Quality Assurance framework (Clinical)

Preamble

Governance is all those processes that underpin governing. It defines the interactions and decision making processes that are directed towards addressing an agreed collective problem.

Good governance is an indeterminate term popularised in the public sector as a descriptor of how those managing public affairs should manage public resources in the pursuit of public benefit.

In health, it is often conceptualised as comprising distinct elements of corporate governance and clinical governance. Additional elements of financial governance and risk management may be expressed separately or considered sub elements or corporate governance.

Regardless of the definition system in place, all organisations must have rules, policies procedures and agreed behaviours that drive the organisation towards achieving its goals and moving it from its present position to a position closer to that expressed in its vision statement.

The Board is the ultimate governing body in the District Health Board arrangement. At this time in our institution the commissioners are the Board defacto.

Historically, health has approached clinical governance in parallel to the corporate or financial governance of the institution. This approach finds its roots in an attempt to address the propensity of financial drivers to supersede all else in a financially resource constrained environment. A more pragmatic observation would be that no decision can be made of the financial nature without impact in other domains. Similarly, it would be the expectation that clinical decisions would impact the financial position of an organisation with capped fiscal resource, in the absence of the ability to increase revenue or reallocate budget.

Effective governance requires an understanding of authority and its delegation, responsibility, accountability, a sense of stewardship, effective leadership, and an agreed mission to move the organisation from its present state to one nearer the Board's vision. Activity and outcome must be measured, standards set and maintained and opportunities for improvement sought out.

When governance in its totality is working well, there will be clear line of sight from bedside to boardroom with confidence that we are all looking at the same picture, albeit from different angles.

Waikato District Health Board will approach governance such that corporate and clinical performance will:

- be addressed in concert
- be focused on the needs of our consumers
- be managed at the lowest level possible and at every level
- approached in clinician-management partnership
- fortify and underpin the purpose of the multivirate model of service management
- minimise risk
- be informed by reliable data made available to those who need it and those who want it
- be overseen by a structure/structures that foster the delivery of safe and effective care
    - that is evidence based
    - that is accessible
    - that is designed in partnership with consumers
    - as equitably as possible

- to the greatest proportion of the population/minimises unmet need
- directed to those who will likely receive greatest benefit
- with resources chosen and allocated wisely
- recognises the value of our people individually, to the community as service providers and as part of the community
- respects the finite nature of the funding envelope

Waikato District Health Board recognises that much, but by no means all, of the governance activity within the hospital will be focused on addressing clinical management of our consumers by clinicians. This is not a value statement around any clinical group, but a recognition of the fact that the decisions to admit, diagnose, treat and discharge are the touchpoints at which governance is required in order to be effective. Where these activities are directed by any group; Medical, Nursing or Allied/Technical, it is expected that governance focus will follow the resource consuming activity. All resource allocating clinical staff must therefore be accountable for the impact of those decisions and involved, where possible, in partnership with their "non clinical" counterparts. This accountability should not be transferred by virtue of organisational structure or organisational cultural expectations.

The organisation acknowledges the concept of clinical ***engagement***, but actively seeks clinical ***involvement*** as a more effective ideal.

The Chief Executive Officer is responsible for ensuring that this occurs.

All staff have their part to play.

Waikato DHB will establish a Hospital and Community Services Clinical Board

- to oversee those matters directly and indirectly pertaining to the quality of the care delivered via services provided by those directly employed by Waikato DHB. It is acknowledged that the nomenclature "Hospital and Community Services Clinical Board" (hereafter Clinical Board) is a poor descriptor of the quantum of activity the board will oversee. In time, it is anticipated that this will be expanded to encompass mechanisms for oversight of all care delivered under the aegis of Waikato District Health Board, including primary care, community care and care delivered through locality hubs.

The Clinical Board is considered an independent committee in partnership with the Executive Leadership Team, and will work collaboratively in recognition of the inseparability of the elements of corporate-clinical governance. It will occupy a similar position to the Finance Management Committee (FMC). It is anticipated that the two entities will manage the expected tensions that arise and lever off the relationship of CMO/CNO/Chief Advisor of Allied and Technical as clinical partners to the CEO. Unified decisions are the expected outcome and unified recommendations where relevant should be presented to the Board and unified decisions delivered to the services. It is viewed as critical that the discrete nomenclature of these entities does not foster a siloed, parallel or separable approach when integrated governance is the desired outcome. To this end, the ELT and Clinical Board must overlap to a notable extent in membership, agenda and remit. A corporate-clinical divide or an arrangement that appears satisficing only as an artifice for appearance purposes will be deemed an intolerable outcome. Any cultural construct that absolves the leadership team from responsibility for the delivery of safe and effective care to our population in favour of the Clinical Board will be rejected at every level of the organisation. Waikato District Health Board in all

its parts will share a single vision. The Clinical Board will provide reporting to the Commissioners and to the Hospital Advisory Committee via the CEO. At all times, the Board is expected to apprise the ELT of the nature of such reports and associated action plan.

A number of assumptions are made that underpin the effective functioning of the Clinical Board. These assumptions must be embedded as a reality, requiring that they are fostered by organisational structure, accountabilities are embedded in position descriptions, and the office services of the organisation are oriented in a suitably outfacing arrangement to supporting the clinical services. A commitment is made to acquire the cleanest possible data, cut by ethnicity, relevant to the service and its consumers, and present it to those charged with delivery of care to our community.

Assumptions that must be realised:

There is an established incident management system which is used effectively within the hospital.

- This must address
    - critical incidents of a major nature affecting our people, our community, our infrastructure
    - serious incidents affecting our consumers
    - lesser incidents representing opportunities for improvement

There is an established risk register which is integrated into service management at every level and rolls up through the organisation.

Services will be established with standardised operating parameters

- in a multivirate model of service governance or variation thereof which embeds shared ownership of clinical governance and corporate governance
- have functional morbidity and mortality review process which, where relevant, are multidisciplinary
    - A register exists of :
        - their structure
        - meeting frequency
        - referral pathways for case acquisition
    - Actions are captured with respect to
        - ensuring risk registers are updated
        - mitigations are implemented
        - learning is shared
        - exceptions are escalated
- have data dashboards of service specific and service relevant information on aspects of the:
    - quantity of care delivered (including clinic volumes, wait times to triage, FSA, intervention discharge rates, follow up performance, ESPI compliance)
    - quality of care delivered (including infection rates, readmission rates and other service specific metrics)
    - equity
    - financial data and performance against budget
    - staff satisfaction, turnover, wellness and injury
    - all and any data which is supplied at an aggregated level to external agencies or internal committees is supplied first or simultaneously to the services with a view to action at the lowest possible level

- are aware of training and accreditation standards and associated review dates and track maintenance of those standards. Escalation of unresolvable variance
- deliver service specific elements of Quality Improvement initiatives
- develop QI projects in response to service specific data
- ensure all staff undergo annual appraisal (informed where possible by data)
- have appropriate support relationships with HR & OD, IS, Data and analytics, legal services, professional advisors. The support services will be oriented in an outfacing manner towards the services that they are charged with supporting. This looks like named individuals supporting named services, reports and analytics pushed not pulled, live dashboards prepared and supported to service specifications

Services are aggregated into divisions

- under multivirate arrangements led by Clinical and Non clinical Directors. This is a team arrangement underpinned by partnership
- It is recognised that some elements of the aggregation will appear arbitrary, but where possible, services of like purpose or operation should be aggregated, and at times services in tension with each other should be aggregated
- Divisions oversee the aggregated service performance informed by service specific data
- The leadership of each service within a division will make arrangements to review matters of common interest, communicate up and down the hierarchy and review performance metrics
- It is expected that the leads maintain close connection with the Executive Director of Hospital and Community Services and their respective professional leads

Accountability

The service level multivirate is accountable for all activity occurring within the service or clustered services over which it has responsibility.

This includes:

- the financial performance of the service against plan
    - its revenue, costs and productivity
- the behaviours and performance of its team members
    - informed where possible by data
    - captured in annual review/credentialing processes
- ensuring the safety of the activity it undertakes
    - monitoring complaints, incidents, and quality metrics
- ensuring that it is compliant with external accreditation standards at all times
- escalating exceptions where mitigations are exceeded
- managing risk - identifying, mitigating, reporting, and escalating where relevant

Quality and Patient Safety

Is a support agency for activities targeted towards improvement in patient outcomes. Its activity will be intimately connected to the services and oversees a number of the quality systems and processes including

- a risk register
- an incident register, incorporating aggregation and escalation elements and a system for serious event review
- a background hospital mortality review system, incorporating an alert system for service review and thematic aggregation
- a consumer complaint system including monitoring and tracking of responses and reports to governance
- a portal for external agencies such as the HDC to connect to the services and a monitoring and tracking system for investigations and recommendations. A reporting to governance function
- an audit function
    - to support and advise the services
    - to execute internal audit in response to specific request including external agencies
- an interface between the HQSC and the DHB including support for national activity within the services
- a support and leadership function over major national Quality Improvement initiatives

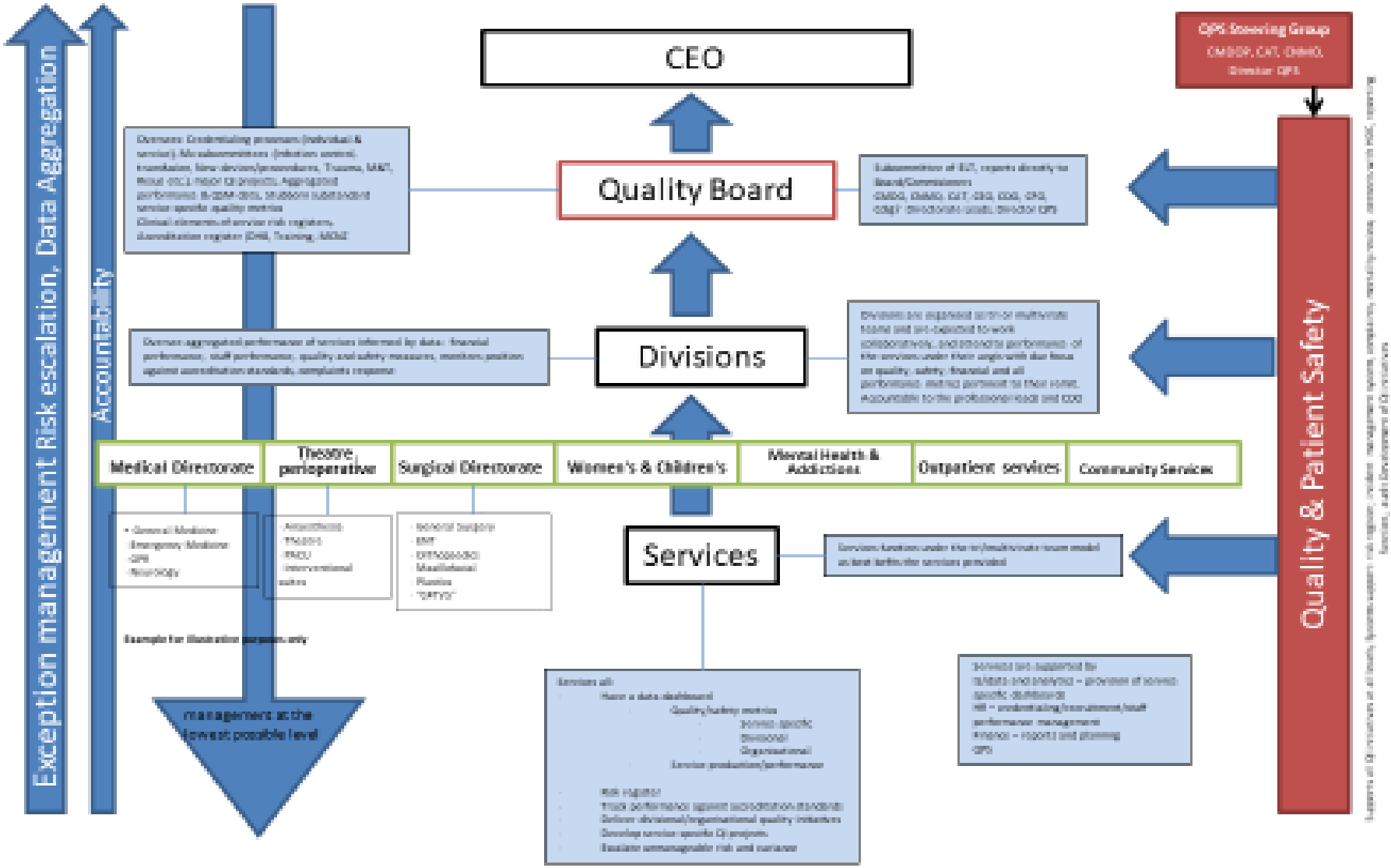
The Clinical Board will oversee

- HR & OD processes that ensure that our clinical people are fit for purpose at all times
    - credentialing processes
        - medical credentialing on appointment
        - maintenance of credentialing by mechanism of annual appraisal
        - nursing, nurse practitioner and Allied Health credentialing for expanded scopes
        - service credentialing
            - service planning
            - training accreditation
            - staff credentialing
    - on boarding arrangements pertinent to the dissemination of code and policy
- Subcommittees associated with clinically focused ongoing governance activity including but not limited to
    - New procedures, new technology and devices
    - Resuscitation committee
    - Deteriorating patient committee
    - Trauma committee
    - Infection control
    - Transfusion
    - Medicine and Therapeutics

- Major Quality Improvement Projects and any steering groups or committees associated with such projects
    - internally developed
    - nationally directed (HQSC)
- Aggregated performance data including internally generated, HRT and HQSC data
    - an organisation wide agreed dashboard
    - the establishment of targets
- Exception management of stubborn and unsatisfactory service specific data which has exceeded the capacity of the service to manage
- Policy
- An educational program in conjunction with HR &OD for leadership of services, units and divisions for all clinical groups
- DHB governance initiated clinical Audit
- Safety 1 recommendations
    - findings and recommendations of SER
    - recommendations of HDC
    - recommendations of ACC
    - mortality review
- Risk register as it pertains to clinical risks
    - exception management of risks with failing mitigations and controls
- Training and accreditation register

Appendix 1

Corporate-Clinical Governance Structure



Waikato District Health Board

Waikato District Health Board Hospital Clinical Board

TERMS OF REFERENCE
1 Committee Name Waikato DHB Hospital and Community Services Clinical Board (Clinical Board)
2 Purpose The Waikato DHB Clinical Board is the governance entity overseeing matters relating to the provision of quality care to the Waikato community. It has been established in accordance with the DHB governance framework revision of February 2020. It will coordinate and oversee the operation of the framework across the DHB, monitoring quality markers and directing improvement initiatives in the domains of: • patient safety • effectiveness • efficiency • timeliness • consumer centricity • equity
3 Membership Appointment will be at the discretion of the Professional leads and Executive Director of Hospital and Community Services following expressions of interest with the advice of Te Puna Oranga. Appointment will be for a term of 3 years, subject to annual review. Reappointment will not be automatic, and will balance the competing needs for stability, experience and intended Board composition**.** Twelve years will be the maximum service without leave of the CEO to extend. Members appointed by role/position do not have a finite term. When making appointments, consideration must be given to maintaining a wide range of perspectives and interests within the total membership, ensuring in particular that Maori health and rural health interests and expertise are reflected, as well as other equity and diversity foci. **Standing members by role** • Chief Medical and Dental Officer (Chair) • Chief Allied and Technical Officer • Chief Midwifery and Nursing Officer • Executive Director Hospital and Community Services • Director Quality and Patient Safety • Te Puna Oranga nominee • Consumer/ consumer council nominee **Appointed members:** Not less than 6 and not more than10 members of Waikato DHB Clinical staff to include

TERMS OF REFERENCE	
	Senior Medical Officers x 3 Senior Nurses x 2 Senior Allied Health, Scientific & Technical x 2 **Observers:** • by standing invitation Divisional Leadership Team members and CEO
4	**Chairship** The Chair will be the Chief Medical Officer, or if not in attendance, The Chief Allied or Nursing/Midwifery Officer.
5	**Accountability** The Clinical Board will be expected to work in partnership with the Executive leadership team. It will report through the CEO to the Waikato District Health Board or Commissioners. All matters of concern will be highlighted to the CEO if not in attendance and the Executive Leadership Team via minutes which will be circulated to the Executive leadership team as a matter of course. Reports from the Clinical Board will also inform the HAC.
6	**Meeting frequency** The board will meet monthly and by exception at the request of the Chair. Out of cycle matters may be considered electronically.
7	**Attendance** Standing members are expected to attend or provide a suitable delegate for 100% of meetings. Appointed members are expected to attend at least 80% of meetings.
8	**Quorum** All meetings require the attendance of a Professional Lead or delegate, and at least four other members to be deemed quorate. In the absence of a quorum, the meeting may proceed and matters for decision brought to the next calendar meeting or out of cycle meeting (which may be electronic) as the Chair dictates.
9	**Operational Purview** The Clinical Board will oversee organisation wide quality and safety support systems and metrics including but not limited to: • Maintenance of a contemporary governance framework • (benchmarked) HRT data • (benchmarked) HQSC data

TERMS OF REFERENCE

- Hospital wide or major quality and safety improvement initiatives - locally generated or externally driven/recommended
- Implementation of recommendations associated with:
  - external accreditation of all types
  - internally generated service reviews
  - serious event reviews, HDC reviews, coronal enquiries
- Exception management of service and divisional level negative variation in quality and safety markers
- Divisional Level risk registry - exceptional risk level, failing controls or mitigations
- Credentialing and Annual appraisal of clinical staff and services
- Oversight of subject matter expert subcommittees including:
  - Infection control committee
  - Medicines and therapeutics committee
  - Resuscitation and Early Detection of the Deteriorating patient committee
  - Transfusion committee
  - Restraint committee
  - Trauma committee
  - Clinical records committee
  - Transfusion committee
  - Laser safety committee
  - point of care testing committee
  - Clinical products and equipment committee
  - New procedures and equipment committee
  - Trauma Committee
  - Wound care committee
  - Falls prevention committee
  - Radiation Safety committee
  - any and all ad hoc or enduring committees formed for the purpose of addressing quality of care
- Policy and procedure pertinent to clinical care and the associated committee

10 Support

Agenda will be developed, circulated and meeting minutes managed by the Office of the CMO. Quality and Patient safety will develop and maintain a suite of reports in conjunction with data and analytics for organisational governance.

11 Process

Agenda items will be submitted to the Chair at least one week prior to the meeting date and agenda circulated at least 5 days prior. Late items will be at the discretion of the Chair.

Standing items will include all matters articulated within the operational purview, and any additional matters considered relevant to the membership. Reports pertinent to the activities within that purview should be submitted from data and analytics, services, and subcommittees.

Discussion will be inclusive and open with the expectation that a wide range of views will be considered. Decisions will, where possible, be by consensus, with majority where consensus cannot be reached. Should the committee be even in number and in the unlikely event a

majority decision cannot be reached, the Chair will arbitrate.

12 Actions

The Board may, at its discretion:

- Refer matters to the DHB Board/Commissioners for information, decision or action
- Bring issues to the Chief Executive and or Executive Leadership team for consideration
- Refer matters to the relevant subcommittee
- Direct action from or within services via the Executive Director of Hospital and Community Service
- Seek additional information from data and analytics, organisational support, subcommittees, services or other entities to better info decision making

13 Review

TOR will be revised at 6 months post inception and 3 yearly thereafter or earlier at the discretion of the Chair.

Leadership and management for Clinicians

All incumbent members of a multivirate should have the knowledge, training and experience required to execute the role. Accountability requires commonality of language and an understanding of process. It is unreasonable to expect that non clinical staff can acquire an understanding of the sciences of medicine and healthcare, albeit that they may acquaint with its basic lexicon over time. It is not, however unreasonable for the clinical members to acquire an understanding of operational and financial management in addition to matters such as healthcare law.

A program must be developed and supported in the organisation to ensure that a critical mass of clinicians receive appropriate training to support their governance roles including the role in clinical governance. Non clinical members, similarly need to be supported to fortify those aspects of quality improvement capability in which they are deficient.

Potential leaders from within the services should be identified in advance and directed towards a suite of learning and development activity that may support future roles. An upskilling of incumbents should proceed without delay.

A preliminary diary of activity may include:

<u>Externally provided:</u>
Otago Health systems law intensive
RACMA fellowship or RACMA associate program
RACMA Leadership workshops
AICG Clinical Governance courses
NZ Institute of company directors
- Finance essentials
- Full directorship course

Leadership and management programs from various providers including the tertiary education sector
Quality Improvement theory and methodology

<u>Internally provided:</u>
An in-house program should be established covering
- rudimentary finance - balance sheet and variance
- rudimentary health system law
- employment law and process
    - complaint investigation
    - performance management
    - contract interpretation and application
- Audit and Quality improvement