WHĀNAU HQ CLINICAL GOVERNANCE GROUP
2 December 2021

Venue: Bledisloe House, 24 Wellesley Street West, Level 9, Onetangi Meeting Room & Zoom @ 4.45pm

Members:	Owen Sinclair	Gary McAuliffe
Jonathan Christiansen (Co Chair)	Ruth Large	Greg Williams
Rawiri McKree Jansen (Co Chair)	Saleimoa Sami	Harriet Pauga
Christine McIntosh	Sally Roberts	Kara Okesene-Gafa
Allan Moffit	Tim Cutfield	Kate Dowson
Carmel Ellis	Willem Landman	Kim Arcus
Gabrielle Lord	**As Required Attendees:**	Lara Hopley
Hinamaha Lutui	Anthony Jordan	Teuila Percival
Maria Poynter	Gary Jackson	Vicky Tafau (Secretariat)

AGENDA (note not every item will be discussed at each meeting)

4.45pm	**1.**	**AGENDA ORDER AND TIMING (Welcome & Karakia)**	**Page No.**
	2.	**GOVERNANCE**	
4.50pm	2.1	Apologies (Attendance Schedule)	**002**
	2.2	Confirmation of the minutes from the previous meeting held on 25 November, 2021	**003**
	2.2.1	CIQ Summary for GPNZ (presentation from 25.11.21)	**009**
	2.3	Action Items	**020**
	3.	**STANDING UPDATES**	
4.55pm	3.1	Patient Experience/Consumer Engagement/Complaints and responses (9 December)	
	3.2	Adverse events reporting, implementation of recommendations	
	3.2.1	Discuss the Review (sent out by Christine McIntosh on 28.11.2021)	
	3.3	Dashboard of key metrics tracking quality	
	3.4	External reporting: HQSC/HDC/Coronial/Other	
	3.5	NRHCC Update	
	4.	**NEW CLINICAL GOVERNANCE BUSINESS**	
5.25pm	4.1	Policies/Procedures brought forward for discussion/endorsement (Christine McIntosh)	
	4.1.1	Clinical Triage Scoring in NCTS by desktop clincal review	**021**
	4.1.2	Draft Acuity Scoring in BCMS for Community-Supported Isolation & Quarantine (with NRHCC COVID-19 Request for Advice/Review)	**024**
	4.2	MOC Discussions	
	4.3	Questions/Advice sought from Steering Group or NRHCC Exec	
	4.3.1	Cross service communication (eg Oranga Tamariki), Highlighting cases of concern and referral pathways; Managing potential psychological distress in children eg where children are medically well (common) and watching parents deteriorate; getting access to assistance, sometimes older kids acting as interpreters (Ruth Large)	
	4.4	Other	
	5.	**PROVIDER UPDATES**	
5.35pm	5.1	Māori Providers Update/New Business (Christine, Kate, Kim)	
	5.2	Pasifika Providers Update/New Business (Christine, Kate, Kim)	
	5.3	Other Community Providers Update/New Business	
	6.	**OTHER BUSINESS**	

Next Meeting: 9 December, 2021 @ 4.45pm

MEMBER ATTENDANCE SCHEDULE 2021
WHĀNAU HOME QUARANTINE CLINICAL GOVERNANCE GROUP

Name	25 Nov	2 Dec	9 Dec	16 Dec	23 Dec
Jonathan Christiansen (Co-Chair)	✓				
Rawiri McKree Jansen (Co-Chair)	✓				
Christine McIntosh	✓				
Allan Moffit	✓				
Carmel Ellis	✓				
Gabrielle Lord	✓				
Hina Lutui	✓				
Maria Poynter	✓				
Owen Sinclair	✓				
Ruth Large	✓				
Saleimoa Sami	✓				
Tim Cutfield	✓				
Willem Landman	✓				
Anthony Jordan					
Gary Jackson	✓				
Gary McAuliffe					
Greg Williams					
Harriet Pauga					
Kara Okesene-Gafa					
Kate Dowson	✓				
Kim Arcus	✓				
Lara Hopley	✓				
Teuila Percival					

MINUTES	
Meeting Title	**Whānau Home Quarantine Clinical Governance Group (WHQCGG)**
Date and Time	Thursday, 25th November 2021 @ 5pm
Venue	Zoom; Bledisloe House, 24 Wellesley St West, Level 9, Onetangi Meeting Room
MEMBERSHIP	
Attendees	Jonathan Christiansen, Rawiri McKree Jansen; Christine McIntosh; Hinamaha Lutui; Owen Sinclair; Allan Moffitt; Gabrielle Lord; Tim Cutfield; Willem Landman; Sally Roberts; Maria Poynter; Ruth Large; Kate Dowson; Carmel Ellis; Kim Arcus; Saleimoa Sami
Optional Attendees	Lara Hopley; Gary Jackson
Apologies	Anthony Jordan; Gary McAuliffe; Kara Okesene-Gafa; Teuila Percival

1. Welcome, Introductions & Karakia

Meeting commenced at 1700 with a mihi and karakia from Rawiri and was followed by a round table of introductions.

2. Terms of Reference & Membership

The TOR hase been considered by other groups. Current document is a starting point.

Does this group require stronger representation from Pacific & Maaori?

- The groups' initial focus will be on Whaanau HQ. Everyone was in favour of Clinical Governance over the end to end COVID with initial focus on the CIQ programme.
- It was determined that Group membership will remain as is; others can be opted in when needed.

Ruth from Whakarongorau (WA) - Our Māori service experience executive Mary Losē would be a great addition here to represent service users/patients, she has been pivotal in the development of our kaimahi team and our Māori pathways.

3. CIQ processes - Currently and in the Future

Started four weeks ago and were adapted from MIQ to CIQ processes.

Interim model running well, now in transition model phase. Work underway to on-board Maaori and Pasifika providers and on to establish Primary Care providers. Plan to move to scaled model and embed as BAU.

Current Interim model – see powerpoint (attached to minutes).

Discussion on the various components of care:

- The clinical and health & wellness assessment needs to be brought further forward in the process.
- The manaaki part of the process is essential for those isolating in the community. Ruth - We have now negotiated with countdown and have a process now to get staples to people same day. It's working really well.
- In terms of the Testing of Contacts and Release part of the process, there is a lot of admin work required to maintain this. As new members of the household test positive the other contacts need a recalculation of quarantine and testing.
- Noted ARPHS, WA and NRHCC have implemented a lot of efficiencies on the technical side of the process.
- Pulse oximeters can sometimes be a 2-day process until the household receive this.
- Public Health Whakarongorau escalations happen as needed.
- Hospital in the Home is on board, which has helped a lot. They are currently looking after 20+ people in the community. They also tackle things like dialysis which have to be set up.
- We are looking to improve clinical care of those in the community. There are currently gaps in IT systems connectivity to Primary Care systems which are making it harder to bring PC on board. Working to have visibility of the Border Clinical Management System in the GP Practice Management System.
- There needs to be an understanding that cases exist in a bubble that may extend beyond the bubble in the home. A different way of thinking is requiring different types of solutions.
- We are seeing long periods of isolation (90 days is the longest). Patients may also have other health needs that require attention during this time.

Thoughts from members:

How can we change the settings so we don't have to do so many of the administrative processes? General acknowledgement that the administration is quite a burden in the system at present.

There needs to be more public health awareness for those with Covid at home. It could be helpful to encourage whaanau to view MIQ as a tool that could make isolation a shorter period of time.

We will need to tailor responses for those with higher health/social needs. The Manaaki response is hugely complex and requires a lot of resource, but is a crucial part of the processes.

How do we ensure that we have a cycle of continuous improvement, what mechanisms do we need to see so we have line of sight that quality and safety are where we want them to be, consistently?

All regions will run Whaanau HQ services so we want to ensure there is a national framework so we are all aligned.

4. Framework & Priorities for CIQ Clinical Governance (HQSC Clinical Governance structures and approaches)

Look to the HQSC framework – what should we be prioritising?

The Ministry of Health's five key dimensions of quality rest on the foundations of the partnership, participation and protection principles of the Treaty of Waitangi.

- **People-centred** is the extent to which a service involves people, including consumers, their families and whānau, and is receptive and responsive to their needs and values. It includes participation, appropriateness, adherence to the Code of Health and Disability Services Consumers' Rights 1996 and other consumer protections such as the Health Information Privacy Code 1994.

- **Access and equity** is the extent to which people are able to receive a service on the basis of need and likely benefit, irrespective of factors such as ethnicity, age, impairment or gender. It includes the physical environment, and the extent to which this is a barrier to accessing health and disability support services. Being able to physically access health and disability support service facilities can be a significant issue for people with disabilities.
- **Safety** is the extent to which harm is kept to a minimum.
- **Effectiveness** is the extent to which a service achieves an expected and measurable benefit.
- **Efficiency** is the extent to which a service gives the greatest possible benefit for the resources used.

We have the 4 pillars of Clinical Governance – consumer engagement and participation, clinical, quality improvement and safety, engagement and an effective workforce.

How do we record adverse events? Need the system to be learning from within itself.

How do we bring the patient experience into the feedback?

From a clinical perspective it is important to develop and get endorsement of clinical services. NRHCC Clinical Technical Advisory Group (CTAG) have supported this. There will be a number of things from a Clinical point of view that we'll be keen to get some endorsement of a way forward.

How do we know we're doing well? Good data is required. E.g. CTAG have provided advice around Clinical Acuity score. We can use clinical metrics to build dashboards to monitor clinical care.

In setting up dashboards it will be important to have ethnicity metrics. Data will be contributed by data in the National Contact Tracing System (NCTS) and BCMS. There was discussion about correct recording of It was said that BCMS don't have a field to indicate ethnicity. Christine advised this has been fixed. Question is where does the data come from? Often the field isn't completed in the information they receive. End user should be pulling it in. Ethnicity comes from NHI.

When we set a KPI we need to see ethnicity every time. Rely on data from Click Dashboard.

Do we have KPIs yet? Currently pulling together regular reporting. A key KPI is length of time from positive notification to first assessment. Christine advised we could put together a strawman and bring it back to this group.

Need to ensure the date of the beginning of the patient journey matches so that it's known which day patients are getting swabbed on. Quite a lot of backlog going on but date in e-notification is day zero. Earliest release date is automatically calculated. When you look at summary screen, day zero is date of onset of symptoms or date of diagnosis if no symptoms.

Tim advised he was happy to chat regarding outcomes felt to be useful to inform remote service we set up in London. There are a lot of important variables, many difficult to measure consistently.

Could members think (offline) around what could be on a dashboard that will indicate clinical effectiveness.

It was noted that it's Important to recognise the disenfranchisement of whaanau not wanting to go to hospital, which can be for multiple reasons. It takes effort to convince people to accept a higher level of care.

How many people decline medical advice? Can we capture this?

It is Important to consider that it's hard to define success. Where you set the bar will change over time

depending on circumstances. Trying to convince people that this is a successful programme can be difficult if there is resistance on the other end.
Consumer engagement – any process to capture this at the moment? Standard 6 weekly feedback process. Have been receiving feedback – have appointed a role that will collate and analyse this feedback and report to the group. Whakarongorau are undertaking focus groups. Planning going on in NRHCC to do something similar where Whakarongorau leave off.

Mary Losē doing a lot of work in this area, including looking at doing a redesign of Patient surveys as they're currently not suitable. Hook up with HQSC?

Maria – might have to get something up and running and then look to work with HQSC.

Willem – one of the issues that whaanau are facing is too many (virtual) cars in the driveway. Patient experience requests could be one car too many. We lose clients when they feel that we're not coordinated. Focus more valuable than questionnaires.

In terms of people that don't get called at all, the process is Whakarongorau make three calls. If there is no response it's escalated to Manaaki. Team are confident that the manaaki process is now working. With the volume in the system, this does vary.

We are currently attempting to prioritise Māori and Pacific and those living on their own. We are finding that the high volumes, people are starting to disengage. Providers are getting abused for the high volume of door knocking or phone calls.

Pressure will come off Manaaki with the deal in place with Countdown. In terms of the calls, medical handover point. Paeora team told to keep calling for the first few days. Need to hand the ball on. Difficult as we're apprehensive about 'losing' patients in the system. Need to be able to supply patients a secure method of being able to get back in touch with us if they need to. We are currently looking to empower people to escalate their own care if they need to.

Tim - Agree it's a major task to improve literacy in community about what to do / who to call if deteriorate.
Maria – it is good to see that the uncontactable processes are aligning across the board.

Action
Dial back the reassurance if not needed. Deep dive has been done to ensure that we can dial back services if required. Maria/Ruth to pick up offline.

In terms of people we are unable to make contact with where does txting come into this? Txting is more appropriate for most clients. When a txt is sent out, there is a number attached to the txt so whaanau can call for assistance if they don't want to wait to be called.

Adverse Events

Gary - is it clear in the data systems who has clinical responsibility for the case and their household at any point in time? Ruth – not really. We just pretty much assume anyone in our facility is our responsibility. Operational Team that needs to do the mahi. Should be reported to this group and have oversight of the process.

Adverse events – recruiting a Quality & Risk role. This is a big piece of work and will take more than one person to manage.

In hospital Adverse Events would go on to and Adverse Events committee. Need to think about this further.

It's an important workstream to pick up this side of Christmas.

Rawiri – need to be cautious how we characterise patients.

Hina advised that from pacific perspective she is waiting to see how this will play out. It was noted that the Maaori model is different to Pacific model. In terms of some of the risk level stuff, getting out pulse oximeters etc, Pacific whaanau want the info in their language. Health literacy can be low so whaanau want the info even if they are low risk.

Ruth - Janine Bycroft from Health Navigator is pulling a lot of this information together including language resources.

The large amounts of documentation can be overwhelming for whaanau.

Where are clinical pharmacists placed in the notification processes? There is a meeting being held tomorrow with Pharmacy leadership. We will talk though how we link better with pharmacy. Methodone provision and other regular medication provision will be looked at as well. Symbicort advice is important to remember especially for non-asthma sufferers who may be first time users.

5. Clinical Handover between Services

Clinical handover to be brought forward.

6. Specific Policies or Other Documents for Consideration

6.1 Protocol for Non-Contactable People

Non-contactables – cases and contacts; need clinical decision making around this. How much do we try to contact people and what is the threshold? When do we stop trying to contact people?

Allan - Also do we provide ability for them to have comms – eg. if higher clinical risk providing a phone and SIM card etc. Kate - Yes we provide phones/tablets + data.

6.2 Guidance Documents Development Discussions

Defer protocol documents. Putting together an SOP for Community Isolation and Quarantine. Christine is looking to have a draft available for the meeting next week.

Everyone OK with circulating. Limit to once or twice a week. Use MACCCGG in the email title.

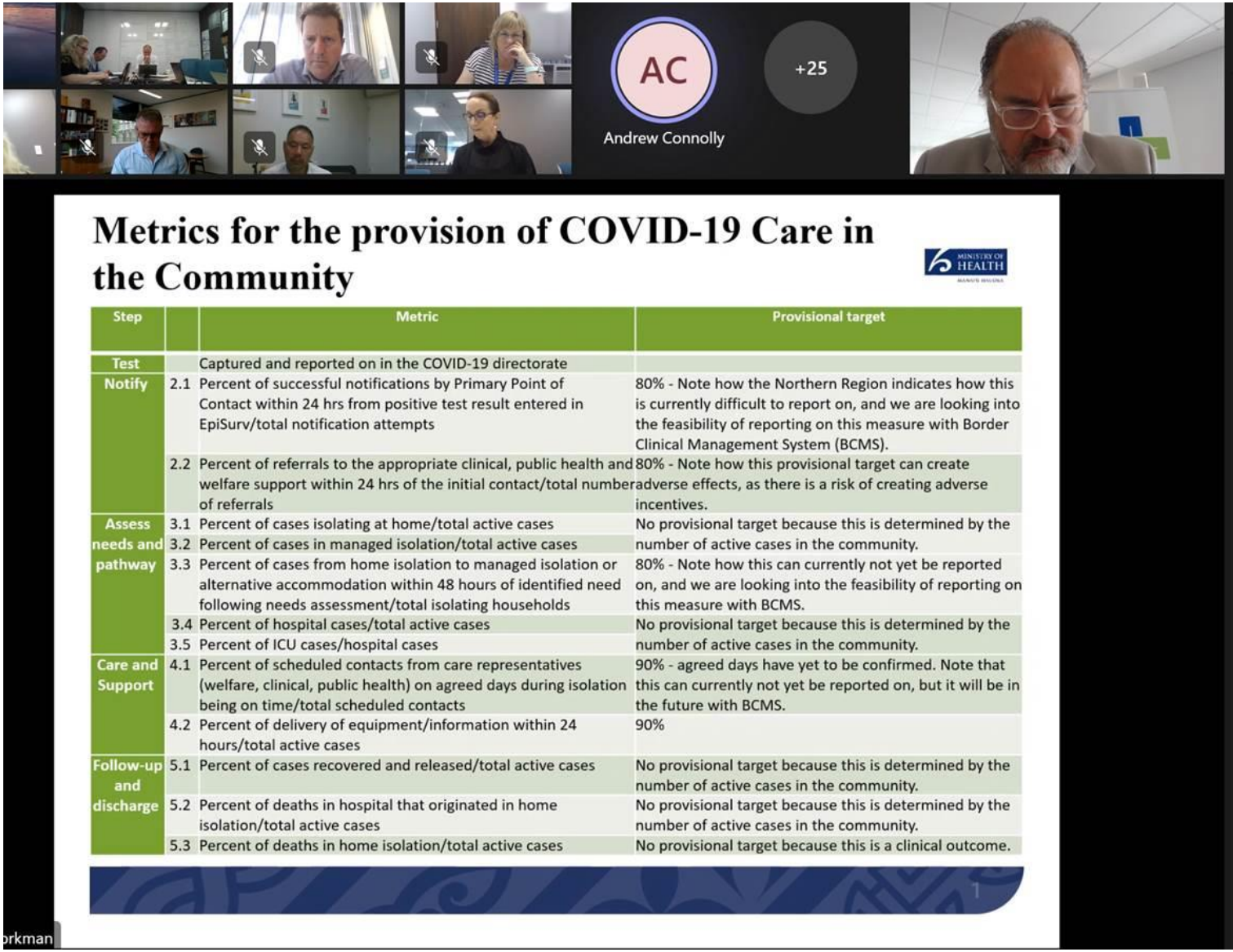
Translation needs to be brought forward too. This item will be on the agenda next time. Get the papers out in a timely fashion.

Confirm meeting is weekly? 5pm seems to work each Thursday.

Meeting concluded at 1810 with an agreement to meeting every Thursday at approximately 1700 until 23 December 2021.

The next meeting will be held on Thursday, 2 December.

Rawiri concluded the meeting with a karakia.



Metrics for the provision of COVID-19 Care in the Community

Step		Metric	Provisional target
Test		Captured and reported on in the COVID-19 directorate	
Notify	2.1	Percent of successful notifications by Primary Point of Contact within 24 hrs from positive test result entered in EpiSurv/total notification attempts	80% - Note how the Northern Region indicates how this is currently difficult to report on, and we are looking into the feasibility of reporting on this measure with Border Clinical Management System (BCMS).
	2.2	Percent of referrals to the appropriate clinical, public health and welfare support within 24 hrs of the initial contact/total number of referrals	80% - Note how this provisional target can create adverse effects, as there is a risk of creating adverse incentives.
Assess needs and pathway	3.1	Percent of cases isolating at home/total active cases	No provisional target because this is determined by the number of active cases in the community.
	3.2	Percent of cases in managed isolation/total active cases	
	3.3	Percent of cases from home isolation to managed isolation or alternative accommodation within 48 hours of identified need following needs assessment/total isolating households	80% - Note how this can currently not yet be reported on, and we are looking into the feasibility of reporting on this measure with BCMS.
	3.4	Percent of hospital cases/total active cases	No provisional target because this is determined by the number of active cases in the community.
	3.5	Percent of ICU cases/hospital cases	
Care and Support	4.1	Percent of scheduled contacts from care representatives (welfare, clinical, public health) on agreed days during isolation being on time/total scheduled contacts	90% - agreed days have yet to be confirmed. Note that this can currently not yet be reported on, but it will be in the future with BCMS.
	4.2	Percent of delivery of equipment/information within 24 hours/total active cases	90%
Follow-up and discharge	5.1	Percent of cases recovered and released/total active cases	No provisional target because this is determined by the number of active cases in the community.
	5.2	Percent of deaths in hospital that originated in home isolation/total active cases	No provisional target because this is determined by the number of active cases in the community.
	5.3	Percent of deaths in home isolation/total active cases	No provisional target because this is a clinical outcome.

Whānau HQ Clinical Governance Group Meeting
Action Items Register for 25 November 2021

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
25.11.2021	4	**Whānau Reassurance:** Dial back the reassurance if not needed. Deep dive has been done to ensure that we can dial back services if required. Ruth and Maria to connect offline.	2 December 2021	Ruth/Maria		

Clinical Triage Scoring in NCTS by Desktop Clincal Review

A standardised use of the Clinical Triage Score in National Contact Tracing System (NCTS) software by clinicians performing a desktop review of clinical records (Clinical Portal and Your Health Summary) will enable the list of cases to be sorted by the highest priority and provide a view of clinical acuity prior to allocation to place of isolation across all cases. The Clinical Triage Ccore categorises the person for risk of more severe COVID-19 based on available information in the persons digital record looking for evidene of health, mental health or social need.

This protocol is based on the information in the Auckland HealthPathways COVID-19 Case Management pathway. The HealthPathway has important information on co-morbidity, severity of symptoms and about virtual clinical history taking and exmaination.

Determining the Clinical Triage Score is based on the underlying clinical risk based on available information. Further descriptions of co-morbidity and symptoms are below table 1.

Table 1. Determining Clincal Acuity Score Category to be used in NCTS

Notes:

1. The Clinical Triage Score is obtained before contacting the person and should be used as a way to prioritise care. A full Clinical Acuity Score should be completed at the time of the first Clinical Assessment.

	Clinical Notes findings: health, psychosocial, welfare clues	**Clinical Triage Score**
COVID Care Level 2	Has required hospital admission for COVID-19 during the illness	6
	Any of: • Pregnant (within 6 weeks of pregnancy) and/or, • Mental health concerns and/or, • High and complex medical incl. Palliative, disability and/or, • High and complex social	5
	Any of: • Partial or unvaccinated (Māori ≥28, Pacific ≥25y, Other ≥50) and/or, • ≥ 2 Co-morbidity and/or, • High social need	4
	Any of: • Parital or unvaccinated (Māori 12-28y, Pacific 12-24y, Other 12-49y) and/or, • Infant < 3 month age and/or, • 1 Co-morbidity and/or, • High social need	3
	All of: • Fully vaccinated (Māori ≥44 y, Pacific ≥39y, Other ≥65y) and, • No co-morbidity and, • No high 4social needs	2
COVID Care Level 1	All of: • Fully vaccinated (Māori 12y-43y, Pacific 12-38y, Other 12-64y) or • Child > 3 month age and < 12years, and, • No co-morbidity and, • No high social needs	1

High risk medical history and/or co-morbidity all ages

- Chronic lung disease
- Cardiovascular disease
- Active cancer
- Immunosuppression
- Chronic kidney disease
- Diabetes (Type 1 &2)
- Liver Disease
- Significant frailty or disability
- Major mental illness
- Pregnant < 20 weeks
- Obese BMI > 30

Very high risk medical history and/or co-morbidity all ages

- Dialysis patient
- Home oxygen requirement or known severe lung disease
- Transplant patient
- Active haematological malignancy.
- Currently receiving chemotherapy or severely immunocompromised
- Pregnancy> 20weeks

High social needs

Complex social circumstances e.g.:

- Access to phone/video consult
- language barriers,
- large households, absence of a suitable caregiver,
- socially isolated,
- geographical location and transport factors that impact speed of access to higher levels of care

[Local DRAFT] Acuity Scoring in BCMS for Community-Supported Isolation and Quarantine

The introduction of a standardised use of the acuity score in Border Clinical Management System (BCMS) for Community –SIQ will enable the list of cases to be sorted by the highest priority and provide a view of clinical acuity across all cases. The acuity score will categorise the person with COVID-19 for symptom severity and for higher risk from a health, mental health or social need.

This protocol is based on the information in the Auckland HealthPathways COVID-19 Case Management pathway. This pathway has important information on co-morbidity, severity of symptoms and about virtual clinical history taking and exmaination.

Determining the acuity score is based on either the symptoms or the underlying clinical risk. Further descriptions of co-morbidity and symptoms are below table 1.

Table 1. Determining Acuity Score Category on Boarder Clinical Mangement System

Either Symptoms	Or Risk	= Acuity Score	Telehealth review
Moderate • SaO2 93-95% • Breathlessness • Concern about hydration • Haemoptysis • Fever >37.5	Has required ED or hospital admission during the illness	6	Twice daily review, telehealth video if possible Doctor or nurse practitioner consulted COVID-19 MDT review May require in person May require GP involvement
Mild-moderate • SaO2 > 95% • Some Breathlessness • Adequate hydration	• Pregnant (within 6 weeks of pregnancy) • Mental health concerns • High and complex medical incl. Palliative, disability • High and complex social	5	Once daily review Doctor or nurse practitioner consulted +/- COVID-19 MDT review May require in person May require GP involvement
Asymptomatic/mild, • SaO2 > 95% • Not breathless • Adequate hydration	• Partial or unvaccinated (Maori ≥28, Pacific ≥25y, Other ≥50) and/or • ≥ 2 Co-morbidity and/or • High social need	4	Once daily telehealth video if possible
Asymptomatic /mild, • SaO2 > 95% • Not breathless • Adequate hydration	• Parital or unvaccinated (Maori 12-28y, Pacific 12-24y, Other 12-49y) and/or • Infant <1 month age • 1 Co-morbidity and/or • High social need	3	Once daily telehealth

Asymptomatic /mild, • SaO2 > 95% • Not breathless • Adequate hydration	• Fully vaccinated (Maori ≥44 y, Pacific ≥39y, Other ≥65y) and • No co-morbidity and • No social needs	2	Once daily telehealth or self completed (consider Alt day)
Asymptomatic/mild • SaO2 > 95% • Not breathless • Adequate hydration	• Fully vaccinated (Maori 12y-43y, Pacific 12-38y, Other 12-64y) or • Child > 1 month age and < 12years, and • No co-morbidity and • No high social needs	1	Alternate days telehealth or self completed (consider dropping to day 4, 7 and 10)

Asymptomatic/Mild symptoms

Person has no symptoms, OR:

- Mild cough or upper respiratory tract symptoms including sore throat
- No breathlessness
- Nausea, loss of appetite, vomiting but tolerating fluids/food

Moderate symptoms

Person has:

- Fever > 37.5
- Marked cough/sputum, haemoptysis
- Mild breathlessness, chest pain
- Diarrhoea, abdominal pain, vomiting with < 50% usual fluids
- Dizziness on standing

High risk medical history (all ages)

- Chronic lung disease
- Cardiovascular disease
- Active cancer
- Immunosuppression
- Chronic kidney disease
- Diabetes (Type 1

Very high risk medical history (all ages)

- Dialysis patient
- Home oxygen requirement or known severe lung disease
- Transplant patient
- Active haematological malignancy

High social needs

Complex social circumstances e.g.:

- Access to phone/video consult
- language barriers,
- large households, absence of a suitable caregiver,
- socially isolated,
- geographical