HB Clinical Council Meeting

Date: **Wednesday, 8 May 2019**

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

Apology:

In Attendance:

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

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and receive apologies	3:00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Board Report – April (public) - for information only	
6.	Workplan	
7.	Clinical Council Annual Plan – Progress Review	
	Section 2 – Reporting Committees to Council	
8.	Clinical Advisory & Governance Group – verbal update – Chris McKenna	3.15
9.	Council Representatives and Committee Reports	3.20
10.	Collaborative Pathways update – Mark Peterson	3.20
	Section 3 – Presentation & Discussion	
11.	HB Health Strategy – Chris Ash & Kate Rawtsron	3.30
12.	Te Ara Whakawaiora CHILD HEALTH combined report – Patrick le Geyt	4.10
13.	After Hours Care Service update – Wayne Woolwich, Peter Satterthwaite & Jill Garrett	4.20
14.	Primary Care Workforce Survey – Wayne Woolwich & Rochelle Robertson	4.35
15.	PHLG Nurse Navigators – Bernard Te Paa & Talalelai Taufale	4.45
16.	**Section 5 – Recommendation to Exclude the Public**	

Public Excluded

Item	Section 6 – Routine	Time (pm)
17.	Minutes of Previous Meeting (Public Excluded)	4.55
18.	Matters Arising – Review Actions (Public Excluded)	
19.	Board Report – April (public excluded) - for information only	
20.	Topics of Interest – Member Issues / Updates	

NEXT MEETING:

Wednesday, 12 June 2019
Te Waiora Meeting Room (Boardroom), HBDHB Corporate Office
Cnr Omahu Road & McLeod Street, Hastings

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

*Showing **respect** for each other, our staff, patients and consumers*

	✔	x
Welcoming	Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles	Is closed, cold, makes people feel a nuisance Ignore people, doesn't look up, rolls their eyes
Respectful	Values people as individuals; is culturally aware / safe Respects and protects privacy and dignity	Lacks respect or discriminates against people Lacks privacy, gossips, talks behind other people's backs
Kind	Shows kindness, empathy and compassion for others Enhances peoples mana	Is rude, aggressive, shouts, snaps, intimidates, bullies Is abrupt, belittling, or creates stress and anxiety
Helpful	Attentive to people's needs, will go the extra mile Reliable, keeps their promises; advocates for others	Unhelpful, begrudging, lazy, 'not my job' attitude Doesn't keep promises, unresponsive

ĀKINA IMPROVEMENT

*Continuous **improvement** in everything we do*

	✔	x
Positive	Has a positive attitude, optimistic, happy Encourages and enables others; looks for solutions	Grumpy, moaning, moody, has a negative attitude Complains but doesn't act to change things
Learning	Always learning and developing themselves or others Seeks out training and development; 'growth mindset'	Not interested in learning or development; apathy "Fixed mindset, 'that's just how I am', OK with just OK
Innovating	Always looking for better ways to do things Is curious and courageous, embracing change	Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done
Appreciative	Shares and celebrates success and achievements Says 'thank you', recognises people's contributions	Nit picks, criticises, undermines or passes blame Makes people feel undervalued or inadequate

RARANGA TE TIRA PARTNERSHIP

*Working together in **partnership** across the community*

	✔	x
Listens	Listens to people, hears and values their views Takes time to answer questions and to clarify	'Tells', dictates to others and dismisses their views Judgmental, assumes, ignores people's views
Communicates	Explains clearly in ways people can understand Shares information, is open, honest and transparent	Uses language / jargon people don't understand Leaves people in the dark
Involves	Involves colleagues, partners, patients and whanau Trusts people; helps people play an active part	Excludes people, withholds info, micromanages Makes people feel excluded or isolated
Connects	Pro-actively joins up services, teams, communities Builds understanding and teamwork	Promotes or maintains silo-working 'Us and them' attitude, shows favouritism

TAUWHIRO CARE

*Delivering high quality **care** to patients and consumers*

	✔	x
Professional	Calm, patient, reassuring, makes people feel safe Has high standards, takes responsibility, is accountable	Rushes, 'too busy', looks / sounds unprofessional Unrealistic expectations, takes on too much
Safe	Consistently follows agreed safe practice Knows the safest care is supporting people to stay well	Inconsistent practice, slow to follow latest evidence Not thinking about health of our whole community
Efficient	Makes best use of resources and time Respects the value of other people's time, prompt	Not interested in effective user of resources Keeps people waiting unnecessarily, often late
Speaks up	Seeks out, welcomes and give feedback to others Speaks up whenever they have a concern	Rejects feedback from others, give a 'telling off' 'Walks past' safety concerns or poor behaviour

Interests Register

Feb-19

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest e.g. Organisation / Close Family Member	Nature of Interest e.g. Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that agrees the contract.	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Primary Health Alliance	Executive Member	Primary Care advocacy organisation	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
	General Practice New Zealand	Executive Member			
	General Practice Leaders Forum	Member			
Dr John Gommans	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
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
David Warrington (Service Director - Mental Health & Addictions)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National GM of Mental Health & Addictions	Member		No	Low
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	National Advisory Committee of the RNZCGPs	Member and CP Teacher	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)	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	Health HB	Employee	Role: Clinical Performance Support Lead	Yes	Low
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 (Chief Medical Officer - Hospital)	Dental Council of New Zealand	Appointed Member	Oral health professions regulator	No	

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
	Royal Australasian College of Dental Surgeons	Fellow	Continuing Professional Development	No	
	NZ Institute of Directors	Member	Professional Network	No	
	NZ Dental Association	Hon Life Member	Professional Network	No	
	Australian NZ Society of Paediatric Dentistry	Member	Professional Network	No	
	Association of Salaried Medical Specialists	Member	Trade union	Yes	Potential pecuniary interest
	NZ Society of Hospital and Community Dentistry	Member	Professional Network	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Director	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health			
	Kidney Health Australia - Caring for Australasians with Renal Impairment	Member		No	Guidelines group - involved with the group "Management of chronic kidney disease among Aboriginal, Torres Strait Islander Peoples and Maori".
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
Dr Peter Culham (GP)	Havelock North Properties Limited	Shareholder	Medical Centre owner	Yes	Low, pecuniary, hold leases with healthcare providers
	Te Mata Peak Practice	GP and Director	General Practice	Yes	Low, pecuniary, provides primary care services
	C&G Healthcare	Director	Private business	No	No further exposure beyond mentioned above
	Royal NZ College of General Practitioners	Fellow		No	
Daniel Bernal	New Zealand Hospital Pharmacists Association	Member	Discussion	No	
	Pharmaceutical Society of New Zealand	Member	Access their resources, record my CPD on their website.	No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 10 APRIL 2019 AT 3.00 PM

PUBLIC

Present:	Dr John Gommans (Chair) Dr Robin Whyman Dr Peter Culham Dr Mark Peterson Debs Higgins Lee-Ora Lusis Dr Daniel Bernal Dr Russell Wills Dr Andy Phillips Anne McLeod David Warrington (from 3.20 pm) Chris McKenna (from 3.25 pm)
In Attendance:	Ken Foote, Company Secretary Kate Coley, Executive Director – People & Quality (ED P&Q) Tracy Fricker, Council Administrator and EA to ED P&Q Peter Satterwaite, Health Hawke's Bay Representative
Apologies:	Jules Arthur and Dr Nicholas Jones

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

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

2. INTEREST REGISTER

No conflicts of interests were noted for today's agenda items.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 13 March 2019, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 Investments Update (Outcomes of Budget Prioritisation)
On agenda today under item #10. *Item can now be closed.*

Item #2 New Clinical Governance Structure / Terms of Reference

- CAG – TOR still in draft. There is still no CAG Representative on Council. This is a concern as primary health representation on Council is sparse following resignation of David Rodgers. Discussions are ongoing at CAG.

- TOR for Advisory Groups. Email reminder sent to all Committee Chairs. Not all Chairs have provided the TOR of Advisory Groups that report to their committee to Clinical Council for endorsement.

  Action: List of Advisory Groups who have not sent their TOR to be provided to the Chair.

Item #3 Information Services Governance Group
TOR received. A small steering group has been established to cover information services governance. Dan Bernal was nominated as the Clinical Council representative on the group by the Co-Chairs. This was endorsed by Council members present. *Item can now be closed.*

Item #4 Workplan / Annual Plan
Discussed under item #6. *Item can now be closed.*

Item #5 Screening for Harms
Dr Wills advised that discussion has begun within the Health Improvement & Equity Group. An update will be provided at the July meeting.

5. BOARD REPORT - MARCH (CLINICAL AND CONSUMER COUNCILS' COMBINED)

The combined report to the Board was provided in the meeting papers for information. The Board accepted the recommendations in the report and it was endorsed by the CEO. Management is to present a paper at the June Board Meeting on how the DHB will ensure that Person & Whanau Centre Care happens, including training and developing our workforce and how consumers can become more empowered.

6. WORKPLAN

The workplan was provided in the meeting papers. The Company Secretary advised that the workplan is a full governance workplan for all governance groups and the format cannot be changed for Clinical Council.

Action: Send the workplan as a separate attachment for ease of reading.

7. CLINICAL COUNCIL ANNUAL PLAN – PROGRESS REVIEW

The Chair commented that following the previous meeting, members were to advise Co-Chairs of areas of interest. Members to advise Co-Chairs in the next week, otherwise they will be assigned to an objective to distribute the work between members.

Progress on the objectives was discussed:

1. A small sub-group is overseeing the sign-off of the 5 year strategic plan. Robin Whyman has been nominated as the Clinical Council representative by the Co-Chairs. There is a meeting to be held on 2 May.

2. The Person & Whanau Centred Care workshop with Consumer Council has been held and a recommendation has gone to the Board, which was approved. The Executive Director P&Q will bring together a small working group of Clinical and Consumer Council members to prepare the report for the Board in June.

3. Still chasing TOR for all Advisory Groups. Council Administrator has been asked to provide the Co-Chairs with the full list of AGs and status of their TOR. It was noted that most groups are functioning, the biggest challenge for these groups is administrative support and a good

reporting structure. This is a key area for Council. Effective resourcing is required to support the clinical governance structure.

4. Workshop to be held on Risk Management, date to be determined by C0-Chairs with EDP&Q.

5. One of the components of the new People Plan is a workforce development plan for the clinical and non-clinical workforce which will help address objective 5 regarding capacity of clinical workforce. Discussion also held around model of care changes influencing future workforce requirements. .

6. This is aligned with the Objective 5 but focused on capability of clinical workforce. This has not progressed in terms of action. Given other key work required of the P&Q Directorate including PWCC and Risk Management for Council this aspect of workforce development has a lower priority and won't be addressed within the next 6 months.

In discussion regarding workforce development under objectives 5 and 6 it was noted that areas of risk regarding clinical workforce need to be identified e.g. clinical consequences have already occurred with the failure to maintain adequate training in nursing such as increase in pressure injuries, falls and failure to identify the deteriorating patient. There has also been an impact with senior staff leaving the organisation being replaced with junior staff. The Primary Care Workforce Snapshot report is to be shared with Council

Actions: The progress template will be populated with the updates.
Members to advise Co-Chairs of areas of interest.

SECTION 2: REPORTING COMMITTEES TO COUNCIL

8. CLINICAL ADVISORY & GOVERNANCE GROUP – VERBAL UPDATE

Chris McKenna provided an update from the last CAG meeting including: dashboard development; Clinical Council representative (should have a resolution soon); position statement on non-regulated workforce and phlebotomy; implementation of Health Care Home; expanding the acute care pathway; promoting primary care removal of skin cancers; quality use of medicines; TOR being reviewed; clinical services plan; clinical portal and information governance.

9. COUNCIL COMMITTEE REPORTS

The Company Secretary noted that as well as committee reports, council member representative reports will also be included for information.

- Te Pitau Health Alliance Governance Group – report tabled at the meeting (previously attended by David Rodgers). Clinical Council unanimously supported Peter Culham to be the replacement Clinical Council representative.

- Clinical Effectiveness & Audit Committee – the inaugural meeting minutes were tabled at the meeting. Co-Chair Dan Bernal spoke to these. Issues raised included review of process for reviewing critical incident management; Laboratory receiving after-hours referrals for tests from primary care that have labelling errors with no ability for urgent follow-up; Trauma Advisory Group have raised a concern regarding a letter to HDC in 2014 stating approval for 1.0fte Trauma Co-ordinator and there is only 0.5fte, it was noted that this should be raised with the Medical Directorate. A more substantive report will be provided once the Committee is up and running.

SECTION 3: DISCUSSION

10. INVESTMENTS UPDATE (OUTCOMES OF BUDGET PRIORITISATION)

Andy Phillips provided a presentation on "Making Prudent Decisions". Key points noted:

- Three guiding sets of principles; HBDHB values, NZ Triple Aim and IOM Quality Elements
- Rationale – having a clear process and criteria to identify areas and services open to change
- Core components – prioritisation approach, two stages:
  - Stage 1 – weighted numerical approach – assigning a score to each service
  - Stage 2 – values based framework to provide equitable outcomes; ethical to give competing needs a fair hearing; support governance; maintain staff, consumer and community confidence.

General discussion held regarding the methodology and prioritisation tool used. It was noted that although the current tool is not perfect, we need to start somewhere to make rational decisions.

Feedback to be provided to andy.phillips@hbdhb.govt.nz

Action: Copy of the presentation to be sent to Council members.

11. CLINICAL COUNCIL MEMBERSHIP AND REPRESENTATION

The Chair provided the following updates:

Council Representatives to other bodies confirmed:
- Robin Whyman - Health Strategy Group
- Dan Bernal - Health Information Services Steering Group
- Peter Culham – Te Pitau Health Alliance Governance Group

Council Representatives required:
- GP Representative to replace David Rodgers – Expressions of Interest to be circulated
- CAG - Clinical Lead vacancy

Council composition will need to be reviewed at the AGM in August.

John Gommans' last meeting will be at AGM after 10 years on Council. A new SMO replacement (and a new Council Co-Chair) will be required. A new Co-Chair of Professional Standards Committee will also be required to replace John Gommans as TOR require this to be a Council member.

Tenure of members Russell Wills, Lee-ora Lusis and David Warrington are up for renewal this year.

12. CLINICAL GOVERNANCE STRUCTURE

The Company Secretary advised that Clinical Committees TOR have been previously approved by Council. Committee Co-Chairs need to approve the TOR for their respective Advisory Groups, and for visibility all Advisory Groups' TOR should come to Clinical Council for endorsement.

Appropriate membership, administration support, reporting structure and how this is going to be managed, payments for PHO and non-DHB members, induction and training around the function of clinical governance for members was also discussed.

SECTION 4: FOR INFORMATION

13. MATARIKI HB REGIONAL DEVELOPMENT STRATEGY AND SOCIAL INCLUSION STRATEGY

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

14. VIOLENCE INTERVENTION PROGRAMME REPORT (UPDATE)

The paper was provided for information only. Dr Russell Wills advised that Cheryl Newman is leading this project, with good stakeholder buy-in. A meeting has been had with the MoH. How we use the resource currently isn't working. Challenge is how to use the resource more effectively and integrate in the community. Cheryl Neman is leading the team well and talking to the right people.

15. SECTION 5: RECOMMENDATION TO EXCLUDE THE PUBLIC

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

16. Minutes of Previous Meetings (public excluded)
17. Matters Arising – Review Actions
18. Joint Clinical and Consumer Councils' Workshop Notes
19. Topics of Interest – Member Issues/Updates

The meeting closed at 4.25 pm.

Confirmed: _____
Chair

Date: _____

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/04/18	***Investments Update (Outcomes of Budget Prioritisation)*** • Presentation to be emailed to members • Feedback to be provided to Andy Phillips	Admin All Members	April April/May	
2	12/09/18	***New Clinical Governance Structure / Terms of References*** • CAG TOR to be provided • Committee Chairs to review/approve TOR for respective Advisory Groups and provide TOR to Clinical Council for endorsement • Reminder to be sent to Committee Co0 Chairs	C McKenna Committee Co-Chairs Council Co-Chairs	TBC ASAP April	Pending approval Ongoing
3	13/03/19	***Screening for Harms*** Small working group to prepare starter for 10 paper for discussion	Nick Jones, Russell Wills, Andy Phillips and Debs Higgins		
4	10/04/19	***Clinical Council Annual Plan – Progress Review*** • Members to advise Co-Chairs which of the six annual plan objectives then have an interest in • Progress Template to be updated	All members Co-Chairs/ Company Secretary	17 April April	

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OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 35
	For the attention of: **HBDHB Board**
Document Owner:	Dr John Gommans (Co-Chair) Jules Arthur (Co-Chair)
Month:	April 2019
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

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

HB Clinical Council met on 10 April 2019. A summary of matters discussed is provided below:

BOARD REPORT – CLINICAL AND CONSUMER COUNCIL COMBINED WORKSHOP.

Council reviewed the Chairs Report to the Board in March, and noted the Board's approval of the recommendations. There is a lot to be gained by implementing a Person and Whanau Centred Care culture within the Hawkes Bay health system and Council members are keen to see some real traction, particularly in:

- Educating, training and developing our workforce
- Empowering our consumers to become more involved in both their own care and the design of the health system that supports them.

CLINICAL COUNCIL ANNUAL PLAN

Progress on the six key objectives was discussed. Issues that appeared to be on track included;

- Input into strategic planning
- Person and Whanua Centred Care

Implementation of the 'new' clinical governance structure was progressing, but it was noted and agreed that full implementation and effective ongoing performance is dependent on good management, coordination and administrative support. Options for how this support will be provided are still under discussion. The development of a clinical workforce plan also still needs further consideration.

The critical area of concern remains the reporting and management of clinical risk. It was noted that this is a wider DHB/sector issue and that further education, training and reporting process improvement is currently being developed. Clinical Council will run a workshop on this once these are available.

COUNCIL COMMITTEE AND REPRESENTATIVES REPORTS

Council received reports from:

- Clinical Advisory and Governance Group (PHO)
- Clinical Effectiveness and Audit Committee
- Te Pitau Governance Group (Board Report)

A number of 'new' representative appointments were approved:

- Robin Whyman – Health Strategy Group
- Dan Bernal – Information Services Programme of Work Governance Group
- Peter Culham – Te Pitau Health Alliance Governance Group

MATARIKI HB REGIONAL DEVELOPMENT STRATEGY AND SOCIAL INCLUSION STRATEGY

Council noted this report

VIOLENCE INTERVENTION PROGRAMME REPORT

Council noted that how we are using the resources around this programme appear not to be working. The challenge is to use the resource more effectively and integrate into the community.

GOVERNANCE WORKPLAN PAPERS

Updated: 24 April 2019

CLINICAL & CONSUMER MEETING 8/9 MAY 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				8-May-19			
Collaborative Pathways update (Nov - **May**) 6mthly Clinical Council	E	Mark Peterson	Penny Rongotoa	21-May-19		8-May-19			
Te Ara Whakawaiora - Access Rates 0-4 (local indicators) CHILD HEALTH	E	Chris Ash	Mark P/ Jil Garrett / Patrick	23-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	E	Wayne Woolrich		30-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19
PHLG Nurse Navigators - roles & responsibilities		Bernard Te Paa		30-Apr-19		8-May-19	9-May-19		29-May-19
Primary Care Workforce Survery		Wayne Woolrich	Rochelle Robertson			8-May-19			
Strategy Workstream presentations/feedback sessions (30mins + 10mins Equity discussion (20min MRB))		Chris Ash	Kate Rawstron		8-May-19	8-May-19	9-May-19		29-May-19

CLINICAL & CONSUMER MEETING 12/13 June 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Annual Plan 2019/20 SPEs to Board by end of June (include committees?)		Chris Ash	Robyn Richardson	4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				12-Jun-19			
IS updates/presentations 30 mins - Bi-monthly Feb Apr **Jun** Aug Oct Dec		Anne Speden				12-Jun-19		26-Jun-19	
People Plan Progress Update Report (6 monthly - Dec, **Jun 19**)		Kate Coley		4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Early Supportive Discharge service Model of Care		Colin Hutchison	Allison Stevenson	14-May-19		12-Jun-19			
Person & Whanau Centered Care actions		Kate Coley		28-May-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19

CLINICAL & CONSUMER MEETING 10/ 11 July 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				10-Jul-19			

CLINICAL & CONSUMER MEETING 14/15 August 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Alcohol Harm Reduction Strategy (6 monthly update) Feb **- Aug**		Bernard TePaa	Rachel Eyre	13-Aug-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
Annual Plan 2019/20 draft to the Board		Chris Ash	Robyn Richardson	6-Aug-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				14-Aug-19			
Clinical Council Annual Plan 2019/2020 discussion on the year ahead		Jules Arthur / John Gommans				14-Aug-19			
Clinical Council Annual General Meeting						14-Aug-19			
HB Health Awards - preparation for judging **2019**-2020	E	Kevin Snee	Anna Kirk	30-Jul-19		14-Aug-19	15-Aug-19		28-Aug-19
IS updates/presentations 30 mins - Bi-monthly Feb Apr Jun **Aug** Oct Dec		Anne Speden				14-Aug-19		28-Aug-19	

CLINICAL & CONSUMER MEETING 11/12 September 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				11-Sep-19			
Health Certification Audit Findings (sept19)	E	Kate Coley	Kaye Lafferty	27-Aug-19		11-Sep-19		25-Sep-19	
Matariki HB Regional Development Strategy and Social Inclusion Strategy update (6 mthly) **Sept**-Mar	E	Bernard TePaa	Shari Tidswell	27-Aug-19	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept) last one in cycle	E	Wayne Woolrich		27-Aug-19	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19
Serious Adverse Events FULL REPORT		Robyn Whyman		3-Sep-19		11-Sep-19		25-Sep-19	

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2018/19

ACTION/PROGRESS REPORT

OBJECTIVE	PROGRESS TO Apr 2019
1. Provide a proactive and prioritised clinical perspective on issues and strategies to be addressed in the new 5 Year Strategic Plan for the HB health sector by 30 June 2019	A small sub-group is overseeing the sign-off of the 5 year strategic plan. Robin Whyman has been nominated as the Clinical Council representative by the Co-Chairs. There is a meeting to be held on 2 May.
2. Co-design with Consumer Council and initiate the implementation of a detailed plan for the implementation of PWCC in HB by 30 June 2019	The Person & Whanau Centred Care workshop with Consumer Council has been held and a recommendation has gone to the Board, which was approved. The Executive Director P&Q will bring together a small working group of Clinical and Consumer Council members to prepare the report for the Board in June.
3. Ensure the Clinical Governance Structure is fully implemented and integrated, with appropriate reporting, management and administration processes in place, by 30 June 2019	Still chasing TOR for all Advisory Groups. Council Administrator has been asked to provide the Co-Chairs with the full list of AGs and status of their TOR. It was noted that most groups are functioning, the biggest challenge for these groups is administrative support and a good reporting structure. This is a key area for Council. Effective resourcing is required to support the clinical governance structure.
4. Ensure the development and implemention of a sector wide process for monitoring, managing and reporting clinical risk, by 30 June 2019	Workshop to be held on Risk Management, date to be determined by C0-Chairs with EDP&Q.
5. Facilitate the development of a HB Clinical Workforce Plan to support the new 5 Year Strategic Plan, by 30 June 19	One of the components of the new People Plan is a workforce development plan for the clinical and non-clinical workforce which will help address objective 5 regarding capacity of clinical workforce. Discussion also held around model of care changes influencing future workforce requirements.
6. Promote and support the development and delivery of education and training of all clinicians on the Quadruple Aim and PWCC, and what these mean for clinicians, by 30 June 2019	This is aligned with the Objective 5 but focused on capability of clinical workforce. This has not progressed in terms of action. Given other key work required of the P&Q Directorate including PWCC and Risk Management for Council this aspect of workforce development has a lower priority and won't be addressed within the next 6 months.

Clinical Advisory & Governance Group

Verbal update

Council Representatives and Committee Reports

Verbal updates

Collaborative Pathways

Verbal update

HAWKE'S BAY
District Health Board
Whakawāteatia

HB Health Strategy

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Late paper

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Child Health**
	For the attention of: **HB Clinical Council**
Document Owner	Patrick Le Geyt, Director Māori Health
Champions	ASH 0-4 years – Chris Ash Child Oral Health – Robin Whyman Breastfeeding – Chris McKenna Child Healthy Weight – Bernard Te Paa
Document Author(s)	Shari Tidswell, Intersectoral Manager, Te Puni Matawhanui Tracy Ashworth, Health Equity Advisor, Te Puni Matawhanui Jeanette Frechling, Acting Deputy Director, Communities, Women, and Children's Directorate Marie Beattie, Planning and Commissioning Manager, Primary Care Directorate Charrissa Keenan, Programme Manager, Te Puni Matawhanui
Reviewed by	EMT
Month/Year	April 2019
Purpose	The purpose of this report is to present information about the status of Child Health and equity targets for: • ASH 0 – 4years • Breastfeeding • Oral Health • Healthy Weight. The report presents relevant data, progress to date, and advice about intended actions over the next 12 months to achieve respective equity targets.
Previous Consideration Discussions	Previously each child health indicator was reported separately and annually; it is now presented as one report annually.
Summary	This is the first collective report on key Child Health indicators. Progress across all indicators has been mixed. Data shows: • Increases in inequities in ASH 0 – 4 year olds, particularly for asthma, lower-respiratory infections, and cellulitis among Māori and Pacific children. • Child oral health shows some improvement in the number of caries free children at age five across all ethnic groups but no equity gain, and an increase in ASH GA dental rates. • There has been a slight improvement in breastfeeding rates across Māori, Pacific, and high deprivation groups. • HBDHB is meeting the target for Child Healthy Weight. Over the past year, concerted and considered efforts have been applied to develop and implement whānau-centred, equity focused actions, but it's too early to know how effective or what difference these efforts are

	having on equitable health outcomes for tamariki Māori, Pacific, and Other children of low socioeconomic backgrounds. The oral health prevention initiative and the Māori breastfeeding service are examples of these efforts and while showing positive signs of responsiveness to whānau Māori, will be monitored for their equity impact over the coming quarters. In addition to the actions and activities outlined in this report, a new programme is proposed to establish a Child Health kaupapa to lead, influence, monitor and track how we develop, deliver, fund child health across HBDHB. This will bring a more cohesive and collaborative approach to organising child health activities across the organisation, and will ensure health areas are working unitedly toward equitable health outcomes for tamariki.
Contribution to Goals and Strategic Implications	Health Equity report 2018 – Actions to create a responsive and equitable health system and services; Clinical Services Plan - Whānau centred, kaupapa Māori approaches; HBDHB expectation - Equitable health outcomes for Māori.
Impact on Reducing Inequities/Disparities	Tamariki Māori, Pacific, and children from low socioeconomic background are prioritised in planning, development, and service implementation. The implication is improved health outcomes for the poor and under-served tamariki and their whānau.
Consumer Engagement	Included where appropriate in respective planning and development activities within each child health indicator.
Other Consultation /Involvement	Not applicable
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable

RECOMMENDATION:

It is recommended that the HB Clinical Council

1. **Note** the contents of the report.
2. **Note** the planned improvements and activities over the next 12 months to achieve equitable health outcomes for tamariki.
3. **Support** the intention to establish a Child Health kaupapa to bring a more cohesive and collaborative approach to track progress and improve effectiveness in child health activities across the organisation.

HAWKE'S BAY
District Health Board
Whakawāteatia

CHILD HEALTH – TE ARA WHAKAWAIORA REPORT

Author/s:	Shari Tidswell, Intersectoral Manager Tracy Ashworth, Health Equity Advisor Jeanette Frechling, Acting Deputy Director, Communities, Women, and Children Marie Beattie, Planning and Commissioning Manager Charrissa Keenan, Programme Manager, Māori Health
Designation:	As above
Date:	April 2019

PURPOSE

This report presents the inaugural Child Health – Te Ara Whakawaiora report (report). The report provides information about the status of Child Health in Hawke's Bay with a description of relevant indicators, equity targets, and current and planned activities to achieve equitable health outcomes for tamariki Māori and other disadvantaged tamariki.

CONTEXT

Te Ara Whakawaiora (TAW) was first introduced in 2014 as an equity improvement programme where significant inequities in health outcomes exist between Māori and non-Māori. Following a review in 2018, changes were made to the Te Ara Whakawaiora programme to improve the way child and other health priorities are being actioned, tracked and reported across the organisation. For the first time, Child Health indicators are being collectively reported under a new Child Health TAW report that includes:

- ASH 0 – 4 years
- Breastfeeding
- Oral Health
- Child Healthy Weight

The above indicators were part of the previous TAW reporting, and were included because of their national and local significance. For the purposes of this report they have been retained however, recommendations are made in this report to ensure future indicators remain relevant and applicable to areas disproportionately affecting the health and well-being of tamariki Māori in Hawke's Bay.

WHY IS THIS INDICATOR IMPORTANT?

The HBDHB has committed to equitable health outcomes for Māori. Early childhood is recognised as critical to health equity, as children in families with limited economic resources often face multiple physical and psychosocial hardships in early childhood that can impact their health, and can result in lifelong consequences. To advance our committment to equity it is imperative HBDHB health services and programs reflect whānau-centred approches to grow and nuture pepi and tāmariki in a supported way with their whānau.

Evidence supports a number of health and intersectoral inititaives which, when designed well with communities improve maternal and child outcomes. Healthy nutrition including breastfeeding, on time immunisations, raising awareness of family harm, reducing harm from alcohol, tabacco and other drugs, supporting parenting and attachment programs and addressing mental health all reflect protective factors for early childhood. Aligned intersectorial intiatives to raise incomes, improve

housing conditions and provide high quality early childhood education also interact with the health sector to support healthy childhoods. Environments and practices which are responsive and culturally competant enhance health when interwined with Te Ao Māori princples of health and wellbeing.

IMPLICATIONS

Child health kaupapa

In addition to the actions and activities outlined in this report, a new programme is proposed to establish a Child Health kaupapa with a Child Health Governance group to lead, influence, monitor and track how we develop, deliver, fund, and track child health across our region. This kaupapa will bring a more cohesive and collaborative approach to organising child health activities across the organisation, and will ensure health areas are working unitedly toward equitable health outcomes for tamariki.

It is proposed that the first tranch include: aligning Safe Sleep, Breastfeeding, and Smoking Cessation programmes. There are common risk factors across all three areas impacting on child health outcomes that would benefit from more joined up planning. This first tranch will test out this new approach and identify information needed to track progress and improve the effectiveness of child health services.

Governance and integration of child health indicators to maximise opportunities and leverage potential for targeted and sustainable programs of work is essential. Alongside the Child Health kaupapa we propose a fuller set of indicators reflective of the first 5 years of age be included in the next TAW annual report of Child Health, essentially a child focused Health Equity report to be published annually.

The new Child Health kaupapa is a partnership approach between Primary Care Service, Primary Health Organisation, Māori Health, Population Health, Maternity Services, Children Womens and Communities Services, and will also include community and whānau participation.

Annual Planning

The 2019/20 HBDHB Annual Plan includes measures of Child Wellbeing and intersectorial action of which this annual Child Health TAW report will measure progress of measures of health equity for our tāmariki. By looking at the indicators we gain an understanding of the environments tāmariki are experiencing which impact on their health. A number of these indicators reflect modifiable risk factors and inequities which often have underlying causal links, such as, smoking and unhealthy housing and yet are often looked at in isolation in terms of systems, strategies and monitoring.

Inclusion and exclusion of new child health areas

During the preparation of this report, it has been recommended that the following health areas be considered for inclusion in future Child Health – TAW reports. These areas are requested because of the significant immediate and long-term health and social impacts on tamariki health and well-being:

- Family Violence
- Smokefree
- Immunisation

It is also recommended that Child Healthy Weight be excluded from future reports because equity targets are being met.

CHILD HEALTH PRIORITY INDICATORS

The table below provides a description of each priority health area, including: the indicator, measure, and the respective Equity Champion.

Priority	Indicator	Measure	Champion	Responsible Manager/s
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH):		Chris Ash	Emma Foster Marie Beattie
	1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections.	≤82%		
Breastfeeding *National Indicator*	Improve breastfeeding rates for children at 6 weeks, 3 months and 6 months:		Chris McKenna	Shari Tidswell Jules Arthur Charrissa Keenan
	1. % of infants that are exclusively or fully breastfed at 6 weeks of age;	≥75%		
	2. % of infants that are exclusively or fully breastfed at 3 months of age;	≥60%		
	3. % of infants that are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	≥65%		
Child Oral Health *National Indicator*	1. % of eligible pre-school enrolments in DHB-funded oral health services. 2. % of children who are carries free at 5 years of age	≥95% ≥67%	Robin Whyman	Liz Read Charrissa Keenan
Child Healthy Weight *National Indicator*	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	≥95%	Bernard Te Paa	Shari Tidswell

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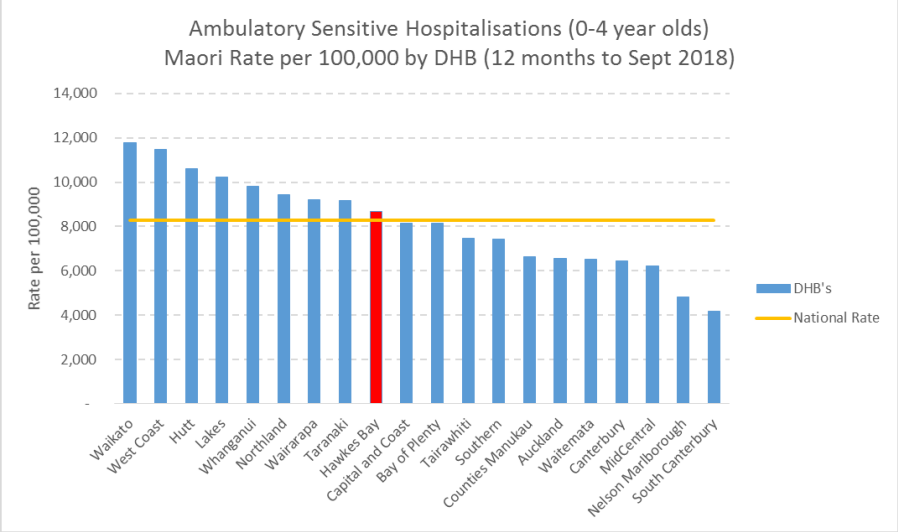
CHILD HEALTH PRIORITY: AMBULATORY SENSITIVE HOSPITALISATIONS (ASH) CHAMPION'S REVIEW

When compared to national rates, HBDHB ASH rates for tamariki Māori aged 0 – 4 years have worsened over the previous 12 months to September 2018. HBDHB is now ranked 12th compared to 8th in 2017[1].

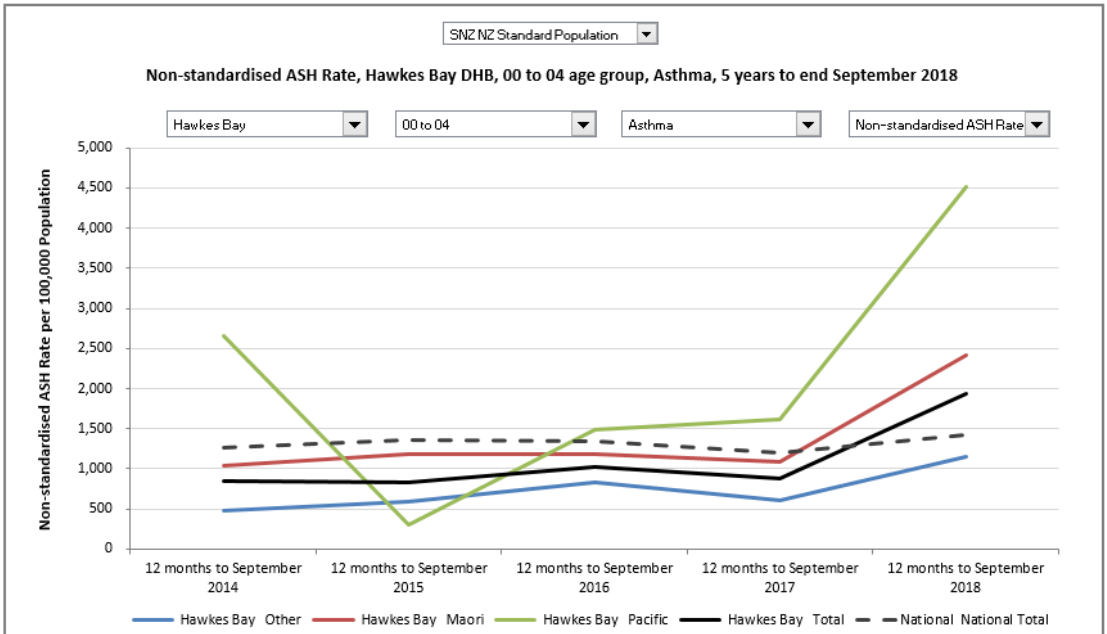


Graph 4. Hawke's Bay Māori ASH rates 0-4 age group 12 months to September 2018 – Benchmark against DHBs

Asthma

The ASH rate for Asthma 0-4 year olds has increased in the 12 month period from September 2017 (882) to September 2018 (1,982). This increase represents an additional 116 children admitted to hospital for asthma. Of these admissions, 67% were tamariki Māori, 28% Pacific children. The Pacific rate is particularly concerning; when compared with 2017 the rate increased by 190%.

[1] ***Note:*** *Data is reported in the non–standardised format for this age band. It is important therefore to examine the number of events over a 12 month period and comparisons to previous periods to get a picture of progress or decline against specific ASH conditions.*



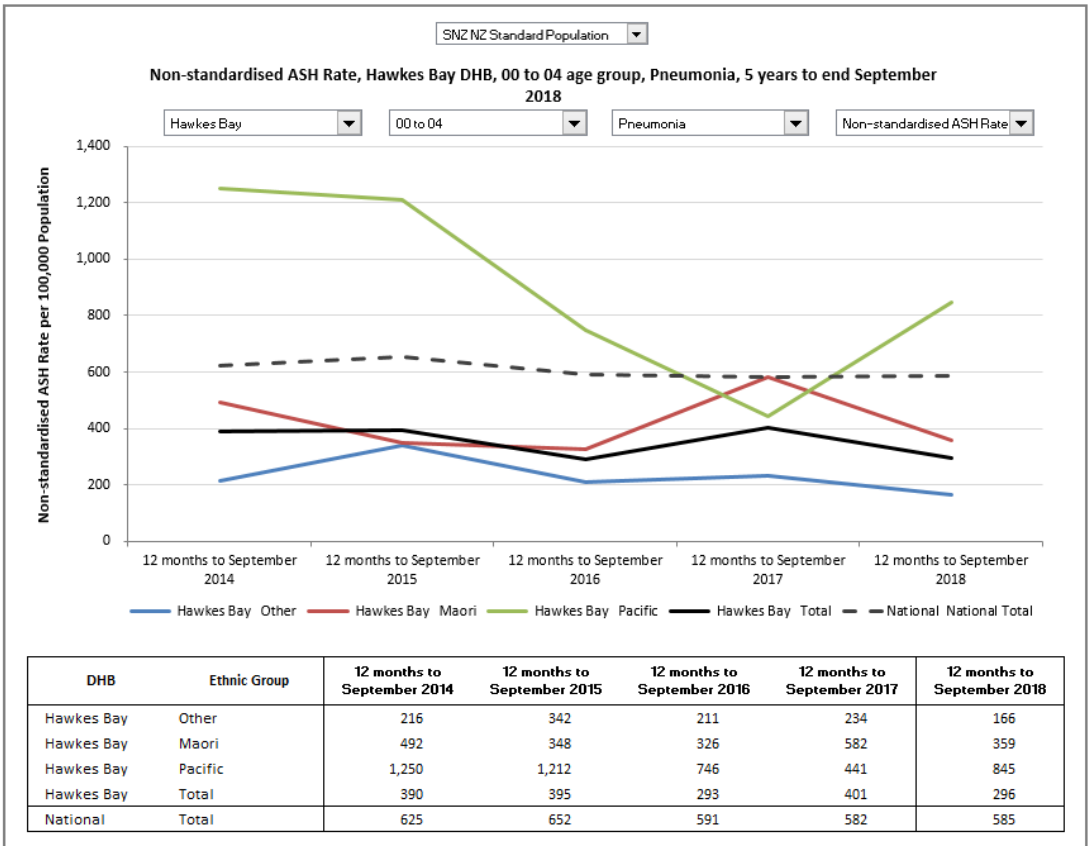
DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	481	598	827	612	1,144
Hawkes Bay	Maori	1,045	1,189	1,181	1,084	2,410
Hawkes Bay	Pacific	2,656	303	1,493	1,618	4,507
Hawkes Bay	Total	840	834	1,021	882	1,928
National	Total	1,269	1,362	1,342	1,204	1,425

Asthma Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	29	35	47	34	62
Hawkes Bay	Maori	51	58	58	54	121
Hawkes Bay	Pacific	17	2	10	11	32
Hawkes Bay	Total	97	95	115	99	215
National	Total	-	-	-	-	-

Pneumonia

The ASH rate for Pneumonia 0-4 year olds has decreased in the 12 month period from September 2017 (401) to September 2018 (296), this was due to a decrease of 12 events. Despite the overall rate decreasing, Pacific actually had an increase in its ASH rate, this was due to numbers going from 3 (12 months to Sep 2017) to 6 (12 months to Sep 2018). Māori events decreased by 9, from 29 (12 months to Sep 2017) to 18 (12 months to Sep 2018).



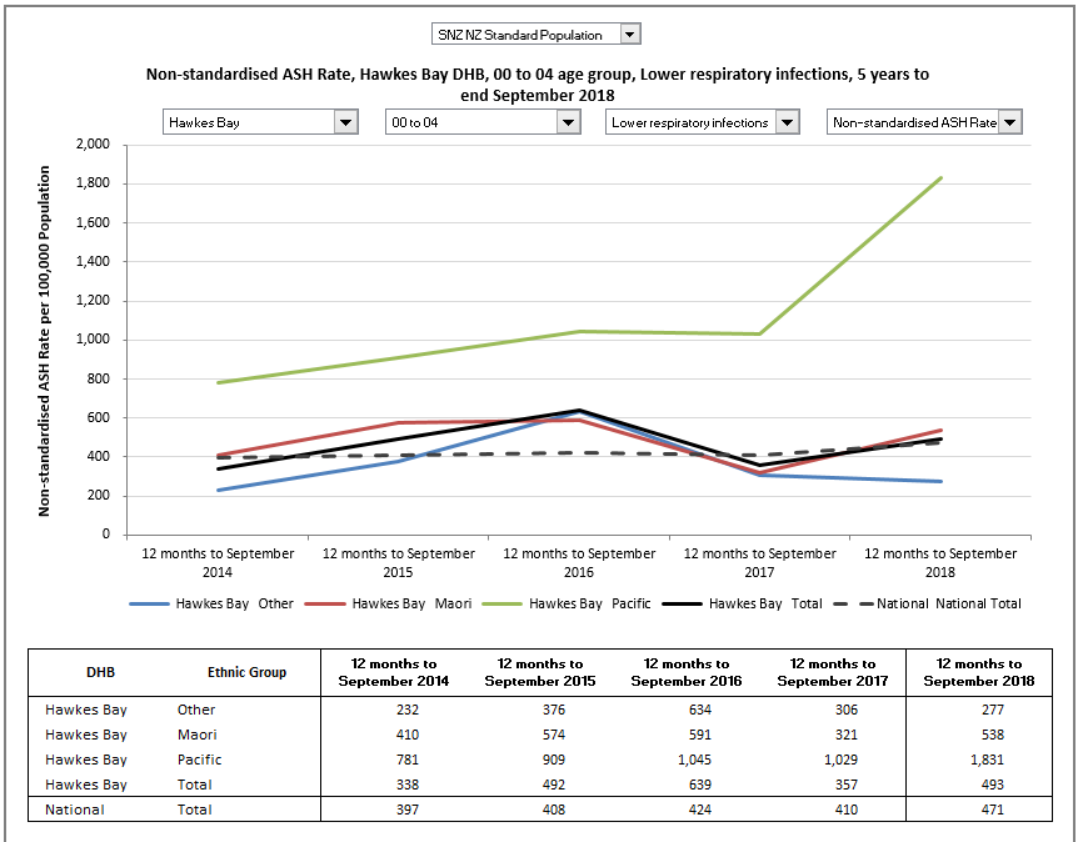
DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	216	342	211	234	166
Hawkes Bay	Maori	492	348	326	582	359
Hawkes Bay	Pacific	1,250	1,212	746	441	845
Hawkes Bay	Total	390	395	293	401	296
National	Total	625	652	591	582	585

Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	13	20	12	13	9
Hawkes Bay	Maori	24	17	16	29	18
Hawkes Bay	Pacific	8	8	5	3	6
Hawkes Bay	Total	45	45	33	45	33
National	Total	-	-	-	-	-

Lower respiratory infections

The ASH rate for Lower Respiratory Infections 0-4 year olds has increased in the 12 month period from September 2017 (357) to September 2018 (493), this was due to an increase of 15 events. Tamariki Māori saw the largest increase in actual events (11) and Pacific saw the largest increase in rate, this was due to events increasing from 7 (12 months to Sep 2017) to 13 (12 months to Sep 2018).

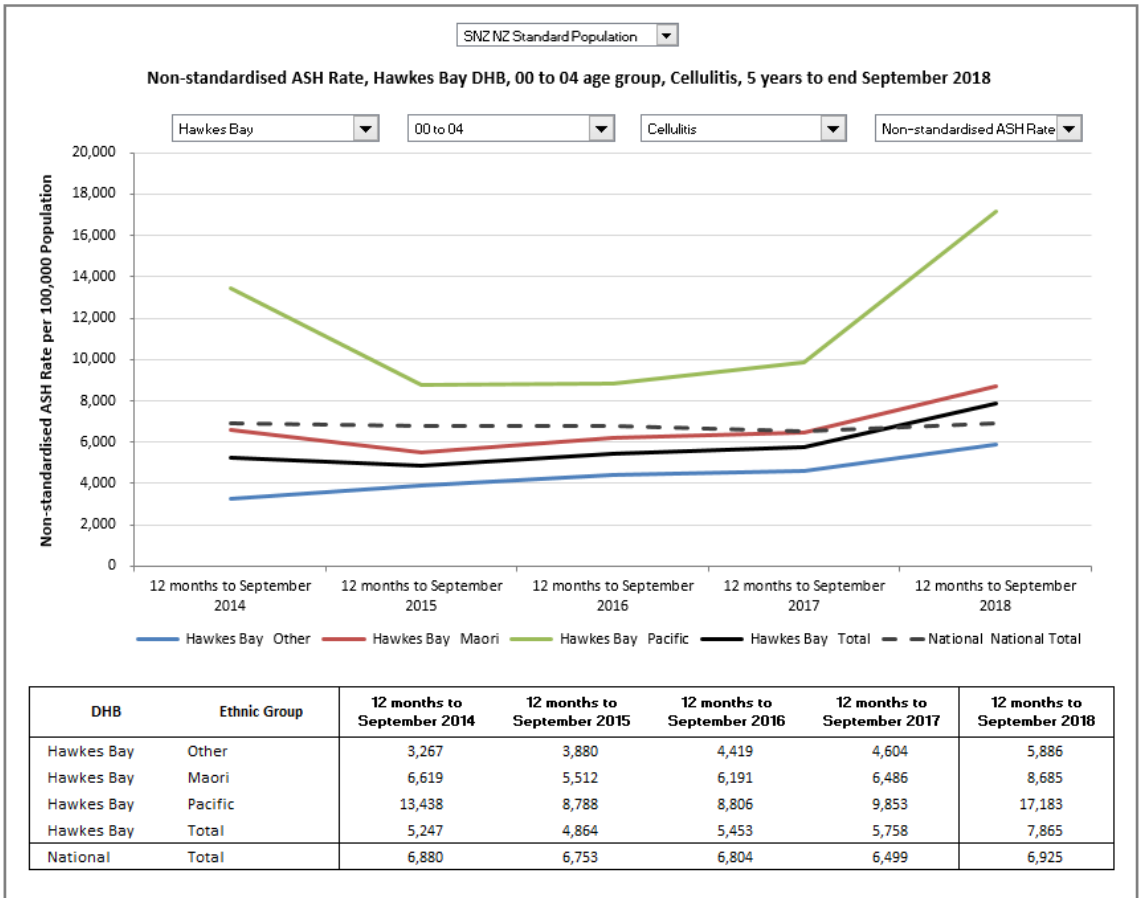


DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	232	376	634	306	277
Hawkes Bay	Maori	410	574	591	321	538
Hawkes Bay	Pacific	781	909	1,045	1,029	1,831
Hawkes Bay	Total	338	492	639	357	493
National	Total	397	408	424	410	471

Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	14	22	36	17	15
Hawkes Bay	Maori	20	28	29	16	27
Hawkes Bay	Pacific	5	6	7	7	13
Hawkes Bay	Total	39	56	72	40	55
National	Total	-	-	-	-	-

Cellulitis



DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	3,267	3,880	4,419	4,604	5,886
Hawkes Bay	Maori	6,619	5,512	6,191	6,486	8,685
Hawkes Bay	Pacific	13,438	8,788	8,806	9,853	17,183
Hawkes Bay	Total	5,247	4,864	5,453	5,758	7,865
National	Total	6,880	6,753	6,804	6,499	6,925

Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	197	227	251	256	319
Hawkes Bay	Maori	323	269	304	323	436
Hawkes Bay	Pacific	86	58	59	67	122
Hawkes Bay	Total	606	554	614	646	877
National	Total	-	-	-	-	-

The ASH rate for Cellulitis 0-4 year olds has increased in the 12 month period from September 2017 (5,758) to September 2018 (7,865), this was due to an increase of 231 events. Tamariki Māori saw the largest increase in actual events (113) and Pacific saw the largest increase in rate, this was due to events going from 67 (12 months to Sep 2017) to 122 (12 months to Sep 2018) a 82% increase.

CHAMPION'S REPORT OF ACTIVITY TO INCREASE PERFORMANCE OF THIS INDICATOR ANALYSIS AND ADVICE: ASH 0 – 4 YEARS

Respiratory support for tamariki and their whānau

Following a 2017 review of the ASH 0 – 4 respiratory care pathway an action plan was developed to provide better, responsive, and appropriate support for tamariki and their whānau with a respiratory illness. Overseen by an ASH 0 – 4 Respiratory Working Group, actions implemented in the previous 12 months include:

- Improvements to the respiratory referral pathway
- Process to ensure every child admitted to hospital receives a referral to the Child Healthy Housing Programme
- Paediatric respiratory training for primary care respiratory nurse champions to improve confidence working with young children

- Improvement to the primary care respiratory care pathway for following up whānau in the community after a hospital admission
- Winter respiratory support pilot programme.

A main finding of the review identified HBDHB do not fund a child respiratory support service. Without any resources or dedicated funding, the Working Group has not been able to implement any actions that have resource implications. To mitigate this lack of prioritisation, Māori health using Well Child Tamariki Ora quality improvement funding, invested in a pilot winter respiratory support service for the 2018 winter months. Whilst the program was postive in regards to the upskilling of staff and kaiawhina in respiratory care for tamarki, the service did not have the intended impact at the whānau level.

Current activity: A main barrier to the winter pilot was the timely access to information from secondary to primary care services to enable immediate support and follow up in the home when the child was sick. Learnings from the pilot have been considered by the ASH 0 – 4 Respiratory Working Group, and plans are underway to deliver a sustainable long term whānau-centred child respiratory support service. The service will be implemented in two phases over the coming 12 months:

- Phase 1) establishment of a Respiratory Resource Nurse Māori to directly support tamariki and their whānau who present to hospital for a respiratory related illness. The service will have a hospital presence but will be the link between secondary care services, whānau in the home, and their primary care provider.
- Phase 2) establishment of a Community based Respiratory Resource Nurse Māori based in primary care but interfacing with whānau and secondary care services.

Tamariki Māori living in Flaxmere disproportionately carry the burden of respiratory illness in Hawke's Bay with higher rates of presentations and admissions than any other group or location. Therefore, in the first instance, the service will support tamariki Māori living in the Flaxmere community.
The ASH 0 – 4 Respiratory Action Plan will also be reviewed and updated.

Child Healthy Housing program
The Child Healthy Housing Programme (CHHP) provides access to housing resources for whānau at risk of, or who have, a respiratory illness. Cold, crowded, damp housing leads to child illnesses such as respiratory infections. Key results of the CHHP show:

- 68.5% of all eligible referrals identify as whānau Māori, and 17.5% Pacific. There has been good progress to identify, refer, and assess whānau Māori and Pacific referrals compared to previous years.

In July 2018/19 whānau feedback was sought to gather information about the responsiveness and effectiveness of the CHHP. Feedback from whānau showed:

- 89% felt their home was warmer and dryer; and their children less sick.
- 97% felt they had increased knowledge regarding maintaining a warm dry home
- 16% of tamariki had been admitted to hospital with ASH symptoms since receiving the intervention
- 2 whānau were re-referred to the CHHP as their circumstances had changed.

As housing is such an important determinant of health, the CHHP actively seeks opportunities to engage in other health and non-health areas to collectively work together to improve child health and well-being. These activities, which have a specific goal to improve equitable health outcomes for tamariki Māori include:

- HB Cot Bank – a programme for older pēpi to minimise barriers to access for whānau with limited or no means to provide a safe sleep environment for their babies once they have outgrown the wahakura/pēpi pod.
- 1000's of pairs of Jammies for June were distributed.
- HBDHB Government submissions to property legislation and housing standards have been enhanced with 'reality stories' and advocacy through the programme.
- A collaborative pilot with Habitat for Humanity homes are receiving minor repairs to maintain a thermal envelope and reduce dampness.
- Collaboration with companies/organisations such as Tumu Timbers and Red Cross to attain resources for warm dry homes at very low or no cost to whānau.
- Pathways and relationships with NGO's and Government Organisations, such as MSD, HNZC improves access to services and supports.

Current activity: A comparison of healthy homes program data between 2017/18 and 2018/19 has revealed a 40% increase in eligible referrals that were unable to be contacted/ or disengaged with the CHHP (17 to 42 whānau). An investigation to find out what is happening, and how we can improve this, is planned.

Supporting tamariki and their whānau with skin infections

The HBDHB Skin program aims to reduce admissions to hospital for skin infections and infestations. The programme promotes healthy skin, providing appropriate resources to support whānau with preventative measures, and facilitating access to early treatment.

After feedback from the Early Childhood Education Centres (ECE's) including Kohanga Reo, flip charts and talk cards have been produced in Te Reo Māori, Samoan and English. Resources have been distributed in each language to all education settings via Public Health Nurses who are trained to work with kaimahi. The resources are also available through outreach immunizations, B4 School Checks, Māori health providers, and have also been requested and shared with other regions. The program has also established links with Kidscan to support a head lice prevention pilot in seven ECEs that include Kōhanga Reo and Pacific Language Nests. The pilot involves education for staff regarding the treatment and prevention of head lice.

Tamariki aged 0 – 4 years can now access treatment for impetigo, boils, cellulitis, head lice and scabies when their older siblings are identified with skin infections at school. PHN with standing orders are able to provide treatment directly to whānau on the day. The Schools involved in the programme are targeted to low decile schools that have 1 – 2 visits per week by a PHN. Tracking ethnicity data for tamariki accessing this service is being investigated.

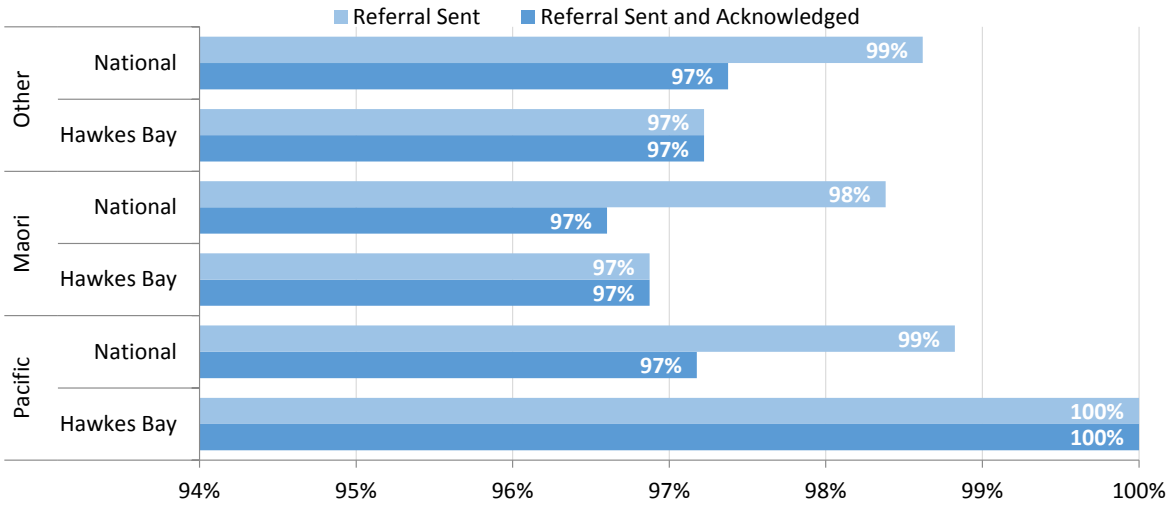
Current activity: An audit is underway for an in depth analysis of ASH rates for children admitted to hospital with preventable and/or recurrent skin infections and infestations. This will identify equity gaps for tamariki Māori.

Equitable immunisation rates

Childhood immunisation significantly reduces pneumonia and lower respiratory infections in children. Hawke's Bay continues to maintain equitable immunisation rates for tamariki Māori. However , one area of being monitored is the declining immunisation rates in infants aged under 8 months. 89.8% of infants were up to date with their immunisations at 8 months in the quarter ending 31 March 2019, down 3.5% from the previous quarter. Immunisation coverage is influenced by a complex mix of social, behavioural, demographic and structural factors. Immunisation data should be included in the proposed wider set of indicators for Child Health - TAW.

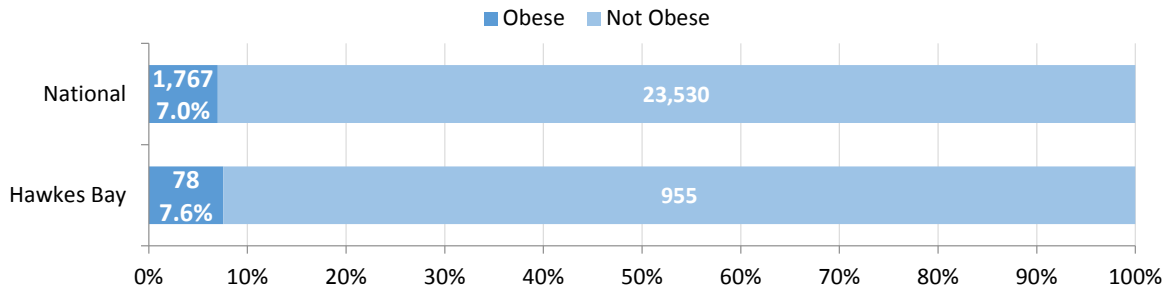
CHILD HEALTH PRIORITY: CHILD HEALTHY WEIGHT CHAMPION'S REVIEW

The national target for child healthy weight is - 95% of all children identified as obese are referred to a health professional for follow up support. The graph below shows that of the eligible tamariki Māori, 97% were referred for follow up support, and that referral was received. There is no equity gap for this target and the target has been consistently achieved for over a year.



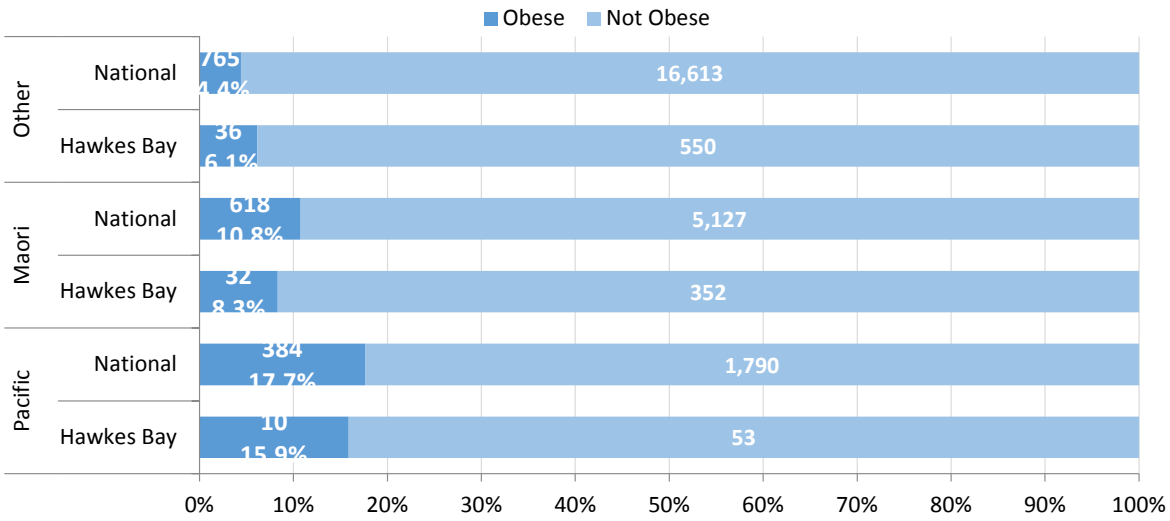
Graph 1: Child Healthy Weight Referrals sent.

Data collected at the Before School Check at age 4 years shows a continued decline in obesity rates in this age group at 7.6% for this quarter, and Hawke's Bay is moving closer toward the national average of 7%.



Graph 2: B4 school check percentage of tamariki Obese national versus HB comparison.

Graph 3 below shows tamariki Māori (8.3%) and Pasifika (15.9%) rates for obesity are lower than the national average (Māori 10.8% and Pasifika 17.7%). However, the small numbers for Hawke's Bay will require ongoing monitoring of this trend, but it is positive to see HBDHB moving toward a child health vision where ***every*** tamariki Māori gets a healthy start in the first four years of life.



Graph 3: B4 School check percentage of Obese tamariki in Hawke's Bay data by ethnicity.

12

CHAMPION'S REPORT OF ACTIVITY TO INCREASE PERFORMANCE OF THIS INDICATOR: ANALYSIS AND ADVICE: CHILD HEALTHY WEIGHT

Since 2016, HBDHB has continued to implement the HBDHB Best Start: healthy nutriton and activity Plan. The Plan delivers actions to support equitable healthy weight in four areas:

Increase healthy eating and activity environments: School programmes to support healthy environments in and around education settings. Early Childhood providers are using a healthy conversation tool to use with whānau to support healthy eating in early childhood. The tool was codesigned with Māori parents and Pacific parents. The next step is to work with Kohanga Reo to develop a reo/tikanga based tool.

Develop and deliver prevention programmes: supporting ante-natal programmes to support māmā to have a healthy pregnancy, including access to the Maternal GRx programme. Active Families programmes via Sport HB and Iron Māori are also funded for whānau. All programmes have achieved their Māori engagement targets. Active Families under 5 years has 82% Māori referral rates and for Maternal GRx 42% of hapū māmā referrals are Māori.

Intervention to support children to have healthy weight in the last 12 months an evaluation of Before School Check referrals has been completed to inform equity based improvements. A number of changes have been subsequently implemented including the referral pathway to ensure informed whānau decision making, and a new referral pathway for school aged children identified as needing supporting to achieve healthy weight. The evaluation targeted whānau Māori input and their feedback has been incorporated accordingly.

Provide leadership in healthy eating: a water only policy has been implemented in the Paediatric Ward. Besides the fact that fizzy drinks have no nutritional value, and are a major cause of tooth decay and a contributor to dental hospitalisations under GA, it was agreed it would not be appropriate to have fizzy drinks on the children's ward. Overall, whānau and staff have been receptive and supportive of the policy. HBDHB is considering extending the policy to other areas. HBDHB is supporting contracted providers to develop healthy weight policies.

CHILD HEALTH PRIORITY: BREASTFEEDING CHAMPIONS REVIEW

	Target	Total	Māori	Pacific	High dep	National
Jun-18	70%	52%	36%	35%	44%	59%
Dec-18	70%	57%	43%	58%	46%	58%

December 2018 data shows an increase in the breastfeeding rate at 3 months old across all ethnicities and high deprivation groups. However, there is a persistent equity gap still evident across all these groups, and still well below the national rate, and national target of 70%.

CHAMPION'S REPORT OF ACTIVITY TO INCREASE PERFORMANCE OF THIS INDICATOR ANALYSIS AND ADVICE: BREASTFEEDING

HBDHB is undertaking a program of work that reflects our commitment to achieving equitable breastfeeding outcomes for Māori and also alignment of Child Health indicators. To inform our decision making and to improve our response to māmā Māori and their whānau, interviews with fifty māmā Māori from a 2017/18 birth cohort were conducted in September 2018. Breastfeeding issues and a lack of breastfeeding support was one of the main challenges māmā identified after the birth of their baby. Māmā expressed feelings of confusion and isolation during this difficult time but also desperately wanting to do their best for pēpi.

Maternity Service, Population Health, Primary Care, and Māori Health are working closely to better design and deliver breastfeeding support for māmā Māori. A main piece of work ahead is the proposed establishment of a Child Health kaupapa; breastfeeding will be included under this umbrella of work. Activities to date are outlined below.

Māori Breastfeeding Support Service

Māori Health has invested in a whānau-centred breastfeeding support service for māmā Māori delivered by all three Well Child Tamariki Ora services. The service is delivered by lactation consultant and/or peer support outreach to whānau in the home and community settings. The service provides added support targeted specifically to whānau Māori to help establish and maintain breastfeeding through those first few months. The services have only been in place since October/November 2018 but are already reporting positive activities and feedback from whānau, including:

- Visits in the home are good with a māmā sharing, '*Thank you for your help today…it means a lot that you came over*'. Visits in the home also enables other whānau to be present and involved. Whānau are willing and eager to gain knowledge and how to support māmā and pēpi
- Māmā are using texting to communicate with the LC to share how their breastfeeding is going, which also allows the LC to adapt support for māmā as needed
- Māmā are expressing that the ongoing support phone calls are appreciated as they feel valued and supported during times of vulnerability and uncertainty.

Current activities: growing the service to reach māmā that need breastfeeding support, establishing and embedding referrals pathways, collaboration with the other WCTO breastfeeding support services. Actions are also underway to improve mental health support for māmā.

Hospital to Home – Breastfeeding support

An aligned investment from population health into the community midwifery team was to support transition from hospital to home with increased visits available for breastfeeding to determine if more time spent post natal with women in the home improved rates. Due to staff pressures in midwifery this position has not been realized.

Current activity: Previous investment recommendations for a Kaiawhina role to actively engage with māmā and provide a defined early post-natal resource dedicated to breastfeeding and an engagement point between LMCs, Maternity Services and the community based support services are being re-scoped.

Kaupapa Māori Health Programmes

Two Māori health providers are currently in the process of developing Kaupapa Māori Maternal Health Programmes. The programmes will have a specific emphasis on breastfeeding support for māmā Māori, and to work with whānau to identify any unmet needs. One of the providers is due to start the programme by 1 July 2019, the other will likely be in 2020.

Whanake te Kura is the HBDHB funded ante-natal education programme. Delivered by a local Māori health provider, the programme includes information to support establishing and maintaining breastfeeding, and where to go for breastfeeding support. The programme is receiving very positive feedback from whānau.

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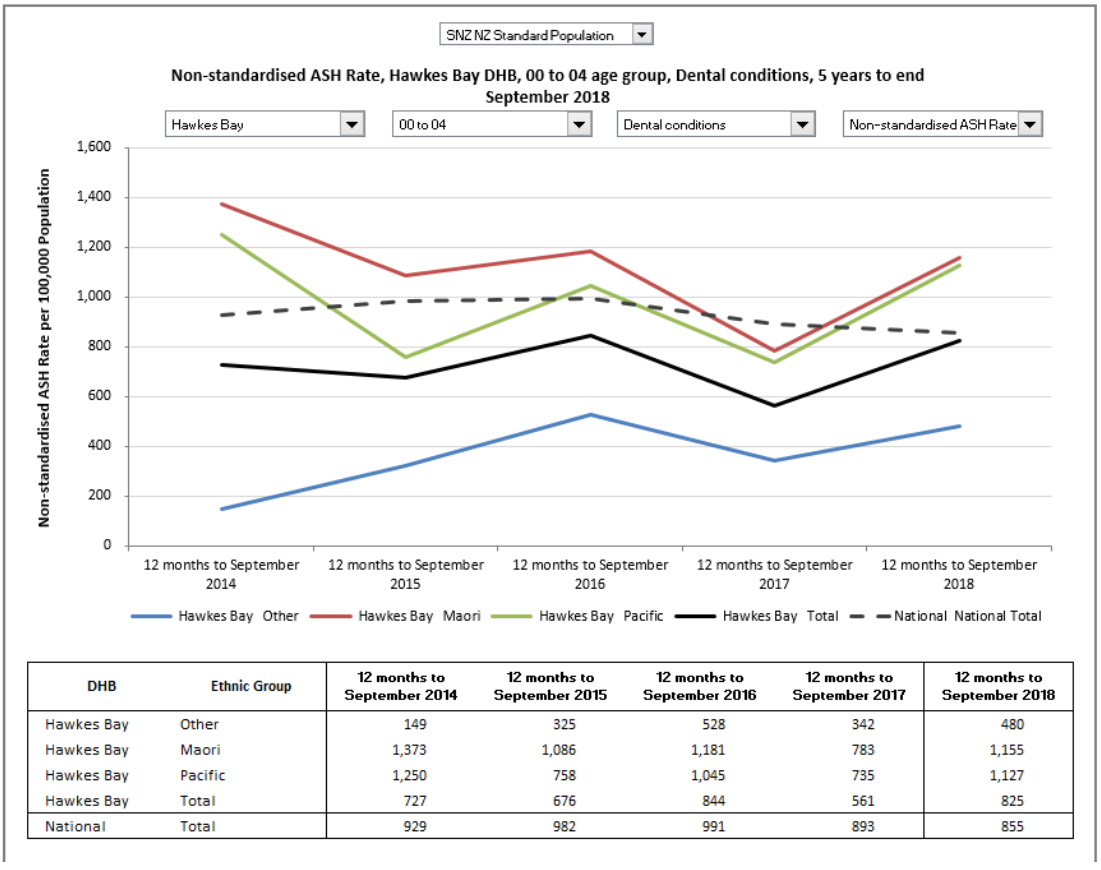
CHILD HEALTH PRIORITY: DENTAL CHAMPION'S REVIEW



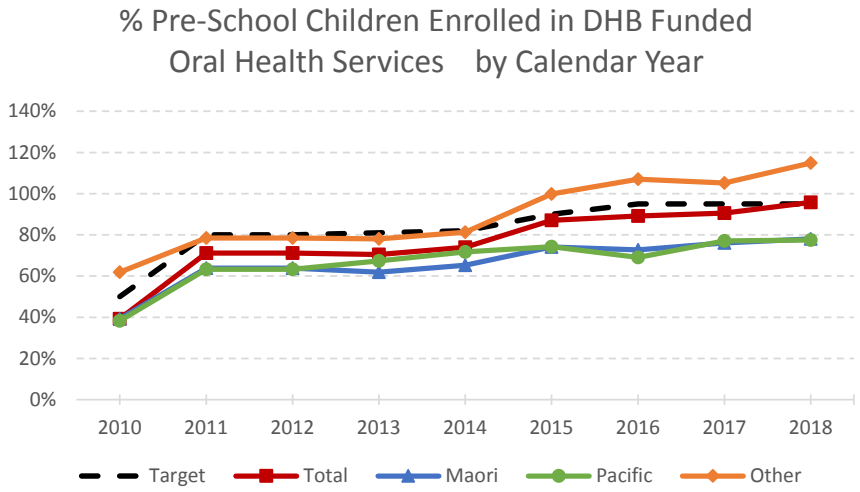
DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	149	325	528	342	480
Hawkes Bay	Maori	1,373	1,086	1,181	783	1,155
Hawkes Bay	Pacific	1,250	758	1,045	735	1,127
Hawkes Bay	Total	727	676	844	561	825
National	Total	929	982	991	893	855

Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	9	19	30	19	26
Hawkes Bay	Maori	67	53	58	39	58
Hawkes Bay	Pacific	8	5	7	5	8
Hawkes Bay	Total	84	77	95	63	92
National	Total	-	-	-	-	-

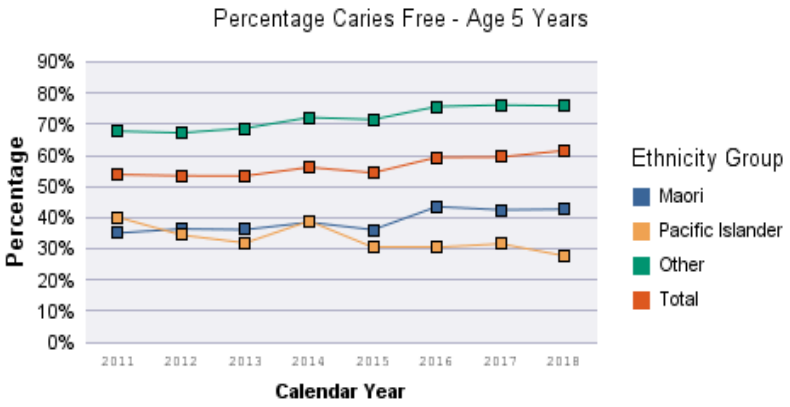
The ASH rate for Dental 0-4 year olds has increased in the 12 month period from September 2017 (561) to September 2018 (825), this was due to an increase of 29 events or an additional 29 tamariki admitted to hospital for dental under a general anaesthetic. Māori saw the largest increase in actual

events at 65% (19) and Pacific saw the largest increase in rate, this was due to events increasing from 5 (12 months to Sep 2017) to 8 (12 months to Sep 2018).



	Target	Total	Māori	Pacific	Other
2010	50%	39%	39%	38%	62%
2011	80%	71%	64%	63%	78%
2012	80%	71%	64%	63%	78%
2013	81%	70%	62%	67%	78%
2014	82%	74%	65%	72%	81%
2015	90%	87%	74%	74%	100%
2016	95%	89%	73%	69%	107%
2017	95%	91%	76%	77%	105%
2018	95%	96%	78%	77%	115%

It is pleasing to note the target of 95% enrolment has been meet, although with caution due to data challenge. The data challenges are evident from the recording of 115% of tamariki identified as Other. This is being actively addressed within both the Oral Health Service and Information Services. Previous work in 2017 checked that the Oral Health database is capturing the correct ethnicity as provided to Oral health. The concern remains accuracy of the denominator used to calculate the indicator which is externally provided from Ministry of Health data, or the accuracy of initial ethnicity capture at time of birth and used for quadruple enrolment of children at birth in HB health services.



% Caries Free	2011	2012	2013	2014	2015	2016	2017	2018
Māori	35.1%	36.4%	36.2%	38.5%	36.1%	43.5%	42.5%	42.7%
Pacific Islander	40.2%	34.4%	31.9%	38.9%	30.5%	30.5%	31.6%	27.8%
Other	67.3%	65.5%	66.9%	70.8%	70.1%	74.2%	75.1%	75.2%

Total:	**53.8%**	**53.5%**	**53.4%**	**56.2%**	**54.4%**	**59.4%**	**59.5%**	**61.6%**

The target of 67% caries free has not yet been achieved for Māori or Pacific children, and results for both groups remain particularly concerning. A small closure of the inequity of Māori to Other in the 2016 period has been maintained but not improved. The inequity for Pacific children may have increased in 2018, although very small numbers in this group do cause greater year to year data movements.

The percentage of children caries free (decay free) at 5 years measures the proportion of children that are 5 years of age, and commencing school education without dental decay severe enough to have caused cavitation (holes) to develop in the primary teeth. Caries free at 5 years is an important indicator as longitudinal studies indicate that children with good early childhood oral health have improved Year 8, adolescent and adult oral health. Children that are free of dental decay in the preschool and early primary school years are also less disrupted with education, eating and sleeping and have better general health.

CHAMPION'S REPORT OF ACTIVITY TO INCREASE PERFORMANCE OF THIS INDICATOR ANALYSIS AND ADVICE: ORAL HEALTH

There is a stronger focus on equity within the Oral Health Service with concerted effort to deliver an whānau responsive, interdisciplinary, community engaged approach to the design and continuous improvement of oral health delivery.

A preventive clinical practice and a service focus on equity also exists in the context of the complex interplay of societal factors that affect oral health. The importance of ongoing DHB influences on improving these for tamariki cannot be underestimated when considering the oral health outcomes at 5 years. Environmental influences are also important. The caries free outcomes have been achieved in an environment of loss of access to community water fluoridation in Hastings during 2017 and 2018, and therefore no community water fluoridation across the whole DHB in that time. Specific assessment of the Hastings results for caries free Māori 5-year-olds indicates that the proportion of children caries free plateaued during that time following several years of sustained small improvements. In Central Hawke's Bay it appears the losses in the proportion of caries free Māori 5-year-old children sustained in the 2013-2016 period have continued through 2017 and 2018.

Enrolment

There remains a potentially significant opportunity to progress enrolments for tamariki Māori, which do trend positively, but an apparent inequity between Māori and Other remains, contingent upon the data quality. Several workstreams within the Communities Women and Children Directorate's Oral Health Equity Under 5 years five project specifically target enrolment and we would expect to observe improvements, provided data quality can be assured.

Activity planned to support these indicators has been progressed since that outlined within the 2017 report. Many of the activities are now business as usual with an ongoing continuous improvement focus to ensure they are meeting expected outcomes. These include:

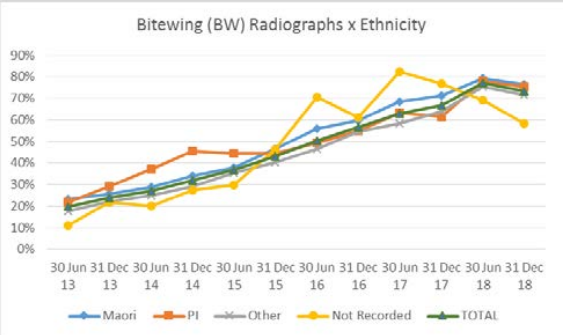
- Quadruple enrolment in the oral health service from birth, alongside enrolment for primary care, Well Child/Tamariki Oral and immunisation services.
- Population health strategies, including the delivery of oral health key messaging at other health touchpoints – including the Before School Check

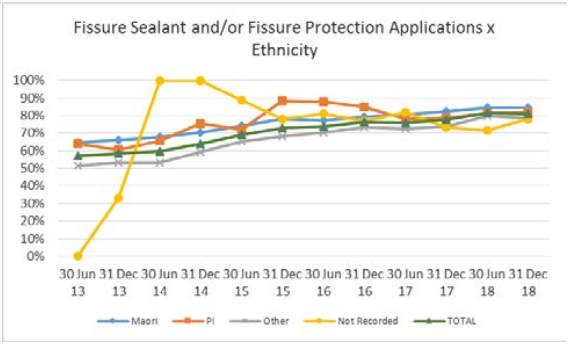
Oral health prevention

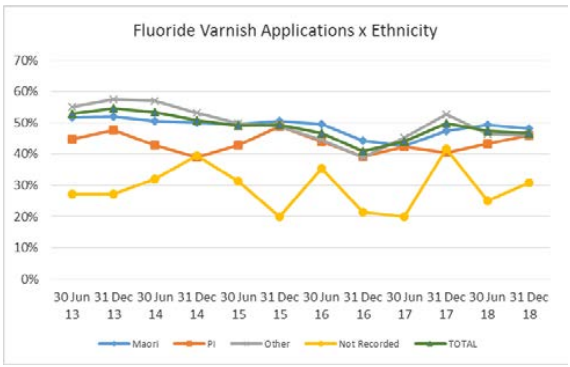
In 2018, the focus was on ensuring preventive practice continued to strengthen across the Community Oral Health Service. The use of preventive clinical care measures including fluoride varnish, fissure sealants, and radiographs are monitored on an individual therapist level, with positive trends noted across the service. The aim of this activity is to ensure individual clinicians focus their clinical activity

on preventive oral health care, and not just interventional treatments. It also aims to ensure clinicians consider equity at a clinical level in their day to day work.

This ongoing work commenced in 2015-16 with a focus on three key quality indicators led by the Clinical Director. Progress is reflected in these graphs. Pleasingly these demonstrate that the highest rates of preventive interventions are provided for Māori and Pacific tamariki and that particularly for use of fluoride varnish in 4 -year-old children the use for Māori and Pacific children has increased to levels consistent with appropriate consideration of clinical risk of dental caries and equity.







We are anticipating a further increase in the use of Fluoride Varnish now that the Kaiawhina is actively working under Standing Orders to provide Fluoride Varnish applications within community settings. Noting in the first six months of 2018 no fluoride applications were untaken by the Kaiawhina, with 90 in the latter half of 2018, and 80 within the first three months of 2019. The clinical impact of these applications is unlikely to be clearly seen within the 'Caries free' indicator for 2-3 years as it is measured at 5 years of age. The number of tamariki Māori seen within this programme is also increasing as more Kohanga Reo engage, which will also be evident within the enrolled children indicator in time.

The focus of the Kaiawhina has been adjusted to meet the needs of the Community. While remaining focused on improving service utilisation for tamariki Māori (pre-schoolers in particular), most of the work is now through engagement with Te Kohanga Reo, facilitating engagement with the local hubs / mobiles and delivering a preventative package – including fluoride varnish and brushing programmes. The oral health team are seeing the benefits of this work as the oral health of tamariki visiting the clinics has already visibly improved.

The kaiawhinia also accepts referrals from the Outreach Immunisation team, who refer 15 month to 4 year old children who are not engaged with the dental service – these may be children who are new to Hawke's Bay or have changed address, phone numbers etc so have not been able to engage with the dental service easily. In the 12 months ending March 2019, 44 children were referred .

Equity under 5 years project

The Under 5 years equity project is the key driver of activities to address the persistent inequities within Community Oral Health Services, although this is supported by additional changes within the service. Key achievements include:

- Ensuring workforce cultural responsiveness – 78.4% have now completed Engaging Effectively with Māori, and 92% Treaty of Waitangi training
- Changes within staffing allocation – to improve ratios of Therapist / tamariki in areas of high need; to provide cover across more work days for example two part-time Therapists now have a Hub open five days / week.
- Community Oral Health Service Model of Care review and decisions
- Te Roopu Mātua – Māori Oral Health Advisory Group
- Water-Only Policy in the Paediatric Services

Planned activities

Over the next 12 months a number of activities are planned to ensure we are consistent and persistent in our commitment to improve equitable oral health outcomes for Māori. There is a willingness and recognition across the workforce that 'doing the same thing will produce the same results'. Planned activities include:

- Initial presentation of an Oral Health Business case focused on increasing capacity of the workforce needs to be progressed with additional information
- Continue quality control of the ethnicity coding and patient status accuracy within the oral health patient management system (Titanium)
- Extend capacity of those providing fluoride varnish, exploring opportunities to train others in the application of fluoride varnish. Noting the standing order has provision for dental assistants to undertake this.
- Health HB to trial the 'teething brief' at 5 month immunisation with 2 high needs practices (2019 - 2021)
- Agree recommendations from preschool child GA audit and develop action plan
- Continue to transition clinical service delivery towards a preventive care focus using clinical quality indicators to monitor service performance

RECOMMENDATION:

It is recommended that the HB Clinical Council:

1. **Note** the contents of the report.
2. **Note** the planned improvements and activities over the next 12 months to achieve equitable health outcomes for tamariki.
3. **Support** the intention to establish a Child Health kaupapa to bring a more cohesive and collaborative approach to organising child health activities across the organisation.

HAWKE'S BAY District Health Board Whakawāteatia	**PRIMARY CARE AFTER HOURS SERVICE REVIEW**
	For the attention of: **HB Health Clinical Council**
Document Owner	Chris Ash, Executive Director of Primary Care Wayne Woolrich, CEO, Health Hawke's Bay
Document Author(s)	Peter Satterthwaite, GM Health Services & Innovation, Health Hawke's Bay Jill Garrett, Senior Commissioning Manager
Reviewed by	Executive Management Team
Month/Year	April 2019
Purpose	Information only
Previous Consideration Discussions	Te Pītau Health Alliance Support Group (17/04/19); Te Pītau Health Alliance Governance Group (scheduled for 08/05/19)
Summary	Review of current After Hours primary care model
Contribution to Goals and Strategic Implications	Strengthening Primary Health Care / Community based care delivery
Impact on Reducing Inequities/Disparities	Achieving equitable access for priority populations
Consumer Engagement	Consumer consultation (existing and new) will form part of the data resource to inform decision making
Other Consultation /Involvement	Primary care sector engagement
Financial/Budget Impact	N/A at this stage
Timing Issues	N/A at this stage
Announcements/ Communications	N/A at this stage

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RECOMMENDATION

That the HB Health Clinical Council:

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

OVERVIEW

A process has commenced to strategically review the current Primary Care After Hours service model alongside a review of the City Medical service contract. Key stakeholders have been engaged and a strategic approach to the review has been presented and endorsed at the After Hours Steering Group.

BACKGROUND

- A new Primary Care After Hours service model was implemented in December 2017 after a long process of review. A review drafted by Dr David Rodgers in August 2018 identified deficiencies and concerns with the model. For example, some parts of the service model are expensive and have low utilisation.
- Since the commencement of this model, City Medical has not been delivering the overnight GP availability aspect of their contract. In lieu of this, 12 months' notice on their current contract was issued in December 2018. Negotiations are well underway reviewing and negotiating a replacement contract. There are opportunities for City Medical to provide an expanded range of services which are being explored in separate discussions.
- The DHB continues to fund and support the overnight nursing service operated from City Medical and staffed by DHB employees.
- The current service model also has direct funding by the PHO sourced through a levy on capitation of practices.
- The overnight provision of services is the service being reviewed.

KEY ISSUES

- Overall the Napier based overnight service is considered to be relatively efficient and cost effective.
- There is no overnight service in Hastings apart from the HB Hospital Emergency Department (ED). Use of the ED is high with a low percentage of patients admitted. Indications are that there is a high Primary Care component to ED presentation. ED attendance by residents of suburbs surrounding HB Hospital is very high.
- A comprehensive 2018 ED attendance dataset has been obtained. Analysis of attendance patterns by domicile and decile by hour of day is underway to inform a future service model.
- A strategic framework for developing a new service model has been proposed and is currently being socialised.
- The current After Hours Governance Group have endorsed the intentions of the framework. Active discussions continue with City Medical and the wider Napier network as required.
- A Hastings Practice Working Group is being established to develop an evening and overnight service model.

HAWKES BAY PHO WORKFORCE ANALYSIS
Sept 2018-March 2019
The Snapshot

RNZCGP Survey 2018

The most recent RNZCGP GP Survey has been published. Of note:

- Over the next five years, 27 percent of GPs intend to retire. Over the next 10 years, 47 percent intend to retire.
- Increasing numbers of GPs say they work in practices that have a GP vacancy (31 percent in urban areas and 39 percent of rural practices).
- GP burn-out rates are increasing (26 percent, compared to 22 percent in 2016).
- The average GP income hasn't changed too much in recent years, but male GPs working full-time are more than twice as likely to earn $200,000 than females

The full report can be found at: https://oldgp16.rnzcgp.org.nz/assets/New-website/Publications/GP-Workforce/WorkforceSurvey2018Report1-APPROVED.pdf

Rationale

- No workforce data for general practices existed (HB PHO)
- Regular monthly reports received only reflected GPs and nurses; allied health and other roles were not captured.
- Hours of work, ethnic group, and age were not recorded.
- There had been no opportunity for practices to identify roles they might consider in the future
- Workforce Planning needed a start position.

Results

- 24/26 practices provided their workforce data to HHB.
- One declined to provide the information,
- One provided totals based on role only.
- Participation was voluntary and took 6 months to get the information required.

HAWKES BAY PHO WORKFORCE ANALYSIS

	Workforce in role	1 practice, no detail provided	Total Workforce per role
Medical	161.5	50	211.5
Nursing	184	46	230
Administration	148	21	150
Care & Support	13	4	17
Allied Health	18	9	27
Business	12	8	20

Enrolled population of HB 161, 074

WORKFORCE ANALYSIS - MEDICAL

	Workforce in role	FTE equivalent	Average FTE hrs pp	> 60 years	Maori	Pacifica
Medical	161.5	94.46	.58	13%	0.6%	0.6%

WORKFORCE ANALYSIS - NURSING

	Workforce in role	FTE equivalent	Average FTE hrs pp	> 60 years	Maori	Pacifica
Nursing	184	104.7	.56	13%	8%	2.1%

WORKFORCE ANALYSIS - ADMINISTRATION

	Workforce in role	FTE equivalent	Average FTE hrs pp	> 60 years	Maori	Pacifica
Administration	148	81.5	.54	17%	14%	4%

WORKFORCE ANALYSIS – CARE & SUPPORT ROLES

	Workforce in role	FTE equivalent	Average FTE hrs pp	> 60 years	Maori	Pacifica
Care & Support	13	4.6	.35	0	30%	15%

WORKFORCE ANALYSIS – ALLIED HEALTH

	Workforce in role	FTE equivalent	Average FTE hrs pp	> 60 years	Maori	Pacifica
Allied Health	18	10.8	.6	16%	16%	0

WORKFORCE ANALYSIS – BUSINESS

	Workforce in role	FTE equivalent	Average FTE hrs pp	> 60 years	Maori	Pacifica
Business	12	5.6	.46	8%	0	0

HAWKES BAY PHO WORKFORCE ANALYSIS

	Workforce in role	FTE equivalent	Average FTE hrs pp	> 60 years	Maori	Pacifica	1 practice no detail.
Medical	161.5	94.46	.58	13%	0.6%	0.6%	50
Nursing	184	104.7	.56	13%	8%	2.1%	46
Administration	148	81.5	.54	17%	14%	4%	21
Care & Support	13	4.6	.35	0	30%	15%	4
Allied Health	18	10.8	.6	16%	16%	0	9
Business	12	5.6	.46	8%	0	0	8

Deductions & Assumptions

- The current primary care workforce are increasingly a part time workforce. (Work-life balance, personal choice, job on offer at the time).
- Maori and Pacifica persons are not well represented across the general practice workforce
- Maori and Pacifica are represented in administration, allied health (SW, counsellor roles), and health support with a low clinician percentage.
- Our workforce is ageing with no sustaining pipelines for the future
- Businesses acknowledge workforce concerns but have limited resources to address them.
- Developing the workforce pipeline - grow, recruit, develop, train, and sustain requires ongoing review and development to meet changing health environment.

Next Steps?

- Workforce gap analysis –from now to the next 5 years
- Model of Care – change support, workforce opportunities - *grow, recruit, sustain*
- Extended Care teams – stakeholder meetings, driving change
- Incubator – health career map *grow and recruit*
- Maori/Pacifica workforce action plan alignment– *grow, recruit and sustain*
- Nursing development, pathways, education – *recruit, develop and sustain*
- GP, recruitment MOU DHB – *recruit and sustain*
- Administration – *grow, train and sustain (Exploring EIT coursing and online or cost effective training for this workforce)*
- Care support *grow, train, and sustain, Careerforce NZ, EIT, Wananga o Aotearoa*
- Business education, business mentors *develop and sustain*
- Allied Health, *interprofessional training opportunities*

PHLG: NURSE NAVIGATORS

Verbal update

15

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

17. **Minutes of Previous Meeting (Public Excluded)**
18. **Matters Arising – Review of Actions (Public Excluded)**
19. **Board Report – April (Public Excluded)**
20. **Topics of Interest / Member Issues**

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

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