Clinical Council Terms of Reference (District)

This document provides guidance to members of the Southern DHB Clinical Council.

Clinical Council

Purpose

The purpose of the Clinical Council is to give balanced, clinically-informed advice to the Southern DHB Board and its operational arms, Alliance South, WellSouth and other health service providers contracted by the DHB.

Clinical Council will advise on substantial issues around the current performance of existing services or proposed changes in service configurations or functions, based on key principles.

Functions

The council provides key clinical knowledge or expert advice to the board or other bodies when requested, or when the council otherwise sees fit, in regard to:

- Patient safety and clinical quality
- The impacts of proposed system or service changes including:
  - Related or interdependent services;
  - The health status of the population; and
  - Health inequalities
- The strength and effectiveness of:
  - Clinical and consumer engagement in Southern DHB and related bodies; and
  - Clinical leadership
- The most effective use of resources and prioritising that use.

Principles

1. The Clinical Council will base all of its recommendations and advice on the fundamental principles embodied in the Fourfold Aim — the foundation of the Performance Excellence + Quality Improvement Strategy (District) (73658) — and make best endeavours to balance those principles in all of its decision-making in a way that best serves the people of the Southern district.
2. The Clinical Council will be focused on governance and oversight and the broader consequences/outcomes of policies and systems, and will not involve itself with the day-to-day operational functions of provider organisations or their constituent parts.
3. The Clinical Council will restrict its considerations to issues of major impact and not become a forum for litigation of specific or individual issues unless it considers they have a wider relevance or significance.

The Fourfold Aim
Population Health This means improving the health of a defined population (the residents of the Southern district) and reducing inequities of care and outcome between subsets of that population. This incorporates a strong sense of fairness in all the services we provide. It also incorporates an obligation to devote significant resources to health promotion and disease prevention strategies not just to provide quality clinical care for those who already have health problems.
Experience of Care This means that the care as experienced by individuals who come under our care needs to be of the highest achievable standard and we should strive to exceed their expectations. We will commit to 'zero harm' for all those under our care. Crucially this dimension includes not only the quality and safety of care provided to individual patients, but their actual experience. Things like timeliness, avoidance of waiting, respect, excellent communication, co-ordinated and convenient services are key elements. At every turn we need to be asking (and able to answer) "How is this for the patient? Are our patients truly at the centre of everything we do?"
Cost per Capita (or Value for Money) This means we will strive to reduce the cost per case of care, by providing value for money (i.e. the most cost-effective care that we can) and reducing waste. Waste means any input (resource use) that does not add value to the patient's care. This will allow us to provide more and better care for the same amount of money. Focusing constantly on quality improvement (value) has been shown all over the world to consistently decrease cost per capita.
Teaching and Learning This means that we will always try to optimize teaching and learning in all of our activities. It means teaching and learning for staff needs to be universal, lifelong and appropriate. It further acknowledges that teaching and learning are a major output of the organisation, which consumes and competes for resources, and this needs to be weighed equally with our other obligations. It recognises not only that high-performing organisations need to be constantly learning and improving by keeping up with current knowledge, but they need to contribute to training their own future staff as well as meeting the societal obligations of providing health care professionals for the nation. It underlines the general moral duty to advance knowledge by discovering new truths through research, from which we all benefit either directly or indirectly. A key teaching and learning principle will be to improve the health literacy of our communities and individuals as a key enabler to

improve health outcomes.

Level of Authority

The council has the authority to make recommendations to the Southern DHB Board, WellSouth, Alliance South and the DHB's Provider Arm Executive.

To assist it in this function the council may:

- Request reports and presentations from particular groups.
- Establish sub-groups to investigate and report back on particular matters.
- Commission audits or investigations on particular issues.
- Co-opt people from time to time, as required for a specific purpose.

Membership

Initial membership

Subject to review in November 2015, and then two-yearly.

Half of the elected/nominated members of the council will be appointed for a two-year term and the remaining half for three years. Thereafter, terms will be of two years' duration. Members may be reappointed but for no more than three terms. Ex-officio members do not have a finite term.

Ex-officio members:

- Chief executive officer (CEO)
- Primary care advisor
- GP advisor – primary health organisation (PHO)
- Chief medical officer (CMO)
- Executive director of nursing and midwifery (EDNM)
- Director of nursing – PHO
- Executive director of allied health, scientific & technical (EDAHST)
- Medical officer of health for Southern DHB
- Representative – Division of Health Sciences, University of Otago
- Chair of the consumer council (when constituted)

By-election or nomination by peers:

- One GP
- Five senior medical officers (nominated by clinical leadership groups — one from the Clinical Leaders Forum, two from SMS (Southland) and two from GMS (Otago)
- One professional leader allied health
- One charge nurse manager (CNM)
- Māori clinician
- One rural health clinician
- One nurse representative – primary care

	When making appointments, consideration must be given to maintaining a wide range of perspectives and interests within the total membership, ensuring in particular that Māori health and rural health interests and expertise are reflected.
Referral Process to the Council	Southern DHB staff who have raised matters relevant to council functions (as above) through the usual processes, and feel that they have not had the matter fully addressed (i.e. it was rejected), may submit the item for consideration by the Clinical Council. The subject matter will be submitted to the clinical council co-ordinator and it will be referred to council chair who will determine whether or not it is suitable for Clinical Council consideration. A list of all such items will be provided to council members at the next meeting. This list will include the reasons why the item had been rejected.
Meetings	Meetings will be held monthly at least ten times per year, or more frequently at the request of the chair/co-chairs. The meetings will take place in the last week of the month on a Monday from 1700 – 1830 hours. Meetings will be public-excluded and conducted in accordance with Southern DHB Board standing orders as if the council were a committee of the board. Matters may be dealt with between meetings through discussion with the chair/co-chairs and other relevant members of the council and should be reported back to the next council meeting for ratification
Accountability / Reporting	The Clinical Council will report to the Southern DHB Board via the CEO, and one of the elected senior clinicians should also be present to speak on relevant clinical items. A monthly report of Clinical Council activities / decisions will be placed on the DHB's external website when approved.
Quorum	A quorum of 12 members is required to conduct the business of council meetings.

Roles

Chair	Initially, council meetings will be chaired by the CEO. Subsequently, council members will elect a chair and deputy chair / co-chairs.
Minute Taker	The medical director of patient services assistant (MDPSA) will co-ordinate the functions of council.
Minutes Distribution	Minutes will be circulated to all members of the council within one week of the meeting taking place.

Meetings

Location of Meeting	TBA with videoconferencing links between sites.
Time / Day of Meeting	Meetings will be held on the last Monday of the month at 5.00pm with an anticipated duration of no more than 1½ hours.
Frequency	Monthly (at least 10 times per year).
Review	This document will be reviewed in February 2016.

Associated Documents:

- Performance Excellence + Quality Improvement Strategy (District) (73658)
- Public Records Act 2005