Ref FOI18-35

[redacted]

Dear [redacted]

Freedom of information request – FOI18-35

I refer to your application received by ACT Health on 22 May 2018 in which you sought access to information under the *Freedom of Information Act 2016* (the Act).

In your application you have requested documents related to minutes, action items and agendas for the meetings of the leadership committee since the departure of former Director-General of ACT Health, Ms Nicole Feely.

I am an Information Officer appointed by the Director-General under section 18 of the Act to deal with access applications made under Part 5 of the Act. ACT Health is required to provide a decision on your access application by 21 June 2018.

Decision on access

I advise that 16 documents have been identified by ACT Health within the scope of your request.

I have decided that six documents are to be partially released in accordance with Schedule 2.2 (a)(ii) of the Act, as the information is personal information about an individual.

The partial release of these documents is outlined in the Schedule of documents attached. The remainder of the documents are released in full.

Charges

Processing charges are not applicable for this request.

Online publishing – disclosure log

Under section 28 of the Act, ACT Health maintains an online record of access applications called a disclosure log. Your original access application, my decision and documents released to you in response to your access application will be published in the ACT Health disclosure log not less than three days but not more than 10 days after the date of decision. Your personal contact details will not be published.

You may view the ACT Health's disclosure log at http://www.health.act.gov.au/public-information/consumers/freedom-information/disclosure-log.

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601

Via email: ACTFOI@ombudsman.gov.au

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision.

Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on 6205 1340 or email HealthFOI@act.gov.au.

Yours sincerely

Denise Lamb
Executive Director, Safety and Quality

20 June 2018

FREEDOM OF INFORMATION REQUEST SCHEDULE

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.

Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.

Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	File No
[redacted]	All minutes, action items and agendas for meetings of the leadership committee Minister Fitzharris referenced in the Legislative Assembly on 9 May 2018 in response to a question by Mr Jeremy Hanson MLA. I ask that this search include all meetings since the departure of the former director-general of ACT Health, Ms Nicole Feely.	FOI18/35

Ref No	No of Folios	Description	Date	Status	Reason for non-release or deferral	Open Access release status
1	1	Meeting Agenda Quality Governance and Risk	12 April 2018	Full release		Yes
2	2	Meeting Agenda National Standards Leadership Committee AC90	19 April 2018	Full release		Yes
3	3	Meeting Agenda National Standards	26 April 2017	Full release		Yes

		Leadership Committee AC90				
4	**4**	Meeting Agenda National Standards Leadership Committee AC90	2 May 2018	Full release		Yes
5	**5**	Meeting Agenda National Standards Leadership Committee AC90	10 May 2018	Full release		Yes
6	**6**	Meeting Agenda National Standards Leadership Committee AC90	17 May 2018	Partial release	Documents contain perosnal information about an individual	Yes
7	**7-10**	Action Minutes DDG National Standards Leadership Committee AC90	19 April 2018	Full release		Yes
8	**11-15**	Action Minutes DDG National Standards Leadership Committee AC90	26 April 2018	Partial release	Documents contain perosnal information about an individual	Yes
9	**16-23**	Action Minutes DDG National Standards Leadership Committee AC90	2 May 2018	Partial release	Documents contain perosnal information about an individual	Yes
10	**24-30**	Action Minutes DDG National Standards	10 May 2018	Partial release	Documents contain perosnal information about an individual	Yes

		Leadership Committee AC90				
11	**31-38**	Action Minutes DDG National Standards Leadership Committee AC90	17 May 2018	Partial release	Documents contain perosnal information about an individual	Yes
12	**39-43**	Action Log National Standards Leadership Committee AC90	16 April 2018	Full release		Yes
13	**44-50**	Action Log National Standards Leadership Committee AC90	26 April 2018	Full release		Yes
14	**51-56**	Action Log National Standards Leadership Committee AC90	9 May 2018	Full release		Yes
15	**57-65**	Action Log National Standards Leadership Committee AC90	16 May 2018	Partial release	Documents contain perosnal information about an individual	Yes
16	**66-69**	Action Log National Standards Leadership Committee AC90	18 May 2018	Full release		Yes
Total No of Docs						
16						

ACT Government Health

Meeting AGENDA
Quality Governance and Risk

Subject	Deputy Director-Generals Meeting to Discuss Not Met Actions from Accreditation
Date	12 April 2018
Time	1pm to 2pm
Location	Conference Room 2.04, Bowes Street

Name	Position/Title	Present	Apology
Jane Murkin	Deputy Director-General, Quality Governance Risk		
Mary Wood	Deputy Director-General, Innovation		
Chris Bone	Deputy Director-General, Canberra Hospital and Health Services		
Karen Doran	Deputy Director-General, Corporate		
Lynton Norris	Deputy Director-General, Performance Reporting and Data		
Margaret McLeod	Chief Nursing & Midwifery Officer		
Jeff Fletcher	Chief Medical Officer		
Jo Morris	Chief Allied Health Officer		
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety & Quality Unit		
Vanessa Dal Molin	Business Manager, Office of the Director-General		

Subject
1. Review and confirm accountabilities against Not Met Report
2. Draft Process to provide assurance
3. Role and remit of DDG leadership oversight group
4. Weekly meetings and membership
5. Communications
6. Other business

ACT Government Health

Meeting AGENDA
NATIONAL STANDARDS LEADERSHIP COMMITTEE
AC90

Date	19 April 2018	Meeting # 2
Time	1:15pm to 3:15pm	
Location	Conference Room 3.05, Bowes Street	

Name	Position/Title	Present	Apology
Michael De'Ath (Chair)	Interim Director-General, ACT Health		
Jane Murkin	Deputy Director-General, Quality Governance Risk		
Mary Wood	Deputy Director-General, Innovation		
Chris Bone	Deputy Director-General, Canberra Hospital and Health Services		
Karen Doran	Deputy Director-General, Corporate		
Lynton Norris	Deputy Director-General, Performance Reporting and Data		
Margaret McLeod	Chief Nursing & Midwifery Officer		
Jeff Fletcher	Chief Medical Officer		
Jo Morris	Chief Allied Health Officer		
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety & Quality Unit		
Vanessa Dal Molin	Business Manager, Office of the Director-General		
Felicity Martin	Secretariat		

Subject
1. Minutes and Action Log
2. Draft Terms of Reference
3. Reporting Template
4. Mapping Not Met against progress to date
5. Not Met Action Plan
6. Staffing
7. Other Business

ACT Government Health

Meeting AGENDA
NATIONAL STANDARDS LEADERSHIP COMMITTEE
AC90

Date	26 April 2018	Meeting # 3
Time	9:15am to 10:15am	
Location	Conference Room 3.05, Bowes Street	

Name	Position/Title	Present	Apology
Michael De'Ath (Chair)	Interim Director-General, ACT Health		
Jane Murkin	Deputy Director-General, Quality Governance Risk		
Mary Wood	Deputy Director-General, Innovation		
Chris Bone	Deputy Director-General, Canberra Hospital and Health Services		
Karen Doran	Deputy Director-General, Corporate		
Lynton Norris	Deputy Director-General, Performance Reporting and Data		
Margaret McLeod	Chief Nursing & Midwifery Officer		
Jeff Fletcher	Chief Medical Officer		
Jo Morris	Chief Allied Health Officer		
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety & Quality Unit		
Vanessa Dal Molin	Business Manager, Office of the Director-General		
David Jean	Media Officer, Government and Communication		
Felicity Martin	Secretariat		

Subject	Responsible Member
1. Minutes and Action Log	**Chair**
2. Weekly Reporting Templates	**DDG QGR**
3. Not Met Action Plan progress	**Accountable DDGs**
4. Communications	**DDG Innovation / Media Officer**
5. Other Business	

ACT Government Health

Meeting AGENDA
NATIONAL STANDARDS LEADERSHIP COMMITTEE
AC90

Date	2 May 2018	Meeting # 4
Time	1:00pm – 3:00pm	
Location	Level 5, Conference Room, Bowes Street	

Name	Position/Title	Present	Apology
Michael De'Ath (Chair)	Interim Director-General, ACT Health		
Jane Murkin	Deputy Director-General, Quality Governance Risk		
Mary Wood	Deputy Director-General, Innovation		
Chris Bone	Deputy Director-General, Canberra Hospital and Health Services		
Karen Doran	Deputy Director-General, Corporate		
Lynton Norris	Deputy Director-General, Performance Reporting and Data		
Denise Lamb	Executive Director, Accreditation		
Margaret McLeod	Chief Nursing & Midwifery Officer		
Jeff Fletcher	Chief Medical Officer		
Jo Morris	Chief Allied Health Officer		
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety & Quality Unit		
Vanessa Dal Molin	Business Manager, Office of the Director-General		
David Jean	Media Officer, Government and Communication		
Felicity Martin	Secretariat		

Subject	Responsible Member
1. Minutes and Action Log	**Chair**
2. Tracking and Reporting – Traffic light	**DDG QGR**
3. Not Met Action Plan progress	**Accountable DDGs**
4. Communications	**DDG Innovation / Media Officer**
5. Other Business	
a) Walk arounds	**CNMO**

ACT Government Health

Meeting AGENDA
NATIONAL STANDARDS LEADERSHIP COMMITTEE
AC90

Date	10 May 2018	Meeting # 5
Time	1300-1500 hrs	
Location	Level 5 Conference Room, Bowes Street	

Name	Position/Title	Present	Apology
Michael De'Ath (Chair)	Interim Director-General, ACT Health		
Jane Murkin	Deputy Director-General, Quality Governance Risk		
Mary Wood	Deputy Director-General, Innovation		
Barb Reid	A/Deputy Director-General, Canberra Hospital and Health Services		
Karen Doran	Deputy Director-General, Corporate		
Lynton Norris	Deputy Director-General, Performance Reporting and Data		
Denise Lamb	Executive Director, Accreditation		
Margaret McLeod	Chief Nursing & Midwifery Officer		
Jeff Fletcher	Chief Medical Officer		
Jo Morris	Chief Allied Health Officer		
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety & Quality Unit		
Vanessa Dal Molin	Business Manager, Office of the Director-General		
David Jean	Media Officer, Government and Communication		
Felicity Martin	Secretariat		

Subject	Responsible Member
1. Minutes and Action Log	**Chair**
2. Accreditation Co-ordination Team Progress Report	**DDG QGR**
3. Not Met Action Plan progress	**Accountable DDGs**
4. Communications	**DDG Innovation / Media Officer**
5. Other Business	

ACT Government Health

Meeting AGENDA
NATIONAL STANDARDS LEADERSHIP COMMITTEE
AC90

Date	17 May 2018	Meeting # 6
Time	1300-1500 hrs	
Location	Level 5 Conference Room, Bowes Street	

Name	Position/Title	Present	Apology
Michael De'Ath (Chair)	Interim Director-General, ACT Health		
Jane Murkin	Deputy Director-General, Quality Governance Risk		
Mary Wood	Deputy Director-General, Innovation		
Barb Reid	A/Deputy Director-General, Canberra Hospital and Health Services		
Karen Doran	Deputy Director-General, Corporate		
Lynton Norris	Deputy Director-General, Performance Reporting and Data		
Denise Lamb	Executive Director, Accreditation		
Margaret McLeod	Chief Nursing & Midwifery Officer		
Jeff Fletcher	Chief Medical Officer		
Jo Morris	Chief Allied Health Officer		
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety & Quality Unit		
Vanessa Dal Molin	Business Manager, Office of the Director-General		
Elaine Greenaway	Acting Deputy Director Internal Communication		
[redacted]	Consultant (Observer)		
Katrina Bracher	Executive Director, MHJHADS		
Felicity Martin	Secretariat		
Mike Wallace	Chief Operating Officer, Australian Commission on Safety and Quality in Health Care (Guest)		

Subject	Responsible Member
1. **Minutes and Action Log**	**Chair**
2. **Accreditation Co-ordination Team Progress Report**	**DDG QGR**
3. **Not Met Action Plan progress**	**Accountable DDGs**
4. **Recommendation 1.1.2 – Staff Exposure to Passive Smoking**	**Katrina Bracher**
5. **Communications**	**DDG Innovation / Media Officer**
6. **Other Business**	

ACT Government
Health

Action Minutes
DDG National Standards Leadership Committee AC90

Meeting Date: **19 April 2018**

Subject: Minutes of Meeting 12 April 2018

Source: CSQU Division of Quality Governance and Risk

Purpose/comments: For decision

DDG National Standards Leadership Committee AC90
12 April 2018
MINUTES

1. **Attendance and Apologies**

Attendees	Division / Service / Title	Present	Apology
Jane Murkin (Chair)	Deputy Director-General, Quality Governance Risk (QGR)	X	
Mary Wood	Deputy Director-General, Innovation	X	
Chris Bone	Deputy Director-General, Canberra Hospital and Health Services	X	
Karen Doran	Deputy Director-General, Corporate	X	
Lynton Norris	Deputy Director-General, Performance Reporting and Data	X	
Margaret McLeod	Chief Nursing & Midwifery Officer	X	
Jeff Fletcher	Chief Medical Officer	X	
Jo Morris	Chief Allied Health Officer	X	
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety & Quality Unit, QGR	X	
Vanessa Dal Molin	Business Manager, Office of the Director-General	X	

2. **Background and Opening**

DDG QGR thanked members for their attendance and outlined the intent of the meeting is to review the Not Met report provided by ACHS surveyors. DDG QGR outlined the key next steps and to identify key actions to meet recommendations and develop an action plan for progress implementation. ACT Health has 90 days to take action to meet these required actions prior to a site visit from two ACHS surveyors to assess compliance which will occur 3-5 July 2018. Supporting evidence is to be submitted through the ACHS portal three weeks prior to the repeat site visit (by 12 June 2018).

3. **Review and confirm accountabilities against Not Met Report**

Members discussed the importance of allocating DDG accountabilities against each standard and associated recommendations. Karen Doran stated DDG QGR was to lead the coordination and reporting of this work. DDGs assigned leadership accountability as set out below:

- Standard 1 – Governance for Safety and Quality in Health Service Organisations
  Assigned to: Karen Doran, DDG Corporate
- Standard 3 – Preventing and Controlling Healthcare Associated Infections
  Assigned to: Chris Bone, DDG CHHS
- Standard 4 – Medication Safety
  Assigned to: Margaret McLeod, Chief Nursing and Midwifery Officer
- Standard 5 – Patient Identification and Procedure Matching
  Assigned to: Jo Morris, Chief Allied Health Officer
- Standard 6 – Clinical Handover
  Assigned to: Jeff Fletcher, Chief Medical Officer and Lynton Norris, DDG, Performance, Reporting and Data

4. **Draft Process to provide assurance**

A proposed process to provide assurance was discussed which includes:

- Tracking activity and progress against actions
- Confirming that the actions will achieve the recommendations and therefore provide assurance.

Nominated DDGs will track activity and progress against each action, and will escalate and provide assurance reporting to this meeting about status of actions. DDG QGR will take responsibility for

reporting progress to DG. DDG QGR recommended a standardised reporting template to be utilised by DDGS to report progress updates.

ACTION

1) QGR to develop action plan and tracking sheet for not met actions.
2) QGR to develop standardised reporting template to track progress
3) QGR to compile supporting standard documentation associated with each recommendation to be circulated to members to inform development and evidence of key actions and activities.

5. **Role and remit of DDG leadership oversight group**

Discussed and agreed the function of the DDG leadership oversight group is to provide:

- strategic leadership
- provide assurance that actions will meet ACHS surveyor's recommendations from the Not Met report
- track progress against actions
- reporting of progress and escalation of issues or risks
- internal/external communications and media around Accreditation report and actions not met.

ACTION

1) QGR to draft TOR and circulate with agenda prior to next meeting.

6. **Weekly meetings and membership**

It had already been agreed that Members will meet weekly and the next meeting would focus on confirming actions against each recommendation and delegation of related work. Attendance will be reviewed on a case by case basis if required.

ACTION

1) DDG QGR office to schedule and send out meeting invitations.

7. **Communications**

All members agreed that priority should and will be given to internal and external communications. DDG Innovation assigned responsibility for aligning resources and progressing work related activities.

ACTION

1) DDG Innovation to explore options and report to next meeting.

8. **Other Business**

8.1 Additional Staffing Support

DDG QGR raised the requirement for additional support for the National Standards Team to progress this work and support robust project management, tracking and reporting of progress to endorse actions. Director of Clinical Effectiveness supported this requirement. Activity tracking to ensure each standard and related actions are met and that robust evidence can be provided to ACHS.

ACTION

DDG National Standards Leadership Committee AC90
12 April 2018
MINUTES

1) All DDG members to review staffing resources and nominate specific staff to assist National Standards Team. Confirmation of nomination of staff to Josephine Smith, Director of Clinical Effectiveness.

8.2 Competing Priorities
DDG QGR advised the group that from the meeting she and DDG CHHS had facilitated with CHHS Executives to discuss the not met report findings, process and next steps, concerns were raised by attendees that work relating to the Territory Wide Framework, Service Specialty plans and upcoming CHHS restructure moving to the proposed Service Speciality Centre model are competing demands. These will need to be considered in relation to reprioritising timelines to support focused work against the Not Met report.

The other area identified, is the scheduled opening the University of Canberra Hospital on 3 July 2018, which is the same day for the surveyors visit. As this involves movement of staff and patients between services it is a risk to the AC90 on-site review process.

ACTION
1) DDG QGR to brief DG about competing priorities as part of update following DDG meeting.

Next Meeting: Thursday 19 April 2018, 1:15pm to 2:15pm, Conference Room 3.05, Bowes Street.

ACT Government
Health

Action Minutes
National Standards Leadership Committee
AC90

Meeting Date: **26 April 2018**

Subject: Minutes of Meeting 19 April 2018

Source: Clinical Safety and Quality Unit, Division of Quality Governance and Risk

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Purpose/comments: For decision

DDG AC90 Leadership
19 April 2018
MINUTES

1. **Attendance and Apologies**

Attendees	Division / Service / Title	Present	Apology
Michael De'Ath	Interim Director-General, ACT Health	x	
Jane Murkin	Deputy Director-General, Quality Governance Risk (QGR)	x	
Mary Wood	Deputy Director-General, Innovation		x
Chris Bone	Deputy Director-General, Canberra Hospital and Health Services	x	
Karen Doran	Deputy Director-General, Corporate	x	
Lynton Norris	Deputy Director-General, Performance Reporting and Data	x	
Margaret McLeod	Chief Nursing and Midwifery Officer	x	
Jeff Fletcher	Chief Medical Officer		x
Jo Morris	Chief Allied Health Officer	x	
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety and Quality Unit, QGR	x	
Vanessa Dal Molin	Business Manager, Office of the Director-General		x
Nicole Stevenson	Executive Officer, Office of the Director-General	x	
David Jean	Media Office, Government and Communications	x	

The Interim Director-General, welcomed members to the meeting advising that due to the critical importance of the work to be undertaken by this Committee he will attend and Chair this Committee.

The Chair noted the importance of members prioritising attendance at these meetings, requesting that in the event a member is unavailable to attend, the DG Office be emailed with reason of non-attendance and suggested proxy.

2. **Minutes and Action Log**
Minutes from the meeting of 12 April 2018 were endorsed with minor amendment to reflect the correct title for Marg McLeod as Chief Nursing and Midwifery Officer, and that Marg and Jeff Fletcher were both apologies for the meeting.

The Chair has requested that future Agenda's include the presenter for each agenda item.

3. **Draft Terms of Reference**
Terms of reference were endorsed with a minor amendment to remove the reporting to the Director-General provision.

4. **Reporting**
DDG QGR provided members a draft Action Reporting Template, suggesting this template be completed and submitted to the Secretariat 24hrs prior to each meeting to enable collation and distribution of progress updates.

Members endorsed the reporting template, pending minor amendment to include the National Standard action and Surveyor Recommendation. Members agreed to weekly submission 24hrs prior to the meeting to be sent to Secretariat.

DDG AC90 Leadership
19 April 2018
MINUTES

5. **Mapping Not Met against progress to date**
DDG QGR provided members with a mapping document detailing work to date mapped against surveyor recommendations, including mock survey actions and progress prior to OWS. The purpose of this document is to provide members with background and contextual information to support the development of actions against individual recommendations for the Not Met Action Plan. DDG Corporate stated that it was a helpful document and members agreed this document has assisted with defining actions.

6. **Not Met Action Plan**
The Chair requested that members review all actions as progress is reported to provide assurance that activity will meet the National Standard requirements and enable the provision of quality evidence to surveyors. Refer to Not Met Action Plan for specific actions identified and progress reporting provided at the meeting

DDG Corporate, Karen Doran provided an update on Standard 1 Governance Actions, advising that as there is repetition across the seventeen actions she is mapping actions, scope and activity required to address all recommendations. This work is expected to be completed by 24 April. Jodie Chamberlain has been assigned and commenced drafting of the Corporate Governance Statement. Josephine Smith to provide Jodie with the archived Corporate Governance Statement 2015-2018, and Corporate Plan 2012-2017 to assist with development of the new Statement.

Chair confirmed with Karen if additional resources are required to support Standard 1 actions, Karen advised staff within the Corporate Division have been redeployed to this work with no additional resourcing required at this time.

The Chair advised that an external consultant, [redacted] has commenced work with ACT Health and is available to review and support high level governance document development.

DDG QGR had provided updates in relation to work underway to develop the implementation plan and measurement framework for the ACT Health's Quality Strategy. Josephine Smith shared that work was underway to develop the Clinical Governance Framework.

CAHO, Jo Morris questioned the clinical input in development of the governance documents and plans, Karen advised she will liaise with DDG CHHS and DDG QGR to progress this.

Josephine Smith shared that she has been liaising with [redacted] from the Australian Commission on Safety and Quality in Health Care, as an expert in Standard 1 Governance and evidence required by the Commission against this Standard. Members agreed for Josephine to provide the Not Met Report in order to seek Comission advice in relation to how ACT Health can best approach the recommendations and meet the not met Governance Standard actions through the AC90 process whilst the organisation is going through restructure into two entities as of 1 October 2018.

Work to address the mental health recommendations, in particular ligature point minimisation in Mental Health inpatient facilities was discussed in detail. Concern was raised regarding the lengthy remediation process with a 31 August completion date. Members agreed a prototype was not required as the hardware has already been used in new builds. DDG Corporate to feedback to Colm Mooney to proceed with capital works and provide this committee with amended project completion dates.

DDG AC90 Leadership
19 April 2018
MINUTES

DDG QGR provided an update in relation to the Advisory body stating that ED MHJHADS had drafted a Terms of Reference (TOR), and shared that she had advised that she would bring it to the meeting for discussion relating to whether the DG or Minister might want to oversee or Chair. The Chair stated that this should be discussed with the Minister and seek his advice on membership and who might be best placed to Chair. DDG Corporate raised the question of Governance for this Advisory TOR. DDG CHHS stated it should be shared with the National Standards Governance. It was also confirmed that the final version should go to EDC Safety and Quality.

The Chair requested that members provide detailed evidence to support activity to meet the National Standard actions for review at this meeting, including audit reports.

CAHO noted there is a lot of crossover between Standard 5 and Standard 6 actions. Jo Morris stated that she had discussed with DDG QGR and recommended that she and CMO work together and take on lead role. All members agreed to joint accountability for CAHO and CMO for Standards 5 and 6.

DDG QGR is assisting CAHO to review the current auditing tools and associated reporting schedule for Standards 5 and 6 against not met actions to determine measurement plan to monitor progress of any improvement activity.

ACTION
1) DDG QGR to share draft TOR from MHJHAD Advisory Group to members of the NSGC for their endorsement.
2) It was also confirmed that the final version should go to EDC Safety and Quality.
3) Josephine Smith to forward to Jodie Chamberlain the archived Corporate Plan and Corporate Governance Statement.
4) DDG Corporate to provide feedback to Colm Mooney to proceed with capital works and provide this committee with an amended project completion date.
5) All accountable DDG's and Professional Leads to update action plan with specific activity to be undertaken, including responsible officer and sent to Secretariat.

7. Staffing

DDG QGR provided an update in relation to additional staffing being provided by DDG Performance, Reporting and Data and DDG Innovation to the QGR accreditation team. DDG QGR informed members that Denise Lamb had been identified as the Executive Director to work with DDG QGR on the implementation and progress reporting for CHHS specific activity. The Chair noted this and asked for it to be minuted.

ACTION
1) DDG QGR also informed members that once the activities in the action plan were clearly identified, she would align Quality Officers to assist with and support audits and improvement activities.

8. Other Business

8.1 Internal Communication

CNMO questioned release of information to staff as a number of staff have reported learning the accreditation outcomes from the media. Chair and DDG CHHS had requested CHHS ED's discuss the

outcome with Staff. Chris will reinforce the leadership expectations regarding staff communications with CHHS ED's.

The Chair advised a Government and Communications staff member will join this Committee, to manage and action the internal and external communications. A strategy to develop a dynamic communications packages utilising IT platforms will be considered.

ACTION
1) DDG CHHS to reinforce the leadership expectations regarding staff communications with CHHS ED's.

8.2 Draft Comprehensive Accreditation Report

DDG QGR updated members that she has received the draft comprehensive Accreditation Report from ACHS and explained that ACT Health has an opportunity to review the report and check for factual accuracy. The draft report will be circulated by DDG QGR tomorrow (20 April) to National Standard Committee Executive Sponsors and Clinical Leads for review and feedback by 27 April 2018. This will allow for feedback to be collated and provided back to ACHS by the due date of 3 May 2018. Members agreed to this approach.

ACTION
1) DDG QGR to circulate to DDGs, National Standard Governance Committee and Clinical Leads and coordinate feedback on the draft Accreditation report, noting feedback is required by 27 April 2018 to enable collation and feedback to ACHS by 3 May 2018.

Chair stated that he was impressed by the progress the group had made to date and will convey this to the Ministers. There is strong support from Ministers to support us in achieving all required actions.

Next Meeting: Thursday 26 April 2018, 9:15am-10:15am, Level 5 Conference Room, Bowes Street.

ACT Government
Health

Action Minutes
National Standards Leadership Committee
AC90

Subject: Minutes of Meeting 26 April 2018

Source: Clinical Safety and Quality Unit, Division of Quality Governance and Risk

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Purpose/comments: For decision

DDG AC90 Leadership
26 April 2018
MINUTES

1. Attendance and Apologies

Attendees	Division / Service / Title	Present	Apology
Michael De'Ath	Interim Director-General, ACT Health	x	
Jane Murkin	Deputy Director-General, Quality Governance Risk (QGR)	x	
Mary Wood	Deputy Director-General, Innovation	x	
Chris Bone	Deputy Director-General, Canberra Hospital and Health Services	x	
Karen Doran	Deputy Director-General, Corporate	x	
Lynton Norris	Deputy Director-General, Performance Reporting and Data	x	
Margaret McLeod	Chief Nursing and Midwifery Officer	x	
Jeff Fletcher	Chief Medical Officer		x
Jo Morris	Chief Allied Health Officer	x	
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety and Quality Unit, QGR		x
Vanessa Dal Molin	Business Manager, Office of the Director-General	x	
Nicole Stevenson	Executive Officer, Office of the Director-General	x	
David Jean	Media Office, Government and Communications		x
Denise Lamb	Executive Director, CACHS	x	

The Chair advised the Committee that he discussed the ACT Health accreditation outcomes with the CEO, Adjunct Professo[redacted] and Chief Operating Officer, [redacted] of the Australian Commission on Safety and Quality in Health Care (Commission). The Chair indicated that during this valuable telephone conversation he provided a step by step overview of the work being undertaken by ACT Health to address the Not Met Report. The Commission noted the measures in place and indicated that their assistance was likely not required. The Commission also indicated that provided this level of work is sustained, that the Commission would be willing to publicly support ACT Health if needed. [redacted] offer to spend some time at ACT Health to provide assistance was accepted given his expertise in Standard 1 Governance and evidence required by the Commission against this Standard.

DDG AC90 Leadership
26 April 2018
MINUTES

The Chair informed the Committee that he would be meeting with [redacted] external consultant, tomorrow regarding the ACT Health accreditation outcomes and potential of further consultant input around work to address the Not Met Report.

The Committee noted that the interim DG has asked Marg McLeod, CNMO is offline one day a week to undertake walk around audits and provide any necessary support and that Barb Reid as A/DDG CHHS will also be asked to undertake walk arounds to address findings as required. The walk around findings will be directly reported to the Interim Director-General.

Jane Murkin, DDG QGR provided members with the current list of quarterly audits undertaken against the National Standards. The Surgical Safety Checklist audits are now undertaken weekly with fortnightly follow up on non-compliance. It was requested that members review the current list of audits against the National Standards and provide feedback as to further audits required or increased frequency of current audits to enable an audit plan to be finalised or shared and Quality Officers (QOs) aligned to support.

Jo Morris, CAHO advised that there is an audit plan in relation to Standard 5 Patient Identification and Procedure Matching and Standard 6 Clinical Handover in development which will be shared with members. Assistance and support has been obtained from QOs in relation to this work.

Marg McLeod, CNMO advised that a DON audit tool is being developed to include weekly rounding, which Marg will also use for her walk around audits. The Committee noted that the DONs will be accountable for undertaking walk arounds, auditing and signing of on and submitting to the CNMO.

Jane Murkin, DDG QGR raised the point of coordinating activities of audits to ensure a cohesive and joined up approach and the Chair reaffirmed.

The Chair reaffirmed the importance of all activities addressing the Not Met Actions to reflect coordinated efforts.

Members discussed staff concerns that have been raised about accredication outcomes via media.

The Chair highlighted the value of personally speaking with staff when they raise a concern regarding accreditation outcomes. See 8.1 Internal Communication for further details.

Action:

- Members to review the current list of audits against the National Standards and provide feedback to DDG QGR on additional audits or increase of frequency of audits.

2. Minutes and Action Log

Minutes from the meeting of 19 April 2018 were endorsed.

3. Not Met Action Plan progress

<u>Standard 5 and 6</u>

Jo Morris, CAHO acknowledging the progress against work is setout in the action plan and give highlevel dot points in relation to progress.

Jo Morris, CAHO advised the Committee that a Communication Package is being developed for the Not Met Actions relating to National Standard 5 and 6 and will be circulated to members by COB today. David Jean, Government and Communication, has been allocated as a resource to assist with

communication, and the CAHO will send the Communication Package to David for feedback/advice and assist with triaging the release of accreditation related messages.

Face to face workshops will be conducted commencing 14 May 2018 for two weeks. A dedicated 0.6 FTE education resource has been utilised to develop a workstation role play scenario and conduct the workshops. Members noted that SDU resourcing and support will also be available to assist the CAHO with these face to face workshops.

When updating the three existing Standard 5 and 6 eLearning packages (last updated prior to accreditation week), members reaffirmed the importance of ensuring that the updates include staff awareness of their safety and quality roles and responsibilities.

Jo Morris, CAHO also advised the Committee that three audit tools related to Standard 5 and 6 Not Met Actions will be undertaken over the next two weeks. The audits will consider shift to shift, MDT, one on one and medical handover. QOs will support data collation, sharing findings and identifying options for improvement. The Audit Plan relating to Standard 5 and 6 will be provided to members by COB today.

NS 6.1.2

Members discussed the anticipated clinician workload associated with completing the 235 Mental Health uncompleted discharge summaries from 2017. Formal advice will be provided by the end of this week regarding the anticipated clinician workload to complete these discharge summaries recognising that psychiatrist input may be required. The benefit of having a measure of % completion against the backlog was discussed. Denise Lamb, ED CACHS (now part of the Accreditation Project Team) will discuss with Tina Bracher, ED MHJHADS the options available on how to approach the Mental Health uncompleted discharge summaries from 2017. For example, offline dedicated clinician to undertake which will be a highly resource intensive approach.

Members noted the importance of clinician engagement in supporting streamlining discharge summaries and existing inefficiencies i.e. discharge summary needs to be completed twice as there is no single IT solution currently available to clinicians.

Lynton Norris, DGD QGR PRD advised that a meeting between key staff, including clinicians from WYC (NICU, Paediatrics) and Mental Health has been scheduled to discuss discharge summary process issues. The outcomes of this meeting will be outlined to members before the next DDG AC90 Leadership meeting.

Jo Morris, CAHO advised that the discharge summary data does not provide enough break down data to help identify why individual compliance may be low. Members noted that Josephine Smith, Director, Clinical Effectiveness is following on whether additional break down of discharge summary data is available. In the interim, Denise Lamb, ED CACHS will share Divisional break down data which is available with the CAHO.

NS 5.2.2

Jo Morris, CAHO provided an update on the approach to specimen labelling errors, specifically a zero tolerance approach. Work is progressing with input from the Operations Manager Pathology, CMO and CNMO on communication regarding this zero tolerance approach. In addition, Champions from different areas in relation to Standard 5, Standard 6 and zero tolerance for specimen labelling errors are being sought.

NS 5.5.3

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Jane Murkin, DDG QGR provided an update on the progress of this Not Met Action, acknowledging work over several months to increase compliance which was currently at 81% compliance. The highest result recorded for Surgical Safety Checklist (SSC) compliance was 86%. The potential option of removal of theatre time for Staff Specialists/VMOs after a third formal warning of non-compliance was discussed noting pay implications for Staff Specialists compared with VMOs (contracted for theatre time). At present, the first warning is an email from the Clinical Director with the second warning a letter from the DDG CHHS. Registrars have been advised that they are responsible for ensuring that the SSC is completed if they are the first surgeon, but that the Staff Specialist/VMO is accountable as their supervisor for SSC completion.

Members noted most doctors have responded well to the work being undertaken to improve SSC compliance rates. Potential data challenges, specifically that some doctors have been found to complete the SSC post-surgery and issues with completion of the SSC being cumbersome were also noted.

There was discussion regarding the importance of ensuring that SSC compliance rates are sustainable in the current environment and help embed a performance improvement and culture.

Action:

- CAHO to provide Standard 5 and 6 Not Met Actions Communication Package and Audit Plan to members by COB 26 April 2018.
- CAHO will send the Communication Package to David Jean, Government and Communication, for feedback/advice and assist with triaging the release of accreditation related messages.
- DDG PRD to provide outcomes of discharge summary meeting between key staff, including clinicians (NS 6.1.2) by next meeting.
- CAHO to advise of Standard 5, Standard 6 and zero tolerance for specimen labelling error champions.

Standard 4

Marg McLeod, CNMO provided progress against the action plan. She advised that the Pharmacy Department has prepared a Brief seeking cupboard installation in each Operating Theatre. The digital component of the medication fridge temperature wi-fi monitoring project is progressing well, noting feedback from the CIO. The Pharmacy Department will need to continue working on the Communication Plan and staff education, and if there are any delays, it will be reported to this Committee.

Members noted that the Pharmacy Department is auditing concentrated potassium solutions. The CNMO will be discussing these audits with Lisa Gilmore, A/g ED CSS noting that the DONs are checking this as part of their weekly rounding, as is the CNMO has part of her walk around audits.

Marg McLeod, CNMO also advised that she will discuss action to increase the completion of discharge summaries with the CMO as soon as possible so that communication can be send to medical officers and clinical directors.

Action:

- CNMO to advise of timeframes for cupboard installation within the Operating Theatres
- CNMO to provide status update on the Medication Management Plan to be developed in partnership with patients (NS 4.14.1 – developmental action)

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Standard 3

Marg McLeod, CNMO informed members of the outcomes of her recent walk around audit and shared the findings. Members noted that further work is being undertaken in relation to linen storage and the work plan developed to address this has been sent to [redacted] A/g Manager National Standards for input.

With respect to her walk around audit in the TCH kitchen area, the CNMO reported significant concerns regarding cleanliness and timelines for remediation prior to 3 July 2018. For example, kitchen still appeared visibly dirty with dirt in sinks, missing ceiling tiles, pigeons flying around the open space corridor and appeared to be nesting over sealed food containers. The Chair asked if the DDG Corporate had undertaken a walk around to assess status and linen storage.

Members noted the existing infrastructure issues within the TCH kitchen area, which reinforces the importance to maintain regular cleaning, and undertake further works to address this e.g. workplace culture, performance management issues.

There was discussion regarding whom should be allocated responsibility as the delegated action officer for various actions required to meet specific Standard 3 Not Met Actions. The DDG CHHS indicated that Rosemary Kennedy, ED Business Support should have the absolutely authority to take necessary action in relation to NS 3.16.1, 3.15.3, 3.15.2 and 3.15.1.

Chris Bone, DDG CHHS has requested that the Standard 3 Committee to review the Terms of Reference (TOR) and to ensure inclusion as a standing item on the Clinical Governance Executive meeting. Jane Murkin, DDG QGR suggested it should be EDC Safety and Quality, and this reporting will be incorporated into the ED Safety and Quality work program.

DDG QGR asked if QO support was required to support the improvement work in relation to the use and management of invasive devices and Chris Bone, DDG CHHS and Marg McLeod, CNMO agreed that support from QOs would be of benefit.

Members noted that the timeframes for completion of works to address NS 3.1.3 (30 June 2018) will be met, with evidence on the first stage completed uploaded.

Action:

- Chair, DDG Corporate, A/g DDG CHHS to visit TCH kitchen by next meeting
- Accountable DDG and delegated responsible officer to develop clear plan to improve general cleaning schedule in the kitchen

Standard 1

DDG Corporate, Karen Doran indicated that post-budget submission, she will have increased scope to progress Standard 1 Not Met Actions. Members noted that Jodie Chamberlain has continued work in this space with the first draft Corporate Plan 2018-2022 prepared.

There was discussion regarding how best to meet the Standard 1 Not Met Actions noting the organisational restructure commencing 1 October 2018. The DDG QGR confirmed that following discussion with the Commission and surveyor feedback, ACT Health will be reassessed based upon its current state and work progressed against the Not Met report. It is anticipated that when ACT Health is revisited, the surveyors will also consider the governance approach taken within the post 1 October 2018 structure. Jane Murkin, DDG QGR also stated that it would be important to set out how Governance of Quality and Safety would be set out in the new structure.

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The Chair advised that an external consultant, [redacted] is currently undertaking a Form and Function Review to assist with ACT Health management through to 1 October 2018 noting the current lack of clarity around governance structures, reporting lines and how core business functions e.g. governance, strategic planning are embedded.

The Chair encouraged that [redacted] (from next week) be used as a resource to assist with progressing works against the Standard 1 Not Met Actions, in addition to [redacted] from the Commission. The Chair advised that procurement for the post 1 October 2018 structure is being handled by Kathy Leigh, Head of Service's Office.

Jane Murkin, DDG QGR provided an update on work undertake within QGR to progress the development of the Quality Strategy Implementation Plan, Measurement Framework and Draft Clinical Governance Framework (based upon the Commission's document) and aligned to our Quality Strategy. DDG QGR explained she had asked Janine Hammat, ED for P&C to progress work on incorporating Safety and Quality into JDs and performance plans has commenced, with clinician (e.g. CNMO, CMO and CAHO) and HR/IR input being obtained to revised the performance review tool and to progress work to review clinical performance plans.

Jane Murkin, DDG QGR suggested that Safety and Quality be included as a standing item at the DG/DDG Strategy meetings.

There was discussion regarding the conduits of information on the status of Not Met Actions, specifically delegated action officers. The Chair asked that work progressed by DDGs to identify delegated accountable officers for us to receive progress updates from.

Action:

- Safety and Quality to be included as a Standing Item at DDG/DG Strategy meetings
- Focus on Standard 1 Governance to progress at next meeting
- CNMO to report back on walk around audit at each meeting – Secretariat to include as Standing Item
- Accountable DDGs/Professional Leads to advise DDG QGR of any feedback on the draft Comprehensive Accreditation Report from ACHS

Mental Health Recommendations

Members noted that six ensuite (high risk) doors have been replaced, four in one day and that bedroom door replacement has not yet commenced. As a prototype was not required, the timeline for work will need to be revised. Members have sought confirmation that ensuite curtains are consistent with ligature point minimisation in Mental Health inpatient facilities.

The draft TOR for the Mental Health Review Advisory body has been sent out to NSGC members for comment and endorsement. The DDG QGR shared that Darlene Cox (Executive Director, HCCA) has raised some concerns and the Chair stated that DDG CHHS will meet with Darlene Cox to discuss her concerns.

Members noted that the ED MHJHADS and Alison Playford, DG JACS will be meeting to discuss the Hume Centre recommendation. As it relates to accreditation outcomes, it is anticipated that this work will progress and that a meeting with the Minister for Mental Health could support further works if needed.

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Action:

- Confirmation that ensuite curtains are consistent with ligature point minimisation in Mental Health inpatient facilities
- Chair to visit Mental Health inpatient facilities

4. Communications

The Chair advised that the first piece of Internal Communication to staff was communicated by the Chair on 20 April 2018 and included an intranet link to the Not Met Report.

The Committee noted that an Internal communication strategy is being developed in relation to significant issues, including accreditation outcomes and that regular updates on the progress of Not Met Actions will be provided.

There was discussion regarding the governance around communication, and key messages to be communicated.

Members noted that the DDG QGR is providing weekly briefings to the Minister for Health and Wellbeing on accreditation outcomes.

Action:

- Accountable DDGs/Professional Leads to provide DDG QGR of any good new stories, weekly progress updates to assist with weekly briefings to the Minister for Health and Wellbeing

5. Other Business

5.1 Project plan

Jane Murkin, DDG QGR advised that Sam Morgan (part of the Accreditation Project Team) is developing a programme plan and reporting schedule using a traffic light system which will assist in reporting progress and percentage of actiones completed. DDG QGR described the importance of the project team revisiting all of the acitons to ensure that they will meet the recommendations.

Action:

- Accreditation Project Team (Sam Morgan and Denise Lamb) to meet with delegated action officers regarding Not Met Actions status updates and progress

Next Meeting: 2 May2018, Level 5, Conference Room, Bowes Street.

ACT Government
Health

Action Minutes
National Standards Leadership Committee
AC90

Meeting Date: 10 May 2018

Subject: Minutes of Meeting 2 May 2018

Source: Division of Quality Governance and Risk

Purpose/comments:

DDG AC90 Leadership
2 May 2018
MINUTES

1. Attendance and Apologies

Attendees	Division / Service / Title	Present	Apology
Michael De'Ath	Interim Director-General, ACT Health	x	
Jane Murkin	Deputy Director-General, Quality Governance Risk (QGR)	x	
Mary Wood	Deputy Director-General, Innovation	x	
Barb Reid	A/ing Deputy Director-General, Canberra Hospital and Health Services	x (from 1:20pm)	
Karen Doran	Deputy Director-General, Corporate	x	
Lynton Norris	Deputy Director-General, Performance Reporting and Data	x (from 2:15pm	
Margaret McLeod	Chief Nursing and Midwifery Officer	x	
Jeff Fletcher	Chief Medical Officer	x	
Jo Morris	Chief Allied Health Officer	x	
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety and Quality Unit, QGR	x	
Vanessa Dal Molin	Business Manager, Office of the Director-General	x	
David Jean	Media Office, Government and Communications	x	
Denise Lamb	Executive Director, CACHS	x	
Felicity Martin	Secretariat, A/g Manager, National Standards	x	

The Chair visited the kitchen at Canberra Hospital this week, reporting to members the privilege experienced with visiting the kitchen, observing significant dedication, enthusiasm and passion within the kitchen staff sharing that staff are rapidly progressing the actions required to address the issues identified during the accreditation survey. The Chair encouraged members to visit the kitchen.

The Chair advised members he has liaised with the Australian Commission on Safety and Quality in Health (the Commission), Chief Executive Officer Professor [redacted] and Chief Operating Officer, [redacted] to clarify ACT Health's relationship with the Commission during the AC 90 process. The Chair discussed in detail the work ACT Health is undertaking to address the Not Met Core Actions. The Commission indicated their support for the measures we are implementing and confidence this will position us favourably for the AC survey. [redacted] has offered to visit us in the coming weeks to provide advice and support, the Chair will liaise with the Commission to arrange this.

The Chair has liaised with the Australian Council on Healthcare Standards (ACHS) and has confirmed the support and advice ACHS will provide during the AC90 period. The ACHS Customer Service Manager aligned with ACT Health works independently from the ACHS Survey team and is available to provide support for any queries / concerns ACT Health may have. This includes reviewing the detailed Action Plan to ensure the planned actions will meet the surveyor recommendations and opportunity to discuss evidence threshold as required. The Chair advised members he requires the Not Met Action Plan to be developed by COB Thursday 3 May to provide ACHS on Friday 4 May for their review, advice and to provide evidence to ACHS of our commitment to meeting the Not Met Core Actions.

The Chair has observed the highest risk and challenge in achieving accreditation exists where staff are needed to drive and sustain safety and quality changes in clinical care, noting the action required to meet Standards 3, 4, 5 and 6 require significant staff engagement.

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2. **Minutes and Action Log**
Minutes from the meeting of 26 April 2018 were endorsed.

The Chair noted a number of items in the Action Log will be addressed through the agenda.
Jane Murkin, DDG QGR requested member's forward actions against recommendations, progress to date and updates to enable the action plan to be updated.

3. **Not Met Action Plan progress**
The Chair requested members update the Not Met Action Plan to include detail of action required, progress against actions and detail of the evidence to provide assurance. An update is required by COB 3 May 2018 to enable the weekly briefing and Action Plan be sent to the Minister for Health and Wellbeing and the Action Plan to ACHS on Friday 4 May 2018.

Standard 1
Karen Doran, DDG Corporate reported she met with Jane Murkin, DDG QGR and Denise Lamb, Executive Director CACHS finding the meeting useful in progressing Standard 1 actions. Karen advised she has a dedicated staff member who is supporting work on a package of documents to address a number of actions within Standard 1. Documents under development include:
- Organisation Chart, detailing Committees, reporting lines, accountabilities and responsibilities;
- Corporate Plan;
- Governance Statement;
- Business Plan template;
- Clinical Governance Framework, Jane Murkin, DDG QGR advised Quality Governance and Risk staff are currently developing this document with the draft due for completion next week. Once completed the draft document will be shared with Karen Doran.

Mary Wood, DDG Innovation questioned the governance interface with the Policy Advisory Committee, with confirmation this will be reflected in the above documents.

Jane Murkin, DDG QGR reported the Quality Strategy Implementation Plan is currently under development and shared the progress to date including initiation of a working group.

Members discussed the approval pathway of the governance documentation under development. The Chair reported the Terms of Reference for the DG/DDG Strategy meeting are under review as is confirmation of the highest level of Governance within ACT Health. Vanessa Dal Molin, Business Manager, Office of the Director-General will work with Karen in the development of the above listed documents and approval pathway.

Karen advised work is happening to address the Mental Health Recommendations however she has has not received a progress report. Jane Murkin, DDG QGR advised as per her previous correspondences, all actions in the Not Met Action Plan need a delegated responsible officer to ensure progress reporting to the accountable DDG occurs and enables members of the coordinating team to follow up on actions and progress.
The Chair suggested Barb Reid, A/g DDG CHHS consider and invite to this Committee a Mental Health representative to provide progress reporting on the relevant Mental Health Not Met Core Actions.
Jane Murkin, DDG QGR advised Chris Bone, DDG CHHS was providing weekly progress reports detailing status of work to address the ligature points in Mental Health inpatient facilities to the Regulator and

that this could be used for updates against the actions. The Chair confirmed the Regulator has formally notified the Interim DG to advise this patient safety risk is being attended to.

Jeff Fletcher, CMO noted the recommendation regarding provision of evidence that the system for defining scope of practice is used when new clinical services, procedures and/or technology is introduced may be challenging as MDAC is the committee that reviews and confirms Medical staff scope of practice however the minutes of this committee are privileged. The Chair advised clarification from ACHS will be sought regarding the recommendation and evidence required. Josephine Smith, Director Clinical Effectiveness clarified the scope of this recommendation is broader than MDAC, as was in response to the Health Technology Advisory Committee not meeting since August 2016 and surveyors identifying new technology has been introduced at CHHS since this time.

ACTION

1) Barb Reid, A/g DDG CHHS to consider if a Mental Health representative to this Committee is required.

Standard 3

Barb Reid, A/g DDG CHHS reported the full suite of infection control reports are regularly developed and provided to the Standard 3 Health Care Associated Infections Committee. Jane Murkin, DDG QGR advised these reports need to be provide to EDC Safety and Quality. Barb suggested as the Clinical Governance Framework is finalised, reporting of these reports to the highest level of governance will be confirmed.

Action to address the recording of date and time of invasive devices was discussed. Josephine Smith, Director Clinical Effectiveness confirmed the 'National Standard for User Applied labelling of Injectable Fluids and Lines' states an IV cannula must be labelled on the patient. The Division of Quality Governance and Risk have supported CHHS audits in November 2017 and February 2018 which has identified improved labelling of lines needs to occur across CHHS. Marg McLeod, CNMO advised Quality Officers are providing education to the Clinical Development Nurses (CDN's) this week regarding audit results and implementation of this National Standard. Jeff Fletcher, CMO requested a copy of this presentation to be forwarded to the junior's medical officers.

Action to address hepa filter reporting was discussed, Standard 3 have advised all hepa filter maintenance reports are available. Josephine Smith advised the issue identified by surveyors during OWS was the extended time taken to source all hepa filter reports with surveyors identifying the review and governance of this process needing improvement.

The Chair reported Food Services have made good progress in addressing cleaning and work flow of the kitchen. Transportation of food and linen workflow has been mapped with changes implemented. The kitchen cleaning schedule has been reviewed, amended and improvements implemented. Documentation of changes is now required and processes implemented to ensure sustainability of these improvements.

ACTION

1) Josephine Smith to forward audit results and the education package to support implementation of the National Standard for User - applied labelling of Injectable Fluids and Lines to Jeff Fletcher, Jo Morris, Marg McLeod and Barb Reid.
2) Josephine Smith to forward Barb Reid the hepa filter maintenance reports provide to surveyors.

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4.3 Standard 4

Refer to detailed progress reporting as documented in the attached Not Met Action Plan.

Medication Storage in theatre action discussed, although DDG CHHS has signed the brief with a recommended option identified Karen Doran, DDG Corporate reported the preferred option may not be achievable in the AC 90 timeframe. The Chair advised a secure medication storage solution needs to be built in theatres by the AC 90 onsite visit.

ACTION

1) DDG Corporate and DDG CHHS to review the options and decide on a sensible, practical and achievable secure medication storage solution that will be built in theatres by 1 July 2018.

4.4 Standard 5 & 6

Refer to detailed progress reporting as documented in the attached Not Met Action Plan

Jane Murkin, DDG QGR reported that staff have raised concerns regarding the zero tolerance decision and the unintended consequences identified with implementation of Zero Tolerance for mislabelling errors for example, additional samples being taken from children . Further work is needed to identify high risk patient groups in which specimens cannot be recollected. The approach needs to be both person centred and safe. Jo Morris, CAHO confirmed Pathology are convening a small working group to consider what samples/ specimens cannot be recollected and how to address this issue, Jeff Fletcher CMO is investigating pathology specimen policies in interstate paediatric hospitals. Jo reported identification of the high risk patient groups will occur by next meeting.

Eight interprofessional education sessions targeting clinical handover and patient identification are commencing from 15 May 2018. Using a train the trainer model, senior clinical staff are the target audience, expected to teach and model learning in their work areas. The Chair requested a process be developed to identify the staff required to conduct this training and to ensure training is accessible for those staff. Jo is providing the Directors of Nursing education on the Standard 5 &6 Not Mets and actions required. Jane Murkin, DDG QGR offered additional Quality Officer Support if required and referenced the work plan for Quality Officer support already identified to assist Jo with education and training.

ACTION

1) Jo Morris, CAHO to provide detail of how this training will be identified as compulsory for the required staff and the process for compliance reporting.

Josephine Smith, Director Clinical Effectiveness reported the Surgical Safety Checklist (SSC) compliance rate is at 91% today, an increase from 83% last week. The SSC Working Group are reviewing results and writing to non-compliant Medical Staff. DDG QGR raised the importance of seeking advice from HR / Industrial relations regarding the removal of theatre sessions for non-compliant staff. Josephine advised process mapping in theatres is underway to understand and address issues with the processes including use of the electronic system. Josephine clarified for members this compliance rate does not include Category 1 Life Threatening Emergency Surgical Procedures and Category A (delivery within 30 minutes) Caesarean Sections.

Jo Morris, CAHO reported sourcing quotes for ISBAR lanyards. Jane Murkin, DDG QGR identified she has previously requested this be progressed and approved quickly, the Chair advised all that issues be progressed rapidly.

Jeff Fletcher, CMO reported up to five Junior Medical Officers (JMO) have been rostered to work weekends to address the outstanding Mental Health discharge summaries. On average, each JMO is achieving completion of 6 discharge summaries in a weekend, with efficiency projected completion

of 35 discharge summaries per week is anticipated. Jane Murkin, DDG QGR requested a % complete report for inclusion in the action plan as was unsure based on the planned work that the backlog will be completed in time.

Lynton Norris, DDG Performance Reporting and Data questioned if the current KPI of 95% of inpatient discharge summary completed within 48hours is achievable, as other jurisdictions allow longer timeframes for discharge report completion. Josephine Smith noted this KPI is in the National Standards. Jane Murkin, DDG QGR described the importance of separating the two actions, the backlog of discharge summaries from the review of discharges across CHHS which is a complex issue needing to be clearly worked through. DDG QGR offered Jeff support to address this issue.

Josephine Smith, Director Clinical Effectiveness advised members where amendments are needed to clinical policy, to contact as she can assign a Policy Officer to make these changes rapidly.

4. Communications

The Chair identified communication with staff regarding the AC 90 process needs to improve. Jane Murkin, DDG QGR advised members Elaine Greenway from Communications has joined the Accreditation Project Team to assist with and provide support on a communication plan targeted at specific standards. As information is shared regularly with the CHHS ED's, DDG QGR questioned where the barrier is with the dissemination from CHHS Executive Directors. Denise Lamb noted variability with dissemination of information occurs across the CHHS Divisions. Barb Reid, A/g DDG CHHS suggested daily face to face communications are needed across the wards/ clinical areas to reinforce to staff the requirements of meeting the Standards and the Not Met Core Actions. Divisional Managers, CNC's, JMO's need to be aware of and talking with colleagues about the actions all staff need to be implementing to address the Not Met Core Actions. DDG QGR confirmed Josephine Smith, Director Clinical Effectiveness is working with communications staff to recommence the Scoop publication, Barb Reid, A/g DDG CHHS advised this has previously been well received by clinical staff and effective in delivering key National Standards messages.
Mary Wood, DDG Innovation encouraged members to identify and request where additional communication staff are needed to support the communications work. Dedicated Communications staff for CHHS has previously been requested, Mary will discuss this with Elizabeth Tobler.
The Chair requested Barb Reid, A/g DDG CHHS drive communications through the CHHS ED's as a priority, noting the engagement with staff is the highest risk to achieving the actions.

5. Other Business

6.1 Walk arounds

Marg McLeod, CNMO reported conducting visits to 9A and 10A earlier today with 2 additional surgical ward visits planned for later today. Marg identified the following findings during these visits:

- Majority of staff had little knowledge or understanding of the Not Met Core Actions nor the AC 90 organisation wide survey process. Mary Wood, DDG Innovation question if the cause is lack of communication to staff or learned helplessness. Marg noted a number of communications to date are via email with few clinical nursing staff reading emails. The Chair agreed the weekly Interim DG Bulletin can be printed and placed on ward / team quality boards, Marg suggested targeted messaging regarding Patient Identification and Handover should also be placed on the Quality Boards.
- No IV labelling on the patient was observed.
- Patient weight not recorded on medical records, one ward did not have scales to weigh patients.
- Ward Pharmacist conducting regular potassium storage and management checks, however not reporting outcomes to the CNC.

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- All medication trolleys were locked, appropriate dirty /clean linen storage and collection was observed.
- Positively noting 100% manual fridge audits conducted.

Marg confirmed during the walk arounds immediate feedback on good performance and the improvements required was provided to the CNC / Senior Nurse with an email to be provided to the ED and DON of the Division. Collation of general themes are to be provided to all DON's.

Marg identified the potential gap with implementation of actions with after-hours / night duty staff and suggested education and audit should occur after hours. Members agreed regular senior executive presence on the wards should continue post the AC 90 process.

The Chair requested a progress update on the Audit plan. Jane Murkin, DDG QGR stated she had emailed members the current audit schedule tabled at the last meeting , requesting members review and advise on audits increasing in frequency or additional audits required for the Not Met Core Actions. Jo Morris, CAHO is working to progressing Standard 5 &6 audits and Lisa Gilmore, ED Clinical Support reviewing audit's required for Standard 4. DDG QGR stated these would be set out in the audit work plan for the Quality Officers due to be finalised this Friday. Jo noted daily audits and immediate feedback are planned for Standard 5 &6. Josephine Smith, Director Clinical Effectiveness advised members the Measuring Patient Care (MPC) Audits are due this month, members discussed placing MPC audits for any Standards 'Met' on hold with a focus on the Not Met Core Actions required. Jane advised and Denise Lamb supported the audit plan will be reviewed to ensure auditing of what we need occurs and at the frequency required.

6.2 Project Documentation
Jane Murkin, DDG QGR provided members an overview on the approach that will be used in tracking and reporting progress. A 'Programme Management Reporting Guide' document was provided to members providing instruction for assigning percentage complete on action progress reporting. This is to provide accurate progress reporting and action completion projection. Jane Murkin reminded members detailed actions, responsible officers, progress updates and documentation of evidence is required from members by COB tomorrow and weekly ongoing. For project documentation to be successful, Jane explained urgent updates against progress and all actions to be set out in the action plan is required.

DDG QGR confirmed evidence documents are to be sent to her office for collation, highlighted sections of Standard Committee meetings can be provided as evidence.

Mary Wood, DDG Innovation offered members resource support if additional assistance is required to complete actions.

6.3 AC 90 Support
The Chair advised members he met with external consultant [redacted], Friday 27 April. [redacted] will attend this meeting as an observer, reporting directly to the Chair her observations of progress in meeting the Not Met Core Actions. Confirmation of [redacted] procurement and confidentiality agreement is underway.

Next Meeting: 10 May 2018, 1330-1500hrs, Level 5 Conference Room, 2-6 Bowes Street.

ACT Government
Health

Action Minutes
National Standards Leadership Committee

AC90

Meeting Date: 17 May 2018

Subject: Action Minutes of National Standards Leadership Committee

Meeting of 10 May 2018

Source: Division of Quality, Governance and Risk

Purpose/comments:

National Standards Leadership Committee Meeting 10 May 2018

ACTION MINUTES

Attendance and Apologies

In Attendance:

Name	Role	✓	Ap, or ×
Michael De'Ath	Interim Director-General, ACT Health	✓	
Jane Murkin	Deputy Director-General, Quality Governance Risk (QGR)	✓	
Mary Wood	Deputy Director-General, Innovation	✓	
Barb Reid	DDG CHHS	✓	
Karen Doran	Deputy Director-General, Corporate	✓	
Lynton Norris	Deputy Director-General, Performance Reporting and Data	✓	
Marg McLeod	Chief Nursing and Midwifery Officer	✓	
Jeff Fletcher	Chief Medical Officer		A
Jo Morris	Chief Allied Health Officer		A
Josephine Smith	Director, Clinical Effectiveness, Clinical Safety and Quality Unit, QGR	✓	
Vanessa Dal Molin	Business Manager, Office of the Director-General	✓	
David Jean	Media Office, Government and Communications		x
Denise Lamb	Executive Director, Safety & Quality, CHHS	✓	
Felicity Martin			A
[redacted]	Consultant	✓	
Elaine Greenaway	Government and Communications	✓	
Fleur Joyce	Secretariat	✓	

The Interim Director General (DG) opened the meeting by thanking, [redacted] for attending today's meeting and providing her expertise to assist the Committee to address the Not Met Report recommendations satisfactorily so as to achieve accreditation when the surveyors return.

The Interim DG asked for a brief report from members on their observations this week. Marg McLeod, Chief Nursing and Midwifery Officer (CNMO) reported that she has completed walk arounds of various clinical areas across Canberra Hospital, including the Eye Clinic, 12B, 4A, Acute Care – the Emergency Department and Acute Surgical Unit. Observations were more positive than the previous week:

- good conversations with staff with improved understanding of the Not Met Report and recommendations;
- evidence of messages being heard across all levels of staff; and
- staff were focussed on implementing improvements.

There was still concern that:

- Junior doctors need particular focus. However, it was reported that Jeff Fletcher has started communicating directly with this group.

Jane Murkin and Barbara Reid shared the walk arounds they had undertaken of areas visited and discussions with staff regarding accreditation which on the whole were very positive.

[redacted] queried progress on the Advisory notification relating to the patient safety and quality risk in mental health and ligature points. Weekly reports are being provided to the Regulator (Chief Health Officer) to monitor progress and ensure the risk is appropriately addressed.

DDG QGR stated that she would share the report with [redacted]

1. Minutes and Action Log

1.1 *Action Minutes of Meeting of 2 May 2018*

National Standards Leadership Committee endorsed the minutes from the meeting of 2 May 2018 with the following clarification to page 4 under standard 3:

Josephine Smith corrected information she presented at the 2 May 2018 meeting regarding two separate but inter-related issues – the National Standard for User Applied Labelling of Injectable Fluids and Lines (Standard 4) and the dating of IV cannulas recommendation for Standard 3.

Ms Smith advised that the National Standard is about labelling the container (i.e. bag) and conduit (i.e. lines) and that at the request of Standard 3, audit questions were included around the labelling/dating of cannulas when auditing compliance to the National Standard for User Applied Labelling, even though it's not actually a part of the Standard.

In relation to the action associated with this in the action log, Ms Smith advised she has provided the separate reports produced for both Standard 4 (User Applied Labelling Standard) and Standard 3 (Labelling/dating of cannulas), including education package to DDG CHHS and Professional Leads for their information.

1.2 *Action Log*

Members reported a number of actions are now complete or do not need to be included in the meeting action log, as they are actions relating to recommendations set out within the AC90 Action Plan and progress reporting. Two actions remain outstanding – asking Tina Bracher to attend the committee and standard 5 and 6 training which is addressed at Item 3.5 below.

2. Co-ordination Team Progress Report

DDG QGR and ED S&Q CHHS spoke to the paper, key points below:

- Coordination Team working to define and refine the actions required to address the Not Met Report Recommendations and ensure a robust report for the committee on progress
    - Initiated weekly team meetings;
    - Identifying successes and capturing gaps, challenges and risk;
    - Working to provide robust progress reports to the Committee compliance completed.
- Placing quality officers on site at CHHS to progress work as set out in the Audit and QO work plan
    - Having daily huddles
- ED S&Q CHHS meeting with responsible officers of each recommendation to discuss progress, capture key activities and development of work plans and timelines; identify concerns and clarifying roles.
- There are challenges around mapping and improving linkages for work that sits with more than one sponsor and/or not met action highlighting the coordination challenges for the team to ensure all work is captured and provide assurance that actions will meet recommendations.

- Aiming to have a full program of required actions developed by 11 May 2018 to report against at weekly Committee meetings.
- A central email address has been established for submission of evidence by responsible officer and line areas.
- The team will undertake a quality assurance process to assess all actions and activities against recommendations to ensure sufficient to meet recommendations and identify any gaps and advise where additional evidence is required to demonstrate compliance with the not met action and surveyor recommendation.
- DDG QGR also shared the plans for [redacted] from the Australian Commission on Safety and Quality in Health Care to visit ACT Health next Thursday.
- DDG QGR referred to work with communications team and Elaine to have focussed communications each week relating to Standards 3,4,5 and 6.

3. Not Met Action Plan Progress

3.1 *Standard 1*

The Interim DG commented that:

- It had been clarified that the accreditation related to the interplay between corporate and clinical governance within the health service
- The Action Plan has been provided to ACHS and the Commission with feedback pending.

DDG Corporate reported it had been a productive week and that:

- While accreditation is a point in time assessment and the on-site survey will occur before ACT Health is split into the clinical and Health Ministry functions in October, there is a need to be mindful of the separation of roles and functions when addressing the not met actions so that extensive additional work does not need to occur.
- It is planned to have an organisational structure finalised as soon as possible to inform the ACT Health Corporate Governance Statement and associated tasks including the Corporate Plan and Divisional Business Plans.
- Surveyors want to see clarity in decision making processes and governance.

[redacted] recommended a one-page summary to assist surveyors to understand the work being done in relation to Governance and Standard 1 not met actions and is clearly set out for each Standard not met action and indicated her willingness to assist.

It was noted that there will be no difficulty in finding sufficient words to develop these plans, rather synthesising the information and producing tightly crafted, clear and effective documents is the challenge.

Josephine Smith reported that she has been assigned as the responsible officer and is working on strengthening consent governance and monitoring processes related to NS1.18.2 (action 25). [redacted] noted the need to include the Chief Medical Officer (CMO), Jeff Fletcher in the development of this work. Josephine advised that the proposal would be developed with the input of the CMO, as well as other professional leads and will be submitted for review and approval through appropriate governance pathways.

Barbara Reid, Acting DDG CHHS advised that the terms of reference, application forms and procedures for the Health Technology Advisory Committee (HTAC) had been finalised.

ACTION - DDG CHHS to provide copy of the HTAC Terms of Reference, policy/procedure and application form to Josephine Smith for evidence against 1.10.4.

3.2 *Standard 3*

Members discussed what constitutes evidence for compliance. It was agreed that the action plan reporting provides some evidence but that additional independent evidence should be provided wherever possible. For example, invoices or reporting under external contracts. An example of this is the ISS cleaning contract with ACT Health and the additional commercial cleaning of the kitchens undertaken as a result of the ACHS recommendation.

DDG QGR referred to the process the coordination team will be undertaking to review and assess evidence to ensure it meets the recommendations.

The DDG CHHS reported that the key safety indicator reports have progressed through Standard 3 for reporting to the National Standards Governance Committee and then EDC Safety and Quality to demonstrate reporting to the highest level of governance.

ACTION - DDG CHHS to confirm with Standard 3 Committee that reports are to be provided to NSGC Secretariat for progression through governance processes.

In respect of 3.16.1, DDG Corporate reported that the GANNT chart requires work – the surveyors had been critical of the lack of detail and strategic approach. [redacted] recommended reviewing and potentially adopting the plan of another entity of similar size and features that has already met the National Standard action for this item.

Full review of the action plan and GANNT Chart for AS/NZ 4187 to be undertaken and reported on at next meeting.

[redacted] noted that a plan or recommendation to pursue a future budget submission to fully implement AS/NZ 4187 would support our action to address this matter.

ACTION - [redacted] to provide name of organisation who has successfully addressed AS/NZ 4187 requirement to DDG Corporate.

3.3 *Standard 4*

CNMO reported that:

- there will be a desktop screen saver in relation to the action to address the Standard 4 Not Met Report recommendations.
- NS 4.10.3 (Action 36) – there has been 100% compliance with manual fridge monitoring on rounds so far this week and the process will be fully automated by the end of May 2018.

[redacted] noted:

- the need for improved sign out procedures for concentrated potassium solutions as in other health services to ensure NS 4.11.1is met.
- the need for clarity in the language around clinical handover within the health service or to GPs in NS 4.12.4.
- possible need for further work on reconciliation of medications – [redacted] advised she was happy to assist.

3.4 *Standard 5*

In respect of NS 5.2.2 (action 42), [redacted] expressed concern about the language around exemptions to the zero tolerance of specimen mislabelling policy. Suggested clarification that there are no exemptions to policy, rather an escalation process and procedure to be followed in cases of mislabelling for defined groups where re-collection of a specimen may not occur.

ACTION – ED S&Q CHHS to reconsider mislabelling policy wording and reframing of the narrative in the action plan and report to next meeting.

In respect of NS 5.3.3 (action 43) members expressed concern about capacity to ever report 100% compliance with electronic surgical safety checklist due to potential 1-2% administrative and technology error rate. Reports from clinicians that other health services achieve 100% more easily because they audit a sample of paper records, or have a single checkbox rather than produce a comprehensive data report for every surgery.

Josephine Smith and DDG QGR outlined the significant progress over time to increase compliance taking a sustainable approach to embed the change.

[redacted] noted the need to carefully consider how ACT Health presents the data and agreed to provide information on other health services with 100% compliance that use an electronic checklist to inform ACT Health improvement activity.

ACTION – [redacted] to provide information on other health services with 100% compliance with electronic surgical safety checklist.

3.5 *Standard 6*

Progress with addressing outstanding discharge summaries, including MHJAHDS backlog was noted. Members agreed to reporting this as a good news story.

Members discussed the merits of ISBAR training being mandatory/essential. The Interim DG suggested data on staff who are not completing training was required before considering whether or not it should be made mandatory. The key issue is to demonstrate how ACT Health is addressing those who have not completed the training.

Members expressed concern around compliance rates with training - should it be made mandatory and whether this would create an additional risk to the organisation.

[redacted] suggested that making the training mandatory would send a strong message to the surveyors. Identifying staff that required the training in a plan with associated timeline, which had commenced implementation before the surveyors return.

Members agreed to bring to the next meeting further details of the train-the-trainer course commencing next week and the data collectable through Capabiliti on training completed.

ACTION 1 – ED S&Q CHHS to seek data on ISBAR training from Liz Renton to bring to next meeting.

ACTION 2 – Lynton Norris to report good news stories to Elaine in communications regarding improvements in MHJHADS discharge summaries – see NS 6.1.2 (action 45).

4. Communications

DDG Innovation and Communications Officer reported:

- Working with the Coordination team to develop focussed communications for each standard with a focus on a specific National Standard each time.
- Communications includes DG messages, face to face forums, all staff emails and printed 'key information' sheets for dissemination to staff, particularly those without regular access to emails, e.g. at staff meetings, in tea rooms, on notice boards.
- Communications aim to inform staff of:
  - the action to be taken
  - the reasons for the action
  - their responsibilities to implement the action
- The onus is on managers to ensure their staff are aware of the messaging and their obligations. Talking points to be emailed to EDs to support conversations with staff.
- Communications Unit is a support function not a content maker so seeking examples of best practice and good news stories as well as key messages from EDs as well as advice about the communication channels most likely to be used by staff in their areas. Example of good news stories includes staff demonstrating excellent work and commitment to safety and quality.

ACTION 1 - Elaine to attend CHHS Executive to talk about the Communications Plan.

ACTION 2 – Elaine to finalise dedicated talking points with coordination team.

ACTION 3 - DG to write to individual staff member demonstrating commitment to safety and quality in Marg McLeod's ward walk around.

5. Other Items for Discussion/Information

5.1 *AMC*

Consultant sought information about how ACT Health is addressing the smoking at Hume Health Centre and AMC recommendations. Members reported safety audit undertaken and working constructively with Justice and Community Safety Directorate to resolve concerns. However, moving to a smoke free prison was a lengthy process that would take longer than the AC90 review. This is a potential threshold issue to be raised with ACHS and/or the Commission.

ACTION: Accreditation Coordination Team to raise progress with smoke free environment with ACHS/Commission to determine whether action would meet the recommendation.

5.2 *Timeframe for completing actions*

[redacted] raised concerned that there is only a few weeks until surveyors return to ACT Health and that the current Action Plan does not fully reflect the work that has been undertaken to address the Not Met Report and does not demonstrate sufficient activity to achieve accreditation.

ACTION - All Members to review the actions and progress reporting in the Action Plan to ensure clarity, comprehensiveness and capacity to demonstrate activity to meet the not met Standard actions and ACHS recommendations.

5.3 *Performance review*

Consultant asked if Committee was happy with Performance Plan and review processes for clinical staff and suggested looking at Princess Alexandra Hospital in Brisbane.

ACTION – Consultant to provide name of contact at Princess Alexandra hospital to DDG QGR for follow up in relation to performance plans and reviews.

Meeting ended at 3pm.

Next Meeting:

Thursday 17 May 2018, 1pm to 3pm.

Action Log
National Standards Leadership Committee AC90

ACTION LOG: Updated 16 April 2018						
Action Item	**Person(s) Responsible**	**From Meeting**	**Due**	**Actions**	**Progress/Update (Member to complete)**	**Status Completed Ongoing Outstanding**
Communications	DDG Innovation	12/04/18	19/04/18	DDG Innovation to explore options and report to next meeting.		Ongoing
Corporate Governance Statement	Director, Clinical Effectiveness	19/04/18	26/04/18	Director, Clinical Effectiveness to forward archived Corporate Plan and Corporate Governance Statement to Jodie Chamberlain.	Documents sent 19 April	**Completed**
Leadership expectations	DDG CHHS	19/04/18	26/04/18	DDG CHHS to reinforce the leadership expectations regarding staff communications with CHHS ED's.		Ongoing

Draft comprehensive Accreditation Report	DDG QGR	19/04/18	26/04/18	DDG QGR to coordinate the approach to seek feedback to the draft Accreditation report, noting feedback is required by the 27 April to enable collation and feedback to ACHS by 3 May 2018.	Draft report circulated to DDG's, Executive Sponsors and Clinical Leads of National Standards on 20 April	**Ongoing**
Action Plan update	All	19/04/18	26/04/18	All members to provide secretariat evidence and progress updates 24 hours prior to next meeting.		**Ongoing**
Not Met Action Plan	DDG QGR	19/04/18	20/04/18	Share draft TOR from MHJHAD Advisory Group to members of the NSGC for their endorsement.	Draft TOR emailed to members of the NSGC	**Completed**
Not Met Action Plan	DDG QGR			Final version of the TOR from the MHJHAD Advisory Group to go to EDC Safety and Quality.		**Ongoing**

Not Met Action Plan	DDG Corporate			Provide feedback to Colm Mooney to proceed with capital works and provide this committee with an amended project completion date.		**Ongoing**
Not Met Action Plan	Accountable DDGs / Professional Leads			Update action plan with specific activity to be undertaken, including responsible officer and sent to Secretariat.		**Ongoing**
Staffing	DDG QGR	26/04/18	05/05/18	Once the activities in the action plan were clearly identified, DDG QGR would align Quality Officers to assist with and support audits and improvement activities.		**Ongoing**
Membership Options for MHJHAD Advisory Group	DDG CHHS	19/04/18	23/04/18	Take draft of TOR with membership options for meeting with Minister on Monday.		**Ongoing**

COMPLETED ACTIONS						
Action Plan and Tracking Sheet	DDG QGR	12/04/18	19/04/18	DDG QGR to develop action plan and tracking sheet for not met actions.	17/04 – Action Plan and tracking sheet provided for members review	**Completed**
Reporting Template	DDG QGR	12/04/18	19/04/18	DDG QGR to develop reporting template for not met actions to track and escalate progress and status of actions.	17/04 – Not met Action Reporting template provided for members review	**Completed**
Recommendations Evidence	Director, Clinical Effectiveness	12/04/18	19/04/18	Director, Clinical Effectiveness to compile evidence associated with each recommendation to be circulated to members.	17/04 – Montoring Tool developed and provided to members assigned accounatbility for Standards	**Completed**
TOR	DDG QGR	12/04/18	19/04/18	DDG QGR to draft TOR and circulate with agenda prior to next meeting.	17/04 – Documents drafted and for discussion on the meeting agenda	**Completed**

Meeting Schedule	DDG QGR	12/04/18	19/04/18	DDG QGR office to schedule and send out meeting invitations	Meetings scheduled	**Completed**
Additional Staffing	All members	12/04/18	19/04/18	All members to review staffing resources and nominate specific staff to assist National Standards Team.	DDG Innovation and DDG Performance, Data and Reporting have identified support staff	**Completed**
DG Brief	DDG QGR	12/04/18	19/04/18	DDG QGR to brief DG about competing priorities as part of update following DDG meeting.	DDG QGR briefed DG via email post 12/4 meeting	**Completed**

Action Log
National Standards Leadership Committee AC90

ACTION LOG: Updated 26 April 2018						
Action Item	**Person(s) Responsible**	**From Meeting**	**Due**	**Actions**	**Progress/Update (Member to complete)**	**Status Completed Ongoing Outstanding**
Leadership expectations	DDG CHHS	19/04/18	26/04/18	DDG CHHS to reinforce the leadership expectations regarding staff communications with CHHS ED's		Ongoing
Action Plan update	All	19/04/18	26/04/18	All members to provide secretariat evidence and progress updates 24 hours prior to next meeting		Ongoing
Not Met Action Plan	DDG QGR	19/04/18	26/04/18	Final version of the TOR from the MHJHAD Advisory Group to go to EDC Safety and Quality		Ongoing

Not Met Action Plan	DDG Corporate	19/04/18	26/04/18	Provide feedback to Colm Mooney to proceed with capital works and provide this committee with an amended project completion date		**Ongoing**
Not Met Action Plan	Accountable DDGs /Professional Leads	19/04/18	30/04/18	Update action plan with specific activity to be undertaken, including responsible officer	**26 April 2018 Update:** DDG QGR email sent to members requesting this update (and further details) by COB 30 April 2018	**Ongoing**
Staffing	DDG QGR	19/04/18	05/05/18	Once the activities in the action plan were clearly identified, DDG QGR would align Quality Officers to assist with and support audits and improvement activities	Draft plan under development awaiting confirmation from two areas for QO support	**Ongoing**
Not Met Action Plan	Accountable DDGs / Professional Leads	26/04/18	27/04/18	Members review the current list of audits against the National Standards and provide feedback to DDG QGR on additional audits or increase of frequency of audits	**26 April 2018 Update:** DDG QGR email sent to members	**Outstanding**

Not Met Action Plan	Chair/DDG Corporate/DDG CHHS	26/04/18	By next meeting	Visit TCH kitchen		**Outstanding**
Not Met Action Plan	Chair	26/04/18		Include Safety and Quality as a Standing Item at DDG/DG Strategy meetings		Ongoing
Not Met Action Plan	DDG CHHS	26/04/18 26/04/18	By next meeting By next meeting	Confirmation that ensuite curtains are consistent with ligature point minimisation in Mental Health inpatient facilities Chair to visit Mental Health inpatient facilities		Ongoing
Meeting Schedule	DDG QGR Secretariat	26/04/18 26/04/18	By next meeting By next meeting	Focus on Standard 1 Governance at next meeting CNMO to report back on walk around audit at each meeting – Secretariat to include as Standing Item		Ongoing
Draft comprehensive Accreditation Report	Accountable DDGs/Professional Leads	26/04/18	By next meeting	Advise DDG QGR of any feedback on the draft Comprehensive Accreditation Report from ACHS		Ongoing

Communication	Accountable DDGs/Professional Leads	26/04/18		Provide DDG QGR of any good new stories, weekly progress updates to assist with weekly briefings to the Minister for Health and Wellbeing		**Ongoing**
Project plan	Accreditation Project Team	26/04/18		Meet with delegated action officers regarding Not Met Actions status updates and progress		**Ongoing**

COMPLETED ACTIONS						
Action Plan and Tracking Sheet	DDG QGR	12/04/18	19/04/18	DDG QGR to develop action plan and tracking sheet for not met actions.	17/04 – Action Plan and tracking sheet provided for members review	**Completed**
Reporting Template	DDG QGR	12/04/18	19/04/18	DDG QGR to develop reporting template for not met actions to track and escalate progress and status of actions.	17/04 – Not met Action Reporting template provided for members review	**Completed**
Recommendations Evidence	Director, Clinical Effectiveness	12/04/18	19/04/18	Director, Clinical Effectiveness to compile evidence associated with each recommendation to be circulated to members.	17/04 – Montoring Tool developed and provided to members assigned accounatbility for Standards	**Completed**
TOR	DDG QGR	12/04/18	19/04/18	DDG QGR to draft TOR and circulate with agenda prior to next meeting.	17/04 – Documents drafted and for discussion on the meeting agenda	**Completed**

Meeting Schedule	DDG QGR	12/04/18	19/04/18	DDG QGR office to schedule and send out meeting invitations	Meetings scheduled	**Completed**
Additional Staffing	All members	12/04/18	19/04/18	All members to review staffing resources and nominate specific staff to assist National Standards Team.	DDG Innovation and DDG Performance, Data and Reporting have identified support staff	**Completed**
DG Brief	DDG QGR	12/04/18	19/04/18	DDG QGR to brief DG about competing priorities as part of update following DDG meeting.	DDG QGR briefed DG via email post 12/4 meeting	**Completed**
Not Met Action Plan	DDG QGR	19/04/18	20/04/18	Share draft TOR from MHJHAD Advisory Group to members of the NSGC for their endorsement.	Draft TOR emailed to members of the NSGC	**Completed**

Communications	DDG Innovation	12/04/18	19/04/18	DDG Innovation to explore options and report to next meeting.	**26 April 2018 Update:** David Jean, Media Officer, Government and Communication will be reporting to the Committee.	**Completed**
Corporate Governance Statement	Director, Clinical Effectiveness	19/04/18	26/04/18	Director, Clinical Effectiveness to forward archived Corporate Plan and Corporate Governance Statement to Jodie Chamberlain.	Documents sent 19 April	**Completed**
Draft comprehensive Accreditation Report	DDG QGR	19/04/18	26/04/18	DDG QGR to coordinate the approach to seek feedback to the draft Accreditation report, noting feedback is required by the 27 April to enable collation and feedback to ACHS by 3 May 2018.	Draft report circulated to DDG's, Executive Sponsors and Clinical Leads of National Standards on 20 April	**Completed**
Membership Options for MHJHAD Advisory Group	DDG CHHS	19/04/18	23/04/18	Take draft of TOR with membership options for meeting with Minister on Monday	Discussed at Minister for Mental Health's meeting on Thursday, 26 April 2018	**Completed**

Action Log
National Standards Leadership Committee AC90

ACTION LOG: Updated 9 May 2018						
Action Item	**Person(s) Responsible**	**From Meeting**	**Due**	**Actions**	**Progress/Update (Member to complete)**	**Status Completed Ongoing Outstanding**
Leadership expectations	DDG CHHS	19/04/18	26/04/18	DDG CHHS to reinforce the leadership expectations regarding staff communications with CHHS ED's.		Ongoing
Action Plan update	All	2/5/18	3/5/18	All members to provide secretariat evidence and progress updates 24 hours prior to next meeting.		Ongoing
Not Met Action Plan	Accountable DDGs /Professional Leads	19/04/18	30/04/18	Update action plan with specific activity to be undertaken, including responsible officer.	**26 April 2018 Update:** DDG QGR email sent to members requesting this update (and further details) by COB 30 April 2018	Ongoing

Not Met Action Plan	Accountable DDGs / Professional Leads	26/04/18	27/04/18	Members review the current list of audits against the National Standards and provide feedback to DDG QGR	**26 April 2018 Update:** DDG QGR email sent to members **2 May 2018**– Members reminded to respond to email at Committee meeting. **8 May 2018:** DDG QGR met with individual members, Marg, Jo and Lisa Gilmore to develop audit plan which was sent out on 4 May.	**Outstanding**
Not Met Action Plan	CNMO	26/04/18	10/5/18	Advise of timeframes for for cupboard installation within the Operating Theatres	**2 May 18:** DDG Corporate amd DDG CHHS to report solution at next meeting and project due date	**Ongoing**
Not Met Action Plan	DDG Corporate	26/04/18 26/04/18	By next meeting By next meeting	Confirmation that unsuited curtains are consistent with ligature point minimisation in Mental Health inpatient facilities Chair to visit Mental Health inpatient facilities		**Outstanding**

Not Met Action Plan	DDG CHHS	2/5/18	10/5/18	Barb Reid, A/g DDG CHHS to consider if a Mental Health representative to this Committee is required.		
Not Met Action Plan	Director, Clinical Effectiveness	2/5/18	10/5/18	Josephine Smith to forward audit results and the education package to support implementation of the National Standard for User - applied labelling of Injectable Fluids and Lines to Jeff Fletcher, Jo Morris, Marg McLeod and Barb Reid.	**7 May:** Audit and Quality Officer workplan sent on 7 May 18 to Professional Leads, DDG CHHS and CHHS EDs.	**Completed**
Not Met Action Plan	Director, Clinical Effectiveness	2/5/18	10/5/18	Josephine Smith to forward Barb Reid the hepa filter maintenance reports provide to surveyors.	**4 May 18:** Hepa filter maintenance reports sent on 4 May, cc DDG Corporate	**Completed**
Not Met Action Plan	DDG Corporate	2/5/18	10/5/18	DDG Corporate and DDG CHHS to review the options and decide on a sensible, practical and achievable secure medication storage solution that will be built in theatres by 1 July 2018.		

Not Met Action Plan	CAHO	2/5/18	10/5/18	Jo Morris, CAHO to provide detail of how the Standard 5 & 6 training will be identified as compulsory for the required staff and the process for compliance reporting		

COMPLETED ACTIONS						
Not Met Action Plan	DDG QGR	19/04/18	26/04/18	Final version of the TOR from the MHJHAD Advisory Group to go to EDC Safety and Quality.	Included in May EDC papers	**Completed**

Not Met Action Plan	DDG Corporate	19/04/18	26/04/18	Provide feedback to Colm Mooney to proceed with capital works and provide this committee with an amended project completion date.	Capital work in Inpatient Mental Health Units has commneced	**Completed**
Membership Options for MHJHAD Advisory Group	DDG CHHS	19/04/18	23/04/18	Take draft of TOR with membership options for meeting with Minister on Monday.	Dicussed with Minister	**Complete**
Meeting Schedule	DDG QGR Office	26/04/18	By next meeting	Arrange for Committee meetings for two hour duration	All actions completed	**Complete**
	Secretariat	26/04/18	By next meeting	Arrange for next Committee meeting to focus on Standard 1 Governance		
	Secretariat	26/04/18	By next meeting	CNMO to report back on walk around audit at each meeting – Secretariat to include as Standing Item		

Draft comprehensive Accreditation Report	Accountable DDGs/Professional Leads	26/04/18	By next meeting	Advise DDG QGR of any feedback on the draft Comprehensive Accreditation Report from ACHS	2 May 18 – Feebdack recived form some members, collated and to provided to DG	**Complete**

Action Log
National Standards Leadership Committee AC90

ACTION LOG: Updated 16 May 2018						
Action Item	**Person(s) Responsible**	**From Meeting**	**Due**	**Actions**	**Progress/Update (Member to complete)**	**Status Completed Ongoing Outstanding**
Leadership expectations	DDG CHHS	19/04/18	26/04/18	DDG CHHS to reinforce the leadership expectations regarding staff communications with CHHS ED's.		Ongoing
Action Plan update	All	2/5/18	3/5/18	All members to provide secretariat evidence and progress updates 24 hours prior to next meeting.		Ongoing
Not Met Action Plan	Accountable DDGs /Professional Leads	19/04/18	30/04/18	Update action plan with specific activity to be undertaken, including responsible officer.	**26 April 2018 Update:** DDG QGR email sent to members requesting this update (and further details) by COB 30 April 2018	Ongoing

Not Met Action Plan	Accountable DDGs / Professional Leads	26/04/18	27/04/18	Members review the current list of audits against the National Standards and provide feedback to DDG QGR	**26 April 2018 Update:** DDG QGR email sent to members **2 May 2018**– Members reminded to respond to email at Committee meeting. **8 May 2018**: DDG QGR met with individual members, Marg, Jo and Lisa Gilmore to develop audit plan which was sent out on 4 May.	**Outstanding**
Not Met Action Plan	CNMO	26/04/18	10/5/18	Advise of timeframes for for cupboard installation within the Operating Theatres	**2 May 18:** DDG Corporate amd DDG CHHS to report solution at next meeting and project due date	**Ongoing**
Not Met Action Plan	DDG Corporate	26/04/18 26/04/18	By next meeting By next meeting	Confirmation that unsuited curtains are consistent with ligature point minimisation in Mental Health inpatient facilities Chair to visit Mental Health inpatient facilities		**Outstanding**

Not Met Action Plan	DDG CHHS	2/5/18	10/5/18	Barb Reid, A/g DDG CHHS to consider if a Mental Health representative to this Committee is required.		
Not Met Action Plan	Director, Clinical Effectiveness	2/5/18	10/5/18	Josephine Smith to forward audit results and the education package to support implementation of the National Standard for User - applied labelling of Injectable Fluids and Lines to Jeff Fletcher, Jo Morris, Marg McLeod and Barb Reid.	**7 May:** Audit and Quality Officer workplan sent on 7 May 18 to Professional Leads, DDG CHHS and CHHS EDs.	**Completed**
Not Met Action Plan	Director, Clinical Effectiveness	2/5/18	10/5/18	Josephine Smith to forward Barb Reid the hepa filter maintenance reports provide to surveyors.	**4 May 18:** Hepa filter maintenance reports sent on 4 May, cc DDG Corporate	**Completed**
Not Met Action Plan	DDG Corporate	2/5/18	10/5/18	DDG Corporate and DDG CHHS to review the options and decide on a sensible, practical and achievable secure medication storage solution that will be built in theatres by 1 July 2018.		

Not Met Action Plan	CAHO	2/5/18	10/5/18	Jo Morris, CAHO to provide detail of how the Standard 5 & 6 training will be identified as compulsory for the required staff and the process for compliance reporting		
Not Met Action Plan	DDG CHHS	10/5/18	17/5/18	DDG CHHS to provide copy of the HTAC Terms of Reference, Policy/Procedure and application form to Josephine Smith for evidence against 1.10.4.		
Not Met Action Plan	DDG CHHS	10/5/18	17/5/18	DDG CHHS to confirm with Standard 3 Committee that reports are to be provided to NSGC Secretariat for progression through governance processes.		
Not Met Action Plan	Helen Milne	10/5/18	17/5/18	Helen Milne to provide name of organisation who has successfully addressed AS/NZ 4187 requirement to DDG Corporate.		

Not Met Action Plan	ED S&Q CHHS	10/5/18	17/5/18	ED Accreditation to reconsider mislabelling policy wording and reframing of the narrative in the action plan and report to next meeting.		
Not Met Action Plan	Helen Milne	10/5/18	17/5/18	[redacted]to provide information on other health services with 100% compliance with electronic surgical safety checklist.		
Not Met Action Plan	ED S&Q CHHS	10/5/18	17/5/18	ED Accreditation to seek data on ISBAR training from Liz Renton to bring to next meeting.		
Not Met Action Plan	DDG PRD	10/5/18	17/5/18	Lynton Norris to report good news stories to Elaine in communications regarding improvements in MHJHADS discharge summaries – see NS 6.1.2 (action 45).		

Not Met Action Report	Elaine Greenaway	10/5/18	17/5/18	Elaine to attend CHHS Executive to talk about the Communications Plan.		
Not Met Action Report	Elaine Greenaway	10/5/18	17/5/18	Elaine to finalise dedicated talking points with coordination team.		
Not Met Action Report	DG	10/5/18	17/5/18	DG to write to individual staff member demonstrating commitment to safety and quality in Marg McLeod's ward walk around.		
Not Met Action Report	Accreditation Coordination Team	10/5/18	17/5/18	Raise progress with smoke free environment with ACHS/Commission to determine whether action would meet the recommendation.		

Not Met Action Report	All	10/5/18	17/5/18	All Members to review the actions and progress reporting in the Action Plan to ensure clarity, comprehensiveness and capacity to demonstrate activity to meet the not met Standard actions and ACHS recommendations.		
Not Met Action Report	Helen Milne	10/5/18	17/5/18	Consultant to provide name of contact at Princess Alexandra hospital to DDG QGR for follow up in relation to performance plans and reviews.		

COMPLETED ACTIONS

Not Met Action Plan	DDG QGR	19/04/18	26/04/18	Final version of the TOR from the MHJHAD Advisory Group to go to EDC Safety and Quality.	Included in May EDC papers	**Completed**
Not Met Action Plan	DDG Corporate	19/04/18	26/04/18	Provide feedback to Colm Mooney to proceed with capital works and provide this committee with an amended project completion date.	Capital work in Inpatient Mental Health Units has commneced	**Completed**
Membership Options for MHJHAD Advisory Group	DDG CHHS	19/04/18	23/04/18	Take draft of TOR with membership options for meeting with Minister on Monday.	Dicussed with Minister	**Complete**
Meeting Schedule	DDG QGR Office Secretariat Secretariat	26/04/18 26/04/18 26/04/18	By next meeting By next meeting	Arrange for Committee meetings for two hour duration Arrange for next Committee meeting to focus on Standard 1 Governance CNMO to report back on walk around audit at each meeting	All actions completed	**Complete**

			By next meeting	– Secretariat to include as Standing Item		
Draft comprehensive Accreditation Report	Accountable DDGs/Professional Leads	26/04/18	By next meeting	Advise DDG QGR of any feedback on the draft Comprehensive Accreditation Report from ACHS	2 May 18 – Feebdack recived form some members, collated and to provided to DG	**Complete**

Action Log
National Standards Leadership Committee AC90

ACTION LOG: Updated 18 May 2018						
Action Item	**Person(s) Responsible**	**From Meeting**	**Due**	**Actions**	**Progress/Update (Member to complete)**	**Status Completed Ongoing Outstanding**
Not Met Action Plan	DDG Corporate	17/05/18 26/04/18	23/5/18 10/5/18	Advise of timeframes for cupboard installation within the Operating Theatres	**21 May 18:** The delivery date for the cabinets to Canberra is currently on program for 19 June 2018. Preparation and testing of cabinets by local supplier, Fredon, is required prior to installation. The project timeline indicates a completion date of 29 June 2018 for all planned works (includes contingency). 17 May 2018 Karen Doran to review and fast track the 19 June 18 compeltion timeframe, reporting progress directly to Interim DG. 2 May 18 DDG Corporate amd DDG CHHS to report	Ongoing

					solution at next meeting and project due date	
Not Met Action Plan	DDG Corporate	26/04/18 26/04/18	By next meeting By next meeting	Confirmation that unsuited curtains are consistent with ligature point minimisation in Mental Health inpatient facilities Chair to visit Mental Health inpatient facilities	**21 May 2018:** Approved. Track Curtain to be delivered to site 23 May 2018. Installation of all room curtains to be completed by 8 June 2018. Prototype room completion on track for completion by 8 June 2018 18 May 18 – email sent to DDG Corporate requesting an update	Ongoing
Not Met Action Plan Progress	Program Manager, Accreditation Coordination Team	17/5/18	23/5/18	Sam Morgan to meet with Tina Bracher to review documentation of the action and progress reporting for the Advisory 16/01 patient safety risk to be incorporated into the program plan .	18 May 18 – meeting occurred with clarification on document requirements completed	**Completed**
Not Met Action Plan Progress	DDG CHHS	17/5/18	23/5/18	Barb Reid to email CHHS clinical staff issuing a directive for staff to comply with manual fridge monitoring requirements	21/05/18 - Email has been sent out to CHHS Clinical Staff	**Completed**

Not Met Action Plan Progress	DDG Corporate	17/5/18	23/5/18	Karen Doran to liaise with Digital Solutions and source assistance in addressing the technology issue effecting SSC compliance reporting	**22 May:** Digital Solutions met with the Clinical Safety and Quality Unit and are now aware of the technical issues raised around the electronic surgical safety checklist (ESSC). DSD have advised that there are two main possible issues thought to be occurring, one around the transmission of Date of Birth between systems not being correctly displayed and another about the system logging you out of your computer. DSD have allocated 2 FTE to look into these issues to investigate if they are occurring and what steps need to occur to rectify, there is another follow up meeting scheduled between Clinical Safety and Quality and DSD on 4 June. DSD will provide CSQU and DDG Corporate with a further update by COB this Friday and again the following Friday	**Completed**

Not Met Action Plan Progress	DDG CHHS	17/5/18	23/5/18	Barb Reid to develop an Executive walk around schedule	21/05/18 - Email has been sent to CHHS ED's and will also be discussed at CHHS Executive meeting on 22 May 18.	**Ongoing**