Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 14 February 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
Dr Nicholas Jones
Jules Arthur
Maurice King
Dr Tae Richardson
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Peter Culham

Apology:

In Attendance:

Kate Coley, Executive Director - People & Quality (ED P&Q)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator / EA to ED P&Q
Kerri Nuku, Māori Relationship Board Representative

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome new Member Dr Peter Culham / Receive apologies	3.00
2.	Interests Register	
3.	Minutes of Previous Meeting and Combined Meeting with Consumer Council	
4.	Matters Arising – Review Actions - Verbal Update regarding Person & Whanau Centred Care	
	Section 2 – For Discussion / Decision	
5.	Quality Annual Plan 2017/18 – Kate Coley	3.25
6.	Clinical Portal Project (for Board approval) –Anne Speden / Michael Sheehan	3.30
	Section 3 – For Information / Discussion	
7.	Clinical Services Planning Update – Ken Foote	3.55
8.	Clinical Governance Structure – Value Assessment – Co-Chairs	4.10
9.	Clinical Council's Annual Plan 2017/18 and 2018/19 - Workplan to June 2018	4.30
10.	Adverse Events Upate – John Gommans	4.50
11.	Clinical Governance of Results – John Gommans	4.55
	Section 4 – Monitoring - For Information only – no presenters unless requested	5.10
12.	Ngatahi Vulnerable Children's Workforce Development Progress Report	-
13.	Suicide Prevention Update	-
14.	Te Ara Whakawaiora - Access 0-4 / 45-65 yrs (local indicator)	-
15.	HBDHB Performance Framework Exceptions Dashboard Q2 (Oct- Dec 2017)	-
	Section 5 – General	
16.	Topics of Interest – Member Issues / Updates	5.15

NEXT MEETING: Wednesday, 14 March 2017 at 3.00 pm, Boardroom, HBDHB Corporate Office

Interests Register
Feb-18

Hawke's Bay Clinical Council

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**
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	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a	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
	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	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
	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	No	
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chriopractic 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 Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	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	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary			
	Ministry of Health - First Specialist Assessment Oversight Group	Member		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. 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	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	

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**
	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
	HBDHB employee Mary Wills	Spouse	Employee	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 Manager	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		No	
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	
Maurice King (Community Pharmacist)	Napier Balmoral Pharmacist	Shareholder and Director	Community Pharmacy	Yes	Has various contracts with HBDHB to provide pharmacy based services. Low. Ensure position declared when discussing issues in this area.
	Pharmacy Guild of NZ	Member	Representative and negotiating organisation for Pharmacy	Yes	Negotiations on behalf of Napier Phamacy with HBDHB. Low. Ensure position declared when discussing issues in this area.
	Phamaceutical Society of NZ	Member	Pharmacy advocacy, profressional standards and training.	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Independent Advisor	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, percuniary, 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 LANTERN GALLERY ROOM, HAVELOCK NORTH FUNCTION CENTRE, 128 TE MATA ROAD, HAVELOCK NORTH ON WEDNESDAY, 6 DECEMBER 2017 AT 2.30 PM

PUBLIC

Present:	Dr John Gommans (Chair) Dr Andy Phillips (Co-Chair) Chris McKenna Dr Mark Peterson Dr Russell Wills Dr Robin Whyman (from 3.10 pm) Dr David Rodgers Dr Nicholas Jones Dr Tae Richardson Debs Higgins Maurice King Jules Arthur (from 3.08 pm) Anne McLeod Lee-Ora Lusis
In Attendance:	Kate Coley, Executive Director – People & Quality (ED P&Q) Ken Foote, Company Secretary Tracy Fricker, Council Administrator and EA to ED P&Q Linda Dubbeldam, Health Hawke's Bay Representative
Apologies:	David Warrington

SECTION 1: ROUTINE

1. APOLOGIES / WELCOME / MEETING RULES

Dr John Gommans (Chair) welcomed everyone to the meeting.

Apologies were noted as above and from attendee member, Kerri Nuku.

2. INTEREST REGISTER

No conflicts were noted for items on the agenda. There were no additions or amendments to the Interest Register.

3. MINUTES OF PREVIOUS MEETING

The minutes of the Clinical Council meeting held on 8 November 2017, were confirmed as a correct record of the meeting.

The minutes of the Clinical Council public excluded meeting held on 8 November 2017, were also confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 Laboratory Guidelines
The guidelines document was tabled at the meeting and copies circulated to members. Andy Phillips apologised for the delay in providing these to members. Members were asked to provide comments back to Andy Phillips if they had any concerns. It was agreed by Council that the Laboratory Guidelines were approved subject to any comments from members.

Item #2 Clinical Advisory and Governance Group Report
The HB Health Clinical Governance Strategy document was included in meeting papers for information under item #10. *Item can now be closed.*

Item #3 HB Radiology Services Committee
Congratulations letter signed by Co-Chairs and sent to Radiology Manager and Head of Department. *Item can now be closed.*

Item #4 Laboratory Services Committee
Anne Speden to present IS Roadmap at a future meeting, date to be confirmed for February or March 2018. Andy Phillips advised that the Laboratory has had a recent IANZ visit and a favourable report was received.

Item #5 Clinical Governance Committees' Structure Review
Initial meeting held on 30 November. On today's agenda for discussion, item #7.

Item #6 Misdirected Results Group
Update report included in meeting papers for information, item #8. *Item can now be closed.*

Item #7 Member Issues/Update
Reminder for SMO Group re: dietary information for immunosuppressed patients. An update has been sent to key SMOs. Dr Andrew Burns, Infectious Diseases Physician has advised that Obstetricians and Midwives are consistently providing information to patients. He has reminded the nurses supporting clinics to ensure the pamphlets are used. *Item can now be closed.*

5. CLINICAL COUNCIL WORK PLAN

A copy of the work plan was provided in the meeting papers. The Chair noted that February is a busy month and the meeting time may need to be extended. A decision is also to be made when the half-day strategic meeting will take place.

Andy Phillips (Co-Chair) commented that members had expressed they wanted meetings to be meaningful and have the ability to contribute more. There are things that we have to do to in our clinical governance role to provide advice to the Board. The Co-Chairs welcome feedback from members on items/issues they would like to focus on. This will assist with planning the meeting agendas.

A query was raised whether there is a way to show in the work plan what is being delegated to us by the Board. It was agreed by the co-chairs that they would action this.

Action: Co-chairs to indicate in the work plan the items that council needs to provide advice to the Board.

6. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- ***Dr Tae Richardson*** - First 1,000 days of life – discussion held with Julie Arthur and David Rodgers. Would like to see this added to the work plan for discussion once further information is available.

  Action: Co chairs to add item on first 1000 days to council work plan.

- ***Dr David Rodgers*** – requested an update on the budget prioritisation process. Looking at the quality of our processes, what happened with previous bids/outcomes, how it is decided what comes to Clinical Council and how we make prioritisations going forward.

  Action: Co-chairs to add update on budget prioritisation process to work plan.

SECTION 2: DISCUSSION

7. CLINICAL GOVERNANCE COMMITTEES' STRUCTURE

The Chair tabled a paper on the review of the Clinical Governance Committees' Structure, following the request from the Board to relook at the structure, value and workloads of the committees and advisory groups. A small working group met on 30 November to start this review and have made a number of recommendations in the paper for discussion.

General discussion was held regarding the paper and updated structure contained in Appendix 2. Need to ensure that the advisory groups all report to the right committee. Following discussion the following decisions were made:

- Patient Experience Committee – required, no change.

- Information Management Committee - required. Agreed the current advisory groups be removed. The functions of these advisory groups report operationally to the Executive Director – People & Quality.

- Professional Standards & Performance Committee – required. Agreed that credentialling for services becomes a separate function.

- Clinical Effectiveness & Audit Committee – required. Changes to advisory groups:

  - Clinical Audit and Morbidity and Mortality Advisory Group to remain separate at this stage. There is a lot of background work required to establish these functions and getting them working effectively. Potential to amalgamate these groups in the future, to be reviewed in 12 months.

  - Clinical Pathways – remove. With the withdrawal of Map of Medicine, now is not the right time to have a separate advisory group. Practices need to change substantially. Continue to report to Clinical Council for the time being.

  - Maternity Governance Group – move back to sit under the Patient Safety & Risk Management Committee.

  - Laboratory; Pharmacy & Therapeutics, Radiology and Trauma Advisory Groups – no change.

  - Health Systems Integration – not established at this stage. Formation of this group will be informed by the outcome of the Alliance Group process which has representation from Clinical Council, Health Hawke's Bay and DHB. Establishment of this group

including TOR to be put on hold pending a paper on the Alliance in preparation by the Company Secretary

- Equity – Differing opinions on whether or not this is a role for a clinical governance advisory group. Acknowledged that this is an important issue on which more needs to be done. Also acknowledged that equity is a sector wide responsibility with several groups currently looking at this i.e. Population Health; Public Health Service; Maori Relationship Board and the Pacific Health Leadership Group. Need more information/discussion to determine whether a separate advisory group under Clinical Council is required before making a decision.

- Patient Safety and Risk Management Committee – required. No changes apart from the Maternity Governance group to report to this committee.

Actions: ***Andy Phillips and Tae Richardson to prepare a paper on the clinical governance requirements of equity and integration.***

The working group will meet to discuss changes and to prepare a report for the February meeting of Council.

SECTION 3: INFORMATION

8. MISDIRECTED RESULTS

The Chair advised that a report from the misdirected results working group was included in the meeting papers for information. The group is meeting again next week to continue this work.

9. CLINICAL ADVISORY & GOVERNANCE GROUP

Dr Tae Richardson advised that the meeting was not held yesterday due to lack of quorum. An update will be provided at the February meeting.

10. HEALTH HB – CLINICAL GOVERNANCE STRATEGY 2017-18

Document included in meeting papers for information only. No issues discussed.

The meeting closed at 3.20 pm.

Confirmed: _____
Chair

Date: _____

MINUTES OF THE COMBINED MEETING OF THE HAWKE'S BAY CLINICAL COUNCIL and HAWKE'S BAY HEALTH CONSUMER COUNCIL HELD IN THE LANTERN GALLERY ROOM, HAVELOCK NORTH FUNCTION CENTRE, 128 TE MATA ROAD, HAVELOCK NORTH ON WEDNESDAY, 6 DECEMBER 2017 AT 3.30 PM

PUBLIC

Present:

Dr John Gommans *(Clinical Council Chair)*
Dr Andy Phillips *(Clinical Council Co-Chair)*
Chris McKenna
Dr Mark Peterson
Dr Russell Wills
Dr Robin Whyman
Dr David Rodgers *(until 5.00 pm)*
Dr Nicholas Jones
Dr Tae Richardson
Maurice King
Jules Arthur *(until 5.00 pm)*
Anne McLeod
Lee-Ora Lusis *(until 5.00 pm)*
Debs Higgins *(until 4.25 pm)*
Rachel Ritchie *(Consumer Council Chair)*
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Deborah Grace
Olive Tanielu
Jim Henry
Sarah Hansen
Dallas Adams
Kylarni Tamaiva-Eria
Dr Diane Mara

In Attendance: Kate Coley, Executive Director – People & Quality (ED P&Q)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to Executive Director – People & Quality
Linda Dubbeldam, Health HB Representative
Jeanette Rendle, Consumer Engagement Manager
Graeme Norton (Chair, National Consumer Council)

Apologies: David Warrington, Jenny Peters, Malcolm Dixon, Sami McIntosh and Kerri Nuku

The Chairs of both councils welcomed everyone to the combined meeting of the Clinical and Consumer Councils. Roundtable introductions took place.

Apologies were noted as above.

SECTION 4: PRESENTATIONS / DISCUSSION

11. CLINICAL SERVICES PLAN UPDATE

Ken Foote, Company Secretary and Project Lead for this work, provided an update on the Clinical Services Plan (CSP).

Key points included:

- Why we are doing this – planning is important to sustain a growing population; to identify models of care that will meet future demand; confirm what works well and what needs improvement; reduce inequity.

- What the CSP will deliver - looking at issues and challenges for the future; look at high level options to take advantage of opportunities; provide a strategy and options for the future; inform direction for the strategic plan.

- The CSP will not have details on implementation, financial or workforce planning or a facilities master plan.

- Process to date – development of data packs; horizon scan; identification of issues and challenges and confirmation of current state of analysis by engagement with consumers, primary care, HBDHB services and health sector leadership; production of documents and preparation for future workshops

- Process from here:
  - Future Options Workshops Jan/Feb 2018
  - Integrative Workshop 6 March 2018
  - HB Health Sector Leadership Forum Workshop 7 March 2018
  - Draft CSP Delivered 31 March 2018
  - Engagement Meetings / Workshops April 2018
  - Final Version CSP 30 April 2018

- Communications plan:
  - Regular updates in the CEO newsletter "in focus"
  - Public website were all documents will be available once approved so the process is transparent
  - Ambassadors appointed and briefed to support and assist with enhancing knowledge understanding participation and engagement with staff and consumers
  - EMT/Steering Group meetings and updates
  - Governance Group updates
  - Korero Mai

The Company Secretary advised that the draft CSP will be completed by 31 March 2018. During April there will be widespread engagement meetings and workshops held. Sapere will compile all feedback received and provide a final version of the CSP by 30 April 2018.

It was recommended that Clinical and Consumer Council members attend the leadership forum workshop to be held on 7 March.

12. THE BIG LISTEN – RESULTS & NEXT STEPS

A presentation was provided by Kate Coley, Executive Director, People & Quality (ED P&Q). Results from the Big Listen, feedback was predominately from staff working in the health sector of Hawke's Bay. It was a different approach than before, getting over 800 staff to an interactive "Big Listen" session.

Key points included:

- Background; targeted approach to hear from staff; from the bottom up to develop a people strategy; work will be ongoing not a one-off we want to continue to engage with our staff
- Learnings; timing of the big listen, resources required, useful tools and mechanisms, need to be able to breakdown staff survey by ethnicity and engage better with primary care
- The Big Listen received almost 3,000 contributions from staff and consumers
- Engaged teams deliver better service to consumers
- Balance of satisfaction at work and reasons why; what makes a good day and what makes a bad day
- Areas for improvement identified; 5 key staff priorities and top 5 actions patients would like to see
- Behaviours which patients value; compliments staff want from patients; and behaviour staff want of each other
- Behaviour framework developed to underpin HeART values *(He Kauanuanu - Respect; Akina - Improvement; Raranga Te Tira – Partnership and Tauwhiro - Care)*
- A plan going forward from December 2017 to May 2018

It was acknowledged that we can do better as a health sector and that this is a great starting point to build on for the future.

SECTION 5: WORKSHOP

13. PERSON & WHANAU CENTRED CARE – UPDATE & NEXT STEPS

Rachel Ritchie, Chair - Consumer Council introduced the workshop. Documents to start the discussion were included in the meeting papers. We need to look at what has been done previously and bring this forward into what is being done now so we can build on it.

Members split into groups to discuss the following questions:

- Confirm our mutual understanding of what "Person & Whanau Centred Care" means and what it will look like as a 'total approach' when fully implemented?
- How well do we think we are doing on this currently?
- What is standing in our way from getting this approach fully implemented in Hawke's Bay?
- What can we do as combined Councils to get real progress/ actions on this?
- What messages do we want our Chair/Co-Chairs to send?

Group Feedback:

Group 1:

- Mutual understanding what patient and whanau centred care is, it is holistic relationship-based care
- Patient Charter could be developed – based on PWCC principles
- Inconsistent application of approach at this stage
- Resources and time stand in the way
- Patient and whanau centred care needs to be put into practice
- Need leadership commitment to make this happen, more communication, build a level of trust between leaders, strong relationships

Group 2:

- Change the language to "customer driven" instead of patient centered, and ask "what matters to you" to make it easier to understand
- Need to change the language - things mean different things to people depending on the context they live in
- Carry on the big listen, this should be a continuous way to change our system and we should advocate to resource this appropriately
- We have variations on the same themes, patient and whanau centred care; relationship centered practice we need to have consistent messaging. Maybe consumers should decide what it is called
- Whatever we do, we need to resource it properly if we want to achieve tangible change.
- Nuka did their big listen over a period of 5 months and they tailored their approach to who they talked to and how they talked to them, you would talk to aged residential care differently than youth or people in a rural setting. The big listen was a good start, there is now the opportunity to grow this and be clear on how we communicate and listen to our customers

Group 3:

- Person and whanau centered care – analogy that a patient is a drop in the bucket that causes a ripple and stems out to partners, brothers and sisters, partners family etc this spreads out wide
- Clinicians and other parts of the sector need to learn how to listen, ask questions and let them talk, that is where you can find out more rather than asking direct questions, for consumers to feel comfortable to volunteer information, they will start to like you and trust is built. This can be difficult in a secondary situation, by using people out in the

community who already have those connections established, it is easier to find out what the real problem is
- Message we need to send to the Board is improve information sharing
- Learning to listen and making sure what is developed is fit for the individual
- Improve the connection between primary and secondary care, making services flexible. Gather information once and it travels with the patient
- Capability in primary care, organisation or person can access places that the patient needs to go to e.g. mental health, housing and other services
- Making flexibility in the community
- Important for Health professionals to learn how to listen to patients and whanau, health professionals are experts on the clinical reality and their training, patient and whanau are experts on their own reality
- Integration is important when we talk about whanau it is in the approach going in to work with whanau whatever the setting is i.e. their home, a clinic or hospital. Working with the whole of whanau as they are part of the continuum of care. Whanau may be an organisation that they are connected to e.g. a community group, church etc may be advocating for or with the patient. When the patient leaves secondary care support these are the services which can assist, reciprocal sharing of information, a holistic approach using integration of services secondary, primary, whanau, everybody
- If care is being provided to whanau where is the care record with the whanau, the Ministry of Social Development is a lot better at doing this than the health sector
- There is a disconnect of services / resourcing

Group 4
- Focused on key word "whanau" - whether immediate family or not they still come under one umbrella "whanau". Whanau can be anybody, this is how it is done holistically
- Need a unified message that is being spread on what whanau and people centered care is, one understanding not multiple
- Communicate the message clearly
- Privacy, we are aware there are barriers and sometimes whanau is part of the history, but they can also be part of the future, clinicians can lead/facilitate that process
- Need to accept complexity in how people define their whanau
- Can we fund good work like what is occurring with #whanau at Totara Health
- Messages need to be communicated clearly
- There are people without anyone so they need a good relationship with a support worker or other person, a shoulder to lean on. Whanau could be an organisation, it does not have to be a blood relative.

John Gommans advised that he, Andy Phillips and Rachel Ritchie need to articulate to the Board what do we mean by Whanau and Patient Centred Care and does this translate into the actions that we want to achieve. This workshop was intended to restart the conversation, and it is important for the Councils to continue to work together. It is important to acknowledge that between them, Clinical and Consumer Councils have the knowledge, experience, understanding, capability and ability to heavily influence what gets done within PWCC. A small working group will come together to take this forward to the Patient Experience Committee as their first piece of work.

It was acknowledged that is it important that this work is reported back on a more regular basis and that the minutes from the Health Sector Leadership Forum are circulated and understood.

Rachel Ritchie took the opportunity to acknowledge Graeme Norton's presence at today's meeting and acknowledged his involvement in starting this work and his significant impact during his tenure as Chair of the Consumer Council

John Gommans and Rachel Ritchie thanked everyone for their contributions at today's meeting and invited all to stay for refreshments.

The meeting closed at 5.50 pm.

Confirmed: _____
Chair

Date: _____

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/10/17	***Laboratory Services Committee*** Invitation for Anne Speden to present "IS Roadmap" – extend to include misdirected results and governance of results	Co-Chairs	March	On workplan
2	8/11/17	***Clinical Governance Committees Structure*** • Sub-group to meet to discuss structure and prepare draft report for Board – due February 2018	Co-Chairs/ Company Secretary	Feb	Item 9 on the days agenda
	6/12/17	• Paper to be prepared for equity and integration advisory groups	Andy Phillips & Tae Richardson	Feb	Verbal Update
3	06/12/17	***Clinical Council Workplan*** Indicate in the work plan the items that council needs to provide advice to the Board.	Co-Chairs	Feb	See below**
		Items to be added to workplan: • First 1,000 days	David Rodgers / Tae Richardson	March	On workplan
		Budget prioritisation process update	Tim Evans	March	On workplan

Item 3 Clinical Council Workplan: Indicate in the workplan the items that council needs to provide advise to the Board.

Generally the Board receives most papers which go through to Clinical Council.

On the February 2018 agenda, the Board receive all papers except preliminary discussions/paper(s) around the Board's request for a "Clinical Governance Structure – Value Assessment".

The final of this paper will be provided to the Board in March.

To note: The front page of all reports submitted to Council show a lot of detail, including the intended pathway to the Board and who have reviewed the report provided.

PERSON & WHANAU CENTRED CARE

Verbal Update

5

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Quality Annual Plan – Review 2017 – 18 (6 month progress report)**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and Finance Risk and Audit Committee**
Document Owner and Author	Kate Coley, Executive Director of People and Quality
Reviewed by	Executive Management Team
Month/Year	February, 2018
Purpose	For Information & Update on progress against Quality Annual Plan
Previous Consideration Discussions	Quality Annual Plan was endorsed by EMT, FRAC, and Clinical & Consumer Councils August 2017. This progress report will be presented for information to each of those committees prior to FRAC
Summary	Progress has been made in a number of areas including: • Improvement advisors becoming embedded with Directorate leadership teams and providing a high level of support and expertise in key programmes of work including Faster Cancer Treatment, FLOW, and Surgical Expansion. • Improvement in directorates and services engagement with consumers in co-design projects. • Achievement of all HQSC Safety markers and maintaining number one or second position in Hand Hygiene for the last 12 months. • Agreement and contract signed to proceed with the implementation of a new integrated risk management system. • Delivery of Relationship Centred Practice development programme supporting clinicians to improve their face to face engagement with consumers across the central region.
Contribution to Goals and Strategic Implications	The Quality Improvement and Safety Framework is an initiative of the Hawke's Bay Clinical Council, in partnership with the Hawke's Bay Health Consumer Council which was endorsed in 2013. The purpose of the Working in Partnership for Quality framework is to support integrated quality improvement and performance across the Hawke's Bay health sector by providing direction and priorities. It will enable the entire health sector to have a shared sense of direction in provision of quality care for the Hawke's Bay people. (Extract from Working in Partnership for Quality 2013)
Impact on Reducing Inequities/Disparities	Equity in health outcomes can be improved by ensuring equitable access to the determinants of health such as income and education, equitable access to health services and equitable treatment within health services. Good quality health services and care pathways will therefore help reduce inequities. (Extract from Working in Partnership for Quality 2013)

Consumer Engagement	Consumer Council endorsed the Quality Plan for 2017/18.

RECOMMENDATION:

It is recommended that HB Clinical Council, HB Health Consumer Council and Finance Risk and Audit Committee :

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

Quality Annual Plan – Review 2017 – 18
(6 month progress report)

Author:	**Kate Coley**
Designation:	**Executive Director of People & Quality**
Date:	**February 2018**

PURPOSE

The purpose of this paper is to provide EMT, Clinical & Consumer Councils and FRAC with a six month update in regards to progress against the Quality Improvement & Patient Safety Annual Plan 2017/18.

EXECUTIVE SUMMARY

The DHB has both a stated commitment to quality and safety and a well-established patient safety and quality management system in place. The annual plan for 2017/18 was aligned to a number of foundational documents as follows:

- Hawke's Bay "Working in Partnership for Quality Framework"
- National programmes & safety markers (Health Quality & Safety Commission)
- Regional priorities (RSP through the Central regions Safety & Quality Alliance)
- Transform & Sustain

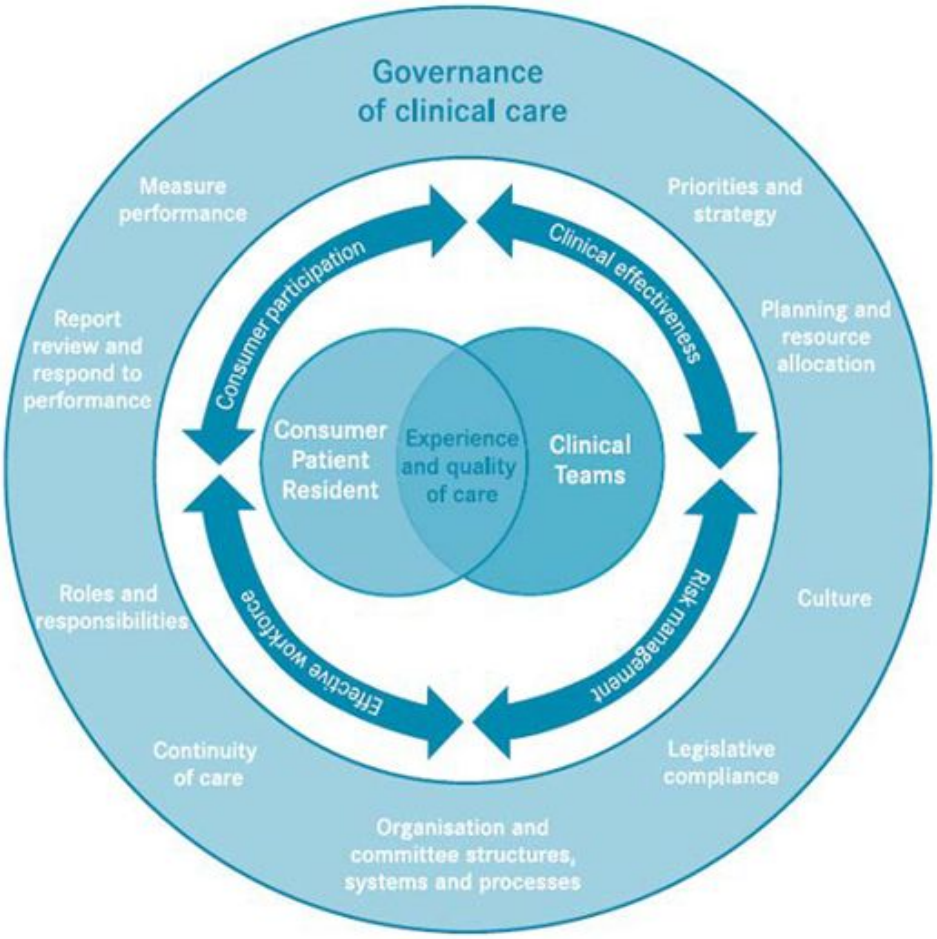
.
In addition to this the DHB aligned the annual plan to the recognised definition of clinical governance and framework.

Clinical Governance is defined as

"*the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks and fostering an environment of excellence in care for consumers, patients, community*"

An effective system of clinical governance at all levels of the health system is essential to ensure continuous improvement in the safety and quality of care, Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement.

The below framework aligns to both the domains of quality and safety and provides the key principles on which good clinical governance is based.



The key challenge as an organisation and the wider sector is to continue to maintain and embed the quality framework so as to ensure that patient safety and quality of clinical care is part of everyone's business and is embedded in our culture.

Appendix 1 details the 6 month update against agreed objectives for 2017-18 in relation to embedding a clinical governance framework.

SUMMARY OF PROGRESS

The following highlights the key areas of progress:

- Improvement advisors becoming embedded with Directorate leadership teams and providing a high level of support and expertise in key programmes of work including Faster Cancer Treatment, FLOW, and Surgical Expansion.
- Improvement in directorates and services engagement with consumers in co-design projects. The Consumer Engagement manager has provided support and advice for projects, improvement initiatives and developed capability around ensuring that the consumer's voice is heard.
- Achievement of all HQSC Safety markers and maintaining number one or second position in Hand Hygiene for the last 12 months.
- Agreement and contract signed to proceed with the implementation of a new integrated risk management system.
- Delivery of Relationship Centred Practice development programme supporting clinicians to improve their face to face engagement with consumers across the central region.

- Making Health Easy to understand framework, tools and guidelines developed and tested with core user group, and initiatives implemented including support to Customer Focussed booking, Patient Safety week, and discharge planning improvements.
- Better relationships built at a local level with the PHO, Primary Care and other contracted providers through interactions with experts from the People & Quality directorate.

KEY ACTIVITIES FOR REMAINDER OF 2018

The following identifies the key priorities for the remaining 6 months:

- Specific directorate/service related initiatives in regards to Making health easy to understand (health literacy)
- Full implementation of the clinical governance committee structure and the establishment of an effective communication and reporting framework, ensuring clinical assurance and the sharing of learnings across the sector.
- Development and sharing of the Quality dashboard with FRAC, Clinical Council and all staff.
- Implementation of the new Integrated Risk Management System across the DHB by end of June 2018.
- Finalisation of programme of work in regards to the Consumer Engagement Strategy, Patient Stories policy/process and the effective gathering and use of Patient Experience feedback.
- Continue to grow the capability of clinical teams across the sector ensuring a sustainable improvement and accountability model going forwards.

RECOMMENDATION:

That the HB Clinical Council, HB Health Consumer Council and Finance Risk and Audit Committee

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

Appendix 1 – Quality Plan 2017-18 Update Report

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Timeframe	Progress Report
Wellness	Ensure that our systems of communication are responsive to the people of Hawke's Bay	Implementation of Health Literacy Framework	Action plan developed and monitored on a monthly basis through Transform & Sustain programme report	Q4	Action and project plan in place. Framework endorsed. Toolkits and support documentation developed and tested with user group. Introductory video explaining "Making Health Easy to Understand" developed. Work underway in specific projects including Customer Focussed Booking, respiratory programme, PHO programmes of work.
	Improving the Communication between health professionals and the consumer	Implementation of HL Training programmes to support clinicians to understand how to best engage with consumers	Training programmes developed and utilised	Q2	Introductory Health Literacy video developed. Training programme being developed and will be used in orientation. Relationship Centred Practice (RCP) training programme launched March 2017. As at 31 Dec 2017, 197 staff had completed face to face RCP workshop training, 31 staff have completed the online e-learning modules. Additional training sessions are planned for March and May 2018.
	Presentation of quality health information	Review of information provided to patients on admission and on discharge, with a view to making improvements.	Plan developed and implemented with improved patient responses to national patient experience survey	Q3	Patient Experience project brief developed. Met with MRB 12/17 and feedback gathered regarding mechanisms to gather patient experience information. Big Listen workshops and the CSP patient journey workshops identified as potential mechanisms moving forwards alongside the national patient experience survey and the potential development of a local patient experience survey.

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Timeframe	Progress Report
Monitoring & Measuring	Ensuring that quality improvement and safety reporting and monitoring is provided and communicated effectively	Ensure reporting of Serious Adverse Events and ACC Treatment Injury information is completed with learnings identified and recommendations implemented.	SAE Report provided annually	Q2	Completed. New National event reporting policy endorsed and currently updating and refreshing our local policy and process to meet with the new standards and requirements. 6 monthly report to be provided to EMT in February. Patient Safety Learnings developed with all clinical teams to ensure learnings are shared.
		Implementation and completion of work in Primary Care relating to misdirected results.	Action plan developed and implemented leading to reduction in number of issues relating to mis-directed results to GP Practices	Q2	Ongoing project of work. Working with PHO, IT, Administration, Pharmacy and Labs to identify the core issues and sustainable solutions.
		Align to new national event reporting policy and review of new investigation process	New investigation process in place with all staff having received training	Q4	New event reporting process and policy under development and endorsed by the Clinical Event Advisory Group. Will be implemented in March/April 2018.
		Implementation of an Adverse Events reporting framework for Primary Care	Framework developed and implementation of training and tools to support Primary Care.	Q3	Patient Safety Advisor working with Improvement Advisor attached to Primary Care to support this piece of work. Supported by the PHO Clinical Advisory Group
		Development of a quarterly sector wide quality dashboard focussed on IOM core dimensions of quality	KPI's developed	Q2	HQSC Quality Dashboard under development and first draft will be shared with FRAC in March. Work to be undertaken to be able to present this information in a useful format so that comparison can be made against other Central Region DHBs and at a national level.
		Implementation of new clinical governance	Committees established, with TOR, cross sector representation	Q2	Further discussion to be undertaken with Clinical Council in February before finalising advisory group structure. Clinical Committees (5) reporting directly

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Timeframe	Progress Report
		committee's structure to ensure effective reporting			to Clinical Council all endorsed and terms of reference developed.
		Implementation of all HQSC Quality safety marker programmes	Maintain and improve DHB positions against all markers	O1 – Q4	Continue to participate with all relevant HQSC markers. New HQSC dashboard will be shared with FRAC and Clinical Council moving forwards on a regular basis to provide greater visibility of performance.
		Ensure implementation of an effective morbidity and mortality monitoring framework and audit process	Process and reporting framework established Ongoing monitoring of HSMR	Q1	Completed. Data provided to relevant clinical groups and ongoing monitoring of performance undertaken through review of Health Roundtable data and the HQSC quality dashboard.
		Facilitate and lead the implementation of a new Integrated Risk Management System in DHB & Primary Care.	Project plan developed and implemented	Q2 – Q4	Contract signed with RL Solutions. Project plan developed with implementation of new system by June 2018 in DHB and thereafter a rolling implementation programme with Primary Care.
Working With HB Community & Patient Experience	Improving clinical oversight in all provider contracts	Consider the development of a mechanism to collect information to monitor quality and safety within our contracted providers	Ensure appropriate reporting processes in place	Q4	Continue to develop this mechanism with contracts team – yet to be finalised.
	Improving the process of gathering patient experience data and stories, sharing them widely across the sector.	Continue to participate in the National Patient Experience Survey	Communication & Awareness building strategy implemented	Q1	Continue to participate. Patient Experience project will ensure that we are able to gather patient experience feedback in multiple ways which can be shared with governance groups and the relevant directorates and services to ensure improvements are implemented.

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Timeframe	Progress Report
		Support the implementation of System Level Measures relating to Patient Experience	Effective implementation of National Patient Experience survey in Primary Care and the effective sharing of results	Q3	As at 30 June 2017 26 practices had systems in place to participate in the HQSC Primary Care Patient Experience Survey. As at January 2018 HQSC Inpatient experience survey transitioned to fortnightly. HBDHB and HHB working together to ensure joint analysis and reporting
		Development and implementation of a local patient experience survey aligned to the values of the sector ensuring survey reflects our population.	New local experience survey in place Results shared on a quarterly basis	Q3	Patient Experience project brief developed. Met with MRB 12/17 and feedback gathered regarding mechanisms to gather patient experience information. Big Listen workshops and the CSP patient journey workshops identified as potential mechanisms moving forwards alongside the national patient experience survey and the potential development of a local patient experience survey.
		Implementation of new complaints management process	New processes in place with reporting/monitoring implemented	Q3	Policy and process refined. Frontline complaints management training to be delivered by HDC 2018. Await implementation of the new Integrated Risk Management system to enable further enhancements.
		Identify a variety of mechanisms to engage effectively with our Community around health matters to gather their feedback and ideas	Identify provider to support effective community engagement and implement programme	Q4	Phase 2 of Consumer Engagement Strategy will be to develop business case for community engagement platform
		Implementation of a Consumer Engagement framework and guideline for all staff.	Guidelines, tools and training completed	Q2	Co-design toolkit developed by WDHB available for use. Working with MRB to develop guidelines specifically for engagement with Maori and hard to reach communities

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Timeframe	Progress Report
					Recognising consumer participation policy developed. Consultation with stakeholders underway
Leadership & Workforce	Improving workforce engagement	Implementation of GEMBA Walks	Agree approach and purpose & implementation plan	Q3	Work still to be undertaken – links with the feedback from the Big Listen and will provide a mechanism to increase leadership visibility.
		Clinical Documentation Improvement Programme	Reduction in patient complaints Improvement in Certification report	Q2 & Q4	Ongoing work being undertaken to improve documentation quality. Education sessions held through Buddle Findlay. Mid-point certification Surveillance undertaken 23-25 January 2018.
		Certification – Midpoint surveillance audit	Audit completed with reduction of corrective actions	Q2	Corrective actions completed with a small number still outstanding. Mid-point certification Surveillance undertaken 23-25 January 2018
		Choosing Wisely Campaign	TBD	Q4	CMDO to lead this piece of work. Priority at present on the HQSC Deteriorating patient programme and consideration of implementation of this overarching programme of work to be determined in June 2018. Work is underway within Pharmacy and Labs to ensure the principles of "Choosing Wisely" are incorporated into policy, guidelines and procedures.

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Clinical Portal Implementation Business Case**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner	Anne Speden, CIO
Document Author(s)	Michael Sheehan, Clinical Portal Implementation Project Manager
Reviewed by	Ken Foote, Company Secretary; Keith Buckley, IS Transition Manager; and Executive Management Team
Month/Year	February, 2018
Purpose	Approval of the Clinical Portal Implementation Business Case that will span two (2) financial years - 2017/18 & 2018/19
Previous Consideration Discussions	Approval from Boards across the Region to proceed with the development of a regional solution (previously called CRISP & RHIP) was provided in 2011. The Clinical Portal Implementation follows on from that decision with the implementation of Clinical Portal and Radiology Information System (RIS) components of the Regional Solution
Summary	The recommendation is that the Business Case is approved. This is in support of realising the benefits of the Regional Solution for the regions health care. Approval of the Business Case also realises a return on HBDHB's investment in the Regional Solution and supports progress towards a single electronic health record (eHR).
Contribution to Goals and Strategic Implications	The Project contributes to the organisational goals by: • Improving the quality of care through the presentation of patient clinical information in one portal • Improving the health of our population by having patient notes available wherever they may present • Enabling efficiencies by sharing the cost of clinical systems across the region and providing a consistent interface for clinicians to access information
Impact on Reducing Inequities/Disparities	CP version 2.3 for HBDHB is externally developed and not yet available. The Health Equity Assessment Toolkit (HEAT) would be used to explore equity considerations in further detail once the product is available to HBDHB, in second calendar quarter 2018.
Consumer Engagement	The RHIP Regional Steering Group has provided input to the design and functionality of CP and RIS. A number of consumer representatives sit on the RHIP Regional Steering Group and one of the consumer representatives is from the Hawkes Bay. As a result, there has been consumer representation and local engagement in the development of the products.
Other Consultation /Involvement	Clinical engagement & leadership continues to have significant input and involvement in CPs development. This has been led by Whanganui's CMO supported by a range of clinical representation from all the region's DHBs.

	HBDHB continues to have strong, proactive clinical & technical involvement.
Financial/Budget Impact	No additional capital is required. It has been agreed that the capital budget for Clinical Portal Implementation 2017/18 & 2018/19 will be funded from the IS Capital allocation. This is was supported by the Executive Director Corporate Services. The IS Governance Group (chaired by Sharon Mason) are across the key program priorities which included this implementation. The capital budget for 2017/18 & 2018/19 have the support of Executive Director Corporate Services. **Capital Costs** FY 2017/18 $651,578 FY 2018/19 $633,141 Total Capital Estimate $1,284,719 The operational budget allocation for 2017/ & 2018/919 have the support of Executive Director Corporate Services and is less than the pre-project estimate of $368,000 per financial year **Operating Expenditure** FY 2017/18 $262,500 FY 2018/19 $258,544 Total Operating Estimate $521,044
Timing Issues	Current targets for the implementation of CP (including RIS) are: Dec 2017 - VPN connection to Regional Solution - Complete April '18 - Clinicians view regional clinical information in CP June '18 - Clinicians view regional & local clinical information in CP June '18 - Progressive rollout of CP functionality, including RIS, across the DHB, in consultation with Operations, Clinical Council, clinicians & IS.
Announcements/ Communications	A Communications Strategy is currently in development as an asset for the CP Project alongside monthly communications planning sessions with the HB Communications Manager. Key communications points are initially based on the April & June dates shown in the Timing section above. Further communication plans & details for activities after June will be developed once the post June project time line is completed. All communications activities are being developed in conjunction with the HBDHB communications team.

RECOMMENDATION:

It is recommended that the HB Clinical Council, HB Health Consumer Council and HBDHB Board:

1. **Note** that the Clinical Portal Implementation Business Case implements the regional solution that has been funded by the regional DHBs including Hawke's Bay DHB
2. **Approval** of the Clinical Portal Implementation Business Case.

Approval of the Clinical Portal Implementation Business Case

Author:	**Michael Sheehan,**
Designation:	**Project Manager for Clinical Portal Implementation**
Date:	**February 2018**

PURPOSE
The purpose of this paper is to obtain approval of the Clinical Portal Implementation Business Case

BACKGROUND
The region's six DHBs have been funding the development of the Regional Solution including Clinical Portal and RIS.
Progressively from June 2016, Whanganui and Mid Central DHBs have been migrating to the Regional Solution with their completion due in February 2018. Migration planning for Wellington's three DHBs is underway and they will begin their migration processes in the first calendar quarter this year.

From June 2018, Clinical Portal & RIS will be available for Hawke's Bay DHB to implement. Planning is underway and a progressive roll out approach is being taken to distribute and minimize any potential impacts and risks. WebPAS, as the third component of the Regional Solution, will be considered after the completion of the Clinical Portal Implementation Project.

In April our clinicians will be able to view regional patient data in Clinical Portal. June will show Hawke's Bay's own patient data in Clinical Portal. This will be followed by a progressive rollout of Clinical Portal functionality across Hawke's Bay DHB. Prioritisation and timing for the rollout will take place in consultation with Operations, Clinical Council, clinicians & IS.

RECOMMENDATION:

It is recommended that the HB Clinical Council and HBDHB Board:

1. **Note** that the Clinical Portal Implementation Project implements the Regional Solution that has been co-funded by the regions DHBs
2. **Approve** the Clinical Portal Implementation Business Case.

ATTACHMENTS:
- Clinical Portal Business Case (January 2018)
- Board Minutes Extract (21 December 2011), to proceed with CRISP

Better Business Cases

Clinical Portal Implementation

Prepared by:	M Sheehan
Prepared for:	A Speden, T Evans
Date:	01 February 2018
Version:	1.0
Status:	Released for EMT

Business Cases
Clinical Portal Implementation

Document Control

Document Information

	Position
Document ID	
Document Owner	M Sheehan
Issue Date	01/02/2018
Last Saved Date	01/02/2018
File Name	Clinical Portal Implementation Business Case v1.0

Document History

Version	Issue Date	Changes
1a	12/01/18	First draft
1b	17/01/18	Format & additional content
1c	26/01/18	Feedback & Executive Summary
1.0	01/02/18	Released for EMT

Document Review

Role	Name	Review Status
Company Secretary	Ken Foote	
Chief Information Officer	Anne Speden	
Head of Contracts	Ashton Kirk	
IS Transition Manager	Keith Buckley	
Management Accountant	Barry King	
Project Management Office Manager	Kate Rawstron	

Document Sign-off

Role	Name	Sign-off Date
Project Manager	M Sheehan	
CIO	A Speden	
ED Corporate Services	T Evans	

Contents

Executive Summary

Significant investment has taken place to deliver Clinical Portal as the future facing platform for Hawke's Bay DHB, the Region and the patients in our care. This new Regional Solution platform, agreed to in 2011 and previously known as RHIP, delivers access to patient clinical information for all clinicians across the Region. The option endorsed by this Business Case is to fund the implementation of Clinical Portal for Hawke's Bay DHB in order to deliver on the five original key investment objectives from 2011:

- Consolidated view of patient clinical information across Regional DHB providers
- Enable workforce flexibility to work across providers
- Standardise core processes and procedures
- Move to a high availability regional structure to support 24/7 operations
- Bring all providers up to minimum supported levels

These five key objectives will be enabled through the delivery of the Clinical Portal Implementation Project providing a modern, base platform from which we can advance.

The Project team has invested significant time and effort in planning the initial stages and will begin progressive rollout for Hawke's Bay DHB clinicians in April with a targeted completion in December 2018 as agreed. This progressive rollout approach has been adopted due to lessons learned from Mid Central and Whanganui where a "Big Bang" all at once approach initially proved disruptive for clinical teams and hospital operations.

No additional capital is required for the implementation of Clinical Portal. The budget for this phase of implementation was not originally scoped, defined or allocated. It has now been agreed that the capital budget for Clinical Portal Implementation 2017/18 will be funded from the IS Capital allocation. This decision was supported by the Executive Director Corporate Services. The IS Governance Group (chaired by Sharon Mason) was established in mid-2017 and are across the key program priorities for 17/18 which included this implementation.

Capital requirements for 2018/19, shown below, will again be funded from IS capital allocations.

The IS operational budgets for 2017/18 and 2018/19 has been allocated, as shown in below, and are less than the $368,000 originally indicated prior to this project being scoped.

		FY 2017/18	FY 2018/19	Totals
Capital expenditure	*Additional detail are in the Financial Case section*	**$ 651,578**	**$ 633,141**	**$ 1,284,719**
Operating expenditure		**$ 262,500**	**$ 258,544**	**$ 521,044**

The following structures and activities are in place and underway to support our Clinical Portal Implementation. These include the following:

- Project reporting to IS Senior Leadership Team, Transform and Sustain, FRAC
- Oversight structures in place with broad clinical representation
- Engaged with 32 clinical subject matter experts to inform ECA to Clinical Portal shift
- Risk mitigation and innovative communication plans underway
- A process to identify, triage and stream policy, procedure and patient safety elements to the People and Quality team has been agreed
- IS resources now fully engaged and focused on the project delivery
- New staff have been recruited to supplement and support the existing IS Team skillsets.

In addition, Hawke's Bay DHB's approach and engagement across the Region has enabled:

- An external review to advance the performance and stability of the Regional Solution
- Alignment of final Clinical Portal functionality to our progressive rollout plan
- Agreed bulk funding for Orion to enable agile development and faster delivery
- Dedicated Orion development team
- Strong supplier partner engagement and commitment to our delivery timelines
- Central Technical Advisory Service (CTAS) has agreed to fund clinically led service design workshops to define future functionality and advancements of Clinical Portal
- Orion has approached Hawke's Bay DHB to act as a clinical product development review site, one of only two in the country.

It is the recommendation of this Clinical Portal Implementation Business Case that the Board approves this Business Case to implement Clinical Portal and realise the benefits of the original investment.

Introduction

This Clinical Portal Business Case seeks formal approval from the Board to fund the Clinical Portal implementation (Clinical Portal previously known as CRISP and RHIP) for Hawke's Bay District Health Board (Hawke's Bay DHB). This follows the decision in 2011, by Boards across the Region, to proceed with the development of a regional solution (The Hawke's Bay DHB Board's "Minutes Extract 21 December 2011" is attached in the Appendices, reflecting this decision).

This business case follows the Treasury Better Business Cases guidance.

Strategic Case

The strategic context

At the time of the decision to proceed with the Regional Solution known as CRISP, the Central Regional Information Plan (2011) stated "The proposed regional system has tightly integrated patient administration and clinical workstation functionality; available through a single clinical applications portal…designed to support a single patient shared care record available to clinicians across the region at the right time and place."

The document goes on to say "The founding principle of the Portal is to provide users with a single log in to patient vitals, clinical documentation, patient demographics, patient administration and a shared care record. The system also supports the sharing of clinical information between all health care providers and the patient within a robust privacy and access model that is fully audited."

Following on from these strategic statements of intent, this Business Case for Clinical Portal Implementation is the final stage to realise the benefits, for Hawke's Bay DHB, of the original decision and gain a return on the investment in the Regional Solution with better access to patient information and improved health outcomes for our population.

The case for change

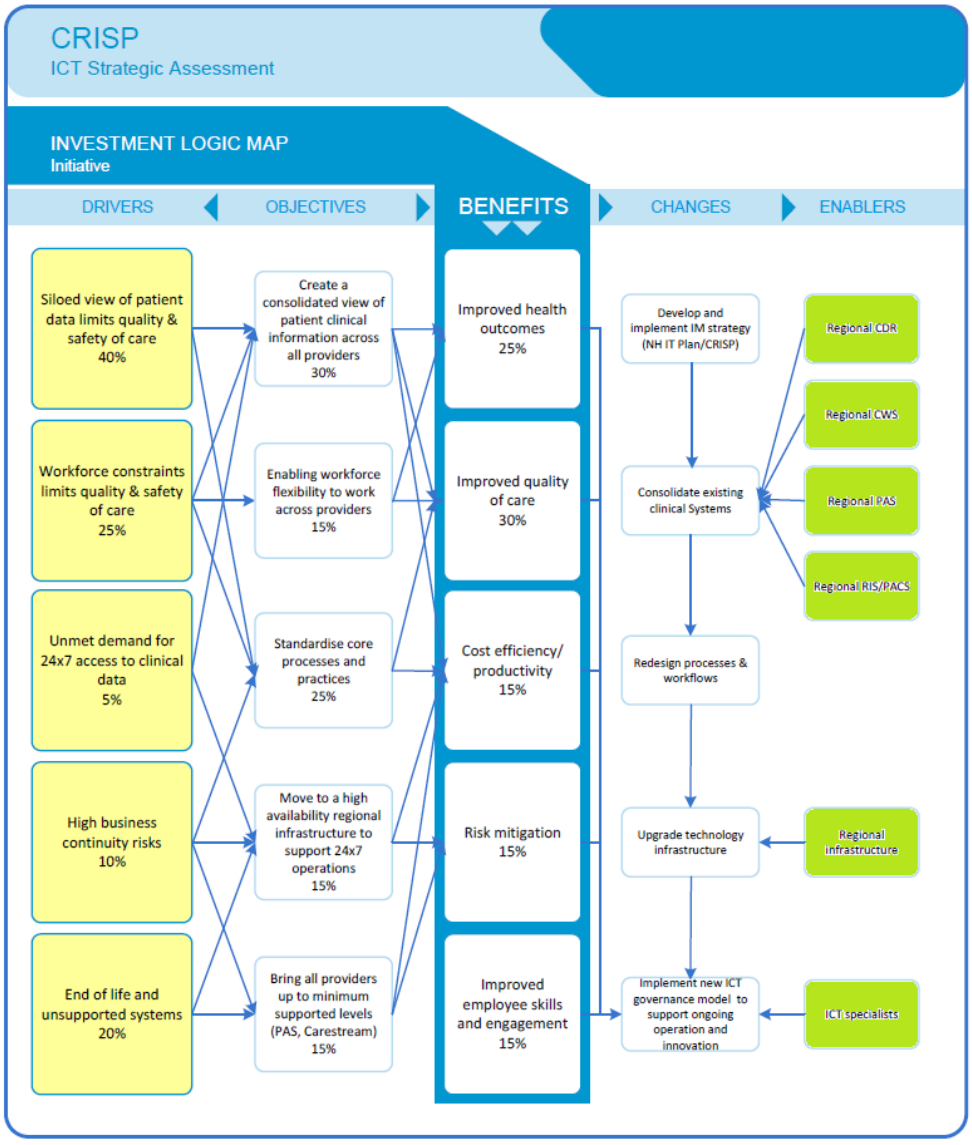
The original CRISP Phase 1 proposal highlighted the need to move the Region's DHBs from a then current state of disparate, fragmented, and in some cases obsolete, clinical and administrative information systems.

The objective was a future state of shared, standardised and fully integrated information systems that would enhance clinical practice, drive administrative efficiencies, enable regionalisation of services, reduce current operational risks and enhance patient care.

The key aims of CRISP were to deliver a clinical framework through the delivery of key enablers being:

- Regional CDR - Now available (known as medical documents, tests, results etc.)
- Regional CWS - Now available (known as the Clinical Portal))
- Regional PAS - Now available (out of scope for the Clinical Portal Implementation)
- Regional RIS/PACS - Now available
- Regional Infrastructure - Now available
- ICT Specialists - Now available

The Investment Logic Map from 2011, shown below, highlights all planned key enablers in green as now being available and operational. The Clinical Portal Implementation project for Hawke's Bay DHB takes up all enablers with the exception of Regional PAS. A significant reason to exclude PAS at this stage was the risk inherent in changing all foundational clinical systems for Hawke's Bay DHB at one time. Regional PAS may be considered for implementation after Clinical Portal rollout is complete.



In addition, the Clinical Portal Implementation provides a foundational capability for the region to improve integration across primary/community and secondary/tertiary providers, introduce mobility, interoperate with other national data repositories and implement shared care records which is also in alignment with the Transform and Sustain strategy.

Original key CRISP stakeholders identified five investment objectives for the regional development to take place:

- Consolidated view of patient clinical information across providers
- Enable workforce flexibility to work across providers
- Standardise core processes and procedures
- Move to a high availability regional structure to support 24/7 operations

- Bring all providers up to minimum supported levels

These five investment objectives will be realised through Clinical Portal Implementation.

In addition, as a secondary care facility, Hawke's Bay DHB have a number of patients that need to travel within the Region for tertiary level care. With current disparate systems, viewing clinical tests, results and discharge summaries from other facilities is challenging. With Clinical Portal, an immediate benefit will be the availability of patient information from across the Region for all clinicians involved in a patient's care. This means a Hawke's Bay DHB clinician can view and monitor a patient's treatments and progress in other Regional facilities and review tests, results, clinical notes and discharge summaries on the patient's return to their care.

Clinical Portal also provides us with a future facing extendable platform which the Region can enhance for integration with Primary Care Partners and additional modules to better serve patient and clinical needs.

Economic Case

A range of options were identified and short-listed by IS stakeholders. As a result the Hawke's Bay DHB CIO and Executive Director of Corporate Services endorse option three, below, as the preferred way forward.
The following short-listed options were selected for analysis in this business case:

Option one: Status quo of Staying on ECA (retained as a baseline comparator)
This option has Hawke's Bay DHB remain on its current ECA system.
This system has been heavily customised over many years, often to the needs of micro groups within the DHB. The interface is unique to Hawke's Bay DHB, has a steep learning curve with high training needs and is often described as unintuitive and obsolete.
In addition:

- ECA has become more brittle and will require significant efforts, and costs, to bring into alignment with modern approaches, technologies and practices
- The costs and risks associated with the ongoing support of a bespoke legacy system are likely to increase
- ECA has an internal focus and does not support the availability of patient notes, presentations, tests and results to support patients receiving appropriate care wherever they may present within the region
- Continued use of ECA keeps Hawke's Bay DHB on bespoke locally modified systems rather than meeting the objective of moving to standardised, interoperable, core Regional Solutions
- This option does not fulfil any of the original CRISP (2011) Investment Logic Map objectives.

Option two: Install a local Hawke's Bay DHB Clinical Portal
This option has Hawke's Bay DHB purchasing and installing its own stand-alone instance of Clinical Portal along with the associated infrastructure.
This allows Hawke's Bay DHB to migrate clinical functionality from ECA to a local Clinical Portal similar to the regional solution while being independent of the region. While viable, Hawke's Bay DHB would:

- Be spending additional funds on a new local portal solution that has already been funded through supporting the Regional Solution
- No longer support the visibility of patient information across the region for improved patient care and outcomes
- Be removed from the shared funding approach for advancement of the Regional Solution, placing full future development costs back on to Hawke's Bay DHB

- Become isolated from the country wide progress of moving towards a single instance of Clinical Portal per region.
- This option meets two of the original CRISP (2011) Investment Logic Map objectives for only as long as the local solution mirrors all development that takes place in the Regional Solution.

Option three: Fund the Clinical Portal Implementation (the preferred way forward)
This has Hawke's Bay DHB continuing with the 2011 agreement to bring the region on to a common and unified platform.
This also provides:

- Consolidated view of patient clinical information across providers
- Enable workforce flexibility to work across providers
- Standardise core processes and procedures
- Move to a high availability regional structure to support 24/7 operations
- Bring all providers up to minimum supported levels

This delivers on all of the original five investment objectives that drove the establishment of the Regional Solution.

Options Analysis

The three business options presented are all possible. A key point in assessing the viability of these options is the decision to fund the Regional Solution and an assumption that the Regional Solution will deliver the enablers and realise the five investment objectives as per the Investment Logic Map. An additional assumption is that Hawke's Bay DHB will want to realise a return on its investment in the Regional Solution.

Option 1 to remain on the current system will not realise any of the investment in the Regional Solution that Hawke's Bay DHB has contributed to. Nor will it deliver on any of the objectives As a result, any investment to date would be a sunk cost with no benefits or returns realised for Hawke's Bay DHB. Additional costs will be incurred in order to maintain ECA.

While being the most viable alternative to the Regional Solution, Option 2 carries costs with the need to establish a regional like solution internally for Hawke's Bay DHB. This approach would also deliver only two of the five objectives of the planned Regional Solution. These two objectives will only be fulfilled if the local solution remains in development lockstep with the Regional Solution's development. Investment to date, in the Regional Solution, would be a sunk cost and Hawke's Bay DHB would remove itself from the shared funding development model the Regional Solution offers.

The recommended option is to proceed with Option 3 as it will realise a return on the investment to date of the Regional Solution and share the costs of future enhancements. It will also align Hawke's Bay DHB, and Central Region, to the emerging common platform of Clinical Portal across New Zealand's DHBs and deliver on the five objectives of the original development efforts.

In addition, the regional RIS solution enables a regional wide workflow where the imaging/modality can be completed in one DHB with the interpretation and reporting by radiographers completed at any DHB within the region. This distributed workflow has the potential to leverage a pool of radiographers, on the proviso that the staff resources are available to meet that demand.

Commercial Case

The approach to developing the Regional Solution was defined in 2012. It is an externally hosted solution shared across six DHBs with a point of escalation for system support based out of Capital & Coast DHB. The development of the solution has been in conjunction with Orion Healthcare and with Central Technical Advisory Services (CTAS) providing Regional project management.

The procurement strategy for the Clinical Portal Implementation at Hawke's Bay DHB is to:

1. Use internal staff where possible to leverage existing knowledge and to up skill staff in the Regional Solution. This builds internal intellectual property (IP) that remains with the organisation post project completion.

2. Fixed term staff will be used to supplement internal skills where additional resources are needed for capacity reasons. Broader skill sets will also be hired, such as Project Management and training, that will address any temporary shortfalls. All hiring goes through the appropriate approval process with signoff by both the Hawke's Bay DHB CIO and ED Corporate Services as appropriate

3. Third parties will be contracted in to do specialised one off pieces of work. As an example, Orion Health are performing data analysis work in preparation for migrating Hawke's Bay DHB data into Clinical Portal, which is one of Orion's products. These third party arrangements, and any associated contracts, have been confirmed as appropriate, in consultation with Hawke's Bay DHBs' Head of Contracts.

Project Plan

Planning for the implementation of Clinical Portal and RIS has begun.

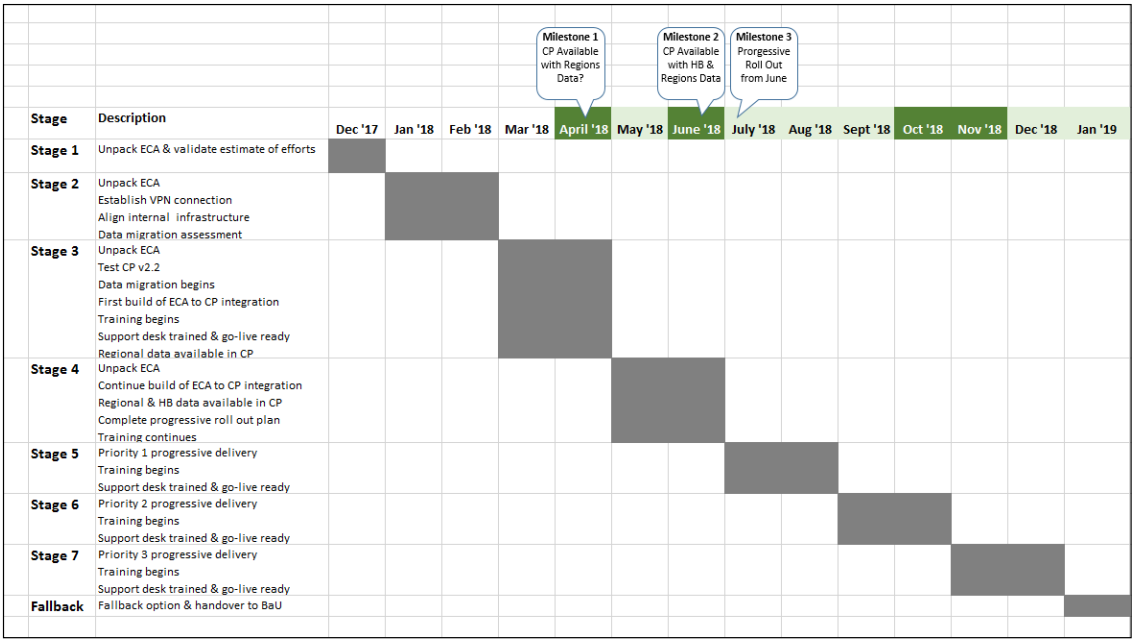
Rollout Options

Both "Big Bang" and progressive rollout options were explored. The key lessons learned from Mid Central and Whanganui, where a "Big Bang" approach was taken, were:

- Elevated patient safety concerns
- Elevated workloads for some staff
- Large amount of training for patient facing staff across tight timeframes
- Some disruption for clinical teams and the organisation
- Significant increase in peak loads on the Regional Solution

As a result of the lessons learned from Mid Central and Whanganui, a progressive rollout approach has been taken. This is to contain disruption, risks and short term negative impacts. It also has the benefits to spread the required training over a set of lower intensity sessions that have a lower impact on staffing and the organisation.

A high level view of the project plan is shown below.



High level view of the Clinical Portal Project plan

IS have committed to our Chief Executive Officer (CEO) and the Board for the delivery of three Clinical Portal Implementation milestones:

Milestone	Date	Description
Milestone 1	April 2018	Hawke's Bay DHB clinicians view available regional data in Clinical Portal
Milestone 2	June 2018	Hawke's Bay DHB clinicians view regional and Hawke's Bay DHB clinical data in Clinical Portal
Milestone 3	June through December 2018	Progressive roll out of functionality across Hawke's Bay DHB from June through December.

Note the prioritisation of the progressive role out will be made in collaboration with Operations, Clinical Council, clinicians and IS to address a range of challenges such as peak seasonal presentation times, staff availability and technical interdependencies.

Training

The progressive approach to the Clinical Portal rollout supports a lower intensity training approach. Our first Milestone of viewing Regional data in Clinical Portal provides for low impact training to cover logging on and searching for patients. This builds familiarity with the Clinical Portal interfaces. We add to this with Milestone 2 by viewing local patient data and viewing information such as tests, results and discharge summaries. This means that as we progress the rollout there will already be a level of familiarity with interfaces and menus. This forms the foundation that further progressive training builds on. This approach also allows us to bring elements of training in-house to contain costs.

Financial Case

Costs to develop the Regional Solution for the region's six DHBs were agreed to at Board level in 2011. These allocated funds have covered the solution development to Version 2.3, the version Hawke's Bay DHB is planning to implement. Implementation costs are the responsibility of each individual DHB.
The project to implement Clinical Portal will span two financial years being 2017/18 and 2018/2019 and this is reflected in the budget estimates below.

Capital and Operational Budgets

Capital Budget

No additional capital is required for the implementation of Clinical Portal.

Prior to this project, the capital budget for implementation had not been scoped, defined or allocated. It has now been agreed that the capital budget for Clinical Portal Implementation 2017/18 will be funded from the current IS capital allocation. This decision is supported by the Executive Director Corporate Services. The IS Governance Group (chaired by Sharon Mason) was established in mid-2017 and are across the key program priorities for 17/18 which included this implementation

The capital budget for Clinical Portal Implementation 2018/19 will also be funded from the IS capital allocation supported by the Executive Director Corporate Services. The IS Governance Group will prioritise key IS program activities across 18/19 in support of this high priority implementation.

Operational Budget

The operational budget for Clinical Portal Implementation in 2017/18 and 2018/19 are as shown below. The operational expenses are less than the $368,000 originally estimated, prior to this project.

Budget Estimate Details

		FY 2017/18	FY 2018/19	Totals
Capital expenditure	Description			
	Fixed Term Staff & Contractors	$ 305,839	$ 198,710	
	Existing Internal Staff	$ 194,254	$ 284,887	
	Training Planning & Coordination	$ 47,779	$ 83,544	
	Travel & Accommodation	$ 31,800	$ 43,200	
	Hardware & Services	$ 71,906	$ 22,800	
	Totals	**$ 651,578**	**$ 633,141**	**$ 1,284,719**
Operating expenditure	Description			
	Project Manager - non delivery time	$ 42,148	$ -	
	Training - Internal	$ 43,700	$ 83,544	
	Training - External	$ 63,452	$ 55,000	
	Applications / development & support backfill	$ 87,200	$ 120,000	
	Software & Support	$ 26,000	$ -	
	Totals	**$ 262,500**	**$ 258,544**	**$ 521,044**

Investment Appraisal

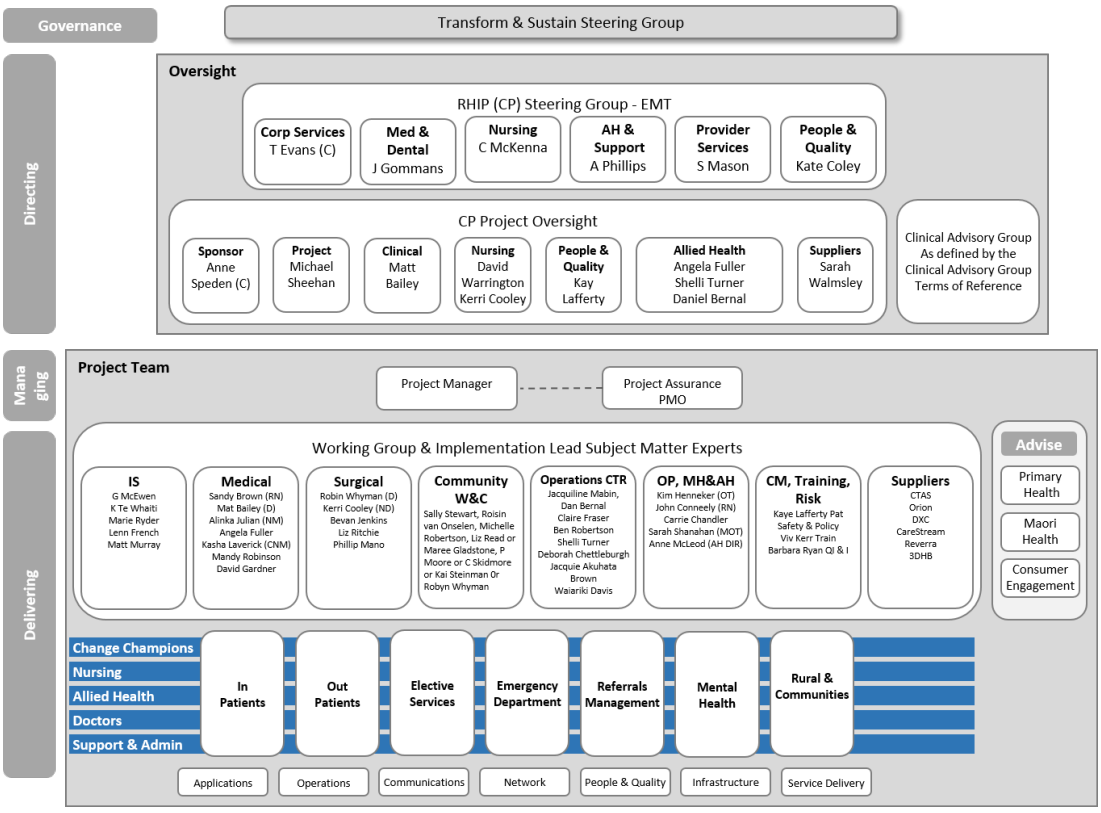
The aggregated benefits of implementing Clinical Portal across the region are the patient health outcomes, a standardised interface and the shared cost model to further enhance the new base platform the Clinical Portal project will deliver. These benefits reflect an ongoing long-term investment in supporting the Hawkes Bay's, and the wider regions, ongoing healthcare by enablement through modern and appropriate solutions.

The capital investment required for the implementation of Clinical Portal (and RIS) for Hawke's Bay DHB reflects the final stage of a program of work than began in 2011, to provide a region wide, modern digital platform. This platform sets a level across the region from which the region can drive efficiencies and clinically led enhancements for advancing patient care and outcomes.

Management Case

In the event that this Business Case receives formal approval, the project will proceed with the delivery of the regional Clinical Portal and RIS solutions. The project will be managed using the Prince2 project management methodology.

The relevant project management and governance arrangements are proposed as follows:



Project Organisational Chart

Structured Meetings

- The IS Team Leads and Project Manager meet weekly to plan, review, discuss and advance the Clinical Portal Implementation Project

- The Project Working Group & Implementation Subject Matter Experts are meeting monthly to provide detail and feedback on how ECA is used by staff
- The Clinical Portal Implementation Project Oversight Group will meet monthly from February to provide project oversight, focused Project steerage and inform solutions to challenges along the way.
- The project will consult with the Steering Group to identify their meeting requirements. This group will provide strategic oversight and influence. They will also be consulted regarding an appropriate approach to progressive roll out planning

The IS Project team has invested significant time and effort in planning the initial stages of the Clinical Portal Implementation Project. Progressive rollout for Hawke's Bay DHB clinicians will begin in April with a targeted completion in December 2018 as agreed. This progressive rollout approach has been adopted due to lessons learned from Mid Central and Whanganui where a "Big Bang" all at once approach proved disruptive and for some clinical teams

Progressive Roll Out

The progressive roll out may take the form of a function by function, group by group or service by service approach. This will be informed by technical dependencies and process sequencing bought to light by the ECA "unpacking". Once IS has a fuller understanding of the possibilities we will work with stakeholders, including Operations, Clinical Council and clinical groups, to identify the most effective approach to the rollout.

Reporting

The Project Manager provides the following reports:

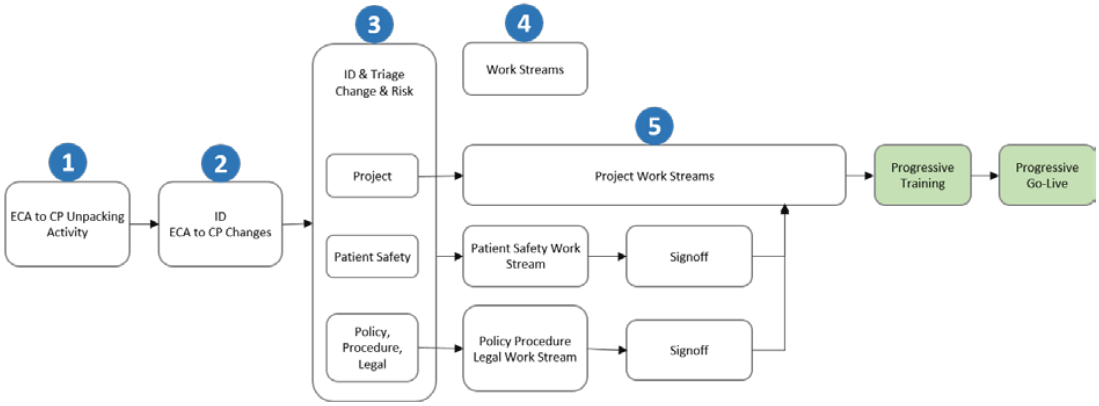
- Fortnightly reports to the IS Senior Management Team (SMT)
- Monthly reports to Transform and Sustain (T&S)
- Reports to Finance Risk and Audit Committee (FRAC)

Change

The plan for dealing with change has been scoped with the People & Quality Team. The agreed approach to be taken is:

1. Project team identifies activities in ECA by "unpacking" staff's daily activities
2. The results of "unpacking" are documented and compared to corresponding actions in Clinical Portal and identify change
3. A triage group, comprised of IS and People & Quality staff will triage all changes for policy, procedure, legal and patient safety matters
4. These changes will be streamed to the appropriate teams and people, elevating them to others as required, to be managed, approved and addressed with staff
5. These resolved change streams will then feed back into the projects training program as part of the progressive roll out.

A process flow is shown below.



Process for tracking and managing identified change

Risk

The strategy and plan for assessing and managing risk is underway. The following key risks have been identified from the initial analysis:

Main Risks	Consequence (H/M/L)	Likelihood (H/M/L)	Comments & Risk Management Strategies
Change to clinical systems and interfaces impact on patient safety as clinicians will be working with an unfamiliar product, & a new interface	H	M	The project is working with People & Quality team to identify scale & scope of change in support of Patient Safety. Once assessed, training will be built to mitigate against impacts.
Internal reputational risk with staff	M	M	Consultation & communications across our 2501 clinicians is underway. This will be followed with a range of training prior to rollout. The organisation will need to support the time & effort required of staff to ensure they are fully supported throughout training & the ECA to Clinical Portal migration.
Internal Change Management	M	M	Clinical Portal represents an elevated amount of change for staff that interact with clinical information. A process to identify change is in place to allow it to be managed at the appropriate point in the organisation e.g. clinical, policy, legal etc. This approach will be refined throughout the project to ensure it adapts the change management needs.
External business reputational risk with suppliers & partners	M	L	Clinical Portal is initially an internal facing implementation. The DHB has taken a strategic partnership approach with our suppliers & we are collectively focused on a collaborative & successfully delivery.
Community Reputational Risk	M	L	As part of the communications plan, preparation to communicate with the wider Hawke's Bay is being considered, with mitigating actions is required
If the delivery of Version 2.1 is delayed it may	M	L	The project, with the Hawke's Bay DHB CIO, are actively engaged with TAS and

impact the project's progressive rollout timeline, pushing back completion dates.			Orion Health to underpin the importance of Hawke's Bay DHB delivery timelines. All parties are committed to the milestones & the project will continue to monitor & report.

The objective is to manage risks by working collegially and collaboratively with our clinical, People & Quality and Communications teams to minimise the potential of an occurrence and mitigate any impacts if something should occur.

The Regional Solution has also had initial performance challenges. CTAS developed a "Consolidated Regional Improvement Plan" as a result of initial concerns. This action plan has delivered progressive improvements of the Regional Solution across a number of areas. The Clinical Portal Project, and Hawke's Bay DHB's IS team, will continue to monitor progress to ensure the Regional Solution is ready for Hawke's Bay DHB to on-board to and progressively go live.

Communications

An overall communications strategy is in draft format and being further developed with the Hawke's Bay DHB Communication Manager. The communications plan is aligned to the three key milestones and the progressive rollout approach.

Investment Logic Map Benefits

The original Investment Logic Map showed five benefits of proceeding with the Regional Solution. There were:

- Improved health outcomes 25%
- Improved quality of care 30%
- Cost efficiency/productivity 15%
- Risk Mitigation 15%
- Improved employee skills and engagement 15%

The shown benefits and associated percentages reflect a benefits weighting approach. This highlights that of the health benefits accrued through the Clinical Portal Implementation it is anticipated that 25% will be improved health outcomes, 30% improved quality of care etc.

Post Implementation review

The listed benefits of the Regional Clinical Portal Implementation will take time to become visible and measureable. As part of the Clinical Portal Implementation a Benefits Review Plan should be developed. We are in discussions with CTAS and the Regional project team as to whether this be led from a Regional or individual DHB perspective.

Next Steps

This Clinical Portal Implementation Business Case seeks approval from the Board to proceed with the Clinical Portal implementation as outlined and by using this Business Case's recommended option (Option 3).

Once approved, the Clinical Portal Project will continue toward the delivery of the milestones and a progressive rollout.

Appendix (Attached)

- Board Minutes Extract 21 December 2011

References

- M Sheehan (September 2017). RHIP Project Brief v1.2
- M Sheehan (2018). CP Project on Page & Charts v9.
- M Sheehan (2018). CP Project Plan – Stage 1-2.
- M Sheehan (2018). RHIP CP Project Budget Estimates.
- Health Quality & Safety Commission New Zealand (2016). Governing for Quality, A Quality & Safety Guide for District Health Boards.
- D Beesley (2016). End of Project Report, Southern DHB HCS Implementation.
- C Sullivan, A Stalb et al (2016). Pioneering digital disruption: Australia's first integrated digital tertiary hospital.
- OCG (2009). Managing Successful Projects with Prince2.

All references are available, as required, from the IS Clinical Portal Implementation Project Manager or CIO.

Extract of Board Minutes 21 December 2011

Supplied by Brenda Creene

Central Region Information System Plan

A summary paper had been distributed prior to the meeting which coordinated and summarised the papers distributed with the Agenda.

The papers were introduced by Peter Reed (Chief Financial Officer) supported by Vidhya Makam (IS Manager) and Kevin Snee (CEO).

The CFO provided a presentation on the project and covered off some of the key financial issues. Following active discussion agreement in principle was obtained with several additions/amendments requested.

The Board then resolved:

Procurement Strategy for CRISP

RESOLUTION

That the Hawke's Bay District Health Board, having considered the following matters:

- The memo from the Programme Director CRISP (dated 29 November 2011);
- the Board's view that, as discussed in the Business Case, the approach of standardising existing implementations and consolidating to a single regional instance [significantly,] reduces technical and financial risk;
- this selective procurement approach is consistent with the National Health IT Plan and has the support of the National Health IT Board;
- the finding of the State Services Commission Gateway Review report, Gate 0/1 review, April 2011, that "given the history of large projects in the public sector, the proposed solution for consolidation of currently used and proven applications is an appropriate low risk approach";
- the approval of the Business Case by the DHBs and the requirement that TAS implement Phase One of CRISP in accordance with the Business Case; and
- the Board's view that selective procurement in this case is consistent with the OAG Guidelines;

Resolves, subject to approval by the TAS Board, for TAS to engage the existing application vendors to provide the applications as specified in the CRISP Business Case, and

Resolves, subject to approval by the TAS Board, for TAS to engage in a full market request for proposal process to provide the infrastructure as specified in the CRISP Business Case.

Moved **Kevin Atkinson**

Seconded **Peter Dunkerley**

Carried

CLINICAL SERVICES PLANNING

Verbal Update

CLINICAL GOVERNANCE STRUCTURE VALUE ASSESSMENT

LATE PAPER

HAWKE'S BAY CLINICAL COUNCIL - ANNUAL PLAN 2016/17

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.	• 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	• 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.	• 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

	• Provide input through representation on EMT, Alliance Leadership Team and through attendance at HB Health Sector Leadership Forum.	experience' through the health system.	• 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.	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.
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**
OBJECTIVES 2016/17	• Prioritise meeting time to focus on papers with significant clinical issues. • Encourage proactive presentations / discussions on innovative issues / ideas. • Ensure risk management processes provide for early Clinical Council visibility (and input) of all significant clinical issues. • Align portfolio areas of responsibility to clinical governance structure memberships (once confirmed).	• Work in partnership with Consumer Council to develop an appropriate "Person & Whanau Centred Care" approach and culture. • Monitor "Quality Dashboard" and support performance improvement initiatives as appropriate. • Promote and support ongoing enhancements to information systems relating to clinical process and consumer records. • 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.	• Implement and progressively develop the proposed new Clinical Governance Committee / Advisory Group structures. • Monitor and report on the implementation of the action plan for "Governing for Quality. • Oversee and monitor the achievement of objectives within the QIPS Annual Plan.	• Enhance the profile and perceived value of Clinical Council within the sector, through improved effective two way communications. • Facilitate the development of a HB Clinical Workforce Sustainability Plan • Promote Strategies to enable the HB Clinical Workforce to adapt to meet the challenges of the future. • Support and promote the ongoing implementation of clinical leadership training and developments.

HB CLINICAL COUNCIL WORKPLAN 2018

Meeting Dates	Papers and Topics	Lead(s)
14 Feb 18	***For Discussion - Decision***	
	Clinical Governance Structure – value assessment discussion	Co-Chairs
	Suicide Prevention Update	Sharon Mason
	Quality Dashboard Quarterly (commences Feb 18, previously Nov 17)	Kate Coley
	Clinical Portal Project	Tim Evans
	Radiology Expansion Programme – corrective actions	Sharon Mason
	Monitoring and for Information	
	Clinical Services Plan Update	Chris Ash
	Te Ara Whakawaiora / Access 0-4 / 45-65 year (local indicator)	Mark Peterson
	Quality Annual Plan 2017/18 (progress against objectives 6 mthly)	Kate Coley
	Ngatahi Vulnerable Children's Workforce Development Update	Kate Coley
	HBDHB Performance Framework Exceptions Dashboard Q2	Russell Wills
	No Committee Reports: Lab, Radiology or CAG	
7 March	**HB Health Sector Leadership Forum – Napier Sailing Club**	
14 Mar 18	***For Discussion - Decision***	
	Oncology Model of Care	Sharon Mason
	Radiology Expansion Programme	Sharon Mason
	Building Culture – the Big Listen	Kate Coley
	Annual Plan 2018/19 first draft (likely delayed)	Chris Ash
	Collaborative Clinical Pathways	Mark Peterson
	First 1000 Days of Life	Tae and Andy
	Budget Prioritisation Process Update	Tim Evans
	IS Roadmap	Anne Speden
	Monitoring and for Information	
	Te Ara Whakawaiora / Breastfeeding (national indicator)	Chris McKenna
	Te Ara Whakawaiora - Culturally Competent Workforce (local indicator Building a Diverse Workforce and Engaging Effectively with Maori	Kate Coley
	Establishing Health and Social Care Localities in HB (6 monthly)	Chris Ash
	Acute Flow Update	Sharon Mason
	Maternity Clinical Governance Group Update	Chris McKenna
	Quality Dashboard – *Quarterly reporting to commence*	Kate Coley
	Mobility Action Plan Update	Andy and Tae
	Committee Reports	
	Clinical Advisory & Governance Group Report	Tae Richardson
	Falls Minimisation Committee Update (6 monthly)	Chris McKenna

Meeting Dates	Papers and Topics	Lead(s)
11 Apr 18	***For Discussion - Decision***	
	Building Culture	Kate Coley
	Consumer Experience results – where to from here	Kate Coley
	Implementing the Consumer Engagement Strategy	Kate Coley
	Policy on Consumer Stories (from Sept 17)	Kate Coley
	Monitoring and for Information	
	Te Ara Whakawaiora / Did not Attend (local indicator)	Sharon Mason / Carleine
	Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations	Kate Coley
	Legislative Compliance (6 monthly)	Kate Coley / K Lafferty
	Committee Reports	
	HB Nursing Midwifery Leadership Council Update incl. Dashboard	Chris McKenna
	Clinical Advisory & Governance Group Report	Tae Richardson
9 May ***(Quarterly Mtg)***	***For Discussion - Decision***	
	Annual Plan 2018/19 2nd draft	Chris Ash
	Building Culture	Kate Coley
	Monitoring and for Information	
	Best Start Healthy Eating & Activity Plan update	Sharon Mason
	Smokefree Update (6 monthly) include board action detail	Sharon Mason
	HBDHB Performance Framework Exception Dashboard Q3	Tim Evans
	Committee Reports	
	HB Clinical Research Committee Update	John Gommans
	Infection Prevention Control Committee	Chris McKenna
13 Jun	***For Discussion - Decision***	
	Youth Health Strategy (board action June 2017)	Chris Ash
	Building Culture	Kate Coley
	Monitoring and for Information	
	Consumer Experience Feedback Q2	Kate Coley
	Collaborative Pathways (4 monthly update)	Mark Peterson/ Leigh
	Committee Reports	
	Clinical Advisory & Governance Group Report	Tae Richardson (final report as Chair -tbc)
	Lab and Radiology Reports dependant on Governance Structure	

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Adverse Events – 6 month Interim report 1 July – 31 December 2017**
	For the attention of: **Clinical Council and Finance Risk and Audit Committee**
Document Owner	John Gommans, Chief Medical & Dental Officer – Hospital, Chair of Clinical Risk and Event Advisory Group
Document Author(s)	John Gommans, Chief Medical & Dental Officer – Hospital, Chair of Clinical Risk and Event Advisory Group
Reviewed by	Kate Coley, Executive Director of People and Quality; Kaye Lafferty, Patient Safety & Clinical Compliance Manager; Jane Bailey, Patient Safety Advisor; Andy Phillips, Chief Allied Health Professions Officer; Chris McKenna, Chief Nursing and Midwifery Officer; and the Executive Management Team
Month/Year	January, 2018
Purpose	For Information
Previous Consideration Discussions	The 2016-17 annual adverse events report released in November 2017 identified 21 adverse events (AE), an increase of from the 11-13 reported the 4 previous years. FRAC requested an interim report at six months.
Summary	Limited conclusions can be drawn from the part year data available but it appears that; • Reported AEs continue at a similar rate to last year. • Falls remain a significant issue and continue to be the focus of the Falls Minimisation Advisory Group. • Management of deteriorating patients remains a concern particularly when the hospital is busy or out of hours. Last November's report outlined a programme of work to address this issue, which is well under way. • Events relating to access to radiology are no longer apparent
Contribution to Goals and Strategic Implications	Monitoring of and responding to reported adverse events is an important element in ensuring and maintaining patient safety and the delivery of high quality health services
Impact on Reducing Inequities/Disparities	The limited data available does not identify any significant inequity
Consumer Engagement	Nil to date. The new national adverse event policy from HQSC expects consumers to be actively engaged in event reviews as part of its new strategic approach. The HQSC expects DHBs to work towards this goal this year (2018) and HBDHB is already in discussions with the consumer engagement team.

Other Consultation /Involvement	Clinical Risk and Event Advisory Group
Financial/Budget Impact	N/A
Timing Issues	This is an interim report of adverse events reported for the first six months of year to date. A definitive year-end report is expected by November 2018
Announcements/ Communications	N/A

RECOMMENDATION:

It is recommended that HB Clinical Council and Finance Risk and Audit Committee**.**

1. **Note** the contents of this interim report and the previous annual adverse event report dated November 2017 (refer appendix 1).

END

Adverse Events – 6 month Interim report 1 July – 31 December 2017

Author:	**Dr John Gommans**
Designation:	**John Gommans, Chief Medical & Dental Officer – Hospital, Chair of Clinical Risk and Event Advisory Group**
Date:	**24 January 2018**

EXECUTIVE SUMMARY

This interim report is to provide the DHB governance bodies with an update regarding reported Adverse Events (AE) for the half year to 31 December 2017. Fifteen AE have been reported in this period, which is the same as reported in the same period in 2016.

It is important to note that 7 of these 15 AEs are still under review and therefore some may be reclassified to a lower level of severity by the Clinical Risk and Event Advisory Group (CREAG), which reports to Clinical Council's Patient Safety and Risk Management Committee.

Last year CREAG identified three main areas of concern in the 21 AE reported to the Health Quality & Safety Commission (HQSC); inadequate management of deteriorating patients in the hospital; falls resulting in patient harm and access to radiological investigations.

Limited conclusions can be drawn from the part year data available but it appears that;

- Reported AEs continue at a similar rate to last year.
- Falls remain a significant issue (8/15 AE) and continue to be the focus of the Falls Minimisation Advisory Group.
- Management of deteriorating inpatients remains a concern particularly when the hospital is busy or out of hours. Last November's report outlined a programme of work to address this issue, which is well under way.
- Events relating to access to radiology are no longer apparent.

It is appropriate to reflect that the demand on the health system is increasing with clinical staff continuously under pressure to maintain high service quality. The available data from Health Round Table and Health Quality and Safety Commission shows that HBDHB has average levels of mortality and harm. However, the CREAG is concerned to note that there appears to be an increasing number of serious events that occur due to staff resources being stretched. The demand pressures for clinical staff also give them limited time to participate in quality improvement that would prevent harm events recurring.

INTRODUCTION

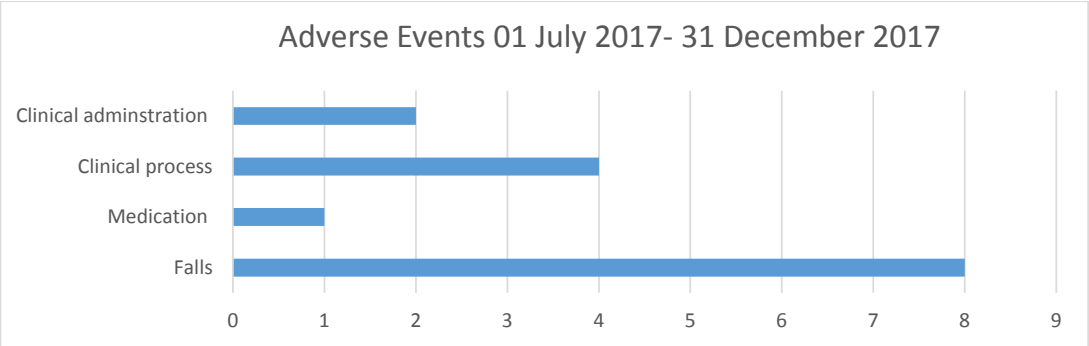
Each DHB provides an annual report to the HQSC on their Adverse Events (previously referred to as serious adverse events or serious and major events). The HBDHB 2016-17 report released in November identified 21 AEs (average 1.7 per month), an increase from the 11-13 AE reported annually during the four previous years. The CREAG noted that some of this increase reflects the renewed focus in the DHB on reporting of events as a means of ensuring patient safety. Activities encouraging increased reporting included appointment of a dedicated patient safety advisor, presentation at Hospital Grand Round and creation of a regular publication updating staff about events and outcomes of reviews.

REPORTED ADVERSE EVENTS

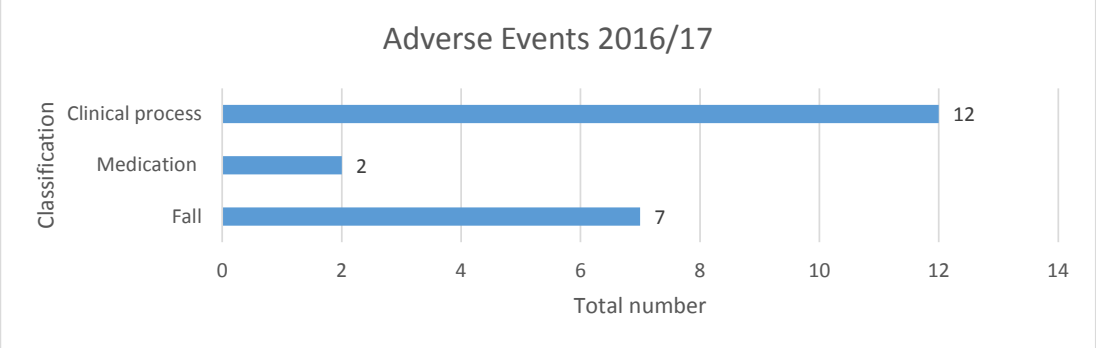
1 July – 31 December 2017

Total general health reported AEs is 15 at 31 December 2017 – this excludes Mental Health AEs. Eight event reviews have been completed and confirmed as actual AEs and 7 potential AEs are still under investigation. Therefore some AE may be reclassified to a lower level of severity by the CREAG and not require reporting to the HQSC

These 15 are broken down into the below categories:



Last reporting year comparison data (total of 21 confirmed AE).



The AE investigations completed to date are consistent with those reported in 2016-17 reflecting issues with management of patients whose condition is deteriorating in the hospital particularly when the hospital is busy or after hours and with falls resulting in injury. Importantly no new issues of concern have been identified.

Nine of the 15 patients involved in AEs reported to date are NZ or other European and 6 Maori. Of the 21 cases reported last year 13 were NZ or other European and 8 Maori; for 2015-16 of 13 cases reported 10 were NZ European and 3 Maori.

MENTAL HEALTH SERVICES

Mental Health AEs are excluded from the HQSC annual report and are not covered by this paper. Currently there are 7 reported adverse events but not all have been confirmed as AEs. The HQSC is currently has a working party reviewing management of Mental Health AEs.

ANALYSIS OF LEARNING FROM NZ ADVERSE EVENTS 2016 – 2017

The HQSC national report *'Learning from adverse events 2016-2017'* allows us to compare HBDHB's reported AE (21) with other DHBs. Of note:

- There is significant variability amongst DHBs – more than threefold between similar-sized DHBs
- Tertiary level DHBs (with the exception of Capital & Coast) report more events than secondary level DHBs
- Hawke's Bay, MidCentral and Northland DHBs reported the same volume of events but more than other secondary level DHBs e.g. Bay of Plenty and Nelson Marlborough.

Professor Alan Merry Chair of the HQSC states that the role of adverse events reporting, review and learning system is to enhance consumer safety by learning from adverse events. He noted that the number of nationally reported events has increased over time and that this probably reflects a change in culture towards increased transparency and willingness to learn from system failings, rather than an increase in adverse events themselves.

THE CLINICAL RISK AND EVENT ADVISORY GROUP

The CREAG is also involved in other initiatives designed to further enhance the quality and safety of care in the hospital.

- Preparing for implementation of new incident/event reporting software in 2018
- Updated membership of CREAG to include representation from Directorate leadership teams
- Updating the systems and policy around events to ensure they are investigated in a standardised and timely manner
- Developing an expert panel to assist in investigation reviews
- Establishing training for staff involved in event reviews.

RECOMMENDATION:

It is recommended that HB Clinical Council and Finance Risk and Audit Committee**.**

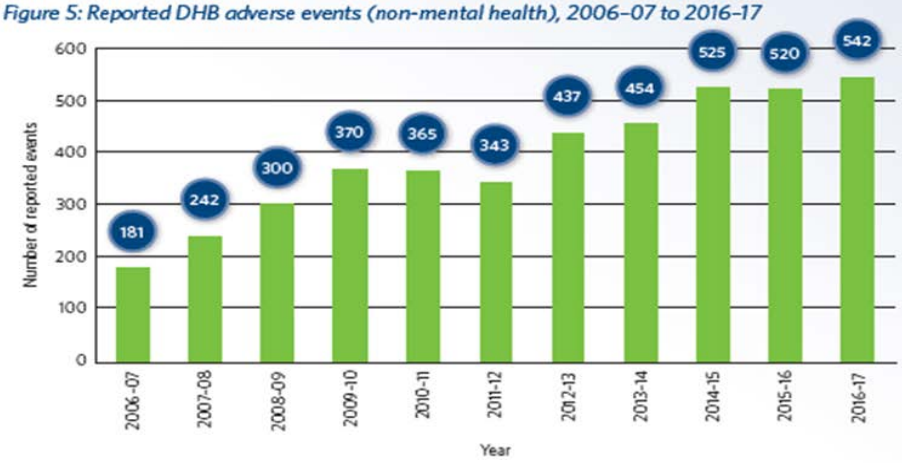
Note the contents of this interim report and the previous annual adverse event report dated November 2017 (refer appendix 1).

Data from the HQSC report Learning from adverse events 2016-2017

Total DHB events over time

The total number of events reported in 2016–17 has increased compared with 2015–16 (Figure 5).

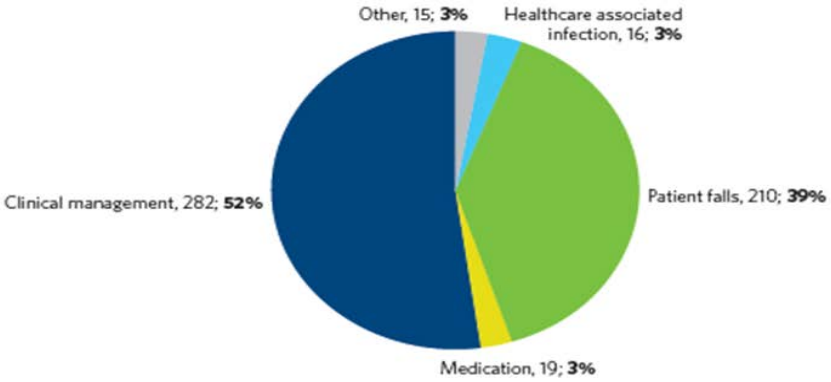
Figure 5: Reported DHB adverse events (non-mental health), 2006–07 to 2016–17



Note: As mental health adverse event numbers are not included in this figure, numbers prior to 2013 will differ from those previously published in adverse events reports.

Following the theme that emerged last year, this relates to a second consecutive increase in clinical management events and a decrease in falls adverse events.

Figure 6: DHB adverse events, by event type, 2016–17



https://www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/

APPENDIX 1 - Serious adverse event report dated November 2017

Clinical Governance Results

Author:	**Dr John Gommans**
Designation:	**Chief Medical and Dental Officer Hospital**
Date:	**1 February 2018**

UPDATE FOR CLINICAL COUNCIL
Numerous issues regarding investigation results has been vexing SMOs in Hawke's Bay Hospital and GPs in primary care; and Radiology and Laboratory services for some time.

This is also a national issue of concern to the health and Disability Commissioner, the Medical Council and the National CMO group.

A small local group including representatives from IT, administration, Radiology, laboratory, PHO/GPs and SMOs (myself, Matt Bailey – IT Medical Lead, Guy Vautier, Liz Ritchie & Ross Boswell – CD of Laboratory) is working on these issues prior to implementation of the new Clinical Portal in the DHB due in about June/July 2018.

The issues include but are not restricted to:

1. No clear policy around clinical governance of and responsibility for results
    a. see attached HB DHB draft based on Waikato DHB policy – feedback is required
    b. see attached advice from Medical Council – extract from Coles Medical Practice 2017

2. Large Volume of historic unsigned results in DHB system
    a. Auto-signoff of GP initiated results has already been implemented
    b. Auto-signoff of biochemistry and haematology results after 6 weeks is planned. NOTE histology, cytology and radiology are excluded.
    c. Auto-signoff of earlier biochemistry or haematology results when a more recent result of same test(s) is signed-off is being considered
    d. Auto-signoff of all other results outstanding > one year may be implemented to reduce backlog before migration to new Clinical Portal.

3. >260,000 open referrals in DHB system and results cc to all
    a. Currently too many patients remain 'open' to SMOs when care has actually been completed – largely due to admin systems & SMOs not consistent with appropriately closing referrals. An OP and admin project (Jacqui Mabin lead) is addressing our systems and processes to reduce this.
    b. Currently results are copied to inbox of all SMOs with patient still 'open' to them, not just the person requesting the test – see below

4. Multiple DHB clinicians getting same result
    a. Currently DHB system copies any result to inbox of all clinicians with patient still 'open' to them, not just the person requesting the test - partial solution is linked to above work on closing referrals that shouldn't remain open.
    b. For patients needing to remain 'open' it is agreed that SMOs don't want cc results generated by others as these are still available to be viewed if required.
    c. Software upgrade in development will stop current auto copy to all to whom patient is 'open' – likely implementation by February/March.

5. Incorrect ID of requestor, event, patient
    a. Multiple causes including transfer of care (ED to IP team to another team etc), out of date or incorrect info e.g. use of old labels, and poor or incosistent systems/processes in clinics
    b. Being addressed within DHB via the admin review process, training and checking up to date details at OP clinic attendance

6. Incorrect or unknown GP
    a. Multiple issues with out of date data, GPs moving practice, GPs working in >1 practice, locums, failure to notify PHO of GP changes and patients giving incorrect information or not enrolled. PHO and DHB working together to address these issues
    b. Current rules update ECA on a quarterly basis using PHO register - more frequent updates e.g. monthly are required
    c. Current rules require patient to be allocated to a named GP not their practice - many GP Practices have changed their processes to only have their patients aligned to the Practice rather than an individual GP whereas current rules in ECA require patient to be allocated to GP. These patients end up with an 'unknown' GP in ECA, and their results and discharge summaries would not be sent anywhere - need agreement that allocation to a General Practice by DHB is acceptable but each practice then needs systems to ensure results and discharge summaries are appropriately allocated/reviewed internally.

7. ECA is cumbersome for results signoff and no ability to transfer responsibility
    a. Clinical Portal will address a number of these issues but we need feedback and SMO engagement in the IT working groups preparing for implementation of Clinical Portal.

8. Issues in consistently transferring results from external providers into ECA
    a. Tertiary laboratory results and updated reports (eg Histology & Cytology)
    b. Radiology results and scans (eg from tertiary or private radiology services including foetal ultrasound images).
    c. Laboratory and Radiology Management are investigating these

Feedback on these issues AND the draft governance paper is welcome - as this will guide how Clinical Portal is configured in the DHB and how links between hospital and primary care services are developed.

RECOMMENDATION:

It is recommended that the Clinical Council

1. **Note** the contents of this paper
2. Provide **feedback** on these issues and the draft governance paper is welcome - as this will guide how Clinical Portal is configured in the DHB and how links between hospital and primary care services are developed.

ATTACHMENT:

- Appendix 1: Clinical Governance of Investigation Results

Appendix 1

Clinical Governance of Investigation Results

Draft v2 16 January 2018

"As … HDC cases indicate, patients do suffer harm as a result of mismanagement of clinical investigations. The number of doctors being reported to MCNZ because of these errors is high and would appear to be rising."

"The Medical Protection Society article 'Handling test results' looks at the issue of doctors' responsibility for tests they did not order and notes the primary responsibility for following up abnormal results rests with the clinician who ordered the tests. However, the HDC has an expectation that an abnormal result will be followed up by a treating doctor regardless of who ordered the test to avoid patients falling through the cracks. This makes sense."

From Coles Medical Practice in New Zealand, Medical Council of NZ, 2017

Purpose: the purpose of this guidance document is to ensure safe and effective patient care by providing clarity around clinical responsibility for investigation results and reports of patients cared for by clinicians working for Hawkes Bay DHB, including electronic acknowledgment.

Responsible Clinician:

While it is generally considered that the requestor of a test should take responsibility for acknowledgment of results and any actions required, in a hospital setting many tests are requested on behalf of teams and results may only be available after the ordering clinician has completed their duties.

Therefore, ultimate responsibility rests with the 'responsible clinician' who is accountable for results/reports of all investigations requested either by them or by those acting under delegated authority such as registered medical officers (RMOs), allied health staff or nurses.

If services allocate patient care to a team such as 'Emergency Department' (ED), 'Acute Medical' or 'AAU'; initial responsibility rests with the duty or admitting senior medical officer but there must be clear arrangements ensuring either transfer of responsibility to a named SMO or that a designated responsible clinician reviews outstanding team results daily. Ensuring this is a clinical Head of Department (HoD) responsibility.

Definition:

Responsible clinicians are vocationally registered clinicians capable of autonomous practice without supervision. Currently this includes

- Senior Medical Officers (SMO)
- General Practitioners (GP)
- Advanced Practice Allied Health staff (AHP)
- Nurse Practitioners (NP) and Nurse Prescribers
- Lead Maternity Carers (LMC)

Accountability:

- There can only be one responsible clinician during any episode of care
- Laboratory and radiology systems must ensure results are only allocated to responsible clinicians
- Every responsible clinician must have a 'results inbox' available to them when they sign in to their clinical portal that includes all outstanding unacknowledged results
- Electronic results should only appear in the 'results inbox' of one responsible clinician
- Registrar clinics must be associated with a named SMO who assumes responsibility for results
- Responsibility may be delegated to another person (see below)
- Responsibility will be transferred when a patient's care transfers to another team such as when patients are admitted from ED

- By acknowledging a result a clinician is also taking responsibility for any action required. Simply reviewing a result without ensuring appropriate action occurs is not acceptable.
- Through acknowledging a result, that result will also disappear off any outstanding results work list, therefore, clinicians must not acknowledge important results that should be viewed and actioned by others.

Locums:

- Locum SMOs or Responsible Clinicians are responsible for investigation results while they work at the DHB and should sign off all results prior to departure
- Responsibility for any outstanding results will transfer to a relevant responsible clinician at the end of the locum's employment. Ensuring this is a Head of Department responsibility.

Role of the responsible clinician:
Is to ensure investigation results/reports are reviewed and acknowledged (signed off), and where required that appropriate action is taken. This may be achieved by either personally acknowledging results or appropriately delegating this responsibility to others.

Delegation:
Responsibility for results acknowledgment may be delegated to other team members such as the responsible clinician's team RMOs and credentialed Clinical Nurse Specialists, Allied Health or support staff following appropriate training and if clear protocols are in place.

It is the responsibility of SMOs to instruct their RMOs or others with delegated authority regarding expectations and indicate

- When they can and should independently acknowledge results
- What results they should not acknowledge; for example histology
- What results they should inform the SMO about before or after acknowledging.

RMOs and others have a responsibility to remain within their area of competence and scope of practice, and to seek guidance when required.

Results not finalized or available before discharge:
It cannot be assumed that GPs will follow up on outstanding test results. This requires either a discussion with the GP to ensure they are prepared to accept responsibility or that explicit delegation for the responsibility is documented in the discharge summary.

- GPs cannot 'acknowledge' results in the hospital system – a hospital clinician will still need to do this
- It is inappropriate to expect GPs to be responsible for results that require specialist knowledge or intervention.

Automatic sign off:
The following results may be automatically electronically signed off in the hospital laboratory system and not appear in any clinician's results inbox – the results will still be available for viewing

- GP ordered investigations
- Outstanding haematology and biochemistry results greater than 12 weeks old
- Proforma reports that are solely for system documentation and contain no clinically relevant information.

Explicitly excluded are all radiology, echocardiography, histology and cytology reports.

Updated results/reports:

- If a result or report is amended or otherwise updated this should result in cancellation of any prior acknowledgment or signoff but the initial report and signoff should remain available in records
- Notification of the new amended or updated report should appear in the responsible clinician's results inbox

Timeframes and monitoring:

- All results should be acknowledged within 5 working days of being finalized.
- Any results not acknowledged within 15 working days of being finalized will be considered non-compliant with acceptable practice.
- If an SMO is on leave explicit arrangements should be made regarding acknowledgement of outstanding results.
- Reports of compliance will be shared with responsible clinicians and their HoD, and will be a performance indicator discussed at professional development reviews.

John Gommans
Chief Medical & Dental Officer – Hospital

Mark Peterson
Chief Medical Officer – Primary Care

Chris McKenna
Chief Nursing and Midwifery Officer

Andy Phillips
Chief Allied Health Professions Officer

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**Ngātahi Project – progress report, end of year one**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owner	Dr Russell Wills
Document Author	Dr Russell Wills, Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor
Reviewed by	Bernice Gabriel, Project Manager; Viv Kerr, Education & Development Manager; Executive Management Team
Month/Year	February 2018
Purpose	For Information only
Previous Consideration Discussions	Previously discussed at EMT, MRB, Clinical Council, Consumer Council and the Board, who supported the project.
Summary	The Ngātahi Project has met all milestones for year one: • Agreement across 24 Hawke's Bay government and non-government health, social service and education agencies on the competencies required for practitioners working with vulnerable children (see Appendix 1 for participating agencies) • 441 practitioners completed assessments against the competencies, noting in particular those additional competencies they needed but did not yet have, or partially had • Leaders from the 24 agencies have agreed the three most important domains of practice to focus workforce development on in 2018 and 2019: Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Care (including burnout and vicarious trauma for practitioners) • Training successfully delivered for 140 staff working in child and adolescent mental health, led by CAFS, has already shown early impacts on practice and outcomes • Three workstreams of local leaders are meeting currently to agree curriculum, who would teach, how to integrate cultural and clinical competencies, how to embed the new competencies into daily practice and evaluate the impact of these • Research report for year one received from Prof Kay Morris-Matthews (EIT) notes high engagement of workforce, exemplary leadership from Project Manager (Bernice Gabriel, CAFS psychologist), support for the competency framework and process to date, early impacts of training in CAFS and lessons learnt • Funding discussed with Deputy Chief Executive for the Ministry for Vulnerable Children for FTE for Y2-3. Project sponsor

12

	currently working to secure funding for evaluation and training costs for Y2-3. • RFP drafted for evaluation for Y2-3, focusing on process and lessons learnt (Y2) and measurable outcomes (Y3)
Contribution to Goals and Strategic Implications	Contributes to HBDHB Statement of Intent 2015-19 (p8, Fig 3): Working with Others; People better protected from harm; Health issues and risks detected early; Longer, healthier and independent lives; High quality, timely and accessible services; Sustainability. Contributes to NZ Health Strategy 2016 goals: Closer to Home; Value and High Performance; One Team; Smart System.
Impact on Reducing Inequities/Disparities	70% of vulnerable children are Māori so this project has been created with tamariki and whānau Māori at the fore: early and regular consultation with Māori providers and leaders, specific domain on Working Effectively with Māori (WEWM), co-constructed with Māori service leaders; cultural *and* clinical competency in teaching and learning; WEWM workstream to have oversight of other workstreams.
Consumer Engagement	Early consultation with caregivers of children and young people in care and with care-experienced young people, facilitated by MVCOT. Strong support for the competencies and process, no additional competencies identified. Evaluation RFP requires direct assessment of outcomes for children, young people and whānau.
Other Consultation /Involvement	MRB, Māori providers, facilitated by HBDHB Māori Health Unit. Support for project, helpful advice regarding tikanga, added several additional competencies to the WEWM domain, WEWM workstream has oversight of other domains to ensure cultural competency.
Financial/Budget Impact	Y1 $250,000 Y2 $232,500 Y3 $212,500
Timing Issues	Secure funding: February-March RFP for evaluation advertised: April Training begins mid-year Evaluation reports mid-2018, early 2019, early 2020
Announcements/ Communications	Outcomes from evaluation will be shared: Internally — Project Sponsor Dr Wills Key Stakeholders — Meetings, conferences Community — Through HBDHB communications team

RECOMMENDATION:

It is recommended that MRB, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council and the HBDHB Board:

1. Note the progress of the Ngātahi Project in the first year
2. **Note** the approach endorsed for Years 2 and 3 of the Ngātahi Project and the forecast budget of $232,500 for 2018 and $212,500 for 2019
3. **Note** that theTransform and Sustain Steering Group will be asked to contribute funding of $80,000 in FY2017/2018 and FY2018/2019 for the evaluation component of the project.
4. **Note** that the remaining funding has been sought from the Ministry for Children Oranga Tamariki and a philanthropic funder.

Ngātahi Project
Progress report - end of year one

Author:	**Dr Russell Wills**
Designation:	**Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor**
Date:	**1 February 2018**

SUMMARY
The Ngātahi Project is about Hawke's Bay health, education and social services (the "vulnerable children's workforce") working together as one to deliver excellent care and interventions to vulnerable children and their families. In this first year of the project we have been successful in meeting all our milestones. We have:

- mapped the skills and learning needs of 441 professionals from the vulnerable children's workforce
- agreed on the three priority training areas for 2018 and 2019
- established three work streams to develop, implement and monitor training and development programmes in these three priority areas to improve the confidence and competence of the vulnerable children's workforce, and improve collaboration
- completed an independent research programme of interviews with a representative group of managers and practitioners, which provides assurance on the current direction, lessons learnt and important pointers for the following two years of the programme.

We are a step nearer to our vision of better collaboration between disciplines and sectors, sharing of effective practices, development of a common language and improved workforce capacity.

This briefing paper describes the context and progress to date. A business case for funding for 2018 and 2019 has been written and will be pitched to potential philanthropic funders.

BACKGROUND
In 2015 an expert panel reviewed Child, Youth and Family. There were a number of reasons that the care and protection system failed vulnerable children and their families[1] and recommendations were made to address these issues.

Children of parents with mental illness, addictions and in violent relationships ("vulnerable children") are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/ whānau and the Government accepted all of the Panel's recommendations.

A new programme was created to reform the way these families are supported, including:

- changes to legislation and accountabilities of Ministry Chief Executives
- dissolution of Child, Youth and Family and creation of the Ministry for Vulnerable Children Oranga Tamariki
- implementation of multi-agency Children's Teams in ten sites
- additional funding and changes to expectations and monitoring of all agencies with a part to play in supporting such families. See Appendix Two for a roadmap of these changes.

In addition to these structural changes, the expert Panel acknowledged, *"the need for a shift from rules, compliance and timeframe-driven practice to professional judgement based on an evidence-based understanding of the impact of trauma on children and young people, the science of child development and attachment, and best practice approaches"* (p65).

There are now many reports[2],[3],[4],[5] that recommend a focus on additional knowledge and skills ("competencies") for practitioners working with vulnerable families. These competencies include the ability to identify vulnerable whānau and families, assess both strengths and risks, formulate an assessment, design and implement a plan with families, and work collaboratively with the agencies involved.

The Ministry of Social Development Children's Action Plan Directorate therefore began a programme of work to develop a *Vulnerable Children's Core Competency Framework*, in partnership with sector leaders from education, health and social services. Hawkes Bay is piloting the Ngātahi Project, leveraging the draft Vulnerable Children's Core Competency Framework.

PURPOSE

The Ngātahi Project aims to assess the skills and development needs of health, education and social service professionals in Hawke's Bay who are working predominantly or exclusively with vulnerable children and families. Over a three year period Ngātahi and its partners will design, implement and evaluate a workforce development plan to support practitioners. By improving practitioners' competencies, including their ability to practice collaboratively and share information, in conjunction with the structural changes above, outcomes for vulnerable children and their families should improve.

PROGRESS TO DATE

Funding was obtained in 2016 from the Hawke's Bay District Health Board (HBDHB), Ministry of Social Development and Lloyd Morrison Foundation to progress the project. Bernice Gabriel, a senior psychologist at the HBDHB Child, Adolescent and Family Service (CAFS) was appointed as project manager in March 2017.

<u>HBDHB CAFS</u>

HBDHB CAFS is a multidisciplinary team of 30 staff working with children and young people (C&YP) with moderate to severe mental illness and their families. Many of these C&YP have experience of abuse, neglect, witnessing parental violence, and developmental issues such as foetal alcohol spectrum disorder. CAFS' staff work with the most complex of these children and families and accept referrals from all the other 24 agencies or services involved in the Ngātahi project.

CAFS' staff completed their competency assessment against the Ngātahi framework and the Real Skills Plus CAMHS competency framework early in 2017[6]. Priorities for staff development were identified and experienced clinician-trainers recruited to deliver training for CAFS. Trainers were asked to give particular thought to integrating clinical and cultural competence, prioritise examples of practice with Māori tamariki and whānau and advise on subsequent activities to support CAFS' staff to integrate the new competencies into everyday practice.

Peer review groups meet regularly to review cases and are the primary mechanism to integrate the new competencies into everyday practice. Four training sessions have been completed to date:

- Attachment & Trauma
- Emotional Regulation/Dialectical Behaviour Therapy*

* Designed as a treatment for people experiencing chronic suicidal thoughts as a symptom of borderline personality, DBT is used to treat people who experience a range of chronic or severe mental health issues, including self-harm, eating and food issues, addiction, and posttraumatic stress, and borderline personality.

- Acceptance & Commitment Therapy[†]
- Family Therapy supervision.

Wider workforce

In May 2017 a hui of 72 leaders from health, education and social services, kaupapa Māori, mainstream, Government and NGO services was held at HBDHB (Appendix One).

The hui agreed on the competencies and tiers of competency that each sector required of its staff. Some competencies were added to the original framework and some were moved between tiers. The revised competency framework included 289 competencies in three tiers: Foundation, Practitioner and Leader of Practice. The original six domains and 12 sub-domains from the Vulnerable Children's Workforce Competency Framework were retained. See Appendix Three for a one-page summary of the framework. The full framework is available if required.

A Survey Monkey tool was created from the framework for practitioners to identify the competencies they did not need (N/A), already had (Y), needed and partially had (P) or needed and did not yet have (N). Staff completed the tool online or on paper in September and early October. Paper copies were entered into the Survey Monkey tool by a data administrator. Results were copied into SPSS and analysed, with a focus on the number (%) of staff in each service and across all services recording P and N responses (Table 1 below). Most practitioners also entered demographic data including discipline and years since graduation.

RESEARCH AND EVALUATION

Professors Kay Morris-Matthews and David Tipene-Leach (Eastern Institute of Technology) were contracted to provide the evaluation. Interviews were completed with staff from CAFS and the wider workforce to understand the process to date, assess manager and staff engagement, what had worked well and could be improved in this first phase of the project, and any additional themes that would inform the next steps for the project. The project manager and project sponsor have also kept logs of lessons learnt, which are reported below.

[†] ACT is an evidence-based approach for young people experiencing anxiety, depression and/or addiction.

RESULTS

Qualitative research

Key themes from staff interviews have included:

- High levels of engagement of managers and staff: Both groups agreed that the competency framework worked well to identify the competencies staff needed. While the 289 competencies initially looked onerous to assess, most staff took only an hour to do so and found the process helpful.
- Value of clinical leadership: There was high agreement that the project manager, due to her clinical credibility and general approach, made the process accessible and understandable, generated high trust in the process, and that these factors were likely to generate more accurate and reliable responses, that would in turn lead to training that would be of value.
- High levels of practitioner stress: High levels of stress, burnout and fatigue were noted in many interviews. Self-care competencies were identified as a high need by many staff, which was a gap in the competency framework.

Lessons learnt

Bicultural approach

- Tamariki Māori are 70% of the target population for this project so it was agreed that tikanga Māori and Māori voices would be privileged in the project. Initial face to face meetings with Māori leaders to agree tikanga and values provided wise advice and guided the development of the project.

Engagement, values, language

- Initial face to face engagement with managers and practitioners is crucial and needs to be led by people with high degree of trust and fidelity in the region.
- Presenting to all staff in a service before mapping the competencies was crucial to get consistent messaging out and to stress values and philosophies
- Neutral, non-judgmental language was more successful in engaging staff. E.g., "mapping/needs analysis" of competencies rather than "performance appraisal"; "additional" needs, rather than "deficits".
- Stressing trust and confidentiality with practitioners.
- Honest and open acknowledgment of NGOs' difficulty with sharing resource/ intellectual property in an environment of competing for funds from the same funding pool.

Reliability of competency mapping

- Competency mapping was more reliable when done with a senior staff member who is trusted and knew staff well.
- With the Leaders of Practice tier, it would have been helpful to remind (in person and in Survey Monkey before that section) them to say N/A if not applicable to their role.
- Self-assessment on mapping is not enough, most people tend to underestimate their competencies and a very few overestimate them.

Pioneering

- Many of the lessons above were learnt from early adopter services/agencies, which changed our subsequent messaging and prevented lessons from being repeated.
- Dedicated admin and event co-ordination time/resource is crucial.

The detailed research report will be completed by 31 January 2018.

Survey Monkey: priorities for competency development

In the final analysis, 441 practitioners from 24 services mapped their competencies against all 289 competencies. The number and proportion (out of 441) of practitioners identifying that they needed but did not have (N) or partially had (P) each competency was ranked. Only those competencies with >25% of respondents N or P were further analysed. Competencies scoring

highly were then grouped into themes that are naturally practised and taught together (Table below).

Table1: Highest-ranked competencies by theme (range, number responding N or P and %)

Competencies (theme)	No.	%
1. Mental health and addictions	113-258	26-59%
2. Working effectively with Maori	110-220	25-50%
3. Trauma-informed practice	112-196	26-45%
4. Professional practice, self-care, UN Convention on the Rights of the Child	109-178	25-41%
5. Child health and development, engaging effectively with children and young people,	110-164	25-37%
6. Assessment, formulation, treatment planning	114-163	26-37%
7. Networking, liaison, legislation, policy, information sharing	110-148	25-34%
8. Child protection, family violence	115-142	26-32%
9. Engaging families, whanau and caregivers	111-127	25-29%

The competency with the greatest number of practitioners identifying themselves as N or P was "Has an awareness of the legislation relating to addiction issues" (258, 59%). Addiction and mental health competencies generally were the highest-ranked by the sector overall.

DISCUSSION AND NEXT STEPS

Stakeholder interviews, surveys and our own observations suggest a high level of engagement has been achieved across sectors for the Ngātahi Project. Four hundred and forty one staff across 24 agencies or services in Hawke's Bay have identified the competencies they believe they need but do not yet have to work effectively with vulnerable children. There is high consistency in the rankings of competency needs between services. The mapping results are also consistent with the competency gaps observed in everyday practice.

On 6th November sector leaders met again to agree the training and development priorities for the Ngātahi Project in 2018 and 2019. Given that staff release time is limited and that there is a large workforce to put through the training, three areas were prioritised: Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Practice. Self-care was agreed as needing to be the first priority of the Trauma-Informed Practice work stream.

Sector leaders joined or nominated staff to join one or more of the three work streams. Work streams are currently in the process of agreeing a chair(s), membership and terms of reference, and will commit to attending and contributing to the work stream. Work streams will be empowered to recommend what will be taught, how and by whom, follow-up activities to embed the new competencies into practice and how each competency should be assessed.

OPTIONS ANALYSIS FOR 2018 AND 2019

Three options have been identified to address the additional competencies/ development needs indicated by the mapping process:

Option one is to buy in external trainers. This is not the preferred option because:

- There is agreement among sector leaders that there is considerable expertise in the identified training areas within the participating agencies and services.
- Buying in training would be expensive.
- Buying in training would not allow for building local trainer capacity, and would not allow for the sustainability of training on an ongoing basis.

Option two is to only use local training resource. This is not the preferred option because:

- While there is considerable skill and expertise in the identified training areas, there are some training areas that are specialised and have been well-developed by experts in the field.
- Buying in some external training will reduce the work load on local trainers.

Option three (recommended) is to use a hybrid approach to training, i.e. a mixture of using external trainers where local expertise needs to be augmented (in a train-the-trainer approach to develop local capacity) and using local training resource.

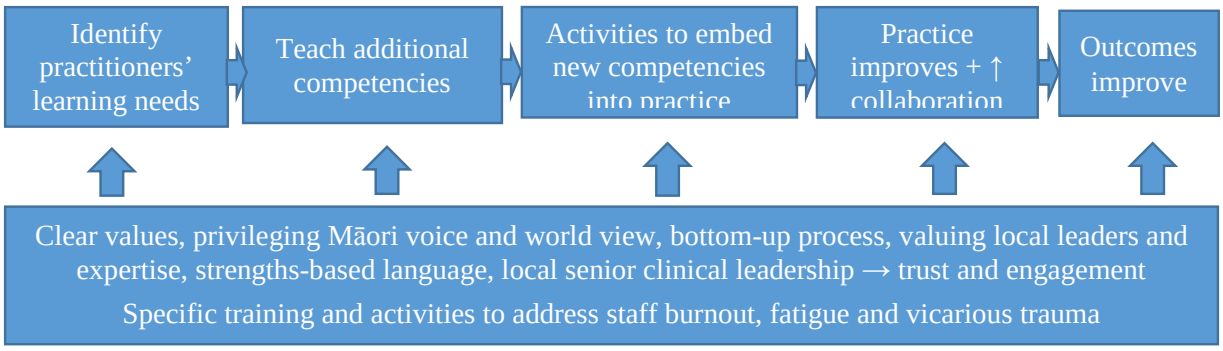
The intended approach for the roll out of training is as follows:

- Leaders chose three training areas to progress in 2018 at the hui on 6th November, i.e. Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Practice.
- Three work streams were formed to determine the content and process of the training, how it will be embedded into practice, and how it will be evaluated. These work streams will make decisions on the internal and external resources needed.
- Working Effectively with Māori work stream members will support the other two work streams to advise on the cultural competency aspects of the training.
- Table 1 above and the detailed analysis suggests that for each programme of learning, up to 250 practitioners may wish to attend training and enter a programme to embed the new competencies into practice. Our experience in teaching assessment of child protection and family violence is that this is best achieved in small groups of no more than 20, particularly when role play is involved, so we may expect registrations for up to 12-15 courses for each theme. In 2018, the estimated number of registrants for the Working Effectively with Māori and Mental Health and Addictions training programmes are 250 each. The competency survey did not allow the estimation of the likely number of registrants for the self-care training, but the research interviews indicate that this will be high-demand training and we estimate approximately 300 registrants for 2018. This could mean approximately 250+250+300=800 registrations and 40 training programmes for groups of 20 people in 2018.

EXPECTED OUTCOMES AND BENEFITS

Hawke's Bay is the first region to undertake workforce development across the vulnerable children's workforce at this scale so we have agreed to undertake the programme in partnership with the Ministry for Children Oranga Tamariki and share the lessons we learn with all relevant ministries and other regions. The original proposal has been discussed with and is supported by leaders in MCOT, MSD, HBDHB, Special Education and NGO social services in HB working with vulnerable children, who have a well-established history of collaborative working. We believe that this project could become a template for development of the vulnerable children's workforce nationally.

Our theory of change is essentially:



Measures and indicators

Outcome sought	Demonstrated by
Engagement	Research interviews year one with practitioners and managers
Practitioners' learning needs identified	Survey Monkey results Research interviews year one with practitioners and managers
Competencies taught	Number of attendees at training, number of trainings provided Evidence of programme delivery with fidelity Pre-post self-report of competence and confidence
New competencies embedded into practice	Description of activities and attendance at these Manager report of initial practice change with examples
Practice improved	Manager report of practice change with examples Practitioner self-report of competence and confidence New evidence-based programmes delivered, description, attendance Direct observation by evaluators
Collaboration improved	Manager report of improved collaboration with examples Practitioner self-report of improved collaboration with examples Direct observation by evaluators Reports from collaborative bodies (e.g., FVIARS, Strengthening Families, High and Complex Needs Interagency Management Group, Maternal Wellbeing Programme, Intensive Wraparound Service)
Reduced staff burnout, fatigue & vicarious trauma	Practitioner self-report HR indicators, e.g. recruitment, retention, turnover Direct observation by and feedback to evaluators
Improved outcomes for children and families	Client direct feedback within services Direct observation by and client feedback to evaluators Substantiated abuse (MCOT) Police family violence (POL 1310) callouts Number of children usually resent at POL 1310 callouts Intimate partner violence convictions (Courts) Referrals for severe behaviour to MOE and HBDHB

All outcomes to be assessed by independent researchers contracted to Ngātahi Programme.
All outcomes dis-aggregated by ethnicity.

ASSUMPTIONS

- Children will continue to be a Government priority, Ministers will commit resource and require ongoing collaboration of agencies for children.
- Relationships and buy-in will continue from:
  - Ministries
  - Local executives
  - Practice leaders and agency managers
  - Practitioners
  - Families, whānau, rangatahi and tamariki
  - Other stakeholders, e.g., trades unions, registration and disciplinary bodies
- Funding and resources will be available from MoE, MCOT, HBDHB and philanthropic sources for years 2 and 3.

RISKS and MITIGATIONS

Risk	Mitigation
If agency leaders do not contribute their agency's time and skills to work streams this risks losing the mandate for that training.	At the hui on 6th November a clear message was given that it is important to engage or will not be able to influence the training. It was also made clear that all contributions are welcome
If work stream members do not agree on the content and implementation approach by the deadline this will impact negatively on the project timeline.	The work stream chairs will be supported to facilitate work stream well, value all contributions and look at best practice evidence. If no agreement in work stream this will be escalated to the governance group.

BUDGET HBDHB Ngātahi Project Financials				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Senior clinical leadership	0.5 FTE	$55,000	$55,000	Clinical leadership is required to engage managers and staff in the learning programme, identify, recruit and brief the trainer, support managers and staff to arrange peer review groups, and support the evaluation.
Event management	0.5 FTE	$27,500 ($55k pro rata)	$27,500 ($55k pro rata)	Experience this year suggests that we need event management capacity for the following: website design; online registration, tracking and reporting attendance and feedback; venue hire, IT, catering and certificates. The HBDHB EDC team is a multidisciplinary team with considerable experience in the above tasks.
External trainers		$50,000	$50,000	We would take a train-the-trainers approach with external trainers but a small budget will be required to bring in external trainers initially and for follow-up peer review.
Evaluation To be sought from HBDHB Transform and Sustain Fund		$80,000	$80,000	Ngātahi is a pilot project that, if successful, is likely to be taken up nationally. There is therefore a strong obligation to ensure the programme is evaluated independently and thoroughly, so clear documentation of lessons learnt and areas to improve are essential. Measures and indicators for 2018 and 2019 are noted above. The budget for 2017 was $80,000. We estimate that a credible evaluation could be expected for $80,000/year in 2018 and 2019.
Training costs		$20,000	$0	See table below re training costs
TOTAL COST		**$232,500**	**$212,500**	

Costs to participating services				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Training costs		$0	Contribution per agency to be determined	There will be costs for venue hire, IT, photocopying, catering and certificates. We will ask services, whenever possible, to donate venues for training and staff to bring their own lunch. Work streams will be asked, wherever possible, to identify local leaders to deliver training and support ongoing activities such as peer review. While this a cost to services (time spent training is time not spent in practice), reciprocity occurs because these services also gain from their staff attending training provided by others, and improving their practice. While we are asking for funding for the training costs in 2018, we will ask agencies/services to contribute to these costs in the 2019. The first year will give us an indication of how much we will likely need in 2019, and the contribution from each agency will then be determined.

RECOMMENDATION

That the MRB, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council and the HBDHB Board:

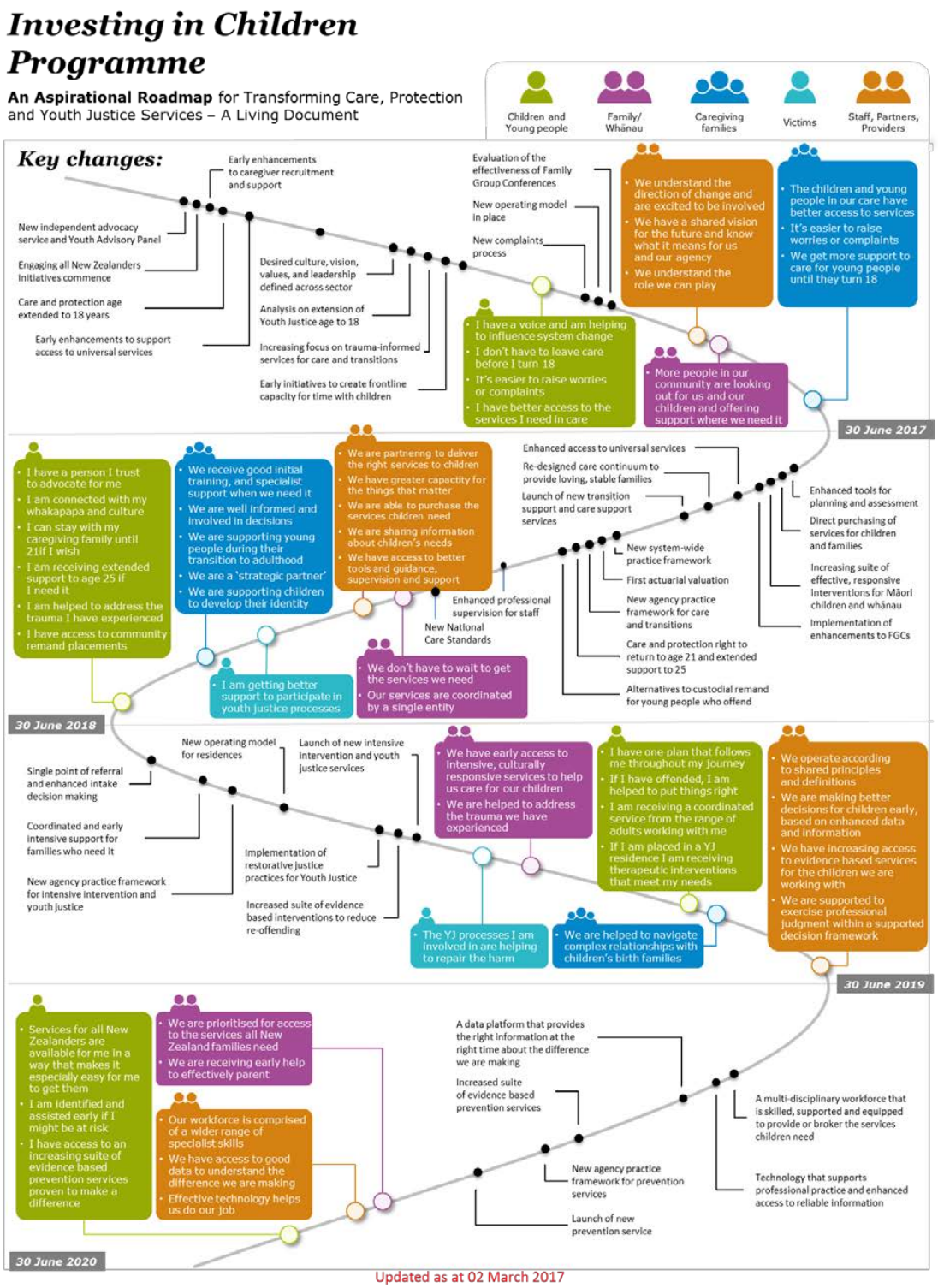
- **Note** the progress of the Ngātahi Project in the first year
- **Note** the approach endorsed for Years 2 and 3 of the Ngātahi Project and the forecast budget of $232,500 for 2018 and $212,500 for 2019
- **Note** that theTransform and Sustain Steering Group will be asked to contribute funding of $80,000 in FY2017/2018 and FY2018/2019 for the evaluation component of the project.
- **Note** that the remaining funding has been sought from the Ministry for Children Oranga Tamariki and a philanthropic funder.

Appendix 1: Agencies/Services Participating in the Ngātahi Project

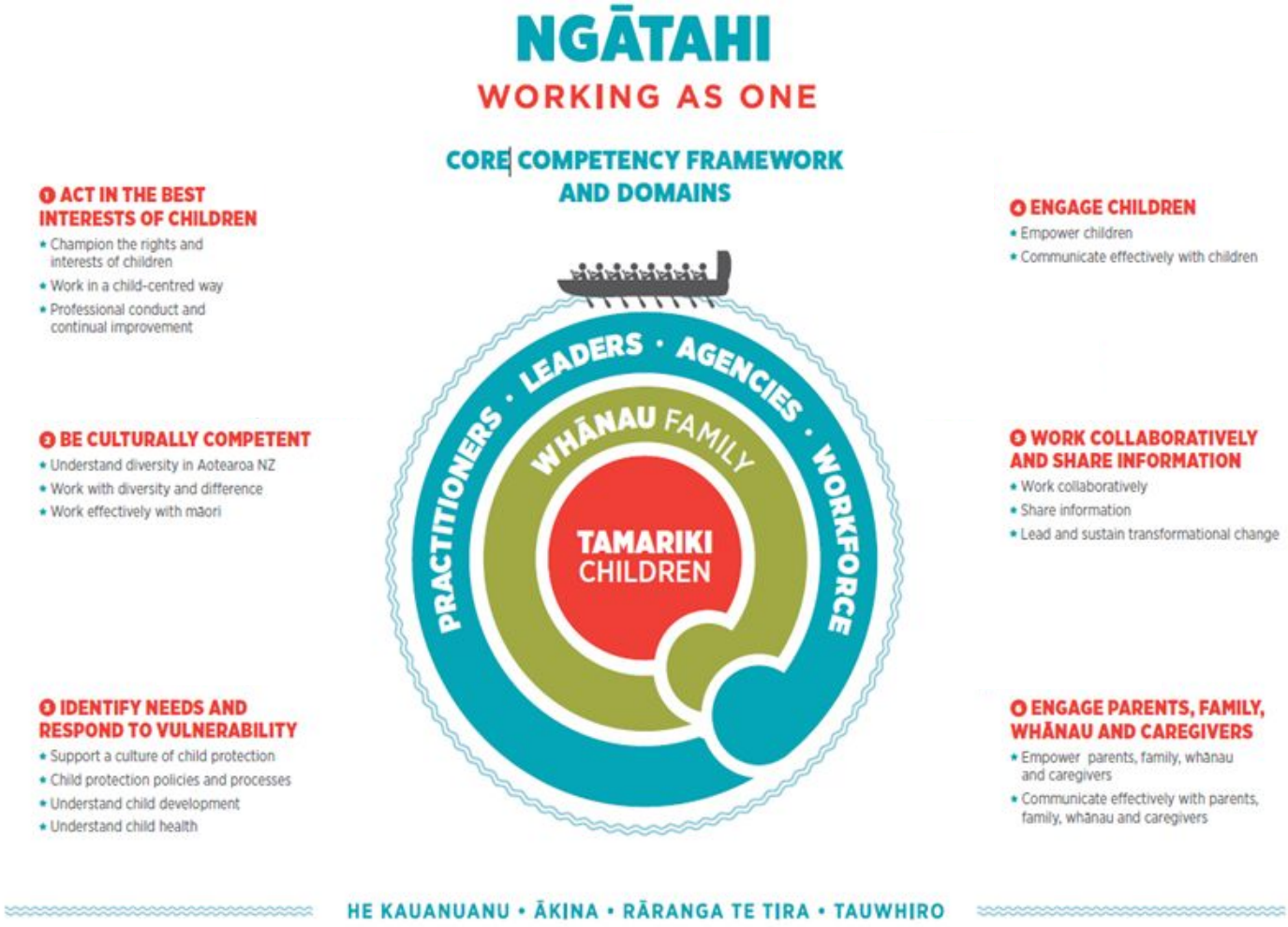
1 HBDHB – Child Development Service (CDS)
2 HBDHB - Child, Adolescent & Family Service (CAFS)
3 HBDHB – Family Violence & Child Protection Programme
4 HBDHB – NASC
5 HBDHB - Public Health Nurses
6 HBDHB – Te Ara Manapou (Parenting & Pregnancy Service)
7 Te Kupenga Hauora
8 Roopu a Iwi
9 NZ Police
10 Youth Horizons
11 Ministry of Education
12 Birthright HB Child & Family Care
13 Napier Family Centre
14 Ikaroa Rangatahi
15 Ministry for Vulnerable Children Oranga Tamariki (Napier)
16 Awhina Whanau Services
17 Open Home Foundation
18 Resource Teachers- Learning & Behaviour (RTLB)
19 Ministry for Vulnerable Children Oranga Tamariki (Hastings)
20 Directions Youth Health Service
21 Dove Hawkes Bay
22 Family Works
23 Te Taiwhenua o Heretaunga (Mental Health, Tamariki Ora, Family Start)
24 Plunket

Appendix 2: Investing in Children Aspirational Roadmap

http://www.msd.govt.nz/about-msd-and-our-work/



Appendix 3: Core Competency Framework Summary



[1] https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/investing-in-children/investing-in-children-report.pdf
[2] Office of the Children's Commissioner. Final report on the investigation into the death of Riri-o-te-Rangi (James) Whakaruru. Wellington, Office of the Children's Commissioner, 2000
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[4] Laming Lord. The Victoria Climbie Enquiry. London, HMSO, 2003. http://vcf-uk.org/wp-content/uploads/2010/07/laming-report.pdf
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[6] http://www.werryworkforce.org/real-skills-plus-camhs

HAWKE'S BAY District Health Board Whakawāteatia	**Suicide Prevention Update**
	For the attention of: **Maori Relationship Board, Clinical Council, Consumer Council and HBDHB Board**
Document Owner:	Allison Stevenson – Acting Executive Director Provider Services
Document Author(s):	Penny Thompson – Suicide Prevention Coordinator
Reviewed by:	Allison Stevenson, Jenny Cawston and Executive Management Team
Month:	February, 2018
Purpose	• Provide Suicide Prevention update to the HBDHB Board
Previous Consideration	N/A
Summary	• Suicide Prevention Activities • Barriers and Limitations • Future Activities
Contribution to Goals and Strategic Implications	• Improving quality, safety and experience of care • Improving Health and Equity for all populations • Improving Value from public health system resources
Impact on Reducing Inequities/Disparities	• Working with Flaxmere Planning Committee • AEIOU voice over via social media
Consumer Engagement	• Community led initiative • Resource revised according to feedback
Other Consultation /Involvement	• Flaxmere Planning Committee • Clinical Advisory Services Aotearoa
Financial/Budget Impact	• Raising Awareness Campaign for December 2017 – March 2018 • Communications System
Timing Issues	N/A
Announcements/ Communications	• Clinical Advisory Services Aotearoa support initiated in late November
RECOMMENDATION **That MRB, Clinical Council, Consumer Council and HBDHB Board** • Provide feedback • Approve this report be submitted to the February HBDHB Board meeting	

Suicide Prevention Update

Author:	Penny Thompson
Designation:	Suicide Prevention Coordinator
Date:	18 January 2018

OVERVIEW

Every year one in five New Zealanders experience some form of psychological distress or develops a diagnosable mental disorder (Ministry of Health, 2006). These numbers are increasing and will continue to do so under the current system and the way services are delivered. According to Stone et al (2017) an effective suicide prevention strategy is strengthening accessibility and improving delivery of suicide care. It is believed that improved delivery for suicide care should occur on a continuum that starts with whanau and ends with acute inpatient services. Our future initiatives will need to add significant value to existing primary and community care services with potential to reduce the economic cost of a range of Government services, as well as improving population health status across both mental and physical health.

BACKGROUND

New Zealand has one of the highest youth suicide rates in the Organisation for Economic Cooperation and Development (Ministry of Health, 2017). Māori have higher suicide rates of 21.1 per 100,000 compared to that of non-Māori recorded at 14.6 per 100,000 in 2013. (Ministry of Health, 2013). According to Gluckman (2017) of particular concern is young Māori males aged 15 to 29. The rates of suicide for 15 to 19 years of age in 2010 was recorded at 15.6 per 100,000 adolescents (Gluckman, 2017).

In Hawkes Bay, twenty nine people took their lives in 2013 (Ministry of Health, 2013). According to Coronial Services New Zealand (2017) the rates of suicide for Māori are disproportionate to that of non-Māori with a decline in non-Māori suicide rates since 1996 and although trends are hard to determine with population fluctuations, there appears to be no decline for Māori nationally.

Suicide is a complex issue and will require multi-faceted interventions to reduce or eliminate suicides such as; building resilient people and communities, creating protective environments and eliminating inequities caused by poverty or hardship (Stone et al, 2017). The social reasons behind suicide is emphasised by adverse childhood experiences suggesting that increased exposures to adverse childhood trauma such as child abuse, neglect, poverty, family violence or parent in prison can significantly increase the occurrence of depression and suicide attempts compared to those people who do not experience adverse childhood trauma (Felitti et al, 1998).

SUICIDE PREVENTION INITIATIVES - CURRENT

The HBDHB has shown a great deal of commitment to suicide prevention since the four youth suicides in December 2013. Such commitment can be seen in the management and operational leadership to drive suicide prevention activities across public sectors, allocating permanent funding, building and creating strong relationships with non-government organisations, schools and communities such as Flaxmere, Central Hawke's Bay and Havelock North. The network of

agencies participating in suicide prevention/postvention continue to improve what they do whilst looking for opportunities to do things differently. There are currently three large initiatives in progress, one working with the Flaxmere Planning committee to implement their community plan and the other being the Local Response Team (LRT), who is responsible for ensuring support is in place for those who have been impacted by suspected suicide. The LRT has extended its scope to include the youth suicide prevention space.

1. Flaxmere Planning Committee
   On the 9th October, the same week of Mental Health Awareness week, the Flaxmere Planning Committee launched a Flaxmere Wellbeing Challenge that finished on the 24th December promoting group, individual activities and events that focus on the Five Ways to Wellbeing. The challenge asked people to register and share their journeys on their Facebook page. The challenge has been driven and created by the Flaxmere Planning Committee with involvement from Flaxmere based services.

2. Youth Suicide Prevention
   The LRT youth suicide prevention work is intended to take a comprehensive cross sector approach for youth up to the age of 17, who have a child protection and suicide attempt event in the Police system. The LRT designate a lead agency, create and/or share plans. This process has taken some time to initiate and the network of agencies working in the multi-disciplinary space is continuously attempting to improve the process and outcomes. This work increasingly requires mental health clinical expertise to guide best practice.

3. Postvention (the time after a suicide occurs)
   Postvention management continues as a component of suicide prevention care. The need to coordinate support increases significantly when a suspected self-inflicted death notification for a youth is received. This is due to the impact of friend's networks, social media and the effect on schools. This year the LRT has actively been working together to support various high schools in the region with timely risk assessments, communications support, promoting services available and parent evenings.

   The suicide prevention network have been working closely with the Clinical Advisory Services Aotearoa Community Postvention Response Services (CPRS) to manage recent suspected self-inflicted death notifications for two people who knew each other. A cross sector response was initiated immediately with the timely review and development of resources, creation of a two month communications plan from December to March, ongoing guidance from CPRS and clear actions for the suicide prevention network. CPRS has commended the Hawke's Bay Suicide Prevention network for the decisive response and will continue to support the network as needed.

BARRIERS AND LIMITATIONS

There are two main barriers and limitations that could significantly improve the capacity of the suicide prevention network.

1. One communication system – patient/client management systems accessible across sectors, especially Ministry of Vulnerable Children, Police and HBDHB.

   Currently, under the guidance of the Privacy Rights and Vulnerable Children's Act, the Suicide Prevention Coordinator provides intensive administration support collating information, assigning clear actions and managing accountability for stated actions. One communication system would make the information more accessible, current for all major sectors and reduce the administrative process overall. The States Services Commission et al (2014) Working Better Together and Getting to Great reports suggest core business effectiveness and efficiencies need to be as strong as an organisations ability to react to events. However, there is no escaping the economic impact of creating one communication system, unless the costs and rewards are shared across sectors.

2. Mental Health – increased demand on services (internal and external to the DHB) could be an acknowledgement of the increased awareness of services in the community. However, the demand compared to the full time equivalents available makes timeliness to access support difficult. In conjunction, there is an increased need for mental health and addictions services available in the community.

   In contrast, there has also been some mental health specific initiatives implemented in the last 18 months that address some of the contributing factors connected to suicides

   - Te Ara Manapo – a maternal and parental mental health and addictions service that works through the parents to give the child the best start in life.
   - Mental Health Credentialing of Primary Care/Practice nurses to increase the confidence of primary care staff to manage mental health in the community
   - Day Programme at Te Harakeke involving group interventions
   - Home-based Services – managing clients care in their home
   - Resilience coaching for youth – through Health Hawke's Bay, the DHB is funding Youth Resilience programmes being delivered in schools. The programme began in Term 2 of 2017 and the feedback from schools has been very favourable.

   However to increase the level of wellbeing, resiliency and equity requires a shift in focus. We need to ensure the services have the flexibility to respond to the social complexity of people's lives. Felitti et al (1998) supports this approach understanding that adverse childhood experiences can have a significant effect on individuals and impact their overall health outcomes.

THE FUTURE OF SUICIDE PREVENTION

- Researching Zero Suicides Quality Improvement Framework
  Zero Suicides Quality Improvement Framework is growing interest in New Zealand with Canterbury and Waitemata choosing to implement. The Zero Suicides workshop for Health Professionals held in October 2017 had international presenters sharing their results such as, improved organisational performance and culture post training, improved patient/client outcomes and service specific results including reductions in restraint care, assaults on staff and disciplinary cases. Joe Rafferty of Mersey Care described the zero framework, as having revolutionised their organisation approaches and that it is not a sprint to the end but rather a journey. It is expected more research into this area is required to determine the resources needed to implement such a framework.

- Community
  A "By Community for Community" approach has been a focus for the suicide prevention network. We have continued to work with Flaxmere Planning Committee to guide and support them to promote wellbeing in partnership with their local community centre, waterworld, GP Practice, church groups, park features (such as disk golf), local businesses and local events. There have been some early learnings which will be discussed in more detail later in the 2018 year. The suicide prevention network in partnership with the Flaxmere Planning Committee intends to utilise a Results Based Accountability (RBA) to gauge effectiveness of a "By Community for Community" approach. In addition, alongside the Hastings District Council the next community we are working with is Havelock North, with the potential to include Omahu and Raureka.

- Resources and Education
  Recently the suicide prevention network have approved back of bus marketing over the summer holidays to further promote "it's ok to ask for help" and the 1737 telehealth service. Furthermore the "it's ok to ask for help" wallet card resource has also been reviewed. This was done as a direct response from feedback acquired from parent evenings and

presentations. The overwhelming need from community is to know what they can do. An acronym AEIOU has been added to the resource and will be included to suicide prevention education/training sessions. In addition, a video clip of AEIOU with Maori voice over has been created to be shared via social media during the summer holidays. Early stages of planning have been initiated with sessions to be held for church groups and schools (including primary and intermediates). Furthermore, we expect to have Le Va – Lifekeepers training available in 2018.

- Post/Prevention
  Lastly, postvention response is a necessary process to ensure those bereaved by suicide have support. Postvention along with the youth suicide prevention work will continue with the overwhelming consensus from LRT agencies to work better together, utilise our resources efficiently and improve outcomes for youth. This work will continue to develop and expand as required and if feasible.

- Strategy Development
  The suicide prevention network expect to focus on the development of a suicide prevention strategy, to submit to the Ministry of Health by 30th June 2018.

In summary the suicide postvention/prevention space requires flexibility to adapt or respond to the needs on any given day. The work across sectors continues to grow with the ongoing commitment of those agencies and services participating in the network. It is clear that ongoing clinical mental health expertise is required to support best practice. We look forward to completing a RBA framework to evaluate the effectiveness of working community by community.

RECOMMENDATION

That MRB, Clinical Council, Consumer Council and HBDHB Board

- Provide feedback
- Approve this report be submitted to the February HBDHB Board meeting

Reference List

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ATTACHMENTS:

- **"**It's Ok to Ask for Help" Bus Backs
- "It's Ok to Ask for Help" Wallet Card

NEED TO TALK?

1737

Free call or text any time

Aunty Dee

Aunty Dee is a free online tool you can use on your mobile phone, tablet, laptop or personal computer

www.auntydee.co.nz

www.commonground.org.nz
www.thelowdown.co.nz
www.sparx.org.nz

SAMARITANS 0800 726 666

WHATS UP 0800 942 8787 (1-11pm)

YOUTHLINE 0800 376 633 (11-11 7 days)

DEPRESSION 0800 111 757 (24 hrs)
www.depression.org.nz

DIRECTIONS YOUTH HEALTH CENTRE
06 871 5307

Child, Adolescent & Family Mental Health Services 06 878 8109 ext 5848

COMMUNITY MENTAL HEALTH

Napier	06 878 8109	ext 4220
Hastings	06 878 8109	ext 5700
Wairoa	06 838 7099	ext 4875
CHB	06 858 9090	ext 5551

EMERGENCY MENTAL HEALTH
0800 112 334

ARE YOU CONCERNED ABOUT SOMEONE?

This is one thing you can do:

A Ask if someone is feeling suicidal. Be direct and matter-of-fact.

E Ensure immediate safety (take away means to suicide like ropes, guns, pills and knives). Don't leave them alone.

I Identify the problems that a person is trying to escape from by taking their life.

O Offer hope that there are other ways out, another way to solve the problem, that there is Hope.

U Use professional / Services / Community / Kaumatua and Kuia to help. Don't be sworn to secrecy. Don't carry this alone.

We would like to acknowledge the original designers of AEIOU Roger Shave and Te Runanga o Ngāti Pikiao

13.1

WINNING WAYS TO WELLBEING

CONNECT
TALK & LISTEN,
BE THERE,
FEEL CONNECTED

Give
Your time,
your words,
your presence

TAKE NOTICE
REMEMBER
THE SIMPLE
THINGS THAT
GIVE YOU JOY

KEEP LEARNING
EMBRACE NEW
EXPERIENCES,
SEE OPPORTUNITIES,
SURPRISE YOURSELF

BE ACTIVE
DO WHAT YOU CAN,
ENJOY WHAT YOU DO,
MOVE YOUR MOOD

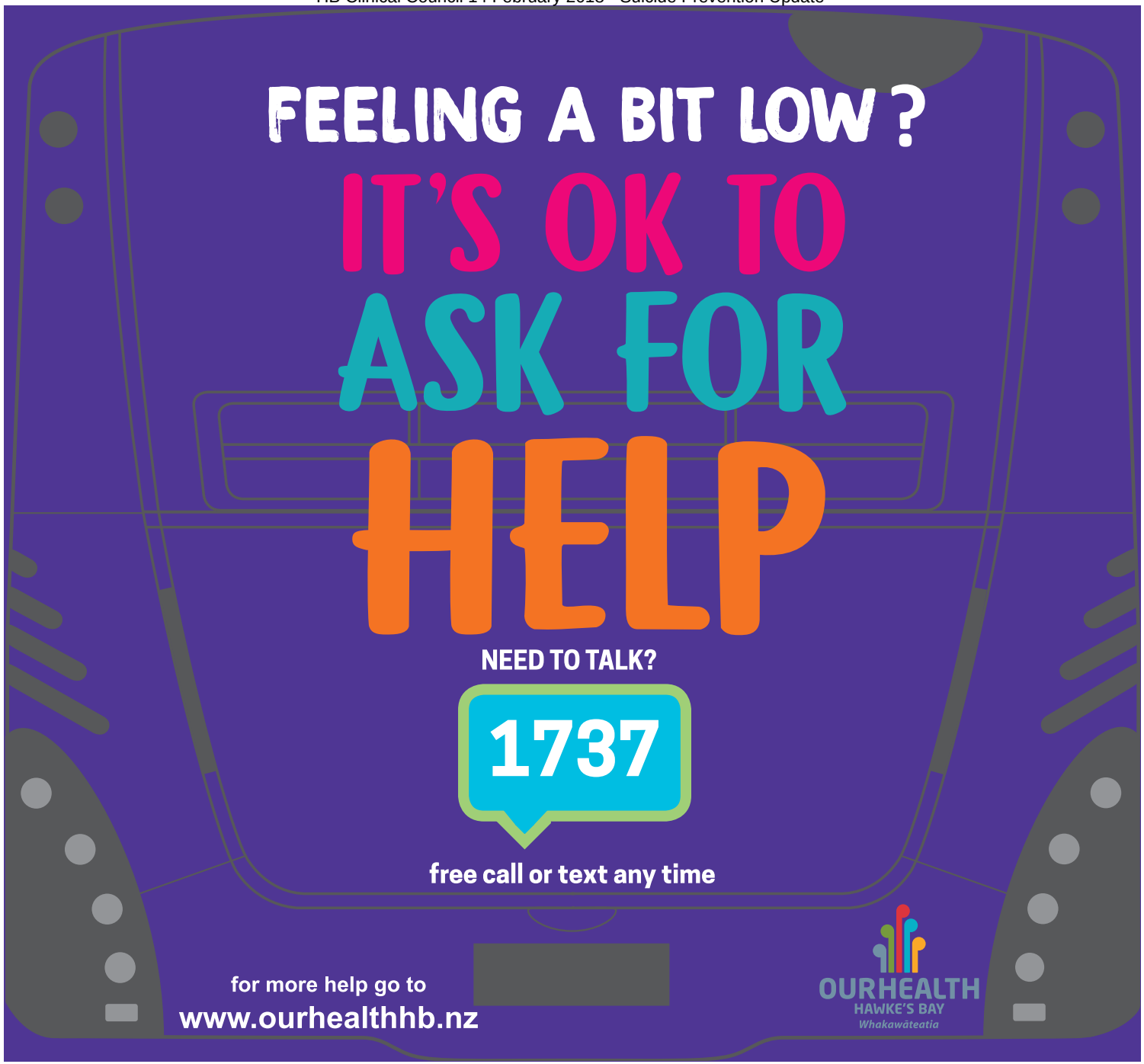
INTRODUCE THESE FIVE SIMPLE STRATEGIES INTO YOUR LIFE AND YOU WILL FEEL THE BENEFITS.

Mental Health Foundation of New Zealand
www.mentalhealth.org.nz

IT'S OK TO ASK FOR HELP

E hika mā, kei te pai noaiho, ki te pātai mō tētahi āwhina

OURHEALTH HAWKE'S BAY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1737
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for more help go to
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OURHEALTH
HAWKE'S BAY
Whakawāteatia

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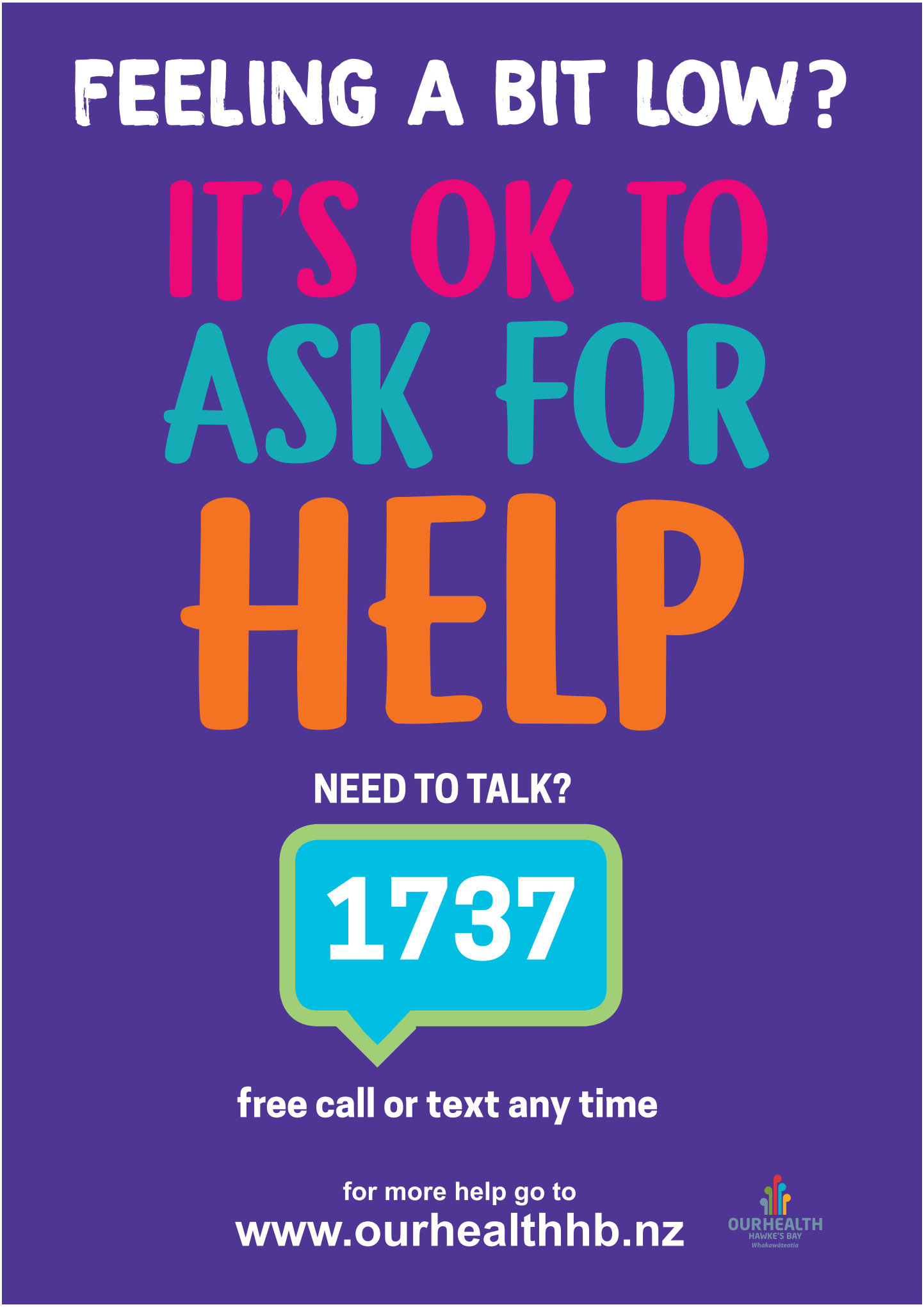
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HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council, HB Health Consumer Council, HBDHB Board**
Document Owner	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s)	Charrissa Keenan, Health Gains Advisor – Māori Health Patrick LeGeyt, GM Māori (Acting), Māori Health Jill Garrett, Strategic Services Manager – Primary Care
Reviewed by	Executive Management Team
Month/Year	February, 2018
Purpose	Provide an update on the Te Ara Whakawaiora priority areas relating to Access (ASH rates 0-4 and 45-64) Māori
Previous Consideration Discussions	Six-monthly update. No previous consideration.
Summary	ASH rates 0-4 (On track) • *Respiratory* - Review of the respiratory care pathways found that care pathways for this age band require development to address service and system barriers to access. • *Immunisation* - Achieving equitable outcomes for Māori. Work however needed to provide information that leads to appropriate time frames for presentation for immunisation by whanau. • *Oral health* – Showing excellent results of improved outcomes. • *Child healthy homes program* – Achieving significant increases in referrals. • *Skin Program* – The program in its initial phase of raising awareness of skin problems, identifying key stakeholders including ECE providers. ASH 45-64 (Not on track) • *System level improvement plan* – All activities are now in place. Utilisation of CPO programs by Māori is low and will need to be addressed in Q3-4. Appointments into rolls for cardiac services are now in place. • *Collaborative Pathways* – 75 pathways developed. Utilisation increasing by full complement of health professionals. New IT platform for the pathways is being sort in partnership with Central and Midland DHBs. Still more work needed to get pathways imbedded in BAU and funded accordingly • *Continuation of the Nurse led respiratory program* – Contract hold ups has meant recommencement of the program has been delayed. Working group in place to identify target groups and attach three-monthly kick start performance indicators to address current COPD rates.

	• *Implementation of the HBDHB Long Term Conditions Framework* Focus areas for the implementation team will be work force development, care coordination and transfer of care processes. The work is multi-disciplinary and spans multiple co morbidities including; respiratory, cardiac, renal and diabetes. Pharmacy is part of the multi-disciplinary team.
Contribution to Goals and Strategic Implications	Focus is on Improving Health and Equity for Māori
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity between Māori and Other
Consumer Engagement	(Forms part of each work stream)
Other Consultation /Involvement	Not applicable for this report
Financial/Budget Impact	Not applicable for this report
Timing Issues	Not applicable
Announcements/ Communications	None

RECOMMENDATION:

It is recommended that the Māori Relationship Board and/or Pasifika Health Leadership Group; HB Clinical Council, HB Health Consumer Council; HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the recommendations.

HAWKE'S BAY District Health Board
Whakawāteatia

Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)

Author(s):	Charrissa Keenan, Health Gains Advisor – Māori Health Patrick LeGeyt, GM Māori (Acting), Māori Health Jill Garrett, Strategic Services Manager – Primary Care
Designations:	As above
Date:	**February, 2018**

OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from AMHP quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board. The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of that TAW programme 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 Local Indicator.

UPCOMING REPORTS

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

Priority	Indicator	Champion	Reporting Month
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections 2. 45-64 year olds - heart disease, skin infections respiratory infections and diabetes	Mark Peterson	February 2018

MĀORI HEALTH PLAN INDICATOR

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) reflect 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 is needed to address 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). But what this also emphasises is the necessity for the health system to be working efficiency, effectively, and equitably in every way to ensure that health does not add to the socio-economic burden of ill-health. 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.

WHY IS THIS INDICATOR IMPORTANT?

System Level Measures

The Introduction of the System Level Measures; targeted performance measures, came into effect beginning 2016-17. The measures include some previous health targets included in the Integrated Performance Incentive Framework and a set of newly introduced, nationally agreed performance measures. Ambulatory Sensitive Hospitalisation (ASH) rates are included in two System Level Measures.

- ASH 00-04yrs is reported against under the SLM-Ambulatory Sensitive Hospitalisation (ASH)
- ASH 45-64yrs is reported under the SLM-Acute Hospital Bed Days.

Each ASH band for total population is divided into; Māori, Pacific, Other[1]. Targets are derived from the DHB ASH rates for the Māori population. The base line rates for the DHB will be compared with national total population rates and targets set accordingly. These are expressed in rates per 100,000. All Māori and Pasifika data reported against for ASH will analysed by Māori vs Other to adequately examine the equity gap.

Targets have been set to work towards eliminating the gap within a 2-5 year period. Using the base line as a measure, reducing the equity gap by half each year. If below 10% the aim is to eliminate the gap. Rates within 5% would be considered equitable (e.g. HBDHB Māori ASH rates to be at or below national total population rates) [2]

0 – 4 years

For the 2017 year the contributory measures regarding the System Level Measure of Reduced ASH rates for 0-4 years as agreed by Health Hawkes Bay and the Hawkes Bay DHB are:

- Paediatric respiratory training
- Increased Immunisation Health Target
- Oral Health Initiative

The 2016 top three ASH conditions for tamariki Māori 0 – 4 years were: dental conditions, asthma and respiratory infections – Upper ENT.

45-64 years

As of September 2016 the Top Three conditions contributing to the ASH rate for 45-64yrs were; cardiac conditions, respiratory (including COPD and Pneumonias) and Cellulitis. This is unchanged.

For the 2017-18 year the target areas as identified in the SLM-Improvement Plan are;

Using Health Resources Effectively: Reduce standardised acute hospital Bed Days per 1000 population for Māori to ≤461 (by June 2018)

Contributory Measures

- ASH rates 45-64yrs (Māori)

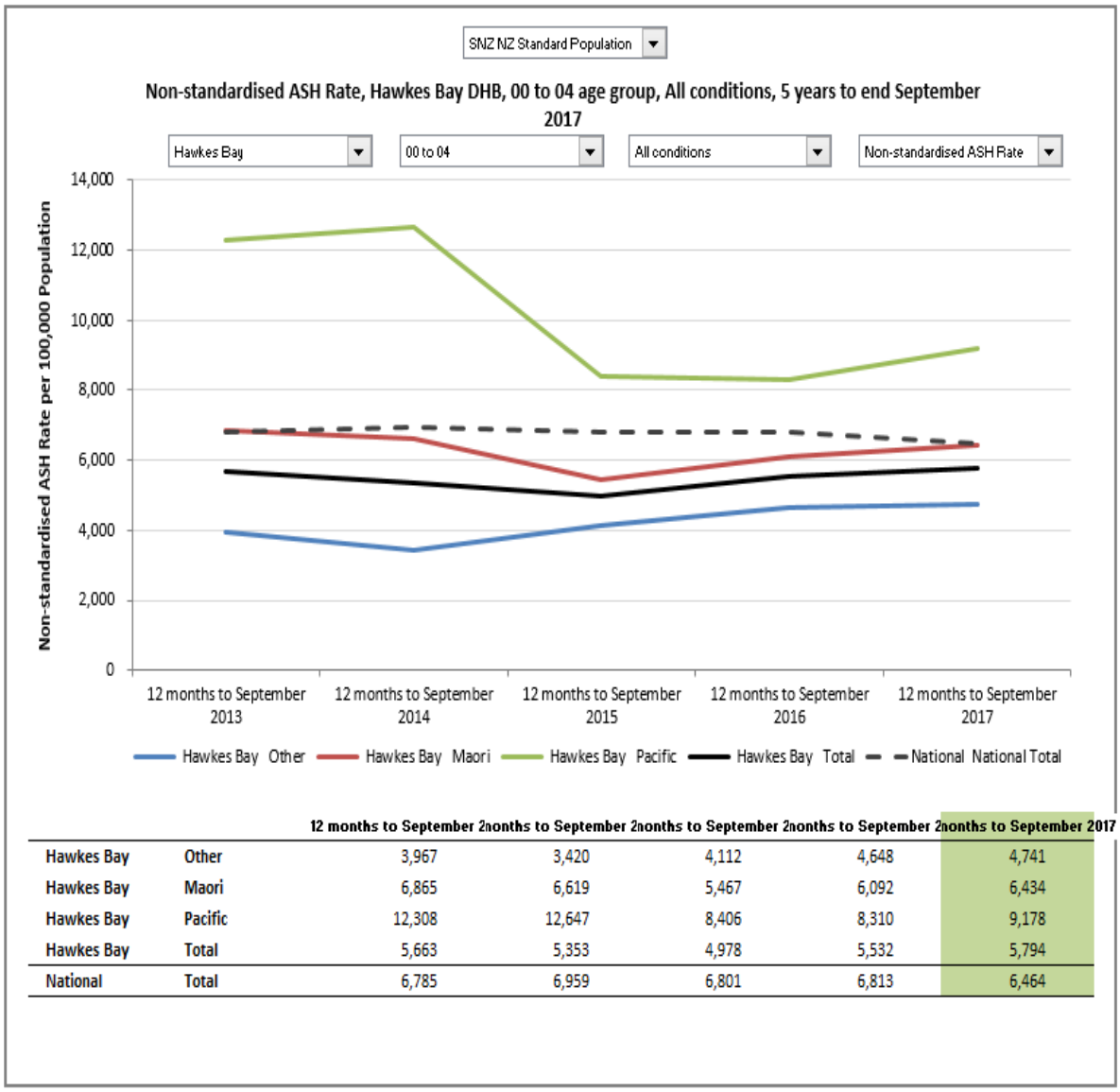
[1] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.
[2] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.

- Increase the number of Māori and Pasifika and Quintile 5 referred into the high needs enrolment program (PHO)
- Increase the number of referrals into the Coordinated Primary Options (CPO) program – Hospital Discharge pathway for Māori – Pasifika and Q4 and Q5.

HAWKE'S BAY DISTRIBUTION AND TRENDS

0-4 YEAR AGE GROUP

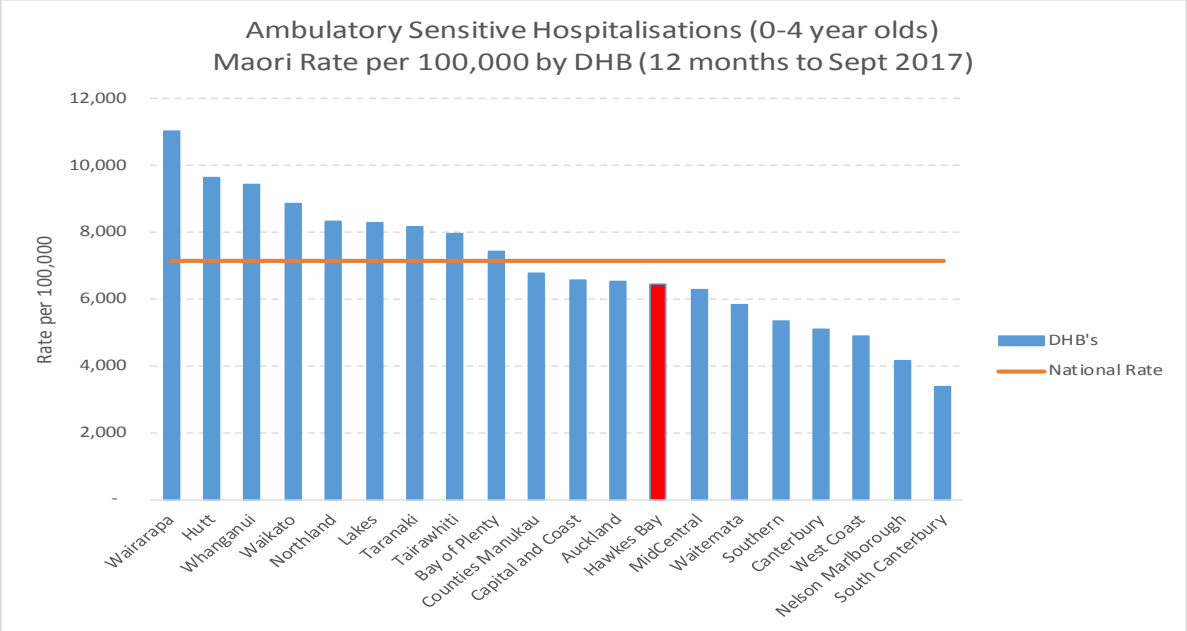
Hawke's Bay ASH rates by ethnicity 0-4 year age group – 12 months to end September 2017



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	3,967	3,420	4,112	4,648	4,741
Hawkes Bay	Maori	6,865	6,619	5,467	6,092	6,434
Hawkes Bay	Pacific	12,308	12,647	8,406	8,310	9,178
Hawkes Bay	Total	5,663	5,353	4,978	5,532	5,794
National	Total	6,785	6,959	6,801	6,813	6,464

As at September 2017 Hawke's Bay tāmariki have lower rates of ASH compared to national rates with the total ASH Rate for HB at 5,794 compared to the national rate of 6,464. Although this is positive HB has seen its overall ASH rate increase in the latest 12 month period by 4.7% decreasing the gap between HB and the National rate by 47.7%

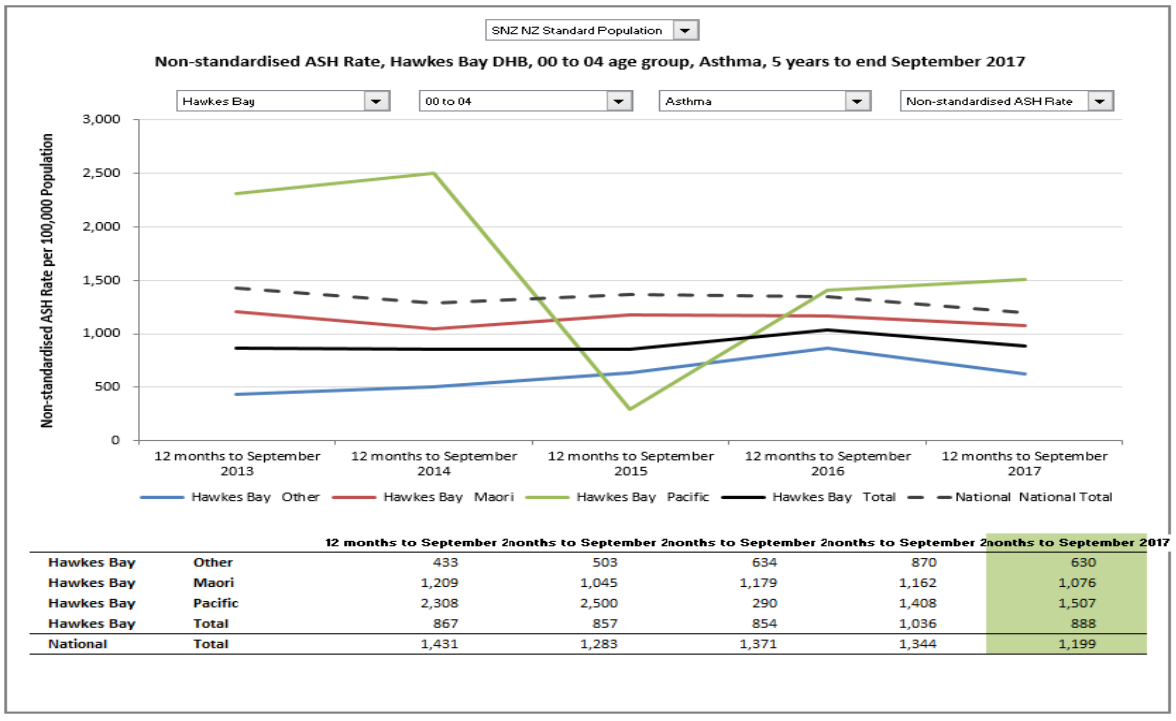
Hawke's Bay Māori ASH rates 0-4 age group 12 months to Sept 2017 – Benchmark against DHBs



In the 12 months to September 2017 the Hawke's Bay Māori rate was 99.9% of the national rate and 8th best performer of all DHB's with Māori rates, in the prior 12 month period we were the 6th best Māori performer in this age group.

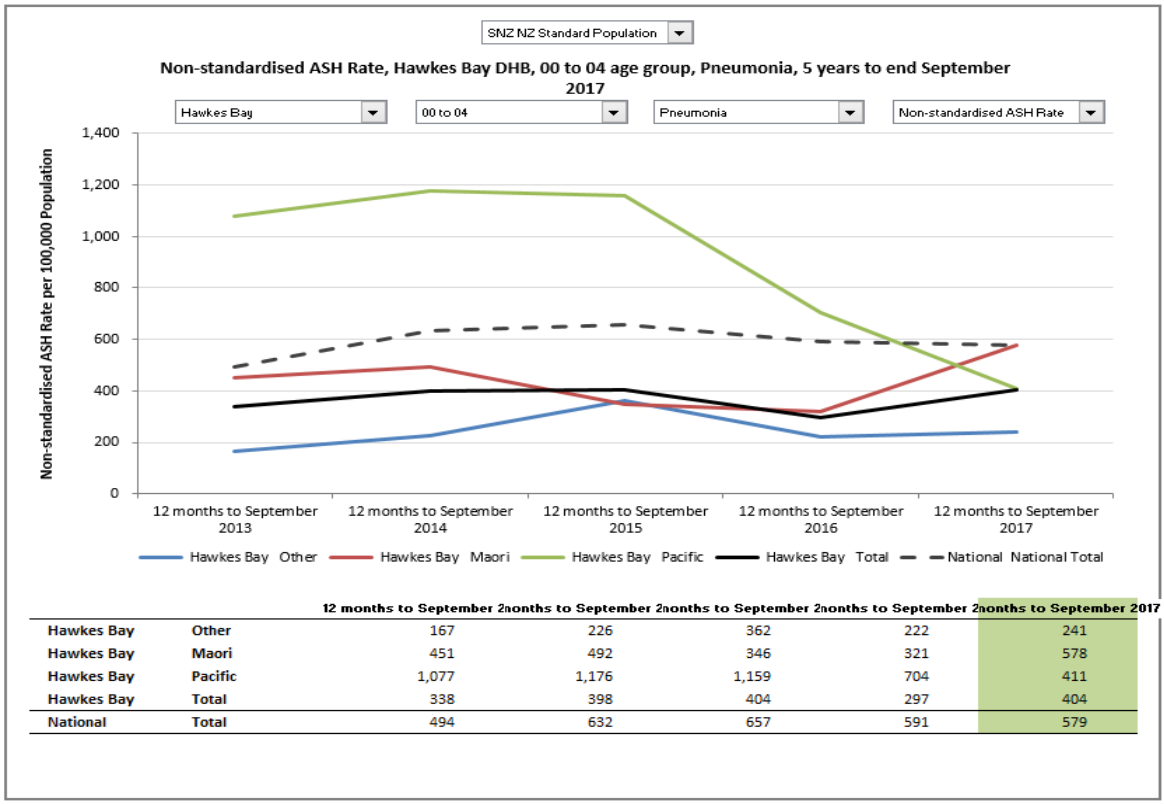
In 2017 one of the largest differences between Hawke's Bay Māori rates and national rates in the 0-4 year age group is Cellulitus, which is 29% above the nation rate.

Asthma



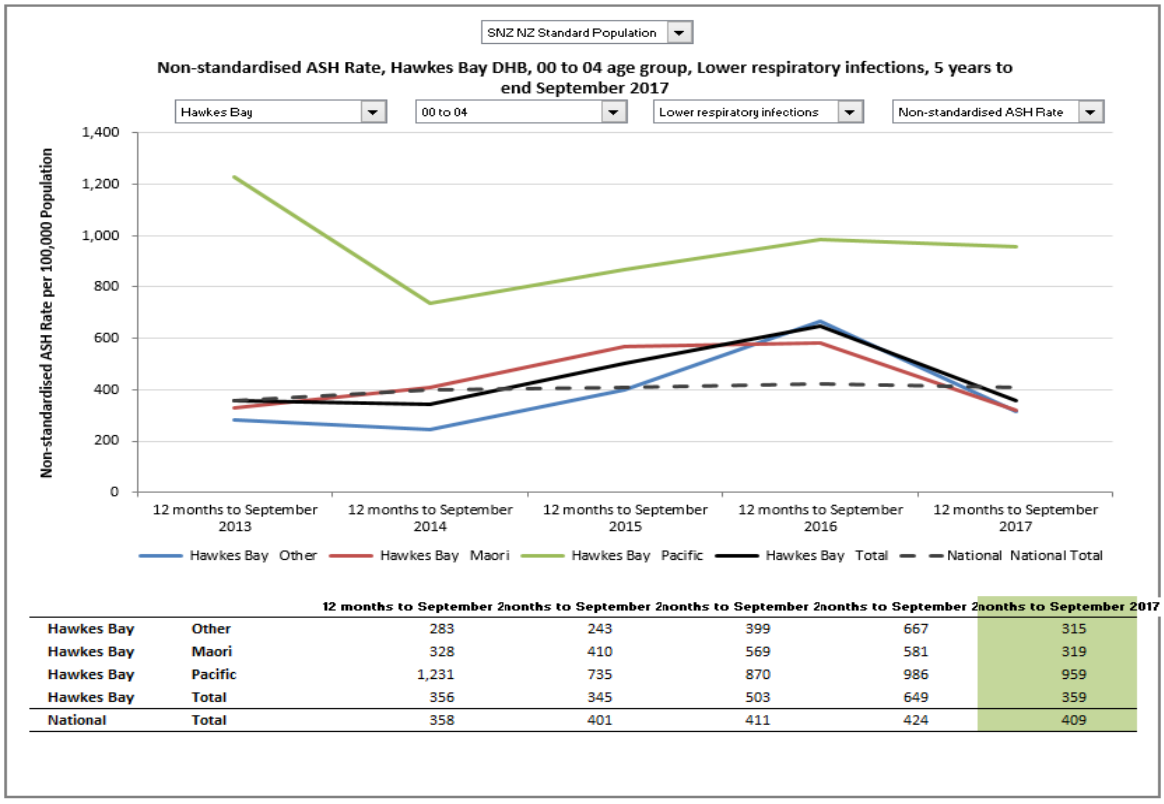
		12 months to September 2	nths to September 2	nths to September 2	nths to September 2	nths to September 2017
Hawkes Bay	Other	433	503	634	870	630
Hawkes Bay	Maori	1,209	1,045	1,179	1,162	1,076
Hawkes Bay	Pacific	2,308	2,500	290	1,408	1,507
Hawkes Bay	Total	867	857	854	1,036	888
National	Total	1,431	1,283	1,371	1,344	1,199

Pneumonia



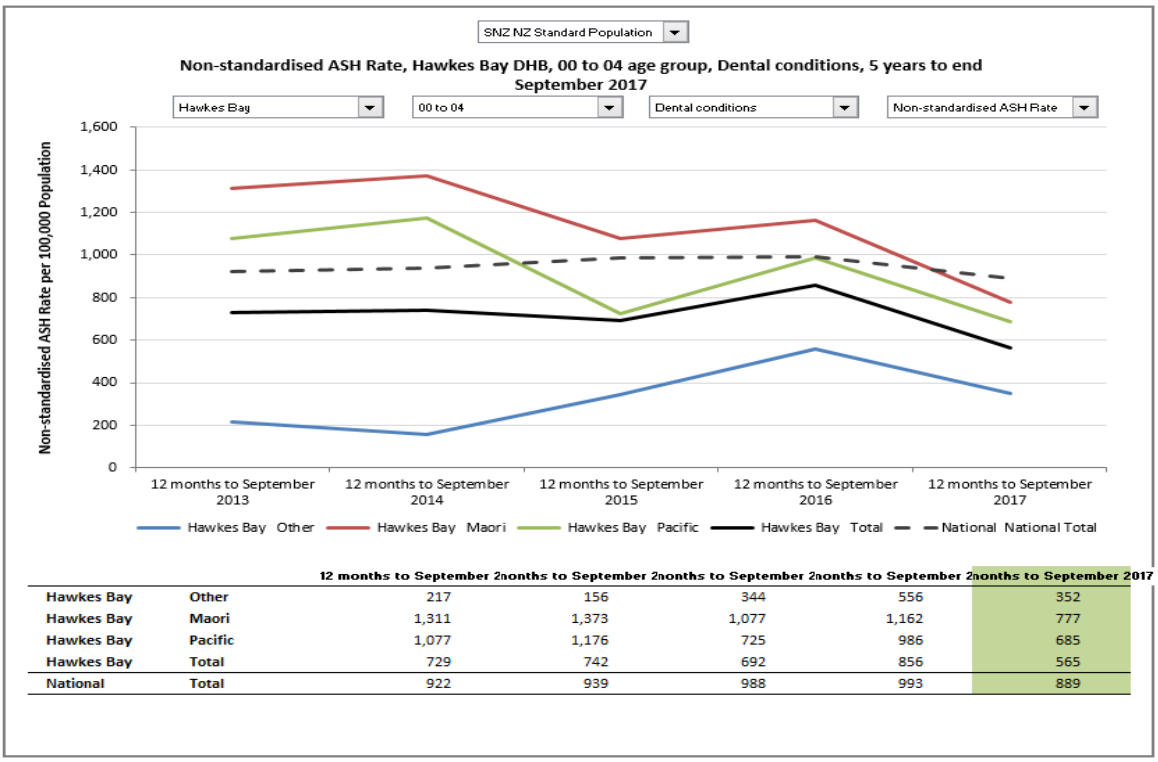
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	167	226	362	222	241
Hawkes Bay	Maori	451	492	346	321	578
Hawkes Bay	Pacific	1,077	1,176	1,159	704	411
Hawkes Bay	Total	338	398	404	297	404
National	Total	494	632	657	591	579

Lower Respiratory Infections



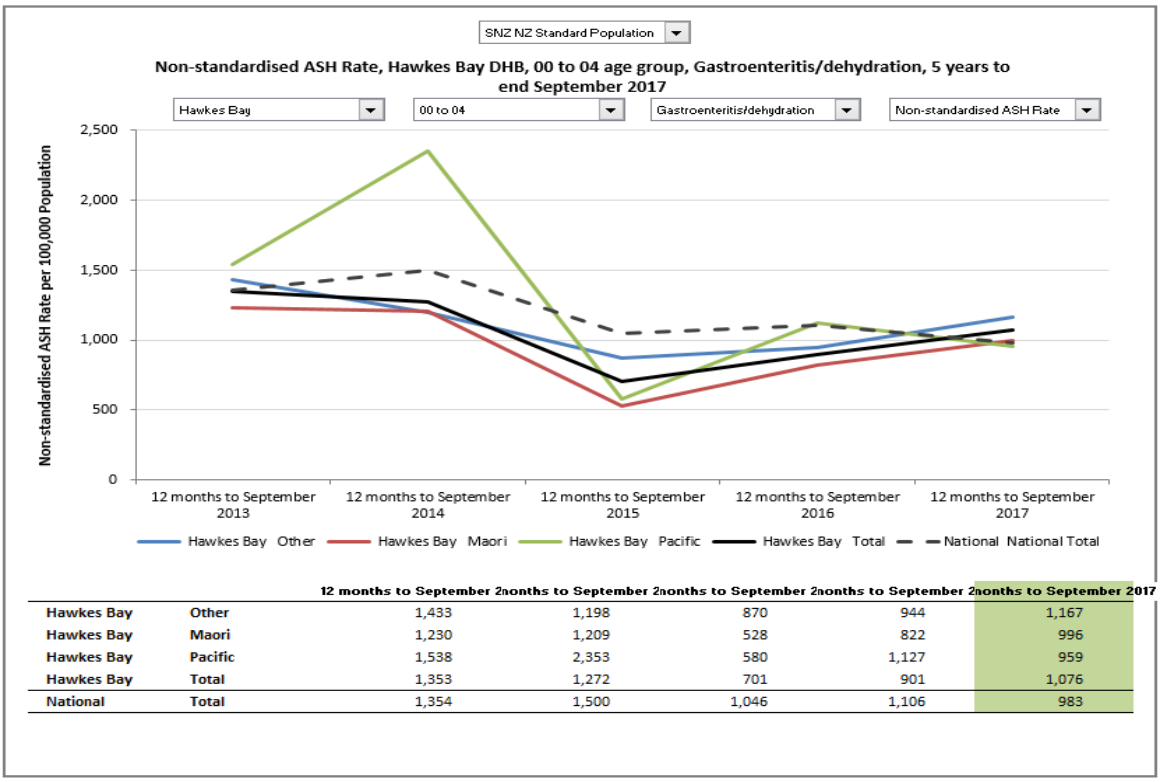
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	283	243	399	667	315
Hawkes Bay	Maori	328	410	569	581	319
Hawkes Bay	Pacific	1,231	735	870	986	959
Hawkes Bay	Total	356	345	503	649	359
National	Total	358	401	411	424	409

Dental



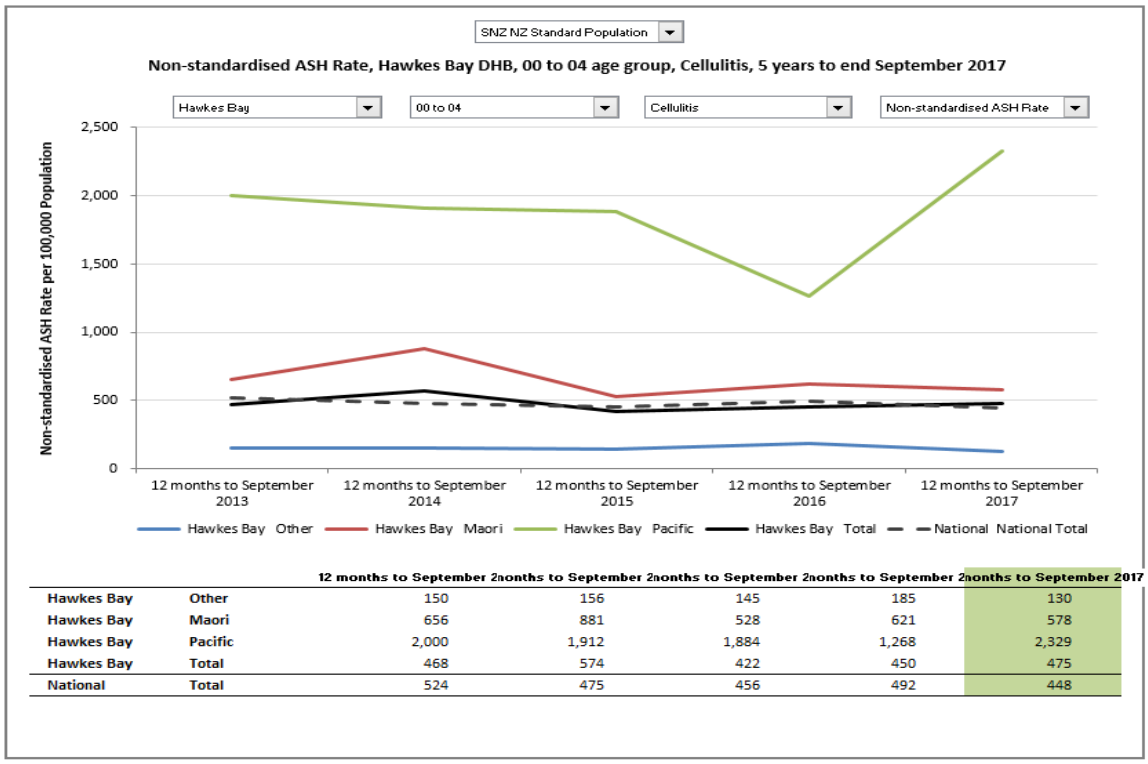
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	217	156	344	556	352
Hawkes Bay	Maori	1,311	1,373	1,077	1,162	777
Hawkes Bay	Pacific	1,077	1,176	725	986	685
Hawkes Bay	Total	729	742	692	856	565
National	Total	922	939	988	993	889

Gastroenteritis/Dehydration



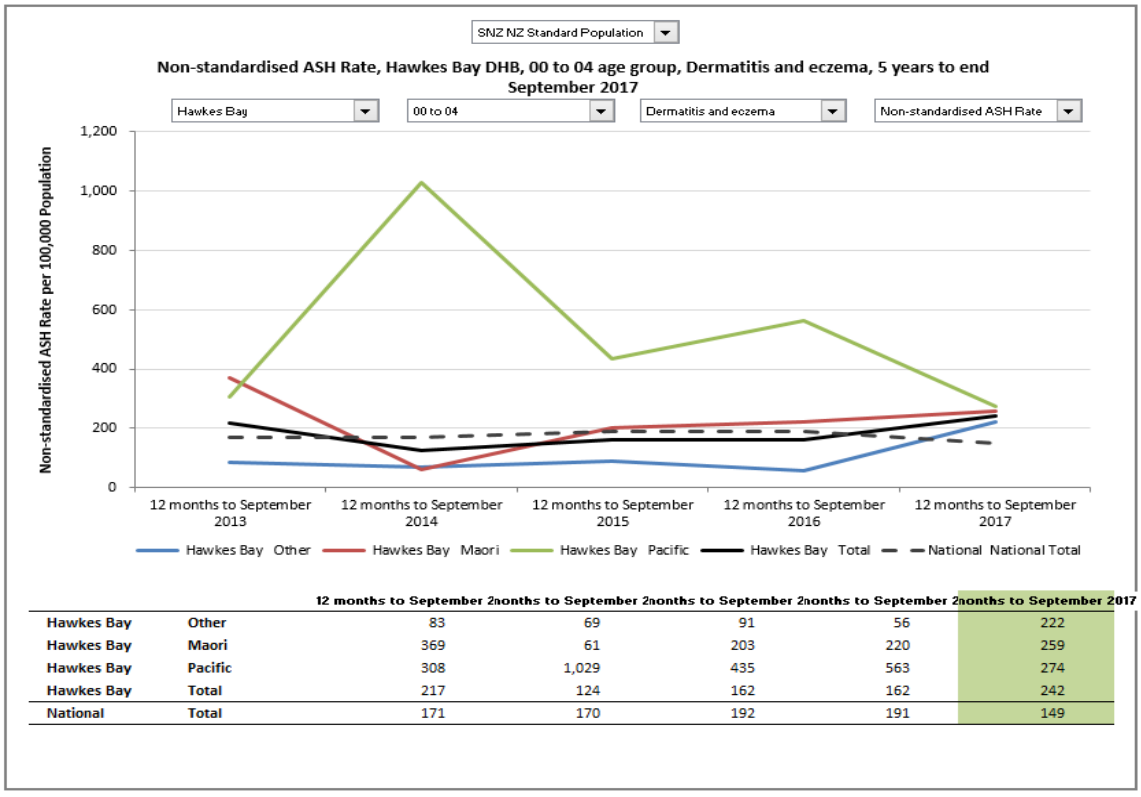
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	1,433	1,198	870	944	1,167
Hawkes Bay	Maori	1,230	1,209	528	822	996
Hawkes Bay	Pacific	1,538	2,353	580	1,127	959
Hawkes Bay	Total	1,353	1,272	701	901	1,076
National	Total	1,354	1,500	1,046	1,106	983

Cellulitis



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	150	156	145	185	130
Hawkes Bay	Maori	656	881	528	621	578
Hawkes Bay	Pacific	2,000	1,912	1,884	1,268	2,329
Hawkes Bay	Total	468	574	422	450	475
National	Total	524	475	456	492	448

Dermatitis and Eczema



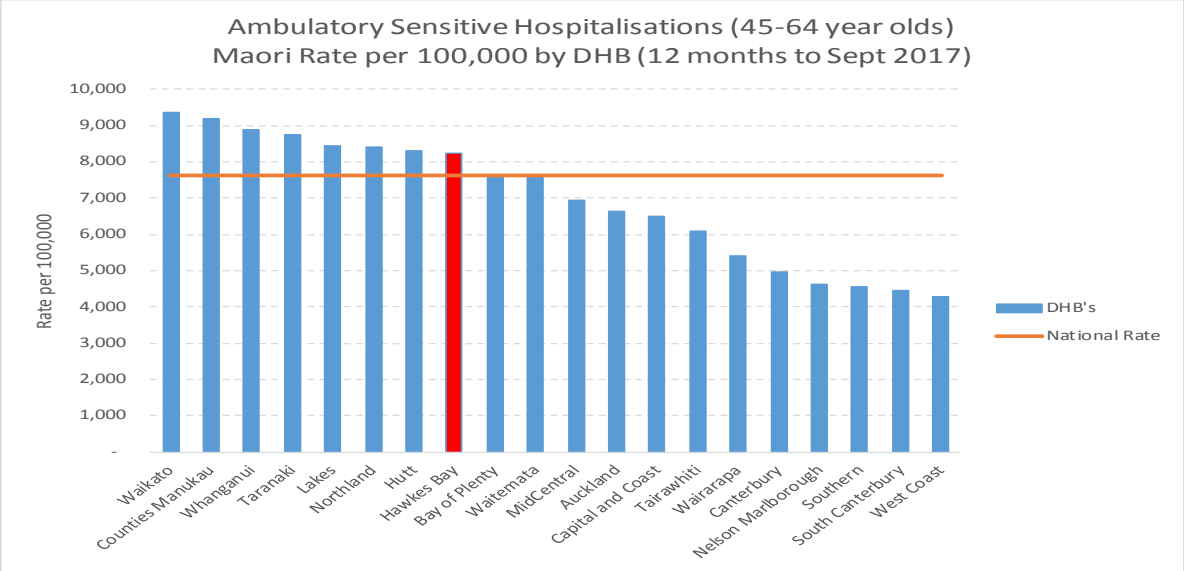
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	83	69	91	56	222
Hawkes Bay	Maori	369	61	203	220	259
Hawkes Bay	Pacific	308	1,029	435	563	274
Hawkes Bay	Total	217	124	162	162	242
National	Total	171	170	192	191	149

ASH RATES 45-64 AGE GROUP

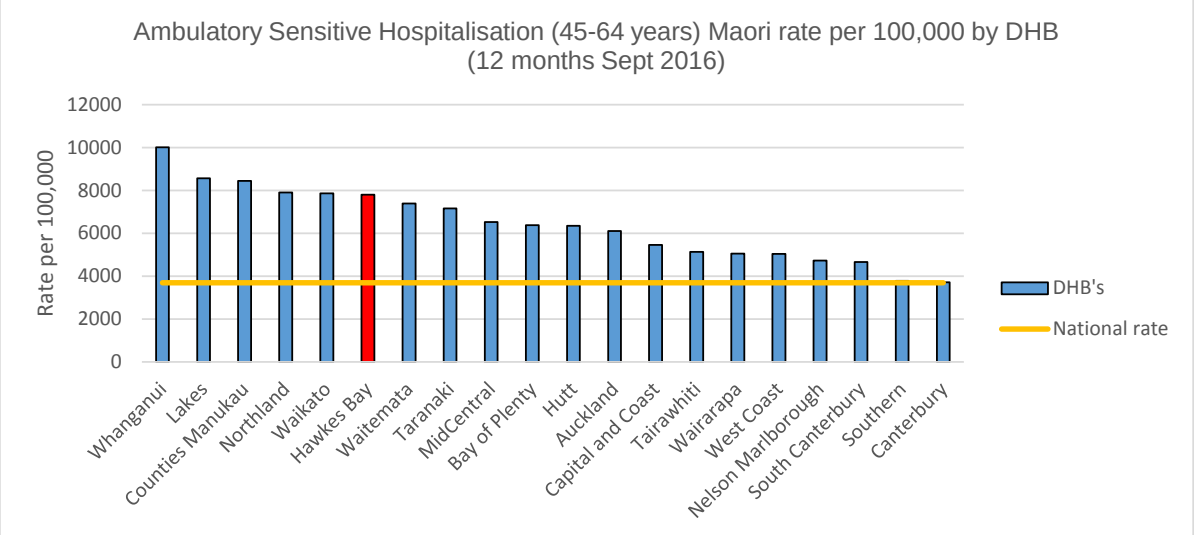
The expectation for ASH 45-64 is that there will be a minimum reduction by half of the equity gap between Māori and national total population base line data over a period of 2.5 years. Within 5% would be considered equity.[3]

Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2017 – Benchmark against DHBs



Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2016 – Benchmark against DHBs



There are four notable points illustrated by these two graphs.

1. The National ASH rate has increased from just under 4000 in the 12 months to Sept 2016 to just under 8000 in the 12months to Sept 2017. This is statistically significant.

[3] As indicated by the MoH specifications for ASH rates.

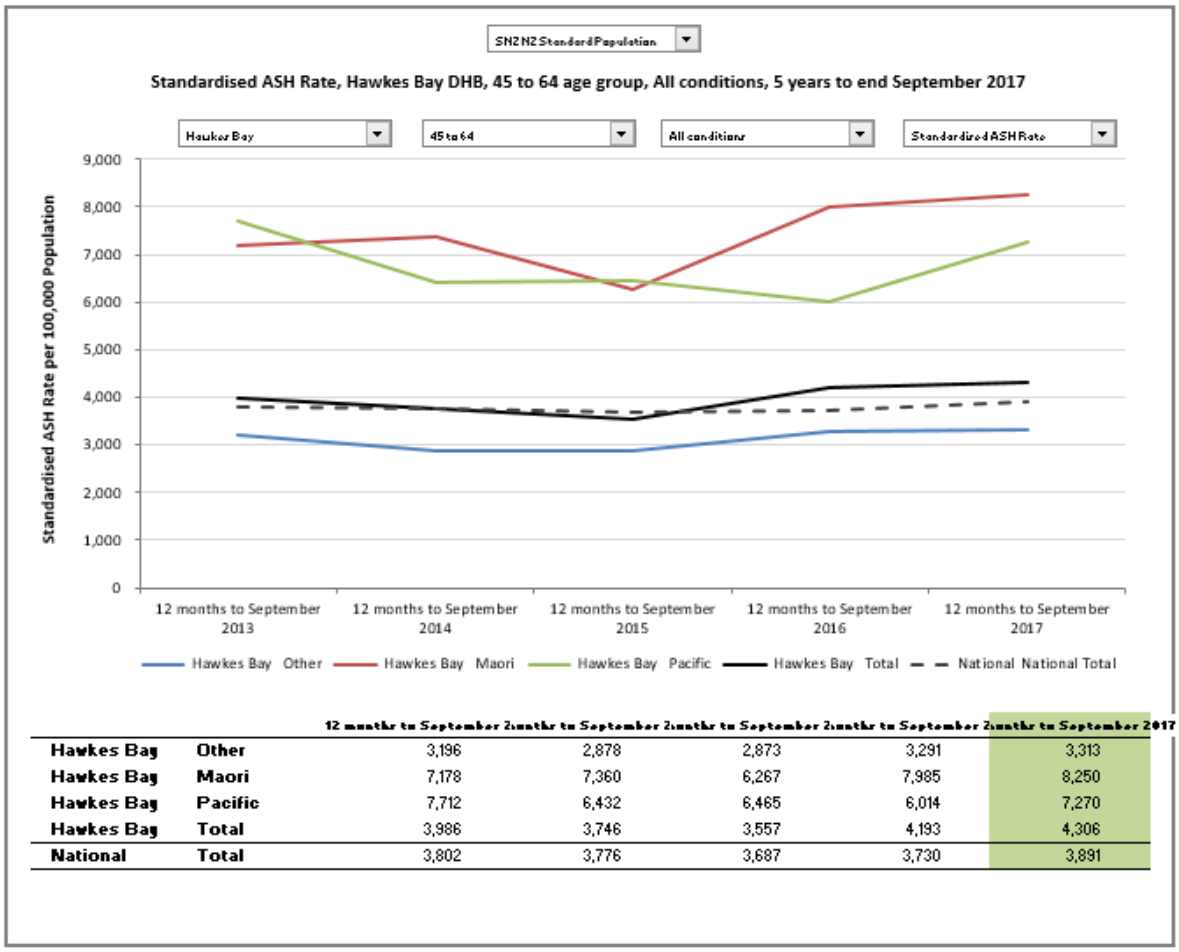
2. HBDHB rates have remained relatively static in the 24 months to Sept 17, at close to 8000.

3. The position of HBDHB has moved from 15thth to 13th position in the national benchmark.

4. All of the above demonstrate that the actions we have taken in the last 24 months have had little impact on our ASH rates. What is also of significance is that the increase in national rates demonstrate that this not peculiar to HB.

The following paragraphs detail what contributes to the ASH rate and findings for each of the top 10 conditions named as follows in order of highest contributor to lowest contributor; angina and chest pain, myocardial infarction, cellulitis, COPD, pneumonia, gastroenteritis-dehydration, kidney-urinary infection, congestive heart failure, stroke, epilepsy.

Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2017 – All conditions (5 Years)



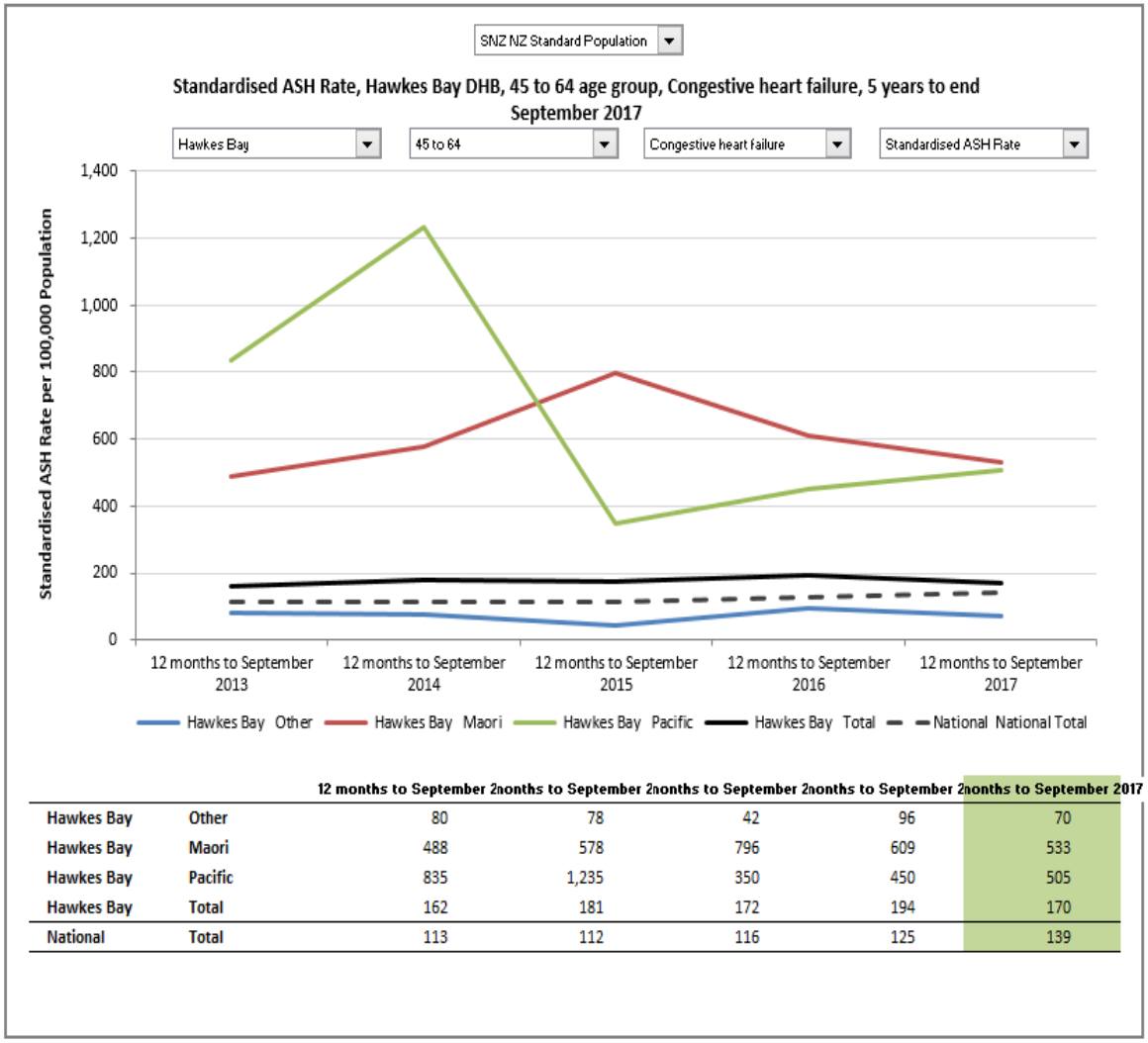
		12 months to September	2 months to September	2 months to September	2 months to September	2 months to September 2017
Hawkes Bay	**Other**	3,196	2,878	2,873	3,291	3,313
Hawkes Bay	**Maori**	7,178	7,360	6,267	7,985	8,250
Hawkes Bay	**Pacific**	7,712	6,432	6,465	6,014	7,270
Hawkes Bay	**Total**	3,986	3,746	3,557	4,193	4,306
National	**Total**	3,802	3,776	3,687	3,730	3,891

In all Top 10 conditions Māori are at least double the rate of other. In some instances e.g. COPD and Congestive Heart Failure, Māori rates are respectively 5 -7 times those of other. This is significant when Māori constitute only 22% of the population of HB. The gap in equity between Māori and Other in HB for ASH rates has increased from 4,694 per 100,000 to 4,937 per 100,000, an increase of 5.1%

Hawke's Bay DHB 45-64 ASH Rates 12 months to Sept 2017

ASH 45-64 Conditions – Contributing to Top 10 Conditions

Congestive Heart Failure



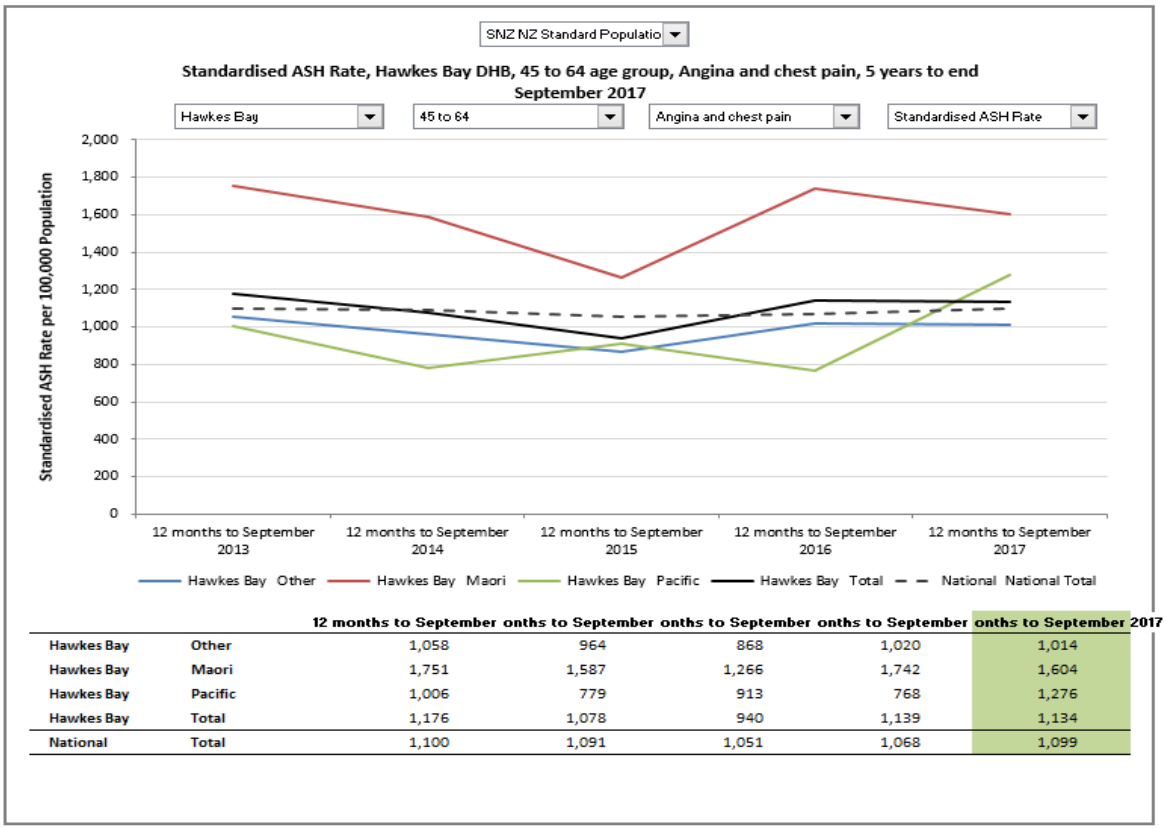
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	80	78	42	96	70
Hawkes Bay	Maori	488	578	796	609	533
Hawkes Bay	Pacific	835	1,235	350	450	505
Hawkes Bay	Total	162	181	172	194	170
National	Total	113	112	116	125	139

In the previous report CHF was ranked 5th out of all conditions contributing to ASH rates for this age group. It is now 8th in the top 10.

Table 1.0 – ASH events 45-64 Congestive Heart Failure

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	29	28	15	36	26
Hawkes Bay	Maori	35	42	59	48	43
Hawkes Bay	Pacific	7	10	3	4	6
Hawkes Bay	Total	71	80	77	88	75
National	Total	-	-	-	-	-

Angina and Chest Pain



		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	1,058	964	868	1,020	1,014
Hawkes Bay	Maori	1,751	1,587	1,266	1,742	1,604
Hawkes Bay	Pacific	1,006	779	913	768	1,276
Hawkes Bay	Total	1,176	1,078	940	1,139	1,134
National	Total	1,100	1,091	1,051	1,068	1,099

The overall rate for Māori is showing a decline in the 12 month period reported.

Table 1.1 – ASH events 45-64 Angina and Chest Pain

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	366	335	299	355	351
Hawkes Bay	Maori	129	122	98	136	130
Hawkes Bay	Pacific	9	7	9	9	15
Hawkes Bay	Total	504	464	406	500	496
National	Total	-	-	-	-	-

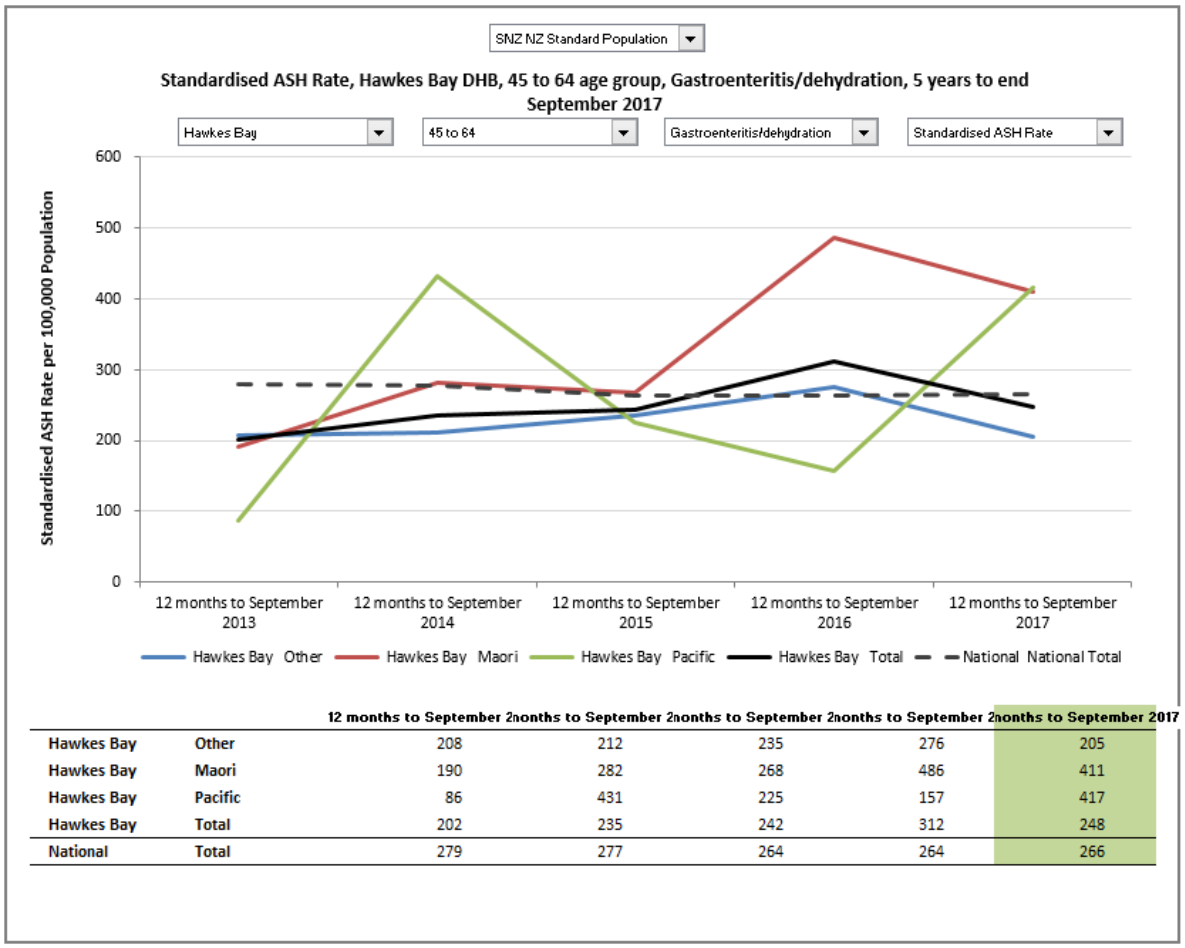
Rheumatic Fever and heart disease

The rate of Rheumatic fever and heart disease is for Māori has also shown a significant drop in the 12 months from Sept 16 to Sept 17 as depicted in table 1.2 below

Table 1.2 – ASH rates 45-64 - Rheumatic Fever

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	6	3	6	6	
Hawkes Bay	Maori	13	38	37	61	37
Hawkes Bay	Pacific					
Hawkes Bay	Total	7	10	12	17	7
National	Total	7	7	8	7	9

Gastro enteritis/Dehydration



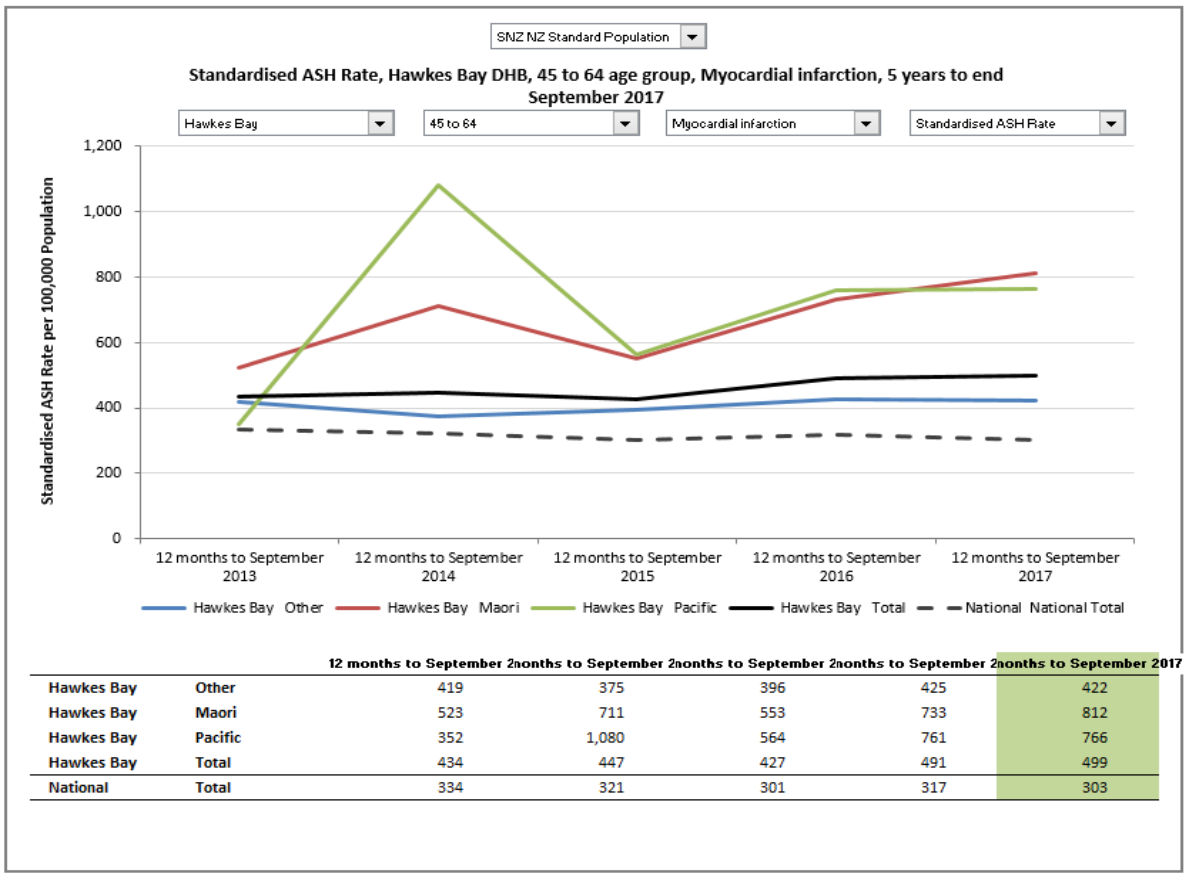
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	208	212	235	276	205
Hawkes Bay	Maori	190	282	268	486	411
Hawkes Bay	Pacific	86	431	225	157	417
Hawkes Bay	Total	202	235	242	312	248
National	Total	279	277	264	264	266

The overall rate has remained reasonably static over time. The rate for Māori is decreasing and the rate for Pasifika showing sharp increase. The pasifika spike can be attributed to the relatively small numbers. The actual events contributing to this statistic - see table 1.0 below.

Table 1.3 – ASH Events 45-64 Gastroentritis/Dehydration

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	72	73	83	96	75
Hawkes Bay	Maori	14	22	21	38	33
Hawkes Bay	Pacific	1	5	2	2	5
Hawkes Bay	Total	87	100	106	136	113
National	Total	-	-	-	-	-

Myocardial Infarction



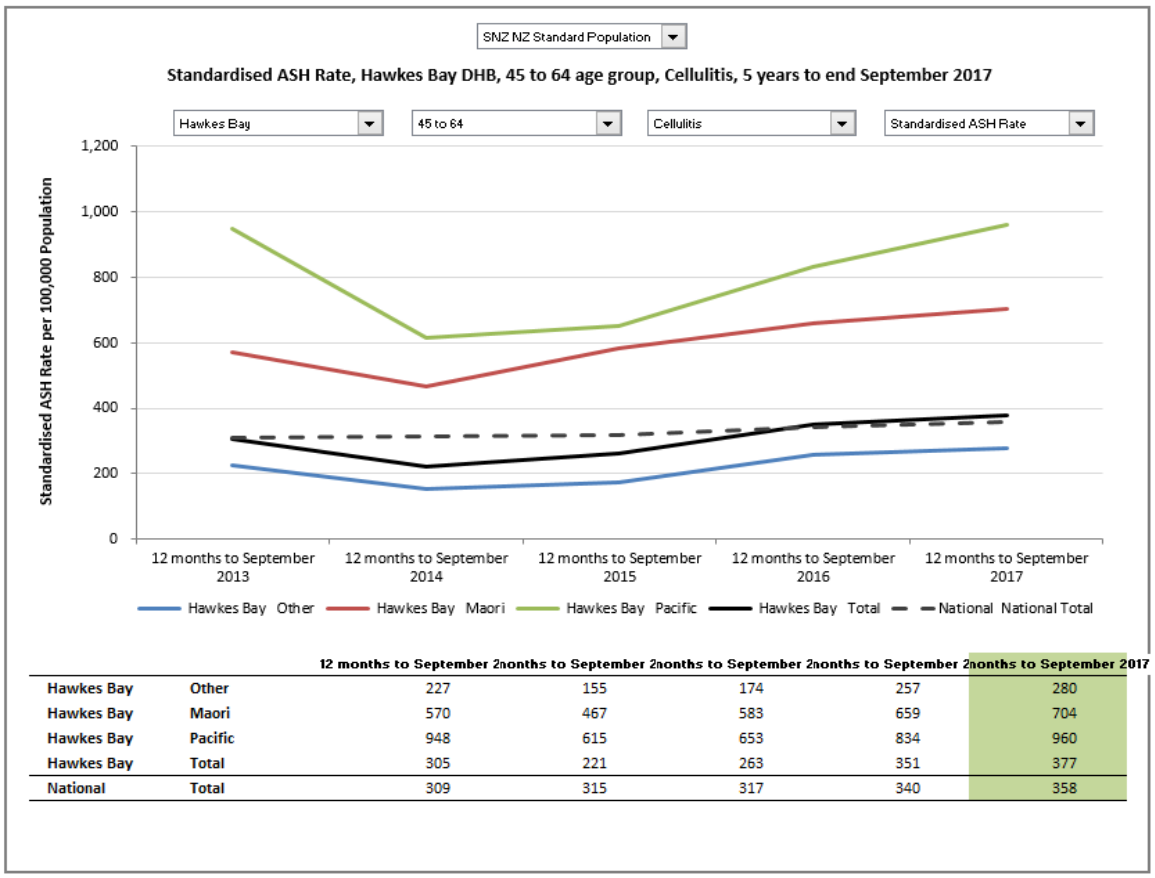
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	419	375	396	425	422
Hawkes Bay	Maori	523	711	553	733	812
Hawkes Bay	Pacific	352	1,080	564	761	766
Hawkes Bay	Total	434	447	427	491	499
National	Total	334	321	301	317	303

The rate for Māori is twice that of Other. The rate for Māori per 100,000 is currently 812 compared with 422 for Other. The equity gap has increased by 26.6%.

Table 1.4 – ASH events 45-64 Myocardial Infarction

		12 months to September	nonths to September	nonths to September	nonths to September	nonths to September 2017
Hawkes Bay	Other	150	133	141	156	151
Hawkes Bay	Maori	37	53	42	57	65
Hawkes Bay	Pacific	3	10	5	8	8
Hawkes Bay	Total	190	196	188	221	224
National	Total	-	-	-	-	-

Cellulitis



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	227	155	174	257	280
Hawkes Bay	Maori	570	467	583	659	704
Hawkes Bay	Pacific	948	615	653	834	960
Hawkes Bay	Total	305	221	263	351	377
National	Total	309	315	317	340	358

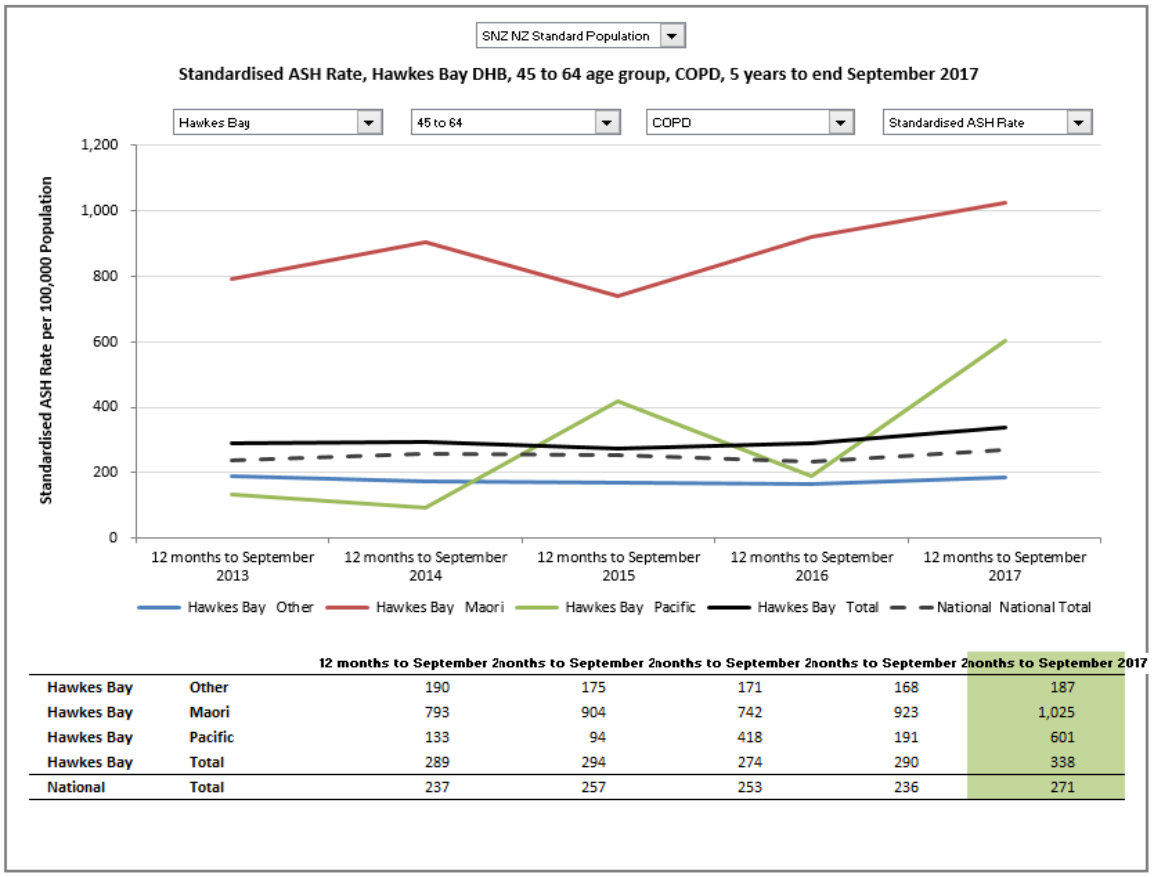
Rate for Māori have increased over the 5 year period. The utilisation rates for the cellulits pathway are showing declines and this is being addressed (see details below pg 18-19). Admissions for rural population occurs where in urban areas patients can be managed from home through the CPO program. The distance that rural patients often need to travel for follow up treatment on consecutive days, can mean that they are admitted.

There was a total of 166 admissions for the 12 month period ending September 2017 which was an increase of 10% over the previous 12 month period.

Table 1. 5 – ASH events 45-64 Cellulitis

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	77	52	61	89	98
Hawkes Bay	Maori	43	36	45	53	57
Hawkes Bay	Pacific	9	6	8	9	11
Hawkes Bay	Total	129	94	114	151	166
National	Total	-	-	-	-	-

COPD



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	190	175	171	168	187
Hawkes Bay	Maori	793	904	742	923	1,025
Hawkes Bay	Pacific	133	94	418	191	601
Hawkes Bay	Total	289	294	274	290	338
National	Total	237	257	253	236	271

Table 1.6 – ASH events 45-64 COPD

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	68	63	62	60	66
Hawkes Bay	Maori	57	66	56	69	81
Hawkes Bay	Pacific	1	1	4	2	6
Hawkes Bay	Total	126	130	122	131	153
National	Total	-	-	-	-	-

REVIEW OF CURRENT AND PLANNED ACTIVITY RELEVANT TO SUPPORT THESE INDICATORS

0-4 YEAR OLDS

Respiratory care pathways for tamariki 0 – 4 years

In 2017, a review of the ASH 0 – 4 years respiratory care pathway was undertaken to understand more about the interactions and experiences of tamariki and their whānau prior to and after they presented to ED for a respiratory related illness. The review involved a case file audit, an analysis of ASH respiratory data, a review of care pathways and referral processes, and stakeholder and whānau interviews. Three main findings of the review are:

- There is currently no clear respiratory care pathway for tamariki 0 – 4 years.
- There are no specific respiratory care programmes for children currently being delivered in the community
- The majority of tamariki and their whānau received no follow-up in the community post presentation to ED and admission to hospital.

The respiratory working group is undertaking a number of activities to progress actions to address system and service barriers to access to respiratory care for whānau. A child respiratory care pathway, with appropriate processes is being developed for primary and secondary care services. The pathway will better support information flow between services, follow up care in the community by Respiratory Nurse Champions. Paediatric respiratory training for RNCs and wider sector stakeholders took place in December. Future training is planned in 2018, and will include, the findings of the ASH respiratory review, equitable respiratory health outcomes, and health literacy considerations for both practitioners and whānau.

The Working Group is also exploring ways to improve service responsiveness to Pacific and whānau Māori, with a view to undertake a future budget bid process. Breathe HB, who are currently contracted to provide adult respiratory support across Hawkes Bay have been invited to submit a plan about how services can reach tamariki Māori and Pacific at risk of, or with, a chronic respiratory illness. The Working Group will consider this plan on 13 February 2018. Small improvements in processes is already reporting positive results. Changes to the way patient information is managed in secondary care has led to a considerable increase in the number of referrals to the Child Healthy Housing Programme. The Working Group will continue to progress actions from the review over 2018.

Increased immunisation Health Target

The 95% target for all 8-month-old infants is proving an ongoing challenge. Families/whānau seeking information and advice via online sources is delaying parent/caregiver decision making. Some families/whanau will go on to immunise their pēpi/child, but this is occurring outside the ideal timeframes. Despite this dilemma, the most recent quarterly report (October – December 2017) shows equitable coverage for Māori. There is an ongoing focus to ensure a targeted outreach service, provision of alternative venues, and opportunistic immunisations in secondary services. An example of these efforts is a short-term agreement with Kahungunu Executive to intensify immunisation support in rural remote areas. This service will help facilitate timely access to immunisation services through improved follow up of children referred to outreach. To do this a 0.2 FTE support worker will work with primary care practitioners, primary health care workers, family/whānau, and liaise with the outreach team.

Oral Health Initiative

The 'Oral health equity for tamariki 0 – 4 years' project is well underway. This is a five year project from 2016 – 2020. Over the last year, main activities have involved establishing the project, building relationships with key internal and external stakeholders, and identifying priority areas of focus. Good progress has been made in a number of areas including:

- The appointment of a Kaiawhina position within the Community Oral Health Service (COHS). Progress in the first six months shows that as a result of this new position 280 tamariki have been re-engaged with the COHS.
- COHS staff have participated in Relationship Centred Practice training.

- Well Child Tamariki Ora providers have been contracted to provide greater emphasis on oral health at Core Health checks. Funded by Māori Health, this service aims to provide whānau with appropriate oral health information and resources, and where appropriate, facilitate access to COHS appointments.
- A closer collaboration with the Early Childhood Education/Te Kohanga Reo sectors to provide staff and whānau with better oral health information and support
- The initiation of the 'water-for-kids' project which will see the Paediatric ward implementing a fizzy free environment for children in hospital from 1 March 2018.
- The establishment of Te Roopu Matua who provide valuable advice to the project group on Māori oral health perspectives and experiences, and appropriate ways to engage whānau Māori to better meet their oral health needs.
- Working with Health Hawkes Bay to increase the focus on oral health in the Whanau Wellness Programme.
- The completion of a review of the ASH dental care pathway for tamariki 0 – 4 years. The review examines the interactions and experiences of whānau prior to and after their tamaiti/child's GA dental procedure. The final report with recommendations is currently being finalised. Early findings are indicating quality improvements in early engagement, improved wait-times for children, better follow up care and support in the community, and appropriate and responsive information and support for tamariki Māori, Pacific, and children living in deprived areas.

Child Healthy Homes Programme

During 2017, there was a significant increase in referrals to the Child Healthy Housing programme (CCHP), with the greatest percentage of these referrals for whānau Māori and Pacific. The increase in referrals can be attributed to two main factors 1) the expanded criteria relating to Rheumatic Fever prevention and vulnerable children aged 0 – 5 years, which now includes pre-schoolers hospitalised for an indicator condition, at risk pregnant women/new mothers, and priority families with pre-schoolers (who have specified risk factors), and 2) the ASH Respiratory review (August, 2017) which has led to improvements to secondary care processes in discharge plans. As a result, there is better referral information flow from secondary care services to the CHHP, so whānau can be appropriately triaged and contacted to assess eligibility.

To date, a total of 811 referrals have been received since the inception of the CHHP. Whānau have received a total of 3025 interventions to promote warm dry homes and reduce transmissible diseases. These interventions have included, but not limited to, curtains (279 homes), beds (333), WINZ FACE (full and correct entitlement assessments), 160 homes insulted, and 59 families/whānau supported to relocate to warmer, dryer social or private housing. In addition, all families/whānau receive 'key tip' messages regarding sustaining a warm dry home.

Skin Programme

The HBDHB Skin Programme aims to raise awareness of skin problems, provide appropriate resources to families/whānau to care for skin, prevent skin infections and infestations, facilitate access to early treatment, enhance help-seeking behaviour, and reduce stigma and discrimination for tamariki with skin problems. A 2014 audit showed high rates of skin problems among tamariki Māori, and children living in high deprivation areas. Skin infections include, cellulitis, scabies, impetigo, infected dermatitis, and boils. HBDHB has responded with a number of activities to provide better support to tamariki and their whānau. Key activities include:

- Skin Standing Orders for Public Health Nurses and School Based Māori health provider nurses have been developed. However, these orders do not include the provision of medication, and while nurses will encourage whānau to seek help from their primary care practitioner, barriers to access to care may prevent whanau from doing so. Expanding these Standing Orders is being explored, but will require resource of time and workforce development.
- The team has been exploring ways to include early childhood education provider information on the first contact form. Currently the form does not capture this information consistently, and it is not coded. Coding this information would enable the team to identify ECEs and target resources and support accordingly.
- Development of appropriate information, and resources for early childhood education centre (ECE) staff and whānau. These resources include flip charts in te reo Māori, and Pacifica.

Relationships with Te Kohanga Reo have been strengthened, with nurses attending purapura hui, and regular ongoing hui.
- Professional training for ECE, Te Kohanga Reo, and Pacific Kohanga kaimahi at a health day in August 2017.

A survey in 2017 of ECE and Te Kohanga Reo found there is a demand among staff and whanau for more appropriate information and resources to be translated. Another area of focus, and reiterated in the 2017 survey, is the need for more face to face visits to staff and whānau. HBDHB does fund multiple visits during the year to Te Kohanga Reo and some ECE based in quintile 5 communities. However, to deliver appropriate education, key messages, and healthy skin promotion and prevention a more comprehensive approach is required. Funding support in both these areas would assist the team to make further health gain in this area.

ACTIVITY TO ADDRESS 45-64 ASH RATES

1. System Level Measures Improvement Plan

Incorporated into the improvement plan and aligned to the SLM-Reducing hospital Bed Days are the following contributory measures and activities and progress towards achieving them;

- *Increase number of Māori Pasifika and Quintile 5 referred to CPO high needs program.*
  The goal currently is to achieve 350 Māori referrals by year end. Currently not on track. As of Q2 only 59 Māori had been referred. CPO steering and management group meeting to discuss how to increase awareness of the program, the criteria for referral and the demonstration of benefits this program produces.

- *Increase number of referrals into the Hospital Discharge initiative.*
  The gaol of this program is 500 Māori referrals by year end. Currently not on track. As of Q2- only 171 Māori had been referred. As above the steering and management group will be meeting to discuss how to increase utilisation of this program.

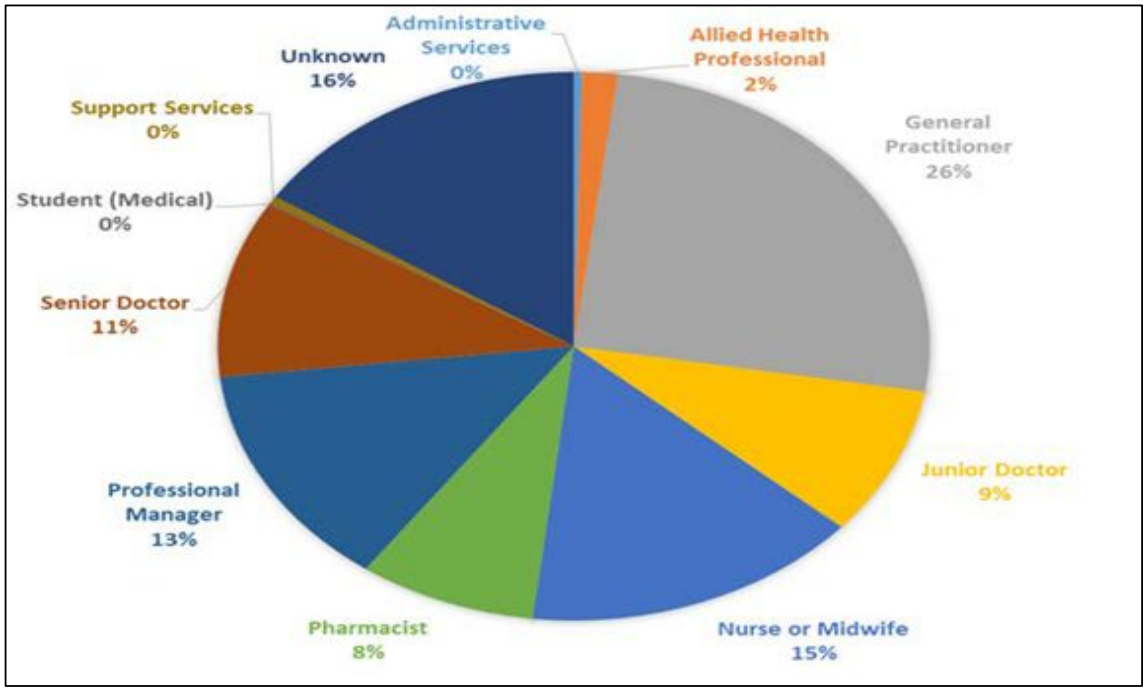
- *Recruit into the position of Nurse Practitioner for Heart Failure with a primary care focus.*
  The appointment process is now completed with preferred candidate being notified. Commencement date TBC. The candidate comes with extensive primary care experience. Recruitment to replace the retiring clinical nurse manager – cardiac has also been completed and again the preferred candidate comes with extensive primary care experience and understanding of integration of services.

- *Develop a program to implement tracer auditing to inform quality improvement (QI) initiatives.*
  The quality advisor team currently offers QI – IHI methodology training across the organisation. A more targeted approach is being implemented in Q3-4 to support the implementation of the Long Term Conditions Framework with a focus on; respiratory / cardiac, renal / diabetes service provision. This will include primary – secondary – pharmacy providers.

2. Collaborative Pathways

The Pathways Program initiated in 2014 as a pilot, with a focus on two interrelated aspects 1) development of pathways and 2) identifying the IT tool best fit for purpose. Pathways have been developed to the extent that we now have 75 pathways being used. The IT tool is under review due to the current vendor exiting the UK market. Work is underway developing a technical options paper with a partnership formed with Central and Midland DHB regions. General Practitioners are the highest users of pathways – see figure 1.0 below

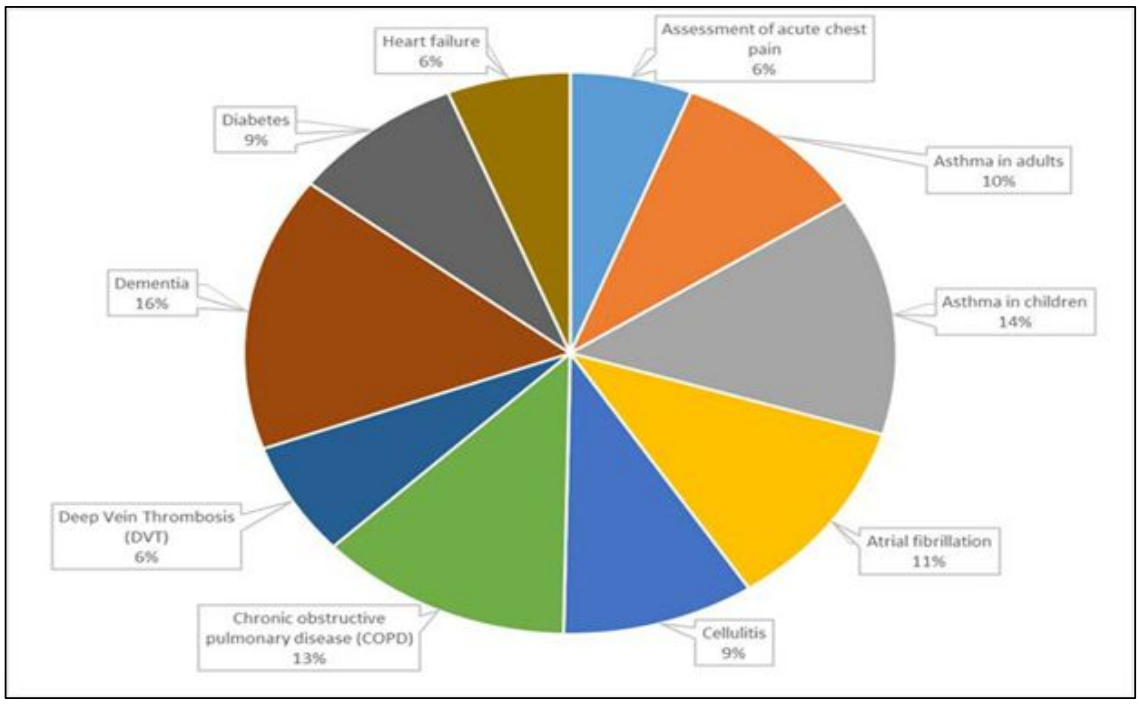
Figure 1.0 – Utilisation of pathways by service provider



Pathways utilised that address the top 5 contributing conditions to HBDHB ASH rates (Adults)

- Cardiac: Heart Failure (6%), Atrial Fibrillation (11%), Assessment of Chest Pain (6%)
- Respiratory: COPD (11%), Asthma in Adults (10%),
- Cellulitis (9%).

Figure 1.2 – Utilisation rates of current pathways



A General Practitioners' point of view (Dr Alan Wright)

Clinical management pathways designed and supported across the whole local health sector are clearly the best way forward to allow timely effective clinical care to be delivered in the best place at the best time. This is what we have been trying to achieve with the Co-ordinated Primary Options (CPO) programme for the last 14 years since its inception. Pathways offers comprehensive understanding of clinical conditions and current "best-practice".

Cardiac Pathways – These pathways are being well used. A program of CME/CNE sessions in 2017 by the Clinical Leads promoted their use and supported follow up within general practice. Visibility of pathways to provider services needs further work outside of ED.

Respiratory Pathways – Partnering with the PHO, Māori and Pacific health teams work is in progress to manage the increases we are seeing in COPD presentations and admissions. (Refer section below – Continuation of the Nurse Led Respiratory Program). Tracer auditing will also form part of this work to map patient journey and experience of care from a quality improvement perspective. This work is being supported by our Quality team.

Cellulitis Pathway – low access to this pathway and increased rates in presentations indicate the need to revisit the pathway as treatment and management changes have been introduced.

Achievements and Challenges: Promotion and socialisation of all pathways is led by a small team who are becoming well known across the health sector. There are now strong links with PHO, Medical Advisors and CMO Primary Care. The team is now proactively approached by clinicians who are seeking pathway development. The challenge now is to provide greater exposure to the use of pathways in multiple provider settings.

3. Continuation of the Nurse Led Respiratory Program

The program contract has now shifted from being outputs to outcomes focused which incurred some time in its development before the contract specifications could be finalised – end of Dec 2017. The contract and program is now ready to progress. In the interim analysis of the data, and meetings with stakeholders and providers has been underway, to determine what is the best targeted approach to address a 24% decrease in the Māori accessing respiratory services.

The team that is involved is cross sector and includes ED, specialist respiratory services and general practice teams using a targeted approach to lists of patients known to general practice and or ED with a respiratory related read code, frequent presentation to ED and or admission. The program team are in the process of identifying target groups and 3 monthly targets performance indicators.

4. Implementation Plan for HBDHB Long Term Conditions Framework

An operational working group has replaced a long term conditions advisory that was formed as it was considered more appropriate to work at this level once the framework was endorsed. The working group is made up of a collective senior group of clinicians (Nursing, Allied Health, PHO and Pharmacist).

The focus of the implementation plan is AKA two of the Long Term Conditions Service Review Matrix - the dimensions of care coordination and transition of care. Areas of focus will be nursing models; Diabetes; 45-65 years COPD patients for Māori; opportunities for improved care coordination for inpatients within secondary services e.g. diabetics-podiatry-vascular; 45-65 years CHF-COPD patients with a focus on Māori, transition of care and discharge processes, and ED high user patient groups.

In addition work is underway with:

- HB Aged Residential Care Educator and linking their educational programmes to dimensions within the LTC Framework and Service Review Matrix

- The PHO Workforce coordinator to include LTC as part of CME/CNE
- Ensuring Clinical Pathway Programme links into System Level Measure activities; and
- Linking with our People and Quality Team to raise the profile of the LTC Framework when educational days on Quality aspects are planned.

RECOMMENDATIONS

	Key Recommendation	Implementation lead	Champion(s)	Time Frame
1.	Clinical pathways become part of business as usual supported by a sustainable funding resource.	Strategic Services Manager Primary Care LTC Portfolio manager	CMO Primary CMO Secondary	Dec 2018
2.	The CPO program be evaluated to inform a strategic approach to the provision of services that; • reflect national guidelines • focus on equity outcomes • use ASH rates as a success indicator and Target the unenrolled population through a range of mechanisms and programs to address unmet need.	Strategic Services Manager Primary Care Innovations and Development Manager - Health Hawke's Bay	GM Health Hawke's Bay GM Māori Health Ex. Dir. Primary Care	Dec 2018
3.	In relation to Cardiac / Respiratory & Renal / Diabetes Service plans include; • workforce development • care coordination • transition of care assessed against the LTC Service Review Matrix[4] to demonstrate progress to towards improved outcomes	Head of Planning Strategic Services Manager Primary Care LTC Portfolio Manager	Directorate Leads Chief Nursing and Midwifery Officer	Dec 2018
4.	Enhance use of CNS / NP in specific LTC, evidenced by the outcomes achieved to date by Diabetes and Respiratory CNS workforce and engagement with primary care	Directorate leads LTC Portfolio Manager	Chief Nursing & Midwifery Officer	On-going
5.	Increase the weighting that is applied to health award applications in relation to equity.	Clinical Council	CEO	July 2018

[4] LTC Service Review Matrix – the evaluation tool designed to assist with implementation of the HBDHB Long Term Conditions Framework

Comments from the Champion for ASH rates – Dr Mark Peterson CMO Primary

The results for the 0-4 age group in the last period have maintained Hawkes Bay as having lower than average rates for other DHBs. While there is still an equity gap for young children it is relatively low and closing.

The ASH rates for respiratory illness (asthma, pneumonia and lower respiratory infection) are all relatively stable and, other than for Pacifica the equity gap is relatively narrow though not closing as we would wish.

For dental admissions there has been a very significant improvement in Māori rates and the gap has closed considerably. This reflects the success of the Oral Health project and the commitment of those working in this field. Further gains are likely to be achieved once water fluoridation is reliably and consistently in place throughout the whole of the region.

The situation with ASH rates for the 45-65 age group is much less encouraging. For the most part ASH rates are not improving and the equity gap is stubbornly wide.

There are some issues with the national date available to us – most particularly I suspect in the benchmarking graphs with other DHBs. It is hard to believe that overall ASH rates have increased by close to 100% in the space of one year.

With the local graphs the Pacifica data is based on very low numbers and consequently the variation is significant between periods. Despite the data issues with the low numbers it is very hard to ignore the wide disparities between Pacific and Māori and Other.

As noted the wider use of Clinical Pathways should lead to better and more consistent care for most of the ASH conditions. Consistent use should also reduce the equity gap such that treatment offered is the same for all ethnicities.

Most of these conditions do not arise de novo at the time of admission. They are the result usually of other conditions such as diabetes, hypertension, smoking, and hyperlipidaemia. This reflects partly on access primary care and to health promotion and health literacy issues and it is clear that these are not equitable and lead on the large equity gaps in the reported rates.

Dr Mark Peterson
Chief Medical Officer - Primary

RECOMMENDATION:

It is recommended that the Māori Relationship Board and/or Pasifika Health Leadership Group; HB Clinical Council, HB Health Consumer Council; HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the recommendations.

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Dashboard Q2 July-Sept 2017**
	For the attention of: **Māori Relationship Board, Pasifika Health Leadership Group, Clinical and Consumer Council and HBDHB Board**
Document Owner	Tim Evans, Executive Director, Corporate Services
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
Reviewed by	Executive Management Team
Month/Year	February, 2018
Purpose	Monitoring
Previous Consideration Discussions	N/A
Summary	Areas of Progress: DNA Rates Areas of Focus: Health Target – Shorter Stays in ED, Mental Health – Section 29 Orders, Long Term Conditions – Diabetes Management.
Contribution to Goals and Strategic Implications	Ensuring the DHB meets/improves performance for our Ministry of Health key performance indicators and local measures outlined in the DHB Annual plan.
Impact on Reducing Inequities/Disparities	This report highlights areas of inequity, comments are provided in relation to programs of work that are underway/planned in order to positively affect equity gaps.
Consumer Engagement	N/A
Other Consultation /Involvement	Comments are supplied from various staff members throughout the DHB including service directors or their delegate, program Leaders and the PHO
Financial/Budget Impact	NA
Timing Issues	NA
Announcements/ Communications	NA

RECOMMENDATION:

It is recommended that the Māori Relationship Board, Pasifika Health Leadership Group Clinical & Consumer Council and HBDHB Board:

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

PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

- Health Targets – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 98%, Maori at 97% and Pacific at 100% against a target of 95%.

- Health Target – For Better help to quit smoking in Primary Care we have achieved a total result of 90.9%. We have also seen slight increases in the rate for Maori 88.5% and Pacific 88.8% against the target of 90%

- DNA – Overall we have favourably remained at 5.2% which is below the target of 7.5%.

Areas of Progress

- Health Target – For Better help to quit smoking in Primary Care we have seen slight increase in the rate for Maori 88.5% and Pacific 88.8% against the target of 90%

- Cervical Screening – We have seen slight increases for the total population, Maori and Pacific ethnicities. The total population result is 77% against a target of 80%

Areas of Focus

We continue to focus our efforts in order to make gains with particular emphasis in the following areas:

- Health Target – Shorter Stays in ED is currently at 92.2% against a target of 95%

- Immunisation at 4 years – The rate for total has dropped 2.9% and currently sits at 91.3% against a target of 95%, there have also been decrease for Maori by 6% and Pacific 10.2%.

- Diabetes Management (HbA1c equal to or less than 64mmols) – The result for the total population is currently 43% against a target of 55%.

- Pregnant Women Registered with an LMC by week 12 – There has been a decrease in all ethnicities for Q2 compared with Q1 and the current result for the total population is 57.9% against a target of 80%. The result for Maori is 50% and Pacific 35.3% highlighting inequity.

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation of 2 year olds – The Maori rate is currently 96% and the Pacific rate is 97%, both are similar to the Total rate of 96%.

- Health Targets – The Maori is currently 97% and Pacific at 100% against a target of 95%. They are similar to the Total Rate of 98%

- Better Access to diagnostic service – The rate for Maori accepted for an urgent diagnostic colonoscopy receiving their procedure within two weeks is currently 100%, the rate for Pacific is 100% and the total rate is 94% against a target of 90%

Areas of Progress

- DNA – Both the Maori and Pacific rates of DNA have declined over the Q2 period which is pleasing to see. The Maori declined by 1.4% in Q2 and now sits at 9.1%, the Pacific rate has declined by 1% and now sit at 10.4% against a target of 7.5%.

Areas of Focus

- Rate of Section 29 orders per 100,000 population – Maori Rates are currently 384 per 100,000 against the target of <81.5 and are 3 times higher than the non-Maori Rate

HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 2, 2017/18

Health Targets:	Target	Baseline	Total		Maori		Pacific		Other	
Shorter Stays in ED	≥ 95%	95%	92%	*	94%		94%		91%	*
Improved Access to Elective Services	≥ 100%	100%	Awaiting data from Ministry of Health							
Faster Cancer Treatment	≥ 90%	65%								
Increased Immunisation	≥ 95%	0%	94%		93%	*	97%		93%	
Better Help for Smoker to Quit (Primary Care)	≥ 90%	99%	91%	*	89%	*	89%	*	94%	*
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	89%	Awaiting data from Ministry of Health							
Raising Health Kids	≥ 95%	40%	98%	*	97%	*	100%	*	100%	*

Output Class 1: Prevention Services	Target	Baseline	Total		Maori		Pacific		Other	
Better Help for Smoker to Quit (Secondary Care)	≥ 95%	99%	96%		97%		97%		91%	
% of 2 year olds fully immunised	≥ 95%	95%	96%	*	96%	*	97%		97%	*
% of 4 year olds fully immunised	≥ 95%	93%	91%		91%		88%		92%	*
Acute rheumatic fever initial hospitalisation rate per 100,000	≤ 1.5	1.9	1.9	*	4.8	*	-	*	-	-
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	73%	*	67%	*	68%	*	75%	*
% of women aged 25–69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	77%	*	74%	*	76%	*	79%	

Output Class 2: Early Detection and Management Services	Target	Baseline	Total		Maori		Pacific		Other	
% of the population enrolled in the PHO	≥ 90%	97%	98%	*	97%		90%		98%	*
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	≤ 6822	-	5794		6434		9178		4741	
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	≤ 4129	-	4373		8165		7168		3388	
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	66%	58%		50%		35%		64%	
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	≤ 65%	40%	43%		35%	*	33%		50%	
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	88%	Awaiting data from Ministry of Health							
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥ 95%	95%	93%		-	-	-	-	-	-
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥ 90%	48%	94%	*	-	-	-	-	-	-

Key:

Within 0.5% or Greater than Target
Within 5% of Target
Greater than 5% from Target

*	Favourable Trend from Previous Quarter

OUTPUT CLASS 3: Intensive Assessment and Treatment Services	Target	Baseline	Total		Maori		Pacific		Other	
% of high-risk patients will receiving an angiogram within 3 days of admission.	≥ 70%	72%	72%		75%		50%		72%	
% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge	≥ 95%	98%	98%	*	87%	*	100%		100%	*
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 8%	8%	7%		15%		6%		0%	
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥ 80%	84%	76%		92%		72%	*	0%	-
% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	58%	58%		80%	*	50%		0%	-
Major joint replacement	≥ 21	21.5	22.90	*	No Ethnicity Data Available					
Cataract procedures	≥ 27	58.7	49.70	*						
Cardiac surgery	≥ 6.5	6.6	4.70							
Percutaneous revascularisation	≥ 12.5	13.1	12.00							
Coronary angiography services	≥ 34.7	39	36.60	*						
Length of stay Elective (days)	≥ 1.47	1.56	0.00	-						
Length of stay Acute (days)	≥ 2.3	2.4	0.00	-						
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	-	Awaiting data from Ministry of Health							
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	≥ 90%	92%	94%		100%		100%		92%	
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	≥ 70%	94%	59%		58%		75%		59%	-
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	≥ 70%	98%	77%		No Ethnicity Data Available					
Did not attend (DNA) rate across first specialist assessments	≤ 8%	7%	5%	*	9%	*	10%	*	4%	
Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)	≥ 4%	4%	4.1%		4.3%		2.4%	*	3.9%	*
Proportion of the population seen by mental health and addiction services: Adult (20-64)	≥ 5%	5%	5.5%	*	9.8%	*	2.4%		4.1%	*
Proportion of the population seen by mental health and addiction services: Older Adult (65+)	≥ 1%	1.1%	1.1%	*	1.3%	*	0.6%		1.1%	
% of 0-19 year olds seen within 3 weeks of referral: Mental Health Provider Arm	≥ 80%	72%	71%		74%	*	65%	*	71%	
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	81%	73%		62%		100%		86%	
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	91%	91%	*	92%	*	87%	*	90%	*
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	95%	92%		92%	*	100%		97%	
% of clients discharged will have a quality transition or wellness plan	≥ 95%	0%	0%	-	0%	-	0%	-	0%	-
Rate of s29 orders per 100,000 population	≤ 81.5	90.1	-	-	384		-	-	124.1	

OUTPUT CLASS 4: Rehabilitation and Support Services	Target	Baseline	**Total**		**Maori**		**Pacific**		**Other**	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 75-79 years	≤ 130	124	149.90		226.30		175.00		133.80	*
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years	≤ 170	208.3	173.60		158.30	*	100.00	*	179.50	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years	≤ 225	216.6	234.60		127.27		400.00		255.16	
% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan	≥ 95%	100%	100%		100%		100%		100%	
Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment	≤ 14%	10%	12%		No Ethnicity Data Available					
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥ 80%	100%	98%							
% of older patients given a falls risk assessment	≥ 90%	97%	98%							
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 98%	98%	96%							

Non Reported in Q2		
Number of babies who live in a smoke-free household at six weeks post natal	≥ -	No data provided
% of pregnant women who are smokefree at 2 weeks postnatal	≥ 95%	
% of girls fully immunised – HPV vaccine	≥ 75%	Reported in quarter 4
% of 65+ year olds immunised – flu vaccine	≥ 75%	
% of infants that are exclusively or fully breastfed at 6 weeks	≥ 75%	No data provided
% of infants that are exclusively or fully breastfed at 3 months	≥ 60%	
% of eligible pre-school enrolments in DHB-funded oral health services	≥ -	Reported in quarter 3
% of children who are carries free at 5 years of age	≥ -	
% of enrolled preschool and primary school children not examined according to planned recall	≤ -	
% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	≥ -	
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9	≤ -	
Acute readmissions to hospital	≤ TBC	Currently not reported
Acute readmission rate: 75 years +	≤ -	
Number of day services	≥ -	No data provided

TOPICS OF INTEREST

MEMBER ISSUES / UPDATES

Verbal