Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 9 March 2016**

Meeting: **3.00pm to 5.30pm**

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

Council Members:

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

Apologies:

In Attendance:

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

HB Clinical Council
Agenda

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	**3.00**
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
	Section 2 – Review	
6.	Davanti IS Review - *Presentation* – Tim Evans	**3.15**
	Section 3 – For Information and Comment	
7.	MoH Mobility Plan - *Presentation* – Dr Andy Phillips	**3.30**
8.	Draft Complementary Therapies Policy – Dr Andy Phillips	**3.45**
9.	Draft Annual Plan Statement of Intent via website – Tim Evans / Carina Burgess	
10.	Annual Māori Health Plan Q2 Dashboard – Tracee Te Huia / Patrick LeGeyt	**4.00**
11.	Te Ara Whakawaiora / Breastfeeding – Caroline / Nicky Skerman / Katie Kennedy	**4.15**
	Section 3 – Reporting Committees	
12.	Urgent Care Alliance Update (monthly) – Mark Peterson and Graeme Norton	**4.25**
13.	Laboratory Services Committee – *verbal* – Dr Kiri Bird	**4.40**
14.	Falls Committee Report (6 monthly) - Chris McKenna	**4.45**
15.	Maternity Clinical Governance Group Update (6 monthly) – Chris McKenna	**4.50**
	Section 6 – General Business	
16.	Topics of Interest - Member Issues / Updates	**5.00**
17.	**Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 7 – Routine	
18.	Minutes of Previous Meeting (public excluded)	
19.	Matters Arising – Review Actions	

NEXT MEETING Wednesday 13 April 2016, commencing at 3.00pm
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Interests Register

Feb-16

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

HB Clinical Council 9 March 2016 - Interest Register

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Dr Tae Richardson (GP and Chair of Clinical Quality 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 Implementation	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low
	Directions Youth Health	Wife Beth involved	Assisting youth in HB	No	
	City Medical	Director and Shareholder	Medical Centre	Yes	Low
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) - more recently HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	No	
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
Debs Higgins	The Hastings Heatlh Centre	Practice Nurse Family Violence Intervention Coordinator	Delivery of primary health care - General Practice and training of Clinicians in family violence intervention.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	LIVE (Local Initiative for Violence Elimination)	Member of management Committee	Network of agencies that provide family violence intervention services.	No	
Anne McLeod	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)					

**MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL MEETING
HELD IN THE HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE
ON WEDNESDAY, 10 FEBRUARY 2016 AT 3.00 PM**

PUBLIC

Present:	Dr Mark Peterson (Co-Chair) Chris McKenna (Co-Chair) Dr John Gommans Dr Tae Richardson (from 4.10 pm) Dr Andy Phillips Dr David Rodgers Debs Higgins Dr Malcolm Arnold Dr Kiri Bird Dr Robin Whyman David Warrington Robyn O'Dwyer Billy Allan Anne McLeod
Apologies	Dr John Gommans, Dr Caroline McElnay and Jules Arthur
In Attendance:	Dr Kevin Snee (CEO) Graeme Norton (Chair HB Health Consumer Council) Kate Coley (Director Quality Improvement and Patient Safety) Tracy Fricker (PA to Director QIPS / Clinical Council Secretary)

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Mark Peterson welcomed everyone to the first meeting of 2016, with a special welcome to the two new members of the Council Dr Robin Whyman and Anne McLeod. Round table introductions followed.

Apologies for Dr John Gommans, Dr Caroline McElnay and Jules Arthur were noted. Dr Tae Richardson will be late attending the meeting today.

2. INTERESTS REGISTER

No interests identified for items on the agenda today.

Malcolm Arnold advised that he has a new interest to include on the register, he is the Chairman of the New Zealand Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy.

Interests template to be sent to new Clinical Council members Dr Robin Whyman and Anne McLeod for completion.

Action: ***Add new interest to the register for Malcom Arnold. Template to be sent to new members.***

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 9 December 2015, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Update on Clinical Council – vacant positions
Dr Robin Whyman has now commenced on the Clinical Council. Dr Kiri Bird has been confirmed as the Chair of the HB Laboratory Committee.

Item can now be closed.

Item 2: Alternative Health Provider
Deferred until March.

Item 3: Responsibility for Results of Investigation
Interest for Dr David Rogers has now been registered.

Item can now be closed.

5. CLINICAL COUNCIL WORK PLAN

The updated draft work plan for 2016 will be provided at the March meeting.

Action: Provide updated work plan at March meeting.

6. CONSUMER STORY

Kate Coley advised that the story today is made up of extracts from a number of complaints received regarding communication from our booking and reception staff, with many common themes regarding their front of house service and telephone manner. 24% of our complaints are about the way we communicate.

A customer focused training programme has been developed by an external agency Business Training New Zealand, who focus on training for health care providers. They have run two half day sessions for us and have also provided training in Canterbury. The feedback from training attendees has been positive. This training needs to occur on a more regular basis and any issues identified need to be managed appropriately.

As part of the customer focused booking they are also looking at how appointments/clinics are scheduled.

Primary Care has also indicated they would be interested in having their staff attend this training. The training works out at approximately $50 per person, which is good value.

Kate advised we will look at a strategy with Learning & Development over the next couple of months around ongoing training and will open it up to primary care to be able to attend.

Action: Provide update on customer service training at a future meeting.

SECTION 2: CONSULTATION

7. HEALTH LITERACY STRATEGIC REVIEW

Mark Peterson welcomed Kate and Jen from Quigley and Watts to the meeting. Ken gave an overview of the purpose of the review. They are meeting with EMT, MRB Clinical and Consumer Councils, staff groups and having one on one conversations to get feedback.

There are four key questions posed in the document provided in the meeting papers:

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

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

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

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

General discussion held and Clinical Council members provided their feedback. Overall feeling is that we need to do better for our consumers. Less jargon, using easy to understand terminology (verbal and written) and spending time to ensure that consumers understand the information they receive. We also need to look at the ways that technology can assist with sharing this information.

Further feedback can be provided directly to kate@quigleyandwatts.co.nz.

8. CLINICAL GOVERNANCE STRUCTURES / COMMITTEES REVIEW (DRAFT)

Report taken as read.

Kate Coley advised that this was a discussion/consultation document for feedback on ideas for alternatives. What we are trying to put in place is a governance structure which is cross-sector, is consistently utilised for reviewing issues/reviewing events, looking at providing assurance to the governance groups, Clinical Council and Boards that we are managing patient safety effectively and looking at quality improvements. It is not necessarily focused on just compliance but more on quality improvement.

General discussion took place. Feeling is that we can do better and that we have moved on since the document was originally written. A challenge is to look at opportunity to bring the sector closer by developing integrated clinical committees. Need to look at consumer representation on all committees. Instead of tweaking what we currently have, we need to be more ambitious.

Feedback will be incorporated into the paper which will be brought back to the Clinical Council for endorsement in April/May.

Further feedback can be provided directly to kate.coley@hbdhb.govt.nz.

9. HEALTH AND SOCIAL CARE NETWORKS

Report taken as read.

Mark Peterson welcomed Liz Stockley to the meeting.

Liz advised we have been talking about health and social care networks for a few months now. We had the instruction from the health sector leadership forum to go ahead and make progress. The steering committee spent a lot of time determining what should be the next steps in moving towards a health and social care network or a programme of networks. This is the first paper. It sets out how we intend to make the first steps towards a health and social care network, it's a very ambitious programme and one of significant change, talking about transforming how we engage with communities, making sure the services across health and social care providers are better designed for our communities. The paper sets out what the long-term ambition is.

The steering group need feedback on this paper particularly on the next steps and on the long-term strategic direction.

Input from MRB meeting this morning requested more principles around Maori concepts to underpin the networks.

Strategic/governance level discussions will be had with other organisations including MSD, WINZ, CYS and other social networks.

General discussion and feedback provided by Clinical Council members.

Recommendation made to endorse the paper and the direction of travel.

10. REFINE CLINICAL COUNCIL MEMBER PORTFOLIOS

Ken Foote advised that the intent with allocation of portfolios is to identify a Clinical Council member aligned to a particular topic, service or health target who could take a champion role within council for that particular activity. It also means that if somebody within the service or primary care needs clinical advice from clinical council they can approach that member in the first instance rather than bringing to the whole council. They can also lead discussion on that topic at Clinical Council meetings. It's not about creating an onerous task.

Ken advised that this document was created by previous councils and was intended to add value. If value is not being added, we can change it. It is up to the Clinical Council now to decide if they want to continue with this allocation of portfolios.

Kevin Snee commented that it is about being clear about what the priorities are for the Clinical Council over the coming year and making sure that members are identified against these priorities – the key is identifying those priorities so that real value can be added. It was also clear that there was a lack of understanding by the members and by services as to the role that Clinical Council members would play in supporting the delivery of those priorities.

Ken advised we will do some more work on the plan, look at the topics/issues from Transform and Sustain and also if Clinical Council members can email Ken and Brenda areas of interest they wish to add. It will then be discussed at the next meeting.

Action: Clinical Council members to email areas of interest to be added to the plan.

SECTION 3: UPDATES

11. URGENT CARE ALLIANCE

Graeme Norton gave a verbal update of progress to date. The proposal that the Clinical Council saw in December has now gone out for consultation as well as a registration of interest process for providers. Two workshops for providers are being held on 15 and 29 February. The expressions of interest consultation process will finish during March, then the next phase of the project will occur.

Mark Peterson commented that if you are asked by your colleagues, particularly those in primary care then some key messages were that urgent care is not just about after hours, it is also about what happens in work hours as well. For practices that are providing urgent care, walk in clinics etc, Mark encouraged them to put in an expression of interest as it may contribute to the discussion. .

David Warrington commented that the consultation document was not that clear on what it was asking. Worked out that it was asking "tell us what urgent care should look like". Graeme advised that the document was deliberately like that. Giving the sector the opportunity to design its future, if they don't take that opportunity a design will come. We are trying to be as democratic as possible and not spoon feed people into a particular model.

The closing date for expressions of interest is 7 March.

12. RESPIRATORY PILOT PRESENTATION

Mark Peterson welcomed Trish Freer, Sue Ward and Dr James Curtis to the meeting to present on the Respiratory Service re-design.

Results achieved:

- ALOS down from 4.84 to 3.68 bed days
- Referrals to secondary care for diagnostics down from over 600 to under 100
- All patients have follow up after gaining an accurate diagnosis
- Most patients are offered back pocket scripts for management of acute ~~epsiosdes~~episodes
- Quality of life improvements have been noted with the link to Pulmonary ~~Rehabiliation~~Rehabilitation programmes/Asthma HB
- Positive feedback from patients and HCPs
- Engagement from ALL
- ACP / smokefree

Where to from here:

- Sustainable funding, through the budget bid process in April.
- Continue to gain accurate diagnosis in primary care – proactive rather than reactive
- Diversifying and providing education to current workforce - support further change
- Working with the bigger picture – other chronic disease management
- Recognise interdependencies e.g. Pulmonary Rehabilitation, Breathe HB
- Work towards early supported discharge and admission avoidance
- Tweak IT forms to gain consent to share data from primary to secondary care
- Ensure ALL HCPs in primary and secondary care are working from the clinical care pathway to encourage consistent messages

We need to continue the focus on proactive management and education rather than knee jerk reactions; eventually it would be great to be able to support early facilitated discharge and even admission avoidance, but we really need primary and secondary care to be ready to support these patients in the appropriate space.

Congratulations extended to the team for their work.

SECTION 4: MONITORING

13. Te Ara Whakawaiora / ~~Access~~ASH Rates

Report taken as read. No issues discussed.

Debs Higgins commented that other factors have an impact on those admissions including domestic and family violence, child abuse and neglect which is not included in there and it is something that we need to address.

SECTION 5: GENERAL BUSINESS

Resolution by Chair that Topics of interest Member/Board Issues be moved to the public excluded section of the meeting.

Approved.

The meeting closed at 5.20 pm.

Confirmed: _____
Chair

Date: _____

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

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	09/09/15	**Alternative Health Provider** Item raised by David Rodgers will be investigated by Andy Phillips and a Draft Policy for the DHB regarding alternative providers will be produced.	A Phillips	Mar	Included on work plan for March 2016
2	10/02/16	**Changes to Interest Register** Malcolm Arnold – new interest to be added. Robin Whyman and Anne McLeod to be sent template for interest register.	B Crene	Mar	Actioned Anne McLeod's Interests actioned. Robin's TBC
3	10/02/16	**Customer Service Training** Update on future training sessions for HBDHB and PHO staff.	K Coley		
4	10/02/16	**Clinical Council Member Portfolios** Members to email Ken/Brenda with areas of interest to be added to the plan.	All		

HAWKE'S BAY CLINICAL COUNCIL
WORK PLAN 2016

Meeting Dates 2016	Papers and Topics	Lead(s)
13 Apr	Clinical Governance Structures - Decision	Kate Coley
	Obesity Strategic Plan (draft)	Caroline McElnay
	Suicide Prevention Plan (draft)	Caroline McElnay
	Refresh Transform and Sustain (Draft)	Tim Evans
	Overview of Investment/Disinvestment Prioritisation (prior to May mtg)	Tim Evans / Peter Kennedy
	National Patient Flow (Patient Focused Bookings	Tim Evans
	ICU Review around Quality – late paper	Kate Coley
	Quality Improvement Programme (saving 4,500 bed days)	Kate Coley
	Orthopaedic Review – closure of phase 1.	Andy Phillips
	AIM 24/7 Quarterly Update	John Gommans
	REPORTING COMMITTEES – written/verbal reports:	
	Urgent Care Alliance Quarterly Update	Mark Peterson
	Radiology Services Committee (not reviewed March)	Mark Peterson
	Clinical Advisory Governance Group	Tae Richardson
	MONITORING	
	Te Ara Whakawaiora / Cardiovascular	John Gommans
	Annual Maori Health Plan Q2	Tracee TeHuia / Patrick
20 Apr	**HB Health Sector Leadership Meeting** – venue and time TBA	
11 May QTLY	***Consumer Council keen to combined for part of this Quarterly Meeting***	
	Food Services Internal Review (draft)	Sharon Mason
	Travel Plan (quarterly update)	Sharon Mason
	Obesity Strategic Plan (final for endorsement)	Caroline McElnay
	Suicide Prevention Plan (final for endorsement)	Caroline McElnay
	Youth Strategy (draft)	Caroline McElnay
	Health Equity Update	Caroline McElnay
	Refresh Transform and Sustain (Final)	Tim Evans
	Integrated Shared Patient Care Record	Tim Evans
	HB Integrated Palliative Care (Draft)	Tim Evans / Mary Wills
	New Patient Safety and Experience Report – prior to new reporting dashboard	Kate Coley
	Clinical Governance Structures / Committee review (following feedback feb)	Kate Coley
	REPORTING COMMITTEES – written/verbal reports:	
	HB Research Committee	John Gommans
	Clinical Advisory Governance Group	Tae Richardson
	Urgent Care monthly report	Mark Peterson
	MONITORING	
	Urgent Integrated Care Monthly Update	Mark Peterson
	WORKSHOP **Prioritisation Process Investment/Disinvestment**	Tim Evans & Finance

8 June	Youth Strategy (Final for endorsement) Health Equity Update Food Services Internal Review FINAL Person and Whanau Centred Culture (draft) **REPORTING COMMITTEES – written/verbal reports:** New Infection Prevention Control Committee (Quarterly rpt) Clinical Advisory Governance Group Laboratory Services Committee Report Radiology Services Committee Report Urgent Care Alliance Quarterly Report **MONITORING** Te Ara Whakawaiora / Oral Health New Patient Safety and Experience Dashboard commences HB Nursing Midwifery Leadership Council Update Annual Maori Health Plan Q3	Caroline McElnay Caroline McElnay Sharon Mason Kate Coley Chris McKenna Tae Richardson Kiri Bird Mark Peterson Mark Peterson Sharon Mason/Patrick Kate Coley Chris McKenna Tracee TeHuia / Patrick

HAWKE'S BAY District Health Board Whakawāteatia	**Information Service Function review**
	For the attention of: **HB Clinical Council, HB Health Consumer Council, Maori Relationship Board (MRB)**
Document Owner: Document Author(s):	Tim Evans Tim Evans
Reviewed by:	Executive Management Team
Month:	March, 2016
Consideration:	For Information and discussion.

RECOMMENDATION

Clinical Council, Consumer Council and MRB

- Note the contents of the attached report.
- Agree the proposed management action in response set out below.

OVERVIEW

The attached report from Davanti Consulting sets out an assessment of the maturity of our Information Services function and recommends a structured approach to improvement.

BACKGROUND

We appointed Davanti Consulting in October 2015 to review the District Health Board's Information Systems function (that is our I.S. department, not our hardware and software).

We asked Davanti to assess and document:

- The challenges and tasks facing the department now, and those likely to arise
- The capability of the department in terms of skills, experience, and expertise
- The capacity of the department in terms of manpower, functions, and scale
- The resilience of the department in terms of business process and practice
- Any gaps (and consequent business risks) between challenge and capability/ capacity/ resilience

We asked them to express a clear opinion as to the fit between challenge and resources and make recommendations on short, medium, and long term actions required to mitigate immediate risks and to maintain or build "fit for purpose" Information Systems function going forward.

The attached report is Davanti's response to this brief.

THE DAVANTI REPORT

The report identifies **3 challenges** facing the I.S. Department:

- Lack of documentation, appropriate team structure, and formal process;
- Focus on managing current state not building the future;
- Lack of formal governance and engagement with stakeholders

The report proposes **5 changes** to the I.S operating model:

- Set up formal governance structures to include IS and business stakeholders to keep IS accountable to their users;
- Create an "Enterprise Architect" function to plan the future and make sure we are moving toward it;
- Separate innovative "build" and routine "operate" functions to improve focus and delivery of both;
- Formalise project delivery capability to standardise and ensure appropriate use of project management methods;
- Reorganise IS resources along the technology layer domains of application and infrastructure, to reduce risk of undocumented knowledge and increase flexibility.

The report sets out in detail 11 project plans to achieve the required change over a 26 month timeline, and recommends the creation of at least three new roles.

PROPOSED MANAGEMENT ACTION IN RESPONSE

The report is a reasoned and balanced assessment of the current state of maturity of our I.S function.

The three challenges and 5 changes set out need to be addressed and implemented respectively.

A steering group for change will be set up immediately to include the GM Planning and Funding (as senior Responsible Owner), Chief Operating Officer (as representative business partner), Head of I.S, and Head of Business Intelligence.

The project approach to implementation needs to be localised to follow DHB documentation and project process.

The restructuring to split the proposed needs to be enacted with two caveats:

- We need to follow our open transparent and consultative approach in designing the necessary organisational restructure.
- We need to balance additional cost with anticipated benefit, this will involve minimising the additionality required (in cost and FTE) to achieve the key outcomes proposed in the report.

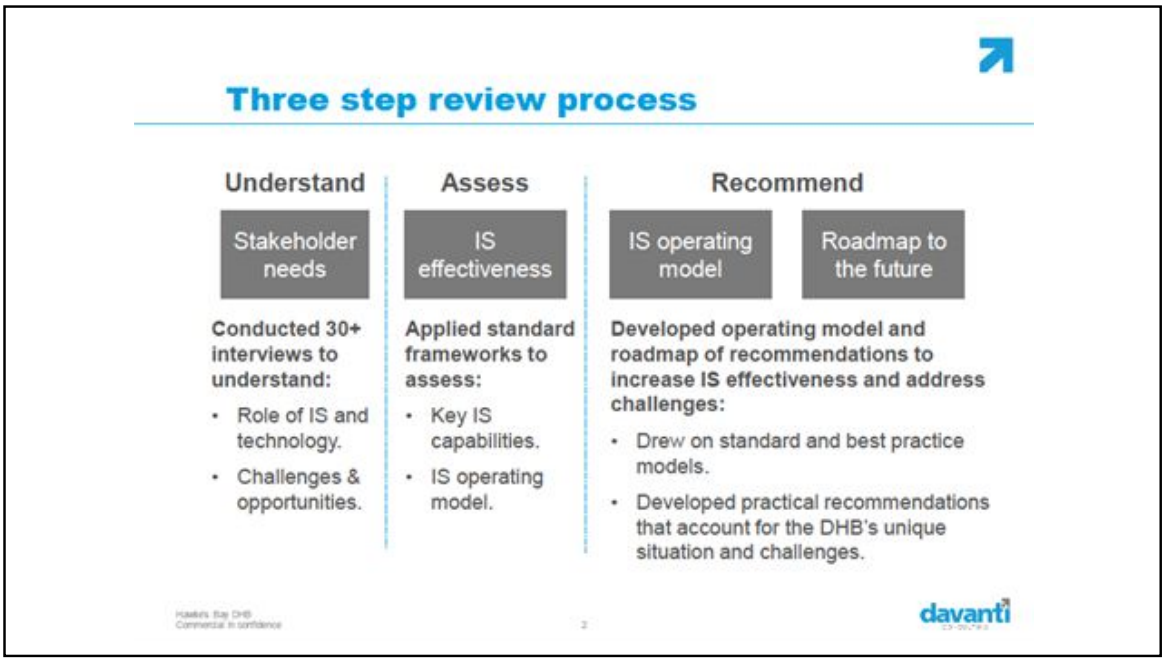
The Board need to be keep abreast of progress, and will need to approve any significant additional spend proposed as a result of the report's implementation.

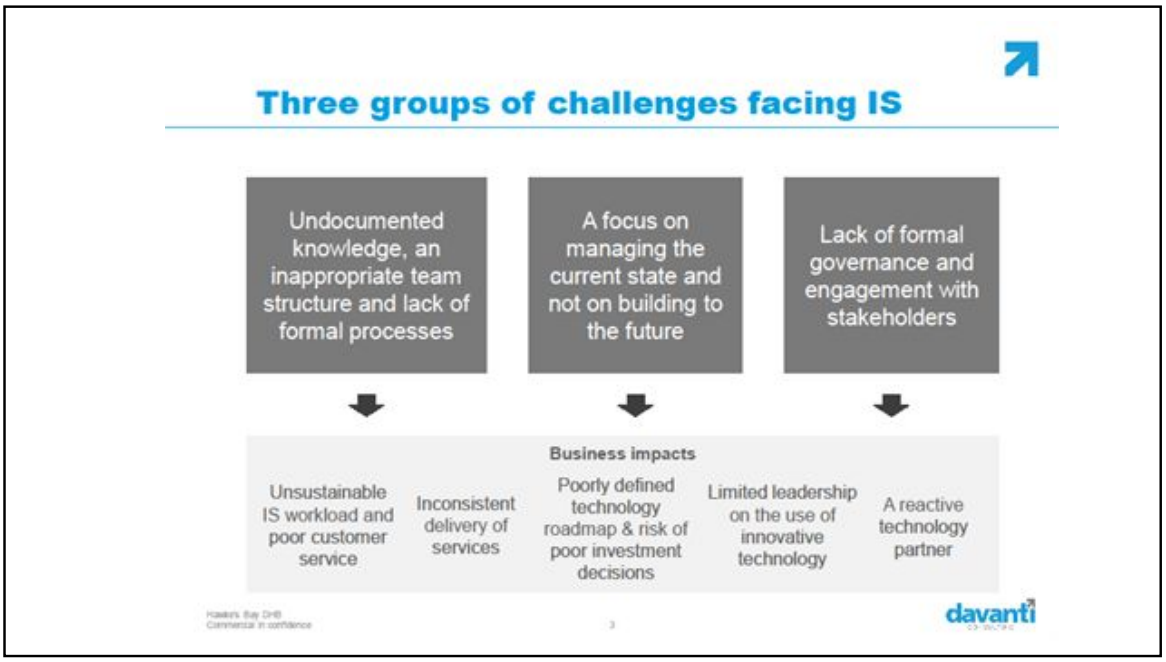
ATTACHMENTS

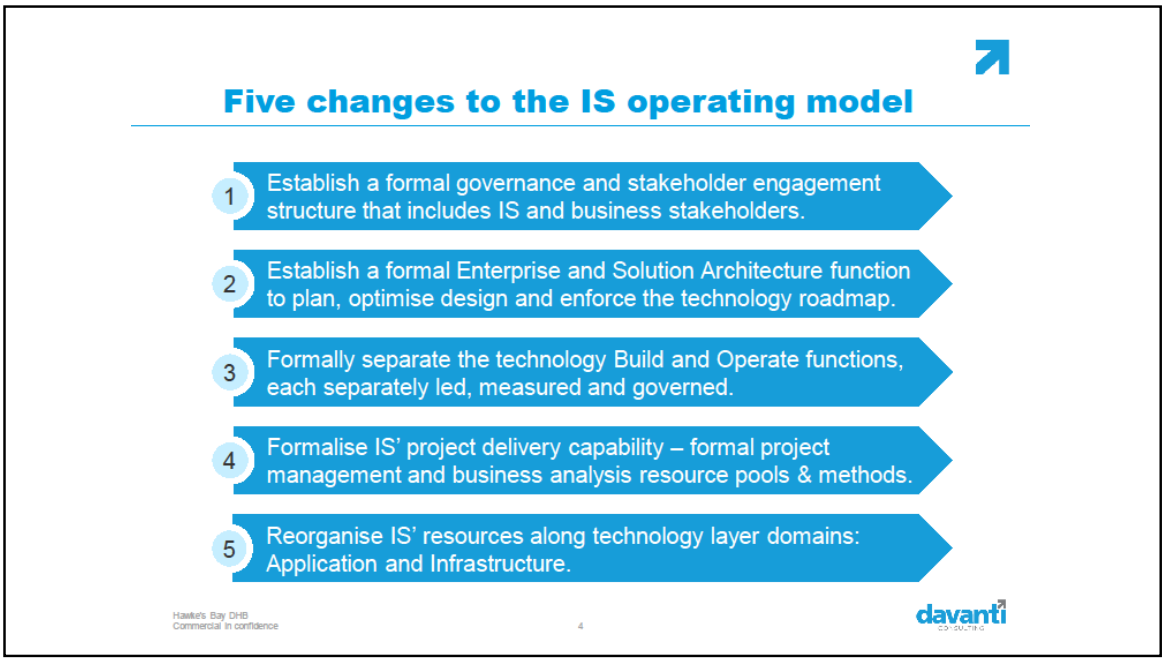
Summary slides Davanti report.

(Full report on Diligent Books, paper copies available on request)


davanti
CONSULTING
IS FUNCTION REVIEW
Summary of findings and recommendations
HAWKE'S BAY
District Health Board
Whakawaiatia


Three step review process
Understand
Stakeholder needs
Conducted 30+ interviews to understand:
• Role of IS and technology.
• Challenges & opportunities.
Assess
IS effectiveness
Applied standard frameworks to assess:
• Key IS capabilities.
• IS operating model.
Recommend
IS operating model
Roadmap to the future
Developed operating model and roadmap of recommendations to increase IS effectiveness and address challenges:
• Drew on standard and best practice models.
• Developed practical recommendations that account for the DHB's unique situation and challenges.
Hawke's Bay DHB
Commercial in confidence
2
davanti


Three groups of challenges facing IS
Undocumented knowledge, an inappropriate team structure and lack of formal processes
A focus on managing the current state and not on building to the future
Lack of formal governance and engagement with stakeholders
Business impacts
Unsustainable IS workload and poor customer service
Inconsistent delivery of services
Poorly defined technology roadmap & risk of poor investment decisions
Limited leadership on the use of innovative technology
A reactive technology partner
Hawke's Bay DHB
Commercial in confidence
3
davanti


Five changes to the IS operating model
1 Establish a formal governance and stakeholder engagement structure that includes IS and business stakeholders.
2 Establish a formal Enterprise and Solution Architecture function to plan, optimise design and enforce the technology roadmap.
3 Formally separate the technology Build and Operate functions, each separately led, measured and governed.
4 Formalise IS' project delivery capability – formal project management and business analysis resource pools & methods.
5 Reorganise IS' resources along technology layer domains: Application and Infrastructure.
Hawke's Bay DHB
Commercial in confidence
4
davanti

Delivering business benefits to the DHB

1. Formal governance structure
2. Architecture leadership
3. Formal Build and Operate functions
4. Formal project delivery capability
5. Restructure of resources

- **An engaged technology partner** that understands stakeholder objectives and has a portfolio of work that is aligned to their priorities.
- **Clear technology leadership**, with a technology roadmap that is optimised for the DHB and its stakeholders, and reduced risk of poor technology investment decisions.
- **A responsive technology partner** that is able to meet changing stakeholder needs.
- **Consistent delivery** and development of technology services, in a manner that meets stakeholder expectations.

A four phase implementation approach

1. Mobilise	2. Stabilise	3. Increase sophistication	4. Embed
(~6 months)	(~6 months)	(~9 months)	(~5 months)
Lay the foundations for moving to the recommended target state.	Address current operational challenges.	Develop target architecture. Standardise approaches. Facilitate innovation opportunities.	Develop and maintain a project portfolio plan and process for continuous improvement.

~26 months timeline, 11 critical projects, three new roles.

HAWKE'S BAY DISTRICT HEALTH BOARD	Action Item from the September 2015 Clinical Council Meeting. Item raised originally by Dr Rodgers, with Dr Andy Phillips offering to provide draft policy for consideration. This item was subsequently included on the workplan.
Complementary Therapies	

PURPOSE

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

PRINCIPLES

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

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

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

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

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

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

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

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

INTRODUCTION

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

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

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

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

In accordance with the above guidelines the complementary therapy:

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

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

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

SCOPE

This policy covers the following complementary therapies:

Rongoa (traditional Maori Healing)
Traditional Chinese Medicine
Massage
Aromatherapy
Reflexology
Indian head massage
Hand & Foot Massage
Relaxation
Reiki
Yoga
Hypnotherapy

DEFINITIONS

Complementary therapies

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

NICE Supportive and Palliative Care Improving Outcomes Guidance (2004)

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The following therapies may be practiced:

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

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

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

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

Hand and Foot Massage- see massage

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

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

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

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

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

ROLES AND RESPONSIBILITIES

Hawkes Bay DHB Management Responsibilities

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

- Where appropriate, negotiating and agreeing with local therapists the place of a complementary therapy as outlined in the protocols to support normal clinical activities, and ensuring where appropriate this is reflected in a written care plan.
- Final agreement prior to therapies being commenced on DHB premises. The management team will be responsible for the monitoring of any therapies practised.
- Ensuring that details held on the DHB register are up-to-date and correct. They will also maintain a list of practising complementary therapists.
- Auditing practitioners compliance with this policy

Complementary Therapy Practitioners Responsibilities

Assessment

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

Safe Practice

- The practitioner should provide written evidence of a qualification in their area of practice recognised by the sector regulator - or the relevant professional association

- Therapists will be required to practice using guidelines based on the current evidence of best practice. Any concerns that arise during treatment should be referred to the appropriate Hawkes Bay DHB health profession.

- All therapists will be required to have indemnity insurance and be a member of an appropriate professional body.

- Any essential oils used are required to be genuine, pure essential oils, of therapeutic origin and preferable of organic origin. No perfume or oils of chemical mix or origin are to be used.

  Carrier oils are to be cold pressed and unrefined, preferably of organic origin.

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

indicators to patients and their disease. There are many information sources available to obtain this advice.)

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

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Consent

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

Written Information

Written information must be provided including the following;

- A description of the therapy and what that entails for the patient.
- A statement to the effect that the therapy is not an alternative to conventional therapies.
- A statement explaining that all therapists have completed relevant qualifications appropriate to their practice.

Record keeping

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

Training Requirements

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

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

REFERENCES

RELATED DOCUMENTS

KEYWORDS

For further information please contact

APPENDIX 1 : TREATMENT GUIDELINES FOR COMPLEMENTARY THERAPIES

1.0 AROMATHERAPY

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

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

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

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

1.1 Special Precautions for patients undergoing/just completed radiotherapy

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

1.2 Special precautions for patients undergoing chemotherapy

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

1.3 Permitted Essential Oils

There is no definitive list available of oils that are suitable for use with condition specific patient groups, and opinion differs amongst aromatherapists themselves on this issue. However, the lists below are oils which have been used as the basis of a national research trial into the efficacy of aromatherapy in cancer care. It is the aromatherapist's responsibility to assess each client for contraindication before choosing appropriate oil.

- Cedarwood
- Eucalyptus (eucalyptus globules, and Citriodora)
- Frankincense (boswellia thurifera)
- Geranium (perlargonium graveolens)
- Lavender (lavandula augustifolia)
- May Chang
- Sweet Marjoram (origanum marjorana)
- Roman Camomile (anthemis nobilis)
- Rosemary
- Rose Absolute
- Petigrain

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

In brain tumours avoid the use of Rosemary.

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

2.0 MASSAGE

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

2.1 Clinical checklist/contraindications

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. 0 REFLEXOLOGY

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

General precautions

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

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4.0 ACUPUNCTURE

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

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

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

Possible Risks

Bruising: This can often occur, especially if the patient is on anti-coagulants

Sickness: This can be mild either during or after treatment. If severe the treatment will be stopped. The cause of sickness can be due to the body producing its own analgesic hormones. Further treatments may be continued with fewer needles and for a reduced time.

Dizziness/Fainting: This is very rare, happening usually during the treatment. Stopping the treatment reverses the symptoms and future treatments are commenced with fewer needles over less time.

Drowsiness/Fatigue: The patient may feel sleepy or tired during or after treatment. This should not affect their ability to drive or operate machinery. If this is a problem they may need a few hours rest in the department. The need for further treatments would be reassessed.

Increased Pain: It is not unusual for patients to experience an increase in their pain either during or subsequently after treatment. This can be a positive sign but if levels continue to increase the treatment will be discontinued. A review appointment with the doctor will be given.

Pneumothorax: All treatments to the thoracic area will be given with caution.

Allergies/Infections: Rare occurrences.

Broken/bent/stick needle

Allergy to swab

Possible Benefits

• Decrease in the pain

• Decrease in analgesia taken

• Relaxation

• Increased sense of well-being

• Improved sleep

• Increased energy

5.0 HYPNOTHERAPY

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

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

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

- Psychotic disorders
- Personality disorders
- Severe clinical depression

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

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

6.0 GENERAL GUIDANCE WHEN GIVING A SESSION

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

Appendix (iii)

Hawkes Bay DHB

Register of Complementary Therapists offering therapy and consulting with patients on HBDHB premises

NAME	QUALIFICATIONS	THERAPIES OFFERED	PROFESSIONAL BODY	INDEMINITY INSURANCE	REVIEW MEETING

Appendix (iv)

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Complementary Therapist Agreement to comply with the Policy

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

Complementary therapist …… Dated: ……

Centre Manager…… Dated: …

Appendix (v)

Consent Form for Complementary Therapy

Patient Name ……

Date of Birth ……

Leaflet/Literature
Provided to the Patient …… (YES / NO)

I sign to confirm that:-

- **I have received the information provided by the therapist YES NO**
- **I have understood this information YES NO †**
- **I consent to the therapy YES NO†**
- **I have an existing medical problem and my GP consents to the therapy**
  YES NO N/A

1. Signed …… Date …… Therapy Offered
   ……..
   (Patient)

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

2. Signed …… Date ……. Therapy Offered
   ……..
   (Patient)

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

3. Signed …… Date ……Therapy Offered
   ……..

   (Patient)

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

4. Signed …… Date …… Therapy Offered
   ……..
   (Patient)

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

HAWKE'S BAY District Health Board Whakawāteatia	**DRAFT Hawke's Bay District Health Board Annual Plan 2016/17**
	HB Clinical Council and HB Health Consumer Council
Document Owner: Document Author(s):	Tim Evans, GM Planning Informatics and Finance Carina Burgess, Acting Head of Planning
Reviewed by:	Executive Management Team
Month:	March, 2016
Consideration:	For Information

RECOMMENDATION

That Clinical and Consumer Council note:

- The draft contents, timeline and process for the Hawke's Bay DHB Annual Plan 2016/17 and provide any feedback to Carina Burgess.

OVERVIEW

The first draft of the Hawke's Bay DHB Annual Plan is currently under development and is due to the Ministry of Health by 31st March.

It is important to note that the draft that is under development and the final guidance was only received from the Ministry of Health (MoH) on 26th Februray. We are also awaiting the final NZ health strategy's release as this will have an impact on the content of the plan.

The draft is being shared at this stage to gather any feedback as it develops.

Timeline

EMT	23rd February
MoH Planning Guidance & NZ Health Strategy finalised	26th February
MRB	9th March
Clinical Council	9th March
Consumer Council	10th March
Board	30th March
Ministry of Health	31st March

Process

The Minister has asked for a refreshed Statement of Intent (SOI) in this year's Annual Plan. The SOI was refreshed last year to incorporate Transform and Sustain. The refresh will focus on incorporating the NZ Health Strategy themes and how we measure the implementation and impact of Transform and Sustain.

Strategic Services, the PHO, Māori Health, Population Health and Health Services are working closely to develop this plan. Each section in Module 2B: Delivering on Priorities and Targets, has a small working group who are responsible for agreeing actions, leads and timeframes which will lead

to better ownership of reporting going forward. Due to conflicting priorities and the late release of guidance from the MoH, not all of these groups have been able to meet but they are all scheduled to occur within the next two weeks. Activities are still being reviewed by management so are subject to change before submission to the MoH.

Changes to the Annual Plan since 2015/16

All priorities in the plan have been reviewed in the working groups and are being sent out for agreement by wider stakeholders.

New or increased focus areas:

- Reducing childhood obesity has been introduced as a National Health Target
- Reducing Unintended Teenage Pregnancy is a National Priority
- The focus for Stroke has extended to cover timely transfer to inpatient rehabilitation
- Increased emphasis on plans to shift services into the community e.g. Health and Social Care networks, District nursing, engAGE, Pharmacy Facilitators etc.

Less focus:

- More Heart and Diabetes checks is no longer a health target but remains a priority
- Nationally there is less focus on child and maternal health activity such as antenatal education and LMC enrolment. However, these remain as activities relating to outcomes such as increasing breastfeeding rates and reducing SUDI in our Annual Plan.

Local Maori Health Priorities:

- Māori Workforce
- Obesity
- Alcohol and other drugs – NEW

ATTACHMENT

Hawke's Bay District Health Board Annual Plan 2016/17 Draft v1.1

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Dashboard Q2 (Oct – Dec 2015)**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and Māori Relationship Board (MRB)**
Document Owner: Document Author(s):	Tracee Te Huia, General Manager Māori Health Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team (EMT)
Month:	March 2016
Consideration:	For Monitoring

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RECOMMENDATION

That the HB Clinical Council, HB Health Consumer Council and MRB:

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on:

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

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

As this report is for the period ending December 2015, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

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

PERFORMANCE HIGHLIGHTS

Achievements

1. HBDHB continues to have the highest percentage in New Zealand for Cervical Screening for 25-69 year old Māori women (71.4%) and the lowest disparity gap between Māori and European (2.4% gap).
2. Immunisation rates for Māori under 2 year olds continue to exceed expected targets of ≥ 95% with 96.1% of all Māori 2 year olds immunized in Quarter 2.
3. Immunised rates for Māori 4 year olds has increased from 93.3% in Q2 to 94.2% in Q2 above the expected target of ≥ 90%.
4. ASH Rates overall are declining for both 0-4 years and 45-64 years with a significant narrowing of disparity gap for 0-4 year old group.
5. Advice to pregnant smokers increased above the expected target of ≥90% up from 87.7% in Quarter 1 to 96.2% in Quarter 2.
6. The number of Māori enrolled in the PHO has risen from 95.9% in Quarter 1 to 97.2% in Quarter 2 above the expected performance target of 97%.
7. Cultural Training for HBDHB staff has increased from 64% in Quarter 1 to 66% in Quarter 2. Medical staff increased significantly from 14% in Quarter 1 to 19% in Quarter 2.

Areas of progress

1. Heart and Diabetes Checks are continuing to improve towards the expected target and have increased from 85.8% in Quarter 1 to 86.3% in Quarter 2.
2. Breast Screening has improved from 66.6% in Quarter 1 to 68.4% in Quarter 2.

Challenges

1. Breastfeeding rates for Māori at 6 weeks, 3 month and 6 months continues to decrease and remain below expected performance targets.
2. Māori women who are smoke free at 2 weeks post natal decreased by 9% from 62% in Quarter 1 to 53% in Quarter 2 well below the expected performance target of ≥ 86%.
3. Immunisation rates for 8 month old Māori dropped below the expected target of ≥ 95%; down from 96.7% in Quarter 1 to 93.3% in Quarter 2.
4. Māori under Mental Health Act compulsory treatment orders has risen 6.7 from 189.3 per 100,000 population in Quarter 1 to 196. There remains a significant inequality between Māori and non-Māori.
5. Māori Workforce remained static in Quarter 2 at 12.3% and is below the expected target of 14.3%

Please note:

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

ANNUAL MĀORI HEALTH PLAN, QUARTER 2 OCTOBER - DECEMBER 2015 DASHBOARD REPORT

Access to Care
PHO Enrolment and ASH rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment	94.7%	95.9%	97.2%	96.5%	≥ 97%	65		↑
0-4 years (6m)	82.0%	95.0%	82.0%	73.0%	≤ -	-		↓
45-64 years (6m)	100.0%	100.0%	98.0%	66.0%	≤ -	-		↓

Child Health
Breastfeeding rates (3m)

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data								
At 6 Weeks	68.0%	69.0%	62.0%	66.0%	≥ 75%	-		↑
At 3 months	54.0%	45.0%	45.0%	55.0%	≥ 60%	-		↑
At 6 months	59.0%	55.0%	54.0%	66.0%	≥ 65%	-		↑

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation (8 Months)	95.9%	96.7%	92.6%	93.3%	≥ 95%	-6		↑
Immunisation (2 years)	95.0%	95.9%	95.1%	92.9%	≥ 95%	0		↑
Immunisation (4 years)	-	93.3%	94.2%	91.1%	≥ 90%	11		↑
65+ Influenza (3m)	68.0%	52.4%	56.5%	65.1%	≥ 75%	0		

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	-	-	-	0.6	≤ 2.6	0		

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate	65.3%	65.3%	Yearly Data, Update in Q3		≥ 82%	-		↑

SUDI

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

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

Time Series Key:
- Target
- Actual

Cardiovascular Disease

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Heart & diabetes checks	83.9%	85.8%	86.3%	91.7%	≥ 90%	-416		↑
Quick access to angiograms	66.7%	38.5%	60.0%	68.7%	≥ 70%	-2		↑
Completion of registry data	12.5%	91.7%	71.4%	84.1%	≥ 95%	-5.0		↑

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs)	73.8%	74.4%	74.1%	76.5%	≥ 80%	-520		↑
Breast screening (50-69 yrs)	67.2%	66.6%	68.4%	75.8%	≥ 70%	-55.5		↑

Smokefree

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal	58.0%	62.0%	53.0%	73.0%	≥ 86.0%	0		↑
Pregnant smokers Brief Advice to Quit	100.0%	87.7%	95.2%	96.5%	≥ 90.0%	0		↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000)	-	189.3	196.0	93.4	≤ 81.5	46		↓

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.7%	2.7%	2.6%	2.9%	≥ -			
Management & Administration	15.7%	16.8%	16.5%	-	≥ -			
Nursing	10.1%	10.5%	10.6%	-	≥ -			
Allied Health	11.9%	12.6%	12.6%	-	≥ -			
Support Staff	26.7%	28.1%	28.2%	-	≥ -			
Māori staff - HBDHB	11.6%	12.3%	12.3%	-	≥ 14.3%			↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	9%	14%	19%	-	≥ -			
Management & Administration	43%	78%	79%	-	≥ -			
Nursing	41%	68%	70%	-	≥ -			
Allied Health	59%	74%	77%	-	≥ -			
Support Staff	12%	38%	36%	-	≥ -			
Māori staff - HBDHB	40%	64%	66%	-	≥ 100%			↑

Te Ara Whakawaiora Priorities

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Obesity (B4SC Healthy Weight for 4yrs)	-	26%	52%	56%	≥ 50%	-		↑
DNA's		11.70%	14.90%	5.30%	≤ 7.50%			↓
Oral Health (% Caries Free at 5yrs)	38.70%	38.70%	-	-	≥ 65%	-		↑

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HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Breastfeeding (National Indicator)**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and Māori Relationship Board**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Nicky Skerman, Population Health Strategist
Reviewed by:	Executive Management Team
Month:	March 2016
Consideration:	For Information

RECOMMENDATION

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

Note the contents of this report.

OVERVIEW

The national GMs Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators in 2013. As a result, individual EMT members agreed to providing a championship role for the Māori Health Plan areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from Caroline McElnay, Champion for the Breastfeeding National Indicator.

UPCOMING REPORTS

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

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Breastfeeding *National Indicator*	Improve breastfeeding rate for children at:		Caroline McElnay	Nicky Skerman	**Mar 2016**
	6 weeks,	>75%			
	3 months;	>60%			
	6 months of age	>65%			
Cardiovascular *National Indicator*	Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission.	70% of high risk	John Gommans	Paula Jones	**Apr 2016**
	Total number (%) with complete data on ACS forms	>95% of ACS patients			
Oral Health *National Indicator*	The total number (%) of children are caries free at first examination after the child has turned five years, but before their sixth birthday	>66%	Sharon Mason	Patrick LeGeyt	**Jun 2016**
Smoking *National Indicator*	Percentage of pregnant Māori women that are	>90%	Caroline McElnay	Shari Tidswell	**Dec 2016**

	smokefree at 2-weeks postnatal				

MĀORI PLAN INDICATOR:

Full and exclusive breastfeeding of infants at 6 weeks (≥ 75%), 3 months (≥ 60%) and full, exclusive and partial at 6 months (≥ 65%).

WHY IS THIS INDICATOR IMPORTANT?

The HBDHB is committed to non-differential targets and significant inequality is seen in this indicator. This indicator is seen to best indicate the health systems performance in the early years of a child's life.

Hawke's Bay DHB acknowledges breastfeeding as a key priority for Hawke's Bay women and their babies. The breastfeeding indicator is reported to the Ministry of Health through the District Annual Plan and Annual Māori Health Plan and is a key component in the HBDHB Maternal Child Youth Strategic Framework 2015-18.

For the 12 month period from 1 June 2014 to 31 May 2015, 36% of babies born in Hawke's Bay were identified as Māori. The Hawke's Bay birthing population has a significantly higher proportion of Māori women compared to the national average. The rate of live births to women under 18 years in Hawke's Bay is consistently higher than the New Zealand average, the teenage pregnancy rate in Hawke's Bay is three-times higher for Māori than for non-Māori.

Breastfeeding

Breastfeeding has a range of advantages for both mother and child. These include; health, nutrition, immunological, developmental, psychological, social and economic benefits. The recognised benefits for mothers who breastfeed include a decreased risk of; breast cancer, ovarian cancer, postpartum bleeding and possibly a decreased risk of hip fractures and osteoporosis in the post-menopausal period.

Despite the health benefits for both mother and child, breastfeeding rates in New Zealand remain low compared to those in the early 20th century. The most common reasons given for not breastfeeding include insufficient milk supply and the need to return to work.

We acknowledge that in Hawke's Bay we struggle to meet the Ministry's targets for breastfeeding across the age bands and ethnicities with breastfeeding rates for Māori being consistently lower than other ethnicities.

The Māori Health Service and the Women, Child and Youth Portfolio are exploring different ways to support breastfeeding, as clearly the current systems and supports are not improving the breastfeeding rates at either six weeks or three months. Several targeted strategies are being considered, an example being the incentivising of Lead Maternity Carers (LMC)/midwives to improve the breastfeeding rates for women engaged in their care. The involvement of LMC midwives in the development of any new actions is essential, and challenging, due to the nature of contracting directly with the Ministry and at a local level engagement with the LMC group.

A concerted effort has been made in the last six months to engage LMC/midwives in both governance and operational forums to ensure the messages we convey are taken back to their operational meetings.

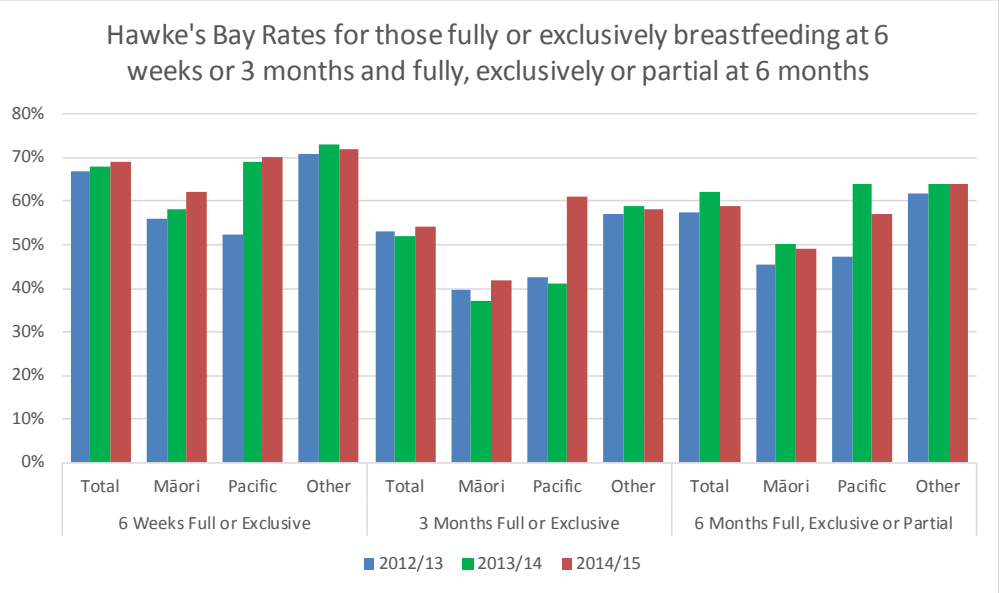
Monitoring progress in breastfeeding rates is hampered by the lack of a central collection point of data in New Zealand. Breastfeeding data at discharge post-delivery is collected by each DHB, breastfeeding rates at two weeks are collected by LMCs and are reported directly to the Ministry of Health under section 88 and is only provided to DHBs bi-annually with a 12 month delay in data.

Breastfeeding data as reported for the annual Māori Health Plan

The most recent data provided for the Māori Health Plan by the Ministry is shown below as Table 1. As per Table 1, breastfeeding rates for Māori at six weeks, three months and six months show minimal variability over the three year time period shown. There is however, no significant improvement and an obvious drop off between six weeks and three months.

Data outlined in Table 1 is Plunket only data. Prior to September 2015 this was the only source of Ministry level breastfeeding data available excluding all DHB contracted Well Child/Tamariki Ora (WC/TO) provider data. From September 2015 all Ministry level breastfeeding data includes both Plunket and WC/TO data. Tables 2 below provides a baseline for future comparison.

Table 1



*Plunket Data

Table 2

		Target	Dec-15
Breastfeeding at 6 weeks	Total	75%	68%
	Māori		58%
	Pacific		74%
Breastfeeding at 3 months	Total	60%	54%
	Māori		46%
	Pacific		62%
Breastfeeding at 6 months	Total	65%	56%
	Māori		46%
	Pacific		57%

*QIF data (Quality Improvement Framework).
Breastfeeding at 6 weeks: Source: National Maternity Collection
Breastfeeding at 3 months and 6 months: Source: WCTO NHI dataset

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

Breastfeeding

1. **Mama Aroha Talk Cards Training and Resource Development**
   One of the overwhelming themes identified in a breastfeeding stakeholder workshop held in August 2014 was ensuring "consistent messaging around breastfeeding resources and advice". The Mama Aroha talk cards have been developed by a Tairawhiti Māori midwife and lactation consultant and supported by the Ministry of Health to ensure all health professionals such as LMC/midwives and WC/TO providers working with new mothers are giving consistent and appropriate advice the same.

   A workshop on the Mama Aroha Breastfeeding support talk cards was held in 2015 and saw 56 local health professionals attend that included' LMC, WC/TO staff, midwifery students, peer support counsellors, antenatal educators and hauroa providers. Excellent feedback was gained with the highly visual and evidence based talk card sets presented to each attendee to use in health care, home, education and community settings.

   A recent follow on from the training has been local collaboration with Amy Wray of Mama Aroha to develop a user-friendly and motivating resource based on the talk cards to be handed out to all mothers delivering in Hawke's Bay as a take home breastfeeding support.

   Based on the Mama Aroha Talk Card, the Hawke's Bay Breastfeeding Group and the Breastfeeding Governance Group developed a resource combining key messages that support the establishment and continuation of; breastfeeding, safe sleep and smokefree. This resource will be used as an educational tool by the community safe sleep coordinator, and will also be handed out to all parents birthing in the HBDHB maternity unit and in the community.

2. Hawke's Bay Breastfeeding Governance Group

The Breastfeeding Governance Group meets quarterly. Their role is to provide a collaborative approach to improving breastfeeding rates in Hawke's Bay. A review of membership is underway to include strategic level representation from stakeholders outside of health (e.g. MSD, Early Childhood Education).

3. Hawke's Bay Breastfeeding Group

An operational group, contributing to the support of breastfeeding in the community, providing resourcing and updates to health professionals and ensuring that the World Health Organisation Breastfeeding Code is upheld and responding to breaches.

4. Workforce Development and Capacity Building Activities

La Leche League NZ (LLLNZ) peer counsellor training delivered by Choices Kahungunu Health Services to community providers across Hawke's Bay. Mama Aroha Talk Card training will be offered to local health professionals over the next year.

5. Well Child/Tamariki Ora Community Breastfeeding Supports

There are loan schemes in place at Kahungunu Executive and Te Taiwhenua o Heretaunga for breastfeeding equipment. These loan schemes ensure all women can access breastfeeding pumps and equipment regardless of cost (e.g. 70 loans were registered over 2015). Central Hawke's Bay Plunket also have six sets of breast pumps they hire out regularly.

Plunket's breastfeeding support in Central Hawke's Bay includes seven breastfeeding peer counsellors that are La Leche League trained. The service receives referrals from the Central Hawke's Bay lactation consultant as well as self-referrals.

To increase early engagement, a Breast Buddy programme has been initiated. Couples who attend antenatal classes are provided the opportunity to sign up to have a "Breast Buddy" contact them before the baby is born which then establishes a relationship, encourages parents to be able to ask for help after the birth. Since the programme was initiated, 100% of couples have signed-up, which is very encouraging. Furthermore, the peer support counsellors are advocates in the community for breastfeeding, providing advice, promoting breastfeeding at local events/social gatherings and playgroups. They also organised the Big Latch On in Central Hawke's Bay in 2015.

6. Breastfeeding Baby Cafes

Baby cafés or support services are run weekly in Napier, Hastings and Wairoa supported by lactation consultants and peer support trainers. Central Hawke's Bay has access to an 'on call' lactation consultant and a strong peer support network. The cafés are run from community locations and work in collaboration with midwives and well child providers.

7. Celebration of World Breastfeeding Week 1-7 August 2015

Big Latch On events organised and supported by Hawke's Bay Breastfeeding Group at local cafés (Hastings and Napier) for the first time.

8. Healthy First Food Promotion

The Healthy First Foods Workshop package (train the trainer) has been provided to two local WC/TO providers. Phase Two is now in progress with all Hawke's Bay WC/TO providers to receive training. The Healthy First Foods programme promotes the optimum timing for solids initiation to infants, including healthy first food preparation, whilst maintaining breastfeeding.

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

- Ongoing training and resourcing of Mama Aroha Talk Cards and Parent resource
- Possible incentivisation programme for midwives

RECOMMENDATIONS FROM TARGET CHAMPION

The first six weeks after a baby is born is critical to establishing successful breastfeeding. There are multiple factors that impact whether this occurs, for example; consistent messaging, health professional engagement and enrolment processes. It is essential that for any sustainable change to occur in the rates of breastfeeding, efforts must be focussed in the antenatal and early postnatal periods (in addition to other activities already established).

A Ministry of Health funded investigation will take place in Quarter 4 with a focus on barriers to referral to WC/TO by LMC, and subsequently timely engagement with whānau by WC/TO. Additionally, discussions around incentivising LMC and growing LMC involvement in breastfeeding leadership should be seriously considered.

Many women return to work shortly after the birth of their baby and this creates extra challenges to continue breastfeeding. More work is needed to identify practical steps to help support women continue with breastfeeding when back at work.

CONCLUSION

Increasing breastfeeding rates remains a significant ongoing challenge. Whilst rates at six weeks have increased for Maori there is still a significant drop at three months.

Caroline McElnay
Director, Population Health

OURHEALTH HAWKE'S BAY Whakawateatia	**Urgent Care Alliance Update**
	For the attention of: **HB Clinical Council**
Document Owners:	Mark Peterson Project Sponsor and Graeme Norton, Chair
Document Author:	Jonathan Amos (Project Manager)
Reviewed by:	n/a
Month:	March, 2015
Consideration:	For Information

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RECOMMENDATION

That Clinical Council:

Note the contents of this report.

Attached is the latest Project Progress Report for the Urgent Care Alliance

Key highlights of this report include:

Following approval by Board an Urgent Care Services Change proposal is now live with a feedback request issued for individuals and registration of interest (ROI) process for providers. Key dates include:

15th February – Face to face meeting with providers
29th February – Face to face meeting with providers
7th March – Deadline for questions/feedback
21st March – Deadline for registrations of interest (ROI)

11th April – Request for proposals (RFP) for new service issued

Following the submission of the year-end report in December 2015 the other Urgent Care work streams are completing their options that were signed off and new work streams are beginning in February (see chart below)

HAWKE'S BAY District Health Board

Project Status Report

Project Name:	Urgent Care – Implementing change in Hawke's Bay
Project Manager:	Jonathan Amos
Sen Res Owner **Project Sponsor**	Mark Peterson Graeme Norton

Date of Progress Report	February 2016
Project Start date	March 2015
Planned Finish Date	December 2016

STATUS SUMMARY

Project Performance Dimensions Key	*Traffic Light Status Key*	Time Status	Financial Status	Overall Status
Time: *Meeting milestones on time as planned* ***Financial:*** *Project Budget Expenditure and/or Savings is on track* ***Overall:*** *Expect to achieve the goal and benefits*	***Red = R:*** *Off Track* ***Amber = A :*** *Generally on track _ minor issues* ***Green = G****: On track*	**G**	**G**	**G**

Summary Comment	Following approval by board an Urgent Care Services Change proposal is now live with a feedback request issued for individuals and registration of interest (ROI) process for providers. Key dates include: 15th February – Face to face meeting with providers 29th February – Face to face meeting with providers 7th March – Deadline for questions/feedback 21st March – Deadline for registrations of interest (ROI) 11th April – Request for proposals (RFP) for new service issued Following the submission of the year-end report in December 2015 the other Urgent Care work streams are completing their options that were signed off and new work streams are beginning in February (see chart below)

Planned Activities next period	Complete the Urgent Care Service Change proposal Feedback process and Registration of Interest (see above). If agreed to proceed by Urgent Care Strategic Group and RFP Evaluation Panel Chair (HBDHB CEO) proceed to the RFP for new Urgent Care services. See below for planned activities for remaining work streams.

	Urgent Care Project - Outline timeline for UCA consideration										
		January	February	March	April	May	June	July	August	September	October
1	**Urgent Care Health services Change Proposal**	ROI / Feedback underway	Face to Face Meetings	RFP developed / Feedback ends / Registration ends	RFP finalised / RFP Evaluation Group formed / RFP issued	RFP ends / RFP Evaluation Group recommendation report drafted	Decision Paper on proposals	Negotiation and contracting / Plan for implementation	Negotiation and contracting / Plan for implementation	Commence implementation	
2	**Oral Health**		Oral Health Group to review options	Cost options narrowed / Pathway work / MSD work	Onoging - Pathway work / MSD work	Business Case preparation?	Decision on Business Case - UCA / Next years budget bids	Handover to group	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion Report	
3	**Public Communication**	Monitor website usage	Review success of campaign	Handover ongoing responsibility for Choose Well / Agree KPI / UCA Monitoring	Ongoing budget agreed	Completion Report					
4	**St John service provision**	UCA reviewed the progress to date on this work stream and made a decision to suspend unitl further notice from St John									
5	**Transport Assistance**	UCA Handover / DHB decision taken to support strategic review	UCA to support review	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report						
6	**Support Pathways**	UCA Handover to engAGE working group	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report							
7	**Timely Access to Data**	UCA Handover to Information services	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report							
8	**Advanced Practitioner Workforce**		Establish Work Stream Group	Set Principles	Develop Options	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to ???	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report
9	**Aged Care Residential**		Establish Work Stream Group	Set Principles	Develop Options	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to ???	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report
10	**Greater Treatment in Pharmacies**		Attend Pharmacy forum / Establish Work Stream Group	Set Principles / Role of Pharmacy facilitators / One health?	Develop Options	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to ???	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report
11	**Affordable Access**		Review evidence of priority area so far	UCA to review Affordable Access definition. Decision to build into RFP weighting and criteria taken by Strategic Group							

MILESTONE UPDATE			
Agreed Milestone Plan as per TOR	**Planned Finish Date**	**% Complete**	**Key Achievements this period**
Project start up and planning • Project TOR signed off • Urgent Care Alliance TOR signed off • Work Breakdown Structure / Timeline drafted • Stakeholder analysis and Comms Plan/ Website • Risk Plan • Benefits Plan • Project Budget • Project Plan acceptance	April 2015	100%	• Project TOR signed off • Key documents are live and being updated. o Risk Plan o Timeline o Stakeholder Analysis • It was agreed by UCA Chair that Comms Plan would be developed alongside work streams • Project Budget bid approved in principle. Each work stream to produce a costed proposal against budget for final approval by UCA/EMT/Clinical Council. • It was agreed with Project Assurance that Benefits Plan would be ongoing
Staged work plan development • Establish UCA Stakeholder Group • Produce UCA Principles document • Produce criteria to be mapped in co-design of service solutions • Review previous solutions • **Workshop with UCA and other stakeholders to develop a staged work plan including stage 1 and 2 solutions that will inform project plan over length of project** • Develop a consultation model for co-design of solutions. • Deliverables acceptance	May 2015	100%	• Staged work plan completed and endorsed by EMT/Clinical Council
Stage 1 – Planning and implementation • Staged implementation of service and community focused solutions o Resources engaged for stage one o Refine stage one implementation plan o Acceptance of stage one implementation plan o Stage one implementation	December 2015	100%	▪ Staged work plan completed and endorsed by EMT/Clinical Council ▪ First Work Streams up and running ▪ Year End Report completed – Work Streams being handed over to business as usual or brought forward into Stage 2 (see chart)
Stage 1 Completion and Stage 2 Design and approval • Review stage one implementation and approve stage two	December 2015	100%	• Year-end report approved by governance process
Stage 2 – Planning and Implementation • Staged implementation of service and community focused solutions o Resources engaged for stage two o Refine stage two implementation plan o Acceptance of stage two implementation plan • Stage two implementation	December 2016	20%	• Staged work plan completed and endorsed by EMT/Clinical Council • Stage 2 Work Streams being started February 2016
Communication • Communication plan to be developed, followed and updated throughout the lifecycle of this project (Effective/Appropriate/Timely).	Ongoing - December 2016	40%	• It was agreed by UCA Chair that Comms Plan would be developed alongside work streams
Project closure • Project completion evaluation sign off.	December 2016		•

RISK MANAGEMENT: *up to date each month including your action plan to minimise these risks and issues.*	
Current Risks or Issues of Note	**Planned Actions to reduce the Impact or Likelihood**
Public consultation does not support the level of change	Communication planning and testing of material Use of UCA Stakeholder Group to enable positive change with Service Providers Use of Expert Panel to support delivery of key messages at community forums
Hawke's Bay Communities will potentially have concerns due to perception that they are losing services	Communication plan with agreed response including: • focus on patient concerns • supplementary meetings with key stakeholders • expert panel to be involved in discussions UCA/Project Manager to jointly develop solutions with consumers and services directly invested in these areas and ensure high levels of communication and seek guidance from Clinical Council / HB Alliance. May involve the development of separate projects / business cases where appropriate
Urgent Care Alliance Membership Changes	Project Manager ensures that there is a process supported by the UCA to select new members and Project Manager/Chair of UCA is responsible for bringing any new members up to speed.
Project deliverables deadlines missed	Due to the complex first time nature of some of the deliverables it may be that some are delayed. Robust project monitoring in place. Alongside project escalation of any issues/problems incurred to Project Board and beyond for resolution.
DHB/PHO Health Alliance break up	Alliance principles stated in signed Health Alliance agreement. This is not a binding contract and can be dissolved by either party.
Communication plan doesn't have a desired effect as specified in plan itself	Project board and Stakeholder group sign off of the Communications plan. Latest techniques (where evidenced) in world-wide medicine copied and utilised where appropriate. Active monthly review to ensure all stakeholders are engaged
Insufficient budgetary provision	Robust business case/s produced for solutions. A number UCA solutions will produce recommendations of reallocation of funding to fund further solutions elsewhere.
Insufficient link to HBDHB EMT	Allocation of EMT member to Senior Responsible Owner to ensure that reporting links to EMT maintained
Lack of visibility of proposed initiatives that have been removed	Project Manager to maintain database recording source and activity status of proposed initiatives
Lack of engagement from Primary Health Care providers	UCA Stakeholder Team formed to influence the design and implementation of the project initiatives Clinical Council / UCA Leadership Team and UCA Stakeholder Team member to encourage cross sector involvement of colleagues Communications plan to raise profile of Urgent Care Project and update all health sectors on monthly progress of initiative that affect them
Potential changes to the delivery of Urgent Care to the different models of primary service provision and subsequently the PHO and its board	The UCA Leadership has a senior PHO staff member and two GP's on the group who were chosen to represent these issues with any future decisions. We are ensuring that our papers are considered by the PHO EMT and Board.
Engagement with Project SRO not sufficient to help him support the project at Governance levels	HBDHB EMT selected a new Senior Responsible Owner - Mark Peterson - Chief Medical Officer - Primary. He is actively involved in the project Project manager and Project Sponsor to ensure that the new SRO is kept involved and informed of all progress to ensure that he is confident and can represent the project at the governance level

CHANGE CONTROL HISTORY *Note any formal requests for change to the agreed project TOR or Charter:*

Date of Request	Request Number	Description of Change	Status

HAWKE'S BAY District Health Board Whakawāteatia	**Falls Minimisation Committee Update**
	For the attention of: **HB Clinical Council**
Document Owner:	Chris McKenna, Chief Nursing Officer
Reviewed by:	N/a
Month:	February 2016
Consideration:	For Information

RECOMMENDATION

That Clinical Council:

Note the contents of this report.

CENTRAL REGIONS FALLS MEETING

The Central Region Falls meeting had been held in Palmerston North and the patient management system, TrendCare was discussed to consider the options around moving away from hardcopy notes to electronic versions. HBDHB will be implementing an electronic falls assessment risk and care plan through Trendcare.

"APRIL FALLS" Campaign

The Health and Quality Safety Commission were providing support to the Central Region DHB's in a month long promotion called "April Falls". Much of the promotional work had been undertaken by Mid-Central and these would be shared with the rest of the central region with the appropriate DHB logo's. A campaign entitled "Eye on Falls" would also be rolled out and posters/banners/resources would be distributed in the month of April.

SPORT HAWKE'S BAY

The recently appointed Health Team Leader, Sue Smith from Sport Hawke's Bay attended the February 2016 meeting and provided a brief overview on the relevant falls programmes provided at Sport HB. There were currently two programmes being run by Age Concern and they were funded directly from Sport HB. These programmes were:

1. "*Up Right and Active*" and

2. "*Steady as you Go*"

FALLS BUSINESS CASE

Strategic Services Manager, Paul Malan provided an update on this business case, and although it had been developed in 2015, the funding available from ACC had not yet been identified. However, there have been a number of developments over the last 18 months that meant it was now timely to revisit the end-to-end services relating to falls and fractures amongst older people in Hawke's Bay.

As a result a Falls and Fractures Workshop had been scheduled 8th March 2016. The purpose of this workshop would be to scope a proposal that would be made jointly to ACC and the DHB for improving the response to the issues and opportunities. The workshop would essentially consider "what was available" and "what ought to be/could be available". The output from that workshop would be used to plan a larger consultation that would then be used to develop the final proposal/s.

QUARTERLY REPORT FOR FALLS 65+

The quarterly report for Falls 65+ was presented at the meeting. This encapsulated five years' worth of data.

The following comments were noted from the data/graph:

- Falls in homes were down by cause and location
- 18% decrease in falls and yet there had been a population increase of over 65's between 2010 and 2015 of 21%
- Ethnic breakdown of over 65's based on 2015 stats: Maori 9%; Pasifika 1%; Other 90%
- Anecdotally Maori tended to live in a group environment and therefore potentially more safety; and elderly are supported.
- Maori also didn't live as long as their Pakeha counterparts

HAWKE'S BAY District Health Board Whakawāteatia	**Maternity Clinical Governance Group Report Q1 & Q2 (2 July – Dec 2015)**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author(s):	Jules Arthur, Midwifery Director
Reviewed by:	Chris McKenna
Month:	March 16
Consideration:	

RECOMMENDATION

That Clinical Council:

Note the contents of this report.

OVERVIEW

The Maternity Quality and Safety Programme (MQSP) Implemented as part of the Maternity Quality Initiative, involves ongoing, systematic review by local multidisciplinary teams working together to identify potential improvements to maternity services and the ongoing work to implement those improvements. This programme is driven by HBDHB midwifery and medical leaders working collaboratively, with consumers, practitioners and managers across our health services continuum.

As per the New Zealand Maternity Standards, the Maternity Quality Initiative seeks to ensure that:

- Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies
- Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage.
- All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

The MQSP additionally works towards meeting the four new priorities published by the Ministry of Health as part of the Maternity Quality Initiative:

- strengthening maternity services to ensure equity of access to a sustainable model of community based continuity of care, to strengthen multidisciplinary collaboration for good outcomes and to promote and protect normal birth.
- better support for women and families that need it most, including better specialist support for women and families with additional needs and better health literacy and engagement of vulnerable population groups.
- embedding maternity quality and safety to meet the national Maternity Standards commitments and to ensure continued growth of local quality and safety activity.
- improving integration of maternity and child health services to reduce access barriers and promote seamless care for women and their families during pregnancy and beyond.

HBDHB Maternity Quality and Safety Programme has the following Key Actions Projects in place to address these four new priorities:

Key Actions Projects 2015-16		
Increase the overall percentage of women in Hawke's Bay who register with a Lead Maternity Carer before 12 weeks of pregnancy to 80% (national target).	• **Proof of concept project - improving access to care in early pregnancy** – short term pilot project to improve and strengthen communication between LMC's and GP's – included the development of an early pregnancy package in partnership between midwifery and GP practice to support information sharing and the provision of key messages to women in early pregnancy. The pilot programme was well received by both consumers and practitioners and the participating women welcomed the free pregnancy packs, stating the information was relevant and easy to understand and that the supplements and scripts were "great". Practitioners found there was increased opportunity for intervention with referrals to smokefree services and into the secondary care system for high risk women. Learnings from the initiative pilot were around the need to further increase awareness and use of the find your midwife website, amendments to the packs to present them in a more discreet fashion and to support a simple pathway to ensure our high needs women receive early pregnancy supplements at confirmation of pregnancy. Recommendations from the proof of concept project are to roll out an ongoing initiative that includes the provision of workforce development, a point of contact midwife, promotional material, free pregnancy packs with informative resources, iron supplements and NRT starter packs were appropriate. • Continue to increase access to the Napier Maternity Resource Centre via promotion in order to increase 'on the spot' LMC registration and improve awareness of the centre amongst primary care providers • Promote registration with an LMC via social media and traditional communication methods including promotion of the Find Your Midwife website	Ongoing
Establishment of the primary birthing facility to increase normal birth and positive outcomes	• Waioha Build project moving along rapidly, with the facility itself being on target to open in July 2016. Ongoing preparation around facilitating normal birth continues with the key focus being to change the birth culture. At the forefront is communication and education within the maternity services	Ongoing
Maternity consumer members network	• Employment of 2 maternity consumer members occurred in November 2015. Their role to provide ongoing representation of consumer views and expectation within all improvement projects across the service is only in its infancy, however a 2 year work plan has been developed with the establishment of a quarterly consumer forum being one of the first directives expected to be achieved. The consumer representatives now sit on the Maternity Clinical Governance Group in order to participate at operational and strategic level discussion and planning for maternity services	Ongoing

	• Online maternity consumer survey - continues to provide the consumer views upon which we are basing our care standards and our implementations. The survey is now being strongly promoted by our two consumer members who are also utilising including face to face conversation with women to complete the survey on the spot. Work around increased visibility and ease of access for the survey will commence in early 2016 • Maternity Services Community Facebook Page additionally provides us with consumer feedback and patient journeys to work from to improve the overall patient experience	
Embed Family Violence screening in a similar manner to Smokefree screening and intervention	• Continue to work closely with DHB family violence co-ordinator with a plan for a larger awareness project for 2016 being developed	Ongoing
Continue the data collection and analysis of the New Zealand Maternity Clinical Indicators	• Detailed analysis of our performance against the 2013 maternity clinical indicators are presented in the table below • Internal current data relating to the calendar year of 2015 is also represented. • A number of clinical audits and actions are underway in order to monitor and address any performances that are suboptimal in relation to the national average.	Ongoing

Clinical Indicators

The New Zealand Maternity Clinical Indicators were established from a collaboration between the Ministry of Health and maternity stakeholders representing consumer, midwifery, obstetric, general practice, paediatric and anaesthetic perspectives. There are currently 21 maternity clinical indicators with the latest six being introduced in September 2015.

The collection of 21 clinical indicators have four different data set groupings.

- Three apply to women who registered with an LMC – **indicators 1, 16 & 17**
- Eight apply to standard primiparae – **indicators 2, 3, 4, 5, 6, 7, 8 & 9** - (women aged 20–34 years old at the time of giving birth who are giving birth for the first time (parity = 0) at term (37–41 weeks' gestation) where the outcome of the birth is a singleton baby, the presentation is cephalic and there have been no recorded obstetric complications that are indications for specific obstetric interventions). This definition applies to approximately 18% of our birthing population.
- Six apply to all women giving birth in New Zealand – **indicators 10, 11, 12, 13, 14 & 15**
- Four apply to all babies born in New Zealand – **indicators 18, 19, 20 & 21**

Evaluators of our indicators need to remain mindful of the population we serve being one with significantly high health inequalities. Compared to other areas of New Zealand, Hawke's Bay is a region with significant health inequalities. This is contributed to by our 25% Māori population (10% higher than average), 35% of our population residing in the most deprived areas of the region, 30% of our young Māori not in education, training or employment, one in three of our adult population determined as obese, one in five are not smoke free, and one in every four Hawke's Bay adults are classed as a hazardous drinker. These, along with numerous other factors, present significant health inequalities that lead to poor access of primary care and high rates of complex pregnancies for Hawke's Bay.

The clinical Indicators data is presented in two different tables within this report, firstly presenting our current internal data indicating trends from 2014 to Dec 2015 and secondly presenting national clinical indicators released in September 2015 based on 2013 outcomes.

Clinical Indicator Overview based on **Current Internal Reporting** Data

Indicator	2014	May 2015	31 Dec 2015	Trend Direction	Performance for 2015
1:Registration with a Lead Maternity Carer in the first trimester of pregnancy- All Women MOH target = 80%	51.4%	56.8%	50.67%	↓	U
2: Spontaneous vaginal birth among standard primiparae (300 women)	61.1%	62.3%	60.1%	↓	U
3: Instrumental vaginal birth among standard primiparae	16.4%	21.2%	19.4%	↓	F
4: Caesarean section among standard primiparae	19.4%	16.4%	20.2%	↑	U
5: Induction of labour among standard primiparae	6.2%	6.2%	8.7%	↑	U
6: Intact lower genital tract among standard primiparae giving birth vaginally	39.2%	39.0%	44.1%	↑	F
7:Episiotomy and no third- or fourth-degree tear among standard primiparae giving birth vaginally	19.9%	21.9%	15.9%	↓	F
8:Third- or fourth-degree tear and no episiotomy among standard primiparae giving birth vaginally	5.8%	6.2%	6.1%	=	S
9:Episiotomy and third- or fourth-degree tear among standard primiparae giving birth vaginally	1.4%	2.7%	2.9%	=	S
10:General anaesthetic for all women giving birth by caesarean section	10.6%	9.4%	11.5%	↑	U
11:Blood transfusion for all women giving birth by caesarean section	5.8%	3.6%	3.8%	=	S
12: Blood transfusion during birth admission for vaginal birth for all women	2.8%	1.9%	2.3%	=	S
13:Diagnosis of eclampsia during birth admission for all women	0	0	0%	=	F
14. Peripartum hysterectomy	New in Sept 2015		1 (0.05%)	Na	
15. Mechanical ventilation during pregnancy or postnatal period	New in Sept 2015		0%	Na	
16:Maternal tobacco use during postnatal period for all women, - at postnatal discharge	Not collated prior		21.7%	Na	
17. Women giving birth with a BMI over 35 at registration	New in Sept 2015		3.42%	Na	
18: Preterm births, 32 to 36 weeks gestation, for all women	6.9%	7.9%	20.31%	↑	U
19. Small babies at term (37–42 weeks' gestation)	New in Sept 2015		Data warehouse still working on retrieving this new data	Na	
20. Small babies at term born at 40–42 weeks' gestation	New in Sept 2015		Data warehouse still working on retrieving this new data	Na	
21. Babies born at 37+ week's gestation requiring respiratory support	New in Sept 2015		2.62	Na	

KEY	
U	Unfavourable
S	Static
F	Favourable

Please find the Clinical Overview based on **2013** MOH Data. Note this is the latest comparative national data set available.

Indicator	Target or national average	HBDHB for 2013	Ranking within 21 DHBs	Outliers (Indicators where HBDHB sit outside the 25% or 75% confidence intervals)
1:Registration with a Lead Maternity Carer in the first trimester of pregnancy- All Women MOH target = 80%	64.9%	63.5%	12th	No
2: Spontaneous vaginal birth among standard primiparae,	67.7%	61.9%	19th	No
3: Instrumental vaginal birth among standard primiparae,	15.2%	17.8%	17th	No
4: Caesarean section among standard primiparae,	16.6%	19.9%	16th	No
5: Induction of labour among standard primiparae,	5.2%	4.7%	11th	No
6: Intact lower genital tract among standard primiparae giving birth vaginally,	28.9%	25.4%	14th	No
7:Episiotomy and no third- or fourth-degree tear among standard primiparae giving birth vaginally,	21.0%	22.8%	15th	No
8:Third- or fourth-degree tear and no episiotomy among standard primiparae giving birth vaginally,	4.3%	3.7%	9th	No
9:Episiotomy and third- or fourth-degree tear among standard primiparae giving birth vaginally,	1.9%	3.7%	20th	Yes
10:General anaesthetic for all women giving birth by caesarean section	8.3%	9.4%	15th	No
11:Blood transfusion for all women giving birth by caesarean section	3.1%	3.68	14th	No
12: Blood transfusion during birth admission for vaginal birth for all women,	2.0%	1.9%	13th	No
13:Diagnosis of eclampsia during birth admission for all women,	n/a	0	=1st	No
14. Peripartum hysterectomy	n/a	0	=1st	No
15. Mechanical ventilation during pregnancy or postnatal period	n/a	0	=1st	No
16:Maternal tobacco use during postnatal period for all women, (2 week PN)	13.5%	42.5%	17th	Yes
17. Women giving birth with a BMI over 35 at registration	8.2%	9.1%	15th	No
18: Preterm births, 32 to 36 weeks gestation, for all women, 2012	7.4%	8.3%	18th	No
19. Small babies at term (37–42 weeks' gestation),	3.1%	3.5%	16th	No
20. Small babies at term born at 40–42 weeks' gestation	36.7%	29.2%	2nd	No
21. Babies born at 37+ week's gestation requiring respiratory support	1.9%	1.3%	14th	No

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

18. Minutes of Previous Meeting
- Public Excluded

19. Matters Arising – Review of Actions
- Public Excluded

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

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

GLOSSARY OF COMMONLY USED ACRONYMS

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

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

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

SUR	Service Utilisation Report
TAS	Technical Advisory Service
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date