Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 11 August 2016**

Meeting: **4.00 pm to 6.00 pm**

Venue: **Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Council Members:

Graeme Norton (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Jim Morunga
Nicki Lishman
Jenny Peters
Olive Tanielu
Jim Henry
Malcolm Dixon
Rachel Ritchie
Sarah de la Haye

Apologies:

In attendance:

Kate Coley, Director Quality Improvement & Patient Safety (DQIPS) – on leave
Tracy Fricker, Council Administrator and EA to DQIPS
Jeanette Rendle, Consumer Engagement Manager
Ken Foote, Company Secretary
Nicola Ehau, Manager Innovation & Development for Health HB
Debs Higgins, Clinical Council Representative

HB Health Consumer Council
Agenda

PUBLIC

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	4.00
2.	Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting	
5.	Matters Arising - Review Actions	
6.	Consumer Council Workplan	
7.	Chair's Update (verbal)	
8.	Consumer Engagement Manager's Update (verbal)	
	Section 2 – For Decision	
9.	Complementary Therapies Policy – Dr Andy Phillips	4.30
	Section 3 – Presentation	
10.	Travel Plan Update – Andrea Beattie	4.50
	Section 4 – For Discussion	
11.	Quality Accounts Draft – Jeanette Rendle	5.00
12.	QIPS Annual Plan Draft – Jeanette Rendle	
	Section 5 – Information only (no presenters)	
13.	Te Ara Whakawaiora / Mental Health	-
14.	Te Ara Whakawaiora / Culturally Competent Workforce	-
15.	Annual Maori Plan Q4 (Apr-June 2016) Non-Financial Exceptions 15.1 Annual Maori Plan Q4 Dashboard	-
	Section 6 – General Business	
16.	Topics of Interest - Member Issues / Updates	
17.	Karakia Whakamutunga (Closing)	6.00

NEXT MEETING Thursday 15 September 2016, commencing at 4.00pm
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Interest Register

Hawke's Bay Health Consumer Council

Jul-16

Name Consumer Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Graeme Norton	3R Group Limited	Director/Shareholder	Product Stewardship	No	
	NZ Sustainable Business Council	Deputy Chair	Sustainable Development	No	
	HB Diabetes Leadership Team	Chair	Leadership group working to improve outcomes for people in HB with diabetes	No	Group is sponsored by HBDHB
	NZ Life Cycle Management Centre	Chair, Advisory Group	Advancing life cycle management thinking across NZ	No	
Rosemary Marriott	YMCA of Hawke's Bay	President	Youth Including health issues	No	
	Totara Health	Consumer Advisor	Health and wellbeing	No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Central Hawke's Bay District Council Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport.	Elected Member	Local body	No	Will declare any perceived interests as they arise.
Tessa Robin	Te Kupenga Hauora - Ahuriri	Finance and Quality Manager	Responsible for overseeing QMS for organisation and financial accountability	No	Potential - Employer holds contracts with HBDHB
Leonna Karauria	NZ Maori Internet Society	Chairperson	Advocacy on Maori Communities	No	
	Computers in Homes HB Steering Committee	Member and Regional Co-ordinator	ICT Project Management through schools and communities	No	
	Computers in Homes, Wairoa Steering Committee	Member and Regional Co-ordinator	ICT Project Management through homes and communities	No	
	Maori Party Wairoa Branch	Chairperson	Supporting Policies at a local level	No	
	Simplistic Advanced Solutions Ltd	Shareholder / Director	Information Communications Technology services.	Yes	If contracted for service, there could be a perceived conflict of interest.
	Hastings District Council Digital Enablement Focus Group	Member	Advisory for digital literacy and internet access initiatives for communities	No	
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest.

HB Health Consumer Council 11 August 2016 - Interest Register

Name **Consumer Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Nicki Lishman	Employee of Ministry of Social Development	Regional Health Advisor	Liaising with health community and supporting Work and Income Staff.	Yes	Could be perceived/potential eg., situation where gaps identified regarding funding.
	Registered Social Worker, member of ANZASW	Professional body	Social work	No	
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Jim Morunga	Nil				
Malcolm Dixon	Hastings District Councillor	Elected Councillor		No	
	Sport Hawke's Bay	Board of Trustees	Non paid role	No	
	Scott Foundation	Allocation Committee		No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Rachel Ritchie	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Sarah de la Haye	Nil				

MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL MEETING HELD IN THE TE WAIORA MEETING ROOM, HBDHB CORPORATE OFFICE ON 14 JULY 2016 AT 4.00PM

PUBLIC

Present: Graeme Norton (Chair)
Rosemary Marriott
Heather Robertson
Jenny Peters
Nicki Lishman
Tessa Robin
Jim Morunga
Terry Kingston
Leona Karauria

In Attendance: Ken Foote, Company Secretary
Jeanette Rendle, Consumer Engagement Manager
Tracy Fricker, PA to Director QIPS and Consumer Council Secretary

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

The Chair welcomed everyone to the meeting.

2. APOLOGIES

Apologies received from Rachel Ritchie, Sarah de la Haye, Olive Tanielu and Malcolm Dixon. James Henry advised by text message that he was having vehicle trouble and did not make the meeting.

3. INTERESTS REGISTER

No new interests registered. No conflicts of interest for items on today's agenda.

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held 9 June 2016 were confirmed as a correct record of the meeting.

Moved and carried.

5. MATTERS ARISING AND ACTIONS

Item 1: ***Refine Consumer Portfolios 2016/17*** – This will be deferred until the Transform and Sustain refresh is completed. Tim Evans will present at today's meeting on the six priorities. The Clinical Council signed off on its committee structure and patient experience is to be strongly aligned with Consumer Council and will inform the link with Clinical Council. There are 5 key commitees and there will be consumer representation on each of those committees.

Action: Email presentation to Consumer Council members.

6. WORK PLAN

No changes to the work plan.

7. CHAIR'S UPDATE

The Chair advised that there is to be an inaugural meeting of the National Collective of Consumer Councils at the end of September in Auckland, 10 DHBs are involved so far. Some have councils are already set up, others are just starting on the journey. The meeting is being sponsored by the Health Quality Safety Commission (HQSC). This will be the first formal meeting leading to a national association of consumer councils. How we work collaboratively from now on and sharing of information.

8. CONSUMER ENGAGEMENT MANAGER'S UPDATE

Jeanette Rendle, Consumer Engagement Manager provided an update on activities she has been involved with over the last month.

Quality Accounts

Work has commenced. The first draft will come to Consumer Council for feedback next month.

Recruitment

Three applications for the youth council member position received. Concern they will only be available for a short time, then off to university. Jeanette has talked to Nicky Skerman, they are going to be having a number of youth forums in the community where youth issues are talked about and feedback into the DHB. Representatives from those groups could be interested in coming to the Consumer Council. We may need to try some different approaches.

It is important to incentivise youth. Suggestion that instead of a meeting fee that funds for training are available instead. Discussion about the ability to cross-credit experience from being part of the Consumer Council and it also being recognised by NZQA.

If the youth voice is varied / chaotic we might need to assign one council member to connect and make sure the voice is coming how ever it comes.

Jeanette advised that the Women and Children Consumer Council member position closes tomorrow. There has been no applications received so far. It has gone through multiple channels. *(Note: A promising applicant came forward the day after our meeting and is being interviewed.)*

Text to Remind Workshop – this was held a couple of weeks ago.

Patient Experience in Day Surgery – survey starts next week.

SECTION 2: PRESENTATION

9. TRANSFORM AND SUSTAIN REFRESH

The Chair welcomed Tim Evans, General Manager Planning, Informatics and Finance (GM PI&F) and Kate Rawstron, Project Manager to talk about the transform and sustain refresh.

The GM P&FI advised that a paper will be presented to the Board in July which looks at the transform and sustain process over the last 2.5 years. We need to keep the programme dynamic for the next two years without changing the whole framework. There will be a time to do a new

strategy but we are not there yet. We are in the middle of transform and sustains five year programme and we need to ensure we keep it invigorated, live and keep delivering good stuff.

The programme and strategy has been reviewed and the 24 statements assessed and scored on whether they had progressed or not. Meetings were held with EMT, Health Services Leadership Team, Project and Change Managers and the Health Sector Leadership Forum and this enriched our understanding

Six priorities where identified that we need to do better:

1. Person and Whānau Centred Care
2. Heath and Social Care Networks
3. Whole of Public Sector Delivery
4. Information System Connectivity
5. Financial Flows and Models
6. Investing in Staff and Changing Culture

Questions and Feedback

- Is this just the government sector or NGOs as well? We have to start with the government sector because it is closer, then we need to move it out. When we talk about working with others we start with the public sector, publically funded but we also need to think about charitable organisations and voluntary organisations.

- You need to look at all of the priorities together, not separately. We are already doing this in the Whānau Ora Forum. Don't try and reinvent the wheel when there is already a wheel rolling out there. The GM PI&F commented that he unbundles problems and recognises the complexities in interdependent relationships because that is the way to get things done. He has often seen people add everything together and not been able to move because it's too big and complex. How do we go about putting everything together and move forward? Advised to talk to the people who already have got something in place; the organisations that have got the systems in place and are now starting to branch out. The GM P&F commented that these conversations have already started in the Leadership Forum and they recognise that everything is connected and problems need to be addressed from lots of different angles. If you want to step forward, you need to look at a lot of steps adding up, different approaches of doing things and understand that we are all moving in the same direction.

- One of the first steps you need to take is to look at the DHB and the silos it's currently operating in and how to work together. Recommendation would be to talk to Claire Naumann at Counties-Manukau DHB about her "onions and balls theory", what they have done to breakdown their silos and how they are now working together with the community and other organisations so the focus is on the person and the whanau. Need to get it right in-house before trying to fix everyone else.

- Systems are already set up to enable collaboration and aligning in the services. We don't want to be micro-managing.

- Do we know how many people are using Manage My Health? The GM PI&F advised he is not aware, but the PHO may know. Manage My Health has been a patient portal, we would like to develop a clinical portal, so not only can you as a patient access your record, we can have in the practice district nursing and other health professionals being able to enter into the record, under appropriate controls. We can use IT to help foster that. It's all about how we access and share information as health professionals and with the patient.

- In financial flows and models, this is the way we charge for or fund services has a huge impact on behaviours and we can do things to change that. At the moment we are looking at the under 18 co-payments in primary care *(i.e. under 18's free healthcare)*. That will be a significant change on how people use primary care.

- The last item investing in staff and change in culture, if we as a sector are going to meet these challenges we need to develop ourselves and our staff. There will some work in the organisational development programme.

- This should not just be government agencies if we are looking at person and whanau centred care we are looking at everybody and representatives from the community who are already doing it.

- If you come up to a road block you tip it on its head and ask the person what they want and start from there, rather than trying to drop it onto them, you will then get the right answer.

- Providing a service is one aspect. Over the last few years we have had a number of our communities who were serviced from a centralised point and the service diminished in the communities, the lack of quality care or any care within those communities because for a set time they come back into the central point. How can you manage something over a period of time to empower them to put the service back into the community instead of controlling it from one central point. It does not work in all our communities.

- We also need to look at the language used in documents. The system needs to get itself health literate.

The Chair summarised the discussion by saying that it is not about having a whole suite of projects but having a joined up approach. Also, others are ahead of us in this process and that we should learn from them.

The GM PI&F advised that an update on the Transform and Sustain programme will be provided each quarter.

SECTION 3: FOR DISCUSSION

10. REDUCING ALCOHOL RELATED HARM

The Chair welcomed Dr Rachel Eyre, Medical Officer of Health to the meeting. The alcohol harm video was played. The video was developed for decision makers.

Dr Eyre introduced her colleague Dr Nicholas Jones, Public Health Specialist. When this was last discussed at the Consumer Council in February she opened this up as a co-design opportunity. The Chair and lead on alcohol Nicki) have been in the loop as the draft discussion paper was developed. The proposal is to get a draft position statement signalling what our intent is as a DHB moving forward, and to get a final position statement signed off by the Board in October. She would like feedback based on the discussion paper what do you think about the position statement and what do you think is critical in the process of developing future actions?

Feedback:

- It is a very difficult question because it is an industry that has widespread acceptance, it is widely available in the community and in homes and employs tens of thousands of people. Organisations do need to make a stand. Like we have had businesses that have gone Smokefree. The DHB needs to start with themselves being alcohol free e.g. no alcohol at the Health Awards.

- If you want any agreement or buy-in you have to work with the people. Expecting an 18 year old not to drink is not going to happen. It is silly to position yourself in a place that is never going to happen. Work with the 18-25 year olds about the consequences and brain development etc. It is important to have a position that is understanding of the social norms. It will take a generation to make the change.

- Good video. Would have liked to have seen more included around family, children only shown at a distance. It was more about the impact and information, the hospital and professional workers. It would have had more punch and resonated if it included impact on the family. Smoking as an example took decades if we think where we have come from, you could smoke everywhere, it was a social norm. The same pathway can happen with alcohol.

- There is not a lot of information about fetal alcohol syndrome and the link of cancer to alcohol.

- Get the ones you are targetting to help develop the plan, ask them what worked for them.

- We need to ask why are people doing these things? Alcohol can't be looked at on its own you need to look at the reasons why e.g. depression, no job, family issues etc all those other things that cause people to drink.

- The DHB should be looking at outcomes on the effect of activities/projects. A specialist risk manager has the skill and knowledge to look deeper, the reason why people are drinking in the first place.

- We need to show more visibly people having fun without the need of alcohol.

- The Health Awards this year should be alcohol free.

- As a Medical Officer of Health Rachel enquires on all special licence applications. Have tried to oppose some applications from schools but has not been successful. There is resistance in the community.

- It is a society problem. We can lead by example and get people starting the dialogue.

- Good first step. There is opportunity to look at community led interventions. What primary health can do as well, what are harmful effects of drink and what can be done to reduce the harm. Fetal alcohol disorder is an area that is under resourced. This DHB has run FASD information days for the last couple of years in the education centre and they are packed, people from community agencies including Ministry of Social Development staff from Gisborne so they can pass the messages on. There is a ground swell for change and raising awareness of intervention. It's about everyone having the conversations.

We need to accept that it is a societal problem. What we can do is lead by example and as a health board is make statements about the impact of harmful drinking and what it does and try to get people thinking. We won't be able to change behaviours overnight but if we do nothing we are condoning it.

Feedback from the Maori Relationship Board (MRD) they would like to see an Iwi lead strategy from a Maori community perspective so they will take ownership of the actions.

The Consumer Council endorsed the proposal for HBDHB to develop a position statement on reducing alcohol related harm.

SECTION 4: FOR ENDORSEMENT

11. HEALTH & SOCIAL CARE NETWORKS

The Chair welcomed Belinda Sleight (Project Manager) to the meeting to provide an update on the programme.

The purpose and principles paper has been simplified to a two page document. Feedback received was having a clear vision for the networks, including examples how consumers would know how we are changing things and having overarching design principles across all the networks that are developed, which can be tailored to the communities.

The second paper is the geographic localities proposal. We are now proposing four networks based on territorial authority boundaries, two small networks of Wairoa and Central Hawke's and two larger ones for Napier and Hastings of around 60-70,000 people. The boundaries are based on where the services are, and consumers will still be able to choose where they go. MRB advised they would like to have smaller communities of interest e.g. Flaxmere focusing on particular issues for that community.

Feedback on the business case from EMT and Clinical Council was to focus on Wairoa and Central Hawke's Bay communities first, learning from them before moving to the bigger areas of Napier and Hastings.

Questions / Feedback:

- Where we came from this is huge progress and the Wairoa model has been very encouraging. Issue that primary care's perception / disengagement of community issues is something that will need addressing.

- Central Hawke's Bay are happy with the progress and there is ground swell down there.

- Good session with MRB yesterday and the leadership from Wairoa. The health needs assessment report was a step toward enabling them to take ownership, and to drive how the health and social network will look like in Wairoa. It is important to hand it over to the community to drive, let them decide what their needs are and how it is best delivered.

- Are there any indicators to measure the impact? Are there some population based figures you want to see change? It is a piece of work that has just started, looking at system level measures. The MoH is tracking measures across the system not just primary or secondary care. The Wairoa community will also have measures they will want tracked. So there are a number of measures that the DHB, Health Hawke's Bay and the community will want to see reported on.

- It is important to go through the process we are currently going through with Wairoa and Central Hawke's Bay.

- We had a conversation earlier around transform and sustain. The message we gave very clearly was the need to look at the whole and not the parts and that they are all fundamentally interrelated. Whole of public sector delivery is fundamentally sitting inside a health and social care network and if it is person and whanau centred it has a better chance of working. Getting the communities to own what their outcomes need to be.

- A lot of work done on social values and the social return on investment. The key area in that is health. It all comes back to health/wellness. It's about collaboration of services whether its government or non-government, whanau etc it's the impact those people can make as well.

- The focus behind transform and sustain is bring everything back as a whole. That is the intent, things are not being done in silos. There is full integration taking place.

- Experience of the way we work in projects at this DHB is they are siloed, with steering groups who do not talk with each other. The Consumer Council is trying to get the message across that 25 projects is not necessarily the way to go.

- It is important that we are challenging the process and not individuals and be respectful of people.

- As a DHB it is difficult there are some things that we don't have any control over.

- There was a model that was in place which was broken down and Maori are now re-building the model of Whānau Ora. It is a perfect model/framework which can be used to bring all of those other sectors together.

- What are the triggers? Why are you not sharing information and for what reason? Is it an interpersonal relationship issue? It is easy to align with other services to get the information, but how good is that pathway to share information.

- Everyone knows where we all want to be regardless of what our cultural backgrounds are. What can work for one can work for another. It's about sharing and everybody taking responsibility.

SECTION 5: INFORMATION ONLY

12. LAST DAYS OF LIFE

The Chair advised that the paper was included for information only.

SECTION 6: GENERAL

13. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- ***Rosemary Marriott*** - received a reminder email received for the HB Health Awards. It advised that the categories had been altered into primary care and secondary care categories. There is so much working going on that crosses over and she wondered why this had been done. Rosemary sent an email back to Chris Lord asking what was the rationale behind this change and was advised that this was what everyone wanted.

  Question: Why when we have a transform and sustain agenda to integrate across the health sector are we separating the health awards into primary and secondary?

- ***Jeanette Rendle*** - The DHB corporate website has been refreshed. There has been some feedback to us about how easy/difficult it is to give feedback (compliments/complaints etc). If Consumer Council members could look at the website from home and see how easy/difficult it is to give feedback on the Our Health and the DHB website we would appreciate the feedback. Jeanette will email the website links.

- ***Lenora Karauria*** – positive feedback about the DHB Facebook page, notifications popping up are great.

- ***Terry Kingston*** – has recently spent time in the Emergency Department and has nothing but praise for the ED staff. He was talking to one of the young doctors who was not aware of positive feedback received for the department. Jeanette advised that copies of all compliments received do get sent to the Service Manager to share with their staff. Some services are better than others at filtering them down to staff. We are currently looking at other ways to get compliments shared with staff.

- General discussion about the Transform and Sustain presentation.

14. KARAKIA WHAKAMUTUNGA (CLOSING)

Meeting closed: 6.10 pm

Confirmed: _____
Chair

Date: _____

5

HAWKE'S BAY HEALTH CONSUMER COUNCIL

Matters Arising
Reviews of Actions

Action	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	10/03/16	***Refine Consumer Portfolios 2016/17*** This has been deferred until after Transform and Sustain Refresh June/July			Ongoing
2	14/07/16	***Transform and Sustain Refresh*** Send copy of Tim Evans' presentation to Consumer Council Members with minutes.	T Fricker	July	Actioned
3	14/07/16	***Member Issues / Updates*** Question re: Health Awards categories being separated into primary and secondary. Form provided for service response	T Fricker	Aug	Actioned

OURHEALTH HAWKE'S BAY Whakawateatia

HB HEALTH CONSUMER COUNCIL WORKPLAN 2016-2017

6

Meetings 2016	Papers and Topics	Lead(s)
15 Sep	Orthopaedic Review – closure phase 1 Draft – Family Violence – Strategy Effectiveness for noting Draft – Reducing Alcohol-Related Harm Draft - Developing a Person Whanau Centred Culture Final – Quality Accounts (co-ord with Annual Report) Draft – HB Integrated Palliative Care Health and Social Care Networks Update Event / Complaint / Hazard / Risk Management System ***Monitoring*** Te Ara Whakawaiora / Obesity (national indicator)	Andy Phillips Caroline McElnay Caroline McElnay Kate Coley Kate Coley Mary Wills Liz Stockley Kate Coley Shari Tidswell
13 Oct	Final – Reducing Alcohol-Related Harm Draft – New Patient Safety and Experience Dashboard (reporting sequence to follow)	Caroline McElnay Kate Coley
10 Nov	Travel Plan – verbal Final - Developing a Person Whanau Centred Culture Tobacco – Annual Update against the Plan (for noting)** Final - HB Integrated Palliative Care Long Term Conditons (information only) ***Monitoring*** Te Ara Whakawaiora / Smoking (national indicator) ** Annual Maori Plan Q1	Sharon Mason / Andrea Kate Coley Caroline McElnay Mary Wills Leigh White / Jill Garret Tracee TeHuia
8 Dec	Discussion - HB Workforce Plan Health and Social Care Networks Update Draft - Orthopaedic Review – Phase 2	John McKeefry Liz Stockley Andy Phillips

OURHEALTH
HAWKE'S BAY
Whakawateatia

CHAIR'S UPDATE

Verbal

8

CONSUMER ENGAGEMENT MANAGER'S UPDATE

Verbal

COMPLEMENTARY THERAPIES POLICY

Dr Andy Phillips

HAWKE'S BAY DISTRICT HEALTH BOARD	Manual:	Clinical Practice Guidelines
	Doc No:	HBDHB/CPG/xxx
Complementary Therapies Policy	Date Issued:	July 2016
	Date Reviewed:	
	Approved:	Clinical Council
	Signature:	Andy Phillips, CAHPO
	Page:	1 of 17

PURPOSE

- To ensure that complementary therapies are practiced safely on DHB premises
- To ensure that patients and Whanau access complementary therapies in an informed and appropriate way.
- To provide a robust framework to support practitioners to provide complementary therapies safely and appropriately.

PRINCIPLES

1. The policy applies to all complementary therapists practicing on Hawkes Bay DHB premises and to all patients receiving complementary therapies within Hawkes Bay DHB premises.

2. All complementary therapists are bound by the Health and Disability Act and Code (2014)

3. The therapist must have written evidence of a qualification in their area of practice recognised by the sector regulator - or the relevant professional association

4. The Manager /deputy of the Hawkes Bay DHB premises will be responsible for ensuring therapists are current members of their relevant professional body and have up to date personal liability insurance.

5. Hawkes Bay DHB will maintain a register of Complementary Therapy practitioners who meet the agreed criteria to practice on Hawkes Bay DHB premises.

6. All therapists must have the necessary knowledge or skills to treat individuals.

7. Individual therapists are responsible for - ensuring confidentiality of client information; maintaining adequate up to date indemnity insurance; ensuring a current knowledge base of treatments and their own area of therapy.

8. Documentation of consent **must** be recorded by the practitioners in the client's records and stored in accordance with Information Governance requirements.

9. Written information on the complementary therapies must be provided to clients to help inform their decision.

10. Consumers have the right to access any complementary therapists they wish.

11. Hawkes Bay DHB does not accept any liability for any patient harm occurring to consumers accessing complementary therapies that are not provided by a Hawkes Bay DHB employee.

INTRODUCTION

Hawkes Bay DHB recognises that there is increasing interest in the practice of complementary therapies in health care. The purpose of these guidelines and protocols for specific therapies is not to limit either practice or patient choice, but to ensure professional standards and high quality service. They also define the safe parameters within each complementary therapy will be practised.

These guidelines offer areas of good practice when a consumer decides to contract with a non-DHB employee for complementary therapy services.

In developing these guidelines the DHB is not making any claims on the validity or evidence base of these procedures. It is the responsibility of each individual practitioner to ensure they discuss fully with the service user the evidence base of the proposed treatment and any potential risks.

The DHB is not yet persuaded that the evidence base of these therapies is sufficiently strong to support the use of public funding to support these therapies.

In accordance with the above guidelines the complementary therapy:

- Must work alongside existing medical treatment without compromising existing care.
- Must be based on current evidence and best practice.
- Must be based on consultation, planning, education and demonstrable competence.
- Must comply with local policies.

The main purpose in the use of these therapies is to help:

- Promote relaxation.
- Reduce anxiety.
- Ease symptoms such as pain, nausea, poor sleep patterns.
- Help the patient find coping mechanisms and strategies.

SCOPE

This policy covers the following complementary therapies:

- Massage
- Aromatherapy
- Reflexology
- Indian head massage
- Hand & Foot Massage
- Relaxation
- Reiki
- Yoga
- Hypnotherapy
- Meditation
- Mindfulness

DEFINITIONS

Complementary and Alternative Medicines (CAM)

CAM is an 'umbrella' term used to describe a range of health systems, modalities and practices that may have little in common other than that they are practised alongside or as an alternative to mainstream medicine. There may however be similarities in philosophy and approach – for example, the need to take a holistic approach to health care, including the interactions between physical, spiritual, social and psychological aspects.

CAMs are considered to be any non-medically prescribed substances that a person uses with the belief that they will improve health or wellbeing. The term includes but is not limited to:

- Herbal medicines; herbalism
- Nutritional therapy (vitamins and minerals)
- Health food supplements (e.g. royal jelly)
- Colloids / cell salts
- Chinese medicine
- Rongoa Māori

The use of Complementary and Alternative Medicines is covered by a separate policy: HBDHB/IVTG/144.

Complementary therapies

Complementary therapies are used alongside orthodox treatments with the aim of providing psychological and emotional support through the relief of symptoms'

NICE Supportive and Palliative Care Improving Outcomes Guidance (2004)

The following therapies may be practiced:

Massage – Massage therapy is a system of treatment of the soft tissue of the body. It involves stroking, kneading or applying pressure to various parts of the body, with the aim of alleviating aches, pains and musculoskeletal problems.

Aromatherapy – is the use of pure essential oils generally applied in the form of massage, but can also be used in special aromatherapy diffusers. Their main use in this situation is to calm and relax the individual, but they can also ease some of the side effects of the cancer treatment. Blends, usually of three different oils are chosen in conjunction with the client, which take account of their preferences and medical history.

Reflexology - Reflexology is based on the principle that certain points on the feet and hands, called reflex points, correspond to various parts of the body and that by applying pressure to these points in a systematic way, a practitioner can help to release tensions and encourage the body's natural healing processes.

Indian Head Massage - has been practiced for over a thousand years, easing tension and promoting a sense of relaxation and wellbeing. Other parts of the body may respond to this relaxed state. A head massage takes 30-40 minutes and covers the upper back, shoulders, neck, face, scalp, arms and hands.

Hand and Foot Massage - see massage

Relaxation – is offered to individuals, or small groups; to help cope with treatments and to promote a feeling of relaxation and general wellbeing.

Reiki - Reiki (pronounced ray-key) is a simple energy balancing technique developed in Japan in the early 1900's. Reiki can produce a feeling of deep relaxation, a boost in energy levels and a reduction in tension and anxiety. During a treatment a reiki practitioner lays their hands on a recipient in a series of positions over head, torso and legs, gently drawing energy through the practitioner to the recipient helping to produce a state of balance.

There are different levels of reiki practitioners; level one is for people who have learnt reiki to treat themselves, or use informally with friends; level two is practitioner level, to give reiki treatments to patients; level 3 is reiki master or teacher. Practitioners should have attained level 2 as the minimum to practice in the centre.

Yoga – is an ancient tradition of mental and physical exercises, which started in India over 5,000 years ago and is now widely practiced in the UK. There are many different styles of yoga. It includes physical exercises, breathing techniques and relaxation.

Hypnotherapy - Hypnosis describes an interaction between a therapist and client. The therapist attempts to influence perceptions, feelings, thinking and behaviour by asking the client to concentrate on ideas and images that may evoke the intended effect. Hypnotherapy can help reduce stress and anxiety, improve quality of sleep and help prepare for investigations and treatments.

Meditation - is a practice where an individual trains the mind or induces a mode of consciousness, either to realize some benefit or for the mind to simply acknowledge its content without becoming identified with that content or as an end in itself. The term *meditation* refers to a broad variety of practices that includes techniques designed to promote relaxation, build internal energy or life force (*qi*, *ki*, *prana*, etc.) and develop compassion, love, patience, generosity, and forgiveness. A particularly ambitious form of meditation aims at effortlessly sustained single-pointed concentration meant to enable its practitioner to enjoy an indestructible sense of well-being while engaging in any life activity.

Mindfulness - is the psychological process of bringing one's attention to the internal and external experiences occurring in the present moment, which can be developed through the practice of meditation and other training. The term "mindfulness" is a translation of the Pali-term sati, which is a significant element of some Buddhist traditions. Large population-based research studies have indicated that the practice of mindfulness is strongly correlated with well-being and perceived health. Studies have also shown that rumination and worry contribute to mental illnesses such as depression and anxiety, and that mindfulness-based interventions are effective in the reduction of both rumination and worry.

ROLES AND RESPONSIBILITIES

Hawkes Bay DHB Management Responsibilities:

The DHB recognises that local management has a responsibility to implement and monitor/audit the use of the Complementary Therapies protocols within their area of management. These responsibilities include:

- Where appropriate, negotiating and agreeing with local therapists the place of a complementary therapy as outlined in the protocols to support normal clinical activities, and ensuring where appropriate this is reflected in a written care plan.

- Final agreement prior to therapies being commenced on DHB premises. The management team will be responsible for the monitoring of any therapies practiced.
- Ensuring that details held on the DHB register are up-to-date and correct. They will also maintain a list of practising complementary therapists.
- Auditing practitioners compliance with this policy

Complementary Therapy Practitioners Responsibilities:

Assessment

- The patient or carer will be assessed by individual therapists at the first visit to ensure the referral is appropriate and any preferred choice of therapy is suitable
- Specific therapies may have contraindications relevant to them – these are covered in treatment guidelines (appendix i).
- Any concerns about contraindications including those arising from conventional treatment must be discussed with a Hawkes Bay DHB health professional closely involved in the patients care

Safe Practice

- The practitioner should provide written evidence of a qualification in their area of practice recognised by the sector regulator - or the relevant professional association
- Therapists will be required to practice using guidelines based on the current evidence of best practice. Any concerns that arise during treatment should be referred to the appropriate Hawkes Bay DHB health profession.
- All therapists will be required to have indemnity insurance and be a member of an appropriate professional body.
- Any essential oils used are required to be genuine, pure essential oils, of therapeutic origin and preferable of organic origin. No perfume or oils of chemical mix or origin are to be used. Carrier oils are to be cold pressed and unrefined, preferably of organic origin.

  Any complementary therapist using products and oils on patients must ensure that they have the up to date information as to whether the patients' condition would be harmed or worsened as a result of their use. (For example this could be in the form of contra indicators to patients and their disease. There are many information sources available to obtain this advice.)

  Each patient must have an individual blend made for them, and the strength is to be in accordance with national guidelines.

Consent:

- Complementary therapy practitioners must obtain appropriate consent.
- Consent for the therapy must be obtained before the complementary therapy practitioner carries out the complementary therapy.
- Documentation of consent must be recorded in the client's records and stored safely in accordance with Information Governance requirements.
- Written information on the complementary therapies must be provided to clients to help inform their decision.

Written Information:

Written information must be provided including the following:

- A description of the therapy and what that entails for the patient.

- A statement to the effect that the therapy is not an alternative to conventional therapies.
- A statement explaining that all therapists have completed relevant qualifications appropriate to their practice.

Record keeping:

Therapists will keep all records of treatments/interventions provided and these will be kept in secured storage according to information governance requirements. As part of the records information on age, sex, ethnicity and address of patient will be documented.

Training Requirements:

All professionals who wish to practice complementary therapies must hold a qualification in their area of practice recognised by the sector regulator - or the relevant professional association.

They must also:

- Be able to show how they keep themselves updated.
- Be able to demonstrate they have personal liability insurance that would cover them for practice within the DHB Premises.
- Understand and acknowledge the boundaries they have with accountability for their own practice.
- Adhere to these guidelines.

REFERENCES

1. Health and Disability Act and Code (2014)
2. NICE Supportive and Palliative Care Improving Outcomes Guidance (2004)
3. Ministerial Advisory Committee on Complementary and Alternative Health. 2004. Complementary and Alternative Health Care in New Zealand: Advice to the Minister of Health. Wellington: Ministry of Health. http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/C64721A66307CAD4CC256EF200701547/$file/Complementary%20and%20alternative%20health%20care%20in%20New%20Zealand%20-%20advise%20to%20the%20Minister%20of%20Health.pdf
4. Wong A and Townley SA. Herbal medicines and anaesthesia. Continuing Education in Anaesthesia, Critical Care & Pain, 2011; 11(1): 14-17.
5. Medical Council of New Zealand. Statement on complementary and alternative medicine. March 2011. http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Complementary-and-alternative-medicine.pdf
6. bpacnz. Upfront: Traditional healing and mental health: measuring the effectiveness of rongoa. www.bpac.org.nz/magazine/2010/june/upfront.asp [Information on rongoa].
7. Ministry of Health. 2014. Tikanga ā-Rongoā. Wellington: Ministry of Health

RELATED DOCUMENTS

Hawke's Bay DHB Complementary and Alternative Medicines Policy.

KEYWORDS

Complementary Therapy
Massage

Aromatherapy
Reflexology
Indian head massage
Hand & Foot Massage
Relaxation
Reiki
Yoga
Hypnotherapy
Meditation
Mindfulness

For further information please contact
Dr Andy Phillips, Chief Allied Health Professions Officer

Appendix 1

TREATMENT GUIDELINES FOR COMPLEMENTARY THERAPIES

1.0 AROMATHERAPY

Topical application with appropriate massage will be the normal method of treatment,

Essential oils are required to be genuine, pure essential oils, of therapeutic quality and preferably of organic origin. No perfume oils or oils of chemical mix or origin are to be used.

Carrier oils are to be cold pressed and unrefined, preferably of organic origin. Use 0.5-1% dilution of essential oils maximum.

Each patient must have an individual blend made for them, and the strength is to be in accordance with professional guidelines.

1.1 Special Precautions for patients undergoing/just completed radiotherapy

- Be aware of appropriate oil choice. Use gentle oils following radiotherapy as skin remains vulnerable. Citrus oils are not recommended.
- Avoid entry and exit site of radiation beam for six weeks or until skin is healed.
- Be aware of possible side effects of radiotherapy such as fatigue, soreness of skin, digestive disturbance.

1.2 Special precautions for patients undergoing chemotherapy

- Be aware of the side effects of chemotherapy such as fatigue, lowered immune function, increased risk of infection and bruising, dry or peeling skin, digestive disturbance, nausea, altered smell preferences, hair loss and skin sensitivity.
- Consider using plain carrier oil and choose oils appropriately.

1.3 Permitted Essential Oils

- There is no definitive list available of oils that are suitable for use with condition specific patient groups, and opinion differs amongst aromatherapists themselves on this issue. It is the aromatherapist's responsibility to assess each client for contraindication before choosing appropriate oil.

Please note the following contra-indications for using some of the above oils.

In brain tumours avoid the use of Rosemary.

In the case of hypersensitive or damaged skin avoid the use of: Eucalyptus (all varieties), and citrus oils.

2.0 MASSAGE

Generally, gentle, non-invasive massage techniques should be employed so as not to over-stimulate the patient's system. Kneading, pummeling and deep massage are not recommended.

2.1 Clinical checklist/contraindications

a) **Body Temperature**
Do not treat patients with a high temperature

b) **Fluid Retention/Swelling/Lymphoedema**
Avoid the area. Never massage a swollen limb/trunk

c) **Undiagnosed Lumps or Areas of Inflammation**
AVOID THE AREA – report this finding.
Very hot areas can indicate an infection, inflammation or intense cellular activity. Therapists should check with DHB staff first to establish appropriateness of treatment.

d) **Skin Problems/Rashes**
These could be circulatory problems or reaction to medication/diet. AVOID THE AREA OF ANY RASHES. Report this finding.

e) **Pinprick Bruising**
These are indicators of a very low blood count. Check with nursing staff or medical staff before treating.
Massage very gently with careful light strokes. It may be suitable to massage hands and feet only in order to avoid affected areas.

f) **Radiotherapy**
Radiotherapy treatment entry and exit sites should be avoided for up to six weeks following treatment or while skin still sore.
Use very gentle strokes following radiotherapy as the skin remains vulnerable to damage.

g) **Stoma Sites, Cannulas, Dressings and Catheters**
AVOID THESE. Massage elsewhere, i.e.: hands and feet.

h) **Scar Tissue/Broken Skin/Lesions/Recent operation sites or wounds**
Avoid areas of recent scar tissue/broken skin or lesions.

i) **Tumor Site**
Do not massage over the tumour site, near the tumour site or adjacent or affected lymph glands.

j) **Deep Vein Thrombosis (DVT)**
Do not massage feet or legs if the patient has a diagnosed or suspected deep vein thrombosis in the legs, or arm/hand if a thrombosis is suspected in the arm.

k) **Areas of Infection**
Avoid all areas of external infection. Employ appropriate infection control techniques

l) **Injury and Bone Metastases (secondaries)**
Avoid areas of injury or bone metastases.

m) **Areas of Infection**
Avoid all areas of external infection. Employ appropriate infection control techniques

n) **Injury and Bone Metastases (secondaries)**
Avoid areas of injury or bone metastases.

o) **Phlebitis (hot/inflamed veins)**
Avoid areas of phlebitis. Work above the area affected.

p) **Hot or inflamed Joints**
Avoid hot or inflamed joints, except to apply cooling oils where appropriate.

q) **Angina, Hypertension, Hypotension**
Exercise caution with patients with these conditions, using gentle massage strokes and appropriate oils.

r) **Jaundice**
Exercise caution with patients with these conditions. Check with the nursing or medical staff before proceeding.

s) **Low platelet counts**
This will contra-indicate the use of massage using pressure techniques as there is a greater likelihood of bruising.

3. 0 REFLEXOLOGY

- Avoid a limb or foot with suspected deep vein thrombosis and avoid varicose veins.
- Be aware of any tender areas on the foot or hand that relate to new surgical wounds.
- Avoid limbs affected by lymphedema and cellulitis
- Avoid areas corresponding to colonic stimulation if there are any symptoms or risk of intestinal obstruction due to causes other than constipation.
- Adjust pressure for patients with a low platelet count, taking note of any existing bruising and skin viability.
- Be aware that peripheral sensation may be affected by a person's psychological state, or medication, such as steroids, opioids or chemotherapy.
- Be aware that peripheral neuropathy may be a symptom of diseases such as multiple sclerosis, certain tumours and a side effect of chemotherapy.

General Precautions:

- Palpate gently and sensitively over the reflexes relating to tumour site(s).
- Assess the condition of the reflexes and adapt treatment accordingly so that the feet are not over stimulated in any way, especially in patients with altered peripheral sensation or peripheral neuropathy.
- Establish a working pressure that is comfortable for the patient at all times, and tailor treatment to avoid strong reactions.
- Use grape seed oil if the skin is very dry.

4.0 ACUPUNCTURE

The following contra indications, precautions, risks and benefits should be managed by the therapist as part of the assessment, patient education and documentation processes.

Where precautions are highlighted the therapist will inform the patient of the potential risks and the patient will decide whether to proceed or not with the treatment.

CONTRAINDICATIONS	PRECAUTIONS
Uncontrolled epilepsy Inability to cooperate Needle phobia Oedema at needle site Infection at needle site Metal Allergy Haemophilia Unstable angina or cardiac arrhythmias Under 16 years of age	Fatigued or hungry patients Diabetes Immune-Deficiency e.g. HIV Anticoagulants Pregnancy Controlled epilepsy Poor circulation or damaged skin. Decreased sensation Increased or decreased or labile blood pressure
Confused patient	Controlled cardiac conditions
Unstable Diabetes	
Patient with PE/DVT	
Pacemaker (electro-acupuncture)	

Possible Risks:

- **Bruising**: This can often occur, especially if the patient is on anti-coagulants
- **Sickness**: This can be mild either during or after treatment. If severe the treatment will be stopped. The cause of sickness can be due to the body producing its own analgesic hormones. Further treatments may be continued with fewer needles and for a reduced time.
- **Dizziness/Fainting**: This is very rare, happening usually during the treatment. Stopping the treatment reverses the symptoms and future treatments are commenced with fewer needles over less time.
- **Drowsiness/Fatigue**: The patient may feel sleepy or tired during or after treatment. This should not affect their ability to drive or operate machinery. If this is a problem they may need a few hours rest in the department. The need for further treatments would be reassessed.
- **Increased Pain**: It is not unusual for patients to experience an increase in their pain either during or subsequently after treatment. This can be a positive sign but if levels continue to increase the treatment will be discontinued. A review appointment with the doctor will be given.
- **Pneumothorax:** All treatments to the thoracic area will be given with caution.
- **Allergies/Infections:** Rare occurrences.
- **Broken/bent/stick needle**
- **Allergy to swab.**

Possible Benefits:

- Decrease in the pain
- Decrease in analgesia taken
- Relaxation
- Increased sense of well-being
- Improved sleep
- Increased energy.

9

5.0 HYPNOTHERAPY

Research suggests that hypnosis can be a useful adjunct to other treatments in a number of areas such as:

- Neurotic Disorders
- Addictive behaviours e.g. smoking, drug and alcohol use, eating disorders and cravings
- Reactive depression
- Post-traumatic stress disorder
- Problems with a psychosomatic element e.g. irritable bowel syndrome, psychogenic pain, immune functioning, allergies, infertility
- Psychological issues e.g. self-confidence, self-esteem, ego strengthening, performance anxiety, accelerated learning
- Stress management.

Contra-indications (although in some instances hypnosis may be used under close supervision of a consultant psychiatrist) are:

- Psychotic disorders
- Personality disorders
- Severe clinical depression.

Any work must be in accordance with the patient's care plan.

It is acknowledged that some components of hypnotherapy may be used to complement other therapies and treatments. In such cases practitioners must be able to demonstrate a sound knowledge of the skill being used and have undergone a reputable and recommended training course. They should also be in receipt of regular supervision regarding this skill.

6.0 GENERAL GUIDANCE WHEN GIVING A SESSION

- Therapists must adhere to any guidance on toxicity of substances contra indicated for patients with cancer and other medical conditions advised by their code of professional conduct and professional indemnity insurance.
- Hands must be washed immediately before and after treatments are given, and alcohol gel should be used in accordance with policy.
- When treating patients with MRSA or similar infectious illness, full protective precautions should be used: wear disposable gloves and apron and treat as last patient(s) of the day.
- No jewellery or watches should be worn on hands or lower arms.
- Adherence to a professional dress code should be carefully observed.

- Aprons and gloves should always be worn when working with any immune compromised patient.
- All therapists should establish a working pressure that is comfortable for the patient at all times.
- All therapists are expected to participate in client evaluation.

Appendix 2

HBDHB REGISTER OF COMPLEMENTARY THERAPISTS OFFERING THERAPY AND CONSULTING WITH PATIENTS ON HBDHB PREMISES

9

Name	Qualifications	Therapies Offered	Professional Body	Indemnity Insurance	Review Meeting

Appendix 3

COMPLEMENTARY THERAPIST AGREEMENT TO COMPLY WITH THE POLICY

I have received, read and understood the policy and will adhere to it.

Complementary Therapist: …… Dated: ……

Centre Manager: …… Dated: ……

Appendix 4

CONSENT FORM FOR COMPLEMENTARY THERAPY

Patient Name: ……...

Date of Birth: ……

Leaflet/Literature Provided to the Patient: YES ☐ NO ☐

I sign to confirm that:

1. I have received the information provided by the therapist YES ☐ NO ☐
2. I have understood this information YES ☐ NO ☐
3. I consent to the therapy YES ☐ NO ☐
4. I have an existing medical problem and my GP consents to the therapy YES ☐ NO ☐ N/A ☐

1. Signed: ……..... Date: ……
   (Patient)

   Signed: …….…. Date: …….
   (Complementary Therapist)

   Therapy Offered: ……..

2. Signed: ……..... Date: ……
   (Patient)

   Signed: …….…. Date: …….
   (Complementary Therapist)

   Therapy Offered: ……..

3. Signed: ……..... Date: ……
   (Patient)

   Signed: …….…. Date: …….
   (Complementary Therapist)

   Therapy Offered: ……..

4. Signed: ……..... Date: ……
   (Patient)

   Signed: …….…. Date: …….
   (Complementary Therapist)

   Therapy Offered: ……..

10

TRAVEL PLAN UPDATE

Andrea Beattie

HAWKE'S BAY District Health Board Whakawāteatia	**Draft Quality Accounts**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Consumer Council**
Document Owner: Document Author(s):	Jeanette Rendle, Consumer Engagement Manager Quality Accounts Working Group and Service Directorates
Month:	August 2016
Consideration:	For Discussion

11

RECOMMENDATION

That MRB, Clinical and Consumer Council

1. Note the contents of the Quality Accounts
2. Provide feedback on the contents of the report
3. Provide guidance on the communications plan

INTRODUCTION / PURPOSE

The publication of the annual Quality Accounts was initiated in 2013, following the Health Quality & Safety Commissions (HQSC) guidance publication in July 2012 and the MOH's request that Quality Accounts should be produced annually detailing our performance against both national and local quality and safety indicators. The Quality Accounts are predominantly aimed at our community and therefore the aim is to keep them as short as possible, be visual, easy to read and understand; using photo's, images, stories, quotes, and examples to enhance the results and achievements. The guiding principles are accountability and transparency, meaningful and relevant whole of system outcomes and continuous quality improvement.

A working group was established of representatives from Consumer and Clinical Councils, Māori Health Service and Clinical teams across the sector to write a document publishing positive stories and the impacts on health outcomes of our community.

CONCLUSION / SUMMARY

The Draft publication is attached for review and feedback. Please note data is still being compiled and there are some pages in the accounts that are yet to have numbers confirmed. Proper formatting will occur after all feedback considered and changes made. Therefore feedback is requested on the overall flow of information, language and images used.

A communication plan is being developed and feedback will also be sought as to how best we communicate the accounts to our community. Feedback will be incorporated and HB Clinical Council, HB Health Consumer Council and Māori Relationship Board will be given a further opportunity for final review in September before going to HBDHB and HHB Boards.

KA ARONUI KI TE KOUNGA

FOCUSED ON QUALITY

OUR QUALITY PICTURE 2016

OURHEALTH
HAWKE'S BAY
Whakawāteatia

DID YOU KNOW THAT EVERY DAY...

6 babies will be born

11 fragile babies will be cared for in the special care baby unit

15 km An orderly can walk on average 15km

16 people will get their free annual diabetes check

20 women will have a mammogram and a further 29 a cervical smear test

35 operations will be completed

55 children will receive one of their vaccinations

100 people will be admitted to Hawke's Bay Fallen Soldiers' Memorial Hospital

153 visits/appointments will be made to support people with mental health issues

223 visits will be made by District Nurses and Home Service Nurses

248 children on average will be seen for their free dental health check

260 people will receive meals on wheels

1,334 people will see their local family doctor

4,400 prescriptions will be written

5,256 laboratory tests will be completed

5,915 items of laundry will be delivered to the hospital

Icons made by Freepik from www.flaticon.com

11

Te hauora o te Matau-ā-Māui: Healthy Hawke's Bay

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RĀRANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT
Showing ***respect*** for each other, our staff, patients and consumers. This means I actively seek to understand what matters to you.

RĀRANGA TE TIRA PARTNERSHIP
Working together in ***partnership*** across the community. This means I will work with you and your whānau on what matters to you.

ĀKINA IMPROVEMENT
Continuous ***improvement*** in everything we do. This means that I actively seek to improve my service.

TAUWHIRO CARE
Delivering high quality ***care*** to patients and consumers. This means I show empathy and treat you with care, compassion and dignity.

CONTENTS

03 WELCOME TO OUR QUALITY PICTURE
04 OUR CLINICAL COUNCIL AND CONSUMER COUNCIL
06 WHO ARE WE?
07 TACKLING HEALTH INEQUITY
09 HELPING PEOPLE STOP SMOKING
10 REDUCING INEQUITIES
11 INCREASING THE NUMBER OF HEALTHY WEIGHT CHILDREN
13 REDUCING OUR DID NOT ATTEND RATES
14 CONSUMER EXPERIENCE
16 OUR SERVICE
32 NATIONAL HEALTH TARGETS
35 SERIOUS ADVERSE EVENTS
36 NATIONAL PATIENT SAFETY PRIORITIES
38 OUR FUTURE FOCUS
39 YOUR FEEDBACK

All quotes are provided by our consumers


2

NAU MAI KI TĀ TĀTOU WHAKAAHUA KOUNGA
WELCOME TO OUR QUALITY PICTURE

We are pleased to share with you our fourth Hawke's Bay Health sector's quality accounts demonstrating our commitment to high quality health care, living our values and sharing with you our successes and future plans. As you will see, we have come a long way and our teams have worked hard to achieve some excellent results in meeting the Ministry's health targets and the Health Quality and Safety Commission's Quality Safety Markers; however, there is still more to do. whānau

Every day people access the health and disability services across our sector and, for some, the experience, the care, and support they receive exceeds their expectations; however in some instances we fall short. As a sector, we believe our consumers should be at the centre of health care and treat them as if they were part of our own family/whānau, so as a sector our commitment is to continually improve the safety and quality of care for all.

In these quality accounts we have focused on some of the improvements currently underway across Hawke's Bay which, we believe, will better meet the needs of our community and give us the opportunity to deliver the best care possible. At the same time we need to continue to manage the risks of providing health care and reduce incidents of unintentional harm that can occur while receiving care. These accounts show how we are meeting these challenges – showing our successes and where we need to improve and focus in the future. We welcome any feedback, as well as any suggestions for future topics.

What quality means to us?

Ākina, one of our sector values means *that we continuously look for ways in which we can make improvements and learn when things don't go as well as we planned. Achieving high quality care across the sector means the care is the right care, in the right place, at the right time, every time. We want to help develop our staff to become far more person and whānau centred, really understanding our consumers' goals and needs, working in partnership to improve the health of our communities.*

KEVIN ATKINSON

CHAIR
Hawke's Bay District Health Board

BAYDEN BARBER

CHAIR
Health Hawke's Bay - Te oranga Hawke's Bay

CHRIS McKENNA

CO-CHAIR
Hawke's Bay Clinical Council

MARK PETERSON

CO-CHAIR
Hawke's Bay Clinical Council

GRAEME NORTON

CHAIR
Hawke's Bay Health Consumer Council

OUR CLINICAL COUNCIL AND CONSUMER COUNCIL

Establishing the Hawke's Bay Clinical Council (2010) and Hawke's Bay Health Consumer Council (2013) has helped us make change across our health sector – hearing the voice of both our clinicians and consumers.

The Clinical Council is made up of a number of health professionals from across our sector, including hospital specialists, family doctors, nurses and allied health (social workers, pharmacists) to provide leadership and oversight around safety and clinical improvements.

The Hawke's Bay Health Consumer Council provides a strong voice for the community and consumers on health service planning and delivery. The Council is tasked with enhancing the consumer experience, making sure our services meet our communities' needs.

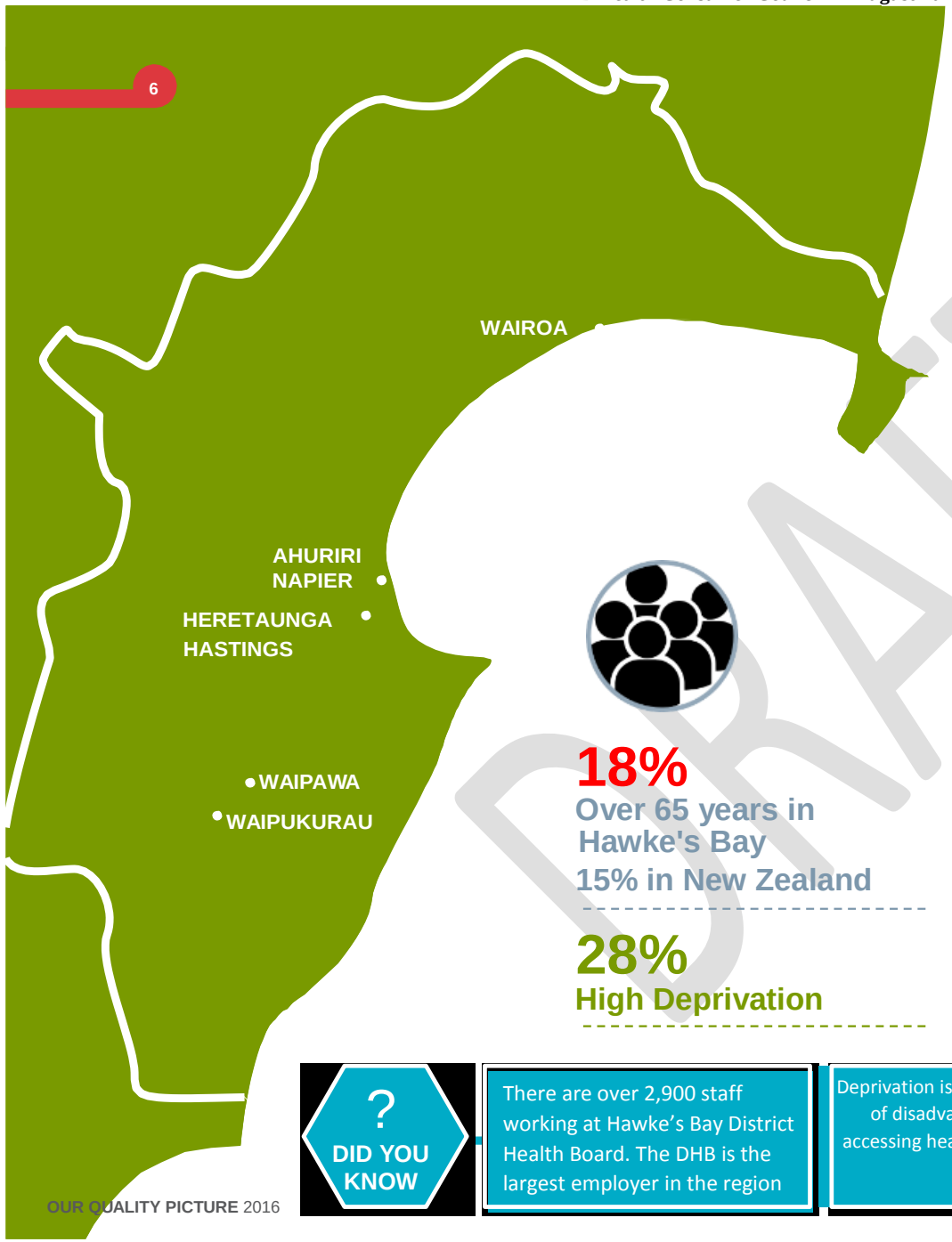
A strong sense of teamwork and working together has been established between the councils which means that all service improvements and changes must be reviewed and recommended by both councils before they are discussed and approved by the Hawke's Bay DHB Board. The key to success to date has been the commitment at board and senior executive levels to support both these councils so that both clinical and consumer voices are able to grow.

As a further advance on working together, the Clinical and Consumer councils held combined monthly meetings in the past year. They worked on deepening their shared understanding of person and whānau centered care and how to advance this way of working across the health sector.

Each of the councils' annual plans has a section they share. Consumers are increasingly routinely invited to "co-design" services with clinicians, managers and other stakeholders. Trusting relationships are being built as a result, and we are getting better at it.

2015 was the year of the consumer with the Partnership Advisory Group for mental health being the supreme award winner at the Hawke's Bay Health Awards in November. Graeme Norton, Chair of Consumer Council also won the leadership award in 2015.


5



WHO ARE WE?

159,600

Hawke's Bay population 2015/16

26%

Māori in Hawke's Bay

4%

Pacific people in Hawke's Bay

18%

Over 65 years in Hawke's Bay

15% in New Zealand

28%

High Deprivation

? DID YOU KNOW

There are over 2,900 staff working at Hawke's Bay District Health Board. The DHB is the largest employer in the region

Deprivation is an indicator of disadvantage in accessing health services

The average income in Wairoa is $XX

X children are unable to attend appointments per year

TACKLING HEALTH INEQUITY

Many things in life are unequal but some things shouldn't be. Health inequities are inequalities in health that are avoidable or preventable. Hawke's Bay is a great place to live, but not everyone currently has the same opportunity to be healthy. Some parts of our community have better health than others and we need to make sure everyone enjoys the same level of health and wellbeing.

A recent update of the 2014 Health Equity Report shows that Hawke's Bay is improving in some areas.

Good progress is being made to achieve equity in the following areas:

- ✓ **Difference between Māori and non- Māori avoidable deaths almost gone.** If current trends continue there will be no difference between Māori and non- Māori avoidable death rates by 2017, largely due to disease prevention, effective treatment and/or medical care.
- ✓ **Reduction in hospital admissions for 0-4 year olds** that could have been avoided by prevention programmes and better access to treatment in primary care.
- ✓ **Reduction in teenage pregnancy** largely due to improved access to primary care contraceptive and sexual health services.

Life expectancy (how long we live) is improving but there is still significant inequity. It will take at least 50 years for Māori to have the same life expectancy as non-Māori in Hawke's Bay if current trends continue.

In the coming year, focus will be given to the areas where health equity is unchanged or worsening:

- × **Acute respiratory.** Child admissions are increasing and are associated with poor housing conditions.
- × **High smoking rates for Māori women.** Forty-three percent of Maori women giving birth in the past year were smokers. At the current slow rate of decrease it will take another fifteen years before rates are the same as non- Māori.
- × **Obesity in four year olds** has increased since 2009 with significant variation across communities. Nearly 12% of children living in places like Camberley and Tamatea are obese compared to less than 1% of four year olds in Havelock North Central or Poraiti.
- × **Oral health for five year olds.** There has been no improvement in oral health for five year olds. Māori and Pasifika children and children living in less affluent communities have significantly more dental decay.

HELPING PEOPLE STOP SMOKING

23% of all women who had a baby at the Hawke's Bay DHB facility during 2014 - 15 were current smokers.

Hapū mama who are Maori are five times more likely to be smokers. Encouraging hapū mama to stop smoking during pregnancy may also help them kick the habit for good and so provide better health benefits for mama and reduce contact to second-hand smoke by pepe.

The Increasing Smokefree Pregnancy programme is a collaboration between Kahungunu Choices Health Services, Hawke's Bay DHC Maternity Services and the Smokefree Team to provide support, education and incentives to hapū mama wanting to stop smoking. Incentives include free nappies at one, four, eight and twelve weeks if they remained smokefree. Those whānau members who smoke and are living with the hapū mama can also receive incentives at one, four, eight and twelve weeks if they remain smokefree.

RANGATAHI MAKE BETTER CHOICES

Smoking rates among Year 10 students are lower now than 15 years ago but one in four young Maori girls of this age remain regular smokers. Over 60% of Maori girls 14 – 15 years have used a tobacco product at some stage. Social supply and retail purchase are the main sources of cigarettes and tobacco for young people.

The "Breaking Cycles Challenge" engaged with Alternative Education providers in Hawkes Bay to provide education to youth aged 15-19 years old to lead healthy, active and smoke free lifestyles. The challenge was run over eight weeks with education, health, social, challenges and cessation components all factored in to the programme. The focus was smokefree and youth health, where engagement with providers once a week provided expert cessation advice and support to youth wanting help to stop smoking. In collaboration with Directions Youth Health Centre the aim was to support rangatahi to make better decisions for their health and wellbeing and create healthy lifestyles.

Kura Tutahi – ki te whakangao i ngā rangatira mo apopo

REDUCING INEQUITIES: Investing in tomorrow

Lifestyle factors such as smoking, diet and physical inactivity are the main causes of premature (early) death. Māori are doing badly in health statistics and the inequity gap is continuing to grow.

Central Health were once again the winners of the Commitment to Reducing Inequalities Award at the Hawke's Bay Health Awards in 2015. Their winning entry has a long term goal of seeing a new generation of Māori – strong, healthy and leading the way for their families/ whānau.

The biggest impact can be made when issues are addressed in children/ tamariki rather than waiting for them to become adults with poor health habits. This project aimed to improve nutrition, establish a habit of physical activity, prevent smoking uptake and access to nurse-led clinics to deliver early health care, and health promotion.

The project started out focusing on schools with the highest proportion of Māori and was later expanded to include the five kohanga in Central Hawke's Bay.

Innovations used were:

- 10 week touch rugby module for all schools to complete
- Kia Tunua – healthy cooking on a budget for children/ tamariki and their families/ whānau
- Supermarket Tour Toolkit
- Healthy Lunches Toolkit
- On-site nurse led clinics
- Social media resource (Facebook)
- Using advertising budget to become lead sponsor for Iron Māori Tamariki in Hawke's Bay

There were many success stories including The Terrace School in Waipukurau (70% Maori) which was awarded the NZ Heart Foundation's Healthy Heart Start Award (Healthy Heart Tick) for their healthy lunches programme. This is an astonishing achievement for a school which, until last year, only offered choices such as pies, sausages, and chips.

Increasing the Number of Healthy Weight Children

The best start for healthy weight children is keeping healthy during pregnancy, breastfeeding and healthy eating for our young children. The evidence suggests that getting it right from day one gives each child a good start in life and can protect against obesity throughout adulthood.

The Maternal Nutrition Programme delivers "Healthy First Foods" with Well Child Providers and gives information and practical skills to families/whānau on feeding children from six months.

Children under five who develop healthy eating behaviours are likely to maintain these over their lifetime. Also the whole whānau needs to model healthy eating and activity to support children.

The Pre School Active Families Programme, developed and funded by the DHB, is delivered by Sport Hawke's Bay. They work with 45 families annually, providing support in the home and engaging whānau in community programmes.

Reducing the amount of sugar children consume not only supports healthy weight, it also improves oral health, concentration and overall wellbeing. "Water Only Schools" are being supported with resources, policy development and activities.

Image to be inserted appropriate to healthy eating

URGENT CARE

Emergency Department and general practice presentations continue to increase (include stat about numbers and increase on last year) and many of those who do come have coughs, colds or other minor medical conditions that would have been better treated by a nurse, family doctor or an accident and medical centre.

Last year we told you that the Urgent Care Alliance (a group of over 50 health professionals, managers and consumers across our region) was working to challenge and change the way health services are delivered, and to break down barriers like getting an appointment at short notice.

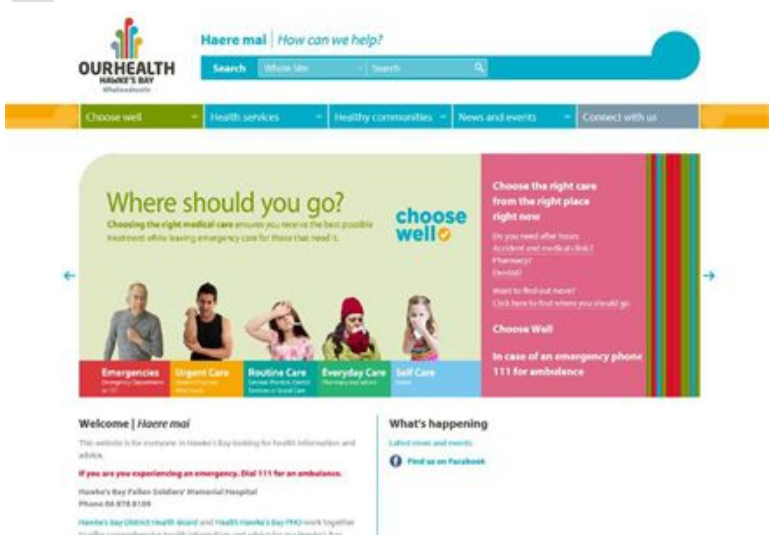
We highlighted several options we were looking at to improve some of the issues and these have been further developed in the last twelve months.

- Improved access to emergency dental treatment - As of 1 October 2016 there will be provision for 720 very low cost appointments available for anyone in Hawke's Bay who needs emergency dental treatment. Consumers can be referred by their own family doctor, by the hospital or simply walk in to Te Taiwhenua o Heretaunga for treatment.

- Communicating better with our community and helping consumers with more information so they can make better choices about where to go for treatment - This led to the implementation of the "choose well" campaign. The launch of a new health sector wide website (www.ourhealthhb.nz) supports our community with information, advice and alternatives. You may also have noticed "choose well" billboards and banners.

- Transport assistance is currently being reviewed and we expect a number of recommendations to be made in the next year to support this.

- Provision of urgent care services continues to be a priority. We are continuing to look at ways to improve access to health professionals both during and outside of normal working hours.



"I love building relationships with whānau, listening to their stories and knowing I have made a difference"

REDUCING OUR DID NOT ATTEND RATES

Rawakore means "without resources". Knowledge, transport, health literacy are examples of resources required to gain access to health services. At the DHB, we strive for equity and equal access to healthcare; however, we know there are many among us without these resources to help them on their journey.

To assist our community, the Māori Health Unit employs Kaitakawaenga to ensure that everyone is aware of their appointments, can get to their appointments, and can truly have equal access to healthcare.

Two of our Kaitakawaenga are Wirihana Raihania-White and Speedy White. Their work involves ringing people when they have appointments, visiting them in person, bringing them to appointments when needed, establishing relationships with whānau and listening to their stories. As they will tell you, "without the relationship, nothing else is possible."

Wirihana and Speedy take pride in their work every day, although they will say, "this is just what we do" to make a difference to people on their healthcare journey.

Customer focused bookings

The Customer Focused Booking project was initiated in Sept 2015. The goal of the project is to co-design a customer focused booking system that will result in improved attendance at appointments, full clinic utility, reduced waiting times and improved levels of customer satisfaction.

The project team have made good progress with placing the customer at the heart of the booking process this year and this focus will continue into 2016/17. Some of our progress is as follows:

Consumer information – we call this "demographics". The information we hold on file is not always up to date and this affects consumers being advised of an appointment. We have completed a review of our demographics form and how we collect this information, and we're getting ready to implement changes.

Online booking system – We completed a thorough review of technology solutions to support consumers being able to book and reschedule their own clinic appointments. We have chosen software we feel is the best for our systems, and we'll be rolling out a pilot within the next few months.

Text-to-remind tool – We have worked together with consumers to find out how we best use our text reminder system to meet consumer needs (see page 14). A set of recommendations are now being implemented to make this service more effective and more valuable to our consumers.

Clinic scheduling – Work to date to support our clinics running efficiently has included a review of clinic capacity and how clinics are scheduled. We continue to look at how our outpatient clinics run and changes we can make to make them even better.

Did not attend rates – There is still inequality for Maori when it comes to not being able to attend appointments. The project group will continue to monitor the data and identify issues to support system changes to promote equity and access to healthcare.

"Mum has dementia, and it is a challenge for her to manage her own appointments. Could you please send the reminder to me as her caregiver as well?

CONSUMER EXPERIENCE

Measuring what matters most to our consumers and how you experience our services is essential in improving the way we do things.

National Inpatient Experience Survey

Feedback about the care provided in our Hospital is a good indicator of how well services are working for patients and whānau. As with other District Health Boards, we send a survey every three months to a selection of adults who spent at least one night in our hospital, inviting them to participate in the survey.

330 people responded to our surveys over the last 12 months (July 2015 to June 2016) and scored us positively across the following four domains: communication, coordination, needs and partnership (see page 15).

In addition to the scores, our reporting captures lots of comments and feedback that we share with our services. This feedback has highlighted those areas we can improve – for example pain management, privacy and discharge planning.

Real time surveys

If you have visited Nga Rau Rakau, Napier & Hastings Community Mental Health, Te Harakeke Child and Family Service (CAFS), and the Home Based Treatment Team recently you may have noticed iPads placed in reception areas and staff encouraging users of the service and their whānau to take up to three minutes of their time to "tell us what you think" in an online survey. This feedback is anonymous and captures your thoughts. We are encouraging consumers to complete the survey after each appointment or interaction as we know experiences can be different each time.

178 surveys were completed between March and July 2016 with the average rating 4.01 out of 5. We received the highest rating to the question "I would recommend this service to friends and family if they needed similar care or treatment".

Workshops

In July 2016 consumers from Wairoa to Waipukurau attended a workshop reviewing the "text to remind" tool - the method used to remind outpatients of their scheduled appointments. This workshop was useful in finding out how we can best use the tool to meet consumer needs, improve the consumer experience and increase attendance of appointments.

The ultimate aims are to ensure equitable health services for all and best use of our resources.

"Whenever I was talking with staff they showed great empathy, displayed a calming sense of humour (yet) … they were professional and competent".

Results from the 2015/16 National Patient Experience Survey

Our scores have improved on last year across all four areas and in some cases are higher than the New Zealand average.

86% Felt we communicated well, and we listened to your questions

(3% increase on last year)

87% Felt you were involved in any decisions about your care and treatment

(2% increase on last year)

88% Felt you received good care and support and we treated you with dignity and respect

(3% increase on last year)

85% Felt you were given consistent information from the teams that were treating you

(2% increase on last year)

We still have room for improvement. The survey did identify areas of concern, such as discharge planning, which we will focus on improving in the coming year.

"I wasn't given info on medications prior to discharge. I felt confused about when to take them when I got home".

Image of consumer engaging with health professional

POPULATION HEALTH

We work with people and communities to prevent disease, have a safe environment and support people to be healthy and well. Population health covers areas such as reducing harm from alcohol, drugs, tobacco and hazardous substances, water safety and sanitation, promoting physical activity and healthy eating, healthy housing, sexual health, preventing disease through on-time immunisation, managing notified communicable diseases, and cancer screening.

KEY RESULTS

- Eight drinking water suppliers signed up to the Drinking Water Assistance Programme and 96 suppliers were assisted with developing water safety plans and risk management plans
- 228 homes were insulated through DHB healthy housing programmes in the last three years
- x pregnant women were helped to give up smoking
- Plans developed to increase the activity and wellness of infants and children – Hawke's Bay Healthy Weight Strategy and Best Start: Healthy Eating and Activity

OUR FOCUS 2016/2017

- Support workplaces to have healthy workplace policies
- Support schools to have policies on drinks with no sugar
- Develop a position statement on alcohol harms and outline actions to address them
- Improve the information on pamphlets given to the public on communicable disease
- Continue to address housing issues and poor insulation

Did you know?

481 communicable disease cases notified

619 liquor licence applications received

187 tobacco retailers had compliance/ education visits

123 women supported to breast & cervical screening services


17

PRIMARY HEALTH CARE

Primary health care is the first place you go to for health services; often this is your general practice or health centre. The doctors, nurses and pharmacists working in our community provide a range of health services aimed to keep you well, from health promotion and screening to diagnosis and treatment of medical conditions.

KEY RESULTS

- More people have been supported to stay at home to look after their respiratory condition (breathing). This is because general practice and hospital services have worked together to support people earlier with better understanding, tools and access.
- 2,197 four year old children have received health checks before they start school. We have exceeded the target of 90% set by the Ministry of Health.
- 344 whānau (1440 individuals) were enrolled in our first Whānau Wellness Resource Programme which is a 12 month step-up programme including support to access general practice, medicines, tests and education.
- Whāriki/Stanford, a self-management programme has supported the development of Māori community champions and 81% of whānau using the programme have completed it (see page 21)

OUR FOCUS 2016/2017

- A review of systems that support patient safety continues within general practice
- Identify how primary and secondary care will work together to support better patient outcomes (system-level measures)
- Patient experience survey for primary care being developed by the Health Quality and Safety Commission is set to come to Hawke's Bay
- Improving Health Literacy - a new online training programme has been developed to support the people who work in general practice to understand more about the people that come to see them, their understanding of the health system and their health needs.

Did you know?

24,666 Cardiovascular Disease risk assessments were completed in general practice

(these forecast your risk of a Heart Attack or Stroke within the next 5 years)

710,857 (2% increase on last year) nurse and doctor consultations in general practice

6,276 Diabetic annual reviews were held in general practice

"Manage my Health allows me to access my general practice 24/7. I can use my tablet any time to book appointments or request repeat prescriptions, which is essential when my asthma medications run out. I can read the doctors notes from my consultation and email her if I need clarification. And there is no more waiting for ages for the receptionist to answer the phone".

Respiratory Programme

Managing your breathing issue is now easier because we have joined together general practice and hospital services to provide better service for patients with respiratory issues and concerns. This is called the Respiratory Programme. The solution has been to increase access to your doctor or nurse, for early diagnosis and to provide education enabling self-management and improved quality of life. Nurses have received education sessions to increase their skills for providing extended services for patients with respiratory conditions.

- More people (300% increase) are now using the Pulmonary Rehabilitation service.
- More people (225% increase) have been provided a spirometry (lung function) test at their health centre.
- The number of days people have not needed to be in hospital because of their breathing problems has been reduced by 740 days compared to last year.
- More people saw their doctor for breathing issues and were treated by their doctor reducing the need to see a specialist at the hospital; this reduced referrals from 658 in 2012 to 28 referrals in 2015.

"I feel I know better how to take care of the little lung capacity I have left… the programme has given me another ten years of productivity".

Supporting you to keep well

Consumer Portal

Did you know that you can access your own medical records and make your own appointments? Ask your practice about Manage My Health or Health 365. Currently ten practices in Hawke's Bay have access to this technology, and by the end of the year most general practices will have access to this technology.

Improving self-management of health issues in our community

Self-management has become a popular term for changing how people manage their own health. This is especially true for those with long term conditions, such as heart disease and diabetes. Health Hawke's Bay has developed a team of Master Trainers and Stanford / Whāriki Facilitators to provide group education sessions to people in their communities which aim to improve people's skills and confidence in managing their own health problems.

Support includes helping people understand their condition, developing the skills to empower good decision making, establishing goal setting and problem solving approaches. The programme supports patients being leaders in their own health and well-being, in close partnership with their medical practitioner. The Whāriki Stanford programme has been in place now for 12 months. During that time, 435 people have participated with 81% completion rate for Maori using the programme.

We have a targeted focus to support individuals and whānau to navigate the complex range of health services rolling out this coming year

Whāriki translates to "the woven mat". It is considered a special skill to be able to weave, taking time and concentration to complete. It allows contemplation and, once complete, is a great achievement.

ACUTE AND MEDICAL

We are responsible for providing safe and effective care across a number of services including:
Emergency Department, Intensive Care Unit, Radiology, Renal Services, Cancer Services, General Medicine, Cardiology, Respiratory and Palliative Care.

KEY RESULTS

- Continuing to reduce average length of stay for medical patients
- Refurbishment of ED front of house
- Dedicated team adding additional support to Patients at risk of deterioration within the hospital 24/7
- Medical Day Unit now well established and providing 6 beds for those admitted to the hospital for minor investigations and procedures

OUR FOCUS 2016/2017

- Continue to focus on flow of acute patients through the hospital
- In preparation for the National Bowel screening programme and to meet current needs in our community, plans are underway to commence building a standalone gastroenterology and endoscopy suite in early 2017
- With the appointment of a Clinical Nurse Specialist, Trauma and national data collection, we will review and optimise our trauma (serious injury) care
- Continue to focus on the right numbers of staff with the right skills at the right place at the right time.

? DID YOU KNOW

We provide a **24 hour** acute service 7 days per week

We manage around **45,000** emergency department presentations each year

We have **97** acute adult medical beds

13,342 people with injuries presented to E, 2,190 admitted to hospital, 79 with severe trauma

The most common cause of severe trauma is motor vehicle accidents

24/7 Stroke thrombolysis

In June 2016, the stroke team began providing 24/7 stroke thrombolysis (a treatment to dissolve the dangerous clots in blood vessels, improve blood flow and prevent damage to tissues and organs) to clinically eligible patients presenting to the Emergency Department with acute stroke.

Our Hawke's Bay stroke team are working closely with our Wellington counterparts, and video conferencing is being used to provide stroke expertise for patients presenting outside of working hours. This technology allows us to be in a position to offer therapy aimed at improving outcomes for clinically eligible stroke patients whenever they need it.

Emergency Department (ED) front of house

Last year we had lots of feedback from the community about how we could improve the ED waiting room. The front of house redesign project is finished, and the improvements are sure to help both staff and patients.

A new wall and electric doors now define ED as its own space, rather than a general thoroughfare into the hospital. This provides a clear process from the front door for patients/visitors and whanau. Increased clinical space – a new triage booth and five assessment/intervention bays – will optimise patient privacy, and commencement of interventions therefore supporting patient flow. The clear view that staff now have of patients in the waiting room will also support staff and patient safety

Integrated Operations Centre (IOC)

The Integrated Operations Centre was opened in March 2016. The main purpose of the IOC is to provide a central hub where the hospital activity is visible and patient flow across the hospital is coordinated. The IOC has become an integral part of the daily management of acute patient flow, which assists us to:

- Provide visibility of real time hospital wide activity
- Predict demand and, therefore, better manage capacity
- Alert us to areas at risk
- Manage patient flow from ED to discharge
- Support us to provide best use of our staff capacity to meet the demand

A key part of the IOC room is the three large screens, which gives us visibility of real time activity and prediction data. These screens show us at a glance what is happening and where any trouble spots are; we can then better support staff to provide high quality care and manage demand through the hospital.

Photo of IOC

"The Doctor chatted to me the day after surgery so I wasn't still foggy... and took time to answer all my questions. The Anaesthetist was calming and talked through his role and made me feel calm. The nurse kept me updated with the discharge process"

SURGICAL

We are responsible for providing surgical procedures for our consumers, whether they be elective (planned) or acute (not planned or accident) in our seven theatres, carrying out day case surgeries and caring for consumers after they have undergone surgery.

KEY RESULTS

- We exceeded the national elective health target and completed xxx surgeries, xxx more than last year
- Of these x % of people waited 4 months or less on the surgical waiting list.
- We completed xxx hip/knee joint replacements. This was {100} more than last year
- Stat about the number of breast cancer ops we did. (General statement about speed without specific number)
- Stat about average length of stay after hip/knee op – improvement on last year?
- Appointment of a Vascular Surgeon meaning consumers don't need to be sent out of the region for vascular surgery

OUR FOCUS 2016/2017

- Continue to improve the numbers of our community receiving surgery
- Updating our theatre facilities to meet the needs of the Hawke's Bay community
- Mobility Action programme – info from Dawn
- National Patient flow?
- Reduce the wait time for acute surgery by increasing our theatre opening times across the week.

? DID YOU KNOW

- X people are seen in the fracture clinic (Villa 1) weekly
- We do around **35** surgeries each day in our 7 Theatres
- **XXXX** patients are admitted to our 3 surgical wards yearly
- Around **XXX** people are seen at surgical outpatient clinics
- **XXX** gynae operations completed this year (?increase on previous years)

"The day before the procedure I had to come in for the pre-op meeting... I had to see 4 different people who all asked the same questions"

Photo of spine clinic

Spine Clinic

Not all people experiencing back pain require surgery. We now have advanced practitioner physiotherapists running a spine clinic providing assessment, diagnosis and physiotherapy treatment. This commenced in Hastings in February 2016 and in Napier in August 2016. These clinics were introduced to provide quicker service to our patients, and release orthopaedics surgeons to focus on surgery.

The clinics have been successful to date with 90% of patients being referred to the spine clinic not needing orthopaedic surgeon follow up.

Improving pre-surgery visits

In February 2016 we commenced the re-design of our pre-admissions process. These are the visits you have with us prior to your surgery to ensure you are safe and ready for surgery.

Our previous system of two different processes and multiple visits was creating confusion and frustration for staff and consumers. Consumers were experiencing significant delays and feeling like they were "double handled" with the same or similar information requested and recorded by different staff members.

We want a consumer centric, safe, efficient, consistent and streamlined process. Ultimately we will have you visit us prior to your surgery only if required, and then only once. In many cases you will only need to be seen by a specialist trained pre-admissions registered nurse. At times, the nurses are able to complete a telephone assessment so that you don't need to come in for a pre-admissions appointment.

So far we have concentrated on improving pre-surgery visits for our healthiest (low risk) patients and have commenced nurse led clinics for orthopaedic, gynaecology, ophthalmology and ear, nose and throat (ENT) specialties. Our next focus will be general surgery and neurology.

"The Spine clinic has provided me with a service that has been focused on rehabilitation catered to my specific needs. Before I began attending the clinic, I had been struggling with menial chores and pain management for around 5 months with no improvement. The clinic has helped me get back into everyday life with a degree of normality by achieving specific milestones. Being able to put my socks on in the morning is just one of those milestones achieved since attending the spine clinic."

WOMEN, CHILDREN AND YOUTH

Women, Children and Youth services provide services from early pregnancy through to whānau with children under the age of 15 in Napier, Hastings, Central Hawke's Bay and Wairoa. We support women, children and whānau through all aspects of their children's health journey from birth to teenagers providing acute and long term conditions assessment and care inclusive of audiology, and ongoing child development services. There is a particular focus on our most disadvantaged with a strong partnership with our violence intervention programmes.

KEY RESULTS

- "Waioha" primary birthing unit completed
- Established Maternity Consumer engagement Reps
- Funding to support implementation of the Foetal Alcohol Spectrum Disorder (FASD) programme secured
- Audiology (hearing clinic) waitlist reduced from 2 years to 8 weeks
- Maternity Wellbeing Child Protection coordinator appointed

Teenagers living with diabetes

Last year we noticed that many of our teenagers were having a tough time following their diabetic plan. It was hard for them to follow medical treatment which ultimately impacted on their diabetes and led to many coming in to ICU and children's ward with serious health issues related to their diabetes. We submitted a bid, which was approved, for funding to employ a children's outpatient social worker who could work closely with these rangatahi. The results so far have been really positive. Relationships have been built, and education and understanding has improved. Important appointments are being attended more consistently now, and engagement with the diabetes team has lifted. Since January 2016 we have engaged with eight high risk teenagers and their whānau, the majority of whom are now participating in their diabetic plan and are starting to be more positive about their future with diabetes.

OUR FOCUS 2016/2017

- Improving consumer engagement to help design and monitor services
- Review of patient management and access to non-acute services
- Engaging with our youth to look at ways to improve their health
- Improving Family Violence Intervention screening rates (see page 27)
- Increasing the number of births without intervention
- Continuing to improve the coordination of care for those children with complex needs
- Continuing to collaborate with children and youth agencies and providers

? DID YOU KNOW

The most common children's illness is acute bronchiolitis (a serious chest infection)

On average we have **16** children in our Paediatric (children's) ward

We gave out **626** Pepi-Pods this year

Child Development service managed 1,500 new referrals this year

"Quote from woman accessing FV services"

Family Violence Routine Screening

Family violence is a serious issue in Hawke's Bay. The New Zealand Police attend a family violence callout every six minutes, and on average across the country there are ten family violence incidents per 10,000 people. In Hawke's Bay we have 52 incidents per 10,000 people. That is over five times the national average!

Violence and abuse in families has damaging physical and mental health effects. The impact of witnessing violence can be devastating for children. Hawke's Bay children are exposed to more violence than any others in the country. We know that being a victim of abuse or witnessing abuse is linked to poor health outcomes such as obesity, diabetes, heart disease and depression.

Health care providers come into contact with the majority of the population regularly and are therefore in an ideal position to assist people experiencing violence and abuse.

Our Visiting Neurodevelopmental Therapists (VNT) working in the Child Development team, are well placed to incorporate routine family violence screening questions into their everyday practice. They find that women are appreciative of being asked, and it often enhances their relationship. Recently, during a consultation for a minor developmental need with her child, one mum disclosed extensive family violence in response to the routine questioning and now works with agencies to support her and her children to move away from that situation. This will have a positive impact.

Photograph to represent screening

"Mum has a plan in place, has talked to family and friends and is considering moving out…"

"The feedback and uptake from our staff has been nothing but positive and likely to continue to grow so we are very happy how the process is going thus far. Through this relationship we can provide our patients with a level of support and follow up care that is unprecedented both in Hawkes Bay and provincial New Zealand. "- St John's Ambulance Service Acting Territory Manager.

OLDER PERSONS HEALTH

We are responsible for providing a range of services to older people in Hawke's Bay. In the last year the engAGE service has been developed to better support frail older people who live at home to remain independent. This service has three main parts:

- engAGE team meetings are held at general practices across Hawkes Bay. These meetings allow health professionals from across the hospital and community to work more closely together and learn from each other. Team members visit older people at home and work with them to make a plan to achieve their well-being goals.
- engAGE ORBIT team works at the Emergency Department to support older people to return to their home rather than having to stay in hospital. This team is now working longer days, 7 days a week. ORBIT also take referrals from St John's Ambulance and see people in their homes to complete assessments, provide equipment and co-ordinate services for older people who need a rapid response (after a fall for instance).
- engAGE Intermediate Care Beds are beds at residential care facilities in the community where older people can stay for a short period. This service can be used by people who are unwell and cannot manage at home but do not need to be in hospital OR by people who have been in hospital and are well again but not independent enough to go home. The engAGE team works with these people to develop a plan together to get them home and back to independence.

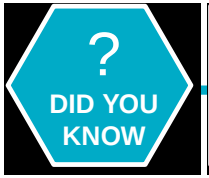
engAGE service fully functional and having a positive impact

4% increase in over 65s with no increase in hospital bed use of rest home placement

engAGE service to be developed in Wairoa and Central Hawke's Bay

engAGE ORBIT team working with Accident and Medical facilities

Evaluating the impact of the new engAGE service



There are around **23,000** older than 65 in Hawke's Bay

Only **5%** of older population live in aged residential care

Fact about over 85's growing

Provide subsidised care for over **1000** people in rest homes each year

"Being at home is just huge to Mum, as it is to us"

engAGE
Age Well

Jessie is an 84 year old woman who lives at home alone with a supportive family.

She had three admissions to hospital in the space of a month with recurrent diarrhoea which is hard to get rid of and difficult to treat. During each hospital admission it would resolve with antibiotics but would recur when Jessie returned home.

Jessie was losing weight, becoming weak and losing confidence to be able to manage at home. Her family were extremely worried and suggested that she should move into a rest home.

Jessie was referred to engAGE for help with discharge planning and follow-up. She spent 3 weeks in an Intermediate Care Bed (ICB) located in the community with regular input from Physiotherapy and monitoring of her weight and food intake. A family meeting took place before discharge.

Jessie went home with support from engAGE and a plan in place for re-admission to an Intermediate Care Bed if she required it. Jessie has remained well and at home with no further hospital admissions.

"I'd much rather be here and have this situation in place thanks to Dr Lucy"- Jessie.

"The change in her from her last hospital release is just incredible. At home she's just Mum"- Jessie's daughter.

MENTAL HEALTH

We are responsible for delivering mental health services to people with moderate to severe mental health illness. We have community teams situated in Wairoa, Napier, Hastings and Waipukurau and a residential addiction service in Napier.

MENTAL HEALTH SERVICES
He Wāhanga Ōranga Hinengaro

KEY RESULTS

- Completion of a $22 million new building - Ngā Rau Rākau Mental Health Inpatient Unit
- Length of inpatient stay has decreased since the opening of the new inpatient unit resulting in more effective care for patients
- Ongoing implementation of a new model of care for the way services are delivered. We have established home based treatment, community resilience programmes and intensive day programmes which have decreased inpatient hospitalisations.
- Wait time for first appointment at Te Harekeke /Child and Family Service has reduced. In December 2015, 59% of people were seen within 3 weeks. In July 100% of people are seen within 3 weeks of referral

OUR FOCUS 2016/2017

- Continuing to develop and implement new services to support our consumers
- Strengthening the Community Mental Health Teams to manage and reduce the number of consumers needing acute treatment
- Recruit further staff to support our Mental Health Crisis Teams
- Continue to reduce the time children and their families wait for their first appointment with Te Harakeke/Child and Family Service

? DID YOU KNOW

- X appointments with Child, Adolescent and Family Service (CAFS) per day
- We have an inter-professional crisis team who are available all day, every day
- We provide Maternal Mental Health specialist services for pregnant women who experience moderate to severe mental health issues

Opening of Nga Rau Rakau

On February 23, 2016, we celebrated the milestone achievement of officially opening the new mental health inpatient unit, Ngā Rau Rākau. Minister of Health, Jonathan Coleman, and Partnership Advisory Group Chair, Deborah Grace, officiated with cutting the ribbon.

The name of the new unit, Ngā Rau Rākau, means a collection of trees. By standing together, as part of the forest, Ngā Rau Rākau, the trees are protected, they are sheltered, they grow healthier, they grow stronger, they are supported and safe. And that's what developing our mental health services has been all about - growing the service, listening and transforming mental health services for Hawke's Bay people.

Home Based Treatment intervention prevents admission

Waekura Home Based Treatment prevents inpatient admissions and makes a positive difference in the life of consumers and their whānau.

A powerful case study: A young adult presented to the ED. The impression gained from the notes was that the client was recommended to be admitted to the inpatient unit.

The mental health assessment indicated moderate risk and the Home Based Team (HBT) thought this was a situation that could be managed effectively in the home setting.

The client was not keen on being admitted to the inpatient unit but needed support to cope with the impact of an upcoming significant event. Staff used multiple strengths-based, evidence-based counselling approaches which gave the family and client confidence to deal with the situation.

The client engaged well with HBT, stayed at home, was monitored at a relative's house, was visited daily by whānau, and received regular HBT clinician interventions.

The client also re-engaged with friends, built confidence, became much more resilient, and developed more positive thinking.

RURAL, ORAL AND COMMUNITY

The Rural, Oral and Community Directorate (ROC) has services located in Wairoa, Central Hawke's Bay, Napier and Hastings. Most of our services support people staying well in their community with a focus on integration and collaboration of services with primary care, Māori providers and other providers. ROC services provide a diverse range of care including: community nursing, pulmonary long term management, continence services, ostomy. Napier Health, outpatients, public health nursing, integrated sexual health services, Health Care Centre – Wairoa (HCC) – a general practice, Central Hawke's Bay Health Centre, diabetes service, endocrinology, hospital dental and community dental service (school dental service).

KEY RESULTS

- Community Nurses working alongside general practices in both Napier and Hastings.
- Increase in pulmonary long term conditions group sessions for patients with breathing issues. 10 groups increased to 22 and are more accessible in the community. For the first time, the programme was implemented in Wairoa.
- Networking with health providers in the community is progressing in Central Hawke's Bay and Wairoa

OUR FOCUS 2016/2017

- Implementing the District Nurses more closely with General Practice into Wairoa and Central Hawke's Bay.
- Involving other health providers in improving access for Māori children and whānau to dental care.
- More healthy warm homes
- Reducing hospital admissions for children.

? DID YOU KNOW

X patients enrolled in general practice in Wairoa

X people attended pulmonary long term management sessions

28692 children enrolled with community dental

X outpatient clinics in Napier Health per day

Development of the Pulmonary Long Term Management Service

During 2014/2105 the Pulmonary Rehabilitation Service experienced a large increase in referrals to attend the Pulmonary Rehabilitation courses which at the time were offered four times a year in Napier, Hastings and twice yearly in Central Hawke's Bay. The increase in referrals was due to improved access to spirometer (lung function) services in the primary care setting.

The Pulmonary Rehabilitation Specialty Clinical Nurse identified the service could not accommodate this level of referrals and a business case was developed to alter the service model and allow for increased service provision throughout Hawke's Bay.

This resulted in the development of the Pulmonary Long Term Management Service and implementation of a new model which commenced in January 2016. This has doubled the availability of Pulmonary Rehabilitation courses in the community, and allowed the service to be offered in Wairoa as well as Central Hawke's Bay.

The programme outcomes for this patient group have demonstrated reduced presentations to the emergency department, reduced hospitalisations, improved quality of life and fitness. Patients and families have an increased understanding of their condition and improved confidence with self-management.

E Tu Wairoa – Violence Free Whānau

In 2015 Wairoa leaders decided to establish an intersectoral network with the purpose of creating a tikanga based approach to eliminating violence in our homes and community.

The network is chaired by the Wairoa Health Centre manager and to date have launched the E Tu Whānau charter with a commitment from many community members and leaders including Wairoa Mayor, Craig Little.

A programme of action has been developed and recruitment of a network coordinator is underway. The network has also secured funding to develop and deliver tikanga based programmes to address family violence.

This is an exciting collaboration of providers and community members who believe in a common goal and have worked across structures and barriers to establish a family violence intervention model that is locally grown and delivered.

NATIONAL HEALTH TARGETS

Our results

✓ TBC surgeries delivered. That's TBC more than the target/last year.

✗ TBC% of people referred with a high suspicion of cancer received their first treatment within 62 days

✓ TBC% of eight-month olds had their immunisations on time.

✓ TBC% of the eligible population had their Cardiovascular Disease risk assessed in the last five years.

✗ 93% of people spent less than six hours in the Emergency Department.

✓ 99% of hospitalised smokers were offered advice to quit.

✗ TBC% of those consumers who are smokers and have a family doctor were offered advice to quit.

NATIONAL HEALTH TARGETS - AT A GLANCE

HEALTH TARGET	TARGET	OUR RESULT	TREND (since last year)	COMMENT
Shorter stays in Emergency Department	95%	Not Achieved	↓	…
Improved access to elective surgery	100%	Exceeded	↑	This year we have continued to focus on 'Operation Productivity' and increasing Hip and Knee surgeries (pg22) to increase the number of people receiving surgery.
Faster Cancer Treatment	85%	Not achieved	N/A	…
Increased Immunisation	95%	Exceeded	↑	Hawkes' Bay DHB remains one of the top performers in this Health Target
Better help for smokers to quit (Hospitals)	95%	Exceeded	-	Hawke's Bay DHB has achieved this target for the last three years.
Better help for smokers to quit (Primary Care)	90%	Not achieved	↓	General Practice continues to have a strong focus on helping smokers to quit.
More heart and diabetes checks	90%	TBC	↑	We have maintained our performance in this area and continue to focus on priority groups who are most at risk of heart disease and diabetes.

KEY:

↑ Improved our performance against the health target.

↓ Our performance against the health target has

– Our performance against the health target has stayed the same.

Photo courtesy of HB Today

11

SERIOUS ADVERSE EVENTS

In hospital

A serious adverse event is an event which has led to significant additional treatment, is life-threatening or has led to an unexpected death or major loss of function.

These events are uncommon; however with 38,715 hospital admissions in 2015/2016, we continue to focus on improving the quality and safety of the care that we provide to all our consumers so that we can prevent these events in the future.

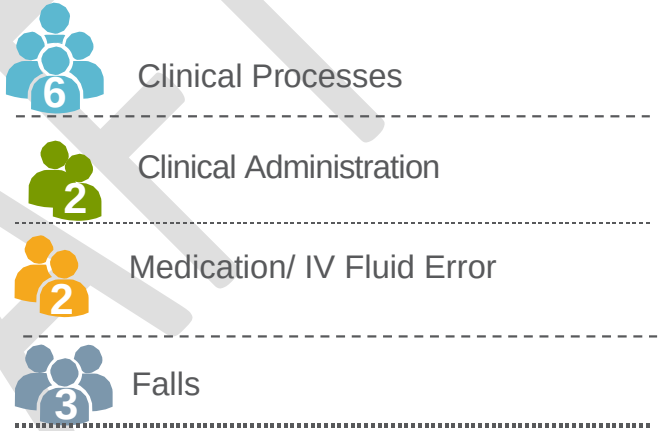
In 2015/2016 Hawke's Bay DHB had 13 serious adverse events which is an increase by two from last year.

When a serious adverse event occurs, we review our processes to try to determine the major cause, or causes that led to the event. When these causes are known, interventions are recommended to try to prevent the recurrence of the same or similar adverse event in the future. The aim is to enhance patient safety by learning from adverse events when they occur.

Did you know?

- Incidents indicate where we need improvement
- The more we report the better we will get through learning and improving
- We reported 4,168 incidents last year
- 13 of these were classified as serious adverse events
- Serious Adverse Event reviews focus on what happened? Why did it happen? What can be done to prevent it happening again?

Serious events 2015/2016



Our focus 2016-2017

- Distribute key patient safety learnings across the sector
- Develop an education programme to train reviewers of serious adverse events
- Work with PHO, GPs and aged care facilities to establish a reporting and learning programme/culture
- Upgrade our electronic risk management system

The Health Quality and Safety Commission releases an annual report titled 'Making our health and disability services safer', which is due to be released later this year. In this report we will provide more detail surrounding these events.

NATIONAL PATIENT SAFETY PRIORITIES

In hospital

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's health care through the national patient safety campaign 'Open for Better Care'. All of New Zealand's District Health Boards need to report on how well they are doing against key targets. These targets are about making sure consumers are not harmed from a fall when in our care, that we reduce the number of infections and that we make sure that when consumers have surgery that they receive the necessary medicines, and that we work as part of a team.

This is how we are doing (results for Jan-Apr 2016 unless otherwise specified):

✓ 97%

Falls prevention 1: older consumers assessed for risk. Target 90%

✗ 86%

Falls prevention 2: percentage of older patients assessed as at risk of falling who receive an individualized care plan addressing these risks. Target 90%

✓ 90%

Hand hygiene: percentage of health professionals who clean their hands before and after having contact with a patient. Target 70%

Surgical site infection targets (Oct-Dec 2015):

✗ 98%

Antibiotic administered in the hour before surgery. Target 100% (Achieved 100% in the three quarters prior)

✗ 94%

Right antibiotic in the right dose.

Target 95%

✓ 100%

Appropriate skin antisepsis in surgery.

Target 100%

Preventing harm from medicines in hospital

In the hospital we commonly use a group of pain killer medicines called 'opioids' (e.g. 'morphine', 'oxycodone', 'codeine'). Unfortunately these medicines can cause serious side effects like constipation. Constipation is when you haven't had a bowel motion ('poo') for three days or more. It can be painful and delay your recovery.

We introduced three things to reduce the number of patients having constipation while on opioids:

1) A patient leaflet and poster to help patients and staff describe bowel motions using the 'Bristol Stool Chart'.
2) A stamp for the patient's health record, to improve how we record each patient's bowel activity - giving us a clearer view of which patients are constipated or at risk of becoming so.
3) A 'laxative ladder' to describe the best laxatives to prevent and treat constipation.

Preventing harm from surgery in hospital

The 'Safe Surgery Program' aims to improve quality and safety of health care services provided to patients having surgery through the use of a 'surgical safety checklist'. The checklist is used to ensure patients receive the right surgery with the right preparation.

This year, a 'paperless' checklist (a poster with prompts) was introduced in our operating theatres. Theatre staff (nurses, doctors and anaesthetists) from Hawke's Bay and Royston Hospitals worked together to ensure they use the checklist in the same way. This enables staff to speak up and ask questions without fear.

Preventing harm from falls in hospital and the community

Last year we planned to take a 'wrap-around' approach to preventing falls and we've made some good progress on this since then. Representatives from HBDHB, Health Hawke's Bay (PHO), Sport Hawke's Bay, St John's Ambulance, ACC, and local Aged Care Facilities meet regularly to actively coordinate falls prevention activities across the region.

During the national 'April Falls' campaign (run in April), the group chose to highlight the falls risk associated with poor vision with 'eyes on falls', offering free eye checks.

An 8-week program called 'Upright and Active' (funded by Age Concern) introduces Tai Chi to improve flexibility and strength. Green Prescription offers individual support programmes and Kori Tinana Mo Nga Kaumatua Taster programmes is offered to kaumatua, based in marae.

We've looked into why people fall in hospital and have found poor lighting at the bedside to be a key factor. We now have an upgrade of the over-bed lighting included in the facilities' maintenance plan.

Preventing Harm from Infection

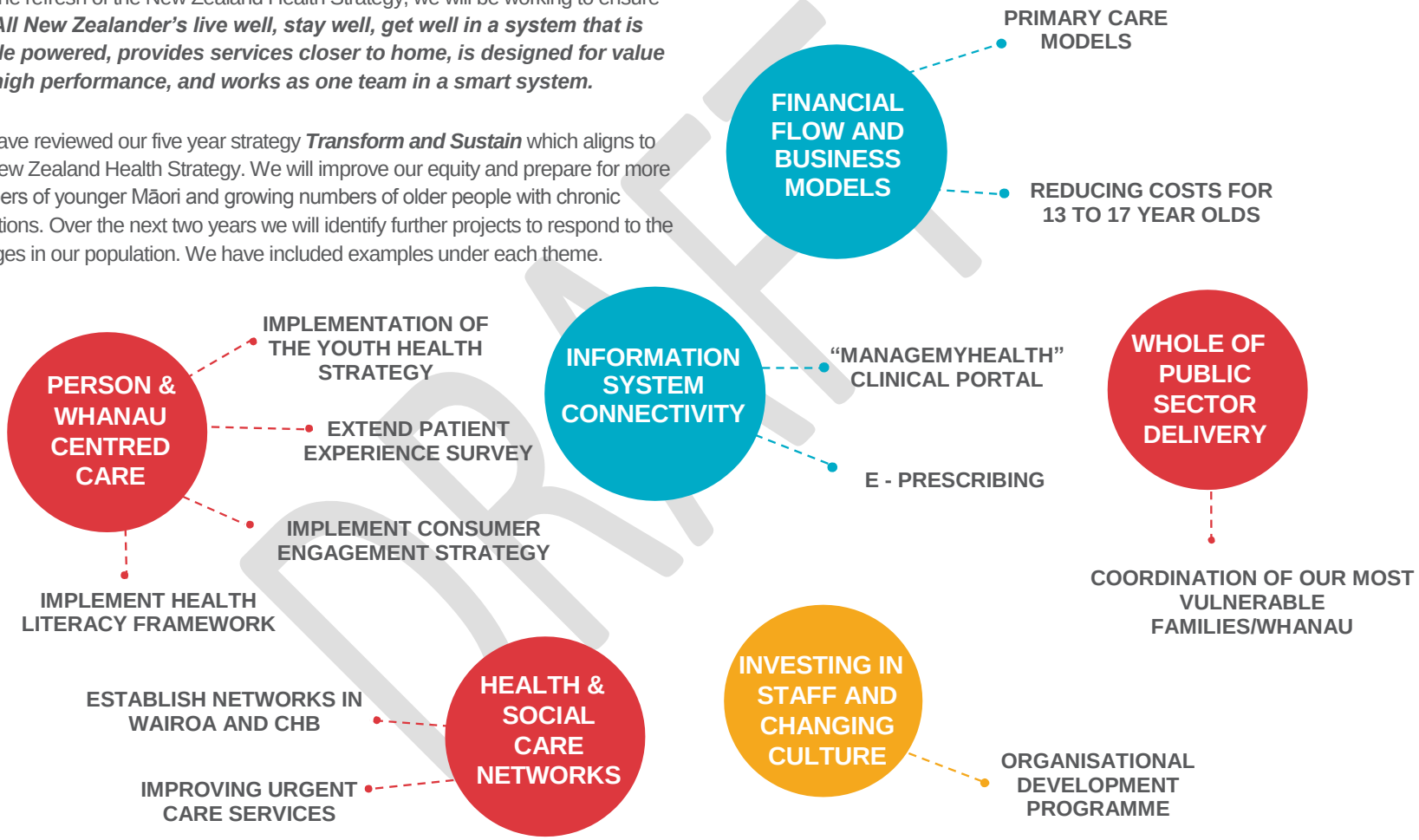
Hand hygiene is recognised as the single most effective way to prevent the spread of infection. As at June 2016 Hawkes Bay District Health Board has achieved 87.5% in the national hand hygiene programme and continues to rank amongst the top performers in NZ.

This year our focus will be the promotion of appropriate usage of antibiotics. We see this as an important patient safety issue to prevent the overuse of antibiotic and the development of multi resistant organisms. Our aim is to improve patient outcomes.

OUR FUTURE FOCUS

With the refresh of the New Zealand Health Strategy, we will be working to ensure that: ***All New Zealander's live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.***

We have reviewed our five year strategy ***Transform and Sustain*** which aligns to the New Zealand Health Strategy. We will improve our equity and prepare for more numbers of younger Māori and growing numbers of older people with chronic conditions. Over the next two years we will identify further projects to respond to the changes in our population. We have included examples under each theme.



YOUR FEEDBACK

Consumer feedback

We welcome and appreciate receiving feedback. To improve our services we need to hear your story. Whether compliments, comments, questions or suggestions, complaints or a mixture, your feedback is valuable. It helps us see where we are performing well and where we could improve.

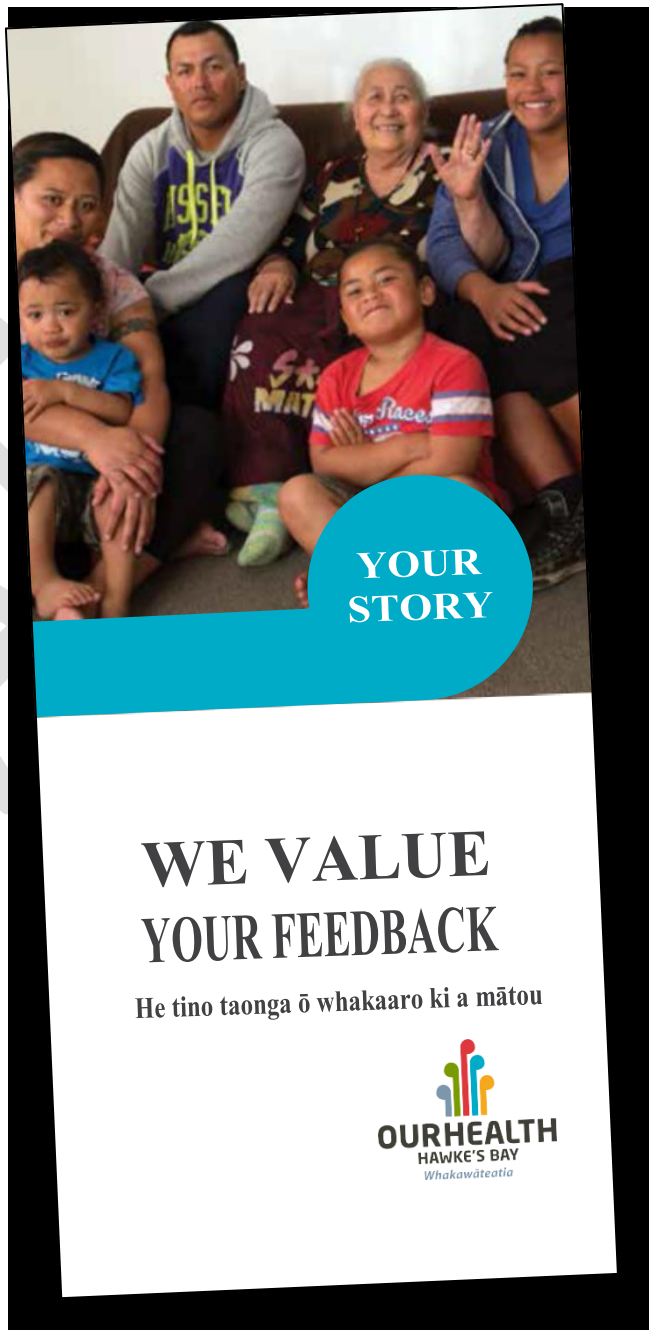
You can give feedback in a number of ways:

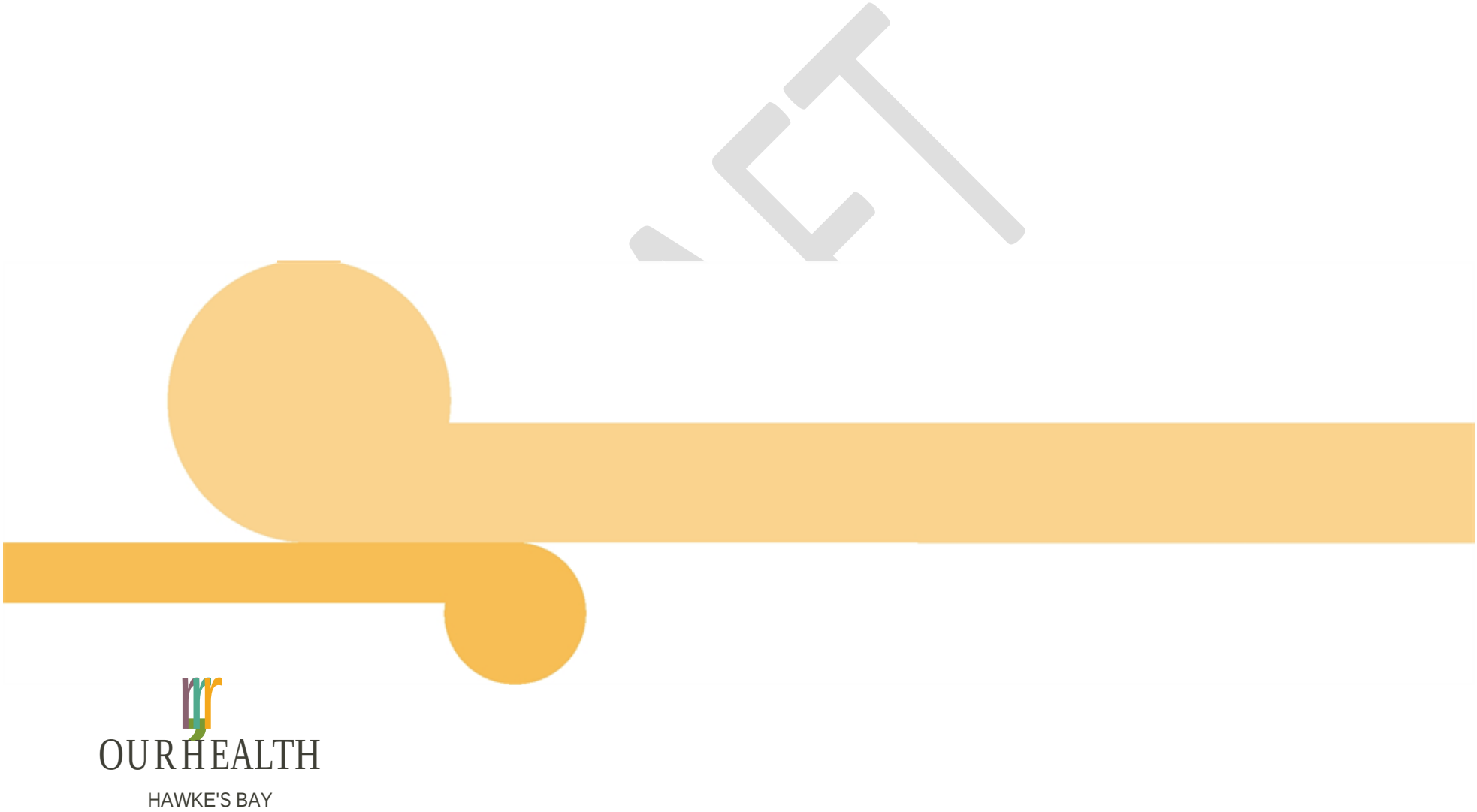
- email us: feedback@hbdhb.govt.nz
- complete an online feedback form: www.ourhealthhb.nz
- phone us: 0800 000 443
- complete a freepost feedback form which may be given to you when you visit, or which can be found in many areas across the DHB's sites.

You may receive a phone call or receive a request to complete a survey based on your experience. It is your choice to take part or not.

Then what happens?

Your feedback will be passed to the manager of the area you are providing feedback on. We will acknowledge your feedback, and if your feedback is a complaint an investigation will take place. We will let you know what we have found out and this may include what we have done to make things better, or what we are planning on doing to ensure things improve.




OURHEALTH
HAWKE'S BAY

HAWKE'S BAY District Health Board Whakawāteatia	**Quality Improvement & Patient Safety Plan**
	For the attention of: **HB Clincial Council**
Document Owner: Document Author:	Kate Coley Kate Coley
Month:	August 2016
Consideration:	For Feedback/Discussion

12

RECOMMENDATION

That Clincial Council:

- Provide feedback and comment on the draft QIPS Annual Plan.

EXECUTIVE SUMMARY

With the introduction of the Working in Partnership for Quality Framework and the now fully established QIPS team there is an opportunity to develop an overarching QIPS Plan to ensure that the priorities and objectives identified in the framework are implemented.

In addition to this, a number of other priorities including HQSC programmes, the Regional Services Plan and other local drivers have been identified.

This plan is in it's first phase of development and will be shared with EMT, Clinical Council and Consumer Council for input and feedback before being presented to the Board for endorsement.

The intention is that progress against the objectives detailed within will be reported quarterly to the relevant groups.

Quality Improvement & Patient Safety

Annual Plan 2016-17

OURHEALTH
HAWKE'S BAY
Whakawāteatia

Contents

Introduction & Context 3
What does success look like? 4
Working in Partnership for Quality Framework 4
Quality Improvement & Patient Safety Structure 6
Annual Quality Improvement & Patient Safety Programme of Activities 7
Appendix 1 – Extract from HBDHB Annual Plan 17
Appendix 2 – Extract from Regional Service Plan 2016-17 21

12

Introduction & Context

The Quality Improvement and Safety Framework developed in 2013 outlines a framework to support integrated quality improvement and performance across the Hawke's Bay health sector by providing direction and priorities. Its aim is to ensure that the entire health sector has a shared sense of direction in provision of quality care for the Hawke's Bay people.

The Working in Partnership for Quality framework breaks quality improvement and safety into four dimensions to provide a focus for our work and help us identify more readily opportunities for improvement.

WELLNESS: Improving the health of our communities.

PEOPLE'S EXPERIENCE OF HEALTH CARE: Continuously improving the safety of our services, underpinned by a culture of care and compassion.

WORKING WITH THE PEOPLE OF HAWKE'S BAY: The patient, family/whānau and carer voice as an essential component of clinical quality improvement and patient safety.

LEADERSHIP AND WORKFORCE DEVELOPMENT: Clinical quality improvement and safety is embedded within the Hawke's Bay health sector workforce and leaders.

The Framework aligns to the NZ Triple Aim focussing on the three core components of Equity, People Centred and Efficiency.

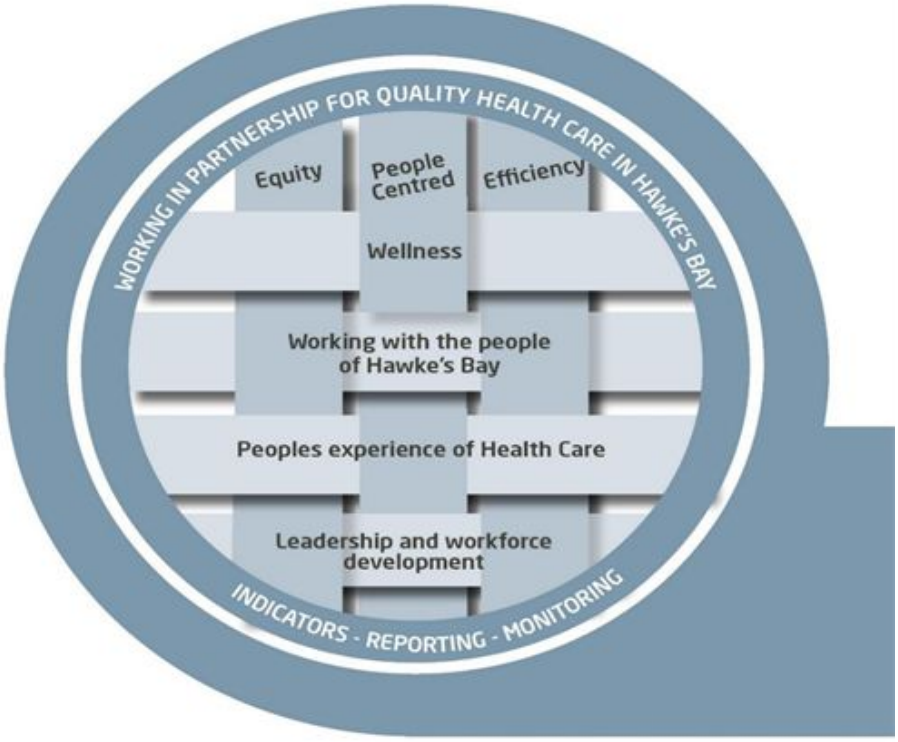
.

What does success look like?

- Every person that works in the Hawke's Bay Health sector will be aware of their responsibility for quality improvement and patient safety.
- Consumers are active participants in determining their wellness and their voice is valued in decision making.
- Clinical participation in management and governance of health services is essential in creating the culture needed for effective quality improvement and patient safety.
- Clinicians are not only responsible for the provision of high quality patient care, but their leadership is also important at all levels of the system.

12

Working in Partnership for Quality Framework



HEALTH CARE MUST BE:

- SAFE: Avoiding harm to patients from care that is intended to help them.
- EFFECTIVE: Providing services based on evidence and which produce a clear benefit, with neither underuse nor overuse of the best available techniques.
- PEOPLE CENTERED: Establishing a partnership between clinicians and patients, inclusive of family and whānau, to ensure care respects patient's needs and preferences; and the person should play an active role in making decisions about their own care.

- TIME: Reducing waits and sometimes harmful delays.
- EFFICIENT: Constantly seeking to reduce waste.
- EQUITABLE: Providing care that does not vary in quality because of a person's characteristics

WELLNESS

Population health and prevention programmes ensure that people are better protected from accidents, ill health and disability. The programmes support people to maintain healthy lifestyles.

As part of this annual plan we acknowledge the importance of making sure that health information about conditions and services, are easily accessible and easy to understand. This will reduce barriers for access to services as well as improve equity in health services and outcomes.

PEOPLE'S EXPERIENCE OF HEALTHCARE

The health experience Hawke's Bay people have is of utmost importance. We understand that some people may be vulnerable and may be going through life changing diagnoses and treatments. It is our goal that we make this experience the best that it can possibly be.

This means we will support a culture of care and compassion, sustain an open, transparent system that will ensure those people that use the health service come first at all times.

We will ensure all those who provide care for these people, both individuals and organisations, are aware of their role in ensuring a high quality and safe service, and are accountable for what they do.

WORKING WITH THE PEOPLE OF HAWKE'S BAY

We acknowledge the people who use our services have a unique perspective of health services and are able to provide us with important information about how we design, deliver and monitor health services.

Working together with the people of Hawke's Bay includes developing and maintaining stronger partnerships to share information between all those involved to ensure that the right care, is given to the right person, at the right time and by the right person.

LEADERSHIP AND WORKFORCE DEVELOPMENT

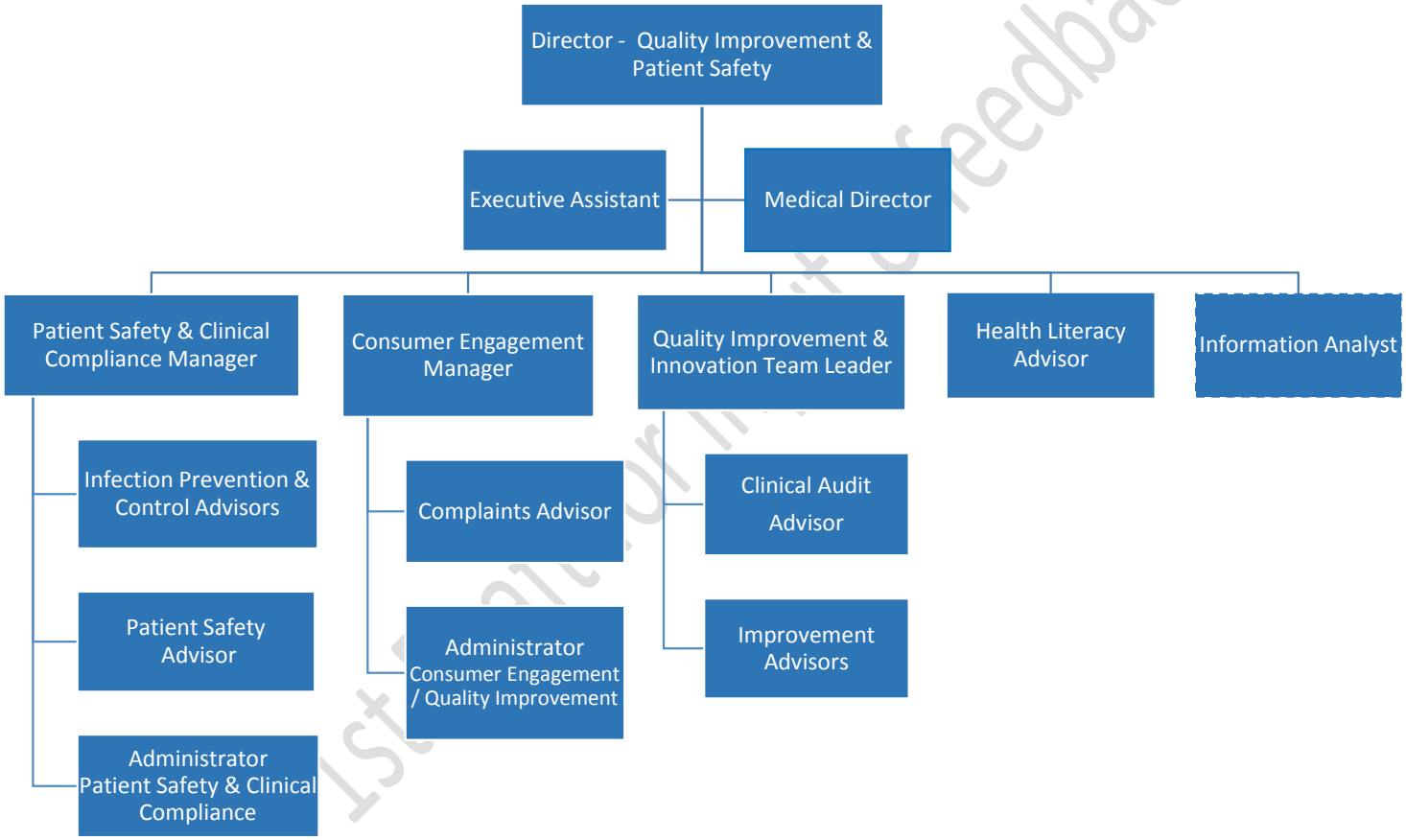
Ultimately we want a health system that focuses on system wide improvements and not on individuals. We want to examine underlying contributing factors and root causes to identify changes that could be made to improve systems and process to improve quality of care.

Ultimately we want a culture of open reporting where staff are empowered to make decisions relating to quality improvement and patient safety as close as possible to the person receiving care.

Whilst the Quality Annual plan is based on the sector implementing the framework, there are also a number of national and regional priorities that are factored into the plan, including the requirements from the Health Quality and Safety Commission (HQSC), the Regional Services Plan (RSP) and the HBDHB's Annual Plan. Extracts of the RSP and Annual Plan are appendices in the plan.

12

Quality Improvement & Patient Safety Structure



Annual Quality Improvement & Patient Safety Programme of Activities

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Responsibility	Timeframe
Wellness	Ensure that our systems of communication are responsive to the people of Hawke's Bay	Development of a sector wide Health Literacy Framework/Principles	Principles endorsed by all relevant governance bodies	HL Advisor	Q1
		Implementation of Health Literacy Framework	Action plan developed and monitored on a quarterly basis	HL Advisor	Q1 – ongoing
		Support development and continual review of our health website in conjunction with Communications team	Website continually updated	HL Advisor	Ongoing
		Continue to support quality improvement initiatives such as the development of Clinical Pathways, Customer Focussed Booking and National Patient Flow.	Projects benefits realised	Consumer Engagement Manager, QI Team	Ongoing
Wellness	Improving the Communication between health professionals and the consumer	Implementation of HL Training programmes to support clinicians to understand how to best engage with consumers	Training programmes developed and utilised	HL Advisor & E&D	Q2
		Rollout of Ko Awatea training modules and review uptake from across the sector	Regular reporting completed	HL Advisor	Q2
		Continue to build awareness with clinical teams around patient centred care e.g. Patient Safety Week (November)		Consumer Engagement Manager	Q2

Monitoring & Measuring	Presentation of quality health information	Development of a quarterly sector wide quality dashboard focussed on patient safety, clinical effectiveness and patient experience	KPI's developed	DQIPS/Business Intelligence	Q1
		Communication of the dashboard to relevant governance bodies and to the sector	Quarterly report communicated & shared	DQIPS	Q2
		Publication of the annual Quality Accounts report	Report completed and positive feedback received from community and HQSC	Consumer Engagement Manager	Q2
		Review of information provided to patients on admission and on discharge, with a view to making improvements.	Plan developed and implemented with improved patient responses to national patient experience survey	HL Advisor/Patient Safety Advisor	Q3
Monitoring & Measuring	Improve HB Health Sector performance against HQSC quality safety markers	Reduce the harm from falls through an integrated approach through the falls minimisation Committee	Improved engagement across the sector leading to a reduction in falls & harm from falls	Falls Committee	Ongoing
		Ensure Falls risk assessment and care plans are completed for all admissions	HQSM achieved/exceeded consistently (90% target)	Clinical Teams	Ongoing
		Review of all falls to ensure learnings are identified and opportunities for improvement are implemented.	Recommendations/learnings shared and implemented	Falls Committee	Ongoing
		Reduce the risk of health associated infection by maintaining the achievement at or above the 80% compliance rate for hand hygiene.	80% compliance rate achieved/exceeded consistently	Infection Prevention & Control/ Gold Auditors	Ongoing

		Reduce the risk of perioperative harm with the continuation of the briefing and debriefing piece of work for every theatre list. Reduce the risk of harm from pressure injury with the establishment of a cross sector pressure injury review committee. Support the development of a pressure injury strategy and implement any learnings from pressure injury events identified. Continue to carryout medicines reconciliations to improve medication safety and report these on a quarterly basis.	Briefing & Debriefing takes place 100% of time for all surgical procedures Establishment of cross sector Pressure Injury Committee Development of programme of work Increase current % of medicine reconciliations completed	Infection Prevention Control & Improvement Advisor Patient Safety & Improvement Advisor Patient Safety Advisor Pharmacy Facilitators	Ongoing Q2 Q2 Ongoing
Leadership	Maintain and build relationships across the sector, regionally and at a national level	Implementation of quality forums within HB bringing together those responsible for quality across GP Practices, ARRC and NGOs to enable sharing of learnings and development of a programme of work to support these providers Ensure effective representation of HB on Central Regions Quality Safety Alliance to support achievement of objectives within RSP Build relationships with HQSC and Ko Awatea	Quality forums established Participation and engagement high from all areas Participate in relevant groups and influence decision making Establish training partnership Implement Improvement Network	DQIPS DQIPS DQIPS	Q3 Ongoing Ongoing

Patient Experience	Improving clinical oversight in all provider contracts	Review all current clinical provider contracts to ensure they meet the HB sectors quality and patient safety requirements. Consider the development of a mechanism to collect information to monitor quality and safety within our contracted providers.	Principles of quality applied to clinical provider contracts Ensure appropriate reporting processes	DQIPS DQIPS	Q3 Q4
Leadership	Facilitating the quality agenda through clinical and management leadership and governance structures, promoting board responsibility for quality improvement and patient safety	Implementation of new clinical governance committee's structure to ensure effective reporting to clinical council. Establishment of an annual audit programme to ensure all clinical areas undertake regular audits against key HQSM and sector wide priorities Develop and implement mechanisms to ensure learnings from patient events and incidents are shared and recommendations are fully implemented. Implementation of new risk management framework Review of current event reporting system.	Committees established, with TOR, cross sector representation and reports provided through to Clinical Council Audit Committee established, and programme of work endorsed by Clinical Council. Reports provided on a quarterly basis Mechanisms agreed, learning shared and recommendation implementation monitored by Clinical Event Advisory Groups Framework, tools and reporting mechanisms in place and utilised Business Case developed and endorsed	DQIPS/Clinical Council/Consumer Council DQIPS/CAPHO Patient Safety Advisor DQIPS/Co Secretary DQIPS	Q2 Q2 Q1 Q3 Q1

		Facilitate and lead the implementation of a new event, risk and feedback reporting system	Project plan developed and implemented	DQIPS	Q4
		Review of current quality policies and procedures to support quality improvements and safety across the Hawkes Bay health system	Policies refreshed	Patient Safety & Clinical Compliance Manager	Q2
		Ensure Privacy action plan is implemented and annual audit it undertaken to meet requirements of GCPO.	Privacy plan reported against on a quarterly basis	Patient Safety & Clinical Compliance Manager	Q1
		Facilitate and support the implementation of Certification corrective actions with all clinical teams	Progress reports provided as per MOH requirements. Corrective actions closed by MOH.	Patient Safety/ Health Services	Ongoing
		Legislative Compliance annual review undertaken	Audit undertaken Report provided to FRAC	Patient Safety & Clinical Compliance Manager/Company Secretary	Q2
Working With HB Community	Improving the process of gathering patient experience data and stories, sharing them widely across the sector	Development of an overarching Person & Whanau Centred Care strategy, encompassing Patient Experience, Consumer Engagement & Health literacy pieces of work.	High level paper developed and feedback sought before finalisation.	DQIPS & Governance Groups	Q1
			Communication & Awareness building strategy implemented		Q1
		Continue to participate in the National Patient Experience Survey	Provide HQSC with information and undertake quarterly analysis of results	Consumer Engagement Manager	Ongoing

		Development and implementation of a local patient experience survey aligned to the values of the sector	Develop and Test questions Identify mechanism to gather data Collate information & Identify trends and themes – share with teams and identify areas for improvement	Consumer Engagement Manager/Business Intelligence	Q2
		Proactively seek out through focus groups, project development and quality improvement initiatives the ideas of our consumers and their whanau.	Plan and implement approaches to individual projects/initiatives	Consumer Engagement Manager	Q1 & Ongoing
		Continue to share patient stories with Board and more widely across the sector.	Mechanisms identified and implemented	Consumer Engagement Manager	Ongoing
Working With HB Community	Improving the process of monitoring consumer feedback and relevant recommendations and improvements	Share quarterly results of both national and local survey results with relevant governance groups identifying themes and areas for improvement	Information provided as part of ¼ dashboard Results shared and teams to identify improvement activities	Consumer Engagement Manager	Q2
Working With HB Community	Developing community engagement and communication channels	Identify a variety of mechanisms to engage effectively with our Community around health matters to gather their feedback and ideas	Identify provider to support effective community engagement and implement programme	Consumer Engagement Manager	Q2
Working With HB Community	Supporting the consumer voice to become part of nay	Development of a Consumer Engagement framework and guideline for all staff.	Consider all research, draft and gather feedback before finalisation and communication to all teams	Consumer Engagement Manager	Q1

	planning or redesign process	Ensure that all Project TOR require specific discussion in regards to the level of consumer engagement Continue to build capability in co-design methodology and utilising patient experience feedback to improve service design and delivery	Discuss with PMO Development of series of programmes Programmes delivered with high participation	Consumer Engagement Manager / PMO Consumer Engagement Manager	Q1 Q2 - ongoing
Leadership & Workforce	Implementing clinical leadership and building leadership capacity at all levels	Development of a programme of work to support building the capability of all teams in matters relating to Patient Safety, Consumer Engagement and Quality Improvement methodology. Continue to map talent across tier 3 and tier 4 management populations across the sector identifying potential. Extend the current talent mapping strategy to identify hidden and emerging talent Implementation of a development strategy for those identified to ensure succession plans are clearly identified and managed. Review of position profiles and performance appraisal process to ensure quality and patient safety components are included.	Annual Education programme developed and delivered Annual Mapping exercise undertaken and reports provided Tool developed and implemented, with hidden talent identified Plan implemented Position profiles & PAS templates updated	DQIPS DQIPS DQIPS DQIPS Human Resources	Q1 Q2 Q2 Q2 – ongoing Ongoing

Leadership & workforce	Improving workforce engagement	Implementation of new Staff Engagement Survey	Staff Engagement Survey run	Human Resources	Q2
		Review of information and feedback with the identification of organisational wide actions.	Reports collated and summarised for presentation	Human Resources/ EMT	Q2
		Implementation of actions	Action plans developed and progress against action monitored regularly.	EMT/HR	Q2 – ongoing
		Implementation of GEMBA Walks	Agree approach and purpose Implementation and identification of areas for improvement	DQIPS	Q2 – ongoing
Monitoring & Measuring	Ensuring that quality improvement and safety reporting and monitoring is provided and communicated effectively	Development of a quarterly sector wide quality dashboard focussed on patient safety, clinical effectiveness and patient experience	KPIs developed	DQIPS/Business Intelligence	Q1
		Communication of the dashboard to relevant governance bodies and to the sector	Report provide quarterly to relevant governance bodies and wider	DQIPS	Q1 & ongoing
		Continue to utilise benchmarking data provided by Health Roundtable (HRT) to identify further areas for improvement.	Quarterly Executive Summary shared with HS and Improvement initiatives identified and implemented	DQIPS/Business Intelligence/HS Leaders	Ongoing
		Ensure reporting of Serious Adverse Events and ACC Treatment Injury information is completed with learnings identified and recommendations implemented.	SAE Report provided annually	Patient Safety & Clinical Compliance	Q2 / Annually

Patient Experience	Ensure all Business Partners are supported to achieve their patient safety and clinical quality improvements.	Continue to facilitate a number of quality initiatives including the Bed Days and Releasing Time to Care programmes	4,500 Bed Days programme achieved Improved RSI Savings achieved	QI Team & Health Services Teams	Ongoing
		Increase collaboration and integration of QIPS team within all areas to educate, facilitate and support services to become more efficient and effective at delivering their services.	Increased & improved relationships Improved performance of services	QI Team QI Team	Ongoing
	Provision of support to projects and programmes of work	Continue to support initiatives to reduce harm, waste and variation Continue to provide expertise and advice to projects and programmes of work across sector. E.g. Operational Productivity, Aim 24/7	Benefits & savings realised Benefits of Projects realised	QI Team supporting HS QI Team supporting HS	Ongoing
Leadership & Workforce	QIPS Workforce Development	Support staff to attend training and conference opportunities to continue to build expertise and skills Support staff to complete annual performance appraisals and development plan to ensure staff are supported to maintain professional competencies Ensure that all staff have annual leave plans	Learnings shared and skills increased Performance Appraisal targets achieved Annual Leave indicators achieved	DQIPS All Managers All Managers	Ongoing Q1 Ongoing

		Ensure that the QIPS team has opportunities to share knowledge and skill across the team through regular team meeting, quarterly sessions and annual planning day. Budget and saving efficiencies for QIPS	Planning days implemented Successes celebrated Budget savings achieved	DQIPS DQIPS / QIPS	Ongoing Q4

Appendix 1 – Extract from HBDHB Annual Plan

1.1.1 Improving Quality & Safety

Delivering consistent high quality care continues to be one of the key themes and enablers to achieving our Transform and Sustain strategy. Over the past twelve months the Quality Improvement and Patient Safety service has been evolving to support the Hawkes Bay health sectors quality improvement and patient safety framework - Working in Partnership for Quality Healthcare in Hawke's Bay. This framework identified clinical leadership and consumer partnership throughout the health sector as the most important aspect of improving quality health care and patient safety. We use our framework to align our local efforts in support of the national quality improvement work coordinated by the Health Quality and Safety Commission (HQSC). In 2015/16 we have established a new Quality Improvement and Patient Safety (QIPS) team and we appointed the Director of that service to Executive Management Team (EMT) in order to further raise the profile of quality and safety at HBDHB. With a focus on consumer engagement, the QIPS team provide support for integrated quality improvement and performance across the Hawke's Bay health sector and help clinical teams to recognise and define priority areas and to identify actions for implementation. Our focus for the coming year will be on continuing to sustain the improvements made in the past twelve months, continuing to meet the required Health and Disability Standards with our full year Certification Audit and to focus on growing the capability of our teams in regards to co-design and improvement methodologies, and enable a shift in the culture of the DHB to see consumer engagement as the norm and move to becoming far more person and whānau centred.

Short-term outcome	Activity	Monitoring & Reporting
Improve HB Health Sector performance against all National Quality and Safety markers (QSM)	QIPS team to support operational teams by supplying regular performance data from routine monitoring and audits, interpreting data and assisting with the development of improvement opportunities	HQSC quarterly QSM reporting on all targets
	Front-line ownership of improvement targets driven by directorate leadership and oversight provided by Clinical Council representing sector wide clinical leadership.	
	Continue to share consumer stories monthly with all governance bodies and present quarterly quality dashboard.	
Reduce risk of harm from falls	Cross sector integrated approach through the Falls Minimisation Committee. Includes representation from primary, aged residential care and secondary care patients and NGPs Links to activity in hospital (intentional rounding, signalling tools in wards); urgent care (fracture liaison); community (aged residential care); and primary (pharmacy, green prescription).	90% of older patients are given a falls risk assessment

	Falls risk assessments and care plans completed for all admissions.	98% of those at risk have an individual care plan completed
	Clinical Nurse managers or Nurse Directors to investigate falls events and provide feedback and learnings to Chief Nursing Officer and Falls Minimisation Committee. Focus on reducing falls in older people that result in serious harm.	
	See Health of Older People Section for activity of falls minimisation	
Short-term outcome	**Activity**	**Monitoring & Reporting**
Reduce risk of healthcare associated infection	Maintain achievement at or above 80% compliance for hand hygiene	80% compliance with good hang hygiene practice
	Maintain the right number of trained hand hygiene auditors and promote good hand hygiene practices to staff, patients and visitors. Supported by the Chief Nursing Officer's sponsorship	
	Monitor quarterly results and implement related improvements, such as implementing local improvement methodology and front-line ownership through our gold auditors	
	Continue to provide education to all staff and take part in hand hygiene initiatives e.g. National Hand Hygiene Day	
	Improve performance for clinical interventions specified by the surgical site infection improvement programme	95% of hip and knee replacement patients receive cefazolin ≥2g or cefuromine ≥1.5g as surgical prophylaxis 100% of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision
	Champions on the wards and in DSU to support the process and educate staff	
	Regularly review the results and implement necessary Quality and Safety initiatives to improve performance	
Reduce risk of perioperative harm	Achieve the old QSM threshold of all three parts of the WHO surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90 percent of operations	All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100 percent of surgical procedures, with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale, 95 percent of the time. TBC
	Checklist will be used in paperless form, as a teamwork and communication tool rather than an audit tool	
	Work with the Commission to continue to implement briefing and debriefing for each theatre list.	

Reduce the risk of harm from Pressure Injury	Establish a pressure injury review committee by December 2016	
	Support clinicians to complete ACC 45 and ACC 2152 (treatment injury claim) forms for all grades of pressure injury except grade one, to provide a more accurate picture of the incidence of pressure injuries occurring while patients are in our care	
	Report all pressure injuries grade three and above as serious adverse events to HQSC	
	Review all Pressure injury events regularly and implement improvement initiatives as required.	
	Improve classification and documentation of pressure injuries by grade in the patient record and ensure they are coded	
	Implement structured risk assessment to support clinical judgment and evidence-based prevention approaches.	
	Provide ongoing education to all staff regarding pressure injuries	
Improve medication safety	Continue to carry out medicines reconciliations and monitor and report these on a quarterly basis with an aim to spread medicines reconciliation through paper-based system	% of medicine reconciliations completed
	Support implementation of electronic medicine reconciliation platform when infrastructure available (dependent on regional programme and implementation of clinical portal) It is anticipated that this will be in 2018.	
Improve Consumer engagement and experience	Continue with initiative to capture correct patient details at 'first point of contact' working closely with the Customer Focused Booking and National Patient Flow Projects	DV4 Quarterly Reporting
	Support implementation of the Patient Experience Survey in Primary Care. Opportunities for improvement will be identified, tracked and implemented	
	Develop a consumer engagement strategy by the end of 2016	
	Support the Hawke's Bay Health Consumer Council	
	Implement a local consumer engagement survey aligned to sector wide values	

	Continue to produce a Quality Dashboard to monitor Safety, Clinical Effectiveness and Patient Experience.	
	Develop and Implement a health literacy framework	
	Co-design Collaborative clinical pathways	
Improve Quality Improvement Capability and clinical leadership	Promote Key messages and themes of Patient Safety Week 2016	Quality accounts demonstrate building of capability for quality improvement and patient safety.
	Sustain the HB sector wide transformational leadership programme	
	Implementation of training and support to all teams in patient safety, QI methodologies, health literacy and co-design.	
Produce Annual Quality Accounts	Continue to produce annual Quality accounts and circulate locally to show improvement in key quality and patient safety indicators. Utilise relevant quality data as per HQSC guidance.	
	Implement a quality dashboard by December 2016 and share regularly with Clinical Council; Finance, Risk and Audit Committee; and HBDHB Board.	
Promote Regional Collaboration for Quality and Safety Initiatives	Implement HB sector wide consumer engagement strategy	
	Participate in Central Region's Quality and Safety Alliance and quarterly Quality and Risk meetings to share learnings and build capability for improvement.	

Appendix 2 – Extract from Regional Service Plan 2016-17

Quality and Safety

Sponsor: Julie Patterson

Clinical leadership and person/family-centred care are internationally recognised as key drivers of improved patient outcomes and effective clinical governance.

Clinical governance systems within health care form the foundation of safer processes for people and their families/whānau and staff. The aim for the Central Region is to work in partnership as a region to improve the quality of care and to reduce patient harm. The Central Region Quality and Safety Alliance (CRQSA) was established June 2014, with the overarching aim of achieving consistent high quality and safety of care and positive patient experiences for people and their families/whānau.

The CRQSA provides a voice for clinical leaders across the region to positively influence planning, reduce health disparities and improve health outcomes for communities.

Partnership between the CRQSA, HQSC, ACC and Ministry of Health quality programmes has been established and will be strengthened through active participation, information sharing and collaborative initiatives that improve the health and wellbeing of communities.

Objectives

- Provide effective regional quality and safety planning, advice and recommendations to the Regional Executive Committee
- Promote the effective and appropriate sharing of quality and safety information and learnings that supports a regional perspective on patient safety issues
- Influence and support clinicians and managers to implement systems and processes that will improve the quality and safety of the care delivered

Q and S Key Actions	Milestones	Measures
Strengthen alliance with primary care participation in the Central Region	Q1: scope opportunities for further engagement points and establish relationships with PHO and DHB Clinical Governance Boards. Q2–Q3: develop and agree Future Engagement Strategy. Q3–Q4: implementation of Future Engagement Strategy.	Q1: Identifying chairs of local clinical governance boards/equivalent and sending key points from CRSQA meetings to be added to local agendas. Q2-Q3: Embed process for raising issues from local clinical governance boards to CRQSA. Q3-Q4: Maintain/increase membership of PHOs on CRQSA.
Improve patient outcomes through collaboration on areas of high patient harm with support from HQSC programmes	Q1–Q4: utilise HQSC regional data on identifying areas of improved patient outcomes/areas of risk. Q3–Q4: develop a regional shared learning framework.	To regionally mark against the national average in the quality and safety markers and outcome measures set by HQSC through sharing regional learnings. Establish a regional shared learning framework for improving patient outcomes.
Support the regional approach of person and whānau-centred care consumer partnerships with implementation of Relationship Centred Practice training	Q1: coordinate information on consumer structures and approaches utilising regional linkages on creating agreed consumer approach across the region. Q2–Q3: develop a training package to support the implementation of a person and whānau-centred approach. Q4: regional phased implementation of the Relationship Centred Practice training.	Information collected and shared on consumer groups and approaches in Central Region and available on SharePoint. Discussion item on every agenda regarding consumer input across the central region. Training package developed on the person and whānau-centred care approach. Report from HQSC regarding central region themes from adult inpatient experience survey. To provide Central Region training on person and whānau-centred care (Relationship Centred Practice training).

Continue to strengthen partnerships with the quality and safety programme of the HQSC, ACC and the Ministry to promote shared learnings	Q1: scope opportunities for shared learning events. Q1–Q4: collaborate with national partners to contribute to HQSC open book.	HQSC reports on every agenda for discussion/action. Regional contribution to HQSC 'Open Book'. Six-monthly report received from HealthCert MoH on regional learning from certification for distribution amongst quality managers. Regional collaboration on adverse event management policy development. Evidence of establishment of central region quality and safety groups such as infection control, falls events, incontinence management, pressure injury prevention, medication safety, central region quality managers, central region directors of nursing – with six-monthly updates from all groups to CRQSA.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Mental Health**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner: Document Author(s):	Sharon Mason – Chief Operating Office (Champion) Allison Stevenson, Service Director & Simon Shaw, Medical Director
Reviewed by:	Paul Malan – Strategic Service Manager; Health Services Leadership Team; Executive Management Team
Month:	August 2016
Consideration:	For monitoring

13

RECOMMENDATION **That MRB, Clinial and Consumer Council and HBDHB Board:** Note the contents of this report.

OVERVIEW

Te Ara Whakawairoa (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly with champions to oversee that monitoring and reporting.

Non-performing indicators are identified by the Māori Relationship Board which require special reporting through a channel of committees and then onto the HBDHB Board.

This report is from Sharon Mason, Champion of Mental Health Services Indicators. It focuses on key indicators to improve Mental Health Services for Māori.

UPCOMING REPORTS

The following are the indicators of concern; allocated Executive Management Team (EMT) Champion and reporting month in 2015 / 2016.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Mental Health	Rate of section 29 Compulsory Treatment Orders	81.5% (per 100,000)	Sharon Mason	Allison Stevenson	August 2016
	Percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan	95%	Sharon Mason	Allison Stevenson	August 2016
	PP8 mental health wait times for non-urgent mental health or addiction services seen within three weeks (mental health provider arm), 0 to 19 years	80%	Sharon Mason	Allison Stevenson	August 2016

WHY ARE THESE INDICATORS IMPORTANT?

Use of Section 29, Compulsory Treatment Orders (CTO) is symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need. Māori are over represented in these statistics, showing that just less than half the consumers on CTO are Māori.

Monitoring the percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan showing the discharge to primary care with a plan in place. Showing the partnership between primary and secondary services. Consumers must have had three face-to-face contacts for a discharge plan to be generated (MoH KPI). HBDHB count all consumers discharged from CAFS Service as having a discharge / transition plan in place.

Ministry of Health monitoring of mental health wait times for non-urgent Mental Health or Addiction Services seen within three weeks, (mental health provider arm), 0 to 19 years, showing people are receiving services within acceptable timeframes of referral to face-to-face appointment. Consumers are not waiting for appointments and the services have been timely and effective in their care.

Inequality in Outcomes in Mental Health Status for Māori

- Māori have a high rate of access to Mental Health Services than non-Māori.
- Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori on average.
- Estimated twelve month prevalence of schizophrenia for Māori (0.97%) is significantly higher than for non-Māori (0.32%[i]).
- Hospitalisation rate and readmission rate is higher for Māori (17%).

Rate of Section 29 Compulsory Treatment Orders

The Office of the Director of Mental Health reports annually on rates of Section 29 use by DHBs. The report comments that Māori have 3 - 4 times higher rates of use of Section 29 compared to non-Māori on average.

Compulsory Treatment Order (CTO) rates are symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need.

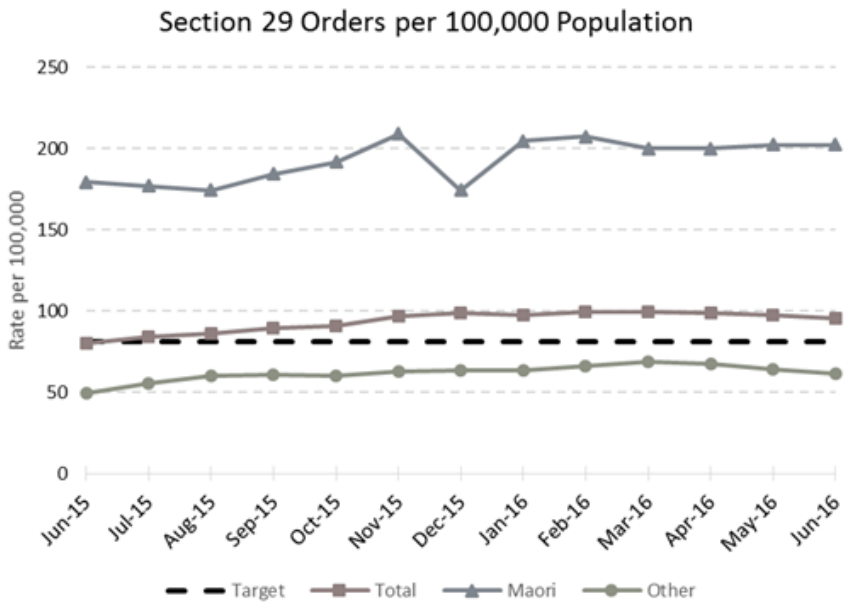
Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies including cultural and social agencies so as to provide a more holistic, integrated and comprehensive response.

No target was assigned to DHBs for this indicator through the "DHB Māori Health Plan Guidance". However, the guidance document does mention that DHBs are to "reduce the rate of Māori on the Mental Health Act". The guidance document goes on to state[ii]:

New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity. There are regional and local differences, not necessarily related to population mix, which DHBs need to understand and work to reduce. The mental health indicator also supports implementing the priority actions for Māori in Rising to the Challenge, and the Mental Health and Addiction Service Development Plan 2012-2017 including other actions in the plan that relate to addressing disparities or self-management.

13

HBDHB Section 29 Orders – June 2015 to June 2016



			Target	Total	Māori	Other
2015/16	Q1	≤	81.5	86.7	178.6	59.0
	Q2	≤	81.5	95.6	191.7	62.2
	Q3	≤	81.5	99.0	204.0	65.9
	Q4	≤	81.5	97.3	201.6	64.5

Audit of Fifty Random Consumer Files That Were Placed on the Community Treatment Order (CTO)

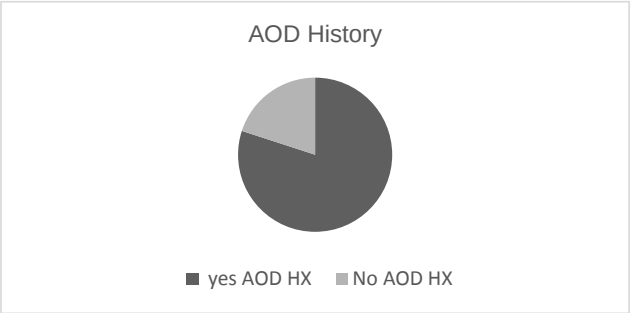
In the 2015 / 2016 Annual Plan, we signalled that we would undertake an audit of patients subject to CTO to determine factors associated with treatment under the Mental Health Act. The Mental Health Service completed the audit of fifty random files under the Mental Health Act over the past year showing the socioeconomic factors that are part of a person being place on a CTO. Some key factors examined were:

Addictions History

Were addictions part of the person's history?

20% had no addictions history.

80% had an addictions history.



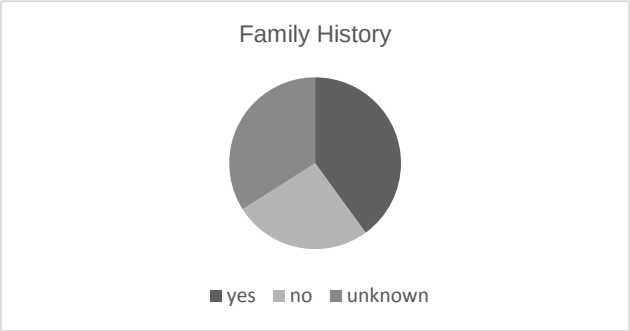
Family History of Mental Illness

Was there a history of mental illness within the family?

40% had a mental illness history.

26 % did not have a history of mental illness.

34 % were unknown**.**



Work Status

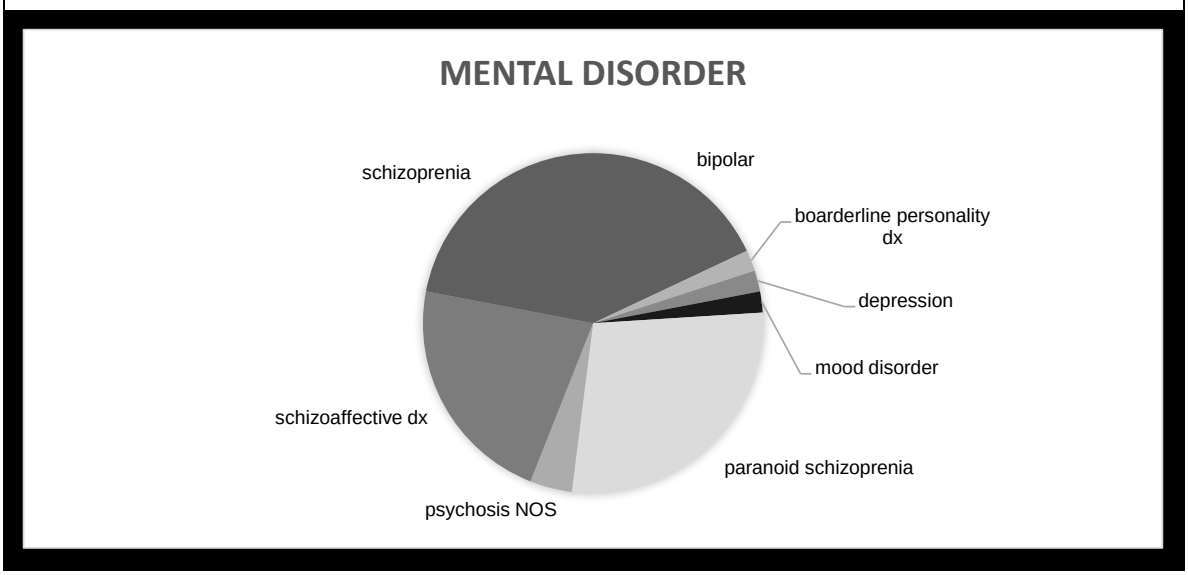
Was the person employed at the time of the CTO?

92% of people on CTO were unemployed.

8% were is some type of employment.

What type of mental illness did people have who were placed under CTO?

People who were under CTO suffered from; schizophrenia 22%, bi-polar 18%, schizoaffective disorder 22% and paranoid schizophrenia 28%



The audit shows that being placed under the CTO is not just about mental health but a complexity of social, family and health factors. In addition, differences in the population rates of these underlying factors may be a significant driver of compulsory treatment and is an important component of any attempt to reduce the rate. Currently we are analyzing the data for Māori vs non-Māori for the same content.

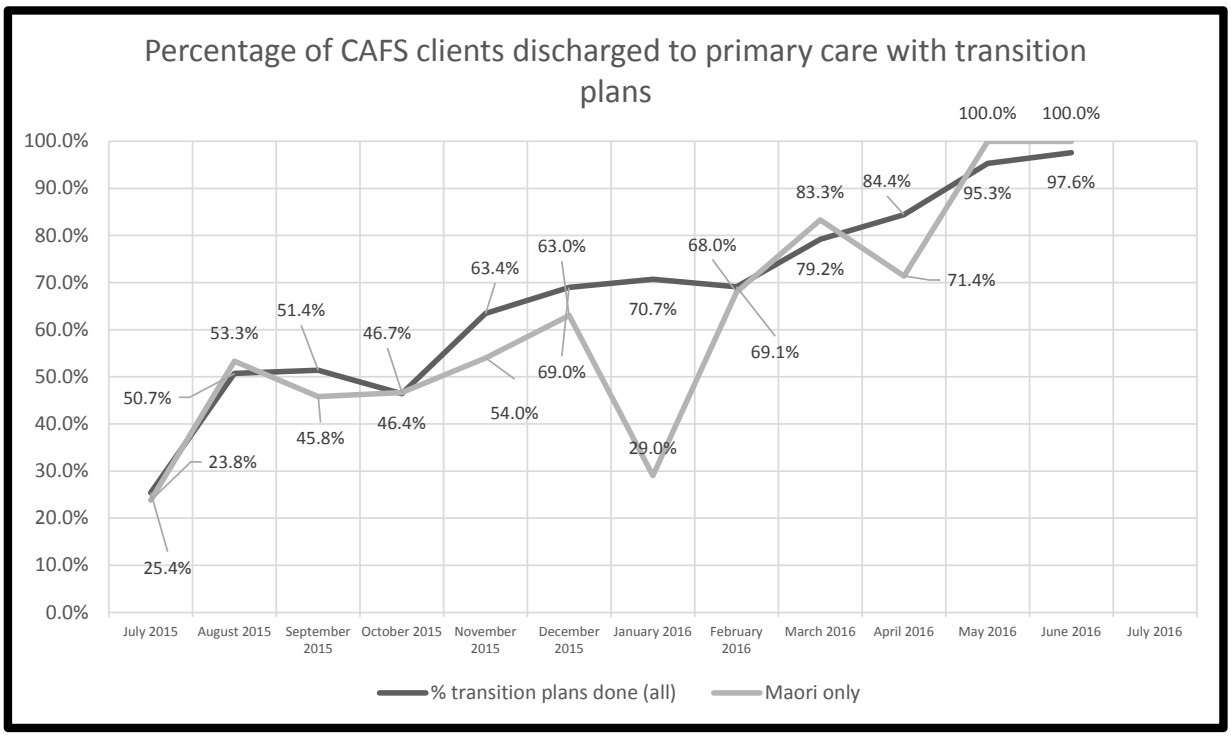
13

NUMBER 2 INDICATOR

Percentage of Clients Discharged from CAFS and Youth Alcohol and Other Drug (AOD) Services with a Transition (Discharge) Plan

This ministry measurement is after three face-to-face meetings with the child and family, a transition or discharge plan must be generated and sent to family and referrer. HBDHB counts all children and family appointment regardless of how many face-to-face contacts have been held.

The below table shows that from July 2015 to July 2016 we have increased from 23.8% to 100%.



NUMBER 3 INDICATOR

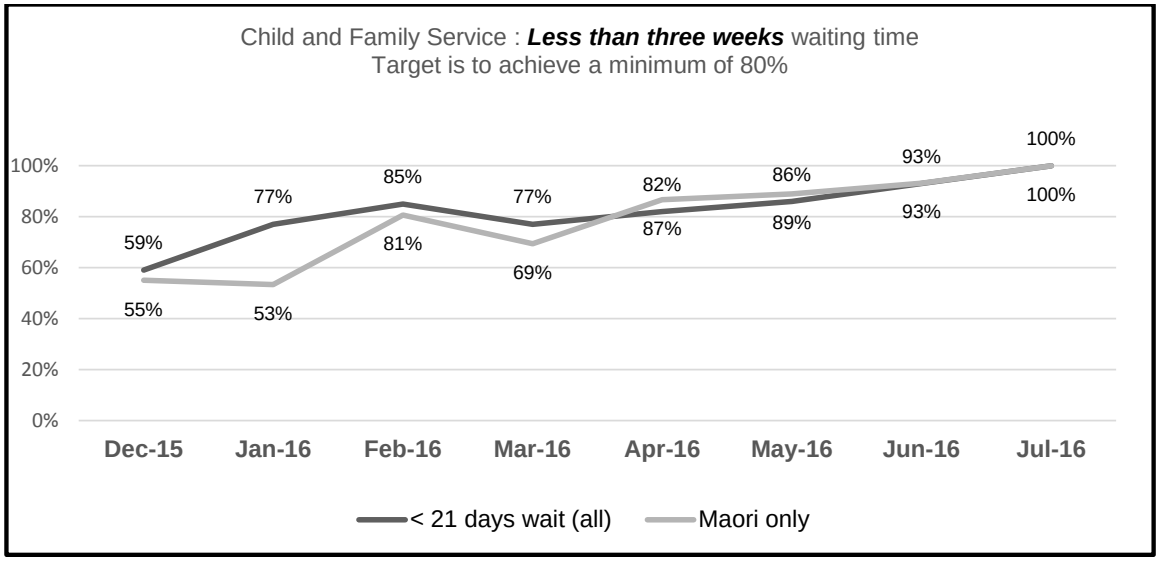
Mental Health Wait Times for Non-Urgent Mental Health or Addiction Services Seen within Three Weeks (provider arm) 0 – 19 years

This indicator shows from the time of receiving the referral from the referrer to the time the child / family are seen by a health practitioner. December 2015 at 59% to July 2016 100%.

Note: the table below is for quarter reporting and only is reported to March 2016.

	Mental Health Provider Arm									
	<3 weeks					**<8 weeks**				
12 months to	Target	Provider Arm Total	Māori	Pacific	Other	Target	Provider Arm Total	Māori	Pacific	Other
Mar-16	80.0%	67.4%	66.4%	71.4%	68.0%	95.0%	90.2%	91.4%	95.2%	89.0%

During the first six months of 2016 (i.e. Q3 and Q4), the CAFS team completed extensive work to improve the waiting time between referral and appointment. A consistent improvement from January 2016 is shown in the graph below, and the service is achieving 100% within three weeks as of July 2016.



The second component of this measure is the proportion of CAFS clients seen within eight weeks, with a national target of 95%. In December 2015 we were at 90% and in March 2016, 91.4% for Māori children and adolescents.

As explained above, the CAFS team have completed extensive work on waiting times and we are now (July 2016) achieving 100% of referrals seen within three weeks. We have been achieving 100% for Māori since April 2016 but the eight week indicator has now become irrelevant as no one is waiting longer than three weeks.

CHAMPIONS REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

Compulsory Treatment Orders
In line with Annual Plan 2015 / 2016[iii], Mental Health and Addiction Services began an audit of CTO in quarter three. That audit has given us some baseline understanding of the population under CTO. Whilst there is still work to do on further investigation of those factors, the services we are already putting in place, are a new model of care for acute and community services. This includes a shift in focus to a recovery approach that builds resilience for people with low-prevalence conditions and / or high needs and is more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment. These changes enhance access by integrating hospital and community services, strengthening collaboration with kaupapa services, and developing better primary care responses.

Transition and Discharge Planning
Over the last year we have developed a standard transition plan document / template that covers secondary mental health and addiction services. Every clinician who has primary responsibility for a case now completes the core transition document and we ensure that the primary care provider or primary referrer is prompted to make a follow-up appointment within three weeks. The completed transition plans are communicated to the primary referrer.

Reducing Waiting Times
The work that was planned to support this indicator was mostly procedural and administrative i.e. establishing prompts with appropriate policies and procedures to ensure proactive management of referrals. This was enhanced with good monitoring of results and attention to DNAs.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR

From the HBDHB Annual Plan 2016 / 2017[iv], the table below shows the activity that is planned to support the CTO indicator.

Short-term outcome		Activity	Monitoring and Reporting
Māori Health Priority	**Reduce the rate of Compulsory Treatment Orders**	Home-based treatment team increases family involvement with planning and crisis intervention by Q4.	**Rate of CTO** in Māori and non-Māori **100% of intensive service staff** trained by Q3 **Number of referrals** to specific services **SI5**: WHĀNAU ORA Key Indicator
		Ongoing daily step up step down with Ngā Rau Rākau, CMH, HBT, EMHS, Wai-O-Rua and TTOH to improve discharge and admission communication.	
		Implement intensive day programme from Q1.	
		Staff education around sensory modulation and trauma informed care to help reduce restrictive models of care.	
		Increase availability of treatment options across community mental health services.	
		Building networks within the community – increased use and referrals to NGOs within the community for follow up; meetings with NGOs and whānau/families to agree on and document plans & outcomes by Q2.	

From the HBDHB Annual Plan 2016 / 2017[v], the table below shows the activity that is planned to support transition planning:

Short-term outcome	Activity	Monitoring and Reporting
Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) services	Formalise implementation of Transition Planning Checklist as standard practice in Q1. Amend discharge documentation to include standard prompt to primary referrer in Q2. Introduce "error flag" in patient administration system to prompt completion in Q3.	**PP7:** 95% of clients discharged with have a transition (discharge) plan + exception reporting
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy.	

13

From the HBDHB Annual Plan 2016 / 2017[vi], the table below shows the activity that is planned to support maintaining waiting times:

Short-term outcome	Activity	Monitoring and Reporting
Improve access to CAFS and Youth AOD Services	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful by Q1.	**PP8:** 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + narrative report
	Liaise with KPI Forum stakeholders and other DHBs regarding "face-to-face" rule for first contact with children and families by Q2.	
	DNA's and joint appointments – review policy and impact of current practice by Q3. Redesign if necessary.	
	Scoping of potential for alternatives to admission for youth to be developed by Q2, e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	

PRIMARY AND SECONDAY SERVICES INEGRATION OF MENTAL HEALTH SERVICES

In March 2015, Primary Health Organisation (PHO) commissioned a review of primary mental health services and this was reviewed and completed with recommendations from the Chiplin group. The recommendations are clear about strengthening the relationships between secondary and primary care to improve and support access for clients. If availability of clinical pathways, provision of advice, joint consultations and case discussions were implemented this may reduce the increasing burden on secondary care and provide better outcomes for mental health clients in primary care.

RECOMMENDATIONS FROM TARGET CHAMPION

Activity to support these three indicators is well underway and should continue. The complexity around CTO will be better understood by further analysis of the audit results and, by sharing this information, the services will be better placed to ensure the most appropriate use of compulsory treatment. I support the intentions to increase family involvement, integrate services and service providers, and develop staff capability and to build networks.

Targets in respect of transition planning and waiting times are now all being met. This is commendable and must be maintained. The intentions in the Annual Plan will all help with ongoing

improvement but it is also recommended that the service ensure robust operational performance monitoring of these aspects of service quality in order to capture the gains.

I support the recommendations within the Chiplin report and encourage primary and secondary mental health services to implement mechanisms to allow for further integration.

CONCLUSION

Our changing models of care are designed to increase access to services, including earlier access for all people across the spectrum of need. Mental Health and Addiction Services have come a long way in the last year and it will be good to maintain that momentum and to keep improving on these and other markers of service quality.

REFERENCES

[i] Kake, Arnold and Ellis. Estimating the prevalence of schizophrenia among New Zealand Māori: a capture-recapture approach. Aust NZ J Psychiatry. 2008 Nov: 42(11):941-9

[ii] http://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package-and-review-plans/mhp-guidance

[iii] Hawke's Bay District Health Board, Annual Plan 2015/16. HBDHB.

[iv] Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.
[v] Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.
[vi] Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora / Culturally Competent Workforce**
	For the attention of: **Maori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner: Document Author(s):	Chris McKenna, Chief Nursing Officer Andrew Phillips, Director of Allied Health John McKeefry, General Manager, Human Resources
Reviewed by:	Executive Management Team
Month:	August 2016
Consideration:	For Information

14

RECOMMENDATION:

That MRB, Clinical and Consumer Council and HBDHB Board

Note the contents of this report.

OVERVIEW

The national General Managers Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators. In September 2013, the executive management team (EMT) considered a paper from Tumu Whakarae about an approach to accelerating Māori health plan indicator performance. As a result, individual EMT members agreed to provide a championship role for the Māori Health Plan across areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from John McKeefry, Chris McKenna and Andrew Phillips, Champions for the Culturally Competent Workforce Indicators.

THIS REPORT COVERS

Priority	Indicator	Champion	Reporting Month
Culturally Competent Workforce	▪ Increase % of HBDHB staff who are Māori ▪ 100% of HBDHB staff have completed Treaty on line training ▪ 100% of HBDHB staff have completed "Effective Engagement with Māori" (EEWM) training ▪ 100% of HBDHB staff have KPI's to accelerate the improvement of Māori health	John McKeefry, Chris McKenna, and Andrew Phillips	July 2016

MRB at its June 2016 meeting identified a number of actions for consideration by EMT as below. These were discussed with MRB at its meeting of 13 August 2016 and have been considered as part of the development of this report.

a) Raise the target to Increase Māori Staff from 10% year-on-year to 25% over a five year period.
b) Present the strategy to Increase Māori staff to MRB before going to the Finance, Risk and Audit Committee (FRAC).
c) Review the current HBDHB hiring protocols and processes
d) Review the conviction policy for the HBDHB and whether a conviction that is old, is relevant now
e) Broaden the scope to the target to all disciplines, not just medical, nursing and allied health
f) Shift the responsibility of achieving the target to Hiring Managers setting KPIs for monitoring
g) Senior Management monitor the progress of the target and provide monthly updates identifying why the target was achieved, or not achieved.
h) Train Hiring Managers efficiently and effectively use the Managers Toolkit
i) Māori Health Service involved in the recruitment process form the development of position profiles, shortlisting and interview stages with a member of the team becoming a compulsory member of all hiring/selection panels.

At the July 2016 MRB meeting, MRB also identified further actions for consideration as below.

- Would like to see the midwifery workforce as part of the strategy as Māori midwifery representation is less than 2% in DHBs. Action: The General Manager, Human Resources will look into this with the Chief Nursing Officer
- MRB raised almost two years ago the issues and the need for Māori nursing students to receive formal coaching, pastoral care and Tuakana/Teina support. While EIT are still working on these student services and the DHB are partnering with EIT to develop these services, MRB were somewhat disappointed that these issues have still not been addressed
- There seems to be a gap in the Hiring/ Selection process. Recruitment panels needs strengthening to ensure they understand the need to employ more Māori and why
- Introduction Relationship Based Management Skills training is being led by Andrew Phillips (Director Allied Health HBDHB). Suggest utilising a Māori to support the training to add more value because of their first-hand knowledge and experience
- There is a lot of comprehensive work around having Māori review recruitment processes to ensure Māori priorities and realities are implemented. We should be identifying what is ***not*** attractive about the DHB rather than trying to make the DHB look attractive. The recruitment process needs to be driven by Māori. Structural issues will impinge on Māori recruitment. The barriers of the recruitment process need to be identified through forensic audits.

MĀORI HEALTH PLAN INDICATOR: Culturally Competent Workforce

% of HBDHB Staff who are Māori

Current Performance

At 30 June 2015 our Māori staff representation figure increased to 12.3% of our workforce from 8.7% in June 2012. This is off the back of increases from June 2012 (8.7%) to June 2013 (9.9%) to June 2014 (10.8%).

Unfortunately our performance has plateaued with our performance at 30 June 2016 sitting at 12.5% against a target of 14.3%. The position for all workforce groupings at 30 June 2016 is set out in Table A below. This shows for all workforce groupings the percentage of Māori staff has increased. Pleasingly there have been significant percentage increases of Māori staff representation from 2012 to 2016 in our two biggest workforces – Nursing 7.0% to 10.8% and Allied Health, 9.4% to 13.2%.
Note: Nursing workforce data is unable to be broken down into Midwifery workforce data.

14

Table A

Report as at 30 June last 5 years

	30-Jun-16					30-Jun-15					30-Jun-14				
	Staff	Target 14.3%	Actual	Actual %	Gap	Staff	Target 12.97%	Actual	Actual %	Gap	Staff	Target 11.78%	Actual	Actual %	Gap
Medical - SMO	142	20	2	1.4%	18	140	18	3	2.1%	15	127	15	2	1.6%	13
Medical - RMO	138	20	7	5.1%	13	119	15	4	3.4%	11	123	14	2	1.6%	12
Nursing	1,504	215	162	10.8%	53	1,453	188	147	10.1%	41	1,386	163	129	9.3%	34
Allied Health	553	79	73	13.2%	6	528	68	69	13.1%	-1	525	62	55	10.5%	7
Support	188	27	55	29.3%	-28	181	23	50	27.6%	-27	174	20	49	28.2%	-29
Management & Admin	457	65	73	16.0%	-8	440	57	78	17.7%	-21	426	50	62	14.6%	-12
Total	**2,982**	**426**	**372**	**12.5%**	**54**	**2,861**	**371**	**351**	**12.3%**	**20**	**2,761**	**325**	**299**	**10.8%**	**26**

	30-Jun-13					30-Jun-12				
	Staff	Target 10.71%	Actual	Actual %	Gap	Staff	Target 9.73%	Actual	Actual %	Gap
Medical - SMO	132	14	1	0.8%	13	128	12	1	0.8%	11
Medical - RMO	122	13	4	3.3%	9	113	11	3	2.7%	8
Nursing	1,393	149	113	8.1%	36	1,313	128	92	7.0%	36
Allied Health	527	56	53	10.1%	3	521	51	49	9.4%	2
Support	182	19	49	26.9%	-30	186	18	46	24.7%	-28
Management & Admin	420	45	56	13.3%	-11	435	42	43	9.9%	-1
Total	**2,776**	**297**	**276**	**9.9%**	**21**	**2,696**	**262**	**234**	**8.7%**	**28**

When we look at Health Services where the majority of our staff work as can be seen in Table B below, the largest gaps are in Acute and Medical and Surgical Services.

Table B

Gap by Service	Nursing	Allied Health
Acute & Medical Services	30	7
Director of Nursing (Hospital)		
Surgical Services	20	3
Facilities & Operational Support	4	1
Laboratory		8
Older Persons & Mental Health	(5)	6
Oral Rural & Community		(6)
Woman Children & Youth Service	6	1
Subtotal Health Services	**53**	**10**

Māori candidates – application shortlisting, interview appointment

Proposed Target

It is proposed by MRB that we increase the target to 25% by 2021 to mirror the population demographic for Hawke's Bay. This would see the percentage increases and gap for the next five years as below in Table C.

A 10% increase for each year would see gaps for each year through to 2021 also set out in Table C.

Table C

Increase year on year 11.82%							Increase year on year 10.00%						
Target	% Target	Emps	Target Maori	Actual	% Maori	Gap	Target	% Target	Emps	Target Maori	Actual	% Maori	Gap
2015/16	14.30%	2,970	425	366	12.32%	59	2015/16	14.30%	2,970	425	366	12.32%	59
2016/17	15.99%	2,970	475	366	12.32%	109	2016/17	15.73%	2,970	467	366	12.32%	101
2017/18	17.88%	2,970	531	366	12.32%	165	2017/18	17.30%	2,970	514	366	12.32%	148
2018/19	19.99%	2,970	594	366	12.32%	228	2018/19	19.03%	2,970	565	366	12.32%	199
2019/20	22.36%	2,970	664	366	12.32%	298	2019/20	20.94%	2,970	622	366	12.32%	256
2020/21	25.00%	2,970	742	366	12.32%	376	2020/21	23.03%	2,970	684	366	12.32%	318

This suggests that increasing the target to 25% by 30 June 2021 will be too high a target because of the sheer number of staff to be recruited and even increasing the target year on year by 10% each year will make the target harder and harder to achieve each year. A target for 2016/17 will be discussed at the FRAC meeting.

Table D

Table D below shows by workforce grouping the recruitment of Māori into the HBDHB, the turnover of Māori leaving the organisation and the total number and percent of Māori staff.

Report as at (or year end) 30 June 2016

	RECRUITMENT				TURNOVER		ACTUAL STAFFING 30 JUNE 2016				
	% Maori applied	% Maori Interviewed	% Maori Appointed	% Maori Appointed v Maori Interviewed	Maori	Total DHB	Staff	Target 14.3%	Actual	Actual %	Gap
Medical - SMO	0.0%	0.0%	0.0%	0.0%	0.0%	4.9%	142	20	2	1.4%	18
Medical - RMO	0.4%	2.0%	2.1%	100.0%	0.0%	0.0%	138	20	7	5.1%	13
Nursing	5.5%	12.3%	13.4%	58.6%	11.0%	9.2%	1,504	215	162	10.8%	53
Allied Health	11.7%	15.7%	13.8%	42.5%	5.3%	8.9%	553	79	73	13.2%	6
Support	29.3%	32.7%	24.0%	35.3%	12.2%	12.3%	188	27	55	29.3%	-28
Management & Admin	13.3%	17.0%	14.3%	29.5%	13.2%	10.2%	457	65	73	16.0%	-8
Total	**9.3%**	**14.5%**	**12.8%**	**44.4%**	**10.4%**	**9.3%**	**2,982**	**426**	**372**	12.5%	**54**

Table D shows that:
For nursing 5.5% of all applicants, 12.3% of interviewees and 13.4% of candidates appointed are Māori, 58.6% of Māori interviewed are appointed.

For Allied Health 11.7% of all applicants 15.7% of interviewees and 13.8% of candidates appointed are Māori. 42.5% of Māori interviewed are appointed.

For Support, 29.3% of all applicants, 32.7% of interviewees and 24% of appointees are Māori. 35.3% of Māori interviewed.

For Management and Administration 13.3% of applicants, 17 of interviewees and 14.3% of appointees are Māori. 29.5% of Māori interviewed and appointed.

This shows we need to increase the number of Māori applying and being interviewed for Nursing, Allied and Management and Administration roles and increase the number of Māori being interviewed and appointed for Support and Management and Administration roles.

As for turnover, Management and Administration and Nursing turnover is higher than the DHB turnover figure. This means we need to do better at reducing turnover in these areas particularly for Nursing as our biggest workforce.

Māori Staff Representation

The DHB wants to achieve Māori staff representation levels equal to the Hawke's Bay population Māori ethnicity of 25%. We want to do this to ensure we can better engage effectively with our communities and provide more jobs (and well paid jobs for Māori).

Overall we have increased Māori staff representation to 12.5% at June 2016. This has largely been achieved through our focus on increasing Māori staff representation in Nursing, increasing from 7.0% at June 2012 to 10.8% at June 2016. Increasing the target form 12.97% at June 2015 to 14.3% at June 2016 did not see a continued lift in performance. Performance at June 2015 was 12.3% only increasing to 12.5% at June 2016. We started the year with a gap of 59 closing to 54 at 30 June 2016. MRB have asked that the DHB commit to a target of 25% by 30 June 2021. This wouldrequire net increases of 109, 165, 228, 298 and 376 additional Māori staff through to 30 June 2021. Increasing the target by 10% each year through to 2021 would require net increases in Māori staff representation of 101, 148, 199, 256 and 318 each year to 30 June 2016.

EMT has considered each of these approaches at their meetings of 12 and 26 July 2016. EMT believes that it is better to commit to a realistic and achievable target for July 2017 and work with Medical, Nursing, Allied and other workforce leaders to confirm the targeted actions that need to be taken workforce grouping by workforce grouping to improve performance against the target. EMT believes a target of 30 June 2017 of 10% increase on the actual percentage achieved to 30 June 2016 of 12.5%. This would mean a new target by 30 June 2017 of 13.75%. A new target for the years' after June 2017 can be set once the targetted actions for each workforce grouping have been identified.

100% of HBDHB staff has completed Treaty on line training & 100% of HBDHB staff has completed the "Engaging Effectively with Māori" (EEWM) training.

Current Performance

We launched the newly developed package EEWM in August 2014 and it has been a success. Current training stats as at 30 June 2016 are attached as Appendix A.

To date 1925 current staff members (65.6%) have completed the EEWM training. A total of 86.3% managers have attended.

Feedback from staff attending has been positive and almost all staff feeding back through formal course feedback sheets state that they would recommend the course. We now automatically enrol all new staff onto the EEWM course and are following up with staff enrolled to make sure they attend.

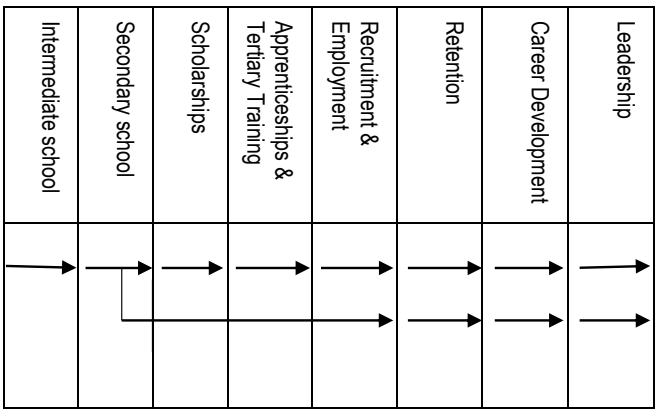
This training is under review and will be modified for internal delivery from within Māori Health Services (MHS) from July 2016 onwards.

Programme Incubator
Our Programme Incubator has been running since 2007. In the 2016 uptake, 19 schools are participating with 352 year 12 and 13 total students of which 89 (28%) are Māori. Our Earn and Learn programme targets year 11, 12 and 13 students that may not have an academic interest but are still interested in working in health. However, once employed into the DHB roles such as Orderlies, Care Associates, Laboratory Technician etc., there is an opportunity to further their career pathway through workplace training to gain national qualifications. This programme has a total of 37 students participating of which 20 (54%) are Māori.

We run our annual Health Careers Expo targeting year 10 and 11 students to get these students interested in health careers and the sciences. Most recently run in June 2016, 492 students in total attended. Ethnicity is not recorded for this.

Turuki
For Turuki we offer Health Workforce New Zealand (HWNZ) funded and other scholarships which have had a total of 79 scholarships taken up over the last three years and promote health careers to Hastings Intermediate students.

Increasing Māori Staff representation
The pipeline for Māori staff out of intermediate and secondary school into employment in the HBDHB is described below:



Students can go from secondary schooling straight into employment or into employment via tertiary training and apprenticeships.

Recruitment and Employment
We need to move our hiring managers to taking on board the challenge of recruiting more Māori staff members from understanding it in their heads to taking it into their HeARTs. We propose to introduce a number of significant new interventions including:

1. Putting in place KPI targets for Māori staff representation into hiring managers' performance plans.
2. Train up all hiring managers to EEWM and live our Values/behaviours.
3. Develop a community engagement campaign targeting local Māori through social media and events in conjunction with Communications.
4. Develop a recruitment campaign to map Māori health workers in New Zealand and Australia and target those workers to work in Hawke's Bay.
5. Understand how MHS is able to recruit high numbers of Māori and share learnings with other hiring managers.
6. Re-balance the membership of interview panels to include the hiring manager, professional lead, Māori staff member/consumer AND a community representative.

The current and proposed new actions for the tertiary training and apprenticeships and for the recruitment and employment parts of the pipeline are set out in Table E. Of the new actions identified some have been completed, others progressed and others only recently identified.

Table E

Intermediate school and secondary school student				Status
Current	Turuki – promoting health careers Incubator – promoting health careers in 19 secondary schools - targets year 12, 13 students Earn and Learn – targets 11, 12, 13 year students Health Careers Expo – targets year 10,11 students	New	Community engagement campaign to be developed including targeting Māori through social media and community events (local and national) held in Hawke's Bay).	Under development
		New	Promote new and innovative models of care that better meet community need /achieve equity e.g. EngAGE.	New
Current	Turuki – scholarships 79 Scholarships offered over last 3 years	New	KPI targets for Māori staff representation into hiring managers' performance plans.	New
Current	Tertiary Training Facebook contact with Incubator students	New	Campaign to promote HBDHB at Tertiary institutions Kanohi ki te Kanohi and on-line.	New

Recruitment and Employment				
Current	Focus on nursing with initial focus on Nurse Entry to Practice (NEtP) nursing and valuing locally trained and Māori applicants by weighting of two.	New	Work with Kia Ora Hauora to identify Māori candidates who are keen to work in the Hawke's Bay and develop ongoing relationships through their course of study.	Underway
Current	Using assessment centres to assess candidates demonstrate relationship management, EEWN skills.	New	Position profiles to be updated (key competencies and essential criteria) to include EEWM.	Completed
Current	Broadened focus to Allied Health and other roles systematically reviewing recruitment processes to audit where Māori applicants aren't recruited.	New	Update interview question template to ensure EEWM is Q2 or Q3 and also it is weighted two or higher for assessment.	Completed
Current	Job adverts include statements in Te Reo for some roles e.g. Community Health. Extend for all roles.	New	Ensure all HBDHB hiring managers complete EEWM course and can effectively assess for the competence EEWM	Ongoing (currently 86.3%)
		New	Ensure all members of an interview panel have completed EEWM and for this eventually to be a mandatory requirement before they can be involved in selection and assessment and complete Values and behaviours online training currently being developed.	Ongoing
		New	Include a Māori consumer representative on interview panel in the interim utilise Māori staff members. For targeted areas re-balance the membership of interview panels to include the hiring manager, professional lead, a Māori staff member/consumer AND a community representative.	In place for Māori staff
		New	Develop "Day in the Life" video of current Māori staff.	First video developed, five more to come

14

		New	Briefing of CNMs, nurse leaders, allied health leaders, other hiring managers and Union bipartite forum to confirm focus on recruiting Māori staff.	All briefings held
		New	Understand what MHS are doing well to attract Māori staff to work for their teams, "bottle" it" and extend to other DHB hiring managers and teams. Then work with these teams to develop initiatives to improve Māori staff representation in their areas.	New
		New	Provide monthly reports to hiring managers (in addition to the Māori staff representation and advise KPI performance to date) - Total no. of Māori applicants / total applicants - Total no. of Māori shortlisted / total shortlisted - Total no. of Māori appointed / total shortlisted EMT to receive monthly report.	Requires system development. Almost complete.
		New	Include question in proposal to appoint to ask "Have you appointed a Māori applicant and if not why not."	Requires system development. Almost complete.
		New	Identify unsuccessful Māori applicants and refer to other hiring managers and MHS for other potential opportunities.	Requires system development. To commence
		New	Systematic debriefing of unsuccessful Māori candidates	To commence
		New	Revise the Request to Recruit form to ask hiring managers to confirm that there is a Maori staff member or consumer on interview panels	Underway
		New	Develop a recruitment campaign to attract Māori staff to the Hawke's Bay Health Sector. Focussed on: - Mapping the talent pool of Māori Health talent in New Zealand and Australia - Developing a talent and recruitment strategy to attract Māori Health talent to work in Hawke's Bay. DHB recruitment team to provide proactive for NEtP candidates	Underway
		New	Improve EIT support for training and for application for nursing roles (tie into contract).	New
		New	Use assessment centres for other roles other than NEtP.	New
		New	Recruitment on Marae?	New
		New	Develop mid-career RN recruitment strategy	New
		New	Develop Allied Health recruitment strategy	New
		New	Work nationally to develop Allied Health career progression framework and remuneration to make Allied Health profession more attractive.	New

Retention
For retention Māori turnover has for the 12 months to 30 June 2016 been 10.4% versus the whole of DHB turnover figure of 9.3%. In previous years Māori staff turnover has been below or the same as DHB turnover.

Staff Turnover 12 months ended 30 June 2016 and reasons given by Māori staff for voluntary resignations for each workforce grouping are set out in Table F. Turnover for RMOs is 0% as all RMOs are fixed term and therefore not included in the calculation for voluntary turnover.

Table F

	DHB Turnover	Māori Staff Turnover	Number of Māori resignations	Reasons
Medical - SMO - RMO	 4.9% 0.0%	0.0%	0	
Nursing	9.2%	11.0%	10	4 move to alternative position 3 not returning from maternity leave 1 retired 2 other reasons
Allied Health	8.9%	5.3%	3	1 move to alternative position 1 personal reasons 1 retired
Support	12.3%	12.2%	5	1 retired 1 relocating outside HB 1 not returning maternity leave 1 personal reasons 1 other reasons
Management & Admin	10.2%	13.2%	9	4 move to alternative position 2 relocating outside HB 1 retired 2 other reasons
Total	**9.3%**	**10.4%**	**27**	

Staff completion of exit interviews is low internationally and in New Zealand as staff feel it is too late and wonder what is the point. It is the same for the HBDHB with only a small percentage of all staff resigning for the 12 months to 30 June 2016 having completed an exit interview. Retention interviews with focus groups of Māori staff would work better and is proposed as a new retention initiative. For the HBDHB by holding focus groups with groups of Māori staff to understand what they like about working for the DHB, what they don't like and what needs to change. The feedback from these focus groups will be used to change practice within the DHB. Changing practice will lead to increased Māori staff retention.

In respect of additional retention initiatives addition we need to:
1. Revitalise the Tuakana / Teina groups in place and where this is not in place set these up by workforce grouping. This can be done post the focus groups.
2. In order to grow more Māori managers, identify aspirant Māori managers and leaders and enrol into the Basic Management and potentially Transformation Leadership programmes.
3. In rolling out our Values and behaviours team by team ensure out team leaders lead at out on our relationship based management and our Values and behaviours to ensure a supportive team environment is created.
4. Our managers to adopt flexible work practices that are family friendly and supportive and therefore better retain our Māori staff.
5. A new staff engagement survey has been selected (IBM Kenexa) and this provides an opportunity for Māori staff to feedback on a range of questions including questions based on each of our Values and new Behaviours. This survey will be run in October 2016.

Supply of Māori health workers

For each occupational group the 2016 supply of Māori Health Workforce is set out in Table G below: This shows that there will be a higher percentage of medical graduates who are Māori in five years' time but not in the interim. Nursing students across all years at 16.5% Māori which is slightly ahead of our 30 June 3016 target. For occupational therapy and physiotherapy indications are that the percentage of Māori students' graduates is low at 8% and 5%. Overall the supply of Māori health workers is not especially high and provides a challenge when wanting to increase the number of Māori applying for Nursing and Allied Health roles.

Table G

	Total Māori %
Medical	20% 2016 intake only
Nursing	16.35% for all employees
Occupational Therapy	8% (estimated)
Physiotherapy	5% (estimated)

Appendix One

Cultural Training at 30 June 2016

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		3 yearly	Once
Medical - SMO	140	61	14
Medical - RMO	137	10	33
Nursing	1480	993	694
Allied Health	540	405	282
Support	187	96	65
Management & Admin	452	360	278
DHB Total - June 2016	**2936**	**1925**	**1366**

By percentage

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		3 yearly	Once
Medical - SMO	140	43.6%	10.0%
Medical - RMO	137	7.3%	24.1%
Nursing	1480	67.1%	46.9%
Allied Health	540	75.0%	52.2%
Support	187	51.3%	34.8%
Management & Admin	452	79.6%	61.5%
DHB Total - June 2016	**2936**	**65.6%**	**46.5%**

14

In addition to the specific recruitment initiatives above, add in the Māori staff representation KPI into all managers and team leaders performance plans and reviews.

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q4 (Apr-Jun 2016) Non-Financial Exceptions Report**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owners:	Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	August 2016
Consideration:	For Monitoring

15

RECOMMENDATION

MRB, Clinical and Consumer Council and HBDHB Board:

Note the contents of this report.

OVERVIEW

The purpose of this paper is to provide MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 4 on the implementation of Annual Māori Health plan. A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of Quarter 4 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indictors. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to shown a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol **'U'** *(indicated on the dashboard in red)* will be used to indicate unfavourable trend and **'**F' for favourable trend *(indicated on the dashboard in green colour)* toward the annual target *(see the table below).*

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2015/16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

Table of Contents

OVERVIEW 1

2015-2016 ANNUAL MĀORI HEALTH PLAN PERFORMANCE HIGHLIGHTS 3

Achievements 3

Areas of progress 3

Areas of focus 4

QUARTERLY PERFORMANCE AND PROGRESS UPDATE 6

1. Access to Care 6

2. Child Health 7

5. Oral Health 8

8. Cancer Screening 9

9. Smokefree 11

10. Mental Health 12

13. Māori Workforce and Cultural Competency 13

2015-2016 ANNUAL MĀORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. Cervical Screening for 25-69 year old Māori women (73.2%) for this quarter is slightly lower than the 74.4% in the first quarter but still puts HBDHB on the top list on Cervical Screening performance in New Zealand. This performance also narrows the disparity gap between Māori and European by 4%. The performance is attributed to the HBDHB integrated service approach where all service providers (i.e. HBDHB Population Health, Health HB PHO (HHB PHO), general practices and Hauora Providers etc.) across the screening pathways are joined up and working together towards a common goal of attaining the national target for Māori women and addressing inequity. Furthermore, Māori women have access to free cervical smear tests and support services across the district.

   In an effort to further improve our services there has, over the years been a strong focus on continued service quality improvement e.g. improving systems and processes within primary care, improving National Cervical Screening Programme (NSCP) participant data quality on patient management systems (PMS) and the NCSP Register, compliance with NCSP policies and standards, offering client incentives, and improving access via clinical and outreach settings and support services.

2. Immunisation rates for 8 month old Māori have remained above or very near the target of ≥ 95% throughout the year with a 95.6% result in Quarter 1 and a 94.6% result in Quarter 4. Similarly, immunised rates for 2 year old Māori remained above or very near the annual target of ≥ 95% with 95.9% in Quarter 1 and 94.7% in Quarter 4. Immunisation results for 4 year olds remains above the expected target of ≥ 90% with 94% immunised in Quarter 4.

   This success is attributable to a number of factors. These range from having a champion in the executive management team; a committed, appropriate, experienced workforce; an action plan focused on bridging any gaps in service delivery; a very experienced NIR (National Immunisation Register) team; good collaboration across all immunisation providers and partners; a budget with a little leeway to try new initiatives; a service that can easily be delivered within the home; and a very effective outreach service team.

3. Ambulatory Sensitive Hospitalisation (ASH) rates overall declined from 82% in Quarter 1 to 79% in Quarter 4 following concerted work in the area of skin management through Public Holiday in early Childhood centres, Kōhanga reo and Primary Schools.. This Quarter has seen a continued focus on strengthening systems and relationships across Oral health services and providers. Resources to support self-care and management of skin have been translated in Te reo and English to support this work. To reduce DNA's at Community oral health clinics WCTO provider relationships with whānau will be strengthened coupled with funding to Tamariki ora and Plunket for advocacy and facilitation role in initiating oral health appointments and attendance. A joint analysis and review of currently contracted respiratory support services is being carried out to extend the Primary Care respiratory Pilot services to cover the 0-4 year age group.

4. Quick Access to Angiograms for Māori exceeded the expected target of ≥70% with 84.6% in Quarter 4 up from 38.5% in Quarter 1. This success is attributed to Locum Cardiologist who completed full Friday angiogram sessions for the time he was here.

Areas of progress

1. Staff completed cultural training is making good progress from 64% in Quarter 1 to 77.5% in Quarter 4. Medical staff had the largest increase of all occupational groupings from 14% in Quarter 1 to 39.6% in Quarter 4 (page 13). This progress is attributed to the growing push from EMT coupled with access to the electronic training reports by Managers and Heads of Service which enable them to keep track of their staff training.

2. Māori Breastfeeding rates at 6 weeks are 67% a 9% increase in comparison to the previous reporting period and Breastfeeding rates at 6 months shows a 2% increase.

Areas of focus

The above achievements notwithstanding, we are challenged to put more efforts in the following areas to gain traction towards targets:

1. Access to Care – Increase Patients Enrolment to the HHB PHO

The number of Māori enrolled in the HHB PHO decreased slightly by 0.3% from 95.9% in Quarter 1 to 95.6% in Quarter 4 and remains below the expected performance target of 97% (page 5). These trends are attributed to the limited availability and capacity of GPs to enrol new patients. Only 5/28 practices are enrolling new patients; 14/28 practices are enrolling new patients with conditions i.e. family member is already a patient, moved into the district from another district etc.; and 9/28 practices are not enrolling new patients at all. Furthermore, some patients are using Emergency Department (ED) for General Practice (GP) services instead of enrolling with a general practice; limited access to affordable general practice services for low income patients; and some patients moving outside of HB.

HHB PHO has been working with GPs to consider models of care that include provision of services to walk in appointments. HHB PHO has also been looking into availability of High Need Enrolment Programme via NGOs, ED, DHB and GPs with initial GP and Nurse Consultations at no cost to patients. HHB PHO feels that efforts to address health inequalities may include: support to practices to recruit general practice clinicians and staff; continue to offer the High Need Enrolment Programme; and supporting general practice to consider and implement walk in appointments.

2. Child Health - Breastfeeding

Breastfeeding rates at 3 months show a decrease of 7% from 46% in the previous reporting period to 39% this quarter. Multiple pieces of work are underway across Well Child and LMC/Midwife workforce to improve these rates. These include promotion of early engagement with services; consistent appropriate breastfeeding messages across sectors and the community; and the development of a responsive breastfeeding support service for Māori (a joint approach between the DHB Māori and Women, Child and Youth portfolios).

5. Oral Health

Pre-school oral health enrolments for Māori under 5 years of age increased from 65.3% in 2014 to 74.1% in 2015 (page 11). There is still some work to do to reach the expected target of ≥90%. We plan to update the data at the end of the calendar year.

8. Cancer Screening - Breast Screening

There has been a slight decrease from 68.4% in Quarter 1 to 67.9% in Quarter 4 and remains just below the expected target of ≥70% (page 9). This can be attributed to a number of factors including a slight increase of 25 women on the Breast Screening Aotearoa (BSA) Māori population which forms the denominator for the coverage data; increased seasonal fluctuations; and access to appointments due to holidays and availability of seasonal work. Efforts will be made on identify unscreened and under- screened women along with other approaches tailored to improve access and encourage women to participate in the BSA programme.

9. Smokefree

Māori women who are smoke free at 2 weeks post natal increased from 62% in Quarter 1 to 65.6% in Quarter 4. However, overall performance remains well below the expected target of ≥ 86% (page 7). In an effort to up these rates, HBDHB is collaborating with Choices Heretaunga in the implementation of Increasing Smoke-free Pregnancy Programme (ISPP) which is currently being used by HB midwives and LMCs to refer pregnant mothers who smoke. Acknowledging the

importance of whānau support for mothers to be smoke-free the programme has expanded its support to whānau members to live with pregnant and post-partum women.

The report also noted that advice to quit smoking for Māori pregnant women at hospital setting declined from 87.7% in Quarter 1 to 86.25 in Quarter 4 and remains below expected target of ≥90%. This is attributed to the high smoking rates among pregnant Māori women ages 20 to 29 years. We also know that most of these women either come from high deprivation areas or transient whānau so our efforts are focused on encouraging HB midwives and LMCs to refer pregnant women who smoke to ISPP, up to six months post-partum.

10. Mental Health

Māori under Mental Health Act Compulsory Treatment Orders has risen from 189.3 per 100,000 population in Quarter 1 to 201.6 per 100,000 population in Quarter 4. There remains a significant inequality between Māori and non-Māori of 104.9 per 100,000 population up from 97.7 per 100,000 population in Quarter 1 (page 12). . An audit has been carried out to better understand the issues around these rates and develop better strategies to lower them.

13. Workforce Development

Māori Workforce only grew 0.2% from 12.3% in Quarter 1 to 12.5% in Quarter 4 and did not reach the 2015-2016 expected target of 14.3% (page 13). The targeted areas for increasing the retention and recruitment of Māori of Nursing and Allied Health increased only marginally over the year. Nursing went from 10.1% to 10.8% and Allied Health from 13.1% to 13.2%. Since these are our two biggest workforce the impact of this trend is reflected across the overall performance figure for the period.

Following a significant rethink of our strategy to increase Māori staff representation we have identified actions that will make this happen. These include increasing the number of Māori applying for positions; number shortlisted and recruited for our roles and actions for better retention of our Māori staff.

An overarching Māori staff recruitment campaign is being developed with targeted actions by workforce grouping also. Focus groups discussions of current Māori staff are to be held to better understand what can be done to improve the work environment for Māori staff.

QUARTERLY PERFORMANCE AND PROGRESS UPDATE

1. Access to Care

Outcome: Increase enrolment in the HHB PHO

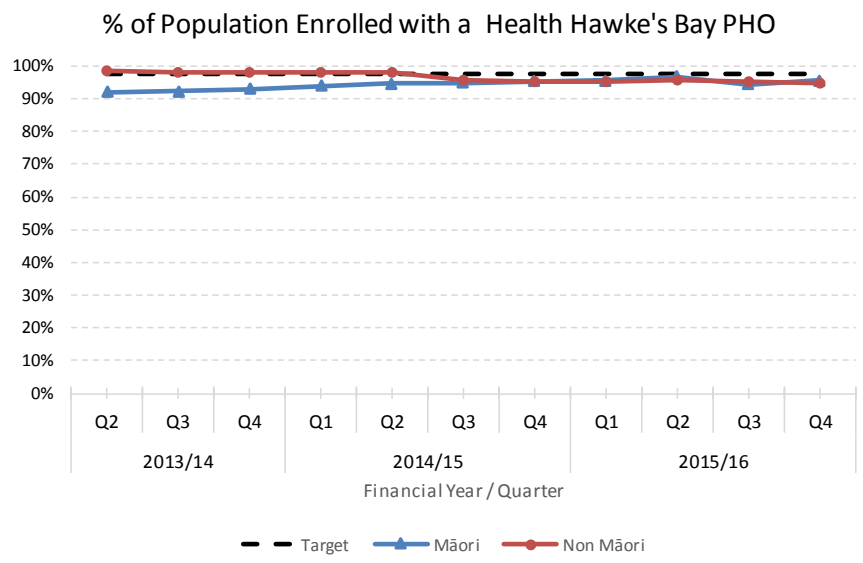
Key Performance Measures	Baseline [1]	Previous result[2]	Actual to Date[3]	Target 15-16	Trend direction
Māori	94.7%	94.5% (U)	95.6% (U)	≥97%	▲
Pacific	99.3%	86.5% (U)	88.4% (U)	≥97%	▲
Other	98.2%	96.0% (U)	96.5% (F)	≥97%	▲
Total	97.3%	95.2% (U)	95.9% (U)	≥97%	▲

Comment:

Limited availability and capacity of general practice to enrol new patients

- 5/28 practices are enrolling new patients
- 14/28 practices are enrolling new patients with conditions i.e. family member is already a patient, moved into the district from another district
- 9/28 practices are not enrolling new patients
  - Patients utilising ED for General Practice services instead of enrolling with a general practice
  - Limited access to affordable general practice services for low income patients
  - Patients moving outside of HB
  - Plan to work with General Practices to consider and review models of care

Time series



1 October 2014 to December 2014

2 October to December 2015

3 January to March 2016

2. Child Health

Outcome: Breastfeeding of pepi improved

Key Performance Measures	Baseline[4]	Previous result	Actual to Date	Target 15-16	Trend direction
Infants are exclusively or fully breastfed at 6 weeks					
Māori	-	58% (U)	67% (U) [5]	≥75%	▲
Pacific	-	74% (U)	82% (F)	≥75%	▲
Total	-	68% (U)	73% (U)	≥75%	▲
Infants are exclusively or fully breastfed at 3 months of age					
Māori	-	46% (U)	39% (U)[6]	≥60%	▼
Pacific	-	62% (F)	63% (F)	≥60%	▲
Total	-	54% (U)	53% (U)	≥60%	▼
Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)					
Māori	-	46% (U)	48% (U) [7]	≥65%	▲
Pacific	-	57% (U)	66% (F)	≥65%	▲
Total	-	56% (U)	58.% (U)	≥65%	▼

Comments:

With the combined Plunket and WCTO Breastfeeding data now being collected by the MOH more accurate breastfeeding data will be available, the new KPI card will over time show this new combined data as a trend line giving an improved picture of Breastfeeding performance for HB.

The most recent Quarterly HB Breastfeeding data shows a 5% increase in Māori Breastfeeding rates at 6 weeks, with 3 month data showing a decline of 6% and 6 months remaining the same.

Work continues on the development of a model of service provision that effectively supports Māori particularly, to sustain Breastfeeding, this is a joint approach between Māori Health and Women, Child and Youth (further details are included below)

15

4 No baseline data available

5 6 months to June 2015

6 6 months to December 2015

7 6 months to December 2015

5. Oral Health

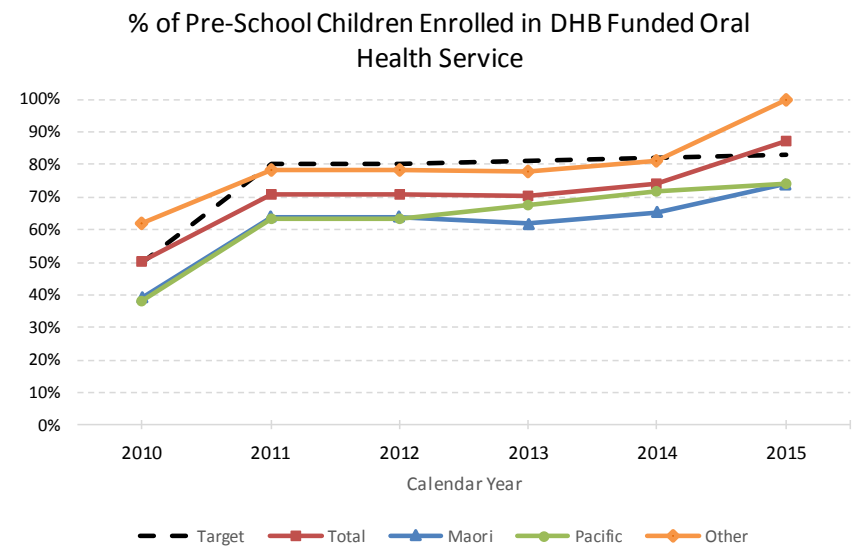
Outcome: More pre-school enrolments in the community oral health service (COHS) - 90% children under 5 years of age enrolled in community oral health services

Key Performance Measures	Baseline [8]	Previous result[9]	Actual to Date[10]	Target 15-16	Trend direction
Māori:	65.3%	74.1% (U)	-	≥90%	—
Pacific:	71.7%	74.2% (U)	-	≥90%	—
Other:	81.3%	99.8% (F)	-	≥90%	—
Total	73.9%	87.1% (U)	-	≥90%	—

Comments

This is an annual indicator which is only reported in Q3 every financial year. Health Intelligence discussing with services about the capability of reporting more frequently.

Time series



8 2013 calendar year

9 2014 calendar year

10

8. Cancer Screening

Outcome: Achieve the National Cervical Screening Programme (NCSP) national target – 80% of 25-69 years

Key Performance Measures	Baseline[11]	Previous result[12]	Actual to Date[13]	Target 15-16	Trend direction
Māori	73.8%	73.2% (U)	73.2% (U)	≥80%	—
Pacific	72.8%	70.4% (U)	71.4% (U)	≥80%	▲
Other	78.0%	77.2% (U)	77.8% (U)	≥80%	▲
Total	76.9%	76.1% (U)	76.6% (U)	≥80%	▲

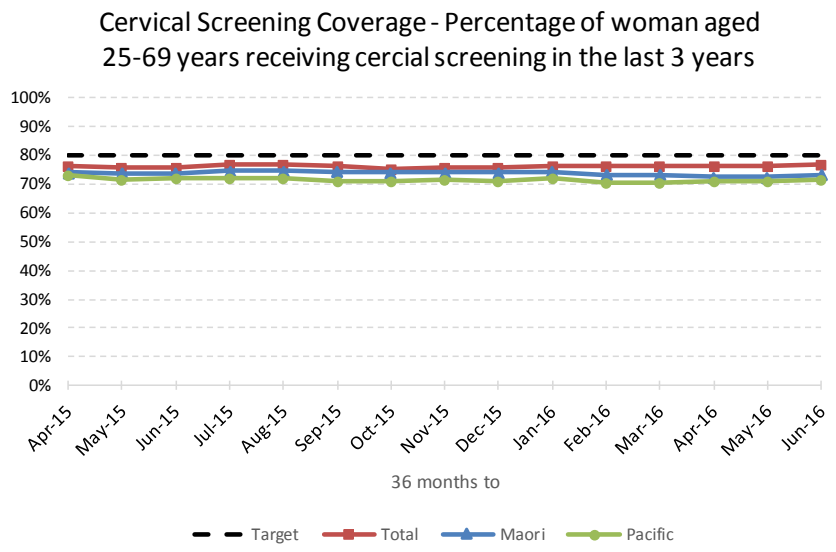
Comments:

Continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, contacting Māori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears. The uptake has been positive.

Continuing to ensure accuracy of participant ethnicity data held on National Cervical Screening Programme Register.

Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. A challenge to the sector.

Time series



Source: National Screening Unit

11 3 years to December 2014

12 3 years to December 2015

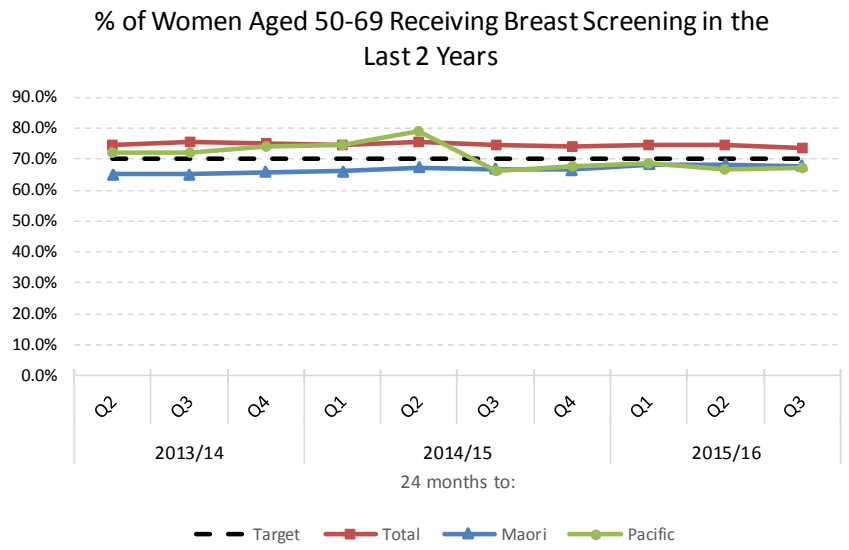
13 3 years to March 2016

15

Outcome: Achieve the National Breast Screen Aotearoa (BSA) national target – 70% of 50-69 years

Key Performance Measures	Baseline [14]	Previous result[15]	Actual to Date[16]	Target 15-16	Trend direction
Māori	67.2%	68.4% (U)	67.9% (U)	≥70%	▼
Pacific	79.0%	66.5% (U)	67.2% (U)	≥70%	▲
Other	77.2%	79% (F)	74.5% (F)	≥70%	▼
Total	75.8%	74.7% (F)	73.4% (F)	≥70%	▼

Time series



Source: National Screening Unit

Comments:

Preparation has begun for the next mobile screening unit visit at the Cook Island Community Centre at Flaxmere on 13-27 September. BreastScreen Coast to Coast is working with Hastings-based GP practices to datamatch Flaxmere-resident clients for the upcoming visit. Invitation and recall letters will be sent out to priority group women offering an appointment for a screening mammogram. The DHB Population Screening, HHB PHO and Māori providers are working together to promote the mobile visit and offering support services to priority women.

HHB PHO and TRG Imaging facilitated an education session for GPs focused on pathology, diagnostics and treatment for breast disease.

Recent population projections released by the National Screening Unit show that in the next four years (2016-2020) Hawke's Bay's BSA eligible Māori population will increase by 8% and the Pacific population by 13%. This will be a challenge to the sector to achieve and maintain targets.

14 24 months to December 2014

15 24 months to December 2015

16 24 months to March 2016

9. Smokefree

Outcome: 90% of pregnant women who identify as smokers upon registration with a DHB- employed midwife or Lead Maternity Carer (LMC) are offered brief advice & support to quit smoking

Key Performance Measures	Baseline[17]	Previous result[18]	Actual to Date[19]	Target 15-16	Trend direction	
Māori	100.0%	95.2% (F)	86.2% (U)	≥90%	▼	**Comments**
Total	98.1%	96.5% (F)	88.6% (U)	≥90%	▼	HBDHB in collaboration with Choices Heretaunga have successfully implemented the Increasing Smokefree Pregnancy Programme (ISPP). HB midwives and LMCs refer pregnant mama who smoke, to this programme. On post-partum up to six months of age, woman who are still smoking can be referred to ISPP. ISPP supports pregnant and post-partum women to be smokefree at 1, 4, 8 and 12 weeks with a supply of nappies, if they have a validated CO monitor reading. Since 1 July, the programme has expanded to support whānau members who live with pregnant mama and post-partum women and pepi to be smokefree at 1, 4, 8, 12 weeks with grocery vouchers, if they too have a validated CO monitor reading.

15

17 October to December 2014

18 October to December 2015

19 January to March 2016

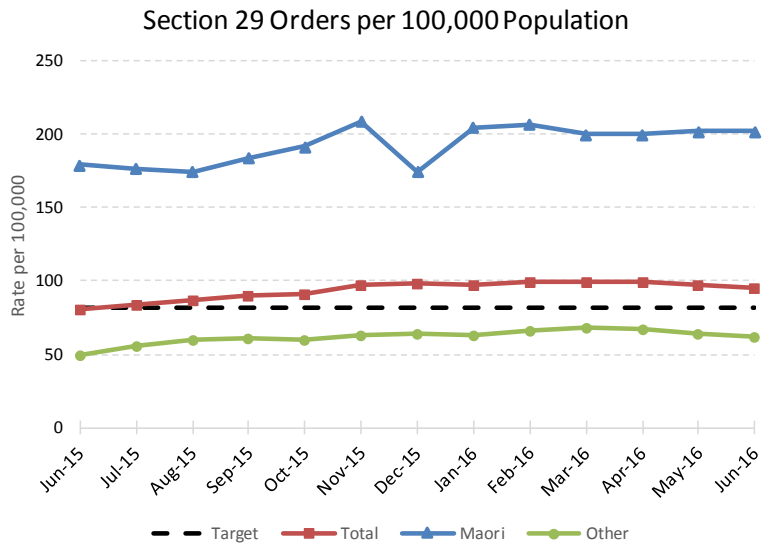
10. Mental Health

Outcome: Reduced rate of Māori under compulsory treatment orders to < 81.5 per 100,000 (total population)

Key Performance Measures	Baseline [20]	Previous result[21]	Actual to Date[22]	Target 15-16	Trend direction
Māori (per 100,000)	-	204.0 (U)	201.6 (U)	≤81.5	▲
Other (per 100,000)	-	98.9 (U)	96.7 (U)	≤81.5	▲
Total (per 100,000)	-	99.0 (U)	97.3 (U)	≤81.5	▲

Comments

We are still undertaking audits to understand the reason for the rate. First audit completed and further audit is now being undertaken.



20

21 *January to March 2016*

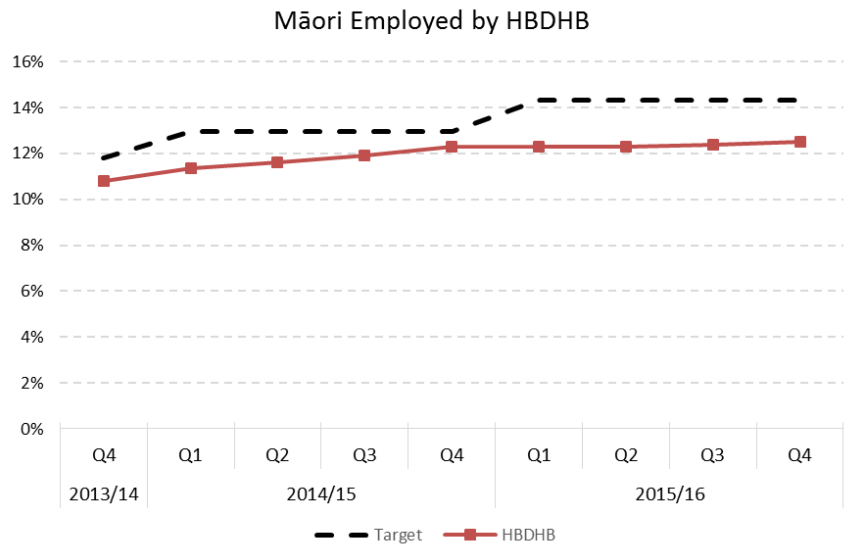
22 *April to June 2016*

13. Māori Workforce and Cultural Competency

Outcome: Increased proportion of Māori employed by 10% yearly across HBDHB. Target 15/16 year 14.3%

Key Performance Measures	Baseline[23]	Previous result[24]	Actual to Date[25]	Target 15-16	Trend Direction
Medical	2.7%	3.2%	3.2%	-	—
Management & Administration	15.7%	16.1%	16.0%	-	▼
Nursing	10.1%	10.7%	10.8%	-	▲
Allied Health	11.9%	12.4%	13.2%	-	▲
Support Staff	26.7%	30.2%	29.3%	-	▼
HBDHB	11.6%	12.4% (U)	12.5% (U)	≥14.3%	▲

Time series



Comments:

The targeted areas for increasing the retention and recruitment of Māori of Nursing and Allied Health increased only marginally over the year. Nursing went from 10.1% to 10.8% and Allied Health from 13.1% to 13.2%. Because these are our two biggest workforce the impact is going to flow through to the overall figure.

As a result of a significant rethink or our strategy for increasing Māori staff representation we have identified actions to increase the number of Māori applying, being shortlisted and recruited for our roles and actions for better retaining our Māori staff.

An overarching Māori staff recruitment campaign is being developed and targeted actions by workforce grouping also. Focus groups of current Māori staff are to be held to better understand what can be done to improve the work environment for Māori staff.

15

23 December 2014

24 March 2016

25 June 2016

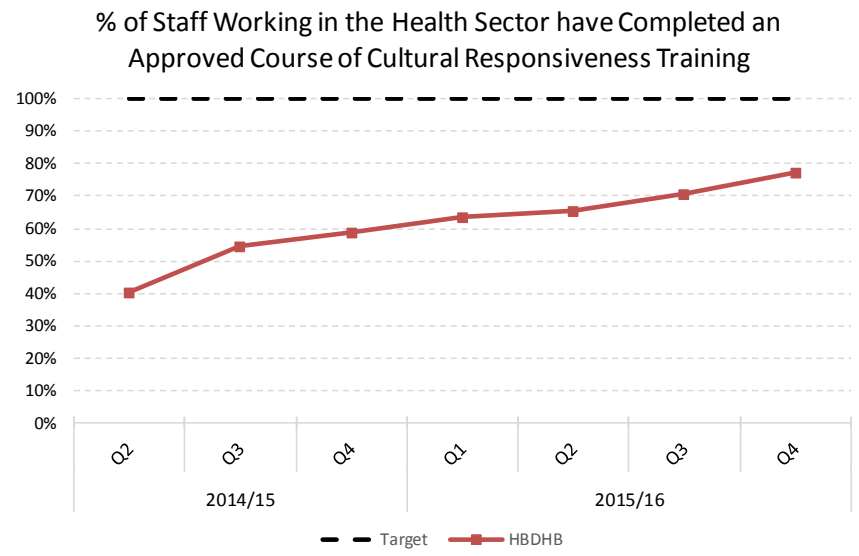
Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

Key Performance Measures	Baseline [26]	Previous result[27]	Actual to Date[28]	Target 15-16	Trend direction
Medical	9.0%	32.4%	39.6%	-	▲
Management & Administration	43.0%	82.1%	85.6%	-	▲
Nursing	41.0%	74.7%	81.4%	-	▲
Allied Health	59.0%	80.4%	85.2%	-	▲
Support Staff	12.0%	38.6%	60.1%	-	▲
HBDHB	40.0%	70.6%	77.5% (U)	≥100%	▲

Comments:

- Current report shows DHB staff who have completed EEWM training or other cultural training.
- The Education & Development Forum are establishing a communication plan to include Primary Care in EEWM training.
- Managers now have access to reports within PAL$ to monitor staff completion rates of EEWM and Treaty of Waitangi.
- The current Engaging Effectively with Māori (EEM) training sessions run to the beginning of September. There is a mandatory training report that all managers have access to and this now enables managers to follow-up on staff who have not attended EEM. This training has been rolled across the HHB PHO and NGOs.

Time series



26 December 2014

27 March 2016

28 June 2016

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q4 (Apr-Jun 2016) DASHBOARD**
	For the attention of: **Māori Relationship Board (MRB), HB Clinical Council and HB Consumer Council and HBDHB Board**
Document Owners:	Tim Evans, General Manager Planning, Informatics and Finance Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick LeGeyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team (EMT)
Month:	August 2016
Consideration:	For Monitoring

15.1

RECOMMENDATION

That MRB, Clinical and Consumer Council and HBDHB Board:

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on:

- The Māori health indicators agreed as part of the development of 2015 /16 Annual Māori Health Plan.

A quick reference summary dashboard is included and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described in the key on page 4) to represent this.

As this report is for the period ending June 2016, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 15-16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

2015-2016 ANNUAL MAORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. HBDHB continues to have the highest percentage in New Zealand for Cervical Screening for 25-69 year old Māori women (73.2%) and the lowest disparity gap between Māori and European (4% gap).
2. Immunisation rates for 8-month old Māori have remained above or very near the target of ≥ 95% throughout 2015-2016 with a 95.6% result in Quarter 1 and a 94.6% result in Quarter 4. Similarly, immunised rates for Māori 2-year olds remained above or very near the target of ≥ 95% throughout 2015-2016 with a 95.9% result in Quarter 1 and a 94.7% result in Quarter 4. Immunisation results for 4-year olds remains above the expected target of ≥ 90% with 94% immunised in Quarter 4.
3. ASH Rates overall have declined from 82% in Quarter 1 to 79% in Quarter 4 and present a significant narrowing of disparity gap for 0-4 year old group between Māori and Other. Similarly, ASH Rates for 45-64 year old group have declined from 193% in Quarter 1 to 170% in Quarter 4 and present a significant narrowing of disparity gap between Māori and Other.
4. Quick Access to Angiograms for Māori exceeded the expected target of ≥70% with 84.6% in Quarter 4 up from 38.5% in Quarter 1.

Areas of progress

1. Staff Completed Cultural Training is making good progress from 64% in Quarter 1 to 77.5% in Quarter 4. Medical staff had the largest increase of all occupational groupings from 14% in Quarter 1 to 39.6% in Quarter 4.

Challenges

1. Breastfeeding rates at 3 months show a decrease of 7% from 46% in the previous reporting period to 39% this quarter. All breastfeeding rates at 6 weeks (67%), 3 months (39%) and at 6 months (48%) for Maori fell below the target rates of 75%, 60% and 65% for the period.
2. Māori under Mental Health Act Compulsory Treatment Orders has risen 189.3 per 100,000 population in Quarter 1 to 201.6 per 100,000 population. There remains a significant inequality between Māori and non-Māori of 104.9 per 100,000 population up from 97.7 per 100,000 population in Quarter 1.
3. Māori women who are smokefree at 2-weeks post natal increased by 3.6% from 62% in Quarter 1 to 65.6% in Quarter 4. However, overall performance remains well below the expected performance target of ≥ 86%.
4. Advice to Māori smokers in hospital who are pregnant to quit declined by 7.5% from 87.7% in Quarter 1 to 86.25 in Quarter 4 and remains below expected target of ≥90%.
5. Breast Screening has decreased slightly from 68.4% in Quarter 1 to 67.9% in Quarter 4 and remains just below the expected target of ≥70%.
6. Māori Workforce only grew 0.2% from 12.3% in Quarter 1 to 12.5% in Quarter 4 and did not reach the 2015-2016 expected target of 14.3%.
7. The number of Māori enrolled in the Health Hawke's Bay PHO decreased slightly by 0.3% from 95.9% in Quarter 1 to 95.6% in Quarter 4 and remains below the expected performance target of 97%.
8. Pre-school Oral Health Enrolments for Māori under 5-years of age increased from 65.3% in 2014 to 74.1% in 2015. There is still some work to do to reach the expected target of ≥90%.

Please note:

- Unless otherwise stated the results presented in this dashboard are for Māori.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.

ANNUAL MĀORI HEALTH PLAN, QUARTER 4 APRIL - JUNE 2016 DASHBOARD REPORT

Access to Care
PHO Enrolment and ASH rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment	94.7%	94.5%	95.6%	96.5%	≥ 97.0%	-595		↑
0-4 years (6m)	82.0%	82.0%	79.0%	70.0%	≤ -			↓
45-64 years (6m)	100.0%	172.0%	170.0%	94.0%	≤ -			↓

Child Health
Breastfeeding rates (3m)

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data								
At 6 Weeks	68.0%	58.0%	67.0%	73.0%	≥ 75%	-		↑
At 3 months	54.0%	46.0%	39.0%	53.0%	≥ 60%	-		↑
At 6 months	59.0%	46.0%	48.0%	58.0%	≥ 65%	-		↑

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation (8 Months)	95.9%	97.7%	94.6%	95.4%	≥ 95%	-1		↑
Immunisation (2 years)	95.0%	94.8%	95.1%	94.9%	≥ 95%	0		↑
Immunisation (4 years)	-	93.2%	94.0%	92.1%	≥ 90%	11		↑
65+ Influenza (3m)	68.0%	56.5%	-	-	≥ 75%	-		

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	4.3	2.48	7.33	1.87	≤ 2.0	-2		↓

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate	65.3%	74.1%	-	-	≥ 90%	-771		↑

SUDI

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Rate per 100,000	4.6	2.9	Update not available		≤ 0.5	-		↓

Indicator Legend
Target attained
Within 10% of target
10-20% away from target
Greater than 20% away from target

Time Series Key:
- Target
- Actual

Cardiovascular Disease

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Heart & diabetes checks	83.9%	86.3%	-	-	≥ 90%			↑
Quick access to angiograms	66.7%	81.8%	84.6%	77.6%	≥ 70%	1.9		↑
Completion of registry data	12.5%	100.0%	90.0%	96.6%	≥ 95%	-1		↑

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs)	73.8%	73.2%	73.2%	77.8%	≥ 80%	-614		↑
Breast screening (50-69 yrs)	67.2%	68.4%	67.9%	74.5%	≥ 70%	-74		↑

Smokefree

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal	58.0%	53.0%	65.6%	79.9%	≥ 86.0%	-		↑
Pregnant smokers Brief Advice to Quit	100.0%	86.2%	81.1%	89.0%	≥ 90.0%	-5		↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000)	-	212.7	201.6	96.7	≤ 81.5	-46		↓

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.7%	3.2%	3.2%	-	≥ -			
Management & Administration	15.7%	16.1%	16.0%	-	≥ -			
Nursing	10.1%	10.7%	10.8%	-	≥ -			
Allied Health	11.9%	12.4%	13.2%	-	≥ -			
Support Staff	26.7%	30.2%	29.3%	-	≥ -			
Māori staff - HBDHB	11.6%	12.4%	12.5%	-	≥ 14.3%	-54		↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	9.0%	32.0%	39.6%	-	≥ -		
Management & Administration	43%	82.1%	85.6%	-	≥ -		
Nursing	41%	74.7%	81.4%	-	≥ -		
Allied Health	59%	80.4%	85.2%	-	≥ -		
Support Staff	12%	38.6%	60.1%	-	≥ -		
HBDHB	40%	70.6%	77.5%	-	≥ 100%		↑

Te Ara Whakawaiora Priorities

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Obesity (B4SC Healthy Weight for 4yrs)	75%	67.0%	61%	69%	≥ 75%	-62.75		↑
DNA's	16.2%	18.2%	15.20%	4.70%	≤ 7.50%	-98		↓
Oral Health (% Caries Free at 5yrs)	38.7%	36.0%	-	-	≥ 65%			↑
Bariatric Surgery	7.00	-	3.0	5.0	-	-		-

15.1

OURHEALTH
HAWKE'S BAY
Whakawateatia

TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

Verbal

16

GLOSSARY OF COMMONLY USED ACRONYMS

A&D	Alcohol and Drug
AAU	Acute Assessment Unit
AIM	Acute Inpatient Management
ACC	Accident Compensation Corporation
ACP	Advanced Care Planning
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ACP	Advanced Care Planning
AOD	Alcohol & Other Drugs
AP	Annual Plan
ASH	Ambulatory Sensitive Hospitalisation
AT & R	Assessment, Treatment & Rehabilitation
B4SC	Before School Check
BSI	Blood Stream Infection
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCN	Clinical Charge Nurse
CCP	Contribution to cost pressure
CCU	Coronary Care Unit
CEO	Chief Executive Officer
CHB	Central Hawke's Bay
CHS	Community Health Services
CMA	Chief Medical Advisor
CME / CNE	Continuing Medical / Nursing Education
CMO	Chief Medical Officer
CMS	Contract Management System
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPHAC	Community & Public Health Advisory Committee
CPI	Consumer Price Index
CPO	Co-ordinated Primary Options
CQAC	Clinical and Quality Audit Committee (PHO)
CRISP	Central Region Information System Plan
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CWDs	Case Weighted Discharges
CVD	Cardiovascular Disease
DHB	District Health Board
DHBSS	District Health Boards Shared Services
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSS	Disability Support Services
DSU	Day Surgery Unit
DQIPS	Director Quality Improvement & Patient Safety
ED	Emergency Department

ECA	Electronic Clinical Application
ECG	Electrocardiograph
EDS	Electronic Discharge Summary
EMT	Executive Management Team
EoIs	Expressions of Interest
ER	Employment Relations
ESU	Enrolled Service User
ESPIs	Elective Service Patient Flow Indicator
FACEM	Fellow of Australasian College of Emergency Medicine
FAR	Finance, Audit and Risk Committee (PHO)
FRAC	Finance, Risk and Audit Committee (HBDHB)
FMIS	Financial Management Information System
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GIS	Geographical Information System
GL	General Ledger
GM	General Manager
GM PIF	General Manager Planning Informatics & Finance
GMS	General Medicine Subsidy
GP	General Practitioner
GP	General Practice Leadership Forum (PHO)
GPSI	General Practitioners with Special Interests
GPSS	General Practice Support Services
HAC	Hospital Advisory Committee
H&DC	Health and Disability Commissioner
HBDHB	Hawke's Bay District Health Board
~~**HBL**~~	~~Health Benefits Limited~~
HHB	Health Hawke's Bay
HQSC	Health Quality & Safety Commission
HOPSI	Health Older Persons Service Improvement
HP	Health Promotion
HPL	Health Partnerships Limited
HR	Human Resources
HS	Health Services
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICS	Integrated Care Services
IDFs	Inter District Flows
IR	Industrial Relations
IS	Information Systems
IT	Information Technology
IUC	Integrated Urgent Care
K10	Kessler 10 questionnaire (MHI assessment tool)
KHW	Kahungunu Hikoi Whenua
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LTC	Long Term Conditions
MDO	Māori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Māori Health Service
MOPS	Maintenance of Professional Standards

MOH	Ministry of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MRB	Māori Relationship Board
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHB	National Health Board
NHC	Napier Health Centre
NHI	National Health Index
NKII	Ngati Kahungunu Iwi Inc
NMDS	National Minimum Dataset
NRT	Nicotine Replacement Therapy
NZHIS	NZ Health Information Services
NZNO	NZ Nurses Organisation
NZPHD	NZ Public Health and Disability Act 2000
OPF	Operational Policy Framework
OPTIONS	Options Hawke's Bay
ORBS	Operating Results By Service
ORL	Otorhinolaryngology (Ear, Nose and Throat)
OSH	Occupational Safety and Health
PAS	Performance Appraisal System
PBFF	Population Based Funding Formula
PCI	Palliative Care Initiative (PCI)
PDR	Performance Development Review
PHLG	Pacific Health Leadership Group
PHO	Primary Health Organisation
PIB	Proposal for Inclusion in Budget
P&P	Planning and Performance
PMS	Patient Management System
POAC	Primary Options to Acute Care
POC	Package of Care
PPC	Priority Population Committee (PHO)
PPP	PHO Performance Programme
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol Group
QHNZ	Quality Health NZ
QRT	Quality Review Team
Q&R	Quality and Risk
RFP	Request for Proposal
RHIP	Regional Health Informatics Programme
RIS/PACS	Radiology Information System Picture Archiving and Communication System
RMO	Resident Medical Officer
RSP	Regional Service Plan
RTS	Regional Tertiary Services
SCBU	Special Care Baby Unit
SLAT	Service Level Alliance Team
SFIP	Service and Financial Improvement Programme
SIA	Services to Improve Access

SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent
SUR	Service Utilisation Report
TAS	Technical Advisory Service
TAW	Te Ara Whakawaiora
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date