Terms of Reference

Clinical Senate of Western Australia
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1. Mission and Role

The Clinical Senate is a mechanism to provide state-wide clinical engagement and advice to the Director General (DG), and as required through to the Ministers for Health on matters relating to:

- the coordination and development of clinical planning
- clinical and resource decision-making
- strategies to improve quality and safety in health
- other relevant issues impacting on the health of Western Australians
- issues of key concern to the DG.

The role of the Clinical Senate is to provide:

- a forum where collective knowledge on clinical issues can be shared and provided to the DG
- a mechanism for increased participation and advice from clinicians in policy setting for the Western Australian health system
- advice on solutions to clinical management issues within the Western Australian health system and develop recommendations for consideration and implementation by the DG
- a forum for clinicians to be informed and develop joint understanding of financial management of the whole-of-Health budget, whilst providing opportunity for senior Department of Health officers to appreciate the priorities for the maintenance and development of clinical services as perceived by clinicians working within the health system
- a forum for greater coordination and integration between service areas
- a vehicle for clinicians to champion reform in health.
2. Vision and Values

The Clinical Senate:

- is a large diverse and dynamic group of clinicians who vigorously debate challenging issues confronting health in Western Australia, provides outcomes from its deliberations that are highly regarded and valued and are able to be operationalised across the health system.
- is recognised as valuable to Western Australian society and provides leadership in healthcare system transformation
- is seen as an innovative body and a driver of systems change
- is a highly considered and sought-after body locally, nationally and internationally.

Core Values

- Clinical leadership with integrity
- Informed debate, led by evidence
- Debate adds value, shows respect for diversity of opinions and practice and promotes equity
- Issues considered are timely and responsive to the needs of the Health System as a whole
- Independence that strives to put aside political agendas and personal allegiances.

2.1 Independence

- The Clinical Senate is apolitical.
- Decisions will be made, where possible, with the support of evidence presented to all members of the Senate.
- Member debate is on a non-representational basis.
- While Senators are nominated by various bodies, decisions are to be made in the best interest of the health and wellbeing of all Western Australians rather than sectional or vested interest.
- Corporate interest of the health system is above sectional interest, with decision-making based largely on a consensus approach.
3. Structure

The membership consists of up to 80 clinician members nominated by bodies outlined in section 7.0 and two consumer representatives. The Clinical Senate operates independently of the formal Department of Health structure (refer Figure 1). ‘Clinician’ refers to any health practitioner working within the Western Australian health system, either as a public and/or private practitioner.

From the membership a 10-person Executive Committee, comprising a Chair, Deputy Chair and eight other members, meets monthly to develop the agenda and direction for the Clinical Senate and to manage the Senate’s operational requirements. The Executive Committee includes the Chief Medical Officer as an ex-officio member.

The Chair and Deputy Chair of the Clinical Senate are nominated by the Executive, and appointed by the Director General.

Figure 1: **Clinical Senate of WA Structure**
4. Office Bearers

4.1 Chair

The Chair is appointed by the DG of Health on recommendation of the Clinical Senate Executive.

The Chair will be appointed for a two-year term. There is an option for the Chair to serve an additional two-year term.

The Chair of the Clinical Senate reports directly to the DG.

The Chair will meet at least quarterly in a face-to-face meeting with the Director General.

The Chair will also attend meetings with the Health Service Board Chairs when requested to discuss the implementation of senate recommendations.

For administration purposes, the Clinical Senate is responsible to the Chief Medical Officer.

The Chair will report back to the Executive and the full Senate at their respective next meeting.

4.2 Deputy Chair

The Deputy Chair must be a member of the Clinical Senate Executive and appointed from within.

The Deputy Chair is appointed by the DG on recommendation of the Clinical Senate Executive.

The Deputy Chair will be appointed for a two-year term. There is an option for the Deputy Chair to serve an additional two-year term.

The Deputy Chair will undertake the Chair’s role in his/her absence. If both Chair and Deputy Chair are absent, the Executive will appoint a temporary Chair from the members of the Executive. The temporary Chair will undertake the full responsibilities of the Chair until the return of the Chair or Deputy Chair.

4.3 Subcommittees and Working Groups

Sub-committees and working groups will be formed by the Clinical Senate as deemed necessary by the Chair and Executive.
5. The Executive Committee

5.1 Role

The Executive Committee is the initial contact for all business of the Clinical Senate. It is responsible for planning the Clinical Senate quarterly meetings and oversees the administration of the Senate. In addition, the Executive Committee:

- ensures regular and timely communication with Senate members and other key stakeholders
- promotes the core values of the Clinical Senate and markets the outcomes from Senate activities
- ensures Clinical Senate deliberations and activities are consistent with the values and vision of the Senate
- identifies potential risk and establishes risk management processes
- debates, develops and establishes operational policy in relation to Senate activity
- represents the Clinical Senate at meetings with key stakeholders
- measures the performance and ensures the administration of the Senate, its Executive, and Secretariat.

5.2 Executive Committee Code of Conduct

In accordance with legal requirements and corporate governance standards, the executive of the Clinical Senate will:

- act honestly, in good faith and in the best interests of the Clinical Senate
- use care and due diligence in fulfilling the functions of Executive Committee Member
- use the powers of office in the best interest of the Senate
- not make improper use of information acquired as a Senate Member
- not take improper advantage of the position of a Senate Member
- not allow personal interests, or the interests of an associated person, to conflict with the interests of the Clinical Senate
- be independent in judgement and actions and to take all reasonable steps to be satisfied as to the soundness of all decisions taken by the Executive Committee
- not allow confidential information to be disclosed without the authorisation of the Clinical Senate
- work together as a team to ensure the success of the Clinical Senate
- disclose/declare potential conflicts of interest.
6. Senate and Executive Committee Meetings

6.1 Clinical Senate

The Clinical Senate meets a minimum of three times a year and the meeting dates and times are advised three months in advance.

**Agenda and Papers**

A formal agenda and relevant background papers (if appropriate) will be prepared for each meeting and be forwarded to Senate members at least two weeks prior to the meeting.

The agenda format and associated background documentation for each meeting is flexible, as it is dependent on the issue to be discussed and the processes required. The Executive, in consultation with the key stakeholders, determines the agenda and processes.

Although there is no formal template to be used, the following items are standing agenda items for each Clinical Senate meeting:

- Welcome
- Apologies
- Chair’s Report
- Director General’s Report on recommendations from the previous debate.
- Debate.

6.2 Executive Committee

The Senate Executive meets on a monthly basis, with meeting dates and times advised at the end of the year for the following year. From time to time, the Executive Committee may elect to change the date and/or time of either the Senate or Executive meetings. This will be advised and agreed by the Senate Executive in advance.

Meetings for rural and remote executive members can be attended by video conferencing.

**Agenda and papers**

The agenda for meetings will be determined by the Chair of the Clinical Senate. A formal agenda will be prepared for each meeting.

The Secretariat shall issue agenda and supporting material at least seven days in advance and prepare minutes from each meeting. The papers will include the agenda, a copy of the previous minutes, work plan and a copy of any significant correspondence, relevant reports and documentation supporting submissions that require decisions.
6.3 Sub-Committees/Working Groups

Working groups of the Clinical Senate will meet as required depending on the issue and need. Similar processes to the Executive Committee meetings, as outlined above, will be followed.

6.4 Minutes of meetings

Minutes will be outcome-oriented and record actions, accountability and deadlines of decisions. The minutes for Executive Committee meetings will be sent to the Executive Committee members within one week of the meeting. The Chair will authorise the minutes as a true representation of the meeting at the following meeting.

Copies of the minutes and outcomes from both the Clinical Senate meeting and the Executive Committee meeting will be circulated in draft form to all members of the Clinical Senate Executive and ratified at the next monthly meeting.

The Secretariat shall keep separate files of the following:

1. agendas and papers circulated for all Clinical Senate related meetings
2. minutes
3. correspondence, papers tabled at meetings and papers circulated other than with agendas.

The files are the property of WA Health and must be preserved in accordance with the State Records Act 2000 and the Freedom of Information Act 1992. The Health Services (Quality Improvement) Act 1994 may also apply to the documents.
7. Membership

7.1 Current membership

The Senate will consist of up to 80 members inclusive of two consumers.

Membership shall be for a three-year duration and will comprise pro rata rural membership Additionally, Emerging Leaders may be nominated for a shorter number of debates.

While Senators are nominated by various bodies, decisions will be made in the best interest of the health system as a whole, rather than sectional or vested interest. Corporate interest of the health system is above sectional interest, with decision-making based largely on a consensus approach.

Membership will be for a three-year term, as follows:

<table>
<thead>
<tr>
<th>No.</th>
<th>Nominating body</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 x</td>
<td>Womens’ and Newborns Health Service – one doctor, one nurse, one allied health (nominated via the Executive Director of the Womens’ and Newborns Health Service)</td>
</tr>
<tr>
<td>3 x</td>
<td>Child and Adolescent Health Service – one doctor, one nurse, one allied health (nominated via the Executive Director of the Paediatric Health Service)</td>
</tr>
<tr>
<td>8 x</td>
<td>South Metropolitan Health Service – two doctors, two nurses, two allied health, two mental health and one Aboriginal health worker/clinician (nominated via the Chief Executive of the South Metropolitan Health Service)</td>
</tr>
<tr>
<td>9 x</td>
<td>North Metropolitan Health Service – two doctors, two nurses, two allied health, two mental health (state tertiary mental health facility ) and one Aboriginal health worker/clinician (nominated via the Chief Executive of the North Metropolitan Health Service)</td>
</tr>
<tr>
<td>8 x</td>
<td>East Metropolitan Health Service – two doctors, two nurses, two allied health, one mental health and one Aboriginal health worker/clinician (nominated via the Chief Executive of the East Metropolitan Health Service)</td>
</tr>
<tr>
<td>15 x</td>
<td>WA Country Health Service – six doctors, four nurses, two allied health, two Aboriginal health, and one mental health (nominated via the Chief Executive WA Country Health Service)</td>
</tr>
<tr>
<td>6 x</td>
<td>Public Health/Ambulatory Care – two doctors, two nurses, one allied health and one Aboriginal health worker/clinician (nominated via the Executive Directors SMHS, NMHS and EMHS)</td>
</tr>
<tr>
<td>No.</td>
<td>Nominating body</td>
</tr>
<tr>
<td>-----</td>
<td>----------------</td>
</tr>
<tr>
<td>3 x</td>
<td>GPs (one x Perth North GPs, one x Perth South GPs and one x Country WA GPs (nominated via the Chair, WA Primary Health Networks)</td>
</tr>
<tr>
<td>1 x</td>
<td>GP (nominated via RACGP)</td>
</tr>
<tr>
<td>3 x</td>
<td>Doctor specialists and one x medical administrator (nominated by RACP, RACS, RANZCOG and RACMA)</td>
</tr>
<tr>
<td>1 x</td>
<td>Mental health practitioner (nominated via the Chief Executive, Mental Health Commission)</td>
</tr>
<tr>
<td>3 x</td>
<td>Emerging Leaders (nominations are made for each quarterly debate from Institute for Health Leadership (one x doctor), Chief Nurse and Midwifery Officer (one x Nurse) and Chief Health Professions Officer (one x Allied Health))</td>
</tr>
<tr>
<td>2 x</td>
<td>Consumers (nominated via the Executive Director of the Health Consumers’ Council)</td>
</tr>
<tr>
<td>3 x</td>
<td>Clinical Leads (nominated via Health Networks)</td>
</tr>
<tr>
<td>7 x</td>
<td>Key State Health Leadership Positions (Chief Medical Officer, Chief Nurse and Midwifery Officer, Chief Health Professions Officer, Chief Psychiatrist, Chief Dental Officer, Chief Pharmacist and Chief Health Officer)</td>
</tr>
<tr>
<td>1 x</td>
<td>Past chair – to serve a one-year term</td>
</tr>
</tbody>
</table>

Senators should be chosen according to their ability to consider issues in the best interest of health services to Western Australia. If additional expertise is required outside of the membership base in order to fully consider the issue under discussion, additional representation from outside the Clinical Senate will be co-opted.

In order to gain nomination as a Senator, each individual (except those attending from the emerging leaders program) should be able to demonstrate they have a wide clinical network.

### 7.2 Alumni

All former senators will be offered to join the Clinical Senate Alumni. This provides them with the opportunity to contribute comments up to 100 words on a debate subject which may contribute to debate.
8. Issues for deliberation

Issues for the Senate to debate may come from many sources. These may include:

- the Minister for Health, via the Director General of Health
- the Director General of Health
- the Chief Health Officer
- the Chief Medical Officer
- the Chief Nurse and Midwifery Officer
- the Chief Health Professions Officer
- Chairs of Health Service Boards
- Clinical Senate members via the Clinical Senate Executive Committee
- independent clinicians or clinician groups.

The Executive will prioritise topics and make a final decision on those to go forward for debate. To make this final choice, the Executive will consider whole-of Health system factors regarding the timing of debates and whether the proposed discussion topic is something where the Senate can add value.

Of note:

- While the Clinical Senate is clinical in its membership, discussion topics should not be restricted to those having a clinical basis.
- The Clinical Senate should not review any individual or organisation's operational role, policy or other issues.
9. Meetings

9.1 Frequency and duration

The full Clinical Senate will meet a minimum of three times per year, or more frequently as required and for the duration as deemed appropriate with the issue under consideration.

9.2 Proxies

Senators are encouraged to nominate a proxy should they be unable to attend a full Senate meeting. The Chair must be advised in advance when a Senator will be sending a proxy on his/her behalf.

9.3 Conduct of meetings

The deliberations of the Senate are expected to be above the consideration of the background discipline of the Senators. The declaration of conflict of interest procedures is outlined in section 13.1 of this document.

9.4 Recommendations

No more than 10 recommendations shall be presented to the Director General from each quarterly meeting.

The Chair and Executive are empowered to determine the ultimate number of recommendations taken forward to the DG. Upon review, recommendations may be merged/strengthened prior to final endorsement as long as the original intent is retained.

9.5 Recommendation process

The Clinical Senate will make recommendations on topics of state-wide interest arising at its quarterly debates. Recommendations will be directed at either the System Manager or the Health Service Provider level.

The Chair of the Clinical Senate will discuss all recommendations with the Director General at a meeting to be held following the debate.

9.5.1 Recommendations at the system manager level

Recommendations directed at the System Manager level will be managed as per Figure 9.5.1. The Director General (DG) will seek additional input from Department of Health staff and will then endorse, endorse in principle or not endorse each recommendation. At the following meeting of the Clinical Senate, the Director General will feedback the decisions to the membership at the next debate.

One year following presentation to the Clinical Senate membership, the Chair will write to the executive sponsor and ask for a report on the implementation of those recommendations that were endorsed or endorsed in principle.
9.5.2 Recommendations at the Health Service Provider (HSP) level

Recommendations directed at the HSP level will be managed as per Figure 9.5.2. The Chair will meet with the DG to ensure there are no barriers from a System Manager perspective to recommendations being forwarded to operational managers and HSP Boards for consideration.

The Chair will then write to each HSP Board to advise them of the recommendations from the Clinical Senate.

HSP Boards will consider recommendations according to their own internal processes.

One year following presentation to the Clinical Senate, the Chair will write to the executive sponsor and ask for a report on the progress of all recommendations.

Clinical Senate Chair provides an annual feedback to the Clinical Senate on HSB endorsement and implementation of recommendation.
9.5.2: Recommendations for Health Service Boards (Operational Managers)

Clinical Senate makes “Recommendations” for Health Service Provider Boards (HSPB) and Chief Executives

Clinical Senate Chair and Executive Sponsor/s meet with the Director General to ensure the System Manager sees no barrier to the recommendations going to Health Service Provider Boards (HSPB) and Chief Executives

Clinical Senate Chair and Executive Sponsor/s will share the Senate recommendations with HSPB Chairs for progression through the HSB internal processes

Clinical Senate Chair asks each HSPB to report on the progress of the recommendations one year from point of notice

Clinical Senate Chair provides an annual feedback to the Clinical Senate on HSB recommendation uptake

9.5.3 Audit of outcomes

The Clinical Senate secretariat will publish an audit of:

- The decisions in relation to recommendations by the Director General and by each HSPB.
- The implementation of endorsed and endorsed in principle recommendations.
10. Decision-making

The deliberations of the Senate are expected to be above the consideration of the background discipline of the Senators.

While Senators may be nominated by various groups, decisions will be made in the best interest of the people of Western Australia.

Decisions will be made, where possible, with the support of evidence presented to all members of the Senate, with debate on an un-representational basis.

Wherever possible, a consensus approach to decision making will be taken. Where consensus is not possible, decisions will be determined by a majority vote.

Decisions can be taken with a quorum of 40 per cent membership at each of the Executive, full Clinical Senate and sub-committee/working group meetings. Senators are encouraged to nominate a proxy who will assume their full voting rights for the say. They should they be unable to attend a full Senate meeting.
11. Resources

11.1 Budget

The budget will be provided and managed by the Office of the Chief Medical Officer.

11.2 Staff

- Secretariat – to oversee administration of the Clinical Senate, coordinate the agenda and maintain principal policy and research role
- Administration/Research Officer – to organise meetings, agendas, minutes and travel for rural members, provide Secretariat support to Clinical Senate members and provide assistance with research and the development of discussion papers on relevant issues.

11.3 Accommodation

The Secretariat and Administration/Research Officer for the Clinical Senate will be located in the Office of the Chief Medical Officer.

11.4 Remuneration/reimbursement of expenses

- Rural members will be reimbursed travel and accommodation expenses (according to standard State Government rates).
- One session per week at industry rates (to be negotiated) is available to reimburse the Chair for their time required beyond Senate sessions and executive meetings.

There is currently no payment for member participation in Clinical Senate or Executive Committee processes. However, as per Department of Health policy, rural members will be reimbursed travel and accommodation expenses (according to standard State Government rates). In addition, the Chair may be paid for up to a total one session per week at industry rates. This is to be negotiated with the Director General and is not available to any Chair who is currently paid as a full-time employee of the Department of Health. Where a Chair is a full-time staff member, consideration of HDA and/or backfill arrangements can be negotiated.
12. Records

The Executive Committee will determine the agenda for the Clinical Senate meetings after referral of matters from the Director General or other sources identified. The Secretariat shall issue agenda and supporting material at least seven days in advance and prepare minutes from each meeting.

The Secretariat shall keep separate files of at least the following:

1. Agendas and papers circulated with them;
2. Correspondence, papers tabled at meetings and papers circulated other than with agendas.

The files are the property of the WA Department of Health and must be preserved in accordance with the State Records Act 2000 and the Freedom of Information Act 1992. The Health Services (Quality Improvement) Act 1994 may also apply to the documents.
13. Conflicts of interest

Conflicts of interest will arise periodically. It is important that these conflicts of interest are handled in an appropriate and transparent manner to protect the interests of both the Clinical Senate and the individuals involved.

A conflict of interest arises in any situation in which a member or related person has an interest which influences, or may appear to influence, the proper performance of the members’ responsibilities to the Clinical Senate. The appearance of a conflict of interest is as important as any actual conflict of interest.

Who is a member? A member is any person who is or has been appointed to membership of the Clinical Senate, a committee or working party or who is or has been engaged to advise or assist the Senate or any working party or committee.

Who is a related person? A related person is the partner or spouse of the member, a member of the member’s family or a close friend of the member.

What is an interest? It is difficult, if not impossible to define exhaustively all situations in which there is an interest that may conflict with the responsibilities of a member. Further, the appearance of a conflict of interest is as important to the Clinical Senate as any actual conflict of interest.

There are generally three types of interest (which in many cases, overlap) and they provide a useful guide for consideration of members. The appearance of any of the following situations will therefore be considered to involve an interest that may conflict with a member’s responsibilities.

Direct pecuniary interest

A direct pecuniary interest arises wherever there is a potential for a member or related person to directly gain or lose financially from the results of Clinical Senate discussions or decision-making processes to which the member contributes.

Indirect pecuniary interest

An indirect pecuniary interest arises from member’s employment or professional interests or from their personal relationships.

Non-pecuniary interest

Actual or potential non-pecuniary interests arise where a member simultaneously has an appointment to, or employment or consultancy or other involvement with, another organisation or body that is in some way involved with the Clinical Senate. The interest may arise if the interests of the Clinical Senate and the other body or organisation are in conflict, or if access to information arising from the Clinical Senate involvement could be used to unfair advantage if divulged to the other organization or body. Such an interest also arises where a member has a relationship, whether professional – as with a colleague in an employment context or a professional association – or personal, with a person who may benefit from a decision of the Clinical Senate to which the member contributes.
13.1 Managing a conflict of interest

A conflict of interest, or the appearance of a conflict, is likely to undermine the credibility of a project, process or decision. Members may find themselves in situations that are not clear-cut where there is a genuine doubt as to whether a conflict of interest exists. Where there is doubt, that is sufficient reason for members to declare their interest. The responsibility to identify and report an interest that is in potential conflict or actual conflict with their responsibilities, or has the appearance of such a conflict, is always that of the member.

Managing conflicts of interest in a vigorous, consistent and transparent fashion is essential.

Committee meetings

Chairs of meetings must provide the opportunity for members to declare an interest in any activity of, or matters being considered by, the Senate, working parties or committees. This should be a standing agenda item for all meetings. At the commencement of each meeting, the Chair should invite members to declare or discuss any relevant matter.

In all cases, the member’s disclosure must be recorded in the minutes of the meeting or if given outside the meeting, be recorded in the minutes of the next Senate meeting after disclosure.

Exclusion

If the Chair of the Clinical Senate has declared an interest, he or she must not be present when the Senate considers the matter, or take part in any decision of the Senate in relation to the matter unless otherwise agreed by the Executive Committee.

If a member of the Clinical Senate has declared an interest, he or she must not be present when the Senate considers the matter, or take part in any decision of the Senate in relation to the matter, unless otherwise agreed by the Chairperson of the Senate or Executive Committee.

If a member of a committee or working party has declared an interest, he or she must not be present when the committee or working party considers the matter, or take part in any decision in relation to the matter, unless otherwise agreed by the Chair of the committee, Chair of the Senate or Executive Committee.

13.2 Responsibility of Secretariat and Chair

Secretariat is to ensure that the Chair and members of the Clinical Senate and of the working parties and sub-committees are made aware of the following operational principles and that verbal/written interests are recorded in the minutes.

- At the beginning of any meeting, members are to be given the opportunity to declare any interests that may be seen to conflict with any matter on the agenda.
- At the beginning of any meeting, members are to be reminded of their responsibilities and obligations in relation to disclosure of confidential information.
- The minutes of the meeting are to record any interest declared and any conflict of interest.
- The minutes are also to record the decision of the Chair in regards to an interest of the Chair, or the decision of the Chair in regards to Senate members, or the decision of the person/committee who has the responsibility under these guidelines to decide the appropriate action to manage the particular situation in regards to any member/person assisting committee with an interest or conflict of interest.
14. Confidentiality

Members may be privy to matters that involve confidential information. It is the responsibility of all members or persons assisting the Clinical Senate not to disclose to any person any confidential information to which they became privy to as a result of the exercise of their responsibilities to the Clinical Senate. Confidential information includes that which:

- is by its nature confidential, and includes information provided to the Clinical Senate to be used only in the exercise of its functions other than functions that will involve public disclosure of the information
- the member/person assisting the Clinical Senate or a committee knows or ought to know is confidential
- is designated by the Clinical Senate as confidential, but does not include information that:
  - is or becomes public knowledge, other than by unlawful means or by breach of confidentiality by the member or person assisting the Senate or committee
  - is in the possession of the member/person assisting the Senate without restriction in relation to disclosure before the date of receipt from the Clinical Senate
  - has been independently developed or acquired by the member/person assisting the Senate.
15. Privacy

The availability of Clinical Senate members’ personal information to people other than Senate members will be limited to:

- name
- official position
- nominating health service/organisation/body.

Members will be made aware and prior consent will be sought if further personal information is to be disclosed publicly. Mailing lists and contact details will not be made available to the Department of Health or other interested parties unless permission is received from the Executive Committee and members advised by the Secretariat.

16. Communication

The following outlines the preferred communication processes for the Clinical Senate, within and external to the membership base:

Appendix 1: Communication Policy – The Executive shall be expected to change the communication process from time to time.

Executive

All written communication is to be by email as a first choice. An email list is to be provided to each member.

Senate members

Email access preferred. Where a member does not have email access or is using email less than once per week then written communications will go by fax. Postage is used only in situations where the documentation is large or the member does not have access to email or a facsimile.

17. Policies

As a committee of the Department of Health, the Clinical Senate abides by all business practices required by the Department of Health. Additional policies relating specifically to the effective and efficient operation of the Clinical Senate will be developed by the Executive Committee and circulated to all members.
18. Member protection

Consistent with the legal nature of the Clinical Senate, members do not have a statutory or legal entitlement to an indemnity when performing their role. However, as the role of the Clinical Senate does not require members or appointees to be of themselves decision-makers, they are not at high risk of exposure to litigation.

It is however, government policy to provide adequate support to persons who become the subject of legal proceedings as a consequence of their carrying out responsibilities of a public nature, provided that the relevant conduct was in good faith and reasonable.

As such, committee members are afforded the same ex gratia coverage in respect of claims and litigation against them as that provided to government employees (more information is available in the “Guidelines relevant to Ministers and Officers involved in Legal Proceedings” tabled in the Legislative Council on 10 July 1990).

19. Performance monitoring

The Executive Committee is responsible for monitoring and reporting the performance of the Clinical Senate to the Director General. The following will be used as indicators of performance:

Process:

- number of full Senate meetings held over a twelve month period
- attendance rate of members at full Senate meetings
- number of Executive meetings held over a twelve-month period
- review and evaluation of Senate meetings – information and processes.
20. Adoption and amendment of Terms of Reference

20.1 Terms of Reference

The Terms of Reference shall be altered only with the approval of the Director General of Health. These Terms of Reference were first adopted by ......................... on ......................... .

The following changes have been made to these terms of reference:

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Nature of change(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>July 2016</td>
<td>Adoption of new TOR following new Health Services legislation (ref new Health Services Act 2016)</td>
</tr>
<tr>
<td>2</td>
<td>July 2017</td>
<td>Adoption of changes to section 9.5.2 Recommendations for Health Service Boards (Operational Managers)</td>
</tr>
</tbody>
</table>
20.2 Historical

Prior to legislative change, the following changes were made to the previous Terms of Reference and Charter. These documents have now been retired.

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Nature of change(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>March 2005</td>
<td>Changes to reporting and delegation titles; some process changes; changes to membership term.</td>
</tr>
<tr>
<td>2</td>
<td>June 2005</td>
<td>Inclusion of Executive Director Health Policy and Clinical Reform /CMO as sponsor for Clinical Senate, and support for Senate being located within the Health Policy and Clinical Reform Division.</td>
</tr>
<tr>
<td>3</td>
<td>June 2006</td>
<td>Increased Membership to 73 with nominating bodies broadened to reflect current changes in health.</td>
</tr>
<tr>
<td>4</td>
<td>March 2008</td>
<td>Added Health Consumers’ Council as nominating body. Two representatives sought.</td>
</tr>
<tr>
<td>6</td>
<td>June 2008</td>
<td>Increase in Membership to 80.</td>
</tr>
<tr>
<td>7</td>
<td>June 2008</td>
<td>Added Office of Aboriginal Health as nominating body. Two representatives sought.</td>
</tr>
<tr>
<td>9</td>
<td>June 2009</td>
<td>Changes to membership reflective of changes across Health.</td>
</tr>
<tr>
<td>10</td>
<td>December 2010</td>
<td>Director General sign off on all recommendations</td>
</tr>
<tr>
<td>11</td>
<td>June 2010</td>
<td>KPI reporting commenced.</td>
</tr>
<tr>
<td>12</td>
<td>June 2011</td>
<td>Membership realignment – Three co-horts</td>
</tr>
<tr>
<td>13</td>
<td>June 2012</td>
<td>Mental Health Commission added to Nominating Body List. Note: 5 additional mental health clinicians called via Area Health Services</td>
</tr>
<tr>
<td>14</td>
<td>June 2012</td>
<td>Realignment Chief Medical Officer to Executive Director System Policy and Planning</td>
</tr>
<tr>
<td>15</td>
<td>June 2013</td>
<td>Change of nominating body from WA GP Network to WA Medicare Locals</td>
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<tr>
<td>16</td>
<td>June 2013</td>
<td>Change of name from Executive Director System Policy and Planning to Executive Director, Strategic System Policy and Planning.</td>
</tr>
<tr>
<td>17</td>
<td>December 2013</td>
<td>Chair fixed terms.</td>
</tr>
<tr>
<td>18</td>
<td>December 2013</td>
<td>Change ex-officio from Executive Director System Policy and Planning to Chief Medical Officer.</td>
</tr>
<tr>
<td>19</td>
<td>May 2015</td>
<td>Changes per DoH restructure.</td>
</tr>
<tr>
<td>20</td>
<td>June 2015</td>
<td>Change to nominating bodies – WA Primary Health Networks replaces Medicare Locals.</td>
</tr>
<tr>
<td>21</td>
<td>June 2016</td>
<td>Terms of Reference and Charter retired</td>
</tr>
</tbody>
</table>
Appendices

Appendix 1: Communication Plan for Information Out

Note: these activities are in addition to the Formal Reporting process

Moderated online discussion or Senate blog

Email to Senators

Email follow up to Senators post DG endorsement

Senate Recommendations

Global notifications

Email to Expert Witnesses

Recommendations, presentations and reports on the website

Encourage Senators to distribute amongst colleagues and networks.

Senators to communicate key messages from the day but not the recommendations until they are formally endorsed.