Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 10 February 2016**

Meeting: **3.00pm to 5.30pm**

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

Council Members:

Chris McKenna
Dr Mark Peterson
Dr John Gommans
David Warrington
Dr Caroline McElnay
Billy Allan
Dr Andy Phillips
Dr Robin Whyman
Robyn O'Dwyer
Jules Arthur
Dr Kiri Bird
Dr Tae Richardson
Dr Malcolm Arnold
Dr David Rodgers
Debs Higgins
Anne McLeod

Apologies: Dr Gommans, David Warrington and Jules Arthur

In Attendance:

Dr Kevin Snee, Chief Executive Officer, Hawke's Bay District Health Board
Ken Foote, Company Secretary
Kate Coley, Director of Quality Improvement & Patient Safety
Tracy Fricker, Council Administrator and PA to DQIPS
Graeme Norton, Chair HB Health Consumer Council

HB Clinical Council
Agenda

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome to Dr Robin Whyman and Anne McLeod	**3.00**
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
6.	Consumer Story (Kate Coley)	
	Section 3 – Consultation	
7.	Health Literacy Strategic Review - Quigley & Watts	**3.40**
8.	Clinical Governance Structures / Committees Review (Draft) - Kate Coley	**4.05**
9.	Health and Social Care Networks – Liz Stockley	**4.20**
10.	Refine Clinical Council Member Portfolios – Ken Foote	**4.35**
	Section 4 – Updates	
11.	Urgent Care Alliance verbal update	**4.45**
12.	Respitory Pilot Presentation – Trish Freer and Sue Ward	**4.55**
	Section 5 – Monitoring	
13.	Te Ara Whakawaiora / Access (local Indicator)	
	Section 6 – General Business	
14.	Topics of Interest - Member Issues / Updates	**5.15**
15.	**Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 7 – Routine	
16.	Minutes of Previous Meeting (public excluded)	
17.	Matters Arising	

NEXT MEETING Wednesday 9 March 2016, commencing at 3.00pm
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Interests Register

Hawke's Bay Clinical Council

07/12/2015

Name Clinical 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
Dr Kevin Snee (Chief Executive Officer)	Community Pharmacy Services Agreement	Lead		Yes	Low
	Warrick Frater	Former COO of HBDHB	Now registered as a provider of services to HBDHB	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Immediate Past President and a current Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Member and Chair elect of NZ Committee	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ	Yes	Low
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
Dr Mark Peterson (Chief Medical Officer - Primary	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary of	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
Dr Caroline McElnay (Director Population Health & Health	NZ College of Public Health Medicine	President until October 2017	NZCPHM represents the interests of Public Health Medicine specialsits in NZ, provides	*No*	
	RNZ Plunket Society	National Board member	Provision of heath and social services to children under 5 years, advocacy for children	*No*	
William Allan (Chief Pharmacist)	Pharmaceutical Society of New Zealand	Executive member	Pharmacy advocacy, professional standards and training	Yes	Low
	Pharmaceutical Management Agency (PHARMAC)	Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee)	Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML)	Yes	Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget
	Executive User Group for eMedicines programme (ITHB/HQSC)	Member (Central Region's representative)	Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines Reconciliation)	Yes	Low
	Pharmacy Steering Group (MoH)	Member	Provide advice to the Ministry on the utilisation of pharmacists within the health workforce	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
Dr Kiri Bird (General Practitioner)	Te Timatanga Ararau Trust (Iron Maori)	Partner is a Trustee	Health and Wellbeing	Yes	Low - Contract with HBDHB
	Te Taiwhenua o Heretaunga	General Practitioner	General Practice	Yes	Low - TToH contract with HBDHB
	Royal NZ College of General Practitioners	Board Member	Health and Wellbeing	No	
	Te Ora Board (Maori Doctors)	Deputy Chair	Health and Wellbeing	No	
	Te Akoranga a Maui (Maori chapter for RNZCGP	Chairperson	Health and Wellbeing	No	
Robyn O'Dwyer (Nurse Practioner Whanau Ora)	Wairoa Health Care Center	Nurse Practitioner	General Practice	No	
	The College of Primary Care Nurses	Member	National submissions/member of nursing leadership	No	
	The College of Maori Nurses	Member		No	
	New Zealand Scientific Society of Diabetes	Member		No	
Dr Malcolm Arnold (Medical Director / HOD)	NZ Society of Gastroenterology	Executive member	Provision of Gastroenteorlogy expertise throughout NZ, study of relevant conditions	No	
	NEQIP (National Endoscopy Quality Improvement Programme)	Clincal Support Lead	Standardising and improving quality of endoscopy services and training throughout the countrv	No	
	Endoscopy Users Group, HBDHB	Chairman	Assessing and improving provision of Endoscopy services in HB	Yes	Potential to influence budget/spending/provision of services
	Hawke's Bay Medical Research Foundation	Member of Scientific Advisory Group	Advising HBMRF on use of funds for research projects	No	
David Warrington (Nurse Director - Older Persons)	Havelock North Chiropractic	Wife is Practitioner and Co-owner	Chiropractic care and treatment, primary and preventative	Yes	Low
	Pilates Works	Wife is CE and Co-owner	Rehabilitation, Primary and preventative.	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Totara Health	Employee	General Practice	Yes	Low. Provides services in primary care
	Loco Ltd	Shareholding Director	Private business	No	

HB Clinical Council 10 February 2016 - Interest Register

Name **Clinical 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**
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and Implementation	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low
	Directions Youth Health	Wife Beth involved	Assisting youth in HB	No	
	City Medical	Director and Shareholder	Medical Centre	Yes	Low
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) - more recently HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	No	
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	

**MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL MEETING
HELD IN THE HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE
ON WEDNESDAY, 9 DECEMBER 2015 AT 3.00 PM**

PUBLIC

Present:	Dr Mark Peterson (Co-Chair) Chris McKenna (Co-Chair) Dr John Gommans Dr Tae Richardson Dr Andy Phillips Dr David Rodgers Debs Higgins Dr Malcolm Arnold Dr Kiri Bird David Warrington Robyn O'Dwyer Dr Caroline McElnay Billy Allan Jules Arthur
Apology	Anne McLeod
In Attendance:	Dr Kevin Snee (CEO) Graeme Norton (Chair HB Health Consumer Council) Kate Coley (Director Quality Improvement and Patient Safety) Tracy Fricker, PA to Director QIPS

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Chris McKenna welcomed everyone to the last meeting for 2015. Anne McLeod's apology noted.

Chris McKenna provided a verbal summary of Anne's professional history and advised that Anne was looking forward to being a member of the Clinical Council next year.

2. INTERESTS REGISTER

No new interests were advised.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 11 November 2015, were confirmed as a correct record of the meeting.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Update on Clinical Council – vacant positions
Clinical Director: Dr Robin Whyman will commence on Council in the New Year.
John Gommans to send information to Ken Foote.

Item 2: Alternative Health Provider
Deferred until the New Year.

Item 3: Responsibility for Results of Investigation
John Gommans advised that no further discussion has taken place on this nationally as there has not been a CMO meeting.

Item 4: Patient Stories – suggested themes to assist with change
Kate Coley advised she has had discussions with Laboratory, Maori Health Service and Te Taiwhenua. Item can now be closed.

Item 5: Quality Accounts
On agenda today for discussion.

Item 6: Combined Council Workshop
Discussed at November meeting. Item can now be closed.

5. CLINICAL COUNCIL WORKPLAN

The work plan which is subject to change was noted.

The Fetal Alcohol Syndrome Disorder Report has been deferred. There is a suite of activities to be clustered together in the New Year, which this will be a part of.

6. CONSUMER STORY

Kate Coley advised that the story today is relevant to the theme of the recent Patient Safety Week "Let's Talk…". There are positives and negatives we can take from this patient story.

This patient story shows the inconsistency in our service on how we engage with our patients and their families.

Brief discussion following patient story. Feedback has been discussed with the doctor concerned.

SECTION 2: FOR DECISION / ENDORESEMENT

7. URGENT CARE YEAR END REPORT

Report taken as read.

Mark Peterson advised that the report is a culmination of a year's work and the building blocks for next year to re-invigorate urgent care in Hawke's Bay. Graeme Norton advised that the next step is laying the ground work on how urgent care is delivered in Hawke's Bay. In January/February feedback will be sought followed in March for expressions of interest /requests for proposals. Communication of progress and the overarching vision was key and it was suggested that as well as the information on the website that it is also placed on the PHO Portal.

Kevin Snee commented that we got to this stage 5-6 years ago but there was no follow through previously and it was important that we continued to engage with all parties so that we were able to achieve the vision. It was noted that primary care is aware that the current ways of working were unsustainable and people were willing to work to a different future however resources were an issue.

There was further discussion in regards to expanding the current model to include advanced practitioners from nursing and allied health and it was confirmed that this thinking would be taken forward into the next streams of work.

Recommendations in the report endorsed.

8. QUALITY ACCOUNTS FOR ENDORSEMENT

Kate Coley presented the latest version of the Quality Accounts. They have also been shared with the PHO's Clinical Advisory Group (CAG).

Discussion on how we get the information out, suggestions included:

- Posters in GP waiting rooms
- "Snap shot" information instead of 40 page booklet
- Social media, Facebook, new website
- Hard copies provided to each GP practice

Chris McKenna thanked Kate and the team for the considerable amount of work done.

Recommendation in paper endorsed.

9. MEDICINE RECONCILIATIONS IN HEALTH SERVICES

Report taken as read.

Billy Allan advised that this report outlined a number of activities that would be undertaken to meet the targets for medication reconciliation. There were a number of reasons why the target was not being met relating to both a capacity issue and a capability/or experience issue of the staff at the time (see figure 3). Acknowledging that the target is not being met, the proposal is for a phased approach to improve medicine reconciliation rates as outlined in the report.

Kevin Snee queried what quality improvements have been undertaken before additional resources requested. Billy Allan advised that a number of improvements had been made i.e. distribution process, releasing time to care process; review of how aseptic services are provided as well as service to oncology and ICU, and pharmacy technicians approved to do checking to free up Clinical Pharmacist's time on the ward.

Ultimately the IT solution across the system, would provide both clinicians and consumers with better access to information in regards to medicines and improve consumer knowledge and understanding whilst providing clinicians with better information to make informed decisions.

Andy Phillips drew attention to Appendix 2 in the paper which outlines the associated risks and the controls in place to manage the risks. He asked that the Clinical Council:

1. Note contents of report
2. Ratify / confirm existing medicine reconciliation targets
3. Note the preferred options to take a phased approach to recruit to vacant positions and put forward an investment for further resource in the 2016/17 financial year.

Andy Phillips also advised that there were potentially some common opportunities across Labs, Pharmacy and Radiology in terms of better utilisation of software, and processes. The expectation is that these area's report back to Clinical Council in the future.

Recommendations in report endorsed.

10. TRAVEL PLAN BUSINESS BASE

Report taken as read.

Andrea Beattie and Louise Baker from Opus presented a summary of the report identifying four options:

1. Do nothing
2. Travel plan without parking charges
3. Travel plan with marking charges
4. Build more car parks

The travel plan links closely with the Customer focussed booking project and has utilised data from that project.

At present based on our current travel patterns the hospital site is short of around 300 car parking places. There was some concern from members of Clinical Council as to whether we should charge and whether a $1 charge would actually change behaviours of both staff and patients.

John Gommans and Andy Phillips expressed concern that we would be charging patients to come to clinics and hospital. John Gommans spoke of the history of the charging of car parking issue and the previous plan had received a mixed reaction from staff and visitors in regard to charging for car parking. Kevin Snee advised that the previous plan was very different, charges were much higher and Wilson's car parking was to run the cark park and would have taken several hundred thousand dollars. The emphasis with this recommendation was a far more holistic view for a travel plan that was not centred on charging. The Board have been previously advised of the potential options and were comfortable with the direction. The proposed option provided the ability to exempt staff on a low income, certain patients etc and it was suggested that we also included an exemption for families of long stay patients.

Graeme Norton as chair of Consumer Council advised that he would be recommending endorsement of Option 3 at the meeting the following day.

Chris McKenna summarised discussion to note the need to strengthen some of the pieces of the business case around charging, the green/exercise friendly lifestyle, matching patient appointments with parking, bus timetables and the impact on the streets surrounding the hospital and colleagues.

Recommendation to support the "Go Well" Travel Plan (Option 3) endorsed.

11. FETAL ALCOHOL SPECTRUM DISORDER - DRAFT

Report taken as read.

Caroline McElnay advised that this report has also been presented at the Consumer Council and Maori Relationship Board. Following on from the last meeting, four priority areas have been identified:

1. Reduce the prevalence of hazardous alcohol consumption in community
2. Increase community knowledge and awareness about FASD with resulting behaviour change
3. Reduce the number of pregnant women who drink whilst pregnant
4. Improve post-diagnosis support for families affected by FASD

The next update will be provided in July 2016.

Recommendation of the four priority areas above endorsed.

12. BILINGUAL SIGNAGE

Report taken as read.

Sharon Mason and Andrea Beattie presented. Sharon Mason advised that currently there are two separate policies relating to signage. It was noted that most of our signage is directional and it is important that signage has good basic language (reading age of 12). There is a need to reduce signage styles and be consistent. Paper will also go to the Consumer Council and the Maori Relationship Board next week.

Andrea Beattie presented the signage options. Following discussion confirmation by Clinical Council that both languages need to have equal prominence with Te Reo Maori appearing first, followed by English.

Clinical Council endorses principles in the paper and is happy to be guided by Consumer Council and Maori Relationship Board in regard to the final choice of signage layout.

13. CLINICAL PATHWAYS UPDATE

Report taken as read.

Mark Peterson introduced Leigh White to the meeting. The paper is an update on where we are at with clinical pathways. Leigh advised that the paper outlines current activity and is seeking endorsement of the pathways identified in the paper (page 2). The aim is to complete 25 clinical pathways each year, 10 are currently underway. Chris queried on capacity to deliver on this work. Leigh advised that the support group has had an increase of 3 editors and 3 facilitators.

It was recommended that in determining which pathway to prioritise and to measure the impact on our community we needed to be clear and understand firstly the disparity issue and then the fundamental impact that the pathway would have on reducing this issue. Mark Peterson commented we need to do the assessment of the outcome and use the HEAT tool (as a method) as they are being developed. Both Mid Central and Whanganui are currently looking at how this can be achieved.

Recommendations for new clinical pathways endorsed.

14. TOR Health and Social Care Networks

Item removed from agenda. To be discussed at a later date.

15. AIM 24/7 UPDATE

Report for information only.

John Gommans advised that the report will be presented at FRAC next week. No decision for Clinical Council at the moment.

SECTION 4: MONITORING

16. Te Ara Whakawaiora / Breast Screening

Report taken as read.

Jenny Cawston and Victoria Speers presented.

Chris McKenna commented that these papers came to EMT and complimented the authors on layout of information and data.

17. Te Ara Whakawaiora / Cervical Screening

Report taken as read.

Jenny Cawston and Victoria Speers presented.

Mark Peterson noted the increased number of Maori women who have been screened, reducing the disparity, but partly that is due to the decrease in Europeans being screened which is not the way to close disparity. There is a difference between Health HB and DHB data and that is because our data looked at our enrolled situation (enrolled in a practice you are recalled and followed up) the other data is based on 2013 census data.

David Rodgers queried did the drop in December 2011 and February 2014 correlate to any initiatives? Jenny could not recall anything specific, but as funding allows we will continue with the $20 grocery voucher programme for Maori women, not just during September/October but throughout the year, and it was suggested that this may have had a positive impact in previous years.

18. ANNUAL MAORI HEALTH PLAN DASHBOARD (JUL-SEPT 15)

Report taken as read.

Patrick Le Geyte presented report. Most of the indicators are trending up.

Chris McKenna noted some really good achievements. Patrick commented that we have had success where there has been collaboration across the sector. Chris McKenna commented on the positive feedback and emphasising collaborative working and thanked Patrick and Tracee. Great progress.

SECTION 5: COMMITTEE REPORTS AND UPDATE

19. CLINICAL ADVISORY GOVERNANCE COMMITTEE

Tae Richardson provided a brief verbal update on the Care Plus re-design and funding from the MoH.

20. MATERNITY CLINICAL GOVERNANCE GROUP Q1

Report taken as read. No discussion held.

21. HB CLINICAL RESEARCH COMMITTEE

Report taken as read. No discussion held.

22. ALLIANCE LEADERSHIP TEAM

Report taken as read. No discussion held.

SECTION 6: GENERAL BUSINESS

23. NEW COMMUNITY BIRTHING UNIT

Julie Arthur advised that the opening for the new birthing unit will occur on 4 July 2016.

The meeting closed at 5.45 pm.

Confirmed: _____
Chair

Date: _____

HAWKE'S BAY CLINICAL COUNCIL
Matters Arising – Review of Actions
(PUBLIC)

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	11/11/15	**Vacant positions on Clinical Council** – ongoing: Clinical Director (Robin Whyman confirmed) to commence in the new year **Plus:** **HB Laboratory Committee Chai**r (primary care lead) position vacant.	J Gommans M Peterson	Dec	Details to be provided to Co Sec Dr Kiri Bird appointed.
2	09/09/15	**Alternative Health Provider:** Item raised by David Rodgers will be investigated by Andy Phillips and a Draft Policy for the DHB regarding alternative providers will be produced.	A Phillips	Mar	Included on Workplan for ~~Dec/Feb~~ March 2016
3	11/11/15	**Changes to Interest Register** David Rodgers to advise an interest via email, for inclusion.	D Rodgers	Dec	Actioned

5

HAWKE'S BAY CLINICAL COUNCIL
WORK PLAN 2016

Meeting Dates 2016	Papers and Topics	Lead(s)
10 Feb	Consumer Story	Kate Coley
	Health Literacy	Quigley & Watts
	Clinical Governance Structures / Committees Review (Draft)	Kate Coley
	Social Care Networks	Kevin Snee/Liz Stockley
	Te Ara Whakawaiora / Access (Local Indicator)	Tim Evans / Mary
9 Mar	Consumer Story	Kate Coley
	Clinical Governance Structures - Decision	Kate Coley
	Alternative Health Providers Policy	Andy Phillips
	Aged Residential Care Risk Report (bi-annual)	Tim Evans / Paul Malan
	Annual Maori Health Plan Q2	Tracee TeHuia / Patrick
	Te Ara Whakawaiora / Breastfeeding (National Indicator)	Caroline McElnay
	Draft Regional Services Plan – for information & comment	
	Draft Annual Plan Statement of Intent - for information & comment	
	REPORTING COMMITTEES – written/verbal reports:	
	Radiology Services Committee	Mark Peterson
	Laboratory Services Committee	Dr Kiri Bird
	Falls Committee (6 monthly)	Chris McKenna / David
	Maternity Clinical Governance and Safety (6 monthly)	Chris McKenna / Jules
	Urgent Care Alliance Quarterly Update	Mark Peterson/Graeme
13 Apr	TBC	

Health Literacy Strategic Review

Information for the Clinical Council

As you may already be aware, Quigley and Watts Ltd (www.quigleyandwatts.co.nz) have been commissioned by the Hawke's Bay DHB to do a high level review of health literacy within the DHB and across the sector to inform the development of a sector-wide health literacy framework. As part of the high level review, feedback is being gathered from a variety of sources on how health literate the sector is currently as well as opportunities to improve going forward.

Internationally there is no unanimously agreed definition of health literacy. The Ministry of Health defines health literacy as the capacity to find, interpret and use information and health services to make effective decisions for health and wellbeing. As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy. This review focuses on the health literacy of the system and not of the individual consumer/patient.

Jen Margaret and Kate Marsh, senior researchers from Quigley and Watts, will be gathering your feedback for half an hour during your next meeting. Your feedback will be presented to the DHB who will use it to develop a sector-wide health literacy framework.

As our time with you is limited, it would be much appreciated if you could consider the questions below prior to attending the meeting and come prepared to provide your feedback.

1. **Where do you think the Hawke's Bay health sector is currently at in terms of health literacy?**

2. **How can the DHB support clinical services to respond to the health literacy needs of communities?**

3. **What do you think are the biggest challenges to be addressed in creating and implementing a sector-wide framework for health literacy?**

4. **What are some solutions to the challenges you just mentioned?**

Please direct any queries about these questions to Kate Marsh – kate@quigleyandwatts.co.nz and any queries about this review process to Jeanette Rendle - Jeanette.Rendle@hawkesbaydhb.govt.nz.

HAWKE'S BAY
District Health Board
Whakawāteatia

Consultation Document

Proposals for change for Hawke's Bay Clinical Governance Structures

Kate Coley
January 2016

Contents:

1. Executive Summary

Hawke's Bay District Health Board (HBDHB) and the HB Health Sector have a shared vision and framework for quality improvement and patient safety for the people of Hawke's Bay. We will ensure that the objectives outlined in the Quality Improvement and Safety Framework are delivered. To do this we are committed to prioritise quality improvement and patient safety within the HB Health Sector. To deliver on our value of Akina, all of our staff will become more proactive by using quality improvement methods to support continuous improvement. This will require appropriate resources to support clinical teams, consumers and managers to deliver high reliability, high quality services by identifying and implementing quality improvement programmes.

With the implementation of the new HBDHB Clinical Leadership teams and the embedding of the new Quality Improvement & Patient Safety (QIPS) structure there is an opportunity to review the current clinical governance structures. In the development of the proposed structure the following principles have been applied:

- Clarity of Executive, Governance, Directorate and clinical leadership for accountability and leadership of quality improvement, patient safety and patient experience
- A clear quality improvement and patient safety vision is articulated
- Engagement across the Hawke's Bay Health Sector
- Clinicians at all levels have responsibility for quality improvement, patient experience and patient safety in their everyday work
- Dedicated infrastructure including Information Technology is provided to support and facilitate quality improvement, patient safety and patient experience
- Measurement of outcomes of quality improvement and patient safety is reported to the Executive Management Team and Board
- Financial and Quality approaches are unified in the understanding that high quality, safe patient care is cost effective

The pressing need to review the operational function of our current hospital clinical governance committees in light of the recent changes in the directorate leadership structures, has been balanced with the need for a strategic whole of sector approach to clinical governance and the roll out of QIPS into Primary care.

The paper provides a high level overview of the intended direction of travel. The intention is to take a strategic approach to refining the current clinical governance committees to reflect increased emphasis on quality improvement and to incorporate and align the directorate leadership teams within this structure. Alongside this aspect, we also need to consider the wider health sector and their needs from a clinical governance perspective. Key requirements include effective strategic leadership, strengthened clinical and consumer partnerships and operational management and resourcing.

Initial feedback has been provided from each of the committees and Directorate leadership teams which has informed this paper.

2. Summary of Proposals

In summary this proposal recommends the following:

- The term 'Committee' will be used for those groups that report directly into the Clinical Council and are sector wide committees. All other groups which are predominantly hospital focussed will change their titles to 'Advisory Groups'. This better reflects their purpose and shifts the potential perception of focus on compliance and bureaucracy to one of quality improvement and clinical best practice.

- Consistent with the nature of the advisory groups, the reporting lines will change to reflect different strategic groups – clinical, professional and business. In some instances the "Professional Governance" and "Business Governance" will be virtual groups that will not necessarily meet unless there are any issues that need to be discussed.

- Each advisory group will meet at least quarterly and for those reporting directly to the Clinical & Quality Advisory Group (Hospital) a quarterly report will need to be provided.

- Terms of Reference (ToR) will be reviewed with clearly defined purpose, functions, parameters and deliverables, as will membership to reflect both clinical and directorate leadership structures. The Clinical Council or Health Services Leadership Group (as appropriate) will approve the ToR with the relevant chairs.

- The Clinical Events Advisory Group (Clinical Events AG) will be the key clinical hospital operational group which will review all SAC 1 and 2 clinical events, complex HDC complaints, major privacy breaches and trends. A summary report/visibility of other types of events e.g. medication events will also be provided regularly to this forum, however the responsibility for investigating, completing reports and identifying improvements will sit with the relevant advisory group but be provided to the Clinical Event AG. This change has already been implemented to support effective hospital services clinical governance.

- The Patient Safety Advisory Group will be renamed the Clinical & Quality Advisory Group (Hospital) and will be the key clinical governance body for hospital services reporting to Clinical Council and the Health Services Leadership team. This change has already been implemented to support effective hospital services clinical governance.

- Establishment of a new Clinical Audit and Outcomes advisory group responsible for supporting and coordinating audit activity across Health Services, developing an annual auditing plan in consultation with the relevant AGs and directorates, and receive key clinical indicators and reports such as harm and mortality, Health RoundTable reports and outcomes of clinical audits. It will provide advice to the Clinical & Quality Advisory Group (Hospital) (replacing the current PSAG) and Health Services Leadership Team.

- A new Advisory Group will replace the current resuscitation committee; with a broader scope that encompasses management of deteriorating patients, patients at risk, and early warning systems. A name for this advisory group will be determined following consultation.

- Quality improvement initiatives as a result of research, best practice, audits, events and incidents will be co-ordinated through the Quality Improvement team and implementation of those improvements will be facilitated with the relevant Directorates/departments by the improvement advisors.

- The current Infection Prevention and Control Committee will extend its current remit to work more widely across the sector, with a strategic focus. This committee will therefore report directly to Clinical Council.

- To support greater visibility of patient safety and quality of care, the changes to clinical advisory groups will be only one part of the change. Additionally within hospital services an operational quality dashboard will be developed for health services identifying specific measures of safety, clinical effectiveness and patient experience.

- Establishment of a new professional advisory group for Allied Health, Scientific and technical staff called Allied Health Professional Forum. This group will have similar terms of reference to the Nursing and Midwifery Leadership Council and will be chaired by the Director of Allied Health.

- Due to the ever changing clinical environment it is envisaged that the current Product Evaluation Committee's role and remit will be reviewed and broadened. There will also be an opportunity to review the current membership to include more senior clinical leaders and because of the relationship with the Procurement team, this advisory group will align and work closely with this team in considering new clinical equipment and technology.

Feedback on this proposal is sought. This document does not articulate confirmed decisions but sets out proposals for wide review and discussion. Effective feedback on this paper would include critical review of these proposals and suggested alternatives and what benefits those alternatives would bring.

3. Current Structure

Current HB Health Sector Clinical Governance Structure

The Clinical Council was established in September 2010. The purpose of this was to provide clinically led decision making and advice to the Hawkes Bay health system on resource allocation and key service changes. The Council also provides clinical leadership and oversight for clinical quality and patient safety across the sector. The Council encompasses clinical leaders and clinicians from multiple professions from both primary and secondary care.

Over time a number of sub committees reporting to Clinical Council have been established, which have a formal reporting and accountability line to the Clinical Council. Their terms of reference are developed and endorsed by Clinical Council, members of the committee are appointed by Clinical Council and membership to those committees is from both the primary and secondary sectors.

There are a number of other committees (shown by the dotted lines on the structure chart) that are not formal Clinical Council sub committees, however they provide informational reports to Clinical Council due to their chairs being members of Clinical Council – these include the PHO Clinical Advisory Committee, Health Services Patient Safety Advisory Group (PSAG), the Nursing & Midwifery Leadership Council and the Maternity Clinical Governance Group.

In Primary care, the Clinical Advisory Committee (CAG) is the advisory committee set up to provide the Health HB Board with clinical advice and information. The clinical lead of that committee is also a member of Clinical Council and provides feedback and updates following their monthly meetings.

Current HBDHB Clinical Governance Committees Structure

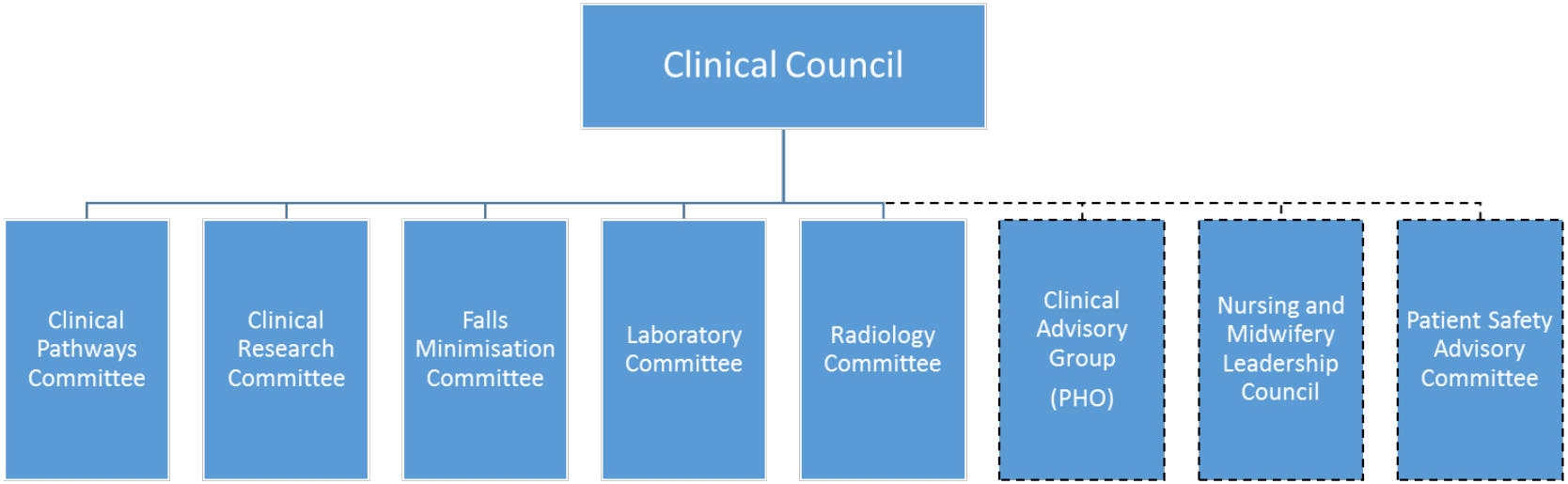
The current health services clinical governance structure was put in place in late 2011, following a period of consultation to bring existing committees under the supervision of the PSAG and update their ToR and membership. At that time the clinical committees were responsible for:

- Overseeing the development and implementation of clinical care delivery systems, processes, policies and clinical risk management
- Clinical practice improvement

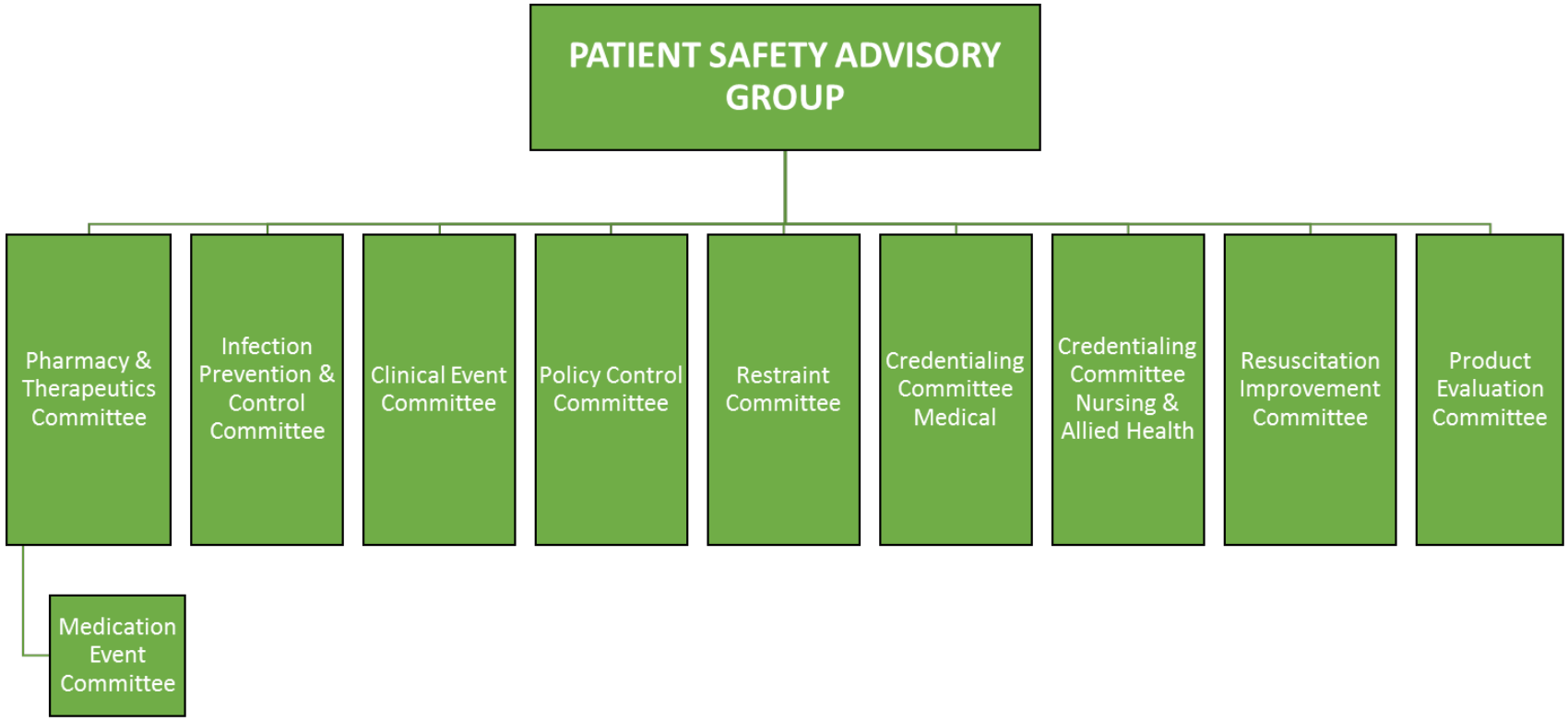
In addition to above formal and informal committees of Clinical Council, there are a number of committees within Hawkes Bay DHB Health services. A number of these are required to meet both legislative and Health & Disability Standards including:

- Pharmacy & Therapeutics Committee
- Infection Prevention & Control Committee
- Clinical Event Committee
- Policy Control Committee
- Restraint Committee

Current HB Health Sector Clinical Governance Structure



Current HBDHB Clinical Governance Committees Structure



Current Key Roles & Responsibilities

The following table provides an overview of each clinical committee's purpose, regularity of meetings, the communication mechanisms and where the reporting/accountability lines are. This information has been drawn purely from a review of the committees current Terms of Reference. These are key components of the ToR and not a full and detailed list of all tasks and responsibilities.

Note: The ToR for a significant number of committees does not necessarily reflect the reality of current practice. This relates to reporting, communications, quorums, reviewing of committee membership and remit.

Committee	Terms of Reference Outline
Confirmed Sub Committees of Clinical Council	
Falls Minimisation Committee (2011) *Monthly*	▪ Advice to Clinical council on strategies and actions to minimise incidence and impact of injuries resulting from falls ▪ Works across sector ▪ Monitor trends ▪ Implementation of actions and strategies ▪ Audits and investigations ▪ Reports to Clinical Council and provides a bi-annual report
Laboratory Services Committee (2011) *Minimum quarterly*	▪ Strategic and operational advice to Clinical Council on how best to meet the stakeholder requirements for efficient and effective medical laboratory service across HB health sector. ▪ Review of policy, procedure ▪ Education ▪ Monitoring trends ▪ Implementation of actions and strategies ▪ Audits and investigations ▪ Reports to Clinical Council and provides a bi-annual report
Clinical Research Committee (2013) *Minimum quarterly*	▪ Strategic and operational advice to Clinical Council on all health and disability research being undertaken in HB ▪ Ensure good and ethical practice, promoting a research culture and review of that clinical research. ▪ Reports to Clinical Council and provides a bi-annual report ▪ Annual publication for HB health sector summarising its activity
Radiology Committee (2014) *Minimum quarterly*	▪ strategic and operational advice to the Clinical Council on how best to meet stakeholder requirements for efficient and effective medical radiology services in Hawke's Bay ▪ seeks to ensure good clinical practice and consistency across primary, community and hospital services and the timely availability of electronic, integrated and accurate diagnostic results
Other Clinical Committees	
Patient Safety Advisory Group (PSAG) (2012) *Bimonthly*	▪ Ensure patient safety and quality of care ▪ Provide a clinical forum of representatives of all HS clinical committees for discussion of sector wide continuous quality improvement and patient safety issues provide an overview of quality, safety and risk management and escalation for clinical risk ▪ Reports to Health Services Leadership Group (HSLG) ▪ Delegated authority to provide advice to HSLG and Clinical Council – provides reports to these same groups ▪ Formal link to COO ▪ Minutes provided to HSLG and as required to other clinical committees
Clinical Event Committee (2013) *Monthly*	▪ Monitor management of serious and major clinical events and complaints ▪ Ensure compliance with statutory requirement, legislation and policies ▪ Define and identify learning & quality improvement as outcomes of events and complaints ▪ Reports to PSAG and provides bi-annual reports in Feb and August ▪ Learnings to be shared through Quality Bulletin, Quality review meetings and education

Policy Control Committee *Monthly*	▪ Ensure effective policy control system for review of policies is undertaken within the designated time frame ▪ Delegation - CEO & Health Leadership teams ▪ Sub Committee of PSAG ▪ Bi annual reports to PSAG
Restraint Committee *Quarterly*	▪ Ensure compliance to NZ Standard Health & Disability standards ▪ Improve clinical outcomes for patients ▪ Approve, maintain and improve systems ▪ Education and development to ensure safe practice ▪ Ensure policies are reviewed within designated timeframes ▪ Reports to PSAG – provides report in April and October ▪ Minutes circulated to committee members
Credentialling Committee – Medical (2011)	▪ Oversee SMO credentialling system on behalf of PSAG ▪ Ensure system reflects national framework ▪ Ensure training, qualifications and experience are verified ▪ Consider recommendations from external review reports ▪ Report to HSLG and provides 6 monthly reports
Nurse & Allied Health Credentialing Committee (2013) (Monthly if required)	▪ Defining and driving sector integration to allow professionals to work at top of scope ▪ Identification and credentialing of advanced activities ▪ Review policies and practices ▪ Reports to Chief Nursing Officer (CNO) and Director of Allied Health (DAH) and COO, findings and decisions will be reported to PSAG every 6 months
Product Evaluation Committee (2011) *Monthly*	▪ Review and recommend the purchase of new products/equipment based upon clinical need ▪ Review policy documentation ▪ Act as central registration point and audit trail for new products ▪ Report to Health Leadership Group ▪ Minutes circulated to HS Leadership group, and information relating to new products and trials published to Staff Notices
Resuscitation Committee (2013) *Quarterly*	▪ Review and maintain resuscitation systems ▪ Review policy & best practice ▪ Educational programmes ▪ Review of incidents and events ▪ Subcommittee exists for operational matters ▪ Bi-annual report to PSAG, reports to PSAG ▪ Minutes circulated to Service Directors, Clinical Council, members liaise within other in Services
Infection Control Committee (2012) *Monthly*	▪ Development, implement and monitor Infection control programme ▪ Provide expert advice ▪ Review and evaluate policies ▪ Identify and manage outbreaks of infection ▪ Education & training ▪ Work across the sector ▪ Delegated authority from Clinical Council, representative on the PSAG ▪ Minutes circulated to members of committee, monthly report to COO, bi annual reports to Clinical Council and FRAC and org wide.
Pharmacy & Therapeutics Committee (2013) *Monthly*	▪ Setting and monitoring standards of prescribing within HBDHB ▪ Audits of drug prescribing and compliance to policy etc ▪ Review of medication events ▪ Review and updating of current policies, guidelines ▪ Advice to Clinical Council ▪ Minutes circulated to committee members ▪ Communication to staff through Pharmacy & Therapeutic Bulletin
Nursing & Midwifery Leadership Council (2012) *Bi-monthly*	▪ Forum for nursing and midwifery to discuss professional matters that impact clinical practice and patient care ▪ Ensure an intentional and responsive approach to advancing nursing and midwifery practice. ▪ Develop strategies and work-plans and working parties to take forward projects ▪ Contribute and endorse documentation pertaining to professional matters ▪ Reports to and provides quarterly report to Clinical Council, and feedback

	to other relevant committees as required. ▪ Minutes circulated to committee members
Maternity Clinical Governance Group (2012) *Monthly*	▪ Consultative forum for managing quality & safety in maternity services ▪ Ensure National Maternity Standards are embedded ▪ Review events and incidence ▪ Ensure action plans are developed and implemented ▪ Communicate findings and results ▪ Review compliance with guidelines ▪ Annual maternity audit programme ▪ Quarterly report to Clinical Council ▪ Unsure of reporting line?

The above table identifies that across these committees there is some consistency in regards to some core roles and responsibilities:

- Approve, maintain and improve systems relevant to clinical aspects
- Review reports, issues and events
- Review of relevant policies and monitor compliance to policies/guidelines
- Education & development

Feedback / Comments from current Committee members, Directorate Leadership Teams

Feedback was sought from current committee members and the Directorate Leadership teams in informing the proposed changes.

Key comments, themes, and issues identified through this feedback are summarised below.

- Need for greater clarity of roles and responsibilities given the implementation of the new Service Directorate structure
- Some committees meet regularly, are well managed, provide reports etc – however there is significant inconsistency of practice
- Difficult to distinguish between true formal reporting and accountability lines versus informal, informational sharing reporting structures
- Need to review current membership
- Disconnect between written Terms of Reference and application and implementation of those in current practice
- Questions around how to make these committees function more effectively across the sector
- Questions / inconsistencies around the levels of accountability and governance
- Potentially too many committees and is there an opportunity to amalgamate these?
- Lack of visibility of some committee structures, roles etc. outside of the members
- Lack of a co-ordinated approach to implementing recommendations and subsequent quality improvements
- Lack of communication from committees to wider groups and staff – this is up, down and across the organisation and sector
- Poor attendance at some committees
- Some committees effectively run by only a few core members e.g. 3 to 4 out a committee of 12 people
- Need to align with the new directorate leadership structure
- Should we have consumer representation on the committees as is the case with the restraint committee
- Inconsistent / lack of administration support
- Frequency of meetings – inconsistency, too regular
- Focus on compliance and retrospective review and not of quality improvement
- Need for more visibility and feedback to all staff in regards to issues and discussions e.g. issues around credentialing, learnings from events etc.
- Question with regards to the implementation of the Health Leadership Group – does this forum exist in the context of Clinical committees

- Confusion as to reporting lines, whether they are sub-committees of Clinical Council, PSAG or Health Services Leadership Group

4. Proposed Changes

The proposed changes reflect the endorsement by the DHB Board of the Quality Improvement and Safety (QIPS) Framework, the new Clinical Leadership structure and the embedding of the QIPS structure. The proposed changes include consideration and reflection of the feedback already received.

It should be noted that the QIPS Framework is a sector wide framework and it is envisaged that the committee structures will evolve to becoming streamlined and sector wide where appropriate. It is intended that the current sector wide Clinical Council will continue to provide leadership and oversight on all clinical and quality matters across the sector.

The following highlights the proposed changes:

- The term 'Committee' will be used for those groups that report directly into the Clinical Council and are sector wide committees. All other groups which are predominantly hospital focussed will change their titles to 'Advisory Groups'. This better reflects their purpose and shifts the potential perception of focus on compliance and bureaucracy to one of quality improvement and clinical best practice.

- Consistent with the nature of the advisory groups, the reporting lines will change to reflect different strategic groups – clinical, professional and business. In some instances the "Professional Governance" and "Business Governance" will be virtual groups that will not necessarily meet unless there are any issues that need to be discussed.

- Each advisory group will meet at least quarterly and for those reporting directly to the Clinical & Quality Advisory Group (Hospital) a quarterly report will need to be provided.

- Terms of Reference (ToR) will be reviewed with clearly defined purpose, functions, parameters and deliverables, as will membership to reflect both clinical and directorate leadership structures. The Clinical Council or Health Services Leadership Group (as appropriate) will approve the ToR with the relevant chairs.

- The Clinical Events Advisory Group (Clinical Events AG) will be the key clinical hospital operational group which will review all SAC 1 and 2 clinical events, complex HDC complaints, major privacy breaches and trends. A summary report/visibility of other types of events e.g. medication events will also be provided regularly to this forum, however the responsibility for investigating, completing reports and identifying improvements will sit with the relevant advisory group but be provided to the Clinical Event AG. This change has already been implemented to support effective hospital services clinical governance.

- The Patient Safety Advisory Group will be renamed the Clinical & Quality Advisory Group (Hospital) and will be the key clinical governance body for hospital services reporting to Clinical Council and the Health Services Leadership team. This change has already been implemented to support effective hospital services clinical governance.

- Establishment of a new Clinical Audit and Outcomes advisory group responsible for supporting and coordinating audit activity across Health Services, developing an annual auditing plan in consultation with the relevant AGs and directorates, and receive key clinical indicators and reports such as harm and mortality, Health RoundTable reports and outcomes of clinical audits. It will provide advice to the Clinical & Quality Advisory Group (Hospital) (replacing the current PSAG) and Health Services Leadership Team.

- A new Advisory Group will replace the current resuscitation committee; with a broader scope that encompasses management of deteriorating patients, patients at risk, and early warning systems. A name for this advisory group will be determined following consultation.

- Quality improvement initiatives as a result of research, best practice, audits, events and incidents will be co-ordinated through the Quality Improvement team and implementation of those

improvements will be facilitated with the relevant Directorates/departments by the improvement advisors.

- The current Infection Prevention and Control Committee will extend its current remit to work more widely across the sector, with a strategic focus. This committee will therefore report directly to Clinical Council.

- To support greater visibility of patient safety and quality of care, the changes to clinical advisory groups will be only one part of the change. Additionally within hospital services an operational quality dashboard will be developed for health services identifying specific measures of safety, clinical effectiveness and patient experience.

- Establishment of a new professional advisory group for Allied Health, Scientific and technical staff called Allied Health Professional Forum. This group will have similar terms of reference to the Nursing and Midwifery Leadership Council and will be chaired by the Director of Allied Health.

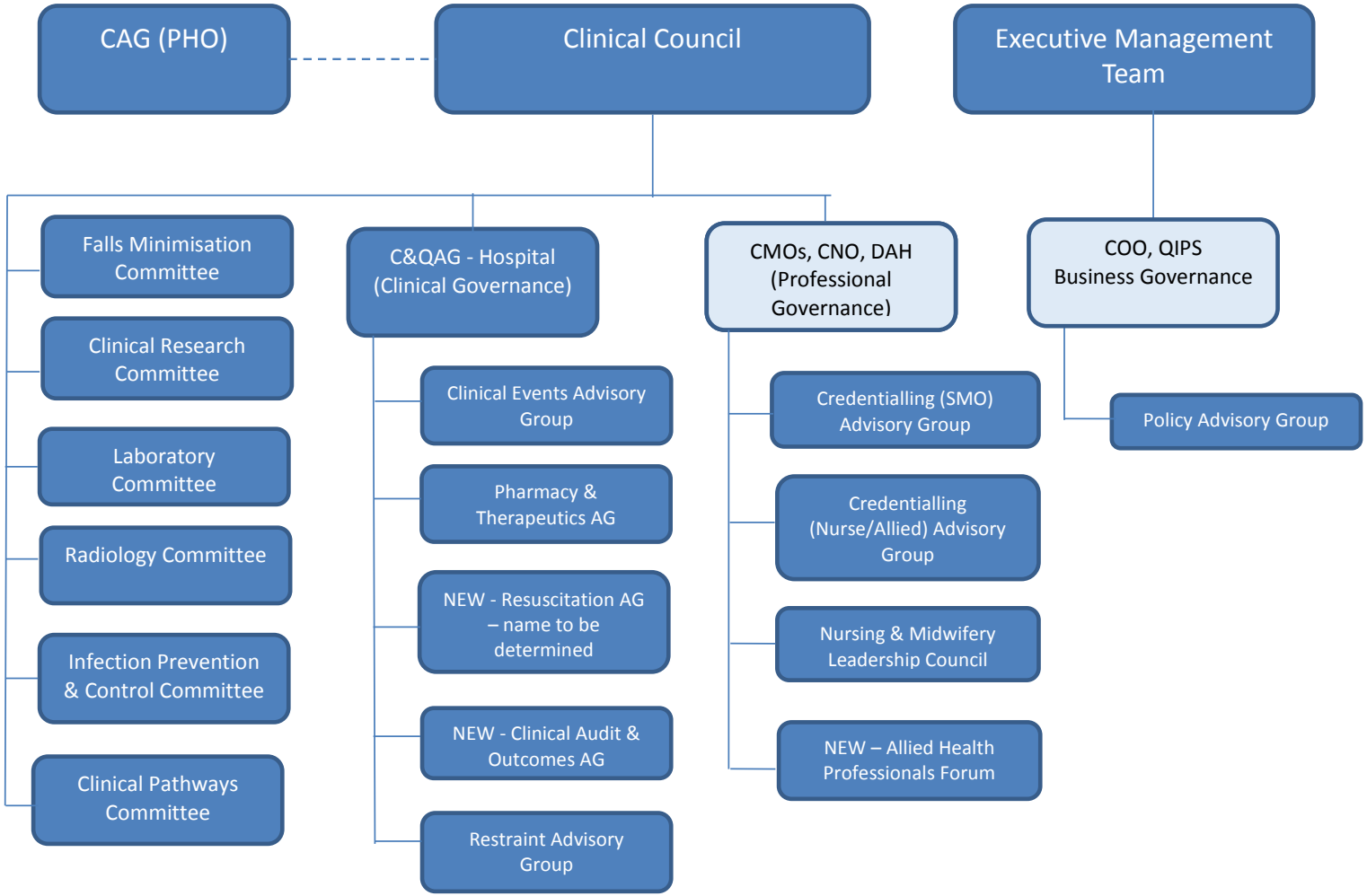
- Due to the ever changing clinical environment it is envisaged that the current Product Evaluation Committee's role and remit will be reviewed and broadened. There will also be an opportunity to review the current membership to include more senior clinical leaders and because of the relationship with the Procurement team, this advisory group will align and work closely with this team in considering new clinical equipment and technology.

- Meetings will be held quarterly at a minimum with an element of flexibility for each advisory group to agree a realistic frequency for meetings. Should events/incidents arise in the interim periods then a subgroup from the relevant advisory group will be responsible for investigating the event and providing a report to the Clinical Event advisory group which will meet on a monthly basis.

- Terms of Reference will need to be reviewed with clearly defined purpose, functions, parameters and deliverables as will membership to reflect both clinical and directorate leadership structures. The Clinical Council or Health Services Leadership Group (where appropriate) will approve ToR, membership and chairs. Accountability and responsibilities will be clearly evidenced.
    - Research, best practice and management / improvement to systems
    - Review of policy
    - Delivery and development of relevant training
    - Quality initiatives aligned and facilitated with QIPS
    - Communication / sharing learnings/ best practice with key stakeholders

  Communication from advisory groups around activities, recommendations; learnings will need to be better co-ordinated, more visible and provided regularly to a wider audience e.g. all staff, sector etc.

Proposed new clinical governance committees and advisory group structures



5. Feedback

We are seeking your feedback on this proposal. The level of detail has been provided to inform people how the proposed changes might affect them and to help them make submissions on the proposals.

Please note that submissions/feedback will be collated and acknowledged throughout the process.

We welcome your feedback on this proposal which is required by **5.00pm** on **Friday, 12 February 2016.** You can provide this feedback, either individually or with others, in writing to the Director, QIPS or by email to dqips@hbdhb.govt.nz.

Thank you

Kate Coley - Director Quality Improvement & Patient Safety

Dr John Gommans-Chief Medical Officer-Hospital

Dr Mark Petersen-Chief Medical Officer-Primary Care

Chris McKenna-Chief Nursing Officer

Dr Andy Phillips-Director of Allied Health

HAWKE'S BAY District Health Board Whakawāteatia	**Health and Social Care Networks Programme Brief**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board**
Document Owner: Document Author(s):	Steering Group – Health and Social Care Networks Kevin Snee
Reviewed by:	Executive Management Team
Month:	February 2016
Consideration:	For Discussion

RECOMMENDATION

That HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board:

1. Endorse the content of this Programme Brief
2. Provide feedback and input on its content and strategic direction

INTRODUCTION

Under the auspices of Transform & Sustain, we are proposing a new programme of work that will significantly change the structure of the Hawke's Bay health sector. This work is transformational in nature, requiring new ways of operating and strong relationships across all stakeholders.

The programme will take a staged approach, with an initial project that will establish the DHB's processes and standard requirements for network development, plus develop standardised documentation and templates. These resources will be available for use in later projects, by stakeholder groups (including patients and community leaders) that wish to establish geographically-based provider networks ("Health and Social Care Networks") that will work collaboratively to better address the needs of their combined enrolled population. One such group is already considering network development (Wairoa), and two others are in the early stages of considering the potential to work together (Central Hawke's Bay and central-Hastings); these groups will be supported and encouraged within the overall programme.

This paper introduces the programme (the Programme Brief) and provides further information on the development of standard tools and processes (Appendix 1), an intial stakeholder analysis (Appendix 2) and a terms of reference for the Steering Group that will oversee all programme work, ensuring alignment and synthesis across all projects (Appendix 3).

BACKGROUND

The health system in Hawke's Bay, as with the rest of New Zealand, will experience significant challenges in meeting the future needs of our population, particularly in terms of the aging cohort and a rise in conditions requiring long term and complex care. To better prepare our sector for these challenges, an alternative service delivery model that integrates primary, secondary and social services has been proposed; this model seeks to increase effectiveness and efficiency of health care delivery closer to where people live, whilst recognising and addressing the key role of socio-economic factors in determining health outcomes.

Recent discussions have centred upon how this integration could be effected, focussing on the establishment of clusters of health and social service providers working closely together with the patients that they have in common; these clusters have been termed *Health and Social Care Networks.*

Initially networks will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians and community leaders. The time frame to achieve this expanded vision may be different for different communities.

Stakeholder engagement and input will be essential to the success of the Health and Social Care Networks Programme. In Phase One, outlined in Appendix 1, this engagement will focus on DHB and PHO stakeholders. This is because the work focuses on determining these organisations' approach to networks, including a proposal on how networks could be structured, the level of decision-making that could be devolved to communities and developing supporting resources to assist communities on this journey. Where possible, Phase One deliverables will be over-arching, rather than prescriptive, as each Network will result from a co-design process and will be as individual as the community it serves. In later projects, in which communities establish networks that meet their needs and aspiations, co-design will be the key process by which a much wider range of stakeholders will be involved in a partnership to design and implement their network. Such projects will be the subject of separate Terms of Reference.

ATTACHMENTS – Programme Brief, Appendix 1, 2 and 3

Programme Brief

Establishing Health and Social Care Networks

January 2016

Purpose of this document

The purpose of this document is to outline the scope and activities required to enable Health and Social Care Networks to be established in Hawke's Bay.

This document is for:

- The Health and Social Care Networks Steering Group – to describe a way forward for sector redesign, providing a clear statement of intent, leadership and responsibility
- EMT – to gain managerial approval and support for this initiative and approach

Background

The health system in Hawke's Bay, as the rest of New Zealand will experience a significant growth in the population of frail older people and a further growth in the numbers of people living with complex long term conditions. The health system is currently not designed to deliver equitable outcomes or access to services for Māori and Pacific populations and there are groups of people who are unable to afford, access or navigate the health sector. This problem is not unique to health. There is a lack of co-ordination between health and social care services that can be frustrating for individuals and lead to lack of engagement and wasted resources across the board.

Transform and Sustain has established a strategic framework and an environment under which significant change can be achieved, and is already underway in some areas. There is a need for primary care to be better positioned to address acknowledged challenges, to be more connected and collaborative, and to deliver services that are accessible and appropriate for the Hawke's Bay population. Other providers of health and social services in the community need to be more connected and services need to be joined up. The concept of Health and Social Care Networks, as a vehicle for addressing these challenges has been discussed in several forums.

This journey will lead to a health service in which the right clinician is delivering an appropriate service in the most sensible location supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness.

The establishment of Health and Social Care Networks requires a significant programme of activity and of change management. We propose to begin this journey by delivering current services differently, to respond to the community more effectively and to encourage and motivate collaboration. This journey will be challenging because of the number and breadth of stakeholders, because it requires changes to the status quo and because the day to day operations of a complex health sector need to continue whilst this vision is realised. It is also an opportunity to revitalise our sector and increase sustainability in terms of service affordability, infrastructure and workforce.

Proposal

We propose to establish a number of networks of collaborative services that are clustered around geographical communities that work closely together to care for patients that they have in common.

Initially networks, with community input, will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This will be the focus of Phase One.

This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians, professionals and community leaders. The time frame to achieve this expanded vision may be different for different communities - this is a long term vision.

Phase One

We will cluster existing services around geographical communities and use the design of these services as a lever to engage providers, other public services, Iwi, NGO's and voluntary organisations in the concept of community networks. We will begin with health services and invite community partners to also review their services through an aligned approach.

In Napier and Hastings the clustering of services will be based on populations of around 30,000 people, in an aligned geographical area. The 30,000 figure represents a likely lower limit at which a network would be viable; an upper limit, although not specified, would be a figure at which a sense of community is lost. In Wairoa and Central Hawke's Bay remoteness rather than population size determines each to be a sensible geographical network and, therefore, smaller network populations are envisaged for these areas.

In order to reshape services so that they are appropriate for the community the HDBHB and HHB teams will work with local general practice teams and other local clinicians, consumers and community partners to:

- Ensure services are appropriate to prevent ill health, enable people to keep themselves well and independent for as long as possible
- Support the development of quality services that are provided in the community
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated and respond to local need
- Improve communication and information sharing between different health, social care and voluntary sector professionals
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.

To achieve this first phase the programme of work detailed below proposes:

1. Background work - understanding ourselves (services, processes and models) and the potential benefits to be gained from networks, developing expertise through a central repository of knowledge, tools and resources that will support sector change. Key activities include:
    - ensuring various projects, existing and new initiatives, are aligned
    - reviewing our services and considering the most appropriate delivery models
    - analysing our systems and processes to reflect the collaborative working environment
    - developing a standard pathway, tools and templates to guide establishment of networks throughout Hawke's Bay
    - reviewing examples of good practice from other places to avoid reinventing the wheel
2. Establishing a network in Wairoa
3. Motivating collaboration in Central Hawke's Bay
4. Supporting collaborative general practice initiatives in Hastings (e.g. Totara health and Hastings Health Centre)

5. Supporting the identification of sensible network groupings in Napier and Hastings
6. Initiating the development of the technology platform in primary care.

Each of the associated individual pieces of work will be subject to appropriate project management rigour and business case processes. Some of these initiatives will be concurrent and will inform each other.

Progress to date:

A proposed scope, deliverables and high-level milestones for item 1 above is provided in Appendix 1. Progress to date in this space has included the health services directorates considering services that could be provided in the community and the consideration of some models from elsewhere (e.g. Nuka). Work has also been done to review what the community wants from services – what have we already been told, and to engage consumers in consideration of the general practice model of care.

On the back of the development of the new facility in Wairoa there have been positive discussions between community providers about working together in a smarter way. This will be nurtured and furthered through joined-up activity. Establishing a network in Wairoa is being developed under separate Terms of Reference document.

An initial meeting was held at the end of 2015 in Central Hawke's Bay which was attended by representatives of the key providers. A further meeting will be held in February to identify what the local priorities for service development are.

Whilst the Totara Health and Hastings Health Centre programme has stalled temporarily the opportunity for collaboration between general practices in Hastings remains. The PHO and DHB will continue to motivate collaboration and initiatives such as urgent care will support a collaborative approach.

The EngAGE, District Nursing and Pharmacy Facilitator projects are essentially trialing geographical groupings of services in Napier and Hastings. Lessons will be learned from these.

The DHB and PHO are currently considering what the next steps with the development of primary care infrastructure should be. A single shared care record will be a priority and some research has been undertaken as to solutions in this space.

Interdependencies

A range of other existing projects will also inform and support the network programme:

Project Name	**Interdependency description**
Patient Experience	Will inform this project by providing patient insight to service requirements and information on patient profiling by geographic practice area
EngAGE; DN GP Alignment; Clinical Pharmacy Facilitators roll out	Information on existing models of service delivery and potential geographical networks
Urgent Care	Some of these services, co-designed with primary care stakeholders, may become part of one or more networks. This may motivate collaboration
Customer Focused Booking	Influenced by, and influences, models of care that could be adopted by practices within a network
Health Literacy	Health literacy will be a key component of models of care implemented by general practices within networks
Model of Care support in primary	PHO project to develop a centre of knowledge regarding

Project Name	Interdependency description
Care	general practice models of care. Will inform and assist general practices

What success will look like

Success in the short term will mean we are delivering more health services in the community and we are supporting services to work collaboratively with other organisations (across the health and social care spectrum) in specific geographical communities to deliver better care for individuals and whānau.

For phase one networks will have a standard set of services but these may be delivered against different models of care depending on the needs and resources (such as clinical skill, capacity and facilities) of the community.

During the implementation of phase one, we will analyse information and engage with consumers and providers within communities to better understand the needs and cultural requirements of the community. We will understand what approach will support successful outcomes for each network. This will set up a solid foundation for progressing networks beyond mechanisms for service delivery to meet our longer term vision.

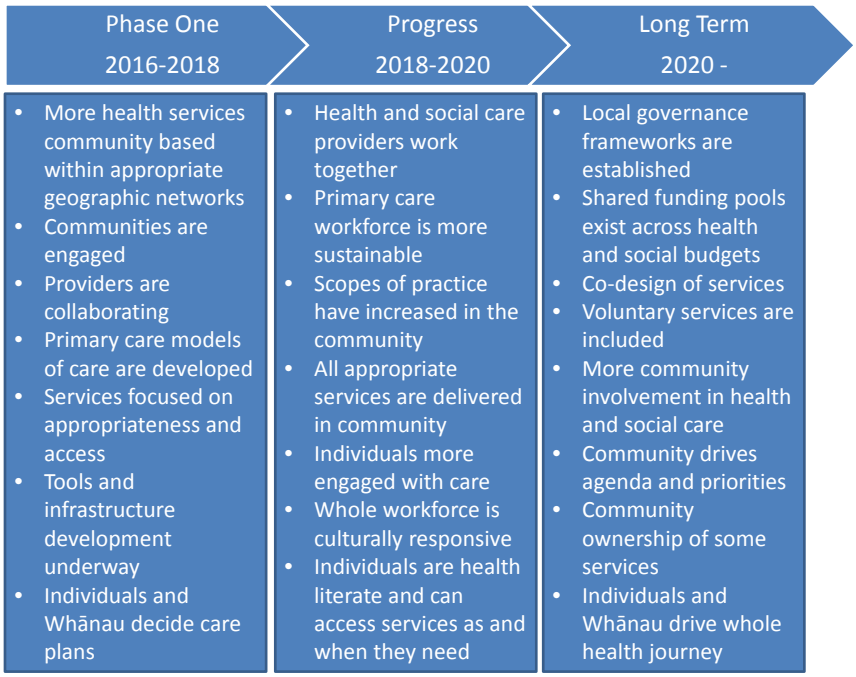
Successful implementation of Phase One means:

- People find it easy to identify and access the help and services they need because they are health-literate, the services have been designed to be easily understood, and there is additional navigation and kaiawhina assistance if required.
- Existing services will be configured in ways that improve the patient experience and respond better to communities.
- Community resources and facilities are increasingly evolving to provide a broad range of services.
- Multi-disciplinary, multi-provider case-management is the established approach for working with people and/or whanau with complex health and social needs.
- There is reduced need for hospital visits because many services are conveniently accessed in a community setting. This has led to reduced waiting times for necessary hospital-based treatment.
- General practice clinicians have the time to work with patients who need it.
- Primary care clinicians have opportunities to increase scopes of practice and develop additional expertise
- General practice business models are motivated to support sector activity
- Patients at risk are proactively identified and supported
- Technology and information is used effectively for joined up service delivery and for to support self-management
- Health outcomes, codified in a set of performance indicators covering central and local expectations, have improved.
- Continuous improvement and innovation is a central tenet of the system,

- Networks are supported by nimble, responsive management, using existing resources where possible. Organisations are working collaboratively to get the best value from all publicly funded resources.

High-level time line

The following diagram highlights the journey networks will take. The dates are indicative only, setting the direction of travel that we intend to take. Some networks may progress more quickly, particularly where geographic locality is clear and there is a group of existing engaged stakeholders. The detail highlights the key anticipated achievements of each phase.



Appendices

The appendices to this document provide additional information on the following:

- Appendix 1 – High level plan for Phase 1 (timelines, financials, deliverables, risks and communication)
- Appendix 2 – Stakeholder Analysis
- Appendix 3 – Terms of Reference for the Steering Group

APPENDIX 1: Phase One – timelines, financials, deliverables, risks

Phase One (Core Network Expertise project) is proposed to run for 7 months (February – August 2016). It will establish minimum/standard requirements of networks and support network establishment in localities.

Deliverables and high-level milestones

Objectives	Deliverables/ high level milestones
1. Set the scene	1. Agreed set of over-arching principles for Network design, operations and benefits realisation • Get approval for progress from EMT • Determine the governance and approvals processes required by HBDHB • Get input/feedback from a wide range of stakeholders (this will get their input and also socialise the ideas) to finalise the principles 2. Review of other current projects (engAGE, Pharmacy and DN) to ensure alignment across these and the Networks programme and identify lessons learned so far 3. Establish an appropriate project management framework, appropriate roles and responsibilities and resources. This will include a communications framework.
2. Geographic groups / communities	1. Localities proposal: proposed geographic regions ('localities') for networks • Analyse HB data (health, economic, other) to characterise the population, identify areas of shared needs or opportunities etc • Propose localities, using principles and interests (populations they serve) to guide boundaries; Wairoa and Central HB are geographically distinct, so work will focus on defining Napier and Hastings groupings • Map current capacity, capability, service provision and facilities in each proposed locality
3. Services and service delivery	2. Standardise a list of services that could be delivered in the community in an integrated way • Map those services for which we have some control over (i.e. DHB and PHO-funded), bring in others as we socialise the networks. • Identify how these services fit with each locality (appropriateness, resources, capability, priorities, local motivations etc.) • With network input identify how individual service lines might work differently to deliver more effective, efficient services in the community that are better of the patient and support a collaborative approach. 3. Service delivery models – options document • Research existing models of integrated services to inform the options (e.g. Nuka, Kaiser Permanente, NHS CCGs, Counties Manukau) • Determine appropriate delivery models (these will be tailored during implementation in each locality) • Create a centre of Knowledge and information around models of integration and primary and community models of care
4. Network development processes and guidelines	1. Document a standard set of requirements and standards that each network will work within. Some of these will be relevant from day one, others will be prepared for when they are needed. These will include: • Governance mechanism • KPIs/targets (minimum standards) and accountability mechanisms • Contracting mechanisms (between funder and provider, between network partners, etc) • Levels of delegated authority and mechanisms to increase autonomy over time • Budget tools and financial accountability requirements

Objectives	Deliverables/ high level milestones
	• Asset mapping tool • Network stakeholder analysis • Communications templates 2. Analyse existing DHB and PHO systems and processes and review/redraft these to reflect the collaborative working environment; develop new systems and processes where required. Examples include funding and contracting arrangements – to enable and support different ways of working. 3. Once we are ready for some decision making to be devolved to networks there will need to be a standard mechanism/pathway for 'applications' from locality groups wishing to establish a network (by submission of an outline business case or similar process). It is prudent to begin drafting what this may look like. 4. Tools and templates as required by locality groups who wish to form a network. Examples could be: • High-level 'how to' plan providing a suggested pathway/series of steps for network establishment (include alternatives/not prescriptive but indicates the minimum requirements) • 'Business Case' application template (for point 3 above) • Terms of Reference template to support establishment project scoping and planning • Terms of Reference for project Steering Groups, Partnership Advisory Groups, etc • Risk identification and management plan • Infrastructure/resource map and plan • budget template • Guide to co-design • Community asset mapping tool (beyond health and social service providers)

Risk Analysis and Management

Preliminary Risk Analysis:

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
Lack of primary care engagement	M	H	Early and clear communication to sell benefits, address concerns; gain their involvement in co-design through workshops, feedback opportunities.
Lack of engagement with secondary care	M	H	Senior clinicians to act as champions for the initiative; keep them fully informed of/involved in the project's work programme. Regular communications and opportunities to contribute in the co-design process.
Project doesn't adequately address consumer priorities	L	H	Consumer input based on a co-design approach will be integral to the establishment and operation of networks.
Project, programme and change fatigue	M	M	Communicate the vision and engage stakeholders at an early stage so that they own the solutions. Communicate regularly.

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
			Promote and celebrate success
Scale of what we're trying to achieve	M	L	Low impact for this current project stage, but recognised as considerably higher likelihood and impact for network implementation. Stage implementation projects, concentrating on those groups most able to move forward as early adopters, so that we can learn from mistakes. Recognise the need to learn from experience.
Too busy keeping the current state afloat	H	H	Adequately resource the project (staff time, resourcing and financials) to ensure that there is enough 'space' to effect change.
New ways of working/new relationships (as equal partners) that parties are not used to (working in partnership with consumers	M	H	Conduct activities to address gaps in knowledge/skills/experience. Be clear that this is change behaviour and all parties need to take responsibility for engagement and the resulting outputs. Support relationship building opportunities.
Governance of networks; how do we account for them?	M	M	Build robust processes based on best practice.
Duplication of efforts across other T&S projects (e.g. patient experience, urgent care, AIM 24/7, etc)	H	M	Project Manager to get a good understanding of results from other projects, and synthesise the lessons.

Financial Profile

This budget covers the Phase One 'Core Network Expertise' project, and is expected to be conducted during February-August 2016 inclusive (7 months). The project manager role is in addition to this budget. Further budgets will need to be supported by business cases to support implementation of health and social care networks.

As the timing of this project spans two financial years, the indicative spend in each year is as follows:

- 2015/16: $71,400
- 2016/17: $28,600

Item	Itemised Description	Cost$	Budget Source and Status (approved / approval in process etc.)
Project resources and operating expenses	o DHB staff (existing resources) o Incidental travel o Catering at meetings o Printing o Room hire o Patient engagement costs	Time $50,000 (combined items) $20,000 (combined items)	Existing staff budget New New

	o Research costs		
External advice	o Specialist advice (e.g. legal and governance); DHB expertise o Graphic design o Qualitative Engagement software and support (Cognise)	Time $30,000 (combined items)	Existing staff budget New
	Total cash investment:	**$100,000**	**New**

APPENDIX 2: Stakeholder Analysis

Stakeholder group	What they may like	What they may not like	Risks
Consumers	Opportunity to fix the problems they experience re choice, access, etc Potential to be involved in the changes/have a voice More responsive to consumer needs and wants	Shared patient records – perceived confidentiality breaches Change Additional expectations for self management	Perception that this is yet another sector restructure (waste of time/money) Rumours / media stories (negative perception or incorrect info)
General practices	General practices are key partners in this initiative – seen as progressive More influence over what services are commissioned Meritocratic increase in authority as networks prove themselves Opportunity to expand general practice scope/ potential for job enrichment May offer opportunities for succession planning Opportunities for efficiencies Opportunities to be seen to do more for patients Opportunities to improve sustainability of business and workforce	Likely to disrupt current business models Uncertainty of funding in the short-term Collaborating with competitors, particularly if there is ill will Shareholders may have other priorities for their business Business needs may be at odds with required network outcomes Out of their depth (planning etc)	Lack of practice leadership may mean that staff don't engage/ get the wrong story Staff uncertainty re jobs, scope of their role Competitive behaviour leads to perverse outcomes May not share data/info Shared geography may not mean aligned aims/objectives/philosophy Poor use of data for strategic planning – can't see the SWOT
General practitioners	Potential to decrease time pressures Ability to specialise in an area of interest Better able to refer patients with non-medical issues to other network providers Sustainability	May be expected to network with practices or people they don't like or respect May feel forced by the DHB Feel out of control	Stall progress by continually bringing up issues and/or avoiding engagement Curmudgeons promulgate negative stories/perceptions Keeping the current state going uses up all their time/energy
Community-based nurses	Work at top of scope in a new model of care; less admin/low level tasks Introduces new roles and development opportunities	Potential for loading a lot more responsibility on them	Nursing workforce in primary care may not want to change
Health Hawke's Bay	Decrease complexity and variability across practice offerings	Changes potentially conflict with nationally-determined priorities	Inability to get cross-practice information sharing and shared IT

Stakeholder group	What they may like	What they may not like	Risks
	More responsive primary care sector Joined up system, improve access, address inequity Doing better for patients More engagement across the sector Efficiency More services in the community Sustainable workforce	Out of our depth? Resource requirements and effort to achieve this change	platform Lose support of practices Communities/providers not wanting to engage
DHB	Keep the hospital the same size despite increased demand for services Local responsibility for infrastructure and resourcing (??) Address equity gap	Devolving control to communities due to lack of certainty/ track record of delivery Has invested in the current state Resource requirement to make this happen If things don't move at the right pace	Could lead to more complexity of 6-8 'different' systems (networks) to interact with Too prescriptive, meaning that communities don't feel that they own the network
Hospital services	Sustainable workloads Efficient service collaboration with primary care	Keeping the current going doesn't allow time for change Scared about jobs/instability? Might have to travel to work remotely? Worry about community capability Effort in addition to day job	Risk adverse, so will 'dig in their heels'? Perverse behaviour re network vs private patients? Services fail / community-based services don't work
MSD (funder)	Collective impact is greater than working in silos Keep people well; keep people in work Fit with national agenda	Potential lack of clarity re budgets (split between H&SC) Conflict between network outcomes and MSD policy directions? Never been done before Control issues?	Change seen as too difficult, too soon, or only benefitting the health sector Targets / national picture gets in the way of local decision making
MSD-funded services	Better access to the health resources available in the health sector, ability to cross-refer patients/clients Clarity of service provision	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term Skills to engage in doing things differently	Service failure Don't meet targets
Maori providers	Better access to the health resources available in the health sector; ability to cross-refer patients/clients Focus on Maori – close gaps, decrease inequities More holistic approach fits with Maori	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term How does this fit with current initiatives? Mistrust of HBDHB gets in the way of progress	Fear of losing autonomy

Stakeholder group	What they may like	What they may not like	Risks
	way of approaching things (e.g. whanau ora) Opportunities for collaboration Opportunities to think strategically	A lot going on with post settlement groups – this is 'another thing'	
NGOs	Better access to the health resources available in the health sector; ability to cross-refer patients/clients Potential to re-direct their services/service delivery to become an integral part of the network Better integration / collaboration with voluntary organisations	Likely to disrupt current business models / have other priorities Uncertainty of funding in the short-term Potential for more referrals; will need to see $$ coming their way	Overloading them No resources to engage Don't have sustainable funding streams

APPENDIX 3

TERMS OF REFERENCE

Health and Social Care Networks
Programme Steering Group

9

Purpose	The purpose of the Steering Group is to ensure sound decision making in the Health and social care network programme, to ensure the programme brief is adhered to and to communicate messages as appropriate.
Functions	At a programme level, the steering group is responsible for achieving the high level strategic vision of the Networks programme. This includes the following responsibilities: • Oversees all deliverables in Phase One - Health and Social Care Networks Programme to ensure strategic fit. • Actively champions the Networks Programme and provides leadership for change • Understands the desired outcomes, and tracks progress towards these, taking corrective action where necessary. • Monitors the management of major programme issues and risks and provides advice on the best approach to resolving these. • Owns the process and the deliverables of the programme. • Maintains a high-level view of project work being conducted across the health sector so that potential synergies with, or impacts on, the Networks Programme can be identified and addressed appropriately. • Reports to HBDHB Executive Management group on a monthly basis. • Holds and allocates the programme budget. • Ensures programme benefits KPIs are tracking positively. • Ensures sound decision making processes are followed • Establishes the brief or terms of reference for subsequent phases • Support and endorse Terms of Reference documents for network establishment projects in each geographic locality.
Decision Making	A consensus is required for any decision. Where meeting attendance is not possible a member will endorse/reject a deicision electronically either before a meeting or upon receipt of the minutes.l
Membership	The Core Membership of the steering group is: GM Primary Care/CEO HHB COO HBDHB GM PIF HBDHB DAH GM Māori Health HBDHB Head of Innovation and development HHB

1

	CMO (Primary) Chief Nursing Officer Medical Advisor Sector Development HHB (GP to be appointed) Manager, Wairoa Health Centre Service Director, Rural, Oral and Community Health Services Medical Director HBDHB Consumer representative Ministry of Social Development representative Other individuals will be invited to provide expertise as and when appropriate. These will include: HHB leadership team members Health Service Directors Specific service or facility managers
Chairperson	The Chair will be the GM Primary Care
Administration	The Project Manager - Network Development will: • administer the steering group • maintain an accurate and up to date record of decisions and activities • Set up meetings of the group • Draft Reports on behalf of the group • Monitor progress against programme plans
Meetings	Meetings will be held on at least a monthly basis, although additional meetings may be set up as required. Meeting attendance will be restricted to the Group members only (and appropriate support staff) with other persons attending only by specific invitation. Matters may be dealt with between meetings through email exchange with a record being maintained by the project manager.
Reporting	The steering group will report to the CEO HBDHB and to the executive management team on a monthly basis.
Minutes	Notes and action points will be circulated to all members of the Group and a summary of discussion from each meeting will be provided to EMT and the HHB Leadership team for information by email.

2

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2015/16
1 September 2015

FUNCTIONS	Provide Clinical advice and assurance to the Hawke's Bay health system senior management and governance structures	Work in partnership with the Hawke's Bay Health Consmer Council to ensure that Hawke's Bay health services are organised around the needs of people.	Provide oversight of clinical quality and patient safety	Provide clinical leadership to Hawke's Bay health system workforce
ROLES	Provide advice and/or assurance on: • Clinical implications of proposed services changes. • Prioritisation of health resources. • Measures that will address health inequities. • Integration of health care provision across the sector. • The effective and efficient clinical use of resources.	• Develop and promote a "Person and Whanau Centred Care" approach to health care delivery. • Facilitate service integrations across / within the sector. • Ensure systems support the effective transition of consumers between/within services. • Promote and facilitate effective consumer engagement and patient feedback at all levels. • Ensure consumers are readily able to access and navigate through the health system.	• Focus strongly on reducing preventable errors or harm. • Monitor effectiveness of current practice. • Ensure effective clinical risk management processes are in place and systems are developed that minimise risk • Provide information, analysis and advice to clinical, management and consumer groups as appropriate. • Ensure everyone in the HB health sector are aware of their responsibility for quality improvement and patient safety.	• Communicate and engage with clinicians and other stakeholders within HB Health Sector, providing clinical leadership when/where appropriate. • Oversee clinical education, training and research. • Ensure clinical accountability is in place at all levels.
STRATEGIES	• Review and comment on all reports, papers, initiatives prior to completion and submission to the Board. • Proactively develop, promote and recommend changes to improve health outcomes, patient experience and value from health resources. • Develop, promote and advise on strategies and actions that could assist with the reduction in health inequities. • Develop and promote initiatives and communications that will enhance clinical integration of services. • Provide input through representation on EMT, Alliance Leadership Team and through attendance at HB Health Sector Leadership Forum.	• Work collaboratively with the Consumer Council to design and implement a Person and Whanau Centred Care approach. • Understand what consumers need. • Understand what constitutes effective consumer engagement. • Promote clinical workforce education and training and role model desired culture. • Promote and implement effective health literacy practice. • Promote the development and implementation of appropriate systems and shared clinical records to facilitate a 'smooth patient experience' through the health system.	• Develop and maintain relevant and effective Clinical Indicator reporting and performance management processes. • Establish and maintain effective clinical governance structures and reporting processes. • Ensure safety and quality risks are proactively identified and managed through effective systems, delegation of accountabilities and properly trained and credentialed staff. • Ensure the "quality and safety" message and culture is spread and applied in all areas of HB health sector. • Promote "value-based decision-making" at all levels. This involves improving the processes by which decisions are made, so they take into consideration all three Triple Aim objectives: o Enhanced patient experience o Improved health outcomes o Better value for money • Ensure attendance at appropriate meetings/forums to provide appropriate assurance and confidence.	• Ensure all HB clinicians and other stakeholders are aware of the role, membership and activities of the Clinical Council. • Oversee the development, maintenance and implementation of a HB Clinical Workforce Sustainability Plan. • Promote clinical governance at all levels within the HB heatlh system. • Ensure appropriate attendance/input into National/Regional/ Local meetings/events to reflect HB clinical perspective. • Promote ongoing clinical professional development including leadership and "business" training for clinical leaders. • Facilitate co-ordination of clinical education, training and research. • Role model and promote clinical accountability at all levels.

OBJECTIVES 2015/16	• Provide clinical leadership decision making and input into significant integration projects: Clinical Pathways, Urgent Care Alliance • Ensure HBDHB Governance/Management Work plan provides adequate time and opportunity to add value to planned initiatives/papers. • Specific portfolio areas of responsibility for 2014/15 are (first person named and underlined to take the lead): • Consumer Council Liaison **?** • Service Development o Mental Health Services **David W** o Primary and Community Healthcare **Mark** o Maternity **Jules** o Health of Older People **?** o Clinical Pathways **John** o Quality Use of Medicines **Billy** o Integrated Urgent Care Services **?** o Specialist Referrals/Advice **Tae** o Palliative Care Integrated Model of Care **?** o **Long Term Conditions** **?** Ministerial Health Targets o Shorter stays in ED **Malcolm** o Improved access to elective surgery **?** o Shorter waits for cancer treatments **Chris** o Increased immunisation **Caroline** o Better help for smokers to quit: - Hospital **David W** - Primary **Robyn** o Better diabetes & cardiovascular services **Kiri** Clinical Committee Chairs o Falls Committee **Chris** o Research Committee **John** o Laboratory Services Committee **?** o Radiology Services Committee **Mark**	• Meet with Consumer Council at least twice to discuss / agree a vision and plan for the development of a "Person and Whanau Centred Care" approach. • Support a review of the "Primary Heatlh Care" model of care. • Support and champion the development of a health literacy framework, policies, procedures, practices and action plan. • Actively engage with Information Systms to develop a prioritised/achieveable plan to enhance clinical systems and shared records to support achievement of functions and roles. • Assist and support the development of a consumer engagement strategy/plan.	• Oversee the development and implementation of the Quality Improvement and Safety Framework **co-Chairs** • Further develop sector wide Clinical Indicators & Quality Accounts within the overall Quality & Safety Framework. **Caroline** • Review, realign and/or redevelop existing clinical, quality and safety "committee" structures and processes across the sector, including integrated and co-ordinated Terms of Reference and reporting requirements including linkages to HS Patient Safety Committee and CAGC **Co-Chairs** • Maintain awareness of issues raised and liaise as appropriate with HQSC. **Quality Improvement & Patient Safety**	• Enhance the profile and perceived value of Clinical Council within the sector, through improved effective two way communications. **?** • Facilitate the development and implementation of clinical leadership appointments, structures, training and development. **Co-chairs/**HR • Facilitate the development of a HB Clinical Workforce Sustainability Plan **David W/HR** • Promote Strategies to enable the HB Clinical Workforce to adapt to meet the challenges of the future. **Co-Chairs/HR**

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)**
	For the attention of: **HB Clinical Council, HB Health Consumer Council, Māori Relationship Board and HBDHB Board**
Document Owner: Document Author(s):	Dr Mark Peterson Mary Wills
Reviewed by:	Executive Management Team
Month:	February 2015
Consideration:	Performance Monitoring

RECOMMENDATION

That Clinical and Consumer Council, Māori Relationship Board and HBDHB Board

Note the contents of this report.

OVERVIEW

The national GMs Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators in 2013. As a result, individual EMT members agreed to providing a championship role for the Māori Health Plan 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 Dr Mark Peterson, Champion for the Access Indicators.

UPCOMING REPORTS

The following are the indicators of concern, allocated EMT champion and reporting month for each.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections. 45-64 year olds - heart disease, skin infections, respiratory infections and diabetes	TBC TBC TBC	Mark Peterson	Mary Wills	Feb 2016
Breastfeeding *National Indicator*	Improve breastfeeding rate for children at: 6 weeks, 3 months; 6 months of age	 >75% >60% >65%	Caroline McElnay	Nicky Skerman	Mar 2016

Cardiovascular *National Indicator*	Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. Total number (%) with complete data on ACS forms	70% of high risk >95% of ACS patients	John Gommans	Paula Jones	Apr 2016
Oral Health *National Indicator*	The total number (%) of children are caries free at first examination after the child has turned five years, but before their sixth birthday	>66%	Sharon Mason	Patrick LeGeyt	Jun 2016

OVERVIEW

This report provides an update on programmes related to Ambulatory Sensitive Hospitalisations (ASH) for 0-4 and 45-64 years of age in Hawke's Bay.

Ambulatory Sensitive Hospitalisations (ASH) reflects hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access. However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via e.g. healthy housing projects and parental smoking cessation programmes may be considerable.

The HBDHB is committed to non-differential targets and significant inequality is seen in this indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

The Ministry of Health ASH definition and methodology has been revised for ASH reporting from quarter one of the 15/16 year. A group of Ministry and health sector subject matter experts made several consensus recommendations for changes to the ASH definition. Implementation of these recommended changes to the Ministry ASH definition have taken effect for all Ministry ASH reporting from Quarter 2 of the current (15/16) year. There was no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning.

However there is an expectation that baseline ASH data (with the revised methodology) be reviewed by DHBs in order to better understand present performance, and in particular variation in DHB performance for different population groups. This will inform the 16/17 planning and appropriately targeted activities for each district. This paper highlights findings from this review.

At the end of June 2014 the results for Hawke's Bay children aged 0-4 were 38% above the national rate of 100%. Analysis of data in 2014/15 concluded that we should focus on the two most preventable ASH conditions (skin infections and dental) which show the highest inequities. The healthy population team has therefore re-established DHB services to Kohanga reo and e introduced new-born oral health enrolment with the aim to reduce hospitalisations for these conditions. We can see from the results outlined in this paper that Maori rates in these conditions have improved.

The highest ASH rates for 45-64 year olds are cardiac conditions and respiratory (including COPD) and cellulitis. Our focus is on development of Clinical Care Pathways.

MĀORI PLAN INDICATOR

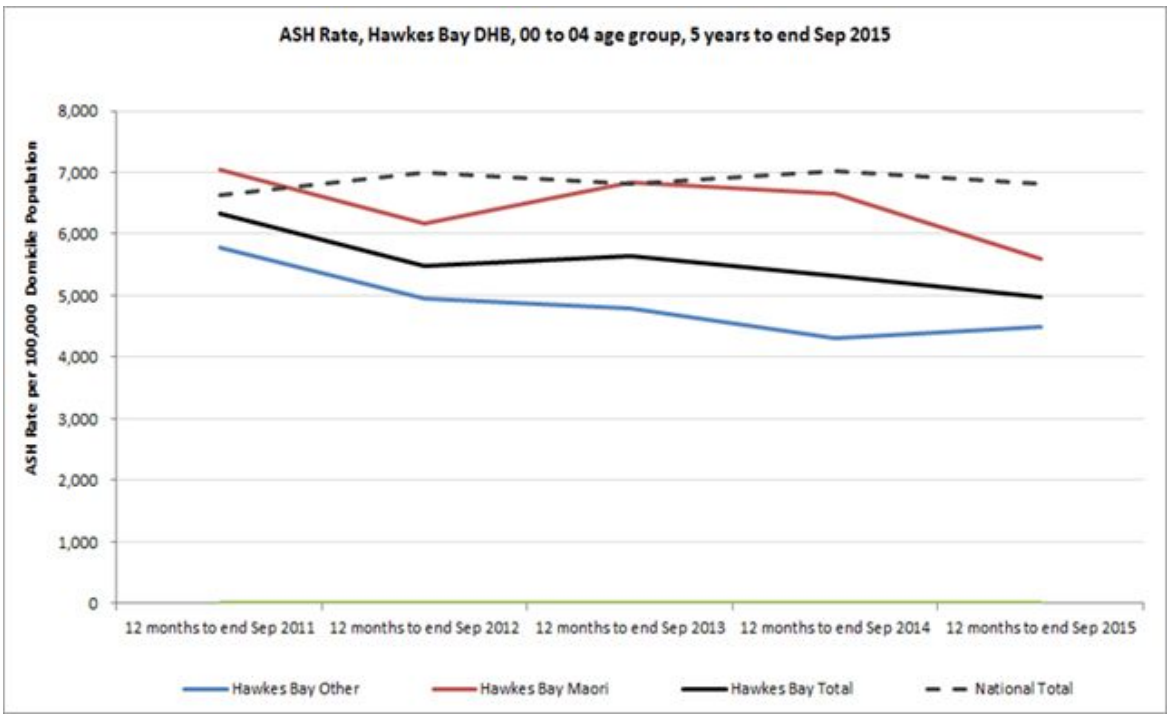
Target 0-4 year age group

There is no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning. DHBs have received 2015/16 baseline ASH performance results using the new ASH definitions and the expectation is that DHBs review the present performance of ASH and in particular variation in performance between Maori and Non Maori results. These results gives us an opportunity to examine performance over a 5 year period.

At the end of June 2014 the ASH results for Hawke's Bay children aged 0-4 were 38% above the national rate of 100%. Analysis of data in 2014/15 concluded that we should focus on the two most preventable ASH conditions (skin infections and dental) which show the highest inequities. The healthy population team has therefore re-established DHB services to Kohanga Reo and the introduced of new-born oral health enrolment with the aim to reduce hospitalisations for these conditions.

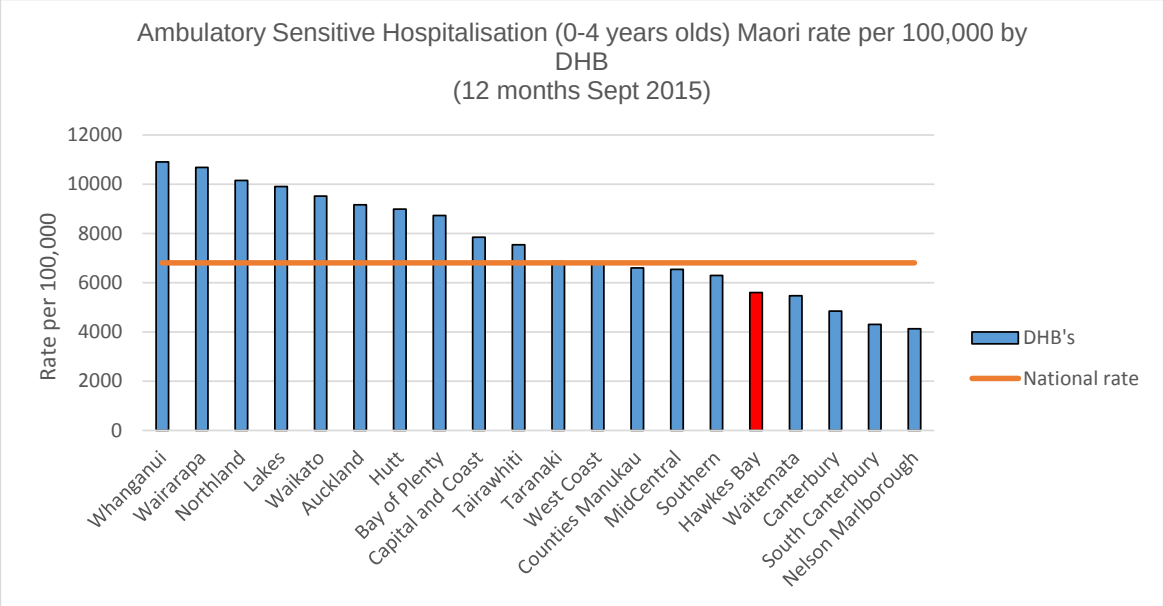
Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 0-4 year age group– 12 months to end Sept 2011-2015



Hawkes Bay tamariki have lower rates of ASH compare to national rates for both Maori and Non Maori. There has been a reduction in the gap between the Maori ASH rate and the National rates particularly in the 12 months to Sept 2015. By 2015 the Top 5 ASH conditions for Maori in the 0-4 year age group are Asthma, Dental conditions, Respiratory Infections- Upper and ENT,Respiratory Infections – Lower, Gastroenteritis/Dehydration and Cellulitis (5th equal).

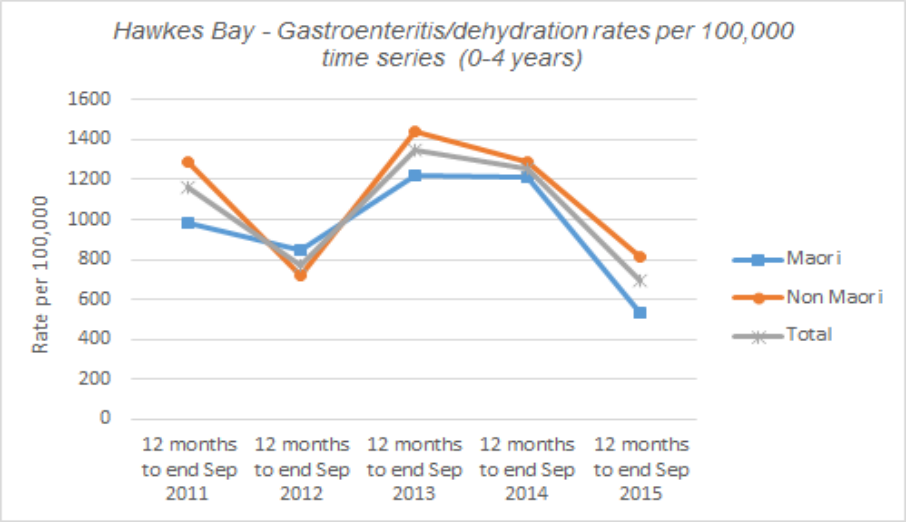
Māori ASH rates 0-4 year age group by DHB's – 12 months to end Sept 2015



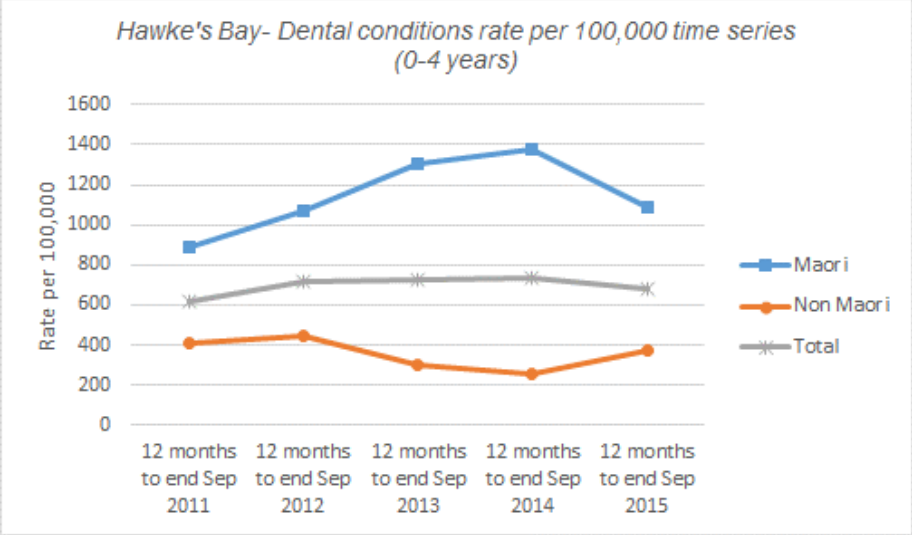
In the 12 months to Sept 2015 the Hawkes Bay Maori rate was 82 % of the national rate and Hawkes Bay DHB was the 5 th best performer of all DHB's with Maori rates substantially lower than national rates in this age group.

In 2015 the largest differences between Hawkes Bay Maori rates and national rates in the 0-4 year age group are in the conditions Asthma and Respiratory infections- lower.

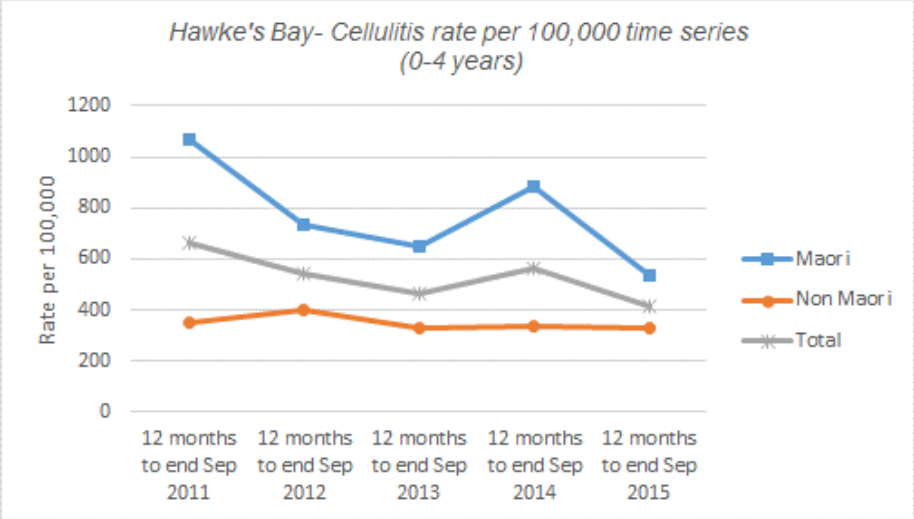
ASH conditions where Maori rates are improving



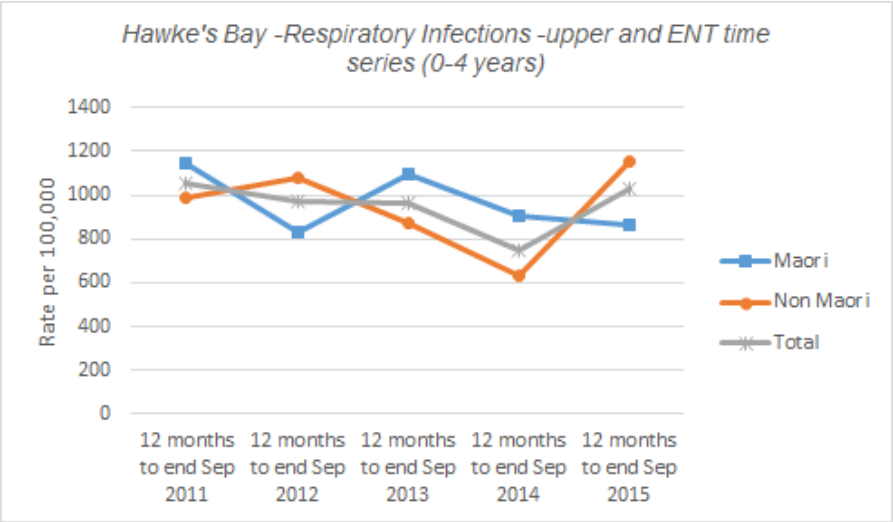
Gastroenteritis/dehydration rates in the 0-4 years have declined in the last 2 years. The Hawke's Bay Maori 0-4 year rate is half the national rate.



Dental is the 2nd ranked Maori ASH condition in the 0-4 year olds. Rates have dropped in the last 12 months to Sept 2015 and the gap has narrowed between Maori and non Maori. In the 12 months to Sept 2015 Hawke's Bay Maori rates are 2.9 times the Hawke's Bay Non Maori rate and 1.1 times the national rate.

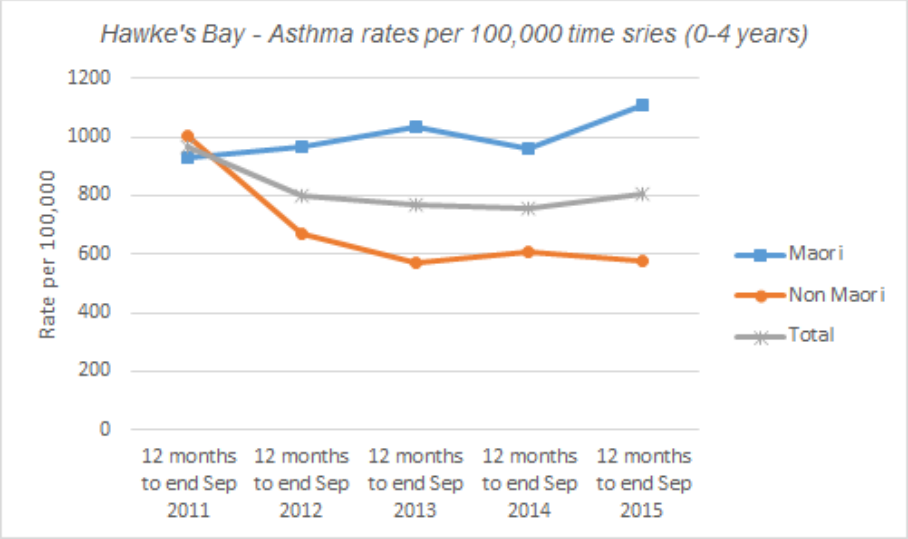


Cellulitis rates for both Maori and Non Maori have improved Maori rates are 1.6 times the Non Maori rates in the 12 months Sept 2015 and 1.2 times the national rate .

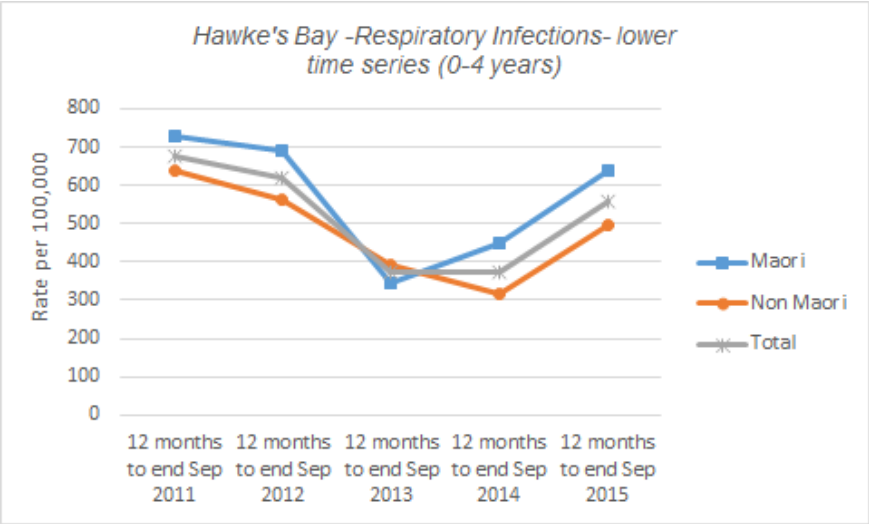


Respiratory Infections – upper and ENT are the 3rd highest ASH conditon for Maori 0-4 year old children. Maori rates have dropped particularly in the last 2 periods. Maori rates are lower than Non Maori rates and national rates in the 12 months to end of Sept.

ASH conditions where rates are not improving



Asthma is the top ASH condition for Maori 0-4 years and rates have been increasing over time and the gap between Maori and Non Maori have widened. By 12 month to end of September 2015 Maori rates were 90 % higher than Non Maori rates.



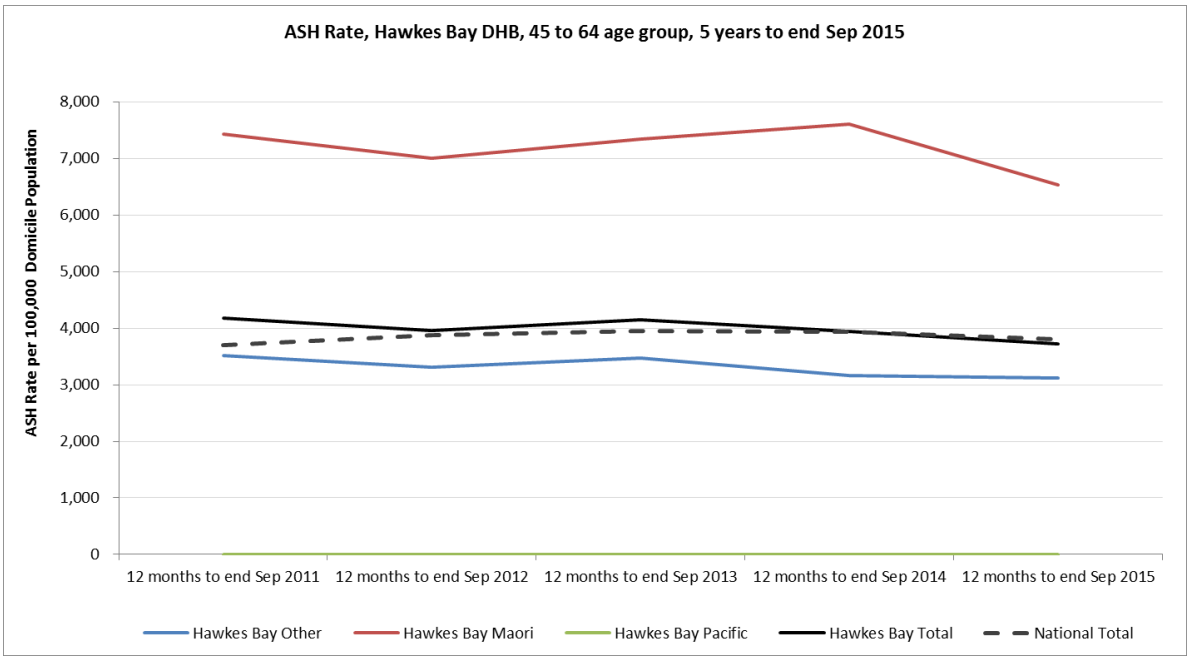
Respiratory infections – lower are the 4th ranked ASH condition in Maori children and rates have increased in the last 2 years.

Target 45-64 age group

There is no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning. DHB's have received 2015/16 baseline ASH performance results using the new ASH definitions and the expectation is that DHBs review the present performance of ASH and in particular variation in performance between Maori and Non Maori results. This has also given us an opportunity to examine performance over a 5 year period.

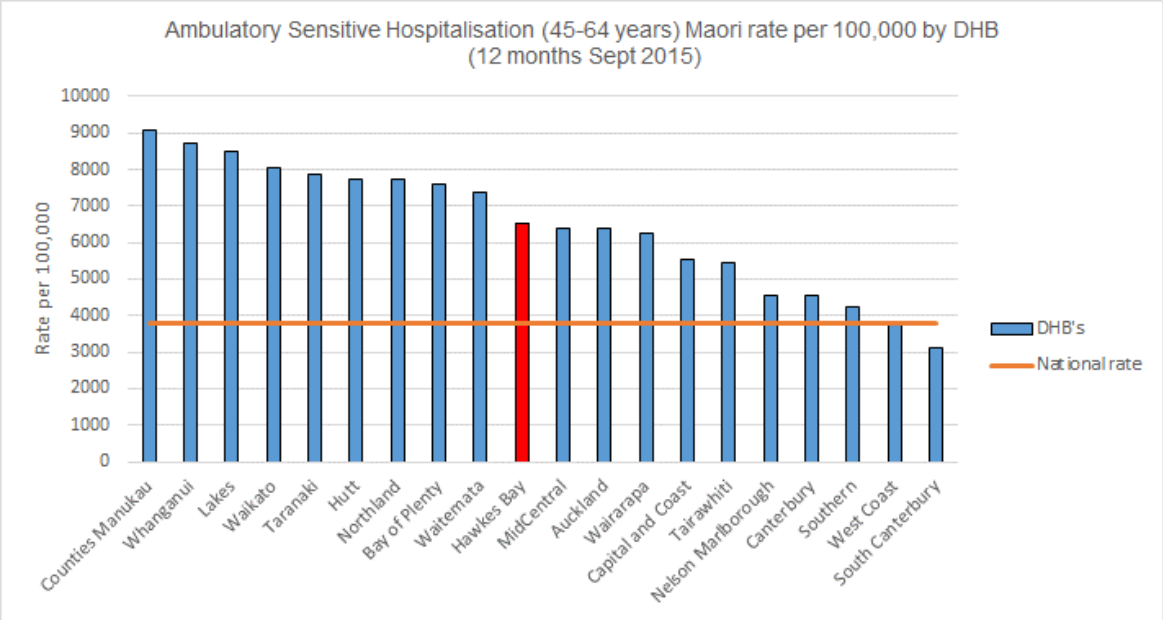
Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 45-64 age group 2010/11 – 12 months Sept 2015



There has been improvement in Hawke's Bay ASH rates in the 45-64 year age group in both Maori and Non Maori. The gap between the Hawke's Bay Maori rate and the Hawke's Bay Non Maori rate has narrowed between 2011 and 2015 as has the gap between the Hawke's Bay Maori rate and the national rate. In the 12 months to Sept 2015 the Hawkes Bay Maori rate was 2.1 times the Hawke's Bay Non Maori rate and 1.7 times the national rate. The top 5 ASH conditions for Maori in this age group are Angina and Chest pain, Congestive Heart Failure, Respiratory Infections- COPD, Cellulitis and Myocardial Infarction.

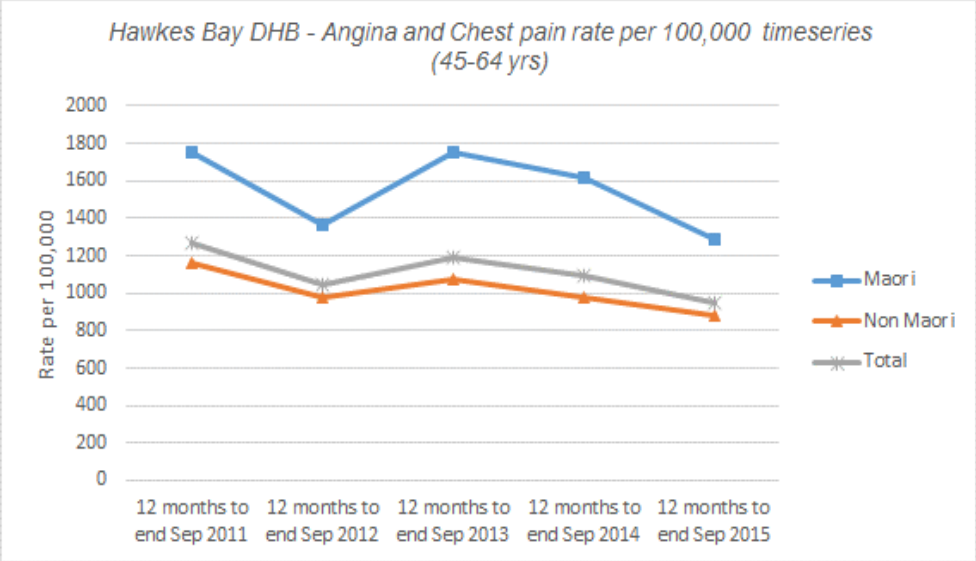
Māori ASH rates 45-64 year age group by DHB's – 12 months to end Sept 2015



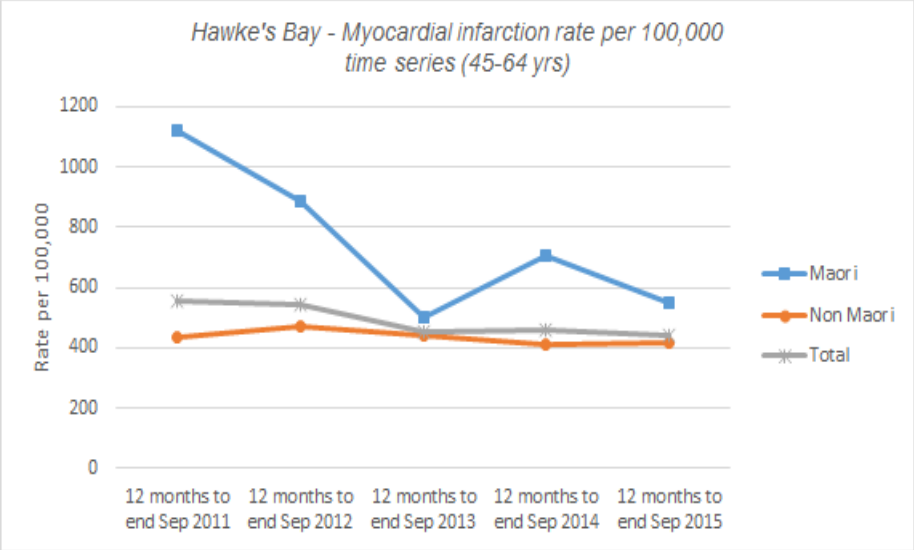
In the 12 months to Sept 2015 the Hawke's Bay Maori rate was 72 % higher than the national rate and Hawkes Bay DHB is ranked 11 th out of 20 DHBs. Maori rates are substantially higher than national rates in this age group across the majority of DHB's.

The largest differences in Maori rates and national rates by ASH condition in this age group are Congestive Heart Failure and Respiratory infections-COPD.

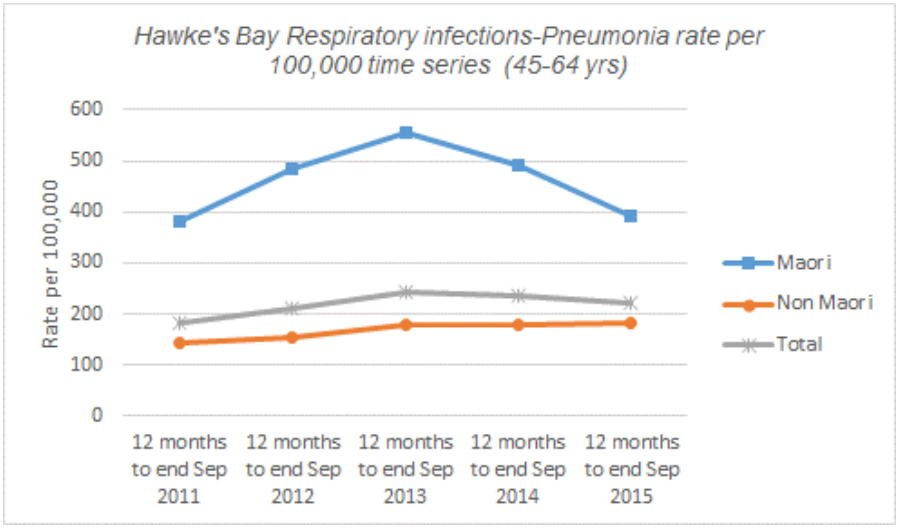
ASH conditions where Maori rates are improving



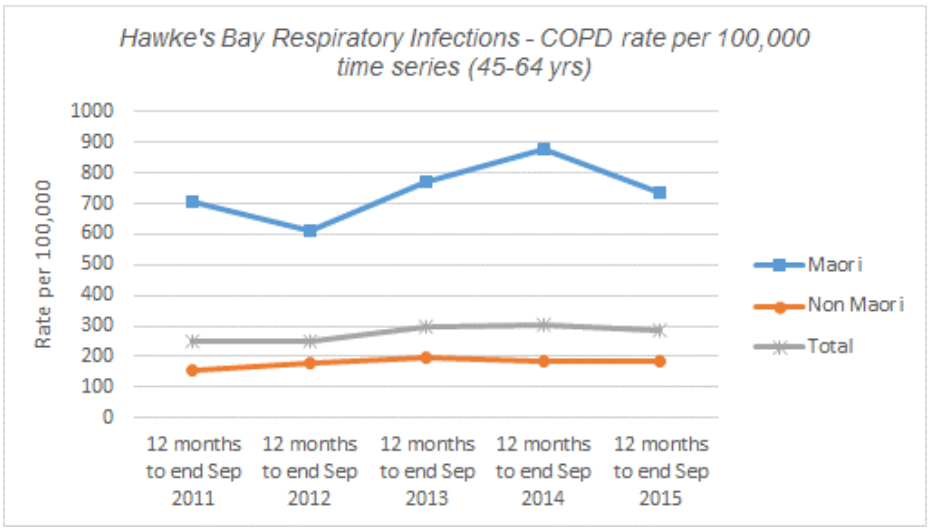
Angina and Chest Pain is the top ASH condiiton for Maori in the age group contributing 20 % of all Ambulatory Sensitive Hospitalisations in Maori in the 45-64 year age group. We have seen Maori rates decline and the gap between Maori and Non Maori narrow. In the 12 months to Sept 2015 Maori rates were 50 % higher than Non Maori rates.



Maori rates in the ASH condition Myocardial Infarction have also improved and by 12 months to end Sept 2015 Maori rates were 30% higher than Non Maori rates.

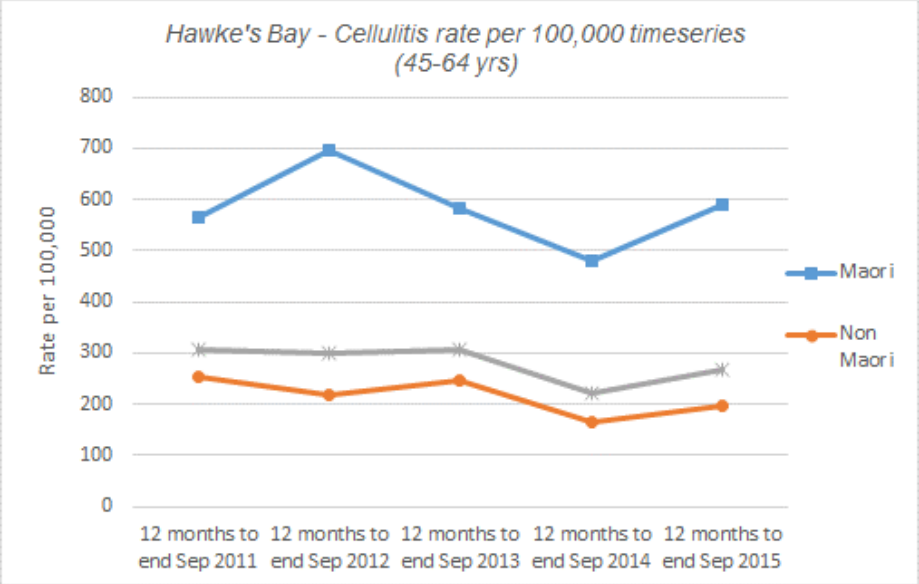


Maori rates in the ASH condition Respiratory Infections – Pneumonia have also improved in the last 2 years.

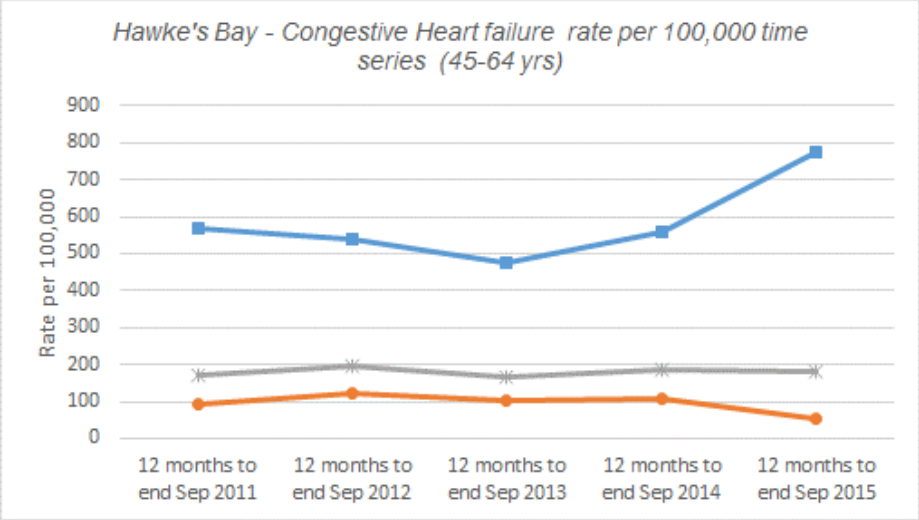


Respiratory Infections – COPD is the 3rd ranked ASH condition in terms of volume of hospitalisations for Hawke's Bay Maori in the 45-64 years age group. There has been some improvement in rates in the last reported period. In the 2015 period Maori rates are 3.9 times the Non Maori rates and 2.9 times the national rates for this condition and age group.

ASH conditions where rates are not improving



Cellulitis contribute 10 % of total Maori ASH hospitalisations in the 45 -64 year age group and is the 4th ranked ASH conditon for Hawke's Bay Maori in the age group. Maori rates have deteriorated in the last 12 month reporting period. Maori rates are 3 times the Non Maori rates and 2.9 times the national rates.



Congestive heart failure is the 2nd ranked ASH condition for Hawke's Bay Maori in the age group 45-64 years. Maori rates have deteriorated in the last 2 years and the gap between Maori and Non Maori rates has widened.

ACTIVITY TO SUPPORT THIS INDICATOR
0-4 YEAR OLDS

New Born Enrolment Programme

All children are linked to general practice as part of the new born enrolled programme with nearly 98% of children linked by 8 weeks. Quadruple enrolment with General Practitioner; Well Child/Tamariki ora; National Immunisation Register and Oral Health is now standard practice.

Kohanga Reo

Public Health Nurse Visits and Vision/Hearing screening for Kohanga continues. Public health nurse's offer education and advice to whānau, tamariki and Kohanga staff around key ASH conditions including gastroenteritis/dehydration and skin conditions.

The recent re-establishment of DHB service provision within HB Kohanga reo enable's the provision of education and advice to whānau, tamariki and Kohanga around the management and treatment of skin conditions. 2015/2016 will see the development of

A skin resource has been translated to be used in local Kohanga. This supports parents and Kaiako around best practice in recognition and management of skin issues. This aims to lead to earlier recognition and treatment of skin infections, avoiding the need for admission.

Co-Ordination of Child Health Data Systems

Excellent communication is maintained between different child health programmes databases in Hawke's Bay due to the goodwill of the NIR/immunisation team, however this is relationship based rather than a reflection of good systems. It is clear that what is required is a national child health database developed at the Ministry of Health level.

Hawkes Bay Child Interagency Network Group

This group is co-ordinated by the HBDHB child health team and meets bi-monthly with a wide range of key stakeholders include representatives from early childhood centres, kindergartens and home-based care for pre-school children. Each meeting a different topic is covered to ensure information provided around the prevention of conditions and promotion of initiatives and services is consistent.

Healthy Homes Programme

HBDHB and HHB continue to fund a programme providing insulation and a range of safety measures for households living in low socioeconomic areas who have significant health need. The greatest percentage of referrals into the Healthy Homes programme are for Maori and Pacific whānau.

ACTIVITY TO SUPPORT THIS INDICATOR
45-64 YEAR OLDS

Collaborative Clinical Pathways

Health Hawke's Bay and Hawke's Bay DHB are developing clinical care pathways across a range of services to increase consistency of practice in Hawke's Bay. In 2015/16 there will be another 24 pathways. Our focus is on promoting the use of the pathways in primary care, ensuring easy access for GPs and developing more pathways for high priority conditions.

Atrial fibrillation and chest pain pathways have been developed and were published in December. Asthma Pathways through Map of Medicine have been completed for children and adults and are currently being published. The next phase is to socialise the pathways into general practice. Key outcomes are evidence based practice, standardisation across Hawke's Bay, care planning continuity of care and reduced hospitalisations. Currently co-ordinating a multi-disciplinary group to work on community acquired pneumonia.

Nurse-Led Respiratory Pilot

Nurse led respiratory (including asthma and Chronic Obstructive Pulmonary Disease-COPD) clinics located in General Practices from 1 September 2014 to 30 June 2015. The project has been jointly implemented by Health Hawke's Bay, Hawke's Bay District Health Board and Asthma Hawke's Bay. Key goals of the project are to reduce unnecessary hospital admissions, emphasis on co-ordination and streamlining of client healthcare, with a strong Primary Health Care ethos focusing on early detection and timely management of chronic conditions at the primary care level. Evaluation of this Project has been undertaken by EIT and results are to be presented to EMT January 2016. In summary:

- nurse-led clinics are effective in co-ordination and self-management.
- the majority of clients enrolled in the pilot were identified as being in Quintiles 4 and 5 (45% Maori accessing from quintile 5, and 65% Pacific) reflecting improved access to healthcare for high-needs clients
- higher representation of women compared with men;
- nurses working in the pilot felt empowered and autonomous in their respiratory practice highlighting a high level of professional development in the management of chronic respiratory conditions.

The pilot has proven that costs and spirometry charges have been a barrier to access. It is clear that for the pilot to continue with success is to have security of ongoing funding (business case will be presented at next bid rounds).

Sharing Primary Care Practice Information

Business Intelligence has produced reports for several general practices on their admission rates to hospital and emergency department attendances. This is now available as a regular report. We are working with Health Hawke's Bay to extend this to all practices, with appropriate oversight.

RECOMMENDATIONS FROM TARGET CHAMPION

The data provided shows quite a bit of variability in the change in rates of ASH in both age groups in the different diagnostic criteria. With the 0-5 age group there is a pleasing drop in the overall Maori ASH rates and a significant narrowing of the disparity gap. It is also notable that HB rates are among the lowest in the country.

Most notable is the change in gastroenteritis admissions in the last two years, and that HB rates are about half the national average. This will need to be correlated with the uptake of the Rotavirus immunisation. HB's high immunisation rate, especially among Maori children may be part of the answer to this (pleasing) improvement.

The ASH rates for the 45-65 age group show higher levels of disparity between Maori and the total population than for the 0-5 group. While rates have come down the disparity gap remains very similar.

Most concerning is the very large difference and climbing rates of admission for congestive heart failure. While the myocardial infarction rate has improved this is not reflected in CHF, which is often a longer term complication of IHD.

A clinical pathway for CHF should be developed and introduced as soon as possible.

CONCLUSION

Kohanga Reo targeted initiatives focussing on specific conditions have seen a decline in cellulitis ASH rates for 0-4 year olds. In addition whanau will have increased awareness of the need for early intervention with skin issues for all family members which includes the 0-4 year age group. The focus of public health nurses on early intervention with skin issues in low decile schools and Kohanga Reo is likely to have contributed to improvements in rates.

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

16. Minutes of Previous Meeting
- Public Excluded

17. Matters Arising – Review of Actions
- Public Excluded

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).

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
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
CFO	Chief Financial 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
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
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
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	Maori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Maori 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
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
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date