Midland
District Health Boards

MENTAL HEALTH & ADDICTION REGIONAL NETWORK

Service Development • Workforce Development • Partnerships & Relationships

Midland Mental Health and Addictions Clinical Governance Project Report

September 2011

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Introduction

The current Midland Region Clinical Leadership forum involves the Clinical Directors and Managers of the Provider Arm Services only, a representative from the Provider Arm Addiction Service and the Portfolio Manager group. Over the last three years engagement with the Midland Clinical Leadership group has been inconsistent due to competing demands. Key clinical decisions are not being made in a timely manner, or followed up due to the cancellation of meetings and non-response to in-between meeting communications i.e. email.

The Minister of Health (Feb 2009) has made it clear that regionalisation and clinical governance are two of the government's key priorities. Fostering clinical leadership is a fundamental driver for improved care. With increasing ring fenced funding moving into primary health, whanau ora and child and youth service development, it is imperative that the Midland Clinical Leadership forum is reviewed and options for improving its functionality is undertaken.

A Project scope was developed and approved by the Midland GMs Planning and Funding and Maori Health and a Project Manager was appointed to undertake a project that will ultimately determine a more effective way of ensuring that key regional decisions have sound clinical leadership endorsement in a timely manner.

A Midland Clinical Governance Reference Group was established via an Expression of Interest (EOI) process and a Terms of Reference was developed to guide the activity of this group (refer Appendix One). A consultation questionnaire was agreed by the Reference group and used to guide focus group discussions with Midland DHBs and key stakeholder groups.

This Project Report provides a summary of the emerging themes from the consultation process over the course of the project, describes the activities that fall within the concepts of clinical governance and also provides some recommendations for a way forward for the Midland region, particularly in light of recent changes that see the Midland Mental Health and Addictions now being moved under the HealthShare umbrella.

Project Objective

The objective was to deliver, by July 2011, clear options for the establishment of a Midland Regional Clinical Governance forum that will provide leadership for regional activity and influence:

Managers, Planners and Funders – regional and local:

- Regional strategic planning
- Regional prioritisation decisions
- Identifying specific requirements for new or existing regional contracts (to ensure services address the particular demographic needs of the area or quality/responsiveness issues)
- Regional workforce development planning
- Regional funding bids.

Service Managers and Clinical Leaders (Provider arm and NGOs)

- Identifying gaps in their own services and how this impacts on the regional picture
- Identifying particular quality or responsiveness issues in their own services
- Identifying services or approaches that may be needed to meet the particular demographic needs in their area
- Workforce development planning
- Funding bids.

Consumers

- Advocacy for re-focusing or re-designing funding and services to provide a more user-centred approach regionally and locally
- Advocacy for meeting service gaps
- Advocacy for addressing service responsiveness or quality.

Family/Whanau

- Advocacy for meeting service gaps regionally and locally
- Advocacy for addressing service responsiveness or quality.

Policy makers at the local, regional and national level

- Advice to government on services
- Information to support budget bids at a local, regional and national level.

Strategic Accountability

The project has been guided by a range of strategic documents including:

- Ministry of Health: Te Tahuhu, Improving Mental Health 2005-2015, The Second NZ Mental Health and Addiction Plan, 2005.
- Ministry of Health: Te Kokiri, The Mental Health and Addiction Action Plan 2006-2015
- Midland Region Mental Health and Addiction Needs Assessment 2010.
- Midland Region Mental Health and Addictions Strategic Plan 2008-2015.
- Midland Region Mental Health Workforce Development Plan 2011 – 2014
- Midland Clinical Services Plan, 2011 - 2012
- Midland Regionalisation Discussion Paper, February 2010.

Project Approach

The project approach included the following processes:

- Establishment of a Reference Group via an Expression of Interest (EOI) process
- Approval of the Project Scope and the proposed content of the report
- Consulting with a range key stakeholder groups
- Reviewing the previous Midland Clinical Leadership documentation
- Undertaking a preliminary literature review
- Collecting, analysing and presenting the emerging themes and issues
- Amending based on feedback
- Regular reporting to the Project Sponsor
- Submitting the final report to the Project Sponsor with recommendations.

Consultation Approach and Process

A consultation framework and approach was developed and endorsed by the Reference group, consisting of seven questions to inform semi-structured interviews and focus groups (Refer Appendix Three).

All DHBs were asked to invite the representatives they would like to participate in the process, and all DHBs were offered a face to face meeting with the Project Manager, tele/videoconference meetings and/or email communications to ensure a range of views were

canvassed and there was good cross sector participation. Each DHB elected to engage in the consultation process in a slightly different way, some opening up the opportunity to a range of clinicians and providers within their district, others preferring to provide direct feedback on behalf of their DHB. Additionally, members of the Reference group were asked to table the project and consultation questionnaire at their respective advisory or regional stakeholder groups to ensure as much input as possible was received from a broad range of perspectives.

In total, over 60 people provided input into the project, either via focus groups, meetings or written submissions. Refer to Appendix Three for a breakdown by DHB.

It was acknowledged that, although consultation necessarily had to occur over a short timeframe (6 week period June/July) in order to meet the project milestones, discussions have been ongoing for some time on the best approach to ensure effective clinical governance and leadership at a regional level.

Stakeholder Groups

Midland region has a number of existing regional groups representing key stakeholders who were also encouraged to have input into the project:

- He Tipuana Nga Kakano "Growing the Seeds". The Midland Regional Consumer Advisory Group
- Nga Purei Whakataa Ruamano. The Midland Regional Maori Advisory Group.
- The Midland Regional Clinical Leadership Forum.
- The Midland Regional Generating Action for Families.
- The Midland Regional Mental Health & Addictions Portfolio Managers Group.
- The Midland Regional Addictions Forum
- Midland Region Workforce Strategic Advisory Group
- Others as identified during the process.

Emerging Themes from the Consultation Process.

Preliminary and emerging themes have been gathered via the consultation process and will be informed by further discussion and feedback from the Reference group, resulting in a set of recommendations to inform a way forward for the Midland Mental Health and Addictions sector.

1.	Inconsistent (or no shared regional) understanding of what is meant by the term “Clinical Governance”.
2.	Participants considered that value was added and efficiencies were gained by endorsing regional approaches to planning and decision making.
3.	Unless all DHBs were committed to contribute and participate regularly, the value of a Clinical Governance network is compromised – a shared voice was supported, but the right people need to be around the table.
4.	All participants mentioned that travel times and distance often made it difficult to prioritise the meetings unless all Midland DHBs attended. Video-conferencing is an option, but these need to be effectively chaired and also alternated with face: face meetings. The preferred option for face: face meetings was Hamilton as the most central location for the majority of the DHBs.
5.	Active representation across Service Managers, Clinical Directors and Planning and Funding was seen as key. There was less clarity (i.e. no shared position) on how this works across the Primary Sector, Allied health and NGOs and this needs to be explored further.
6.	Participants expressed challenges in prioritising attendance in a range of national, regional and local forums and networks. All DHBS had at least one functioning (local DHB) clinical network (some had 6 or more) and understanding the connections between the local, regional and national structures was confusing.
7.	Where the meetings require a consensus decision/position by the group, members would be expected to have reviewed all documentation in advance and be in a position to reach a decision and way forward.
8.	Clear lines of accountability are required (i.e. what is the role of the group, mandate, who would it report to and membership (by virtue of designated role or elected member).
9.	Reporting and information flow (e.g. utilisation of regional services to inform planning, SLAs, access and prioritisation etc) should be ongoing, not just for new services/initiatives.
10.	Expressed tensions between clinical governance and management functions – achieving the balance and recognising that good management incorporates good clinical governance and vice versa.
11.	Participants expressed a view that often ‘mixed messages’ were being communicated in an environment of change. The clear national policy direction is to support regionalisation of activity where sensible to reduce duplication and improve efficiencies for service planning and delivery, but often this is compromised by competing individual DHB demands and priorities.
12.	A number of regional and local activities are occurring and frequently these appear to be progressing in isolation of other regional networking activities (e.g. Service Level Alliance Teams). Participants expressed a desire for transparent communication in order to understand what other regional activity is underway to have a sense of how this activity potentially impacts on the broader Mental Health and Addictions sector.

Clinical Governance at a Glance

What is Clinical Governance?

An emerging body of work internationally describes the concepts of Clinical Governance in detail. Rather than go into lengthy detail reviewing the literature, key documents have been reviewed and specific elements that merit mention are noted in this project report.

The Midland Region Clinical Services Plan notes that strengthening regional clinical governance over regional / vulnerable services is an important element in ensuring Midland region services are sustainable. The definition of Clinical Governance adopted in the Midland Clinical Services Plan is:

"A governance system for health care organisations that promotes an integrated approach towards management of inputs, structures and processes to improve outcomes in health care service delivery where staff work in an environment of greater accountability for clinical quality."[1]

Incorporating a range of views, the key characteristics of clinical governance are:

- Corporate accountability for clinical quality
- Clinical quality becomes an organisational priority, thus balancing clinical governance with corporate governance
- Clinical governance asserts the value of a 'whole system' approach to quality improvement and organisational leadership, culture and systems
- The integration of quality improvement activities – where coordination and coherence will improve effectiveness and give better value for money
- Alignment with corporate governance – extending accountability, integrity and explicitness into the clinical domain of healthcare organisations.

The Ministerial Task Group on Clinical Leadership produced a report "In Good Hands[2]" which noted a number of key drivers impacting on DHBs commitment to greater clinical engagement including:

- Increasing disengagement between clinicians and managers
- Clinicians have felt less able to influence decisions on the delivery of health care
- The report forms part of government policy and DHBs are required to implement it.

The Task Group described clinical governance as the term applied to collecting all of the activities that promote, review, measure and monitor the quality of patient care into a unified and coherent whole.

In essence, clinical governance is described as a framework through which DHBs "*are accountable for continuously 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].

Clinical governance is seen as an essential component to maintain organisational health, focused on the 3 following key domains:

- Quality improvement
- Quality assurance

[1] V Som, 2004 (p.65)

[2] In Good Hands – transforming Clinical Governance in New Zealand (2009)

[3] Donaldson & Scally, 1998)

- Accountability for clinical matters.

It is noted that Clinical governance in New Zealand is still an evolving concept, but is widely accepted as a priority policy direction for the Government.

What Does This Mean in Practice?

The term clinical governance, although originating in the UK and accepted as government policy there, is now being widely used both within Australia and New Zealand. Within New Zealand the term has been formally adopted by the Royal New Zealand College of GPs (RNZCGP), a number of DHBs and Primary Care Organisations (PCO) and has been highlighted as a key focus area for Midland DHBs.

There is a close relationship between clinical leadership and clinical governance. Clinical governance is a substantially broader concept than clinical leadership. Clinical leadership is encompassed within clinical governance. Clinical governance formalises the role of clinical leadership within an organisational setting. Clinical leadership can exist without clinical governance, but clinical governance is vitally dependent upon clinical leadership. Clinical governance must be based upon a convergence and integration between corporate and clinical values and goals[4].

A range of different local clinical networks operate across the 5 Midland DHBs, all with varying roles and functions.

Key Functions of Clinical Governance

- To identify and facilitate the resolution of issues relating to clinical and non-clinical risk, performance monitoring, quality improvement and implementation of a strategic plan

Guiding Principles

- Clear lines of responsibility & accountability
- A comprehensive programme of quality improvement systems (including clinical audits, supporting and applying evidence based practice, implementing clinical standards and guidelines, workforce planning and development)
- Education and training plans
- Clear policies aimed at patient safety and managing risk
- Integrated procedures for all professional groups to identify and remedy poor performance.

OR[5]:

Principles

A process for the New Zealand healthcare system to transform towards clinical governance needs to be based on the following six principles.

1. Quality and safety will be the goal of every clinical and administrative initiative.
2. The most effective use of resources occurs when clinical leadership is embedded at every level of the system.
3. Clinical decisions at the closest point of contact will be encouraged.
4. Clinical review of administrative decisions will be enabled.

[4] Clinical Leadership and Clinical Governance: A Review of Developments in New Zealand and Internationally (August 2001)
[5] In Good Hands

5. Clinical governance will build on successful initiatives.
6. Clinical governance will embed a transformative new partnership which will be an enabler for better outcomes for patients.

Objectives of Clinical Governance

- To plan and support the implementation of quality improvement activities
- To monitor performance against domains such as:
- Risk management
- Clinical effectiveness
- Clinical audit & research
- Service user, carer and community involvement
- Culture
- Staff & staff management
- Education, training and ongoing professional development
- Use of information to support quality & governance (Finance, information, services, infrastructure).

Therefore, Clinical governance should be[6]:

Clinical governance should not be:	Clinical governance should be:
A system for responding to errors, or for justifying areas as unforeseeable	A system for assuring quality and avoiding errors/reducing variations
A top-down exercise, taken on by a clinical governance lead in each service	An activity in which all staff are actively involved, under the leadership of a designated and accountable individual
An extra task to be undertaken alongside clinical or managerial duties	Integral to the everyday activities of clinicians, managers and other staff
A low priority activity which attempts to whitewash over the cracks in the 'real business' of treating patients	A high priority activity which clinicians recognise and enables excellent care to be delivered uniformly across DHBs
A yearly management exercise resulting in a report on service quality activities	A process (like an audit cycle) of review, planning, action, showing and sharing
A system requiring an entire new system of internal monitoring	Built on systems which are already in place and can be adapted and expanded to achieve clinical governance
A means of 'shaming and blaming' under-performing individuals or services	A means to encourage openness about errors and a commitment to work collaboratively across DHBs to improve service
An erosion of self regulation	A way of encouraging a culture of accountability among clinicians
Something which is achieved once and for all, and is therefore set in stone	A developmental process which is responsive to changing circumstances
Tagged on to existing organisation arrangements within DHBs	Consequent upon a culture shift in DHBs, based on the principles above

[6] Adapted from An Introduction to Clinical Governance – Keynote address by Professor Nick Fox, Director, Wisdom Centre (www.wisdomnet.co.uk/keynote1.asp)

The Clinical Governance Cycle[7]

Desriptively, the stages are:

Planning & setting standards	Agree objectives, benchmark against guidelines or research evidence, establish the process, make it explicit in the organisation through communication networks
Doing	Process implemented, including mechanisms for data collection and audit
Monitoring & responding	Set criteria for audit, collect data, compare against standard, formulate and implement action plan to correct errors or variations
Showing & sharing	Document cycle and share findings within and beyond the DHB, annual report and external monitoring

The Midland Collective Action Plan

The Midland Collective Action Plan[8] sets out the desired features of a framework that has been developed to inform regional collective action on priority clinical services. At the heart of the framework, there are five key focus areas that act as building blocks, providing a platform from which Midland DHBs intends to leverage collective regional activity: These are:

- Strengthening regional clinical governance
- Improving Maori health
- Developing primary care led services
- Building the workforce
- Providing robust information for clinicians.

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[7] Adapted from An Introduction to Clinical Governance – Keynote address by Professor Nick Fox, Director, Wisdom Centre (www.wisdomnet.co.uk/keynote1.asp)

[8] Midland Clinical Services Plan (Sept 2010)

Establishing Regional Clinical Governance

Strengthening regional clinical governance over regional vulnerable services is an important element in ensuring Midland region services are sustainable.

Views of clinical governance vary from being narrowly centred on dimensions of quality, safety and risk management; to being more broadly focused on how resource allocation decisions are made and overall system efficiency and effectiveness.

Statement of aspirations for the Midland regional clinical governance framework

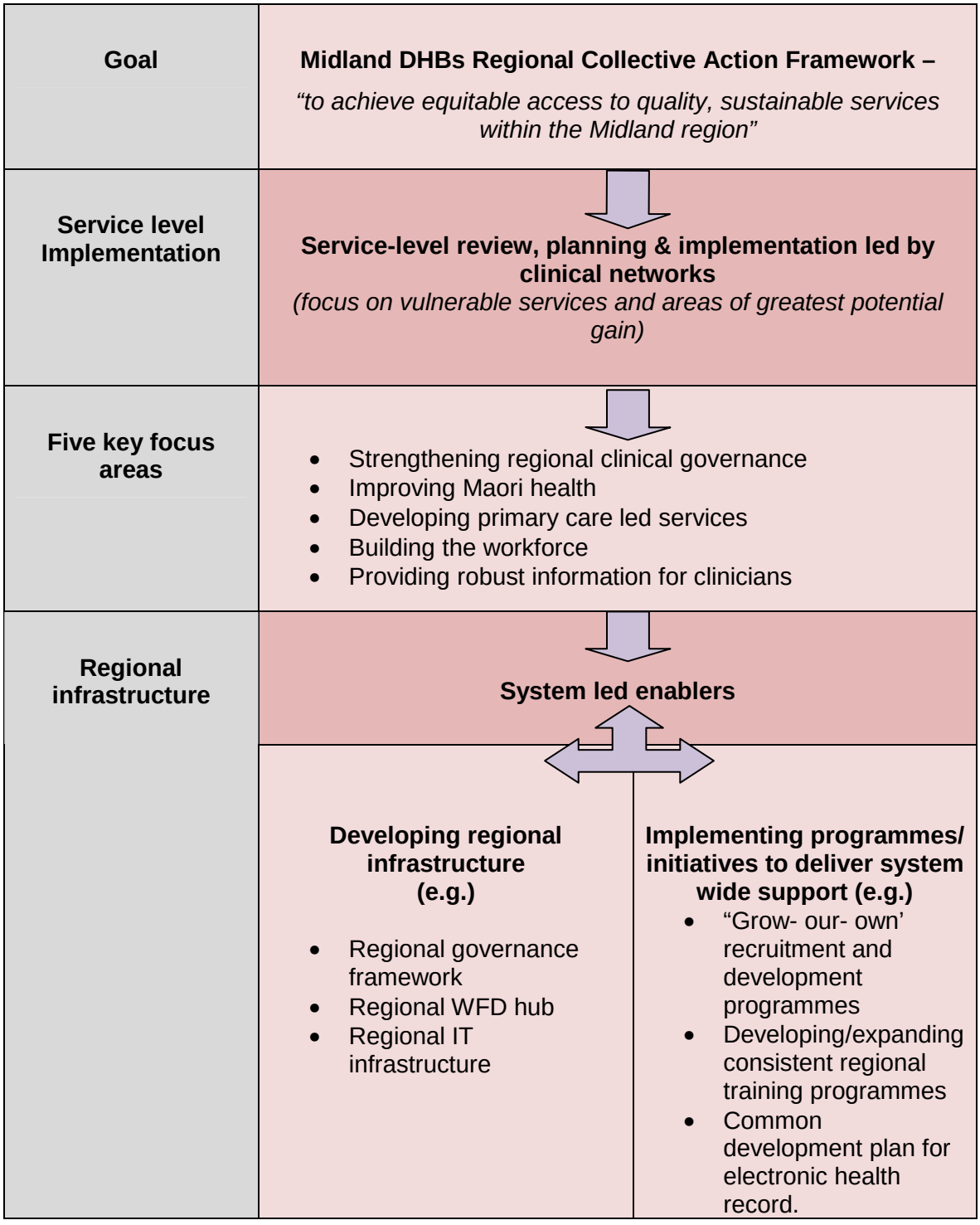
The regional clinical governance framework actively manages service quality and access in order to:

- Measure and reduce variation in care
- Improve clinical effectiveness
- Improve the patient experience
- Improve the sustainability and continuity of vulnerable services
- Maintain local service access where this is consistent with safety
- Manage clinical risks & improve safety
- Reduce inequalities.

Midland DHBs Regional Collective Action Framework

It is intended that clinical networks will be the primary vehicle through which Midland DHBs will drive and deliver changes that seek to achieve equitable access across the region to quality, sustainable services. The five key focus areas provide a set of lenses through which services may be reviewed and planned, while the infrastructure wrapped around them supports the change management process.

Midland DHBs Regional Collective Action Framework



Key tasks of Clinical Governance

The key tasks of Clinical Governance are to:

- Agree strategic priorities and guide operationalisation across the region
- Monitor performance against identified KPIs
- Review & monitor clinical effectiveness activity
- Ensure partnership working with service users and carers across the service
- Identify risks and mitigation strategies.

These tasks are broader than those currently undertaken by the existing Midland Clinical Leaders forum, and therefore it is appropriate that the Midland Mental Health and Addictions clinical governance approach is reconsidered.

How do we get there?

The Midland Clinical Services plan states the DHBs are committed to establishing an overarching effective regional clinical governance framework. The proposed first step is to put in place a regional clinical governance framework that ensures the major components of effective clinical governance are in place at a regional level. It is intended the regional clinical governance framework will:

- Support rather than duplicate local clinical governance arrangements
- Only cover areas where a regional approach aligns with the needs of individual DHBs
- Aim to achieve 'equitable access to quality sustainable services' in the Midland region
- Provide an over arching view of the key elements of clinical quality in the region
- Advise DHB boards on regional priorities, clinical quality improvement and on strategies to manage vulnerable service
- Maintain an overview of the activities and effectiveness of discrete clinical networks
- Have a minimalist infrastructure to support their pre-agreed work programme.

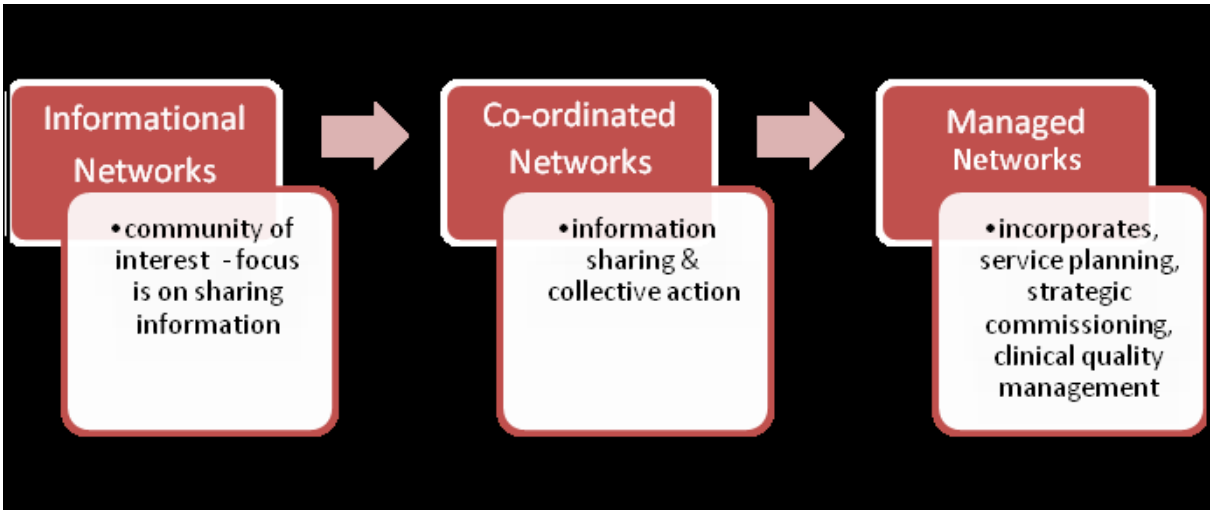
Regional Clinical Governance Key Elements

Using Clinical Networks as a Driving Force

An important adjunct to the proposed Midland Clinical governance framework are clinically led, properly supported, multidisciplinary regional clinical networks covering the major specialties. Clinical networks are envisaged as the operational arm of the regional clinical governance framework. Networks will need to be clinically led, multidisciplinary and involve both professional and consumer perspectives. Mental Health and Addiction services clearly fit within this approach.

There are several different forms of clinical networks. The following figure (adapted from Goodwin 2010) illustrates the continuum of network forms, from informational networks to managed networks.

Health Care Networks: A Continuum of Network Forms



The specific design of the network may vary according to the service, from forms at the more informational end of the spectrum, to forms that include resource management responsibilities. All networks will require a level of administrative and informatics support, and all will require primary care input.

Networks will also require clinical leadership – but the leadership can be expected to be facilitative rather than directive. Research on clinical networks suggests that continued buy in and enthusiasm from individual front line clinicians is vital to make progress.

The Midland region already has some clinical networks in place – e.g. the cardiac network, the renal network, the Cancer network. The Midland Cancer Network takes a leadership role and approach to reduce the inequalities, incidence and impact of cancer across the cancer continuum for the network area (Waikato, Lakes and Bay of Plenty). The network includes broad stakeholder input and includes NGO members. The Midland Cancer Network has identified two major work programmes, patient and service mapping (i.e. developing consistent patient pathways) and reducing inequalities. It is supported by a clinical director role and a secretariat including a network manager and service improvement staff. Some of the likely reasons for the success of the Cancer network include:

- Dedicated resourcing to support both clinical leadership and secretariat functions
- An opt in approach to regional involvement

- Broad stakeholder and clinician engagement – encouragement and facilitation rather than directive statements
- Consumer involvement
- MDT involvement.

Midland DHBs are aiming to replicate these elements in future networks and this approach sits comfortably with the mental health and addictions sector. The standard terms of reference for clinical networks will include the following parameters:

Objectives

- Equitable access to sustainable high quality services
- Elimination of disparities in Maori health outcomes.

Considerations

- Ensuring effective clinical leadership
- Development of patient centred pathways across the primary secondary and tertiary continuum
- Actions required to support vulnerable services
- Changes to models of care and use of technology to meet future needs
- Developing a quality workforce (including strategic assessment of workforce requirements across the region, credentialing, cultural competence, opportunities to promote rotation)
- Clinical audit and reporting against evidence based practice
- Clinical safety and regional review of sentinel events
- Specifying the information systems required to support high quality care.

Networks will be expected to develop an annual work plan (including proposed resourcing) for approval by CEOs and to report on achievement against previous year's objectives and on changes in clinical quality outcomes.

How Will We Know When We Get There?

The Year 1 progress milestones in the Midland Clinical services plan include:

- Set up the regional clinical governance group and confirmation of regional clinical governance group terms of reference
- Approval of Regional clinical governance group work programme by DHB chairs and CEOs
- Approval of clinical networks to support identified priority services.

Measures of success will include:

- Progressive reduction in inequalities of access to services; and
- Progressive reduction in variation in clinical practice toward evidence based norms.

Midland Future Aspirations for Clinical Networks

Regional clinical networks lead service improvement in specific specialties through the use of integrated patient pathways, common clinical policies, and shared clinical audit programmes.

Networks lead workforce planning, clinical governance, Maori health equity, primary care

involvement and information systems in their specific areas.

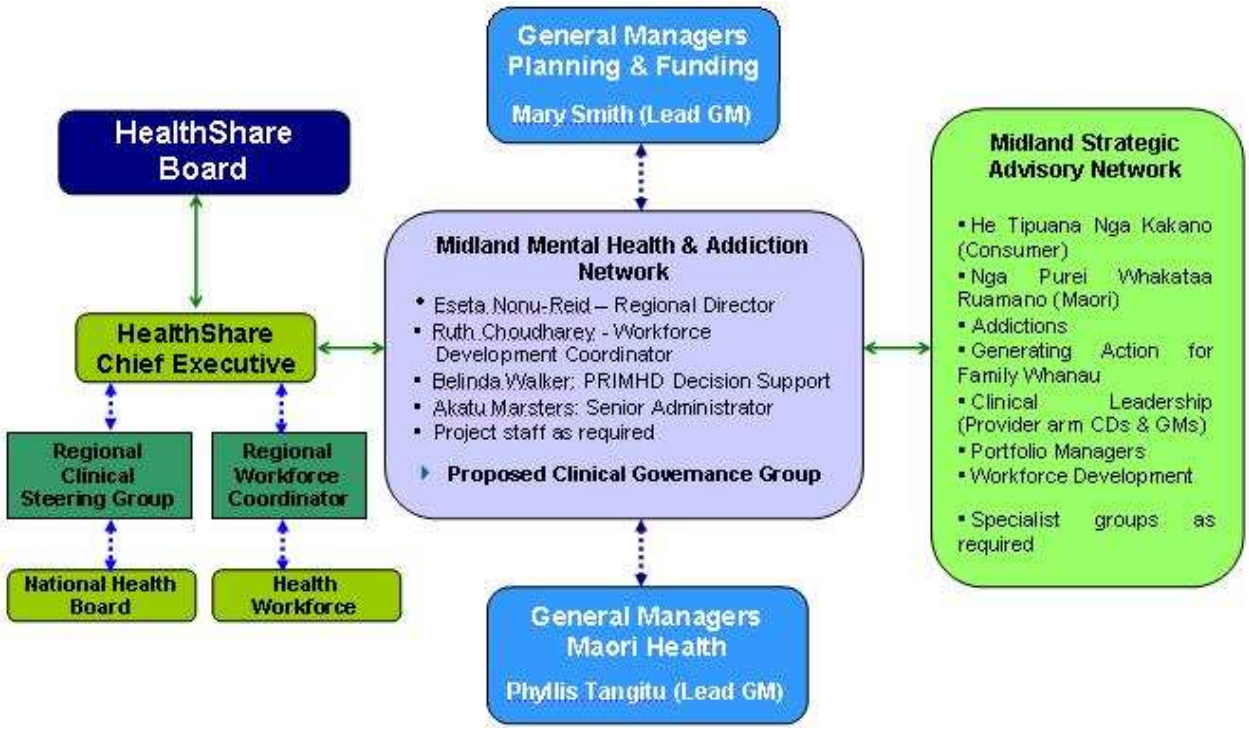
Clinical networks will ensure clinical engagement in service planning, and networks set levels of service to provided at each DHB and provide a forum to agree changes in future levels of service.

Networks will help small FTE services to develop a sustainable services plan to ensure quality and safety. Unsustainable local services are transferred in a planned way to regional locations or supported regionally.

Regional networks will be linked in to national networks and both influence and are influenced by national planning. Networks are driven by local clinicians

What is Needed for the Midland Mental Health and Addictions Clinical Governance Forum?

This project summary report has been informed by stakeholder interviews, the overarching view of the Midland DHBs on regional clinical governance and supporting literature, and proposes a way forward. Since the commencement of the project, the HealthShare Board has been formally established, and as of 1 August 2011, a number of Shared Service Agency functions have been moved under the HealthShare umbrella. As a result, the Midland Mental Health and Addiction Network now has a direct reporting line to the Chief Executive.



Where the direct line reporting has changed, the Midland Mental Health and Addictions Network considers that maintaining strong relationships with the GMs Planning & Funding and Maori Health are key to continued success and these relationships will still be retained. There are

existing processes that have worked well to gain and maintain regional agreements it is important these are not altered in the move into a new environment.

The reporting lines to the CE for HealthShare will relate more to high level strategy, but day to day accountability for service development, workforce development and relationships and partnerships remains with the GMs.

This project to review the current Clinical Governance structure and interface has revealed it is opportune to consider where Mental Health and Addictions Clinical Governance sits within the new HealthShare environment, including pathways into the HealthShare Clinical Steering Group and National Health Board.

In order to achieve this, the following recommendations are made to the Project Sponsors.

1. This project report is accepted as a document that will inform the establishment of a new Midland Mental Health and Addictions Clinical Governance Network.
2. A limited Expression of Interest process is undertaken to establish the new Clinical Governance network. Participants will be appointed based on specific skill sets and sector perspectives – not solely on positions or roles. Such perspectives will include:
    - Funding and Planning
    - Primary Health
    - Provider Arm
    - NGO
    - Maori
    - Clinical Director
    - Service Manager.
3. Terms of Reference is agreed – including meeting frequency, commitment and attendance requirements.
4. A Midland Regional Mental Health and Addictions Workplan is agreed that is informed by:
    - Vision – what the ideal future looks like
    - Mission – what role will the network play in achieving the vision
    - Guiding Principles
    - Values
    - Strategic plan to achieve the above.

Appendix One – Terms of Reference

Midland Clinical Governance Reference Group

Draft Terms of Reference

Title of Policy Manual:	Midland Clinical Governance Reference Group
Date Issued:	May 2011
Review By Date:	N/A
Responsibility:	Project Manager
Authorised By:	Project Sponsor

Purpose & Objectives

This project will determine a more effective way of ensuring that key regional decisions have sound clinical leadership endorsement in a timely manner. The objective is to deliver, by 30 June 2011, clear options for the establishment of a Midland Regional Clinical Governance forum that will provide leadership and influence:

Managers, Planners and Funders – regional and local:

- Regional strategic planning
- Regional prioritisation decisions
- Identifying specific requirements for new or existing regional contracts (to ensure services address the particular demographic needs of the area or quality / responsiveness issues)
- Regional workforce development planning
- Regional funding bids

Service Managers and Clinical leaders (Provider arm and NGOs)

- identifying gaps in their own services and how this impacts on the regional picture
- identifying particular quality or responsiveness issues in their own services
- identifying services or approaches that may be needed to meet the particular demographic needs in their area
- workforce development planning
- funding bids

Consumers

- advocacy for re-focusing or re-designing funding and services to provide a more user-centred approach regionally and locally
- advocacy for meeting service gaps
- advocacy for addressing service responsiveness or quality

Family/Whanau

- advocacy for meeting service gaps regionally and locally
- advocacy for addressing service responsiveness or quality

Policy makers at the local, regional and national level

- advice to government on services
- information to support budget bids at a local, regional and national level

Role

The Midland Clinical Governance Reference Group will:

1. Provide a transparent and cooperative mechanism for meeting the objectives of the overall project.
2. Provide direction, advice, leadership and support to the Project Manager to ensure the recommendations for Clinical Governance in the Midland region ensures agreed approaches which:
   - Clinical outcomes are driven by best practice models and modern mental health care and support methodologies
   - Provide a holistic approach to cultural and clinical care across the sector
   - Recognise the responsibility of shared duty of care and an opportunity for sharing risk arrangements
   - Acknowledge improvement in Maori health as a top priority of the Midland DHBs, while supporting strategies that increase Maori capacity in the delivery of services to high needs Maori populations
   - Provides recommendations to reduce barriers of access by Maori to culturally appropriate, high quality services.
3. Provide input into the planning of a robust consultation and engagement process with all key stakeholders in the sector.
4. Proactively monitor and encourage innovation to manage risks across the project.
5. Based on the principles of partnership and collaboration, agree a Clinical Governance Model that has clear lines of accountability and responsibility, is culturally and clinically safe, consistent, and aligned to best practice quality services, where the client is at the centre.

The Reference Group will also:

- Be informed by evidence based methodologies and practical clinical experience
- Engage all members meaningfully
- Focus on longer term outcomes that reduce barriers to access and effectively partner with service users', tangata whaiora and their family and whanau to achieve sustainable mental health outcomes for the service users', tangata whaiora
- Potentially evolve to represent a clinical and cultural governance group in the longer term to guide the implementation phase of the project.

Assumptions

The following assumptions are considered as part of the overall project:

- This project will ultimately result in improved services and therefore, outcomes, for service users', tangata whaiora and their families and whanau
- Providers will proactively engage, and have the capacity and willingness to engage in the project
- Any recommendations from this Clinical Governance project will be cost neutral and financially viable.

Accountability

- Project Sponsors – Cathy Cooney, Lead CE, Mary Smith, Lead GM P&F and Eseta Nonu-Reid, Regional Director, Midland Regional Network (MRN)

- Administrative support to be provided by the MRN.
- To service users', tangata whaiora and families and whanau
- To Iwi

Membership

The Group members will be appointed for their particular expertise, range of perspectives and credibility in representing stakeholders. Refer to Attachment One for detailed membership and representations.

If a member is unable to attend they will forward written comments and reports in advance of the meeting.

Decision Making Process

Where a decision needs to be made by the Reference Group, all efforts will be made to reach a consensus. When this is not achieved, and the decision is considered material to the project, the issue will be elevated to the Project Sponsor(s).

Meeting Frequency

It is anticipated 3 – 4 meetings / tele/video conferences will be held over the course of this project. They will include:

- Preliminary agreement on the TOR and proposed methodology
- Review preliminary draft
- Agree final report and recommendations.

Meetings will generally be tele/video conference, with one face:face meeting to be scheduled. Meetings will be routinely held 2 – 3 weekly, and email correspondence will be the primary means of communication.

Group member's time is precious, so to ensure meetings are focussed and productive, it is expected that:

- The meeting is held primarily for decision making.
- Where practicable, all papers will be prepared and sent to the Reference Group at least five working days before the meeting to allow sufficient time for each member to read the papers and seek advice from their own networks
- Members may at times be required to read papers and send their recommendations in before a meeting so the Chair can determine the issue and time needed to address this in the meeting
- When the Project Manager may require advice from a specific member with expertise in that area, they may meet/communicate separately.

Declaration of Interest

The membership of the Reference Group is necessarily broad, involving a variety of stakeholders. Each member of the group is present for their knowledge of the mental health and addictions sector, and/or Maori health imperatives. Members have been agreed via an EOI process and do not represent individual organisations. However, where a potential conflict exists within an agenda item, this is to be declared, including the exact nature of the potential conflict. The Reference group will determine the appropriate response.

Confidentiality

All information obtained by the Reference group in the course of this project must be treated as confidential and must not be divulged Reference Group in writing. The requirement for confidentiality does not apply to any information that has become part of the public domain.

When representing the Reference group, members shall take care to reflect the views of the Group accurately. Members shall respect decisions made in due process, even if they do not agree with the decision.

Reporting Relationship

The Project Manager will report to the Project Sponsor, Eseta Nonu-Reid, Regional Director, Midland Regional Network.

Minute Circulation

- MRN Clinical Governance Reference Group
- Project Sponsor

Changes to these Terms of Reference

Any revisions to these Terms of Reference require agreement and acceptance by the Reference Group and must be made through a formal change control process..

ATTACHMENT ONE: Reference Group Membership

- David Benton: Clinical Director, Hamner Clinic
- Maureen Emery: Service Manager, Lakes DHB
- Dr Sue Mackersey: Clinical Director, Mental Health & Addiction Services, BOP DHB
- Dr Graham Mellsop: Professor of Psychiatry
- Michael O'Connell: Clinical Nurse Director, MH&A, Lakes DHB
- Marita Ranclaud: Portfolio Manager, Mental Health and Addictions, Lakes DHB
- Anne Ridgeway: Clinical Services Manager, Mental Health & Addictions, TDHB
- Dr Rees Tapsell: Executive Clinical Director/Forensic Consultant Psychiatrist, WDHB
- Dr Luis Villa: Public Health Advisor, Midlands Health Network
- Belinda Walker: Midland PRIMHD Decision Support Coordinator

Appendix Two – MRN CL Forum TOR

Terms of Reference

Midland Regional Clinical Leadership Forum

Feb 2009

Membership:

Clinical Leaders/Directors/Service/General Managers, AOD Clinician, Professor of Psychiatry and Midland Region MH&AS Director for Waikato, Bay of Plenty, Lakes, Tairawhiti and Taranaki DHB's and 1 Portfolio Manager.

Others: attend meetings for specific topics or agenda items

Administration & Coordination - Midland Region Administrator.

Function:

- To promote the development of regional clinical leadership and accountability;
- To provide advice to DHB Funding & Planning on local and regional clinical business and strategic service development issues
- To provide a clinical perspective to regional and local mental health planning
- Make recommendations on new services
- Make recommendations on the re organising of existing regional services to enhance access to skills and expertise employed across the region
- Make recommendations that will improve service delivery protocols for sharing resources
- Make recommendations in regard to clinical workforce development issues
- To promote shared development across the region, and identify strategies which will promote integration and collaboration across mental health service provider boundaries and other sectors, at a regional and local level.
- To develop a mentorship infrastructure in Midland to:
  - Provide access to group expertise
  - Provide peer review
  - Share positive outcomes and opportunities
    - To participate in local (LAG) and regional advisory groups.
    - To develop regional quality processes – with regional coordination

Meeting / Communication Plan

The Clinical Leaders Forum will meet bi-monthly or more frequently if required.

Minutes will be made available to the wider regional stakeholder network forums.

Appendix Three - Clinical Governance Project – Consultation Questionnaire

Midland District Health Boards
MENTAL HEALTH & ADDICTION
Service Development • Workforce Development • Partnerships & Relationships

Project Overview

The Midland Region Clinical Leadership forum involves the Clinical Directors and Managers of the provider arm services only, a representative from the provider arm Addiction service and the Portfolio Manager group. Over the last three years engagement with this forum has been inconsistent due to competing demands. The Minister of Health has made it clear that regionalisation and clinical governance are two of the government's key priorities. With increasing ring fenced funding moving into primary health, whanau ora and child and youth service development it is imperative that the Midland Clinical Leadership forum is reviewed and options for improving its functionality is undertaken.

The Midland Region Mental Health and Addiction Clinical Governance Project has been commissioned by the Midland CEOs, via the Midland Regional Network (MRN) to determine a more effective way of ensuring that key regional decisions have sound clinical leadership endorsement in a timely manner.

A Project Manager has been engaged to undertake this review, and a Reference Group has been established via an Expression of Interest (EOI) process, to provide advice and direction to the project. Membership of the Reference Group is:

- David Benton: Clinical Director, Hamner Clinic
- Maureen Emery: Service Manager, LDHB
- Sue Mackersey: Clinical Director, Mental Health & Addiction Services, BOPDHB
- Graham Mellsop: Professor of Psychiatry
- Michael O'Connell: Clinical Nurse Director, MH&A, Lakes DHB
- Marita Ranclaud: Portfolio Manager, Mental Health and Addictions, LDHB
- Anne Ridgeway: Clinical Services Manager, MHA, TDHB
- Rees Tapsell: Executive CD/Forensic Consultant Psychiatrist, WDHB
- Luis Villa: Public Health Advisor Midlands Health Network
- Belinda Walker: Midland PRIMHD Technical Support Coordinator

The project will be conducted over the next 6 weeks, and we would appreciate it if you could take time to consider and respond to the following key questions via your networks.

Please email feedback and comments to the Project Manager; Deirdre Mulligan at dmulligan@xtra.co.nz by **Wed 15th June 2011.**

Consultation Questions – MRN Clinical Governance Project:

Name: **Organisation:** **Role:** **Email:** **Date Completed:**	
1.	What is your understanding of Clinical Governance?
2.	Can you provide specific examples of where this has worked well and why (identify models)?
3.	Can you provide specific examples of where this has not worked well and why?
4.	What is your experience to date from a Local DHB perspective?
5.	What is your experience to date from a Midland perspective?
6.	What would be your requirements of a Clinical Governance Network from a Local DHB perspective
7.	What would be your requirements of a Clinical Governance Network from a Midland perspective?
8.	How would this interface with existing national, regional and local forums?
9.	What would be required to implement this?
10.	Any other Comments?

Many thanks for taking the time to complete this questionnaire!!

Contributors

- Waikato DHB – Project Manager attended Waikato MHA Clinical Governance meeting as an observer (18 participants)
- Bay of Plenty DHB (2 participants)
- Tairawhiti DHB (10 participants)
- Taranaki DHB (20 participants)
- Lakes DHB (2 participants)
- Portfolio Managers (6 participants)
- Written submissions (4)