4. Clinical Governance

Clinicians and healthcare organisations providing health services to COVID-19 positive individuals must have robust clinical governance structures in place. Clinical governance structures must ensure that quality and safety are monitored, significant events are reviewed and analysed, and opportunities for quality improvement are identified and implemented.

Across Aotearoa New Zealand, systems are being developed for COVID-19 Care in the Community. There are considerable risks where change is constant, roles, responsibilities and processes are not fully established, and information (IT) systems are not well integrated. There are also challenges related to Māori health and equity, with Māori twice as likely to have severe illness and be hospitalised than non-Māori. Clear, effective, and consistent governance for quality and safety is critical in this context.

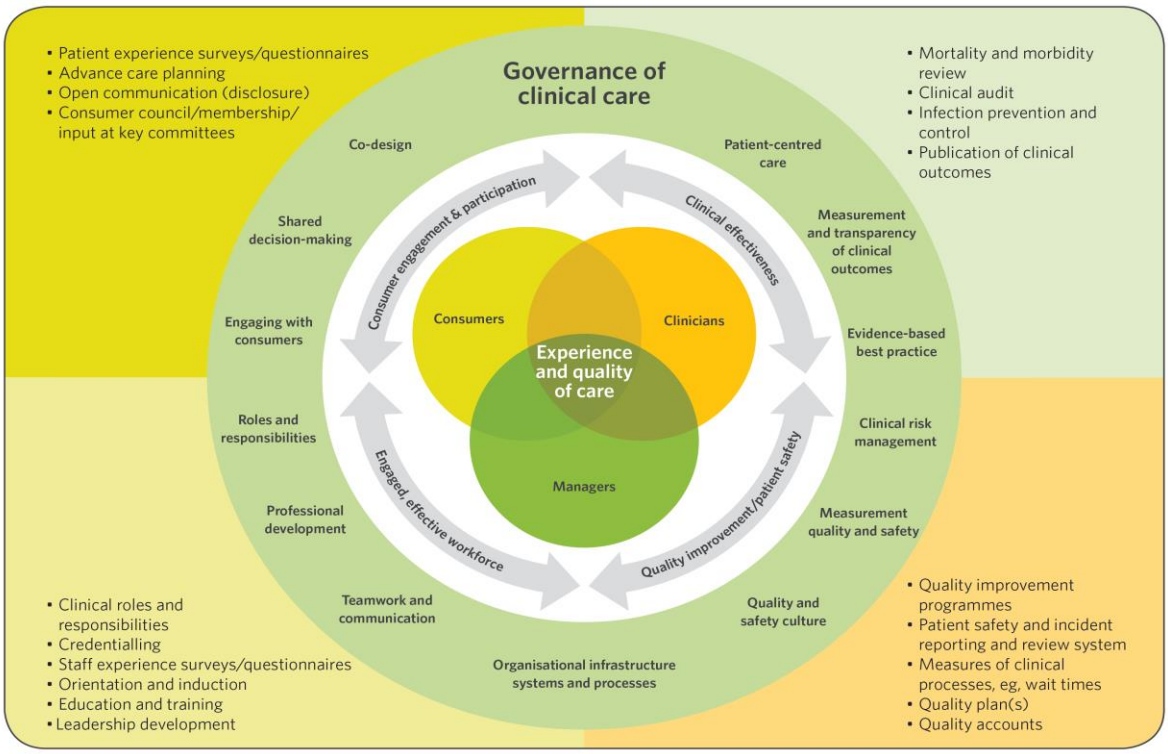
4.1 Purpose

This section and related appendices provide guidance for district health boards (DHBs) and other key stakeholders and partners establishing local quality and safety governance for COVID-19 Care in the Community. It does not include Managed Isolation and Quarantine Facilities (MIQF) or hospital-based settings. It does include transfers into and out of secondary care and MIQF.

4.2 Context

Whilst the guidance is based upon the Health Quality and Safety Commission's (the Commission) clinical governance framework, it is acknowledged the scope of the model is greater than clinical care and incorporates social and wellbeing aspects; neither does it capture mātauranga Māori. The term 'quality and safety governance' is used in this document to reflect these differences.

Figure 3: Clinical Governance Framework



Appendix C describes Initial guidance for establishment of quality and safety governance for COVID-19 Care in the Community.

Appendix D is an Adverse Event Review Guide for COVID-19 Care in the Community.

Metrics for COVID-19 Care in the Community

Metrics are applied to all parts of the patient journey, from testing through to follow-up and discharge. Note that while these are the nationally determined metrics, additional locally determined metrics may be developed, but are not required to be reported to the Ministry of Health.

While locally led, devolved care is the preferred model of care, to have confidence in the care provided, metrics to track performance are needed. While the Ministry of Health has overall stewardship and oversight responsibilities, usual commercial performance management arrangements will apply between the commissioning agency and the contracted provider.

Having a success framework, metrics, and a baseline enables ongoing monitoring of the health system's performance, provision of care in the community, and identifying gaps to address in relation to the changing threat of COVID-19. Where targets have been attached to metrics, these focus on actions taken by the health sector to meet patients' and households' needs.

The metrics will be disaggregated by patients' age, ethnicity, and locality, to track how well the model of care is responding to the needs of specific population groups. The model can be updated to better reflect these needs. The metrics for COVID-19 Care in the Community can be found in **Appendix E**.

Consistent with the Data Protection and Use Policy, collection and sharing of information should be done in ethical and responsible ways. This should include considering issues related to data access and the use, relevance, and quality of data about Māori and Māori Data Sovereignty.

APPENDIX C: Initial guidance for establishment of quality and safety governance

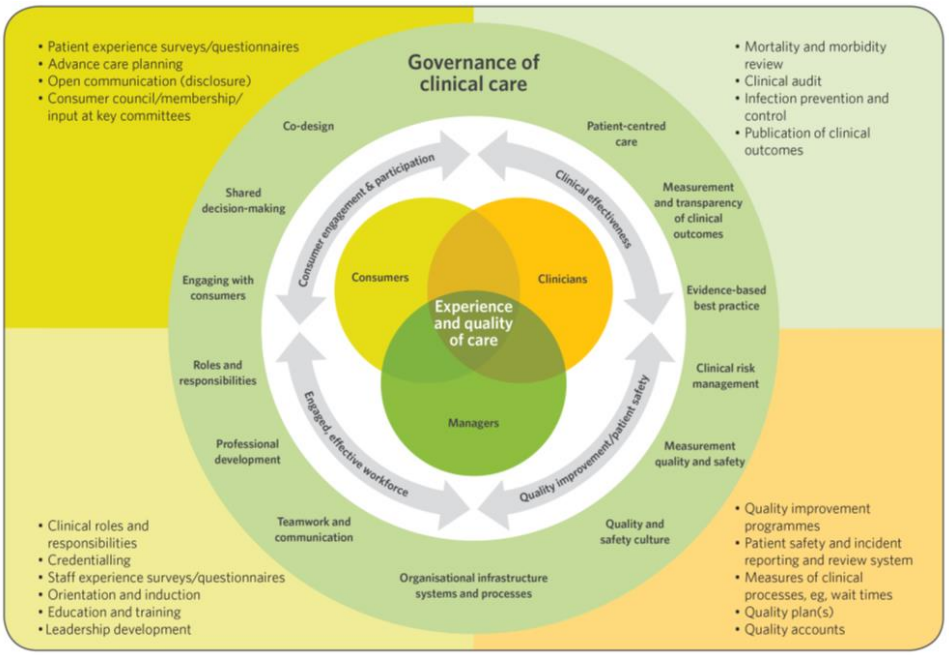
Background
Many New Zealanders with COVID-19 are now being cared for in their homes with clinical care provided remotely, or face to face in homes. Concurrently, welfare needs are addressed by a range of providers. Together this is known as COVID-19 Care in the Community (CCC). It is essential that people with COVID-19 and their household contacts (referred to in this document as 'whānau') are supported to isolate safely whilst receiving a high standard of care that ensures wellbeing – taha tinana (physical health), taha whānau (family health), taha hinengaro (mental health), taha wairua (spiritual health).

Problem definition
Across Aotearoa New Zealand, systems are being developed for CCC. There are considerable risks where change is constant, roles, responsibilities, and processes are not fully established, and information (IT) systems are not well integrated. There are also challenges related to Māori health and equity, with Māori twice as likely to have severe illness and be hospitalised than non-Māori. Clear, effective, and consistent governance for quality and safety is critical in this context.

Purpose
This document provides guidance for district health boards (DHBs) and other key stakeholders and partners establishing local quality and safety governance for CCC. It does not include Managed Isolation and Quarantine Facilities (MIQF) or hospital-based settings.

Context
Whilst the guidance is based upon the Health Quality and Safety Commission's (the Commission) clinical governance framework, it is acknowledged the scope of the model is greater than clinical care and incorporates social and wellbeing aspects, neither does it capture mātauranga Māori. The term 'quality and safety governance' is used in this document to reflect these differences.

Figure 9: Clinical Governance Framework



Establishing local quality and safety governance groups

Approach

While the articles of Te Tiriti o Waitangi provide the constitutional settings for our response to CCC the new principles following the Wai 2575 claim provide some practical guidance for the establishment of local quality and safety governance groups. These principles should be applied collectively and include:

Principle of Partnership	Partnering and shared decision making for quality and safety is informed by Māori experiences and Māori provider knowledge.
Principle of Options	Quality includes having available viable Kaupapa Māori services in CCC so that Māori are not disadvantaged by the lack of choice.
Principle of Tino Rangatiratanga	Ensuring that Māori receiving CCC have the "right to autonomy" and to manage the full range of their affairs in accordance with their own tikanga.
Principle of Active Protection	Actively protecting, supporting and empowering Māori receiving CCC, and Māori organisations to provide services that support wellbeing.
Principle of Equity	Provision of culturally and clinically responsive mainstream CCC services that are equitable in terms of access, process and outcomes. Power and control is shared equitably by Māori and non-Māori.

Figure 1: Wai 2575 Te Tiriti o Waitangi Principles

The role of a quality and safety governance group must be grounded in the strategic direction for the COVID-19 response locally; this is a rapidly changing environment as the CCC systems are established across regions. A suggested objective is to ensure that processes and systems are in place to deliver high quality, coordinated, culturally safe, and responsive care that is continuously monitored and improved. The group with designated responsibility should meet regularly and adjust frequency of

these meetings as systems are embedded, and should be developing and monitoring a set of measures relevant to the local situation.

Guiding values and principles
A set of values and principles have been developed that will drive local COVID-19 CCC quality & safety governance groups. These include:

- whānau at the centre – people with COVID-19 and their whānau receive safe, culturally tailored, high-quality care
- open and transparent culture – individuals/whānau and staff feel safe and are encouraged to express their views and speak up when care is not at expected standards
- accountability – all organisations and individuals are clear about their responsibilities for quality and safety
- privacy and trust are paramount – the health and welfare information of whānau should be treated with respect, following all protocols for ensuring data quality, governance, sovereignty, privacy, and confidentiality.

Membership and chairperson
As the Crown agent responsible for the funding and provision of health services each, DHB should oversee the establishment of the local quality and safety governance group. A partnership approach to leadership of the group is recommended, specifically that an iwi/Māori chairperson or co-chairperson be considered.

Membership should reflect the local population and those impacted most by COVID-19 in the community. Given that Māori represent a large portion of cases, strong consideration must be given to a governance structure which provides at least 50 percent Māori to ensure a partnership approach. In some groups this is likely to include iwi/Māori health or social service providers. Members can also include representatives from the range of services delivering and funding care in the community – primary care, Māori providers, Pacific providers, DHB planning and funding, Ministry of Social Development and/or local welfare providers, individual/whānau, public health and relevant quality and safety leadership. Others that may be included or called upon when appropriate are ambulance services, other agencies such as Oranga Tamariki, Kāinga Ora – Homes and Communities, New Zealand Police, Ara Poutama Aotearoa | Department of Corrections, infectious diseases and, infection prevention and control expertise.

Domains of quality and safety
The following identifies critical components to support the establishment of local quality and safety governance that incorporates the Wai 2575 principles for Te Tiriti o Waitangi (identified in **Figure 1** above), which provide practical guidance for how this can be achieved successfully.

Individual and whānau engagement
Individual and whānau voices need to be central to the design and governance of the way care is delivered in their communities. This can be achieved by:

- ensuring iwi/Māori and individual representation on all local quality and safety governance groups and in groups developing and adapting models of care/clinical pathways
- ensuring there is a mechanism for capturing and rapidly learning from the experiences of individuals/whānau. This may include seeking feedback when interacting face to face or utilising existing DHB or primary care feedback processes
- prioritising listening to iwi/whānau Māori, seek qualitative responses and use to adapt models of care as needed

- providing support for individuals/whānau to share decision-making and be involved in their own care planning. This includes having options for the provision of for Māori, by Māori care; shared goals of care and for end-of-life care in the community.

Clinical effectiveness
Local application of the model of care should be regularly reviewed and updated to reflect evidence acquired locally and from national and international experience by:

- ensuring pathway and guideline development incorporates evidence-based practice and partnership with iwi/Māori and other individuals
- co-design measures relevant to local care in the community priorities, stratified by ethnicity, and deprivation level where appropriate
- supporting learning through multi-disciplinary morbidity and mortality meetings and clinical audit.

Quality improvement and patient safety
Local governance groups must establish mechanisms to ensure care is being provided in a safe way and identify opportunities to constantly improve this. Central to this is that governance groups:

- have an agreed process for the reporting, rapid review, and learning from adverse events that occur in the COVID-19 care in the community setting (see the Commission's COVID-19 Care in the Community Adverse Event Review Guide)
- review local performance in Ministry of Health measures on a regular basis (Ministry of Health metrics for Care in the Community (see Appendix D of Ministry of Health Framework)
- commit to continuous quality improvement, ensure there is access to improvement science capability and Te Ao Māori approaches
- ensure clinical risk management processes are in place. This could be through a clinical risk register where the circumstances that put individuals/whānau at risk of harm are identified, and action is taken to prevent or control risks
- ensure coordination and clarity of the pathway of care and transitions, to ensure care is safe and reducing the risk of gaps or duplication
- ensure clear processes for those who enter CCC following hospital discharge or MIQ stay.

Engaged and effective workforce
The workforce is critical to ensuring care is delivered in a safe way whilst identifying potential areas to continually improve the quality of that care. Local governance should:

- aim for a workforce that reflects the population being provided with care
- ensure cultural safety is well understood by all staff and visible in activities
- seek feedback from the range of service providers: iwi/Māori, Pacific, non-governmental organisations – use to adapt CCC approach as needed
- ensure orientation and induction of new staff occurs, and education and training is provided to all staff. This is particularly important in the context of rapid change and new protocol development and changing rules about testing and isolation regimes
- articulate roles and responsibilities of the different parts of the system and within models of care. Ensure staff have the appropriate knowledge, skills, and tools required to fulfil their roles
- foster teamwork and make communication easy: allocate time to build relationships within and between teams, develop handover processes and collective problem solving
- consider how staff wellbeing will be monitored and maintained throughout the response.