Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 11 July 2018**

Meeting: **3.00 pm to 5.30 pm**

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

Council Members:

Dr John Gommans (Co-Chair)
Dr Andy Phillips (Co-Chair)
Chris McKenna
Dr Mark Peterson
David Warrington
Dr Robin Whyman
Lee-Ora Lusis
Jules Arthur
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Peter Culham
Dr Nicholas Jones

Apology:

In Attendance:

Ken Foote, Company Secretary
Tracy Fricker, Council Administrator / EA to ED P&Q
Ana Apatu, Māori Relationship Board Representative

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and receive apologies	3:00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Workplan	

	Section 2 – Presentation	
6.	Violence Intervention Programme – Russell Wills / Cheryl Newman	3.20
	Section 3 – Discussion	
7.	People & Quality Dashboard (draft) – Andy Phillips	3:40
	Section 4 – Monitoring & Information Only (no presenters)	
8.	Using Consumer Stories	-
9.	Clinical Portal Project (update)	-
10.	Clinical Care Pathways (update)	-
11.	Te Ara Whakawaiora - Smokefree (update)	-
	Section 5 – Reporting Committees	
12.	Clinical Advisory & Governance Group Report (verbal)	-
13.	**Section 6 – Recommendation to Exclude the Public**	-

Public Excluded

Item	Section 7 – Routine	
14.	Minutes of Previous Meeting	3:45
15.	Minutes of Joint Meeting / Workshop with Consumer Council	
16.	Matters Arising – Review Actions	
	Section 8 – Discussion	
17.	Briefing on Patient Safety and Quality – John Gommans and Andy Phillips	3:50
18.	Clinical Services Plan (first draft) – Ken Foote	4:00
19.	Topics of Interest – Member Issues / Updates	5:15

NEXT MEETING:

Wednesday, 8 August 2018 at 3.00 pm, Boardroom, HBDHB Corporate Office

Interests Register
Jul-18

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest e.g. Organisation / Close Family Member	Nature of Interest e.g. 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
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
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice	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
	Family member employed by HBDHB since November 2015	Daughter, RMO	Will note interest if discussions occur around RMOs.	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that agrees the contract.	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Primary Health Alliance	Executive Member	Primary Care advocacy organisation	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	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)	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)	Chair of NZ AMDC	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMDC representing those based in NZ	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	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	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Advisory & Governance Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Clinical Advisory & Governance Committee (CAG) for Health HB (Tenure ends 27/06/18)	Member	Report on CAG meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	
	Locum General Practitioner			No	
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
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. Provides services in primary care
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under 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	

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. 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**
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Director	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health			
	Kidney Health Australia - Caring for Australasians with Renal Impairment	Member		No	Guidelines group - involved with the group "Management of chronic kidney disease among Aboriginal, Torres Strait Islander Peoples and Maori".
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
	National Information Clinical Leadership Group	Member	Professional network	No	
Dr Peter Culham (GP)	Havelock North Properties Limited	Shareholder	Medical Centre owner	Yes	Low, pecuniary, hold leases with healthcare providers
	Te Mata Peak Practice	GP and Director	General Practice	Yes	Low, pecuniary, provides primary care services
	C&G Healthcare	Director	Private business	No	No further exposure beyond mentioned above
	Royal NZ College of General Practitioners	Fellow		No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE MAGDALINOS ROOM, HAVELOCK NORTH FUNCTION CENTRE, 128 TE MATA ROAD, HAVELOCK NORTH ON WEDNESDAY, 13 JUNE 2018 AT 2.00 PM

PUBLIC

Present: Dr John Gommans (Chair)
Dr Andy Phillips (Co-Chair)
Dr Robin Whyman
Dr Nicholas Jones
Dr Tae Richardson
Dr David Rodgers
Debs Higgins
David Warrington
Maurice King
Chris McKenna
Lee-Ora Lusis
Anne McLeod

In Attendance: Tracy Fricker, Council Administrator and EA to Executive Director – People & Quality

Apologies: Mark Peterson, Peter Culham, Russell Wills and Jules Arthur

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr John Gommans (Chair) welcomed everyone to the meeting. Apologies were noted as above.

2. INTEREST REGISTER

Lee-ora Lusis noted an interest for the Youth Health Strategy, in her role at Totara Health she works with Directions. David Rodgers similarly noted that his General Practice was also involved.

No other conflicts were noted.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 9 May 2018, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 Interest Register
Changes actioned for Lee-ora Lusis. *Item can be closed.*

Item #2 Framework for Developing the People Strategy

Kate Coley and Maurice King discussion held re: applying strategy to NGOs and other contract holders. *Item can be closed.*

Item #3 Investments Update (Outcomes of Budget Prioritisation)
Andy Phillips advised that the Board Workshop has been held. A prioritisation framework will be brought back to Clinical Council. It will look at what we do against the triple aim, a value for money analysis, quality analysis and a population health analysis. A group will look at the technical analysis then it will go to a governance group comprising members of Consumer Council, Clinical Council, Maori Relationship Board and the Pasifika Leadership Group. This group will consider whether the proposals meet the values of the organisation, and will make recommendations to the Board. This will be done for the entire budget and innovation investment

Item #4 Clinical Services Plan – Planning for Consultation
No additional feedback received. The Company Secretary will approach Clinical Leaders separately. *Item can be closed.*

Item #5 Clinical Council Meeting Agendas
Change to meeting agendas to be discussed at the July meeting. *Item can be closed*

5. WORKPLAN

The workplan was included in the meeting papers.

SECTION 2: PRESENTATIONS / DISCUSSION

6. HBDHB YOUTH STRATEGY IMPLEMENTATION UPDATE (INCLUSIVE OF ZERO FEES 13-17)

The Chair welcomed Jill Garrett, Strategic Services Manager – Primary Care to the meeting. An information paper was provided in the meeting papers for consideration.

Brief discussion took place regarding consultation and utilisation of programme rates by ethnicity, having a culturally competent workforce to engage effectively with young people and targeting those with the greatest need. It was noted from the data that access has also increased for those in the "other" category, and that this was still higher than Maori and Pasifika rates, with the effect of increasing inequity.

Council advised the strategy is modified to target those in greater need by using the geo-code or school decile.

The Chair commented that the work is heading in the right direction and would like to see this targeted to those with the greatest need.

Further feedback on the paper can be sent directly to jill.garret@hbdhb.govt.nz.

The Clinical Council **noted** the contents of the report.

SECTION 3: INFORMATION ONLY (no presenters)

7. TE ARA WHAKAWAIORA – ORAL HEALTH (NATIONAL INDICATOR)

The paper was included for information only. No issues discussed.

8. CLINICAL ADVISORY & GOVERNANCE GROUP REPORT

The paper was included for information only. No issues discussed.

9. IMPLEMENTING THE CONSUMER ENGAGEMENT STRATEGY

The paper was included for information only. No issues discussed.

10. RECOGNISING CONSUMER PARTICIPATION POLICY

The paper was included for information only. No issues discussed.

SECTION 4: GENERAL BUSINESS

11. TOPICS OF INTEREST - MEMBER ISSUES / UPDATES

- Primary Care Development Partnership Governance - members would have received the email which has called for expressions of interest (EOI) for membership of the governance group, which requires at least one representative from Clinical Council. The Chair is aware of at least one Clinical Council member who is interested to be a part of this group but the EOI is open to all.

- The Chair noted that this was Tae Richardson's last meeting and thanked her for her input while on Council, particularly championing equity issues, which has been invaluable. It is also Maurice King's last meeting and the Chair thanked him for his input while covering the Pharmacist position on Council and wished him well for the future.

12. SECTION 5: RECOMMENDATION TO EXCLUDE THE PUBLIC

The Chair moved that the public be excluded from the following parts of the meeting:

13. Minutes of Previous Meeting
14. Mid-Point HealthCert Surveillance Audit - Corrective Actions

The meeting closed at 2.25 pm.

Confirmed: _____
Chair

Date: _____

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/04/18	***Investments Update (Outcomes of Bubget Prioritisation)*** • Process for presentation, discussion and decision making on innovative service models and funding to be worked up and brought back to a future meeting	A Phillips	TBC	In progress

Clinical Council Workplan as at 4 July 2018 (subject to change)	**EMT Member**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**F R A C Meeting date**	**BOARD Meeting date**
Clinical Services Plan review first draft (July)	Ken Foote	11-Jul-18	12-Jul-18		25-Jul-18
Clinical Council Annual Plan 2017/2018 Discussion on prior year	Andy Phillips / John Gommans	11-Jul-18			
Using Consumer Stories	Kate Coley / John Gommans	11-Jul-18	12-Jul-18		25-Jul-18
Violence Intervention Programme Presentation (Councils then back to EMT) initially presented 5 June to EMT.	Colin Hutchinson/Claire Caddie	11-Jul-18	12-Jul-18		
Clinical Advisory & Governance Group Report (**July** Aug Oct Nov Dec Feb Mar 19)	Chris McKenna	11-Jul-18			
Clinical Care Pathways Update (for information only EMT and Clinical Council)	Chris Ash & Mark Peterson	11-Jul-18			
Clinical Portal Project update - monthly + Clinical Council	Kevin Snee	11-Jul-18		25-Jul-18	
Quality Dashboard Quarterly Report	Kate Coley	11-Jul-18		25-Jul-18	
Te Ara Whakawaiora "Smokefree update" (6 monthly moved to July from May-June) - board action Nov17	Kevin Snee	11-Jul-18	12-Jul-18		25-Jul-18
Addressing Essential Services for People with Diabetes across the Heatlh Continuum	Colin Hutchinson/Claire Caddie	8-Aug-18			
Alcohol Positon Statement INTERNAL and Strategy *for EMT consideration* (board action August 2017)	Kevin Snee	8-Aug-18	9-Aug-18		29-Aug-18
Clinical Servides Plan Monthly Update (aug, sep, oct)	Ken Foote	8-Aug-18	9-Aug-18		29-Aug-18
First **1,000 days** of Life (Clinical Action Dec 17)	Andy Phillips / John Gommans	8-Aug-18			
Planned MRI and Fluoroscopy Equipment Replacement Programme **Detailed Business Case'**	Colin Hutchinson/Claire Caddie	8-Aug-18			29-Aug-18
Quality Annual Plan - 2017/18 - Annual review **August 18** / Feb 19 progress against objectives	Kate Coley	8-Aug-18		29-Aug-18	
Te Ara Whakapiri Next Steps (Last Days of Life) - August Clinical Consumer and Board	Chris Ash	8-Aug-18	9-Aug-18		29-Aug-18
Adverse Events (preliminary Annual Report) - EMT and Clinical Council	John Gommans	8-Aug-18			
Clinical Advisory & Governance Group Report (July **Aug** Oct Nov Dec Feb Mar 19) **WRITTEN**	Chris McKenna	8-Aug-18			
Collaborative Pathways update (May - **Aug** - Nov)	Chris Ash & Mark Peterson	8-Aug-18	9-Aug-18		29-Aug-18
HBDHB Performance Framework Exceptions Q4 **Dashboard**	Kevin Snee	8-Aug-18	9-Aug-18		
Matariki Regional Development Strategy and Social Inclusion Strategy update from Feb 2018	Kevin Snee	8-Aug-18	9-Aug-18		29-Aug-18
Te Ara Whakawaiora - Access 0-4 / 45-65 yrs (local indicator)	Kevin Snee	8-Aug-18	9-Aug-18		29-Aug-18
Urgent Care (After Hours) Service Update **presentation** Aug - Feb - Aug 6 monthly updates	Wayne Woolrich	8-Aug-18	9-Aug-18		29-Aug-18
He Ngakau Aotea - Strategic Priorities for MRB - a courtesty presentation if time available	Patrick LeGeyt	8-Aug-18	9-Aug-18		29-Aug-18
Annual General Meeting					
Clinical Council Annual Plan 2018/2019 discussion on the year ahead	Andy Phillips / John Gommans	12-Sep-18			
Annual Plan 2018/19 - approved Minister	Chris Ash	12-Sep-18	13-Sep-18		26-Sep-18
Clinical Servides Plan Monthly Update (aug, sep, oct)	Ken Foote	12-Sep-18	13-Sep-18		26-Sep-18
Adverse Events FINAL EMT/Clinical/FRAC	John Gommans	12-Sep-18		26-Sep-18	
Establishing Health and Social Care Localities in HB (Mar 18,**Sept)** - update on activity planned	Chris Ash	12-Sep-18	13-Sep-18		26-Sep-18
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Kevin Snee	12-Sep-18	13-Sep-18		26-Sep-18
Clinical Advisory & Governance Group Report (July Aug **Oct** Nov Dec Feb Mar 19) **WRITTEN**	Chris McKenna	10-Oct-18			
Clinical Portal Project update - monthly + Clinical Council	Kevin Snee	10-Oct-18		31-Oct-18	
Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations 6 monthly **(Oct,** Apr, Oct**)**	Kate Coley	10-Oct-18		31-Oct-18	
Clinical Servides Plan Monthly Update (aug, sep, oct)	Ken Foote	10-Oct-18	11-Oct-18		31-Oct-18
Quality Dashboard Quarterly Report (July, **Oct**, jan for Feb19 mtg, Apr, July)	Kate Coley	10-Oct-18		31-Oct-18	
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Kevin Snee	10-Oct-18	11-Oct-18		31-Oct-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)	Kevin Snee	10-Oct-18	11-Oct-18		31-Oct-18
Te Ara Whakawaiora - Did not Attend (local Indicator)	Kevin Snee	10-Oct-18	11-Oct-18		31-Oct-18
Health Equity Report	Colin Hutchinson/Claire Caddie	14-Nov-18	15-Nov-18		28-Nov-18
IS **Presentation** and Discussion (informed by CSP) moved to Nov - see where tracking at that time.	Kevin Snee	14-Nov-18	15-Nov-18		
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May**-Nov18**)	Kevin Snee	14-Nov-18	15-Nov-18		28-Nov-18
Clinical Advisory & Governance Group Report (July Aug Sept Oct **Nov** Dec Feb Mar 19) **WRITTEN**	Chris McKenna	14-Nov-18			
Collaborative Pathways update (May - Aug - **Nov**)	Chris Ash & Mark Peterson	14-Nov-18			
HBDHB Performance Framework Exceptions Q1 **Dashboard** (from main report)	Kevin Snee	14-Nov-18	15-Nov-18		
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year Board action Nov 17	Kevin Snee	14-Nov-18	15-Nov-18		28-Nov-18

VIOLENCE INTERVENTION PROGRAMME

Presentation

People & Quality Dashboard

HAWKE'S BAY District Health Board Whakawāteatia

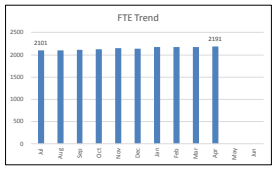
Our People Story

Our People "Growing our People"

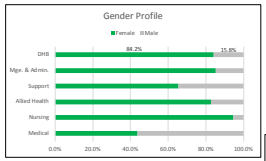
PLEASE NOTE THAT THIS IS STILL A DRAFT DOCUMENT

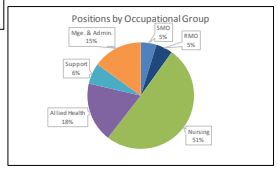
Key Highlights

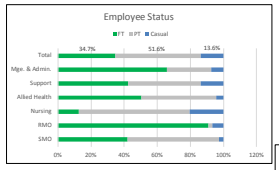
Our People

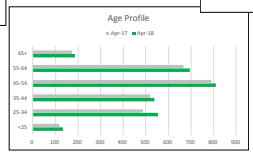


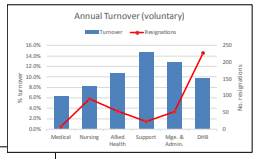
Contracted FTE shows a 4.2% increase since July 2017.





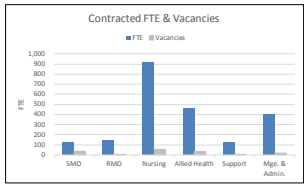


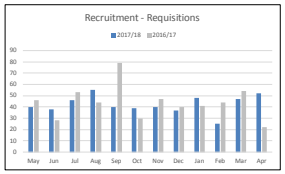


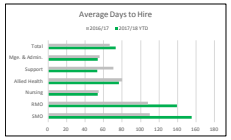


Key Highlights

Our People recruitment

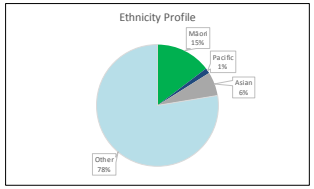




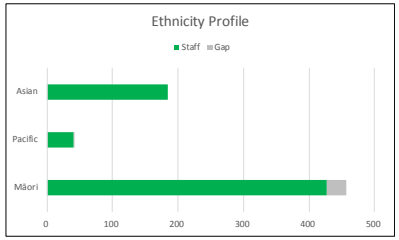


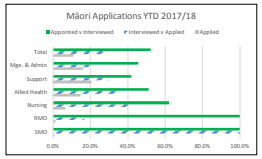
2017/18 YTD to March = 73 days compared to 2016/17 = 66 days

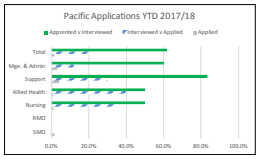
Our People's Diversity



Key Highlights







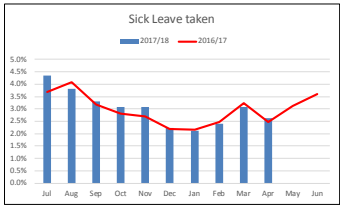
Of the 5375 applicants in last 12 months 11.0% identified as Māori, 29.8% of Māori that applied were interviewed & 52.3% of Māori that were interviewed were appointed
In the same period 1.7% identified as Pacific, 22.6% of Pacific that applied were interviewed and 61.9% of Pacific that were interviewed were appointed

Our People Story

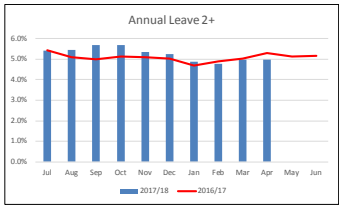
Our People "Growing our People"

Key Highlights

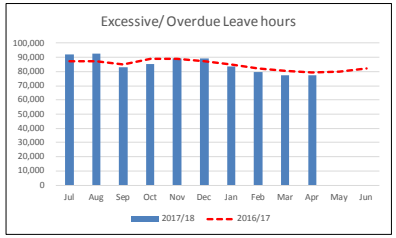
Our People's Wellbeing



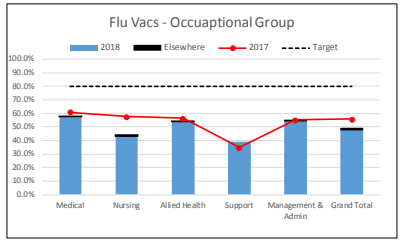
YTD as at April 2018 is 3% compared to 2.9% at the end April 2017.



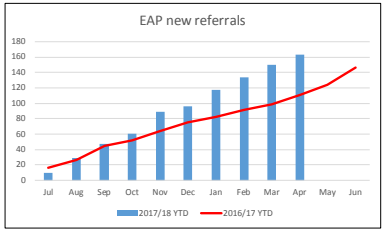
April 2018 = 138 (5.0%) compared to April 2017 = 141 (5.3%)



April 2018 = 77,637 hours compared to April 2017 = 79,206 hours



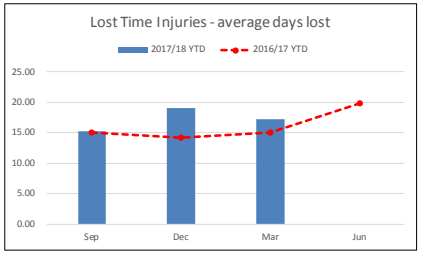
Current staff vaccinated at 3 May 2018 = 48% compared to end of programme 2017 = 56%. The 48% to date compares favourably with this time last year (38%).



EAP Referrals - 2017/18 YTD (to April) = 163 compared to 2016/17 YTD (to April) = 111 which represents a 46.8% increase.

Key Highlights

Our People's Safety



YTD 2017/18 (to March) = 17.2 days (27 injuries) compared to: YTD 2016/17 (to March) = 15.0 days (35 injuries)

Our Quality Story

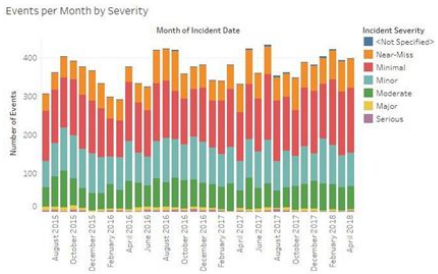
Key Highlights text field

Our Quality Plan

Key Highlights

Key Highlights text field

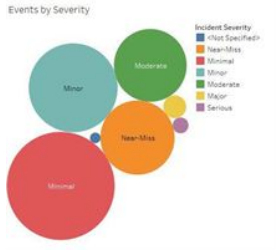
Our Consumer's Experience

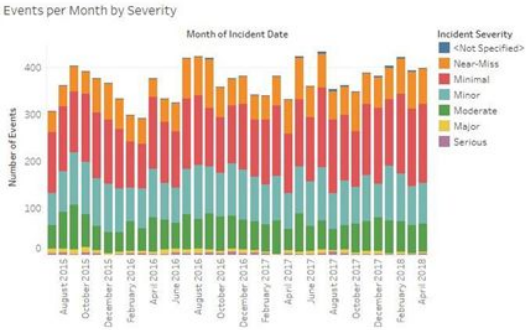


Key Highlights

Key Highlights text field

Our Consumer's Safety





Key Highlights

Key Highlights text field

Health Quality & Safety Commission Safety Markers

HAWKE'S BAY District Health Board Whakawāteatia	**Using Consumer Stories**
	For the attention of: **Maori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner & Author:	Kate Coley, Executive Director People & Quality
Reviewed by:	Executive Management Team
Month:	June 2018
Consideration:	For Information

RECOMMENDATION

That the Maori Relationship Board, HB Clinical Council and HB Health Consumer Council

1. **Note** the contents of this paper
2. **Note** the use of Consumer Stories for education and quality improvement purposes
3. **Note** the implementation of Consumer Stories as part of the implementation of the Consumer Engagement Strategy

PURPOSE

The purpose of this paper is to recommend the use of Consumer Stories for the purposes of education and learning, alongside improvement to services and departments as a component of the Consumer Engagement Strategy endorsed by HBDHB Board in June 2018.

OVERVIEW

It is our ultimate aim to create a culture which puts people at the centre of everything that we do, and one that is respectful of, and responsive to the needs, preferences, and values of our community. Consumer engagement is one enabler of a people centred culture.

The achievement of a person and whanau centred approach to care is a strategic priority for the HB Health sector. That cannot be achieved without listening to the experience of patients and staff, learning from it and most crucially acting upon that learning.

There is evidence that, when they are properly gathered and used, personal stories empower storytellers. People who share their experience, and know how the learning from their stories have been applied, feel that they have been positively involved in service development and improvement. Organisation that use stories to improve services develop a culture of participation and a reputation for listening and acting upon what they learn.

The purpose of collecting consumer experience stories is:

- To capture a consumer's experience in their own words to provide a personal perspective of positive and negative experiences:

  Consumer/whanau/carer stories provide us with a picture of what the reality is behind the care being provided to patients. They provide us with warning signs when things aren't going so well and with feedback when things are going well.

- To collect consumers' views and encourage discussion to gain a deeper understanding of an issue:

  Consumer/whanau/carer stories assist in influencing planning and funding decisions, and future service design. Consumer stories ensure that senior decision makers are closer to the reality of the services that they oversee.

- To gain an understanding of the consumer journey and consumer experience:

  By actively engaging with consumers/whanau/carer in their stories, health service delivery can become more transparent and open to feedback. This reinforces the importance of the patient/consumer as the centre of care. It provides staff with the opportunity to explore alternative ways of working, and supports better quality care.

- To raise the profile of the organisation and enter into a two-way online dialogue with consumers and community members

  Internet-based social media websites, for example Facebook, can be used as a way of interacting between consumers and health and disability services in HB. Consumers and community members can be involved by becoming followers or friends with the organisation and then commenting on or sharing posted information and stories.

  The organisation can also publish links to relevant resources (patient stories, online surveys, or discussion forums) and pose questions to collect feedback on particular topics.

- To help focus projects or programmes of work on ensuring that consumers/whanau/carers are at the centre when developing and implementing changes to systems and processes

It is clear that there needs to be a purpose to using consumer stories. Story gathering must be meaningful. It must not be tokenistic or manipulated to suit a service, nor to meet a compliance objective for governance groups. There has to be an identified purpose and an anticipated outcome that can be clearly explained to participants. Having discussed the use of stories across all other DHBs, it is clear that whilst the intent to share stories at governance groups has value, if connected to a context/strategy/paper in that board meeting, this should not be their primary purpose.

The primary purpose of gathering stories is for quality improvement and educational development. In this context consumer stories are narrative accounts that help us make sense and develop a better understanding of events that happen to ourselves and others. Stories should be seen as one mechanism to capture patient, consumer, carer, service user and staff experience.

Last month the Consumer Engagement Strategy was endorsed by all governance bodies and the Board, and it is recommended with the appointment of both a couple of Consumer Experience Facilitators and a new Quality Manager (Q1 2018/19) that the utilisation Consumer Stories should be incorporated into the implementation of that strategy. It is envisaged that the DHB will develop a toolkit, process and training to support clinical teams, alongside working with Education and Development to ensure that stories are incorporated into training and that a library of stories are held (video, recording, written word) and can be accessed by all.

The recently endorsed consumer engagement strategy has been developed as a key piece of work alongside others to:

- Achieve culture change.
- Strengthen and embed consumer participation at all levels in the health sector
- Ensure consumers are active partners in how we design, deliver and improve services
- Drive improvements - experience of care, quality and safety of care, health outcomes and best value
- Build knowledge and educate health sector staff about the value of consumer engagement.

This is not a standalone strategy. To be effective, consumer engagement should be seen as a "way of working" and part of our 'culture'. It should be linked to other organisational plans and build on existing skills and the work we are already doing. The strategy supports the Hawke's Bay Health Sector vision of "*Healthy Hawkes Bay*" and mission of *"Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community".*

We recognise that across the Hawke's Bay health sector there are a number of examples where consumer engagement is already occurring however there is also a lack of guidance, practical resources and tools to support effective engagement. A systematic approach needs to be developed and implemented to support engagement being effortless and part of business as usual. Consistent processes, policies and guidelines for engagement need to be developed.

IMPLEMENTATION APPROACH

Given that this is not a standalone strategy, an integrated approach to implementation has been adopted. A number of issues have been grouped under the general heading of '**Consumer Experience'**. These include:

- Consumer Engagement
- Recognising Consumer Participation
- Consumer Experience (including Consumer Stories)
- Making Health Easy to Understand (Health Literacy)

This grouping aligns exactly with the terms of reference of the recently approved (but yet to be established) Consumer Experience Committee within the new clinical governance structure, and also with the roles and responsibilities of the currently advertised positions of Consumer Experience Facilitators, who will report directly to a Quality Manager (to be established in Q1 2018/19). With these structures and resources in place, a Consumer Experience Project team will be established to develop the required systems, processes, toolkits and champions that will assist and enable them to achieve their desired outcomes, and ultimately influence the desired culture change and improved experience for consumers.

A project brief is currently being developed for the Consumer Experience Project. The prime purpose of the Project is to assist and provide support to the Consumer Experience Committee and dedicated operational staff. Current objectives for the project include:

- Develop and implement a consumer engagement toolkit for the DHB, and make available for the HB health sector
- Strengthen and embed the level of consumer participation in service redesign and improvement initiatives through co-design methodology
- Ensure effective utilisation of consumer stories for education and development purposes, as well as for quality improvement.
- Ensure that consumer feedback is the key driver in improving experience of care, quality and safety of care, health outcomes and best value
- Build knowledge and educate health sector staff about the value of consumer engagement and how to engage with consumers
- Develop databases and processes for recording and matching service requests for consumer engagement with available and appropriate consumers
- Develop guidelines and procedures for implementing the 'Recognising Consumer Participation' policy
- Develop communication channels for keeping health related community groups informed and engaged in health related developments
- Define specific roles and responsibilities for consumer experience issues
- Develop a preferred patient experience monitoring tool and simplify centralised surveys
- Ensure appropriate IS tools are available to support consumer experience activities and measures
- Further develop 'health literacy' framework, assessment surveys and toolkits
- Champion the goal of a HB 'health literate sector', where health is 'easy to understand'.

- Develop measures of success and relevant monitoring tools and reports.

An update of progress and further details will be provided once the project brief is completed and the project team is established.

Clinical Portal Implementation (CP) – EMT/FRAC Project Progress Report

Project Name	Clinical Portal & Radiology (RHIP)	Date	29 / 06 / 2018
		Prepared by	Jos Buurmans
Project Manager	Jos Buurmans (acting) - Reporting to Anne Speden, CIO		

Description: The Clinical Portal (CP) project is moving clinical information from a customised Patient Administration system (ECA). ECA will remain for patient administration while clinical information will migrate to Orion Health's Clinical Portal as part of a regionally hosted solution, in-line with a region wide agreement.

HBDHB Clinical Portal Implementation Project

OVERALL PROJECT STATUS & TREND – to date ending 29/06/2018		
Status	Trend	Rationale
G	▶	**Status = Green** • Clinical Portal Implementation Project progressing to overall plan **Trend = Green, progress declining** • Due to the pending strike action, the project in support of key stakeholders has taken the decision to delay the start of the migration of data to CP. • Data remediation may impact overall timeline for HBDHB data available in CP.

Planning & Activities – to date ending 29/06/2018

Progress To Date
- 1000 staff attended first Familiarisation sessions with training ongoing as clinicians request CP access
- Successfully upgraded the Picture Archiving Communication System (PACS) in preparation for CP migration, and gain the ability for images to be viewed from the lower North Island DHB's.
- Successfully tested the migration of Patient Demographics, achieving 99.997% compliance.
- Data migration preparation for Presentations & Results ongoing
- Final Regional CP2.3 delivery shifted back 18 days to 1/08 2018. No impact on progressive rollout

Upcoming Activities
- HBDHB migration of Demographic data targeted for completion in July
- Familiarisation sessions with Primary Care and NGOs starting July
- Installation of new PCs & screens supporting user experience of CP progressive rollout starts July

Budget
- Capital & operational expenditure for 2017/18 within budget

Progressive Rollout Out Dates

- April – Hawke's Bay clinicians can view Regional data – complete
- From July - Hawke's Bay can view Regional & HBDHB data – HBDHB Demographic data migration for July
- Through to December 2018 – Progressive rollout to be planned in consultation with stakeholders – rollout options being developed

Issues	Mitigating actions underway
• Pending strike action impacting the commencement of data migration in June • Analysis of ECA data has identified a number of data inconsistencies • Patient Safety is a high risk area	• Issues scoped & actions underway to remediate ECA source data to required quality • Engaged with People & Quality and Patient Safety teams to assess ECA-to-CP changes & build mitigations

HAWKE'S BAY District Health Board Whakawāteatia	**Clinical Care Pathways Update**
	For the attention of: **HB Clinical Council**
Document Owner	Mark Peterson, CMO Primary Care
Document Author(s)	Jill Garrett, Strategic Services Manager – Primary Care;
Reviewed by	Chris Ash, Executive Director Primary Care Paul Malan, Strategic Services Manager and Executive Management Team
Month/Year	June 2018
Purpose	Information update

RECOMMENDATION

That the HB Clinical Council

- **Note the contents of this report.**

BACKGROUND TO ACTION ONE

- Map of Medicine (MoM) is ceasing as a vendor and the contract we currently hold with MoM ends 30th June.
- The DHB needs to secure continued access to pathways until such time as an alternative is secured. This is anticipated to be 1 Jan 2019.
- Canterbury Health pathways are recongised nationally and more recently internationally as providing a platform of best practice in the clinical care pathway environment. The current market would indicate that Health Pathways, the Canterbury Network Pathways are the prefered alternative.
- Midlands Network (Waikato) have began their process to transition from MoM to Health Pathways July 1 to Dec 30th 2018. In doing so they have contracted MoM to allow them access to a static view of the existing MoM pathways until Dec 2018. This is referred to as The Interim Tool (see letter attached).
- For other DHBs to benefit from this arrangement until an alternative has been confirmed, Midlands Network are seeking a contribution from each participating DHB. The HBDHB contribution equates to $15,051.77
- The Midcentral Network (HBDHB, Wanganui, Palmerstone North, Capital and Coast) are seeking agreement from their members to accept this offer.

Agreeed Action 1[1]:

- Accept the offer from Midlands to buy into the Interim Tool at a cost of $15,051.77

[1] Action agreed in discussion with Kevin Snee 19.06.2018

SECURING AN ALTERNATIVE TO MAP OF MEDICINE

- HBDHB has 3 options available for the continuity of pathways provision post Dec 2018

Option 1: Preferred Option
HBDHB Joins the Midcentral Network as a partner to tender an RFP to identify a preferred provider of clincal care pathways; and
Approach Midlands network to secure within their tendering process the option for additional DHBs to be included in their tendered process at a later date.

Option 2: Not preferred Option
Independently approach Midlands network to secure within their tendering process the option for additional DHBs to be included in their tendered process at a later date. (to avoid repeating an independent RFP when there is limited options within the market)

Option 3: Not preferred Option
Independently tender to market for the provision of clincal care pathways by a preferred provider.

Recommended action 2:

- **Agree to option 1** and work with the Midcentral Network to ensure HBDHB develops a partnership relationship within the network to go to market to secure a contracted provider for the provision of fit for purpose clinical pathways

Letter from Midlands Network

15 June 2018

Kevin Snee
CEO Hawkes Bay DHB
Kevin.snee@hbdhb.govt.nz

Dear Kevin

Re: Map of Medicine – regional and other DHBs

I understand you have been working with Paul Malan and you are happy to work with us to progress the use of the interim tool and contribute to the one off licence fees for the Map of Medicine and Health Pathways in the future.

Waikato DHB has signed the MoM Licence Agreement. We now want to seek confirmation that you approve the one off funding needed for the MoM licence.

The overall costs for the interim solution are $119,000 GST exc.

Funding for each DHB s share based on the population splits are:

• Bay of Plenty:	$21,847.46
• Hawkes Bay DHB:	$15 051.77
• Midcentral DHB:	$15, 557.76
• Lakes DHB:	$9,836.24
• Tairawhiti DHB:	$4,968.65
• Taranaki DHB:	$10,266.97
• Waikato DHB:	$35,097.16
• Whanganui DHB	$6,373.99
Total	**$119,000**

Summary

Please confirm your approval to fund the one off interim tactical interim solution and indicate your support of Health Pathways in the future. Once we have that confirmation we can invoice each DHB for their share.

Yours sincerely

Ruth Rhodes

Ruth Rhodes
Senior Portfolio Manager

CC Paul Malan

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora - Smokefree**
	For the attention of: **Māori Relationship Board, HB Clinical and Consumer Councils and HBDHB Board**
Document Owner	Kevin Snee, Chief Executive Officer
Document Author(s)	Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by	Shari Tidswell, Intersectoral Development Manager; Julie Arthur, Midwifery Director; Justin Nguma, Senior Health & Social Policy Advisor and Executive Management Team
Month/Year	June 2018
Purpose	To provide the Executive Management Team (EMT) with an overview of the six months implementation progress on the Smokefree plan for discussion.
Previous Consideration Discussions	Reported six monthly.
Summary	**Smokefree (On Track)** ***95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.*** • HBDHB achieved 95.5% in Quarter two and 95.7% in Quarter three. Health practitioners in secondary care continue to achieve the 95% target of all patients who smoke aged 15 years and over, are offered brief advice and offered support to stop smoking. ***90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months.*** • Health HB achieved 90% in Quarter two and 88.9% in Quarter 3 with 9/25 practices meeting the 90% target and 14/25 practices within 10% of the target. GP practices and staff receive support from an independent nurse who contacts patients who smoke and updates patient smoking status in ten practices. The DHB Smokefree Coordinator based in Wairoa, contacts and updates patient smoking status in the Wairoa GP practices. **Smokefree (Not on track)** ***90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking.*** • Women Smokefree Status at Booking by Lead Maternity Carer for the period 1 January to 31 March 2018 identified a total of 515 pregnant women at booking, 121 (23.54%) were smokers and 13 had an unknown status (2.53%). <u>We note data issues for the following</u>:

	90% of young pregnant Māori women were referred to cessation support. • Data collection was based on all Māori women • Data provided by the DHB employed midwives for the period 1 January – 31 March 2018 identified 24 of 25 Māori women were smokers. Seventeen (70.8%) received smoking brief advice, fourteen, (82.4%) were offered support to quit smoking and six (42.9%) were referred to cessation support services. ***95% of pregnant Māori women who are smokefree at 2 weeks postnatal.*** • Data collection is based on women smokefree status at discharge by Lead Maternity Carer (LMC) • Women smokefree status at discharge by LMC for the period 1 January to 31 March 2018 identified 83 (43%) of Māori women were smokers and 6 Māori women had an unknown status (3%). (See table 4).
Contribution to Goals and Strategic Implications	Improving health outcomes for pregnant women and their whānau. Health equity – smoking at time of registration and at two weeks postnatal is more common among Māori women. Transform and Sustain – increasing focus on prevention.
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity for Māori women and their whānau.
Consumer Engagement	Not applicable.
Other Consultation /Involvement	Face to face interviews were conducted and recorded with pregnant women and post-natal women to help understand why pregnant women continue to smoke during and after birth.
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:

That the **Māori Relationship Board, HB Clinical and Consumer Councils and HBDHB Board**

1. **Note** the content of the report
2. **Support** the next steps.

Te Ara Whakawaiora - Smokefree

Author:	Johanna Wilson
Designation:	Acting Smokefree Programme Manager
Date:	June 2018

OVERVIEW

Following concerns from the National Māori General Managers (Tumu Whakarae) about the slow pace of progress on some indicators in reducing health disparities for Māori, the Hawke's Bay DHB Executive Management Team (EMT) decided to establish a championship role in 2013 for each of the indicators to spur faster traction on implementation. The Champions were tasked to provide the Board with six monthly Te Ara Whakawaiora (TAW) exceptions based report drawn from AMHP quarterly reporting highlighting the implementation progress on these indicators along with recommendations for improvement towards achievement of the annual targets and reducing health disparities. This report is from Kevin Snee, Champion for Smokefree Indicator.

MĀORI HEALTH PLAN INDICATOR: Smokefree

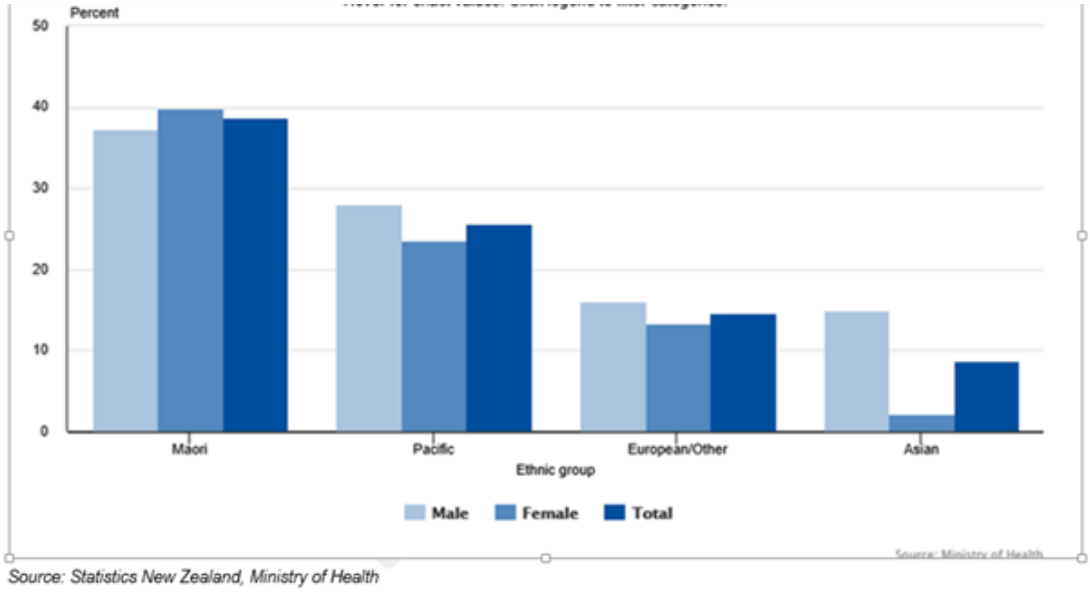
This report provides an update on programmes related to Māori pregnant women and Māori women at two weeks postnatal:

- 90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking
- 90% of young pregnant Māori women are referred to cessation support
- 95% of pregnant Māori women who are smokefree at 2 weeks postnatal.

According to the 2014 Health Equity Report, tobacco use was cited as the single biggest underlying cause of ill health and inequity of death rates in Hawke's Bay. More Māori are known to be dying from smoking related causes than non-Māori. Based on the Statistics New Zealand[1] data published in 2017, Māori had the higher proportion of smokers than non-Māori.

[1] http://archive.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Health/tobacco-smoking.aspx#info3

Figure 1: Proportion of Population who currently Smoke Tobacco



Source: Statistics New Zealand, Ministry of Health

As shown in the National Health Survey (Figure 1), the rates of tobacco smoking are higher among Māori than non-Māori with highest rates of smoking among Māori women (36.5%). This smoking behaviour among women continues even when they are pregnant. While rates of tobacco use have declined over the years, the rates for Māori are not declining fast enough to reach equity levels let alone meeting the national 2025 smokefree target of less than 5%[2].

WHY IS THIS INDICATOR IMPORTANT?

Although there has been a reduction in the overall smoking prevalence in Hawke's Bay from 25% in 2006 to 18% in 2013, Māori smoking rates (36%) are over double those of non- Māori, Non-Pacific (14%). Māori women aged 20 – 29 years have the highest smoking rate of all groups, at 49%. Smoking is most prevalent in high deprivation areas – almost half of the smoking population in Hawke's Bay (475) lives in deprivation areas 9 and 10.

Maternal smoking is the largest modifiable risk factor affecting foetal and infant health in the developed world and the percentage of women smokers in the Hawke's Bay region is a major health concern. Data collected in Q2 (Oct-Dec 2017) shows 24.5% of women booking at maternity care were smokers. Out of these, 47.9% were Māori, 14.6% were Pacific Islanders and 12.9% were Europeans (Table 1).

Table 1: Women Smoking Status at Booking 2017/18 by Ethnicity

	Smokers		Non-Smokers		Unknown	
Ethnicity	**N**	**%**	**N**	**%**	**N**	**%**
Māori	347	47.9%	377	52.1%	19	-
Pacific Islander	19	14.6%	111	85.4%	4	-
European	134	12.9%	905	87.1%	26	-
Asian	1	0.8%	132	99.2%	2	-
Other	0	0.0%	23	100.0%	0	-

[2] Regional Tobacco Strategy for Hawke's Bay update, 2015 – 2020 presented at the MRB, HB Clinical and HB Health Consumer Council, November 2016, update.

As shown in Table 2, these rates showed no significant improvement at discharge, as 41.7% of Māori and 14.1% for Pacific Island women were still smokers.

Table 2: Women Smoking Status at Discharge 2017/18 by Ethnicity

	Smokers		Non-Smokers		Unknown	
Ethnicity	**N**	**%**	**N**	**%**	**N**	**%**
Māori	293	41.7%	410	58.3%	40	-
Pacific Islander	18	14.1%	110	85.9%	6	-
European	112	11.3%	877	88.7%	76	-
Asian	1	0.8%	131	99.2%	3	-
Other	0	0.0%	22	100.0%	1	-

This indicator continued to perform poorly in Q3 of 2017/18 (Jan-March 2018). As shown in Table 3 45% of Māori women were reported to be smokers at booking and only dropped by 2% to 43% at discharge as shown in Table 4.

Table 3: Women Smoking Status at Booking 1 Jan – 31 March 2018 by Ethnicity

	Smokers		Non-Smokers		Unknown		Total
Ethnicity	**N**	**%**	**N**	**%**	**N**	**%**	
Māori	86	45%	103	53%	4	2%	193
Pacific Islander	0	0%	19	86%	3	14%	22
Other	34	11%	259	87%	5	2%	298
Not Stated	0	0%	1	50%	1	50%	2
Total	120	23%	382	74%	13	2%	515

Table 4: Women Smoking Status at Discharge 1 Jan – 31 March 2018 by Ethnicity

	Smokers		Non-Smokers		Unknown		Total
Ethnicity	**N**	**%**	**N**	**%**	**N**	**%**	
Māori	83	43%	104	54%	6	3%	193
Pacific Islander	0	0%	22	95%	1	5%	22
Other	28	9%	256	86%	14	5%	298
Not Stated	0	0%	2	100%	0	0%	2
Total	111	22%	383	74%	21	12%	515

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

Pregnancy is a strong motivator to quit and first-time mothers are the most receptive to cessation advice. Early antenatal advice about the benefits of quitting for baby and her health is crucial alongside obtaining her consent to be referred for cessation support. Some women quit on their own, while others appreciate support to quit and for some, the smoking addiction is so strong that they won't even attempt to quit despite knowing the risks for baby and their own health. The challenges associated with smoking cessation efforts in HBDHB are captured in anecdotal stories from interviews with Wāhine Hapū and their whānau on their journey to become smokefree as presented in Appendix One.

1. Maternity Services

Lead Maternity Carers (LMCs) and HBDHB midwives have a key role in health and wellness promotion and education for the woman, her whānau and the community. LMCs and DHB midwives encourage and assist women and their whānau to take responsibility for their health and that of the baby by promoting healthy lifestyles.

Over the last six months, DHB Maternity services have kept the importance of a smokefree pregnancy and environment by achieving the following:

- Update of the maternity booking form paperwork to better reflect recording of smokefree status, brief advice and referrals to Quit services
- All registered staff in Maternity have received education and training around screening, brief advice, use of Nicotine Replacement Therapy (NRT) and referral pathways for women, partners and whānau who are not smokefree. All staff are asked to discuss their smokefree practice as part of the Performance Development Review (PDR) process
- Free NRT and Quit Cards are available to women and support people in Maternity regardless of readiness to engage with a formal Quit service

- Strong smokefree message entwined with other health practices such as breastfeeding and safe sleep
- Resources available for women not ready to become smokefree encouraging the smokefree message but also making the details for Quit services available when they are ready for this
- Monitoring of targets around providing smokefree advice to >95% of women booking with DHB Maternity services and discharging from Maternity services. Review of all women not receiving advice is undertaken to determine reasons for advice not being given to improve systems.
- However, there were a small number of genuine emergencies when women are not asked their smokefree status and not given smoking brief advice.

2. Increasing Smokefree Pregnancy

HBDHB Smokefree team. in partnership with Choices Kahungunu Health Services. have been supporting Wāhine Hapū and Wāhine with pepe under six months to be smokefree since 2014.

A review of the Wāhine Hapū – Increasing Smokefree Pregnancy Programme in October 2015 identified seven key recommendations:

- Market the programme as whānau opportunity to quit smoking for the new baby
- Promote the programme directly to pregnant women and their whānau to increase self-referrals
- Promote the programme more widely in the health and social sector
- Enhance the incentive package to include whānau members
- Improve the ease and speed of the referral process
- Increase cessation support capacity
- Improve the quality of the programme data and outcome analysis.

The HBDHB has adopted the recommendations with the following adjustments to the programme:

- Inclusion of incentivised package for close whānau members
- Accept referrals from the Special Care Baby Unit, Paediatrics, Te Ara Manapou, GP practices, pharmacies and Well Child Tamariki Ora providers
- A small number of women and whānau have self-referred as a result of viewing the Te Haa Matea facebook page or hearing about the programme via a friend or whānau member
- Te Haa Matea provide cessation support across all services
- Referral process and monitoring of progress and resources adjustments made in response to these findings

Total referrals for smokefree cessation support in 2017 were 357 is presented in Table 5. (57% of women were smokers at booking).

Table 5

Referrals from	Number	Percentage	Ethnicity	Number	Percentage
Antenatal	260	73%	Māori	239	67%
Postnatal	33	9%	NZ European	106	30%
Whānau	64	18%	Pacific Islander	6	1.7%
			Other	4	1.3%

When first contacted, 173 women and whānau agreed to enrol in the Wāhine Hapū programme. Referrals received within the DHB were contacted by the Smokefree team to encourage engagement with the programme. The Smokefree Co-ordinator in Wairoa runs cessation clinics parallel to the antenatal midwife clinics. Of the 173 (48%), 57 participants (33%) of women and whānau completed the 12 week programme.

Challenges to keeping women and their whānau on the programme have been:

- The time between the referral received and a stop smoking practitioner contacting them has given them the opportunity to decline the programme
- Incorrect contact details or are not contactable, once the referral has been received
- Setting a quit date and remaining smokefree in their first week is not always achievable. 43% of those who engaged with the programme initially, did not reach the 1 week carbon monoxide validation.

The communities where young Māori women live, socialise and belong is also the community in which they learn to smoke, keep smoking and try to quit. The relationships young Māori women have with their whānau and friends influence their smoking. Smoking can be a big part of a young woman's life as many of her whānau, friends, school mates, workplace and social circles smoke. In many instances young Māori women start smoking because their whānau and friends smoke and when socialising, the smoking increases as the two often go together.

As part of the Wāhine Hapū programme, women and whānau who complete the programme are encouraged to share their smokefree journey. They may opt to be interviewed by a Stop Smoking Practitioner or complete a smokefree survey either on-line or paper copy. The collection of stories gives the DHB Smokefree Team opportunities to review the programme. In the last quarter, DHB stop smoking practitioners were able to conduct face-to-face interviews with three whānau, using set of questions, delving into their smoking history, their smokefree journey and what it means to be smokefree.

Major findings from the interviews were: -

- Age of initiation
  "I was 12 years old when I had my first cigarette"
  "I was 13"
  "I started smoking at age 15"
  "16 when I started"
- Peer pressure
  "*All my friends were doing it*"
- Looks
  "I thought it was cool at the time"
  "I just wanted to be grown up and be cool"
- Risky behaviour
  "*I would steal one of my mum and dads"*
- Treat / Reward
  "As long as the kids were taken care of, I didn't mind treating myself to smoke, it was my reward".

See Appendix One – Interviews for the full details.

3. Community engagement with pregnant women and their whānau

Providing GP practices with the Wāhine Hapū resources, The Top Five to help my Baby Thrive resource and Te Haa Matea business cards provides opportunities for clinicians to have smoking brief advice conversations with pregnant women and to see cessation support early in their pregnancy. The GP or practice nurse who confirms the pregnancy is able to guide the woman to find a midwife and the benefits in being smokefree. GP practices are gaining confidence in referring pregnant women to the HBDHB Wāhine Hapū programme.

HBDHB (as part of Te Haa Matea) are working in partnership with eleven community pharmacies who provide smoking brief advice, behavioural and motivation support, NRT for one week and a referral pathway to Te Haa Matea.

The focus is on the following priority populations:

- Pregnant women, young Māori and Pacific women especially in conjunction with a pregnancy test or emergency contraception pill provision
- Māori and Pacific women with asthma, or Māori and Pacific women with asthmatic children
- Māori and Pacific populations.

All eleven pharmacies have received the Wāhine Hapū resources and the Te Haa Matea business cards.

Te Haa Matea continues to support pregnant women and their whānau to become smokefree through the Wāhine Hapū programme and Tame Your Taniwha challenge. HBDHB provides smokefree education, training and support to Te Haa Matea partners.

HBDHB are working on approaches which integrate hauora – first steps have been the Top Five to help my Baby Thrive promotion, links to Safe Sleep and Breastfeeding promotion. There is now opportunity for the kaupapa be part of the Kaupapa Māori maternity programme.

4. Innovation and Incentivised programmes

HBDHB developed and implemented the Tame Your Taniwha Challenge. This is an eight week quit challenge for teams of three with a prize to be won at the end of the eight weeks and is open to anyone who smokes and over the age of eighteen years. The first challenge was from the 2nd October to 30th November 2017. Eighteen teams of three took up the challenge with the winners coming from Silver Fern Farms in Central Hawke's bay. The second challenge was from 2nd April to 31st May 2018 (World Smokefree Day). Three of the seventeen teams registered had pregnant women and their whānau participating. The winners were Mr Apple – Central with a Māori pregnant woman and her partner's parents, both Samoan.

HBDHB continues to provide the Wāhine Hapū programme to support pregnant women, women with babies up to the age of six months and their whānau to become smokefree, provide a smokefree home and car for all the whānau.

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

Hospital Smokefree Target

1. The DHB Smokefree team will continue to provide smokefree education sessions for all staff as required.
2. Clinical staff continue to be encouraged to complete the MoH online e-learning tool 'Helping People Stop Smoking' every three years and complete the Nicotine Replacement Therapy Module via Ko Awatea. It is important for all clinical staff to review and receive up-to-date knowledge of smokefree to improve practice and increase confidence with cessation.
3. The Smokefree team will continue to triage all hospital patients who smoke and want help to quit smoking.

Primary Health Organisation Smokefree Target

1. The Smokefree team will continue to work in partnership with Health Hawke's Bay to promote World Smokefree Day in practices
2. All clinical staff in GP practices continue to be encouraged to complete the MoH online e-learning tool 'Helping People Stop Smoking' and complete a refresher every three years
3. The Smokefree team will continue provide Wāhine Hapū and The Top Five to help my baby thrive resources and Te Haa Matea business cards to all GP practices
4. The Smokefree team will meet with GP Smokefree Champions in the next quarter to evaluate the use of smokefree resources in practices.

Maternity Smokefree Target

1. The Smokefree team will meet with the Maternity service to discuss providing LMC's who work with Māori pregnant women Maternity Smokerlyzers to support the need to quit smoking while pregnant, provide smoking status in all documentation and evidence to refer to the Wāhine Hapū programme
2. The Smokefree team will provide an audit on the unknown categories of the Women Smokefree status at Booking and Discharge by LMC to identify smokefree missed opportunities
3. The Smokefree team will review the Wāhine Hapū programme
4. The Smokefree team will develop a programme in schools and alternative education to support young Māori women to stay smokefree.

NEXT STEPS AND RECOMMENDATIONS

1. Smokefree Team to develop a logic model plan for equipping LMCs with the Maternity Smokerlyzer (Carbon Monoxide Monitor).
2. Review / evaluate the Wāhine Hapū (Increasing Smokefree Pregnancy Programme) to determine if this is the right programme for pregnant women and their whānau in Hawke's Bay.
3. Link in with the new Whanake te Kuri – Pregnancy and Parenting Education and Information Programme, providing a referral pathway to the Wāhine Hapū Programme.
4. Identify all ante-natal programmes offered in Hawke's Bay to provide a referral pathway to the Wāhine Hapū Programme.
5. Conduct an audit on a selection of patient files with matching NHI numbers from the Smokefree Status at Booking by LMC and Women Smokefree Status at Discharge by LMC for the quarter three period (1 January – 31 March 2018) to address 'unknown' category for miss opportunities for smoking brief advice.

Key Recommendation	Description	Responsible	Timeframe
Ante-natal programmes in Hawke's Bay	1. Link in with the new Whanake Te Kuri – Pregnancy and Parenting Education and Information Programme providing Wāhine Hapū resources and Te Haa Matea business cards and a referral pathway to the Wāhine Hapū programme. 2. Identify all Ante-natal programmes in Hawke's Bay providing Wāhine Hapū resources and Te Haa Matea business cards and a referral pathway to the Wāhine Hapū programme	Johanna Wilson / Smokefree Team	October 2018
Audit patient files	Select a number of 'Unknown' patient files to determine missed opportunity for Smoking Brief Advice from Quarter 3 data (1 January – 31 March) - Women Smokefree Status at Booking and Discharge by LMC data,	Johanna Wilson / Smokefree / Maternity Services / Medical Records	October 2018
Review / evaluate the Wāhine Hapū (Increasing Smokefree Pregnancy Programme)	Conduct an internal review the Wāhine Hapū programme and action the recommendations.	Johanna Wilson / Smokefree Team / Choices Kahungunu Health Services	September 2018
Equip LMC's the Maternity Smokerlyzer (Carbon Monoxide Monitor)	• Meet with Maternity Services. • Develop Logic Model • Identify smoking status of all pregnant women at booking • Promote Wāhine Hapū (Increasing Smokefree Pregnancy Programme) to increase referrals to be smokefree	Johanna Wilson / Smokefree Team / Maternity Team	November 2018

RECOMMENDATION:

It is recommended that the Executive Management Team:

1. **Note** the content of the report
2. **Support** the next steps.

Appendix One - Interviews

Interview with Māori mama, 31 years. Children aged 14, 13, 8, 7, 6, 4, 2 and 2 weeks. Partner is smokefree.

Chrystal started smoking at age 15, she was smoking up to 40 cigarettes per day. Her motivation to stop smoking was for her babies.

She had previously tried 4-5 times to quit. In the past she had used Nicotine Replacement Therapy (NRT) – patches, gum and lozenges. She has also used Champix.

Since quitting, she has noticed a huge financial saving and has a lot more energy. Chrystal continues to have urges to smoke and continues to use the NRT gum and behavioural support from Choices Heretaunga helpful.

Interview with Māori mama, 26 years, at 39.5 weeks pregnant. 8 year old boy and 2 ½ year old boy and partner.

I was 12 year's old when first cigarette, with my friends. Didn't like it, all my friends were doing it. I thought it was cool at the time. I would steal one of my mum and dads, have a little puff and then get real bad headaches.

Our house was auahi kore, everyone had to smoke. Mum and dad didn't want us smoking at all. They knew how addictive it was.

I'm an on and off smoker, like smoke for a couple of years and give up for a couple of years and start back again.

With my first son, I gave up smoking, I didn't smoke throughout that pregnancy and then my second son I didn't smoke throughout that pregnancy either. This is my first time ever, like I didn't smoke throughout the entire pregnancy but I continued without giving up.

I had no support during that time, my partner moved to HB to start up our company and it was just me in Wanganui. The only thing I relied on was my smokes, that's what put me at ease, kept me sane. I had no whānau in Wanganui, so it was like once the kids were at school and day care there was nothing for me to do besides clean my whare, exercise, have a cigarette. As long as the kids were taken care of, I didn't mind treating myself to smoke, that was my reward.

I wanted to stop because I'd never smoked during my pregnancies before and I didn't understand why I started to smoke with my third baby. I think it was more the fact that everything was so full on. We were in the process of moving and I still had my other two boys. It was just something that relaxed me, calmed me. I met the quit smoking team in Wanganui and they showed me all the stuff that happens during pregnancy and that put me off and that's why I quit. I was about five months pregnant. I gave up as soon as I walked out those doors. I was like nah, I'm not going to do this cause it wasn't fair, I didn't smoke with my boys and then all of a sudden I am smoking again.

My goal is not to smoke. Since I have given up, I feel better, like a better person, my partner and I wanted to change our lifestyle a bit. He has given up smoking too that was his new year's resolution so I think because I've quit it's made him quit and I didn't pressure him or anything.

My trigger was boredom. I'm quite busy now. I've got whānau here, I've got appointments, I've got places to go, more opportunities here. We've got our own whare now, like I'm always on the

go, on the move. This is the most active I've been throughout all my pregnancies, that's what stops me from craving.

Interview with pregnant mama and her partner. Aged 34 years. 26 weeks pregnant. One other child aged five years old. Smoked throughout his pregnancy. NZ European.

My dad was a smoker, ever since I was born. I started smoking myself or stealing smokes from him when I was like thirteen. I loved the smell of it cause he use to smoke in the car with us and you know we would sit behind him and we would get the smoke wafting behind so yeah, I kinda loved that smell. I don't get along with him now, so it's great it's not in my world anymore. It was more with mates really, trying to be cool. There was a dairy just up from school and I was with one of my best mates who still to this day, smokes. We just coughed and spluttered and it was the most disgusting thing ever but we tried to be hard arsed and carry on.

I was thirteen when I had my first puff, gradually increased. When I was 15 / 16 years I went to Japan and that was the smoking culture over there was heavy, I was like a packet a day while in Japan.

I fully had that smoking mentally too you know when you see that ad on TV that's like oh don't smoke and it made me want to have a smoke and I was like whatever, don't tell me what to do blah, blah, blah… whatever, I'm going to have five smokes just to spite you. When actual fact it's hurting you, more than hurting them.

Smoked all the way through with the other pregnancy. Looking back I kept all my notes from them. Shit that was real close man that was so close to losing my baby. You don't think about it and like I said that smoking mentality. It's all good, I will do what I want, but I'll cut down but I will still be smoking. You don't understand that it is having such an affect. Looking back on the notes I was hospitalised during my pregnancy, I got a massive infection that went straight to my kidneys so my body is not already as immune as it should be and then during my labour he was like on deaths door from not being able to breathe properly and stuff like that.

I am monitored a lot less in this pregnancy. My midwife is stoked I'm not smoking anymore.

Dave (partner), NZ European, 36 years.

16 when started smoking. I was already out of school at that stage and I just wanted to be grown up and be cool. Me and my mate started at the same time and then we got another couple of friends into it and tried to be cool together and then it went all down-hill from there.

2012 I stopped for almost six months using the first e-ciggie. I didn't really stop until the end of last year. Sometimes when I am drinking I get a craving for my e-ciggs but not for a cigarette. Because we haven't been smoking we have half the money together for this house and I am way more productive at work now.

CLINICAL ADVISORY & GOVERNANCE GROUP REPORT

12

Verbal

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:

14. Minutes of Previous Meeting (Public Excluded)

15. Minutes of Joint Meeting / Workshop with Consumer Council

16. Matters Arising – Review of Actions

17. Briefing on Patient Safety and Quality

18. Clinical Services Plan (first draft)

19. Topics of Interest – Member Issues / Updates

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).