Governance; Research, Information Management; Human Resources; Communication; Kaunihera; Pasifika Functions; Consumer Team; Family/Whanau and Legal Services; Director of Area Mental Health Services; Business Development and Finance.

MHAIDS Clinical Governance Committees:

There was a 3 DHB Clinical Governance Board, chaired by the CE of CCDHB. This initially covered Radiology, Laboratory and Mental Health, however, the meetings involved large numbers of people and very few decisions were made in the true 3 DHB sense. When decisions were made, they were sometimes re-litigated at each individual DHB. When Radiology and Laboratory pulled back from the 3 DHB process, the meeting fell into abeyance. It has been resurrected, chaired by the CMO of Wairarapa, and was due to meet in May.

In the meantime, the MHAIDS Clinical Governance Committee has been reporting to the MHAIDS Leadership Team (chaired by the GM of MHAIDS). It does not report to the wider DHB clinical governance processes. The MHAIDS Clinical Governance Committee receives reports from its subcommittees and the five divisions.

The five divisions are:

1. Ratonga Rua – Forensic and rehabilitation (includes Prison Mental Health)

2. Intensive Recovery Service – 2 acute mental health units, acute adolescent mental health unit, Crisis Resolution Team

3. Child, Youth MHAIDs – child and adolescent mental health team, maternal mental health, and early presentation

4. Adult Mental Health & Addiction – adult community mental health, addiction services

5. Intellectual Disability – national service

Clinical Governance Sub-committees:

- Patient Safety & Quality Group.
- Medicines Committee
- Restraint Advisory Committee (RAC)

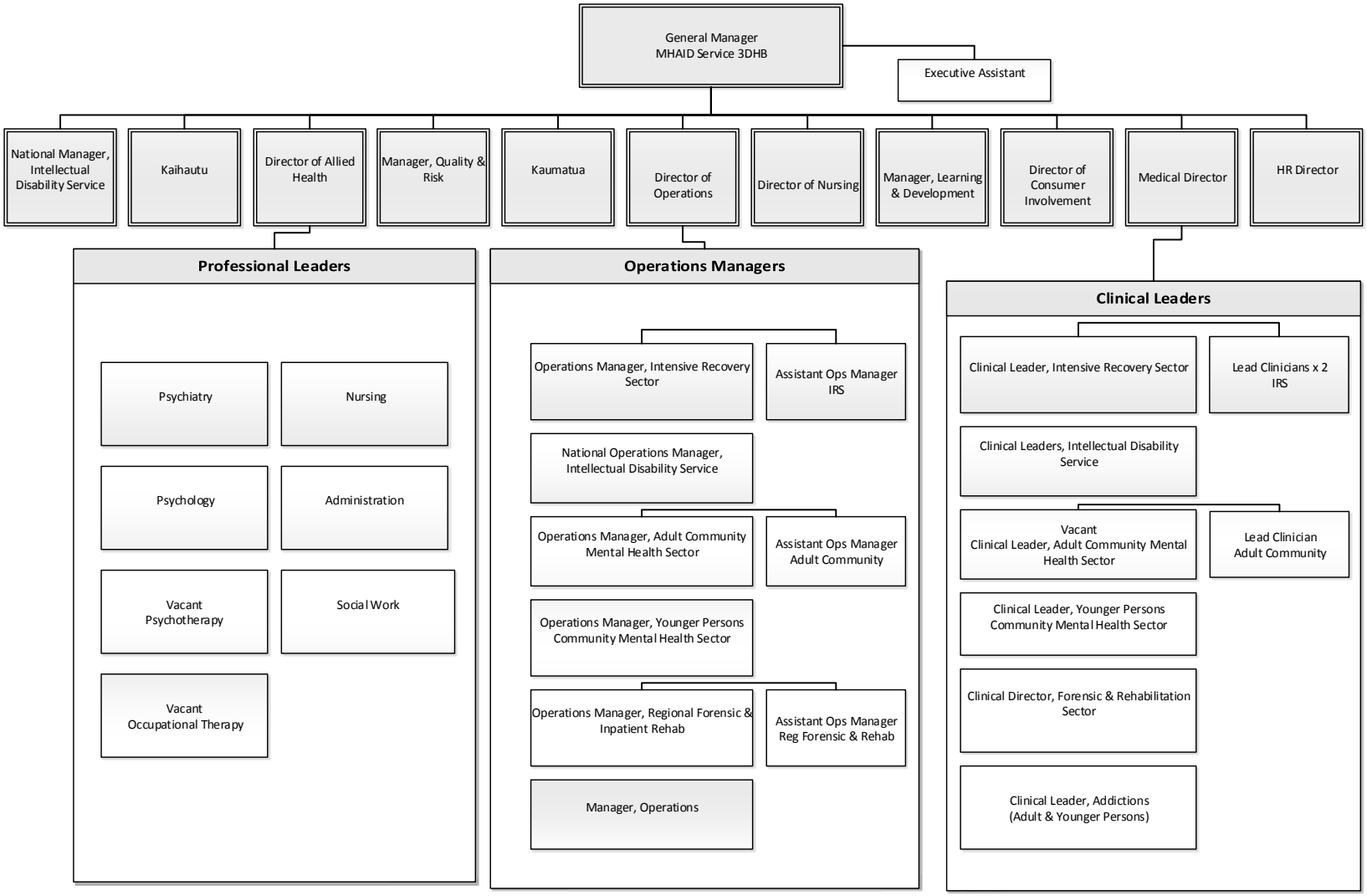
The experience of some was that the Patient Safety & Quality group, which reviews the Sentinel Adverse Events, results in a lot of churn, with very delayed investigations and then recommendations not implemented or monitored.

Each Division has quality facilitators, though most QI work was done on top of clinician's usual work, with little/no governance over projects. The exception was the Single Client Pathway, which was highlighted as a successful co-design project with over 1,000 employees trained in its use.

There is no MHAIDs specific risk register and clinicians were frustrated about an inability to raise risks – for example – 85 vacancies across MHAIDs.

There is a Director of Consumer Involvement and a Consumer team with three paid Family Advisors positions, though only one is currently occupied.

Figure 19. MHAIDS Organisational Structure Chart



Summary of Clinical Governance Structure

There is no one at executive level with accountability for the quality of care delivered across the DHB. The ELT do not appear to be getting regular reports, and the Board only receives reports quarterly.

The Clinical Governance structure is not coordinated and is complex with three different directorates involved (HHS, MHAIDS and Strategy, Innovation and Performance), each taking a different approach to quality. The Quality Improvement and Patient Safety (QIPS) Directorate reports through to the HHS Clinical Governance committee, and their reports are part of the GM HHS reports. SIPs on the other hand has direct ELT visibility and the funding and autonomy to make large scale changes.

The provider arm clinical governance committees all sit under the HHS and at the moment, are of variable quality – many have out-dated terms of reference and are unclear of their reporting. The QIPS Directorate also sits under HHS rather than DHB-wide

MHAIDS has its own challenges operating as it does across 3 DHBs. As the DHBs do not have a common vision for MHAIDS, let alone common organisational processes, there are serious structural impediments to good clinical governance. There is not a clear line of sight from the CE and Executive Team as to the issues in MHAIDS and there is a perception that clinical leaders and the clinical voice is not currently heard effectively. The draft consultation document is a move in the right direction to clarify the future role of the 3 DHB MHAIDS.

Most DHBs have an Infection Prevention and Control Committee, however, CCDHB does not. There is good clinical engagement, however it will be important to ensure that infection prevention and control matters are visible to the ELT.

There is overlap between the ALT ICC and the Primary/Secondary Clinical Governance Committee, which needs to be looked at. The Clinical Council should also refine its scope.

The current structure is overly complex and does not support the flow of information on quality of care to be reported to the ELT and the Board.

Recommendations

1. ELT position accountable for clinical governance/quality improvement and patient safety. This could either be a new Executive Director for Clinical Governance or split amongst the three Professional Heads
2. Reinstate the Strategic Clinical Governance Committee as the Peak Quality Committee. All clinical governance committees would report here (rather than HHS or MHAIDS), and would link with ALT ICC, the Primary Secondary Clinical Governance Committee and Clinical Council
3. Simplify clinical governance committees
    - Amalgamate Death Review Committee and Clinical Recognition and Response Committee
    - The Clinical Practice committee – may become a role for the Clinical Council, but would require funding. Alternatively make it a regional committee.
    - Up-date ToR and reporting lines
4. Quality Improvement and Patient Safety (QIPS) Directorate to move out of the HHS and be a DHB-wide unit. This could either be a stand-alone unit reporting to an Executive Director of Clinical Governance, or it could combine with the Strategy, Innovation, and Performance Directorate
5. QIPS to have a dedicated leadership team – Manager, Medical, Nursing and Allied Health leaders.

6. Ensure that the clinical voice is heard at all levels and that there is reporting through from the MHAIDS clinical governance committee to the Strategic Clinical Governance Committee.
7. Progress with the consultation phase with MHAIDS staff as to the future organisation of the 3 DHB model, with the aim of greater integration and seamless care across the region.
8. Mission statement, Vision, and Values - recommend starting again, simplifying, and co-designing with staff and consumers

Review of CCDHB's Clinical Governance System measured against HQSC framework.

1. Quality Improvement and Patient Safety

Quality of care (including patient safety) must be the top property of any healthcare organisation.

As stated above, healthcare quality can be broken down into its six domains: Safe care, timely care, equitable care, effective care, efficient care and care that is patient centred.

District Health Boards exist to deliver high quality care (both to individuals and the population) within constrained resources. Delivering high quality of care is everyone's responsibility, but it is the responsibility of leadership (Board and ELT) to ensure that a coherent and effective quality and safety framework is in place to enable continuous quality improvement.

This framework must include:

- How to build a safety culture, where improvement and innovation is expected, and where patient safety incidents will be handled in a just way.
- A system to identify risks to high quality care
- The capability and capacity of staff to continuously improve care

The Executive Leadership Team (ELT) and the Board set the culture and must ensure that the appropriate structures are in place to enable staff to provide high quality care. They must also ensure that they have systems that allow them to monitor and respond appropriately to any threats to quality.

Staff require both the skills (capability) and the time (capacity) to recognise problems in the way that care is provided, and to work to improve: working in the system and on the system. The Health Quality & Safety Commission in 2016 released a framework for building quality & safety capability in NZ – "From Knowledge to Action." (10) The framework takes a whole-of-system approach as described by Batalden and Davidoff (11):

"the combined unceasing efforts of everyone – health care professionals, patients and their families, researchers, payers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning)."

CCDHB QI and Patient Safety

There has been a period of change in leadership at the CE and executive level (eight CEs in nine years), and it is not clear whether the ELT or Board are leading the QI and Patient Safety agenda. There is no one on ELT with specific responsibility for Clinical Governance, quality and patient safety. The reports to the ELT are not cohesive and do not cover the whole DHB.

The Board receives a report on quality every 3 months, and this report is predominantly based on compliance. A Board should be devoting as much time to the quality of care delivered, as it does to the financial health of the organisation, which suggests monthly reporting of quality.

CCDHB has a somewhat fractured and siloed approach to Quality and Patient Safety. There are three main areas working in this area:

1. The Quality Improvement & Patient Safety (QIPS) Directorate within the HHS
   - CCDHB Quality Framework
   - Risk Management
   - Patient feedback/patient experience surveys
   - QI education
   - HSQC Quality Markers
   - Reportable events management

2. The Strategy, Innovation & Performance Directorate (SIP)
   - Coordinates the MoH System Level Measures
   - 'Even Better Healthcare' including the Optimal Ward and patient flow
   - Integration programme and healthcare homes

3. Directorate Quality Teams (Quality Managers and Facilitators) in the HHS and MHAIDS reporting to the Operations Managers
   - Reportable events
   - Investigation of Sentinel and Serious Events

There are some issues with this structure. The QIPS and SIP teams are taking different approaches to quality and patient safety. QIPS uses the Model for Improvement, whilst the SIP team appear to use a project management approach. Some of the key clinicians working on the SIP projects (e.g. optimised ward,) are in the HHS, but not linked to the QIPS or to a quality improvement approach. There are two RMOs on rotation with SIP, doing 'projects', however there was initially no link with the Improvement Advisors who could have taken them through the model for improvement. They are now meeting and trying to get back on track.

The MHAIDS have their own dashboard, which includes a patient experience quadrant, workforce, productivity and financial measures.

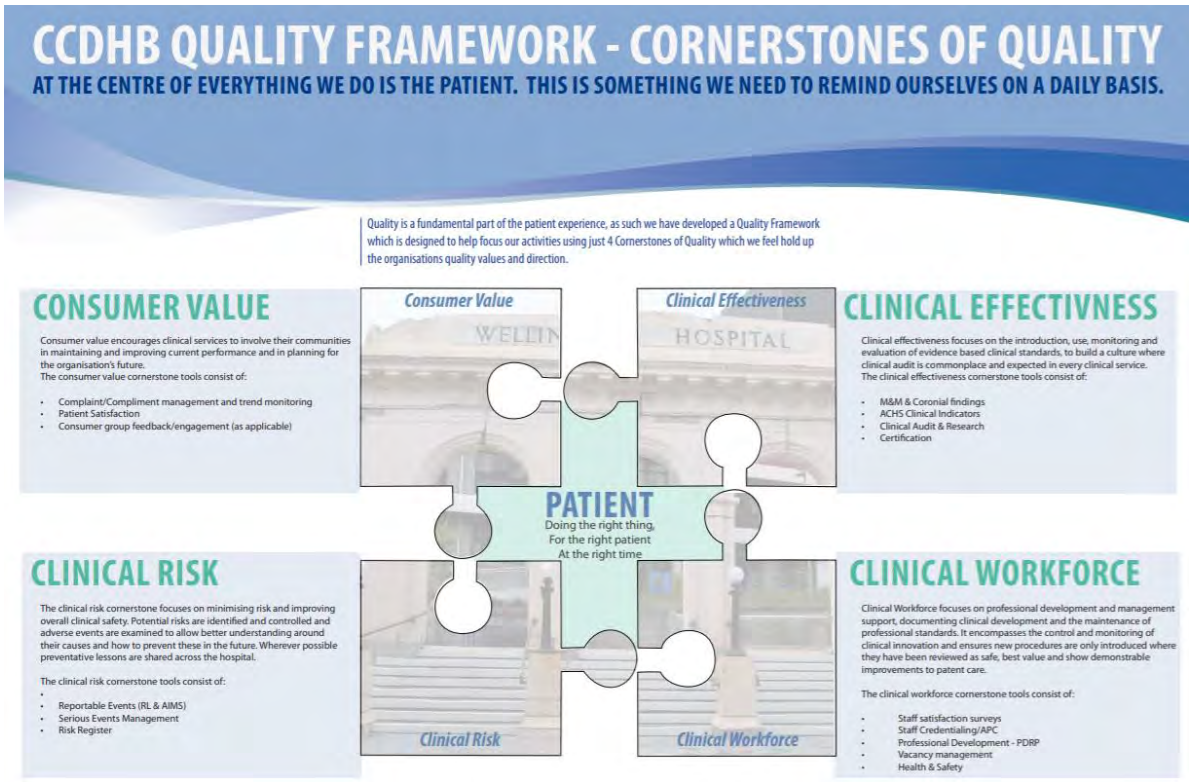
The Directorate Quality Teams are in partnership with QIPS but their accountability is to their Directorate management team. This can cause problems with different local and organisational objectives. This is mitigated to some extent by monthly meetings with the QIPS leadership. The spread of quality managers (QM) and facilitators(QF) is uneven – MCC has 1 QM and 1 QF, SWC has 1 QM and 2 QF, and MHAIDS have 6.8 FTE over 3 DHBs. Furthermore, at least some of the QM and QF have had no training in quality improvement or RCA.

The Quality & Patient Safety Team

The Quality Improvement and Patient Safety Directorate developed the CCDHB Quality Framework – Cornerstones of Quality (see Figure 20). This has the patient at its centre and 4 quadrants that define their work areas:

i. Consumer Value
ii. Clinical Risk
iii. Effectiveness
iv. Workforce

Figure 20. CCDHB Quality Framework - Cornerstones of Quality



Staff see the work done by this unit as positive, though it was noted that much of the work is reactive (e.g. to adverse events), rather than proactive. It was also noted that there is not good alignment with the projects done by the SIP team.

Specific areas of concern:

1. Reporting overload. The QIPs Executive Director Operations produces 4 monthly reports for the HHS Executive:
   i. Clinical & Quality Measures report – this covers a selection of patient safety indices.
   ii. Quality Improvement & Patient Safety report – covering patient experience (compliments/complaints), HDC complaints, and controlled documents.
   iii. SAC1 & SAC2 Adverse Events Report - new SAC1 & 2 complaints and progress against existing cases
   iv. Risk Report – this reports on the risk register, including progress against mitigation strategies

   The Executive Director Operations also produces a quarterly quality report for the CCDHB Board. This is presented via the GM HHS and the Executive Director of Quality is not advised of any changes made to the report, and is not invited to speak to the Board. The report covers complaints & compliments, new HDC cases, patient experience (both monthly CCDHB and quarterly HQSC surveys), a summary of improvement projects, progress against the HQSC quality safety markers, and an up-date on the numbers of staff who have attended the quality improvement training – "improvement movement."

   This workload is unsustainable and not particularly useful. Suggest that a dashboard is developed (see appendix for an example) that gives the ELT and the Board a picture of the six dimensions of quality at the DHB.

There is a lot of work going into these reports and there is possibly some streamlining to be done. The first 3 reports could be combined into a single monthly report, and replace the quarterly report. The monthly reports should be presented to the Board at each meeting.

All the reports present the data using Statistical Control Charts, which is very good to see, however, they lack analysis to inform those who are not familiar with such techniques.

There is also an over reliance on self-reported (reportable events), which lack a denominator and can rise or fall, not because of a change in performance, but because of changes in reporting rates. Finally, the reports present predominantly on quality in the HHS directorate, and do not cover the DHB.

The fact that these reports may be filtered at the HHS executive level, means that there is no transparency of what is actually reported to the ELT or the Board. The last two HHS Clinical Governance executive meetings have been cancelled, meaning that the monthly reports have not been discussed.

2. Child, Youth Mortality Review (CYMR) – This committee investigates and reports on deaths in people aged from 28 days to 25 years. CCDHB is contracted by the HQSC to provide this service, but when funding from HQSC was decreased, the DHB did not pick up the difference. Therefore, there is only funding for a person for 2 days a week, which is not enough to deal with the workload in this area. CCDHB has been close to losing it contract with HQSC because of the delays in reviews. The chair of the review group has no protected time and there is no place to take recommendations. The two areas identified as current concerns were:
    i. Services for young transgender youth – they have a very high suicide risk, but currently it is taking over a year to get an outpatient review
    ii. SUDI – Sudden Unexpected Death of an Infant – rates are still high, and CCDHB is required to review 21 cases (of the ~30 cases) each year

3. Serious and Sentinel Event (SSE) investigations. Both the HHS and MHAIDS are under pressure to investigate SSEs. The reviews take too long (sometimes over a year); some of the leads are untrained in Root Cause Analysis (RCA); the recommendations are weak and not followed up on; and the results are too delayed to engage clinical staff.

   A large proportion are in-hospital patient falls and community suicides. A cluster analysis approach, which has been introduced for SAC 2 incidents, could be extended to some of these common SAC 1 events. A cluster analysis of 'falls resulting in harm,' is arguably more useful than a RCA on each individual fall. Effort can instead be put into preventing 'falls' (e.g. de-clutter wards, increase nursing levels, families as partners in care, regular toileting and decreasing sedation/sleeping pills) and 'harm from falls' (e.g. room and bathroom design, impact resistant flooring and hip protectors). Suicides do need an individual investigation, however, sufficient resources (particularly protected clinician time) to ensure that the investigations are completed in a timely fashion.

CCDHB Quality Improvement and Patient Safety– Feedback from interviews and documents

Quality & Safety Culture	Although CCDHB did the staff surveys last year, they have not to my knowledge done a staff survey on attitudes to patient safety. From interviews, there is a mix of cultures, with some areas very open about patient safety and others considerably less so. There is a common view that quality work is reactive and bogged done with reviewing reportable events and investigating sentinel events. This is dispiriting for the quality workers, but also for the organisation.
Patient experience surveys	The Patient Experience Surveys were important in driving priority areas, but of late the response rate has dropped, and it may be time to explore other ways to get feedback from patients and their families.
Patient Safety and Incident Reporting	There is a strong nursing culture of reporting incidents, using the electronic process (SQUARE), which appears functional. The culture is less strong in other disciplines, with some questioning why they would report something as "nothing is done to improve it." As stated, most of the measures of quality are drawn from the SQUARE reports and are seen as reactive. These are not measures of clinical quality in the true sense. The DHB uses the Global Trigger Tool (GTT) and the Adverse Event Trigger Tool (ADETT), however, no data has been drawn from these in over a year. The issue at CCDHB appears to be two-fold: for the ADETT the staff can no longer get reports out of the database and for the GGT there is a lack of staff to serve as auditors of charts. This is disappointing as they both provide a systematic, standardised measure of harm, that has been used in other DHBs to drive improvement.
Clinical risk management	There is a combined risk register, with both clinical and non-clinical risks. In March there were 94 risks, including 4 patient care risks. In May it was decided that many of these risks were in fact issues and so the register was changed to 21 risks and 67 issues.
Quality Accounts	The last Quality Account (according to the CCDHB website) covered 2015/2016. This provided an overview of CCDHBs performance against the national Quality & Safety Markers (good performance overall) and the national Health Targets (good performance, below average in shorter stays in ED and helping people to quit smoking). There was also an overview of patient experience and the areas being worked on – improving communication, improving food and educating patients on their medication and

	possible side-effects. There was a focus on Advance Care Planning (ACP) and a piece on the GP portal: "Manage my Health." CCDHB are no longer providing a Quality Account -the information has instead been incorporated into the Annual Plan produced by SIP.
Quality Plans	The QIPS unit has developed a quality plan as per previous section.

Summary of CCDHB Quality Improvement and Patient Safety.

There is a good deal of good work going on in this area, though the structure is not supportive of a DHB-wide approach. The reporting to the ELT and the Board is insufficient for them to discharge their duties in this respect.

The DHB has not defined its overall QI methodology – QIPS use the Model for Improvement, whilst SIPS use project management – and middle and upper level managers and leaders are not trained in QI.

Not everyone with a QI job title has received the appropriate training – and this includes in the conduct of Root Cause Analyses (RCA).

There are specific concerns regarding the resourcing of the Child, Youth Mortality Review (CYMR) and the delays in completing RCAs (in both HHS and MHAIDS).

Recommendations

1. Decide on a DHB QI methodology. The Model for Improvement is already being rolled out and there are three improvement advisors trained in its use, so it would seem sensible to continue with this. Train middle and senior leaders in this approach so that they can sponsor others as they complete their projects.
2. Rationalise QI reports. Produce a monthly report for ELT and the Board. This should cover the HHS, MHAIDS and the ICC, with separate sections for each. The reports should cover the 6 dimensions of Quality, and be presented in such a way that Board members can be alerted to areas of concern. The report should be presented to the Board by the person accountable for clinical governance.
3. Ensure that people appointed to Quality Manager and Quality Facilitator roles have the appropriate training in QI and RCA
4. Investigate why the Global Trigger Tool (GTT) and the Adverse Drug Event Trigger Tool (ADETT) reports are no longer available
5. Review current RCA model – consider cluster analysis or shorter investigation templates for common conditions. Ensure that recommendations are sense-checked with the clinical teams and that they are robust and acted on.
6. Use the Strategic Clinical Governance Committee to ensure that all projects are visible and using similar methods.
7. Increase resourcing for the CYMR and ensure that there is a channel for concerns raised by this and the Perinatal Mortality and Morbidity Review (PMMR) group.

2. Consumer engagement and participation.

The Health Quality and Safety Commission (HQSC) have defined consumer engagement as:

'... a process where consumers of health and disability services are encouraged and empowered to actively participate in decisions about the treatment, services and care they need and receive. It is most successful when consumers and clinicians demonstrate mutual respect, active listening and have confidence to participate in full and frank conversation. Systems that support consumer engagement actively seek input from consumers and staff at all levels of an organization.' (12)

Consumer engagement intersects with the concept of patient and family centred care, which has gained prominence over the last ten years, especially in the U.S. and the U.K. The U.S. Institute for Patient and Family Centered Care outlined the core concepts they considered essential, including Dignity & Respect, Information Sharing, Participation, and Collaboration (table 2). (13)

Table 2. Patient and Family Centred Care Core Concepts

Dignity and Respect. Health care practitioners listen to and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
Information Sharing. Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision making.
Participation. Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
Collaboration. Patients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

More recently the focus has moved to the importance of measuring outcomes, and particularly those outcomes that matter to patients. There is a rich literature on 'what matters to patients' but table 3 covers many of the generic themes. (14) It has been shown that hospitals with high ratings for patient experience of care, actually provide clinical care that is higher in quality across a range of conditions. (15) This equates with lower in hospital mortality, lower cost and lower average length of stay.

Table 3: What matters to patients

Feeling informed and being given options
Staff who listen and spend time with me/patients
Being treated as a person, not a number
Being involved in care and being able to ask questions
The value of support services, for example patient and carer support groups
Efficient processes

Patient co-design is seen as an important way to build consumer engagement and participation. It is essentially and evidence-based approach the 'uses patient and staff experience to design better health care services' ensuring that health professionals understand experiences from the perspective of patients and carers.

New Zealand DHBs take different approaches to get feedback from their patients and families. Most use a post-discharge survey; however, responses are generally low. ADHB does the same, however, at the bottom of the survey is an invitation to be patient of a virtual group (in the clinical area of their

choosing) that can be called upon for co-design efforts. Others use Patient and Consumer councils. Some of these work well, however, it is important that such a group has a clearly defined role, so that it does not disintegrate into single issue discussions.

CCDHB Consumer Engagement and Participation– Feedback from interviews and documents

Some exemplars:

Kenepuru –There is good consumer engagement and participation at Kenepuru Hospital. This work appears to be mainly led by the Nurse Manager, who has a good overview of the improvement work. They have a 'little cohort' of eleven consumers that advise on changes, and they have consumers on their Delirium and Nutritional programmes. They have also run patient co-design in their patient falls, wayfinding (signage) and patient information projects. They also employed a diversional therapist for their confused patient, and families are seen as part of the care team. They are active in the Health of the Older Persons and Frailty work with the 'Careful Team.' They have also worked with the Aged Residential Care sector to co-design discharge, employing a discharge coordinator. Some of this work could be transferred to the main Wellington Campus.

Children's Service – Paediatrics have traditionally been strong in family engagement and the CCDHB unit is no exception. There has also been good co-design with patients and families on the design of the new Children's hospital (see below).

MHAIDs – Like Paediatrics, Mental Health has also traditionally been strong in consumer and family engagement. MHAIDS has paid positions for consumers with lived experience of mental health across its networks, and consumers are involved in the key committees. At the current time there however, vacancies in Family Advisor Team positions.

It has been agreed at HHS that CCDHB we will partner with the HQSC regarding co-design training and this is to start in July. Currently the patient experience data is being interrogated to inform four co-design projects focussed on each of the four patient experience survey domains (Coordination/Communication/partnership and physical /emotional needs).

Enabling consumers/patients and their family/whanau as members of the healthcare team.	
Partnerships with patients	This is not well developed. There is a willingness to see families as partners in care, but people are not sure how to go about it.
Patient experience surveys/questionnaires	There is a CCDHB post discharge patient survey, with a response rate of approximately 25%. The HQSC national patient experience surveys are done quarterly and the response rate is similar at 30% Currently these low response rates provide little useful information to drive improvements at a unit level.
Advance Care Planning	There is acknowledgement that this is an important area. This currently sits under the Executive Director of Allied Health, Scientific and Technical. It appears to be under-resourced with only one worker across the three DHBs and there are some technical blocks to information sharing across primary and secondary care. Nurse-led clinics in primary care are being investigated.
Health Literacy	This is recognised as important, especially in the areas that have patient/consumer advisors.
Consumer/patient participation	There are pockets of excellence, particularly in MHAIDs with consumers and family advisors integrally involved, and Women's Health, which has 2 consumer representatives on the Maternity

	Quality & Safety programme. There are some key committees with consumer representatives – the Primary/Secondary Clinical Governance Group, and the Clinical Ethics Advisory Group for example. However, there is not a DHB culture of having consumers on all key committees. One interviewee suggested that CCDHB does "accidental consumer engagement." In 2016 there was a proposal to set up a consumer council, with 55 people applying to be a part of it. Support for such a group was withdrawn by the then CE. In 2017 a Citizen's Council was proposed – with the focus on looking at the health issues that challenge CCDHB citizens, and to look at solutions across the system of care. Initially getting a representative membership was proving difficult so the team have been proactive and have shoulder-tapped representatives and the first meeting is scheduled for July.
Co-design	There has been some patient co-design, evident in the new Children's Hospital Build where families, including families of disabled children have been involved in design. Teenagers were also involved in the design of a teenage space. Patient co-design is also healthy at Kenepuru Hospitals with patients involved in falls prevention, signage and way-finding and patient information.
Patient stories	There is some work in this area, but it could be developed more.

Summary of CCDHB Consumer Engagement and Participation

There are patches of excellent patient/consumer engagement and participation, however, it is not embedded in the CCDHB fabric at this time. Patient feedback is in the form of the Patient Experience Surveys, but it may be time to augment this approach.

The Board has been keen on a consumer council, however, it did not eventuate and instead a Citizen's Council has been proposed with the first meeting due in July. It will be important that the council has a clear scope and that it has direct responsibility for some projects.

That being said, there may be better ways to get patient and consumer feedback and participation in co-design. Several other DHBs collect real-time feedback from patients and establish virtual groups that can be called on for co-design projects. The Kenepuru example is useful, as is the consumer co-design in the build of the new Children's Hospital. In each case, a smaller clinical area built its own consumer representation, facilitated feedback and worked together with staff. Building on this work CCDHB has partnered with the HQSC to progress patient and family co-design.

Recommendations

1. Encourage and support (with training and tools), service specific consumer engagement and progress the HQSC training in co-design
2. Review the Patient Experience Survey – possibly stop the monthly surveys and look at other ways to secure real-time feedback. Investigate alternative methods to gather patient feedback to allow for low response rates for patient experience surveys – e.g. i-pads available during admission/outpatient appointments asking the Net Promoter Question of

patients. Ensure consumers and Maori and Pacific health teams are involved in the design.

3. Develop capacity to video patient stories so that a bank of stories about common issues can be used for staff engagement and education.
4. Ensure that consumer representatives on committees are given training and support.
5. Review resourcing of the Advance Care Planning programme with a view to extending it.

3. Clinical Effectiveness

Definition: The application of best knowledge, derived from research, clinical experience and patient preferences to achieve optimum process and outcomes of care for patients. (16)

Strategic Approach:

- Use evidence-based effective interventions and treatments based on the principles of good practice.
- Evidence and data drive improvement and innovation, minimising harm, waste and variation

Measurement of clinical processes and outcomes doesn't just happen – it requires leadership, resources (data capture and analysis) and a way to involve clinicians in the decision-making.

CCDHB Clinical Effectiveness

Management Operating System (MOS).

One system that is being used at ADHB and that was trialled briefly at CCDHB, is the Management Operating System (MOS). This involves front-line clinical teams identifying the key activities (and measurement) for the year and align this with the organisational strategic aims. The overarching principles are:

- Status at a glance – increased visibility and transparency of performance
- Action – a drive towards 'concern, cause, countermeasure' thinking
- Team ownership
- Alignment – improved alignment across the organisation

The MOS can work at the local department level and at the DHB level. Some of the tools are balanced scorecards and dashboards, A3 plans and improvement science. A key focus is to develop pathways that allow the escalation up and cascading down, of information, decisions and strategy. It is larger than clinical effectiveness, but it is providing a system in which clinical effectiveness can be visible and supported.

As a clinical Director at ADHB said: "this has worked well to give me a clear understanding of what our priorities are and make that clear to all within the department.' (Mark O'Carroll – Clinical Director, Respiratory.

It is unclear why the CCDHB pilot of MOS failed, but it is a large programme that would need to be adopted at an organisational level, be led by strong clinical leadership and adequately resourced.

QLIK sense® and Qlik view®

The other innovation that CCDHB has committed to is Qlik Sense® and Qlik View®. QlikView® is for guided analytics; Qlik Sense® is for self-service visualizations. With Qlik View® you can analyse data and make data discoveries without having to make a request to a business analyst. Clinicians can drill down in the data to the group or individual level – to answer questions, and report on clinical outcomes. Qlik Sense® does not require predefined and static reports, and is not dependent on other users. Waitemata DHB has been rolling this out for 18 months now, and they have taken a clinician engagement approach – building Qlik capabilities based on what the Clinical Directors wanted to see. The programme rollout is under the control of the I3 (Innovation, Improvement and Integration) centre and therefore has a strong quality improvement focus.

In CCDHB the programme is being run out of Corporate Services as a special project. The project lead is coordinating service planning reviews (three completed to date) and then deciding what Qlik sense® will provide those services It seems that there is less clinical engagement than at WDHB and there is limited connection with the Quality Improvement & Patient Safety Directorate.

The decision of whether to introduce the MOS with Qlik sense® would seem to be an ideal discussion for the Clinical Council.

Bench marking of performance

Health Roundtable.

CCDHB is a partner in the Health Roundtable (HRT) and so receives information on a number of clinical outcomes. The HRT also reports on the Hospital Standardised Mortality Rate, which is higher at CCDHB compared with similar hospitals across Australasia. The HRT depends on coding data, which in turn depends on good clinical documentation. This method has led to some reluctance to take the HRT seriously at CCDHB. For instance, mortality from sepsis is noted to be higher than other comparable hospitals. The initial response from the Infection Diseases leadership was that this was an artefact. However, a detailed analysis by the QIPS team, concluded that the data was reliable.

The HRT Top 10 report, suggests that CCDHB could save 3,542 bed days if the performance was as good as the exemplar hospitals. CCDHB could make more use of the HRT data by addressing the clinical documentation/coding issues, establishing a clinical governance framework to regularly review the measures and benchmark against exemplars (suggest a function of QIPS), beef up analytical resources and more proactively engage with the HRT.

Health Quality & Safety Commission (HQSC)

The Atlas of Healthcare Variation identifies variation across NZ in provision of services, timeliness of service and disease specific indices (e.g. use of high risk medications). This provides a wealth of data, but there was little evidence that it is was being used systematically to prioritise improvement areas.

Choosing Wisely

There is a 'choosing wisely' committee, which meets every fortnight and reports directly to the CEO/COO. Those involve realise that they can only act as influencers to change culture and have been working on several projects recently – ED cannulation (decreasing the automatic cannulation in ED), working with the team on Antibiotic stewardship and on blood and iron transfusions. They connect with the national choosing wisely network.

CCDHB Clinical Effectiveness – Feedback from interviews and documents

Culture of measurement and improvement	Most of the measurement taking place is compliance-based and there is not an obvious culture of measuring clinical effectiveness. Some units – Women's Health, ICU, the stroke team and sections of MHAIDS – submit measurement to the MoH or to college databases. However, even when this is done, the information is not fed back in a timely fashion to drive clinical improvement. Most were aware of the HRT, however, not many were aware of what the data could be used for. Few services appear to have a plan for measurement of clinical effective metrics.
Mortality & Morbidity Reviews	Most units conduct some form of M&M, however, not all are multi-disciplinary (some are conducted off site), and there seems to be no organisational learning from these efforts. There are no hospital - or even directorate - wide M&Ms. There is variation in how the M&M meetings are conducted – suggest CMO reviews the NSW M&M guide (see appendix 4) and discusses with clinical leaders. This guide sets out the objectives and principles for conducting M&Ms.

Evidence-based practice	There are some very good clinical models that follow best practice: The frail elderly programme with the 'Careful Team' The Delirium pathway Others like Enhanced Recovery After Surgery (ERAS) have not been sustained or well-enough resourced to have the expected outcome There are also a large number of pathways (368) in the Integrated Care Collaborative space
Measurement and transparency of clinical outcomes	There is little evidence of systematic measurement of clinical outcomes – there are measures of processes (e.g. Surgery start-on-time KPI), but much less on outcomes and in particular outcomes from the patients perspective -e.g time to return to full function post-surgery, quality of life measures. The Medical Emergency Team callouts and Arrest data are collected as part of the Clinical Recognition and Response Committee.
Clinical audit and Research	There is a good deal of audit activity, and many registrar training positions and professional colleges require participation in clinical audit. There is concern about closing the loop and embedding changes to produce improvement. There is also concern over the governance of clinical audits with some areas having multiple audits on the go at the same time, many of which fail to be completed. The Clinical Audit Advisor position has been vacant for 9 months and this is causing strain. Research is self-funded (by trials) and is run at the Directorate level. Some departments (e.g. Blood and Cancer, endocrinology, and Women's Health), do a large number of trials and will fund their own research teams. Overall there are 35-40 staff. There is a variance of opinion about support for and research governance– with some saying that there is good clinical engagement, whilst others have noted that there has only been a quorum for the Research committee for 2 out of the last 6 meetings. The recent chair of the Committee has taken a year's leave. The Research office itself has had to cope with frequent changes in leadership. Research is signed off Executive Directors for the individual areas and research ethics goes through the National Health and Disability Ethics Committee. Bi-annual reports on research are sent to the ELT, professional leads and individual clinicians involved in research. The physical research trial space is threatened each winter as the demand for beds increases, which means that trials have had to be stopped and it is difficult to do any long-term planning. There is no attempt to align research activities with the strategic objectives of the DHB.
Open publication of clinical outcomes	Very little open publication of clinical outcomes, and it is unlikely that the clinical leadership of CCDHB would be keen on such disclosure at this stage.

Summary if Clinical Effectiveness

This element requires some work at CCDHB, to ensure that the clinical care delivered is effective and that data on its effectiveness is available for front line clinicians (to encourage improvement), and in summary format for the Executive and Board. There appears to be no organizational view of clinical performance with some units not measuring clinical indicators, and others participating in Australasian registries but the data is not viewed locally.

CCDHB does contribute to the Health Roundtable, which allows benchmarking with peers, however the data appears to be underutilized.

The governance of research and clinical audit work could be improved and more could be done to build useful clinical databases to support audit.

A recurring theme from the interviews is that there is good clinical engagement at CCDHB and that staff are resilient because of years of fiscal constraint – "austerity means that people stick to their knitting." It maybe that this is the reason for the lack of obvious measurement and energy in the Clinical Effectiveness domain.

Recommendations

Mortality & Morbidity Meetings:

1. CMO to discuss with clinical leaders, seen as core expectation, should involve whole team
2. CMO to review the NSW M&M process, and if suitable, to introduce it
3. Annual report to Strategic Clinical Governance Committee on themes from each meeting

Clinical Audit

4. Summary of clinical audits undertaken and results reported to the Strategic Clinical Governance Committee

Clinical Indicators

5. Scan of each department to document clinical indicators currently collected and assess barriers to greater engagement in this activity
6. Clinical Council to consider whether the MOS system would assist in embedding key clinical effective measures

4. An Engaged, Effective Workforce

Background.

Definition: "An engaged, effective workforce that works in partnership with consumers/patients and their families/whanau and actively participates in an ongoing process of self and peer review." (5)

Employee engagement is not 'soft stuff', it is what delivers the 'hard stuff.' (17)

The recognition that an engaged, capable, and happy workforce, improves the quality of care received by patients and their families/whanau, has led to increased focus in this area

Engaging doctors can be difficult, but they are arguably the most important group, capable of sabotage or great support depending on their engagement. Dr. Don Goldman (18) starts engagement by asking doctors "what ticks them off" and working from there. He goes onto outline seven rules for engaging with doctors (see table 4). (19)

Table 4: Six rules for engaging with doctors

1. Emphasize improvement, not accountability/quality assurance
2. Simple language (avoid manufacturing QI – lean and six sigma
3. Ensure that QI will assist doctors with their clinical concerns
4. Show respect for his or her clinical work and sensitive to their workload – values their time
5. Be up-front about the fiscal agenda
6. Establish that QI is not less rigorous than research and it can lead to an academic carer

Good employee engagement is a hallmark of high reliability organisations, that value the experience of staff in identifying the problems and the potential solutions in complex systems.

Many healthcare organisations survey their staff annually. The results can be illuminating, but others have found that asking the simple question: "What is the likelihood you would recommend company X to a friend or colleague?" works best to predict staff and customer loyalty and overall growth. It can be used to develop a Net promoter score for the organisation. (20) The same question can be asked of patients and their families.

Organisational Culture.

The culture within an organisation is rarely uniform with multiple (often competing) subcultures, "stratified by hierarchy." (21) Patient safety culture is part of organisational culture and there is some evidence that patient safety improves when the focus is on the unit-level (with the subcultures). (22) One such example is the Comprehensive Unit-based Safety Program (CUSP) as promoted by Peter Pronovost. (23) This 8-step program starts with measurement of the unit's culture of safety, and staff then identify and prioritise the safety concerns in their area. Using the science of improvement and with senior executive support, they then trial improvements and measure the outcomes.

A Just Culture.

An important part of a culture of safety, is the way that an organisation reacts to adverse events. Initially a lot of effort internationally was aimed at instilling a 'no-blame' culture so that staff would feel safe to raise their patient safety concerns and report adverse events. This was a necessary first step, as there was a culture of blaming the individual when things went wrong, promoting a culture of fear and secrecy. This has become more nuanced and it is recognised that there are some, rare, blameworthy acts. So, the term 'A Just Culture' has been coined. The central tenants of a just culture are outlined in West Moreton's A Just Culture Policy.

"West Moreton commits to holding individuals accountable for their own performance in accordance with their job responsibilities and our West Moreton Values. However, individuals should not carry

the burden for system flaws over which they had no control. Blaming individuals does not improve patient safety and may harm organisational learning from errors."

A Just Culture recognises that individuals come to work with the best of patient safety intentions and the initial response to an adverse event should focus on the system weaknesses that contributed to the incident (and which are likely to cause future incidents). However, a just culture also recognises blameworthy acts:

"a 'blameworthy act', that is, an intentionally unsafe act, deliberate patient abuse or conduct that constitutes a criminal offence."

CCDHB's Engaged, Effective workforce.

Workforce matters come under the People and Capability Directorate with human resource managers for the large directorates – MCC, SWC, MHAIDS, and Corporate & Executive (which handles senior clinical recruitment). Also in the directorate is the Capability Development unit and a smaller unit looking at Organisation Development. Although not noted in the organisational structure, Occupational Health & Safety sit under the Corporate Directorate.

Staff Engagement Survey.

This survey had a good response rate – overall 52.5%, though lower for the major clinical areas – MCC (40%), SWC (45%), and MHAIDS (45%). The highest response rates by profession were the Allied Health (75%) and Non-Clinical staff (65%), with both Medical (45%) and Nursing (39%) further behind. Nearly 3,000 CCDHB staff and 200 MHAIDs staff completed the survey.

Engagement with CCDHB was very good overall, with only 3% of respondents strongly disagreeing with the statement "I feel engaged with CCDHB." There were two areas where the majority responded negatively:

1. Quality Communication: "CCDHB communicates well with me." Thirty five percent answered this question in a positive way, however, 24% were negative or very negative. Formal communication is currently through a weekly CE report and the 'daily dose,' however, the survey revealed issues with the flow of information from the Board and ELT to the frontline.
2. Safe and Supportive Working Environment: "My workplace feels supportive and safe." Seventy-five percent of respondents answered this question either in the neutral or negative category (10% strongly negative, 28% negative and 37 neutral). This result has given impetus to the adoption of Standing up for Safety programme (see below)

The results have been fed-back to staff in a number of workshops, with an emphasis on using the data for action. The survey was also the springboard for the development of the draft CCDHB People Strategy 2018, through co-design workshops (186 participants in 20 workshops). These workshops were clear that "respect and kindness underpin the way we work together" and identified 8 key themes:

i. Inspirational Leaders – "we inspire and enable our people to do their best work"
ii. Healthy Workplace – "we care for each other to ensure a safe and supportive workplace"
iii. Smart and simple ways of working – "we make it easy to do great work here"
iv. Robust workforce – "we know and value our people"
v. Continuous learning – "every day we learn, reflect and review"
vi. Meaningful communication – "we understand, share and create together"
vii. High performance – "we are able and motivated to do our best"
viii. Future thinking – "we look to the horizon in everything we do"

Each theme was then further analysed, differentiating "Work as Experienced' (WAE) and "Work as Imagined" (WAI). This provided rich data to lead change in each to the themed areas and also to develop the key principles for positive change (see figure 21).

Figure 21. Four key principles for positive change

The organisational development team are leading a research programme to determine if there is any change in the CCDHB safety culture over a three-year period, with a safety attitude questionnaire (baseline survey due August 2018), triangulation with other data (e.g. unprofessional behaviours reported to HR, unions and exit interviews; sickness leave and staff turnover), feedback from patients and in-depth interviews with leaders.

There were also some departmental surveys conducted – for example the Anaesthetic department has done a RMO survey with good feedback.

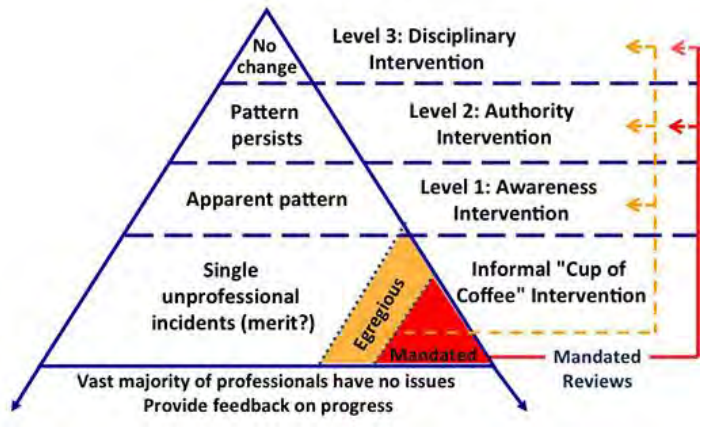
Speaking up for Safety

This program developed by the Cognitive Institute aims to improve patient safety culture using nudging theory and graded accountability. This recognises that there is still fear when confronting disruptive clinicians and instead staff can call a 'safety code' – in effect the organisation subs in for them. There are two types of code:

1. There is a suspicion that a patient is about to be harmed
2. The safety culture is being threatened in the absence of imminent patient risk.

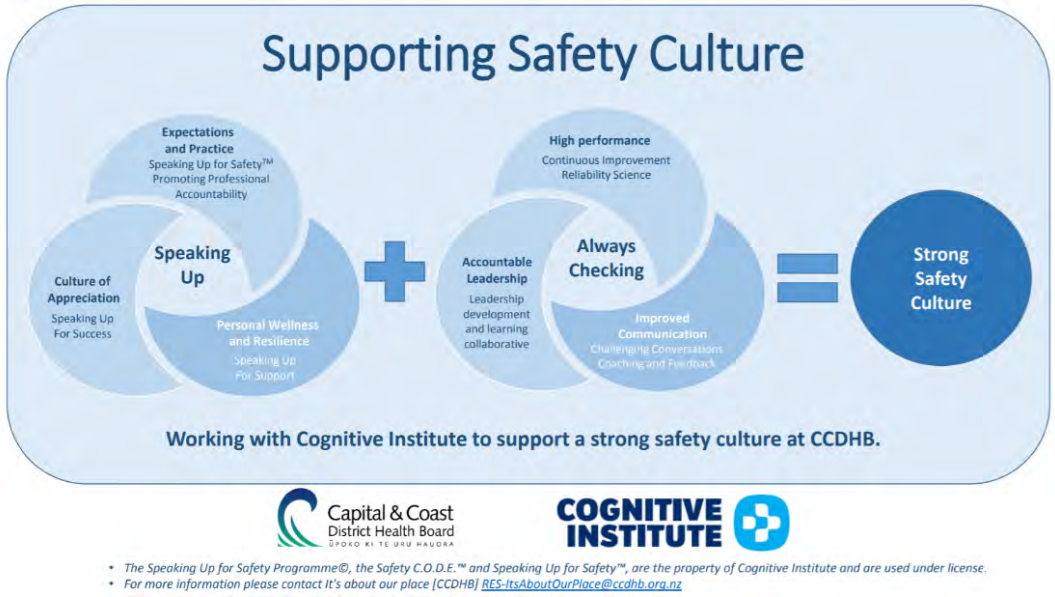
The graded response to a code is based on Hickson's pyramid of accountability (figure 22). The first response is a peer-to-peer conversation about the behaviour (as many lack insight on the impact of their behaviour), and 90% of clinicians will amend their behaviour and not receive another code. The second is another peer-to-peer conversation with a different clinician. Only 1% will receive a third code and this is handled by a conversation with their professional line manager. If there is a 4th code, then there is a mandatory medical and psychological assessment to determine if the clinician is impaired ("don't performance manage people who are sick"). If there is no impairment, then the person is performance manged, usually out of the organisation. This requires the full, unblinking support of the executive and the Board, but over time it can become a powerful modulator of organisational and patient safety culture.

Figure 22 Hickson's pyramid of accountability



'Speaking up for Safety' and 'Always checking' together support a strong safety culture (see Figure 23). The Cognitive Institute's original aim was to improve patient safety, however, CCDHB has extended this to staff safety as well. The programme is therefore run out of the People and Capability Directorate, rather than out of QIPs. This focus on staff safety has caused some consternation as the balance seems to have swung more towards the safety of staff, rather than of patients.

Figure 23 Cognitive Institute Supporting Safety Culture.



Safe Nursing Staff initiatives.

CCDHB utilises the Care Capacity and Demand Management programme (CCDM), which came out of the Safe Staffing Health Workplaces initiative. CCDM has the following features:

- matching the nursing workforce availability and skill mix to patient acuity in each ward on the day

- providing a suite of indicators that enable a 'real time' view of the patient, the ward and the hospital in relation to workforce availability and patient acuity, in order to identify any gap between demand and capacity
- providing tools that enable variance in the predicted nursing workforce availability, skill mix and patient acuity to be managed safely and efficiently on the day.

In addition, CCDM now includes a set of core data (Table 6) that contains a comprehensive set of output and outcome measures. It is used to provide clinical staff, patients and management with a transparent picture of the impact of the programme.

Table 5: CCDM core data set

Measure	Purpose
Clinical hours required versus clinical hours provided	Are patients receiving all the care they need?
Health and Quality Standard markers	Are adverse events occurring?
Productivity	Is the budget being maintained?
Flow	Are flows and volumes being achieved?
Staff satisfaction	Are staff satisfied with what they are able to achieve?
Work effort	Is the work effort to maintain service levels reasonable?

Occupational Health & Safety.

There has been an increased focus on staff health and safety over the last year. It also coincides with the new Hazardous Substances National Policy, which has implications for CCDHB.

There are 3 steering committees:

1. Health & Safety Steering Committee
2. Workplace Violence & Aggression Steering Committee
3. Moving and Handling Steering Committee

The Health & Safety Manager provides a monthly report for ELT, which covers:

- Reported incidents – physical assaults on staff featured highly in the last 2 reports
- ACC injury claims and Medical Fee Only (MFO) claims
- Pre-Employment screening (only 77% completed prior to start),
- Training of managers (between 67% and 83% completed)
- Referrals to EAP services.

There are 10 staff in this unit and there are good linkages with the QIPS unit.

The Hazard register is currently paper-based but the aim is to have this electronic.

It would be fair to say that Health & Safety Management had fallen off the radar at CCDHB and the new manager has worked hard to get the organisation to focus on this area again.

Capital and Coast's Engaged, Effective workforce – Feedback from interviews & documents

An engaged, effective workforce that works in partnership with consumers/patients and their families/whanau, and actively participates in an ongoing process of self and peer review	
Strategic approach	
The People and Capability Directorate is moving away from a simple transactional human resources approach to a more strategic, future focused and data driven approach. Recognising that the organisation "will require an agile and flexible workforce that is constantly evolving in response to changing health needs, demographics and technologies." The staff engagement survey has informed the People Strategy and the decision to introduce the Speaking up for Safety programme.	
General	It was mentioned that in several clinical areas both the nursing and medical rosters "were thin" and at least for medical staff this made it very difficult to take leave. There is also a view that staff are resilient because of a long history of DHB debt.
Orientation and Induction	The CCDHB orientation policy apparently has not been up-dated since 2008. There is an organisational orientation for half a day that occurs monthly and is considered mandatory. Orientation for medical staff is devolved to the units, except for first year RMOs – Post Graduate Year 1 (PGY1) – that have a week of orientation. On-boarding for other staff is variable. MHAIDs orientation is 2 days and is run quarterly. It involves a powhiri and introduction to the consumer and familiar advisor team. There is intensive orientation and induction for new nursing graduates
Education and Training/Professional Development	There seems good organisational support for ongoing education and training; most of those interviewed had no difficulty accessing courses. The exception was in MHAIDS where access to training was an issue when dealing with three different DHBs and HR departments, causing "enormous problems." There is an on-line education tool – "connect me"- which is synced with the HR system and is the single repository for all learning records. It has a core list, but it does not yet stipulate mandatory courses. Core list for all staff: CCDHB orientation Tikanga Maori Treaty of Waitangi Health and wellbeing Policies and procedure – Fire & Emergency, Privacy and Health etc. Core training for clinical staff: ISBAR Hand hygiene Manual/safe handling Infection prevention and control Violence intervention

	CPR. The barriers to training include: Difficulty back-filling staff to take part in training Information overload with multiple programmes Professional cynicism from some groups (especially medical workforce) The training is predominantly about clinical care, with less well-developed training in QI. The QIPS team run the "Improvement Movement," (1-hour taster sessions and 12-week project-based courses). The courses are based on the Model for Improvement, and participants are supported by the Improvement Advisors in QIPS. Although the 12-week course is onto its 4th iteration, it is notable that senior leaders and operational managers have not been amongst the participants. This contrasts with both CDHB and ADHB, where senior leaders were the first cab off the rank – this enabled them to understand the value for their staff and can support them in QI work. Apart from the Improvement Advisors, few other staff in QIPS have ongoing professional or QI training.
Teamwork and Communication	There is 'Open Communication' (open disclosure) training for clinicians, which is aimed at senior clinicians and approximately 40 have been trained to date.
Leadership development	Interviewees were generally satisfied with leadership development, though several noted that the time for leadership duties was not sufficient. The two Executive Directors in MCC have recently resigned, and others have noted that the time to devote to leading a clinical unit is insufficient. CCDHB supports medical staff to take a sabbatical every 6 years and there is ring-fenced CPD. Several of the clinical leaders had undertaken a clinical leadership course run by the Francis group. The Frontline Leadership programme in an in-house leadership programme, targeting new leaders. It is delivered in seven 1-day workshops over 7 months. There is also training provided by an external provider – 'Jump Shift' – which targets senior leaders. It is delivered in 2.5 days over 4 months and covers self-leadership, leading and developing teams, and leading across healthcare.
Credentialing	Credentialing of senior medical staff is devolved to those on the interview panel. There is no credentialing committee to ensure appropriate standards and little time spent on determining and publicising the Scope of Practice of new recruits. The recent certification reported that the credentialing process for medical staff, which is to be annual, shows that only 76% of medical staff have completed this process." This actually sounds like annual appraisals rather than credentialing.

Summary of CCDHB Engaged Effective Workforce.

There is a good deal going on in this space and there is good clinical engagement. The main areas in the staff survey were around 'communication' and 'staff not feeling safe and supported.' The People and Capability Directorate have engaged staff in workshops and the draft People Strategy looks very good.

There is good access to training and development (including leadership training), though there is the question of whether rosters are robust enough to release people for training.

Likewise, the time allocated for clinicians in leadership roles needs to be reviewed, especially for the smaller units where it is only a couple of hours per week.

Credentialing and professional appraisal for senior medical staff needs to be strengthened.

Recommendations.

1. Continue with the Speaking up for Safety programme and ensure that staff safety and patient safety are both emphasized
2. Review the current number of, the expectations of, and time allotted to, Medical leaders
3. Perform exit reviews for the two Executive Directors Medical (MCC) that have resigned
4. Develop a standardised credentialing process with an electronic register of each SMO's individual Scope of Practice

References

1. **Health., Ministry of.** *New Zealand Health System: Population of Capital and Coast.* Wellington : s.n.

2. **Ministry of Health.** *New Zealand Health Strategy: Future Direction.* Wellington : s.n., 2016.

3. *Clinical Governance and the drive for quality improvement in the new NHS in England.* **Scally G, Donaldson L.** s.l. : BMJ, 1998, Vol. 317.

4. **ISC Medical.** [Online] [Cited http://www.medical-interviews.co.uk/ct-st-clinical-governance.aspx.: April 7th, 2017.]

5. **Health Quality & Safety Commission.** *Clinical Governance. Guidance for Health and Disability Providers.* Wellington, New Zealand : s.n., February 2017. ISBN 978-0-908345-46-5 (web).

6. **Institute of Medicine.** "Executive Summary.". *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC : The National Academies Press., 2001.

7. **Frankel A, Haraden C, Federico F, Lenoci-Edwards J.** *A framework for safe, reliable, and effective care. White Paper.* Cambridge, MA : Institute for Healthcare Improvement and Safe & Reliable Healthcare, 2017.

8. **Institute for Healthcare Improvement.** [Online] [Cited: 10th April 2017.] www.ihi.org.

9. *Getting Boards on Board: Engaging Governing Boards in Quality and Safety.* **J, Conway.** 4 : The Joint Commission Journal on Quality and Patient Safety, 2008, Vol. 34.

10. *Taking Health Care Governance to the Next Level.* **P J Pronovost, C M Armstrong,R Demski et al.** 31 Jan 2018, NEJM, https://catalyst.nejm.org/healthcare-governance-next-level-quality-committee/.

11. **Health Quality and Safety Commission,.** *From Knowledge to Action. A framework for building quality and safety in the New Zealand health system.* Wellington : 2016. ISBN 978-0-908345-36-6.

12. *What is "quality improvement" and how can it transform healthcare?* **Batalden PB, Davidoff F** : BMJ Quality & Safety, 2007, Vol. 16, pp. 2-3.

13. **Health Quality & safety Commission.** Engaging with Consumers: A guide for district health boards. [Online] 2015. [Cited: 22nd April 2017.] http://www.hqsc.govt.nz/assets/Consumer-Engagement/Publications/DHB-guide/engaging-with-consumers-3-Jul-2015.pdf.

14. **Institute for Patient and Family Centered Care.** [Online] Institute for Patient and Family Centered Care. http://www.ipfcc.org/. [Cited: 20th April 2017.] http://www.ipfcc.org/.

15. **Department of Health and NHS Institute for Innovation and Imporvement.** *What matters to patients? Project report for the Department of Health and NHS Institute for innovation and Improvement.* Warwick : NHS Institute for innovation and Improvement, 2011.

16. *Patients' Perception of Hospital Care in the United States.* **JHA AK, Orave J, ZhengJ, Epstein A.** October 30: N Engl J Med, 2008, Vol. 359, pp. 1921-1931.

17. **Executive, NHS.** *Promoting CLincial Effectiveness: A framework for action in and through the NHS.* London : NHS Executive, 1996. B001AJFX5C.

18. **Listening into Action. [Online] [Cited: 19th April 2017.] http://www.listeningintoaction.co.uk/.**

19. D, Goldman. Institute for Healthcare Improvement. [Online] [Cited: 22nd April 2017.] http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/RulesForEngagingCliniciansInQI.aspx.

20. Goldmann D. ***Institute for Quality Improvement.*** **[Online] [Cited: 22nd April 2017.] http://www.ihi.org/Documents/OpenSchoolCourseTranscripts/DonG-SevenRules.html.**

21. ***Patient, staff and physician satisfaction: a new model, instrument and their implications.*** **York As, McCarthy KA. 2, 1988, International Journal of Health Care Quality Assurance, Vol. 24, pp. 178-191.**

22. ***Will prescriptions for cultural change improve the NHS?*** **Davies HTO, Mannion R: BMJ, 2013, Vol. 346.**

23. ***Strategies for improving patient safety culture in hospitals: a systematic review.*** **Morello RT, Lowthian JA, et al. 1, 2013, BMJ Quality & Safety, Vol. 22.**

24. ***Implementing and Validating a Comprehensive Unit-Based Safety Program.*** **Pronovost P et al. 1, 2005, Journal of Patient Safety, Vol. 1.**

25. Ministry of Health, the Treasury, the Health Quality & Safety Commission. ***Exploring the Links between Quality Improvement Strategies and Organisational Outcomes in Four New Zealand District Health Boards .*** **Wellington : The Treasury, 2016. ISBN: 978-0-908337-66-8 (Online).**

26. NSW Health Department. ***The Clinician's Toolkit for Improving Patient Care.*** **Sydney : 2001. https://wdhb.org.nz/contented/clientfiles/whanganui-district-health board/files/rttc_clinician-s-toolkit-for-improving-patient-care-nsw.pdf**

Appendix 1. Documents reviewed

Board Papers	Board meeting papers 16th May, 28th March
Strategies/Plans	Quality Improvement and Patient Safety Plan 2017-18 CCDHB People Strategy. It's about our place CCDHB Annual Plan 2017/18 Draft Capital and Coast Health System Plan (Working together for better lives, 2018*)* Toe timata le upega. Pacific Action Plan 2017-2020 Pharmacy Review: Programme Management Plan
Policies	Risk Management Policy MHAIDS Whanau/Family Participation Policy 2017 Policy: Audit Schedule: Care process and compliance with internal/external checks
Committee ToR and Minutes	Clinical Ethical Advisory Group Primary/Secondary Clinical Governance Group Patient Quality & Safety Indicators Committee Vascular Access and Treatment Committee Clinical Recognition and Response Committee Restraint Approval Group Death Review Committee Blood Transfusion Committee Clinical Council Clinical Practice Committee ICC Alliance Leadership Team meeting CCDHB Infection Prevention and Control Team meeting Medicine Committee Business Intelligence Stewardship Group Child and Youth Mortality Review Group MHAID 3DHB Clinical Governance Committee Research Governance Group
External Reviews	Certification Report April 2018 The Health Roundtable – Executive Briefing 2017

	Poor to mediocre performance by DHBs in clinical governance and leadership ASMS, 2010
Internal reports	Patient Experience MCC Medicine, Cancer and Community Directorate Report Mental Health, Addictions and Intellectual Disability Service (MHAIDS) Integration. (draft). Staff and Stakeholder Consultation Document version 5, Feb 2018. Infection Prevention and Control Q 3 report CCDHB Serious and Sentinel Events report: 2016-2017 The Value of Clinical Ethics Advisory Groups to Service Planning Processes The Women's Health Service Annual Clinical Report 2016 Trendcare Clinical Training Booklet. Surgical version 3.5.1 Quality Improvement, Patient Safety Directorate. Analysis of Health Roundtable major complications data, Health Quality Safety Commission Sepsis data and Accident Compensation Corporation Treatment injuries Risk report for the month ending February 2018

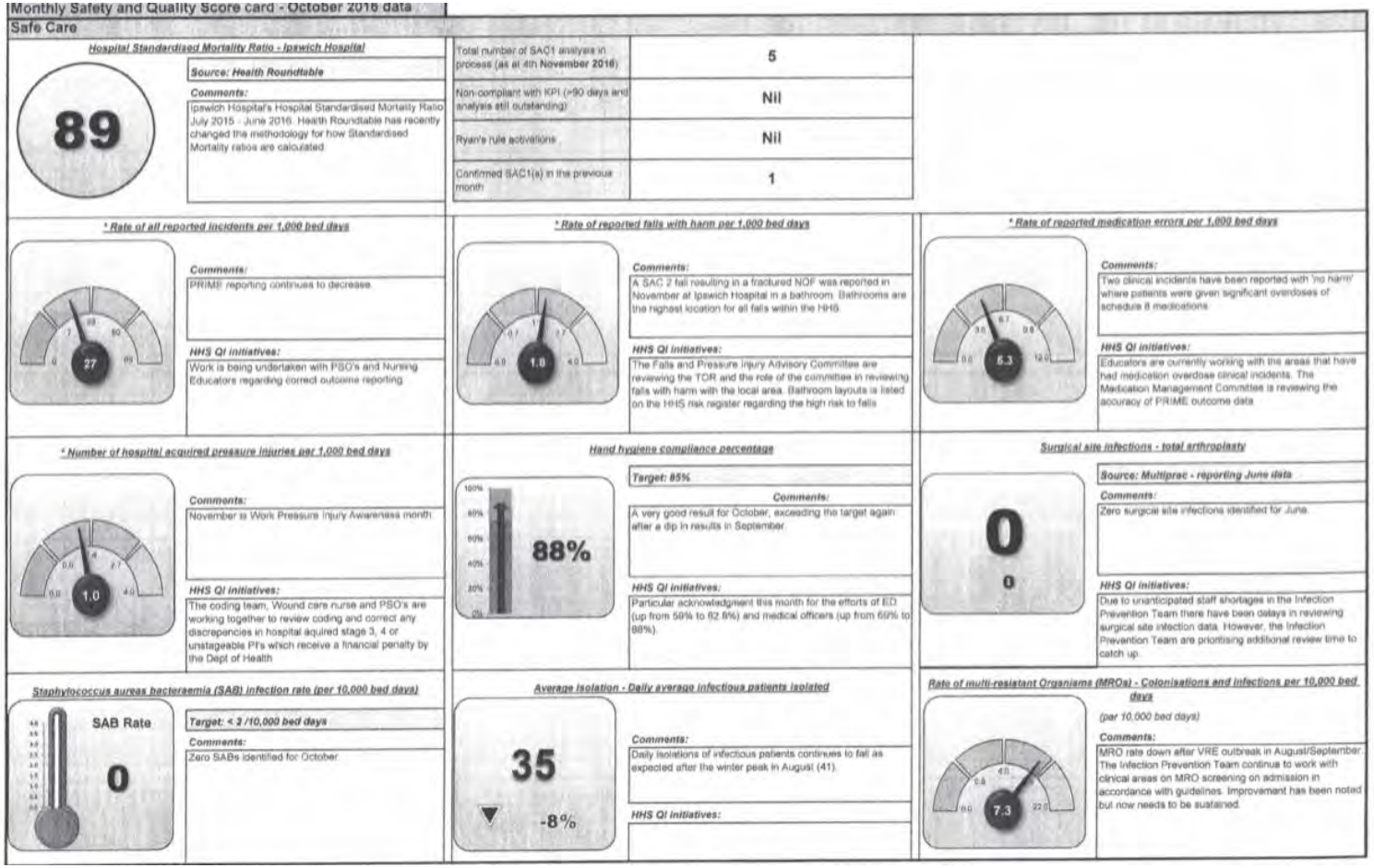
Appendix 2. Interviews conducted

Area	Name	Role
Board	Andrew Blair	Chair of CCDHB Board
Executive Leadership Team	Chris Lowry	General Manager HHS
	Rachel Haggerty	Exec Director Strategy, Innovation & Performance
	Thomas Davis	General Manager Corporate Services (Health & Safety)
	Andrew Wilson	Acting General Manager People & Capability
	Dr. John Tait	Chief Medical Officer
	Andrea McCance	Executive Director of Nursing & Midwifery
	Catherine Epps	Executive Director Allied Health Scientific & Technical
	Shayne Hunter	Chief Information Officer
	Nigel Fairley	General Manager MHAID
		Chair Restraint Advisory Group
Maori Health	Arawhetu Gray	Director Maori Health, and GM MHAIDs
Pacific Health	Taima Fagaloa	Director Pacific Health
QIPS	Caroline Tilah	Executive Director QIPS Operations
	Dr. Shawn Sturland	Executive Director QIPS Clinical
	Anne Stewart	Improvement Advisor QIPS
	Richard Perry	Improvement Advisor QIPS
	Anne Pedersen	Patient Safety Coordinator QIPS and chair Patient Safety Quality Indicator Committee
	Catherine Gibson	Consumer Experience Officer
	Sandra Allmark	Quality Systems Performance Analyst
	Marina Dzhelali	Service Leader Research Office
Strategy, Innovation & Performance (SIP)	Astuti Balram	Integrated Care Collaborative Program Manager

	Pauline Boyles Emma Hickson	Director of Disability Strategy and Performance Healthcare Home
People and Capability Directorate	Rachel Prebble Jo Wailing	Speaking up for Safety Programme
Executive Director of Nursing and Midwifery Office	Helen Costello Carolyn Coles	Associate Director of Nursing Practice Development Associate Director of Nursing & Midwifery Women's Health
Corporate Services (Health & Safety)	Dave Lewis Dianne Wilson Stuart McCaw	Health & Safety Manager Manager Business Intelligence & Analytics Programme manager
3DHB Mental Health, Addiction and intellectual Disability (MHAID)	Dr. Alison Masters Debbie Gell Toni Dal Din Dr. Arran Culver Ann Connell Dr. Susanna Every-Palmer Kitty Marshall	Medical Director 3DHB MHAID Quality & Risk Manager 3DHB MHAID Director of Nursing 3DHB MHAIDS Consultant Psychiatrist (Acting Clinical Director MHAID) Director Allied Health 3DHB MHAIDS Consultant Clinical Director Te Korowai Whariki Learning and Development Manager 3 DHB MHAID
MCC	Dr. Grant Pidgeon Dr. Kyle Perrin Carey Virtue Tracey Kasner Briar Coleman	Previous Ex Director Clinical MCC Acting Exec Director Clinical MCC Exec Director Ops MCC Quality Manager MCC Quality Facilitator MCC

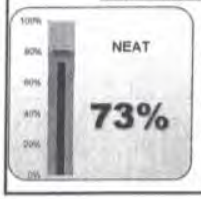
	Mikaela Shannon	Nurse Manager Ora Inpatients Kenepuru
SWC	Dr. Grant Kiddle	Exec Director Clinical SWC
	Dr. Derek Snelling	Exec Director Clinical SWC
	Delwyn Hunter	Exec Director Operations SWC
	Simone Curan Becker	Associate Director of Nursing SWC
	Charlotte Stanzeuk	Nurse Manager Child Health
	Donna McLennen	Charge Nurse Manager
HSS	Leanne Samuel	Director of Integrated Ops Centre
Chairs of Clinical Governance Committees	Dr.Chris Cameron	Chair Medicine Committee
	Dr. Dick Dinsdale	Chair Death Review Committee
	Dr. Sarah Jackson	Chair vascular Access Committee
	Hazel Irvine	Chair Clinical Ethics Committee
	Michelle Balm	Clinical Leader Infection Prevention & Control
	Ryan Salter	Chair Clinical Recognition & Response Committee
	Bob Frances	Chair Disability Advisory Group
	Bob Ure	Chair Blood Transfusion Committee
Radiology	Dr. James Entwhisle	Clinical Lead Radiologist & chair of Choosing Wisely Committee
	Carolyn Orum	Quality Coordinator Radiology
	Dr. Jean Murdoch	Clinical Lead Radiology

Appendix 3. Example of Quality Dashboard



Timely Care

National emergency access target (NEAT) performance



Queensland Target: 80%

Comments:
Improvement in the Emergency Length Of Stay (aka NEAT) is ongoing. Paediatric area not staffed from 31/10 but at present little impact felt. Acuity and presentations remain high through ED

HHS QI initiatives:

National elective surgery targets (NEST) performance

Targets: Cat 1-98%, Cat 2-95% & Cat 3-95%,

Comments:
All targets met

HHS QI initiatives:

Fractured neck of femur (# NOF) - Theatre within 2 days

Source: Coded data - reporting August data

Comments:
There was a slight drop in treat in time for # NOF's for the month of September. Out of the 11 eligible patients, 8 were treated in time. 3 x patients not treated in time were for medical reasons (MET call, cardiac problems).

HHS QI initiatives:

Effective care

Rate of inpatients re-presentations to ED within 14 day of discharge

Source: Coded data - reporting September data

Comments:
No major change in the rate of 14 day ED re-presentation rates for the month of September 2016

HHS QI initiatives:
All patient's reattending the ED with the same or similar presenting complaint are reviewed by the Senior Medical Officer

28 days readmission rate - Ipswich Hospital

Source: Coded data - reporting September data

Comments:
28 day readmissions rate of the months of September 2016 lower compared to previous 3 months

HHS QI initiatives:
Continue to monitor rate of readmissions

Equitable care

Aboriginal & Torres Strait Islander Potentially preventable hospitalisations

Threshold : 11.9%

Comments:
Data not available for this report (quarterly data)

HHS QI initiatives:

Aboriginal &Torres Strait Islander discharge against medical advice

Threshold: 10

Comments:
Data not available for this report quarterly (data)

HHS QI initiatives:

Indigenous Liaison Service - Number of patients seen in the previous month

Comments:
Data not available

HHS QI initiatives:

Efficient care

Elective surgery cancellations - Hospital initiated

Comments:
Top two reasons for cancellations: 1) Change within health status 24 hrs prior to surgery due to condition (tonsillitis, paediatric). 2) Cancellation due to no ICU/HDU beds.

HHS QI initiatives:
Wellness Checks completed on all patients 24-72 prior to surgery

Patient Centred Care

**** Number of Complaints received***

Comments:

The complaints by severity category in October were:
0 'extreme'
0 'major'
4 'moderate'
59 'minor'
11 'negligible'

74
▲ 4%

HHS QI initiatives:

CLO is working on streamlining complaints processes received from other sources (eg. Ministerial correspondence) to promote a single point of entry for complaints management, consistency of approach to resolution and improved data reporting.

**** Number of Compliments received***

Comments:

Please note: all compliments for the previous month may not have been entered at the time of data extraction (3/11/2016) due to variable administration support available during October 2016.

21
▼ -66%

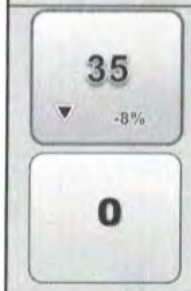
HHS QI initiatives:

CLO will continue to explore ways we can more comprehensively capture compliments across the HHS in our data (ie- we will start to PRIME compliments received through Patient Opinion Australia, the WMHHS website, local media, MD09 etc).

Complaints resolved within 35 days (September 2016)	93%
Complaints acknowledged within 5 calendar days	93%

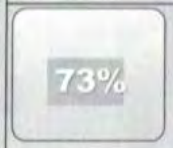
Widget Key

Measure/KPI is monitored using statistical control chart. The position of the needle represents the currents months reading, while the actual number is displayed at the base of the needle. The scale is determined by the limits of the control chart. Readings in the green region of the scale represent normal variation. Any readings within the Blue or Pale Orange regions represent a statistically significant change.

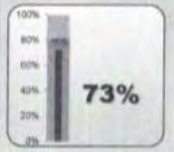


KPI is displayed in the middle of the widget with the smaller digit displaying change since last month.

Measures/KPI have a target or a benchmark. Large digit next to the thermometer image displays the actual measure for the month. The thermometer image represents the measure on a scale. The colour of the chart (Red/Green) indicates if the measure has crossed a threshold.



KPI is displayed in the middle of the widget in large digits and colour of the box (green/orange) corresponds to the KPI meeting the target or not.



This chart displays measures in a single column (black bar) on a graded background. Orange area represents poor performance and green represents good performance. The small bright red horizontal bar represents a target or a minimum standard. The large number / percentage is the actual measure.

Appendix 4. The Clinician's Toolkit for Improving Patient Care (24)

5 Morbidity and Mortality meetings (M&Ms)

Definition

A meeting held on a regular basis to review deaths and adverse outcomes in patients of a specified clinical group or specialty.

Objectives

1. To critically analyse the circumstances that surrounded the outcomes of care provided by a multidisciplinary group of clinicians. These outcomes should include all deaths, serious morbidity and significant aspects of regular clinical practice.[20]
2. To make recommendations for improving the processes of care given to this group of patients.
3. To initiate **action** on these recommendations and to **oversee the progress** of these actions.

Principles for conduction M&Ms[21]

- Morbidity and mortality meetings should be considered to be a 'core' activity for all clinicians.
- All meetings should be multidisciplinary and should include all clinicians, technicians and managers who are involved in the care of that group of patients.
- All levels of staff involved in the care of these patients – both junior and senior – should be involved.
- Meetings should be held on a regular basis and at least once a month.
- All deaths should be identified and if appropriate should include deaths that occurred outside of the acute care setting.
- Focus should be placed on identifying the issues related to the processes or systems of care that lead to the death or incident and not on the individuals who provided the care.
- Discussions should be used for educative purposes and not for apportioning blame to individuals.
- Discussions should focus on measures that can be recommended or implemented to prevent a similar incident or adverse outcome.
- A brief report should be compiled after each meeting which identifies the actions that must be taken as a result of the discussions and review. If there are no recommendations for action, that should be so recorded.
- If action cannot be taken at the clinical level, a report should be sent to the facility or Area Quality Council identifying the issues that should be addressed at that level.
- All action items should be placed on the agenda for the next meeting.
- Feedback must always occur.
- M&Ms should not be used only to review the 'exotic' cases that may be of greater interest to clinicians. M&Ms provide an ideal forum for the regular review of the clinical indicators that are relevant to that specialty or field of practice.
- Everyone who is associated with the care that is being reviewed should have the opportunity to report.
- Case review should be conducted in a timely manner so that it is within recent memory of the people involved in the case.