Meeting of the HB Clinical Council

Combining with Hawke's Bay Health Consumer Council

Date: **Wednesday, 6 December 2017**

Meeting: **2.30 pm to 5.30 pm**

Venue: **Lantern Room, Havelock North Function Centre, Te Mata Road, Havelock North**

Clinical Council Members:

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

Apology: Debs Higgins

In Attendance:

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

PUBLIC MEETING

MONTHLY MEETING		
Item		**Time (pm)**
	Section 1 – Routine	
1.	Welcome / Apologies	2.30
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Workplan	
6.	Topics of Interest - Member Issues / Updates	
	Section 2 – Discussion	
7.	Clinical Governance Committees' Structure John Gommans / Andy Phillips / Mark Peterson / Chris Mckenna	2.35
	Section 3 – Information	3.10
8.	Misdirected Results - John Gommans	
9.	Clinical Advisory & Governance Group – verbal report – Tae Richardson	
10.	Health HB - Clinical Governance Strategy 2017-18	-
COMBINED MEETING WITH HB HEALTH CONSUMER COUNCIL		
	Section 4 – Presentations / Discussion	
11.	Clinical Services Plan Update – Ken Foote	3.15
12.	The Big Listen – results & next steps – Kate Coley	3.30
	Section 5 – Workshop	
13.	Person & Whanau Centred Care – update & next steps - John Gommans and Rachel Ritchie	4.30
	Meeting closed	

Next Meeting:

Wednesday, 14 February 2018
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Interests Register

9 August 2017

Hawke's Bay Clinical Council

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	Nature of Interest **eg Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	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
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for	No	
Dr Kiri Bird (General Practitioner)	Te Timatanga Ararau Trust (Iron Maori)	Partner (Lee Grace) is a Trustee	Health and Wellbeing	Yes	Low - Contract with HBDHB
	Gascoigne Medical Raureka	General Practitioner	General Practice	Yes	Low
	Royal NZ College of General Practitioners	Member	Health and Wellbeing	No	
	Royal NZ College of General Practitioners	Lead Medical Educator in HB	Health and Wellbeing	No	
	Te Ora Board (Maori Doctors)	Member	Health and Wellbeing	No	
	Te Akoranga a Maui (Maori chapter for RNZCGP)	Member	Health and Wellbeing	No	
	Hawke's Bay Community Fitness Centre Trust	Trustee	Health and Wellbeing	Yes	Low - May potentially request funding from DHB
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chriopractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary			
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	

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**
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	HBDHB employee Mary Wills	Spouse	Employee	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Manager	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health		No	
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
	National Information Clinical Leadership Group	Member	Professional network	No	
Maurice King (Community Pharmacist)	Napier Balmoral Pharmacist	Shareholder and Director	Community Pharmacy	Yes	Has various contracts with HBDHB to provide pharmacy based services. Low. Ensure position declared when discussing issues in this area.
	Pharmacy Guild of NZ	Member	Representative and negotiating organisation for Pharmacy	Yes	Negotiations on behalf of Napier Phamacy with HBDHB. Low. Ensure position declared when discussing issues in this area.
	Phamaceutical Society of NZ	Member	Pharmacy advocacy, profressional standards and training.	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Independent Advisor	No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 8 NOVEMBER 2017 AT 3.00 PM

PUBLIC

Present:
Dr John Gommans (Chair)
Chris McKenna
Dr Mark Peterson
Dr Russell Wills (3.30 pm)
Dr Robin Whyman
Dr David Rodgers (3.05 pm)
Dr Nicholas Jones
Dr Tae Richardson
Debs Higgins
David Warrington (3.05 pm)
Maurice King
Jules Arthur
Anne McLeod (3.10 pm)
Lee-Ora Lusis

In Attendance:
Ken Foote, Company Secretary
Dr Kevin Snee, Chief Executive Officer (from 4.20 pm)
Tracy Fricker, Council Administrator and EA to Executive Director – People & Quality

Apologies:
Andy Phillips

SECTION 1: ROUTINE

1. APOLOGIES / WELCOME / MEETING RULES

John Gommans (Chair) welcomed everyone to the meeting.

Apologies were noted as above and from attendee member Kate Coley.

2. INTEREST REGISTER

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

SECTION 2: DECISION

3. SURGICAL SERVICES EXPANSION PROJECT – INCREASING SURGICAL CAPACITY (BUSINESS CASE AND PRESENTATION)

Sharon Mason, Executive Director - Provider Services gave a brief introduction on the project and reason for the detailed business case. The business case outlines the options on how Surgical Services can respond to the gap in surgical capacity in a way which can be built upon once the outcomes from the Clinical Services Plan work are known. The preferred option is to change the model of care, build internal capability and continue to outsource, with the majority of the gap being provided for through increasing internal capability with an eighth theatre, and increasing the wrap-around services that support theatre to enable them to cope with increasing volume of work.

A presentation was provided by Rika Hentschel, Service Director – Surgical Services, Dr John Rose - Surgical Director, Anna Harland - Perioperative Unit Manager and Ben Duffus - Improvement Advisor.

Key points included:

- Current production / limitations
- Predicting growth in surgical demand
- Surgical delivery in 2019/20
- Consultation process
- Implementation plan

The Chair thanked the project team for the presentation. It was noted that the business case is part of the solution, outsourcing will still occur and it does not address current unmet need.

General discussion took place including outcome measures for patients; location of the Day Surgery Unit within theatre; information systems, future proofing for theatres 9 and 10; extending the theatre week to 6 or 7 days, the patient journey and having an appropriate environment which has privacy if difficult conversations need to be had.

It was acknowledged that the hospital needs to work more closely with GPs on who is being referred for surgery and patients that can be managed more conservatively in the community. A whole of system approach is needed from time of referral through to discharge back into primary care.

The Clinical Council **noted** the report and **endorsed** recommendations 2 and 3.

SECTION 3: DISCUSSION

4. CLINICAL GOVERNANCE – COMMITTEES AND ADVISORY GROUPS

The Chair advised the Board have raised questions in regard to the new clinical committees' structure and have requested that Clinical Council reflect on the number of committees and advisory groups in terms of value and investment i.e. including staff, clinicians and consumers time to attend these meetings. There needs to be true cross-sector engagement in these committees, which has been a struggle in the past. The Board have requested a report in February.

The Company Secretary commented on the need to look at what it is going to take to make the structure effective, the support to be provided, how groups are co-ordinated, monitored, reports developed and flowed through to the appropriate level and actions monitored and measured. The administrative aspect also needs to be thought through as well as the payment for people who are not DHB employees and how consumer participation is recognised. It is important to have a committees' structure that is effective and adds value.

It was noted that the Consumer Council have looked at the structure and have members assigned to attend the committee meetings when they are in place. The Chair advised that Rachel Ritchie, Chair on the Consumer Council was at the Board meeting when this issue was discussed so is aware of the request from the Board and need to defer till review has occurred.

Action: ***A working group is to be convened to re-look at the committees' structure and draft a report for the Board.***

5. CLINICAL SERVICES PLANNING UPDATE

The Company Secretary advised that he is now the Project Lead for the Clinical Services Plan (CSP) until such time as a new Planning Manager is employed. There has been some confusion on what the CSP is and he requested Sapere Group to put together a definition. A one page document was distributed which outlines that the CSP will:

- Describe the current capability and capacity of services (baseline)
- Describe the challenges facing service provision now and in the future
- Develop high-level options that will help meet those challenges

In summary the CSP is a strategic framework for the things that we will need to address in the future and options on how to do this. There will be a lot of other things that need to be incorporated into our plans going forward e.g. big listen, people strategy, patient safety, social inclusion etc. These also need to be aligned with government policy and the regional services plan. Following this other plans will need to be developed for implementation, financials, facilities and workforce.

Themed workshops on the aging population; high needs and deprived populations; hospital and primary and community will be held during January and February. There will be workshops held on 6 and 7 March to look at the findings. At the end of March the draft plan will be available and feedback can be provided. The final draft CSP will go to the Board in April.

All information on the CSP once finalised and approved for release will be available on the "Our Health" website.

Members thanked the Company Secretary for the clear overview provided.

6. MATARIKI REGIONAL ECONOMIC DEVELOPMENT STRATEGY AND SOCIAL INCLUSION STRATEGY

An update was provided by Bill Murdoch, Senior Advisor - Economic Policy and Evaluation, Hastings District Council and Shari Tidswell, Intersectoral Development Manager on the two strategies developed and the actions to be delivered.

Key points include:

- Matariki Framework: partnership by co-design with outcomes and building on capability, equality and equity, optimising assets in a sustainable way and developing an enterprise mind set
- Regional Economic Development (RED) pillars and actions with HBDHB responsibilities (currently 45 actions, which are to be reviewed)
- Matariki Strategy / Social Inclusion: consultation messages (themes and actions); social inclusion (themes and actions); and outcome measures linked to health
- Where to from here:
    - Governance structure review current activity;
    - Endorsement by all agencies and local authorities and refresh of the REDs,
    - The two strategies to be integrated to one,
    - Outcomes framework to be developed for the Governance Group and CEOs Group for monitoring across the sector,
    - Development of a communication strategy to support engagement and delivery;
    - Engagement with Central Government to ensure alignment with new government priorities and;
    - Quarterly reporting to the Executive Management Team on progress of implementation

General discussion took place regarding small businesses wanting to grow and increase number of employees, land availability and affordable housing, increasing capacity of public transport, linking training with what will be jobs in the future, environmental health and working closely with social agencies.

The Clinical Council **noted** the contents of the report and supports the development of the strategy and actions to be delivered.

SECTION 4: MONITORING / REPORTING COMMITTEES

7. BEST START HEALTHY EATING & ACTIVITY PLAN – HEALTHY WEIGHT STRATEGY

The report was provided in the meeting papers for information only. The Chair asked whether members had questions.

A brief discussion took place regarding outcome goals for the future. Shari Tidwell, Intersectoral Development Manager advised that this has been difficult and they are currently looking at what they could use for this.

8. REGIONAL TOBACCO STRATEGY FOR HB: 2015–2020 UPDATE

The report was provided in the meeting papers for information only. The Chair welcomed Joanna Wilson, Acting Smokefree Programme Manager to the meeting and asked whether any members had questions.

A brief discussion took place regarding Nicotine Replacement Therapy (NRT), an issue was raised about lack of information packs for pharmacies. A referral card for pharmacies is being developed and three pharmacies have advised they wish to do the ABC training so they can provide the next level of support for NRT.

9. TE ARA WHAKAWAIORA - SMOKEFREE (NATIONAL INDICATOR)

The report was provided in the meeting papers for information only. No issues discussed.

10. HB CLINICAL RESEARCH COMMITTEE

A verbal update was provided by Dr John Gommans. There are no issues of concern to report. The DHB does not fund research, it provides advice for people looking to do research. The committee are working on a paper on how they set an agenda for research in Hawke's Bay focusing on key priority equity issues; oral health in children, compulsory treatment orders in mental health and breastfeeding.

Membership on the committee has changed and the Clinical Council need to endorse these changes. The new representatives are Justin Nguma representing Maori Health Service, Dr Ross Freebairn representing the University of Otago, and Sara Salman, Pharmacist representing the PHO.

The Clinical Council **endorsed** the new members of the HB Clinical Research Committee.

11. CLINICAL ADVISORY & GOVERNANCE COMMITTEE

A verbal update was provided by Dr Tae Richardson:

- Clinical Governance Strategy – the paper will be shared at the next Clinical Council meeting.
- Misdirected Results – ongoing area of high risk. There is a working group which met fortnightly which has been on hiatus. The plan when the group was established was to have a set of risk mitigations formed by the end of the year, which has not occurred.

General discussion held regarding misdirected results and problems being experienced. The Chair commented that the problems are understood and are not a simple fix with many parties involved. It is a whole of system problem. The groups involved in this work need to report back to Clinical Council and provide an update re: work progress and timelines.

Action: ***Report to be provided for the December meeting.***

SECTION 5: WORKSHOP

12.1 Clinical Council Terms of Reference

The current terms of reference (TOR) were included in the meeting papers. It was noted that changes can be made to these, if required with approval by the CEO who the Clinical Council report to.

General discussion took place regarding membership, including does consideration need to be given to whether Maori and rural health interests are strong enough, system level measures, clinical leadership and members' engagement with strategic activities.

12.2 Annual Work Plan for 2016/17 Review

The Chair noted that a work plan for 2017/18 had not been agreed to at the Annual General Meeting and actions from the 2016/17 work plan and previous meetings had not been started or completed.

General discussion took place regarding the work plan and papers going through to Clinical Council, having time on the agenda and items like member issues, actions and monitoring the work plan not being given enough importance. It was highlighted that Council was not holding itself to account and unless Council regularly reviewed and agreed its upcoming work plan, the Chairs had difficulty preparing the next meetings' agenda

The Company Secretary advised that part of the role of Clinical Council is to provide advice to the Board on clinical issues. There needs to be time at meetings to formulate a view so that the Chair can convey to the Board the members' collective view on a paper. A lot of the monitoring papers are included for information only and unless there are questions there do not have to be presenters for these papers.

The Chair summarised the discussion with the key points agreed being:

- The work plan should be up front as well as the minutes and matters arsing
- Look at other methods of supplying information that was not for discussion like sending out monitoring papers earlier so they can just be noted at the meeting unless members raised a concern with the Chairs
- Co-Chairs to discuss how meetings are run and look at reinstating the quarterly meetings where a strategic issue/topic can be discussed
- Members that have an issue to raise need to advise the Co-Chairs before the meeting so that appropriate time can be allocated on the agenda
- Members to advise Co-Chairs when actions assigned to them are completed.

SECTION 6: GENERAL

13. MINUTES OF PREVIOUS MEETING

The minutes of the Clinical Council meeting held on 11 October 2017, were confirmed as a correct record of the meeting.

A minor change was made to the minutes from what was included in the meeting papers to note members' interest in the first 1000 days of life which was beyond the scope of the Waioha presentation.

Moved and carried.

14. MATTERS ARISING / REVIEW ACTIONS

Item #1 Laboratory Guidelines
Andy Phillips to provide an update at the December meeting regarding finalisation of the guidelines.

Item #2 Clinical Advisory and Governance Group Report
Revised draft of the Clinical Governance Strategy to include feedback has been completed and will come to Clinical Council next month.

Item #3 Waioha Primary Birthing Unit Presentation
Copy of annual report sent via email. David Rodgers and Tae Richardson to meet with Jules Arthur to discuss 1,000 days of life. *Item can now be closed.*

Item #4 HB Radiology Services Committee
Letter of congratulations yet to be actioned. This will be completed before the next meeting.

Item #5 Laboratory Services Committee
Anne Speden to present IS Roadmap at a future meeting. Discussion to include misdirected results and governance of results. Date to be confirmed either December or February meeting.

15. CLINICAL COUNCIL WORK PLAN

A copy of the work plan was provided in the meeting papers. No issues discussed.

16. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- ***Mark Peterson*** – advised he is the Clinical Lead of Collaborative Pathways and is required to sign them off. To be able this sign-off, he requires authority from Clinical Council. This authority was **approved** by Clinical Council.

- ***Chris McKenna (on behalf of Andy Phillips)*** - there are many vacant audiology posts in DHBs across New Zealand. Following the resignation of the three HBDHB Audiologists there is much work being done to mitigate the clinical risks to children's hearing. A number of locums are providing service and there are urgent efforts being made to recruit to the vacant posts. Andy Phillips is leading on this issue nationally and is having conversations with the professional association, with education providers, Health Workforce NZ and National DAH colleagues to find solutions. Andy has been supported by Regional Directors of Workforce to attempt to recruit competent Paediatric Audiologists from the UK.

- ***Tae Richardson*** – with the new Minister the colleges have been putting out briefings. It may be good to discuss these to inform us about directions we want to head strategically.

- ***David Warrington*** – as Clinical Council members they get a ticket to the Health Awards, if unable to attend can the ticket be given to someone else who could not afford to attend? In past years this has been well received. David to discuss with Communications Manager.

- ***David Rodgers*** – what is happening with the budget prioritisation process? There was to be an update before the end of the year by Tim Evans, Executive Director – Corporate Services.

- ***Nick Jones*** – Public Health have been dealing with recent cases of listeria cases. During the previous listeria issue advice was sent out regarding dietary advice for immunosuppressed patients. One of the recent cases has advised they did not receive this information. It may be time to revisit this. ***Action: Reminder to be sent out to the SMO group to provide this information to immunosuppressed patients.***

17. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

18. Minutes of previous meeting (public excluded)
19. Matters Arising - Review Actions (public excluded)

The meeting closed at 5.42 pm.

Confirmed: _____
Chair

Date: _____

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 8 NOVEMBER 2017 AT 5.36 PM

PUBLIC EXCLUDED

Present:
Dr John Gommans (Chair)
Chris McKenna
Dr Mark Peterson
Dr Russell Wills (3.15 pm)
Dr Robin Whyman
Dr David Rodgers (3.05 pm)
Dr Nicholas Jones
Dr Tae Richardson
Debs Higgins
David Warrington (3.05 pm)
Maurice King
Jules Arthur
Anne McLeod (3.10 pm)
Lee-Ora Lusis

In Attendance:
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to Executive Director – People & Quality
Dr Kevin Snee, Chief Executive Officer (from 4.20 pm)

Apologies:
Andy Phillips

SECTION 9: GENERAL

18. MINUTES OF PREVIOUS MEETING

The minutes of the public excluded section of the Hawke's Bay Clinical Council meeting held on 11 October 2017, were confirmed as a correct record of the meeting.

Moved and carried.

19. MATTERS ARISING / REVIEW ACTIONS

There were no matters arising from the public excluded section of the previous meeting.

The meeting closed at 5.38 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	12/07/17	***Laboratory Guidelines*** Approved in principle at July meeting. Guidelines document to be tabled for information at Clinical Council when finalised.	A Phillips	Dec	
2	13/09/17	***Clinical Advisory and Governance Group Report*** Copy of framework document by Linda Dubbeldam to be provided to Clinical Council Members	T Richardson	Dec	Actioned Item #10 in meeting papers
3	11/10/17	***HB Radiology Services Committee*** Send congratulations to Radiology Service on good work re: meeting all targets.	Co-Chairs	Dec	Actioned
4	11/10/17	***Laboratory Services Committee*** Invitation for Anne Speden to present "IS Roadmap" – extend to include misdirected results and governance of results	Co-Chairs	Nov	
5	8/11/17	***Clinical Governance Committees Structure*** Sub-group to meet to discuss structure and prepare draft report for Board – due February 2018	Co-Chairs/ Company Secretary	Dec/Jan/ Feb	In progress
6	8/11/17	***Misdirected Results Group*** Report on progress of work	J Gommans	Dec	Actioned Item #8 in meeting papers
7	8/11/17	***Member Issues/Update*** Listeria – reminder to be sent to SMO Group re: patient information on dietary advice for immunosuppressed patients.	J Gommans	Dec	

HB CLINICAL COUNCIL WORKPLAN 2017-2018

Meeting Dates	Papers and Topics	Lead(s)
14 Feb 18	Quality Annual Plan 2017/18 – 6 month review	Kate Coley
	Quality Dashboard Quarterly (commences Feb 18, previously Nov 17)	Kate Coley
	Implementing the Consumer Engagement Strategy	Kate Coley
	People Strategy (final draft)	Kate Coley
	Policy on Consumer Stories	Kate Coley
	Clinical Services Plan (final draft)	Tracee TeHuia
	Collaborative Pathways Update (4 monthly)	Mark Peterson/ L White
	Annual Maori Plan Q2 Dashboard	Tracee TeHuia / Patrick
	Ngatahi Vulnerable Children's Workforce Development - progress report since August 2017	Russell Wills
	Monitoring	
	Te Ara Whakawaiora / Access 0-4 / 45-65 year (local indicator)	Mark Peterson
	Te Ara Whakawaiora - Culturally Competent Workforce (local indicator)	Kate Coley
	Building a Diverse Workforce and Engaging Effectively with Maori	Kate Coley
	Committee Reports	
	HB Laboratory Services Committee (4 monthly)	Andy Phillips / Lab Chair
	HB Radiology Services Committee (4 monthly)	Mark Peterson
14 Mar 18	Oncology Model of Care	Sharon Mason
	Establishing Health and Social Care Localities in HB (6 monthly)	Tracee TeHuia
	Consumer Experience Business Case	Kate Coley
	Acute Flow Update	Sharon Mason
	Monitoring	
	Te Ara Whakawaiora / Breastfeeding (national indicator)	Chris McKenna
	Committee Report	
	Falls Minimisation Committee Update (6 monthly)	Chris McKenna
11 Apr 18	Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations	Kate Coley
	Legislative Compliance (6 monthly)	Kate Coley / K Lafferty
	Monitoring	
	Te Ara Whakawaiora / Did not Attend (local indicator)	Sharon Mason / Carleine
	Committee Report	
	HB Nursing Midwifery Leadership Council Update incl. Dashboard	Chris McKenna
9 May 18 *(Quarterly Mtg)*	Best Start Healthy Eating & Activity Plan update	Tracee Te Huia
	Committee Reports	
	HB Clinical Research Committee Update	John Gommans
	Infection Prevention Control Committee	Chris McKenna

TOPICS OF INTEREST
MEMBER ISSUES / UPDATES

CLINICAL GOVERNANCE COMMITTEES' STRUCTURE

DISCUSSION

HAWKE'S BAY District Health Board Whakawāteatia	**Misdirected Results**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author:	Dr John Gommans, Chief Medical and Dental Officer - Hospital Dr John Gommans, Chief Medical and Dental Officer - Hospital
Reviewed by:	N/A
Month:	December, 2017
Consideration:	For Information

8

RECOMMENDATION

That the Clinical Council:

Note the contents of this report.

OVERVIEW

The specific issue of misdirected results of investigations and the wider issue of clinical governance of investigation results has been a concern across the sector for some time.

The attached report (appendix 1) from the misdirected results working group indicates that this is a whole of system problem with multiple factors involved and provides a report of progress to date.

A paper on wider the issue of clinical governance of investigation results will come to Council in the first part of 2018.

ROOT CAUSE ANALYSIS REPORT

Appendix 1

ORGANIZATION	
AGENCY	Hawke's Bay District Health Board
DOCUMENT CREATOR	Valerie Shirley, Improvement Advisor
DEPARTMENT/SERVICE	People and Quality Directorate
INITIAL COMPLAINT RECEIVED FROM	Julia Ebbett, General Manager, Hauora Heretaunga
DATE OF EVENT: Initially reported to writer in February 2016	DATE RCA COMPLETED: ongoing

EVENT DETAILS	
EVENT DESCRIPTION	LIST RCA TEAM MEMBERS
Describe the event and include any harm that resulted. Also identify the cause, if known. *This is not a "typical" RCA event. The complaint received centered around misdirected patient results, including Radiology and Lab results and, to a lesser extent, discharge summaries. General Practices were receiving multiple misdirected results with no clear cause.* *Initially, Valerie was provided results from General Practices (GPs) in order to see if trends could be spotted and solutions discovered. This quickly proved beyond the scope of Valerie's role, in part, due to the high volume of misdirected results received.* *Valerie attempted to set up a "Misdirected Results Team group", but, while this group had several meetings, traction was not able to be made due to several factors (discussed below).* *Kate Coley then became involved as an Executive Level sponsor along with Linda Dubbeldam from the PHO. Meetings have been held generally every fortnight with some cancellations.* *Progress-to-date includes identification of several issues with five main headings (this list may not be inclusive and these are explored further below):* • *IT/IS* • *Communication/Lack of Shared Ownership* • *Human Process Error* • *Patient Health Literacy* • *Policy/Procedure/Forms*	Kate Coley, Exec Director of People and Quality Valerie Shirley, Improvement Advisor Tamsin Renwick, Head of Information, Systems and Innovation Michele McCarthy, PHO – Health and Social Care IT Liaison Linda Dubbeldam, PHO - Manager Innovation and Development Jacqui Mabin, Admin Manager Shelli Turner, Lab Manager Angela Fuller, Radiology Manager Riki Davis, Medical Records (ad hoc) Jane Bailey, Patient Safety Advisor (ad hoc) Kerri Te Whaiti, IT/IS (ad hoc) TEAM LEADER: Valerie Shirley EXEC Leader: Kate Coley

BACKGROUND SUMMARY	
Answer these questions with a brief summary. Attach supporting documents, if available.	
Describe the event, and include any harm that resulted. Also identify the cause, if known.	*Description:* ***PLEASE NOTE: THIS IS A BACKGROUND SUMMARY OF EVENTS DATING FROM FEBRUARY 2016 when this writer was informed of the situation*** ***Event –*** *As noted above, this root cause analysis (RCA) did not stem from one particular event and varies from a "typical" RCA in that multiple events (in the thousands) are present and have led to the identification of multiple and interrelated causes. The "events" can be described as the wrong doctor or wrong practice receiving lab and radiology results which were intended for another doctor and/or another practice. The team has been calling these "misdirected results" and this will be the language used in this document.* ***Harm –*** *For most of these misdirected results, there is little to no harm to the patient. Reasons for this will be explained below. In a select few instances, there is potential for harm as a significant result might have been misdirected to an incorrect provider and was not re-directed to the proper provider for review which might have resulted in delay of treatment.* ***Identified Causes –*** *The Improvement Advisor spent many months "digging" into the potential causes of the misdirected results. She worked with lab and radiology staff, IT/IS, and the PHO to discern what might be the causes of the misdirections. Discovered causes are listed as follows (this list may not be inclusive):* • Issues where patients have changed doctors within the same practice (regardless of how that change occurred) which then notifies the Age/Sex Register (managed by the PHO). This is a cumbersome process and one which currently takes a lot of time. The ASR might be months out of date, and ECA is reliant upon this information being correct; • Issues where GPs have left one practice and started at another practice and the General Practices (at either end) have not informed the PHO and/or DHB of the change. The PHO manages the GP Register, and this is issued once per month, but might still have an effect on results being sent to the incorrect GP and/or practice. • The "Audrey Robin" problem where a copy of a radiology report is sent to a provider who did not order the report and is no longer at the practice receiving the copy of the report (often, the patient is not known to the practice either). This was identified as an issue with the Radiology Information System (RIS); • Human process errors – When patients present at ED or at an outpatient clinic, receptionists are responsible for providing the patient with the demographics form, asking them to change their

	details, and then updating ECA. Often, the details were not updated quickly enough (especially if the GP had changed), which resulted in results (and discharge summaries) being directed to the incorrect GP. • Unclear policies, procedures, and forms – There was no demographics collection policy or procedure so staff were not aware of why the demographics need to be updated as quickly as possible which resulted in GPs receiving misdirected results. Because there was no policy/procedure for demographics collection, there was no auditing and monitoring of the demographics collection. A lack of system training has also been identified. Forms are being reviewed, and changes have been made to the radiology form including bringing the data input on the form in-line with how it's entered into the RIS system (and how it will be entered in to Clinical Portal) and identifying the need for the doctor AND the practice to be listed on the form. The lab form is next on the list to be reviewed. • Patient labels – Information is printed on the patient labels affixed to the patient wristband and lab/radiology orders. If the GP is not correct in ECA, the information will not be correct on the label leading to errors and misdirected results. There are also questions regarding the information on the labels – is it the information staff need to do their jobs effectively? Is there too much information on the labels? Are patient labels printed at the right point in the process? Unclear roles and responsibilities were also identified here – whose job is it to print the labels and when? • Patient health literacy and the General Practice obligation to inform patients when their GP has left or changed – it's quite possible that a patient might not have presented to his/her GP office for a year or more and then finds it necessary to come into the ED. In this time, the patient's GP may have changed (for example, if a GP has left the practice), and the patient may not be aware of the change. Thus, the patient cannot change the information on the demographics form which will continue the misdirection of results to the incorrect GP. • General Practice would benefit from training around what happens to results and how they're returned. For example, when a result is returned to the correct provider inbox from the DHB but ends up in the General/Nurse inbox on the practice end, this is likely a practice MedTech/MyPractice issue and not a DHB issue. • General Practices have started assigning their patients to a practice on the ASR rather than a provider. This means that results are sent to a general practice inbox rather than a specific provider. • Lack of shared ownership of the problems and lack of communication around solutions.

Was there any deviation from the expected sequence?	X YES ☐ NO	*If YES, explain the deviation.* *Lab and Radiology results were sent to and/or received by the incorrect GP and/or office.*

Was the expected sequence described in policy, procedure, written guidelines, or included in staff training?	X YES ☐ NO ☐UNKNOWN	*If YES, explain the source.* *The lab and radiology have policies on how to log lab and radiology orders appropriately.*

Does the expected sequence meet regulatory requirements and/or practice standards?	X YES ☐ NO ☐UNKNOWN	*If YES, define references and/or literature reviewed by the team.* *Current policies and procedures meeting regulatory standards but may still be confusing or not "best practice".*

Was there a human action or inaction that contributed to the events?	X YES ☐ NO ☐UNKNOWN	*If YES, explain how the actions contributed.* *Yes – but not in every case. The main human error processes involved reception staff not collecting demographic details from patients at every point of contact – which led to GPs being out-of-date in ECA. It was also discovered that receptionists and clinical staff in outpatient clinics and ED were using out-of-date labels (so to not waste printing new labels). This also contributed to the incorrect GP receiving results.*

Was there a defect, malfunction, misuse of, or absence of equipment that contributed to these events?	☐ YES X NO ☐UNKNOWN	*If YES, describe the equipment and how it appeared to contribute.* *IT/IS discussed below as not really "defect", "malfunction", "misuse" or "absence"*

Did the procedure/activity involved in the events being carried out take place in the usual location?	X YES ☐ NO ☐UNKNOWN	*If NO, explain where and why a different location was utilized.* *Location not really a factor.*

Was the procedure/activity carried out by regular staff familiar with the consumer and activity?	X YES ☐ NO ☐UNKNOWN	*If NO, describe who carried out the activity and why regular staff were not involved.* *Usual staff were involved most of the time. It's certainly quite possible that casual staff may have been involved some of the time, but this would not have been statistically significant in the findings.*

Did the involved staff have the correct credentials and skills to carry out the tasks expected of them?	X YES ☐ NO ☐UNKNOWN	*If NO, explain the perceived inadequacy.*

Was the staff trained to carry out their expected responsibilities?	X YES ☐ NO ☐UNKNOWN	*If NO, explain the perceived inadequacy.* *Staff were trained, but human process errors were uncovered (see above). Staff then received further training in the areas of demographics collection and the need to always print new labels.*

Were the staffing levels considered adequate at the time of the incidents?	☐ YES ☐ NO X UNKNOWN	*If NO, explain why.* *Staffing levels are outside the scope of this report.*

Were there any additional staffing factors identified as responsible for or contributing to the events?	☐ YES ☐ NO X UNKNOWN	*If YES, explain those factors.* *Staffing factors (other than training needs) are outside the scope of this report.*

Was there any inaccurate or ambiguous information that contributed to or caused the events?	X YES ☐ NO ☐UNKNOWN	*If YES, explain what information and how it contributed.* *Many lab and radiology orders were unclear about which GP AND practice were to receive results (GPs often work at more than one practice and often locum).* *Forms are also not aligned with the way data is entered into the Radiology Information System (RIS) and the Laboratory Information System (LIS); the radiology form has been re-done (as noted above).*

Was there any lack of communication or incomplete communication that contributed to or caused the events?	X YES ☐ NO ☐UNKNOWN	*If YES, explain who, what, and how it contributed.* *Communication was identified as a concern at many levels.* *Communication includes the following (this list may not be inclusive):* • *from the practice to the PHO and DHB;* • *from the practice to the PHO and back;* • *from the PHO to the DHB and back;* • *between departments within the DHB;* • *from the practice to the patient and back;* • *from the patient to the DHB and back;* • *electronic "communication" such as updates to ECA from the ASR*

Were there any environmental factors that contributed to or caused the events?	☐ YES X NO ☐UNKNOWN	*If YES, explain what factors and how they contributed.* *No environmental factors were identified.*

Were there any organizational or leadership factors contributing to or causing the events?	X YES ☐ NO ☐UNKNOWN	*If YES, explain what factors and how they contributed.* *The role of the Improvement Advisor is a role without "authority" or leadership function to be able to effectively direct change. This impacted the timeliness of this issue being addressed and solutions/results being implemented. It was necessary to bring in Executive Level leadership in order to see actual change and movement.*

Were there any assessment or planning factors that contributed to or caused the events?	X YES ☐ NO ☐UNKNOWN	*If YES, explain the factors and how they contributed.* *See above regarding the role of the Improvement Advisor. A work group was developed and meetings were planned and conducted by the Improvement Advisor, but due to the nature of the role, change was not implemented until the involvement of Executive Level staff. This contributed to delays in solution and planning efforts.* *Timeliness of assessment was also affected by the sheer number of misdirected results being received by the Improvement Advisor. The improvement advisor reviewed nearly every misdirected result received (thousands) to discern what root cause "category" the misdirected result fit into and whether immediate action was necessary or had already been taken by the practice.*

Were there any other factors that are considered relevant to the events?	☐ YES ☐ NO ☐UNKNOWN	*Describe:*

Rank in order the factors considered responsible for the events, beginning with the proximate cause, followed by the most important to less important contributory factors. Attach the Contributory Factors Diagram, if available.
We have not ranked these factors, but have attached a Contributory Factors Diagram (Fishbone).

Was there a root cause identified?	X YES ☐ NO ☐UNKNOWN	*If YES, explain the root cause.* *Multiple root causes defined- see above.*

RISK-REDUCTION ACTIONS TAKEN	
List the actions that have already been taken to reduce the risk of a future occurrence. Note the date of implementation.	
DATE	**EXPLAIN ACTION TAKEN**
February – October 2016	Improvement Advisor conducted a deep dive into why results are being misdirected. Improvement Advisor met with lab and radiology staff along with IT staff to discuss possible causes, gather data, understand the extent of the problem, and begin to look for improvement strategies
November 2016	Improvement Advisor begins the "Right Patient, Right Clinician, Right Result" group with the intent of gathering staff from IT/IS, lab, radiology, patient safety/compliance, and the PHO around the table to discuss the issues and strategize solutions. The group meets twice and staff gain from education about how each group works and limitations, but no traction is realized (see Incidental Findings: Role of the Improvement Advisor)
April 2017	Executive Leadership from DHB and PHO accessed in order to gain traction with moving work forward
June 2017	IT/IS fixed the "Audrey Robin" hierarchy problem in RIS where RIS would look for any possible GP to send a "Copy To"
June 2017	Communications regarding the Misdirected Results group and its findings have been put out regularly on the PHO Provider Portal, discussed at Practice Managers' meetings, and communication is ongoing with Julia Ebbett
July 2017	Improvement Advisor provides updated Current State documents for Lab, Radiology, and Demographics (see attached). Improvement Advisor also provided a high-level workplan to the group (see attached)
June/July 2017	A demographics policy and procedure were introduced by the Admin Manager. Training was provided to all reception/admin/booking staff regarding collection of demographics at all points of contact with patients – including booking appointments. The "demographics confirmed" box was added in ECA so that patient demographics could be marked as "Confirmed" in the system with a time/date stamp. Roles and responsibilities continue to be discussed.
June/July 2017	A decision was made to use the ASR to update ECA so that the most recent information from the ASR would be in ECA (this was done knowing that some information from the ASR might be incorrect and, thus, ECA would be incorrect for those particular patients). The benefits of doing this outweighed the risks
August 2017	Meeting held with IT to discuss electronic process for General Practices to inform PHO/DHB of when providers enter and exit the practice (including locums). These meetings are ongoing and the electronic process is still under development
September 2017	Meeting held to discuss patient labels. At this meeting, we reviewed the information on the labels, how the labels are used by the lab and radiology, and what information is important to be on the labels (for the lab and radiology). Also discussed was the process of when labels are printed and by whom. All of this continues to be discussed.
October 2017	Auditing of reception and booking staff for collection of demographic information (with a 98% target)
Ongoing	Improvement Advisor still continues to receive misdirected results and reviews them. Improvement Advisor also continues to coordinate the Misdirected Results group meetings
Ongoing	PHO and DHB staff meet monthly to discuss register changes and process changes to that systems can be updated effectively

PREVENTION STRATEGIES		
List the recommended actions planned to prevent a future occurrence of the adverse event. Begin with a rank of 1 (highest). Provide an estimated cost (if known) and any additional considerations/recommendations for implementing the strategy.		
STRATEGY	**ESTIMATED COST**	**SPECIAL CONSIDERATIONS**
More timely updating of the ASR (weekly has been discussed and should be possible with the National Enrollment Service going online)		
Patient Health Literacy – ensuring patients know who their GP is and when their GP has left the practice and/or they've been assigned a new GP		
More timely updating of the GP Register (although an electronic process would potentially "solve" this)		
A thorough review of the patient labels to ensure the "right" information is needed for the lab and radiology		
Training for General Practice on the flow of data from PHO to DHB to the practice and what happens to the data on the General Practice end (e.g. what the DHB can "control" and what we can't)		
Training for DHB and PHO staff in order to better understand each other's roles and how this affects the flow of information and results		
Review of service request forms being sent to lab and radiology from General Practice		
Continued auditing of demographics collection		
Shared ownership (DHB, PHO, General Practice) and continued meetings and communication strategies		

INCIDENTAL FINDINGS
List and explain any incidental findings that should be carefully reviewed for follow-up action.
The findings regarding information on patient labels were unexpected by the Improvement Advisor. These will be reviewed carefully to ensure that the "right", most appropriate information appears on patient labels in order for the lab and radiology processes to run more smoothly. *A separate incidental finding involves the role of the Improvement Advisor which would benefit from a review to incorporate empowerment to lead and manage change.*

APPROVAL
After review of this summary report, all team members should notify the team leader of either their approval or recommendations for revision. Following all revisions, the report should be signed by the team leader prior to submission.

SIGNATURE OF TEAM LEADER:	DATE SIGNED:

All information included in this report is considered confidential. It is intended only to promote safety and reduce risk.

Forward completed report to all Root Cause Analysis team members in addition to the following individuals:

FULL NAME	TITLE/ORGANIZATION	EMAIL ADDRESS

Agenda
Health Hawke's Bay Clinical Advisory and Governance Committee

Date:	5 December 2017	**Time:**	5.30 – 7.30pm
Venue:	Tukituki Meeting Room, Second Floor, GJ Gardner Building		
Present:	Chris McKenna (Chair), Bayden Barber, Julia Ebbett, Maurice King, Mark Peterson, Andrew Phillips, Tae Richardson, Catrina Riley		
In Attendance:	HHB: Linda Dubbeldam, Manager Innovation & Development; Sara Salman, Clinical Advisory Pharmacist; Stephanie Maggin (minutes)		
Guests:	Trish Freer, Health Programmes Manager; Michele McCarthy, Health and Social Care IT Liaison, HHB; Val Guay, Improvement Advisory | People & Quality, HBDHB		

	Paper	Action	Lead
1. Administration			
1.1 Apologies	Verbal	Acknowledge	Chair
1.2 Interest Register	Paper	Noting	Chair
1.3 Draft Minutes 7 November 2017	Paper	Confirm	Chair
1.4 Action Items	Paper	Noting	Chair
1.5 Committee Work Plan	Paper	Acknowledge	Linda Dubbeldam
1.6 Items approved since last meeting	Verbal	Verbal	Chair
2. Strategic Discussion (one hour)			
Primary Mental Health – Model of Care	Paper	Approval	Trish Freer
3. Items for Discussion			
3.1 Misdirected Patient Information	Paper	Acknowledge	Michele McCarthy
3.2 BPAC^{NZ} report	Paper	Acknowledge	Sara Salman
4. Other Items for Information			
4.1 Health Literacy – project update/evaluation	Paper	Acknowledge	Linda Dubbeldam
4.2 Clinical Services Plan update	Paper	Acknowledge	Linda Dubbeldam
4.3 Integrated Primary Care Workforce Strategy Update	Verbal	Acknowledge	Linda Dubbeldam
4.4 Collaborative Pathways Updates	Paper	Acknowledge	Michele McCarthy
4.5 Foundation Standards/Cornerstone Update	Paper	Acknowledge	Victoria Speers
Any other business			
Next Meeting	13 February 2018	5.30pm	

Clinical Governance Strategy 2017-2018

November 2017

Our vision

HEALTHY
HAWKE'S BAY
TE HAUORA O
TE MATAU-Ā-MĀUI

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

Our values

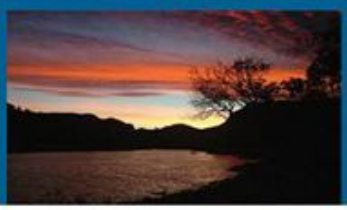
Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

He kauanuanu – showing respect for each other, our staff, patients and consumers

Ākina – continuously improving everything we do




HAWKE'S BAY District Health Board Whakawateatia

HEALTH HAWKE'S BAY Te Oranga Hawke's Bay

Ngati Kahungunu Iwi INCORPORATED

Executive Summary

Obligations inferred on Primary Health Organisations (PHO) with respect to clinical leadership, engagement and governance as outlined in the PHO Services Agreement, include the demonstration of arrangements to ensure clinical leadership and engagement, and an established clinical governance framework are in place.

To achieve this PHOs must:

a) Ensure that currently practising clinicians are involved in key decision making
b) Engage with, and have the support of, clinicians from a wide range of disciplines who deliver services; and
c) Have a documented clinical governance framework that sets out how clinical service delivery will be managed within the PHO and with Contracted Providers and Practitioners.

CAG, a subcommittee of HHB Board, exists to support the Board in its responsibility for clinical advice (leadership) and governance. As per the Committee Framework and Terms of Reference, CAG is specifically responsible for the provision of:

- Advice on clinical matters
- Local clinical governance for HHB
- Clinical input, advice and expertise to all HHB activities
- Advice on clinical quality systems and processes
- HHB membership of Clinical Council
- Clinical leadership to Hawke's Bay Health Sector through the Board of HHB.

'Working in Partnership for Quality Healthcare in Hawke's Bay: A quality improvement and safety framework' (December, 2013) an initiative of the Hawke's Bay Clinical Council, sets out a high level account of integrated quality improvement and performance across the HB health sector. The framework is explicitly aligned to the Health Quality and Safety Commission (HQSC) Triple Aim for quality improvement.

The HQSC has developed a framework for building quality and safety capability in the New Zealand health system, and in doing so has recently published three key documents to support clinical governance. These are:

- Governing for Quality (February, 2016)
- From knowledge to action: A framework for building quality and safety capability in the NZ health system (October, 2016)
- Clinical Governance (February, 2017)

It is therefore timely for CAG to confirm its role in setting and driving the quality improvement and safety culture of HHB on behalf of the HHB Board. The Commission indicates that a strategy to implement, embed and support clinical governance at all levels of HHB endeavour is required.

Introduction

Equity in Health:

The WHO definition of Equity in Health is applied in this Strategy:

(i) the absence of systematic or potentially remediable differences in health status, access to healthcare and health-enhancing environments, and treatment in one or more aspects of health across populations or population groups defined socially, economically, demographically or geographically within and across countries.

(ii) a measure of the degree to which health policies are able to distribute well-being fairly

WHO Health Systems Strengthening Glossary.

Retrieved from http://www.who.int/healthsystems/hss_glossary/en/index4.html

Statements of Intent

Clinical Governance at HHB is a reference to an organisation-wide approach to the continuous quality improvement of clinical services provided by HHB[1] and its subcontracted providers.

This will involve the systematic alignment of all patient safety and quality improvement activities underway and planned for, and requires clinicians to be engaged in the operational, management and governance structures of HHB.

There is an emphasis on shared responsibility and accountability for the culture of engagement in patient safety and continuous quality improvement.

Healthy Hawke's Bay: Te Hauora o Te Matau-ā-Māui

Excellent health services working in partnership to improve the health and well-being of our people and to reduce health inequities in our community

- **Population Health**: to improve the health and well-being of our people
- **Improving Health Outcomes**: for Maori, Pacific People and those impacted by social and economic factors, addressing inequalities through the continued development of strategies
- **Sustainability for our People**: ensuring quality health services through business excellence and collaboration with funders, providers and the community

Health Hawke's Bay Clinical Governance Framework

The Framework describes CAGs approach to the delegations assigned to it by HHB Board and an additional commitment to clinical governance. It will also guide and direct the operationalisation of the HHB patient safety and quality improvement agenda.

Clinical Governance Skills Matrix

The matrix indicates the knowledge, skills and competencies required at all levels of HHB to effect robust clinical governance including driving and supporting a culture of improvement and safety.

[1] Inclusive of Kia Ora (Stanford) and Whanau Wellness Recognition Programme

Clinical Governance Stocktake

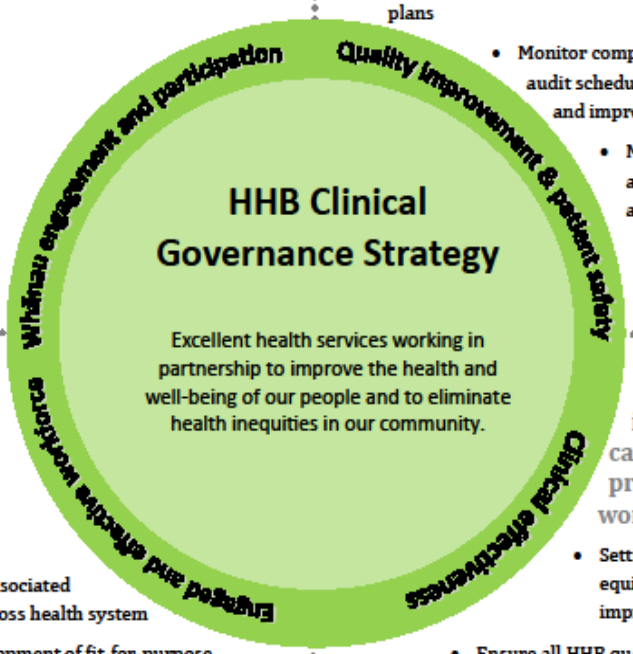
An annual clinical governance stocktake will identify areas of strength and development enabling governance and operational priorities to be determined and improvement targets to be set. The review will be against the activities located within the Framework and the clinical governance capacity and capability as outlined by the Clinical Governance Skills Matrix. The results of the stocktake are to be reported by CAG to the HHB Board.

Enabling whānau as members of the health team

- Monitor the measurement of and response to whānau experience
- Monitor the analysis of the National Primary Care Patient Experience Survey
- Ensure that primary health care is made easier to understand (Health Literacy)
- Drive whānau-centred practice
- Drive open disclosure
- Monitor feedback—complaints and compliments

Application of informed best practice to achieve optimum processes and outcomes of care

- Application of evidence informed best practice through Best Practice books and bulletins
- Monitor variation, mitigation of unwarranted variation
- Provide advice and insight over the development of multi-disciplinary models of care
- Monitor health outcomes associated with HHB and primary care services
- Monitor implementation of action/improvement plans
- Monitor completion of the clinical audit schedule, including findings and improvement plans
- Monitor Health Target and SLM performance and related outcomes



Focussed on partnership and mutual respect

- Drive best use of available clinical workforce and associated support roles across health system
- Pursue the development of fit-for-purpose clinical workforce
- Drive and monitor competence against the HHB Clinical Governance Skills Matrix
- Monitor the communication of the HHB equity, quality and improvement agenda
- Oversee the sharing and learning from failures and successes
- Ensure the HHB staff and contracted providers are appropriately licenced and credentialed to provide clinical care and leadership

Increasing improvement capabilities of the primary care workforce

- Setting and monitoring the equity, quality and improvement culture
- Ensure all HHB quality improvement initiatives are aligned
- Guide and support clinical risk management activities across HHB
- Provide advice and leadership regarding the implementation of clinical and operational risk systems
- Monitor the mitigation of identified clinical risks
- Provide advice and leadership related to the development of annual HB Quality Account
- Oversee primary clinical compliance processes

Health Hawke's Bay Clinical Governance Skills Matrix

Robust clinical governance requires knowledge, skills and competencies at all levels of Health Hawke's Bay (HHB) to effect robust clinical governance including driving and supporting a culture of equity, improvement, and safety.

Equity is a cross-cutting dimension of quality and quality improvement Equity means quality care is available to all and that the quality of care provided does not differ by ethnicity, socio-economic status or any other personal characteristics unrelated to a patient's reason for seeking care. Quality may mean different things to different people	**Governance Responsibilities** To lead HHBs commitment to improving quality and safety by setting HHBs strategic direction and goals. To do so requires the elimination of inequity. Responsibility for the governance of compassionate, whānau centred, quality clinical care sits with HHB Board and subcommittees. HHB has a responsibility for setting and monitoring equity and other quality improvement targets.	**Senior Leadership Responsibilities** Embody HHB values to enable the provision of equitable whanau centred care. Ensure that HHB can adapt to the constantly changing and challenging health care environment. Ensure effective clinical governance structures are in place. Communicate clear expectations in support of a learning culture. Build the capacity and capability of HHB staff to understand and address health equity.	**HHB Team Member Responsibilities** Facilitate and lead change Champion quality and safety internally and externally to general practice and the wider primary care sector to improve the quality and safety of care. Champion and advocate for change. Apply quality improvement methodologies and evidence-informed decision making practices. Build their knowledge about health literacy and understand their role in the elimination of inequity.
	Governance Competence requires the following knowledge and actions:	**Senior Leader Competence** requires the following knowledge and actions:	**Team Member Competence** requires the following knowledge and actions:
Partnerships with Whānau *Emphasis on empowerment to achieve their desired outcomes*	- The core values associated with whānau centred care, health literacy and cultural safety - Engagement and partnership as a key strategy for improving health outcomes	- The core values associated with whānau centred care, health literacy and cultural safety. - Engagement and partnership as a key strategy for improving health outcomes - The need for services to be organised around the needs of individuals and whānau.	- The core values associated with whānau centred care, health literacy and cultural safety - Engagement and partnership as a key strategy for improving health outcomes - Design and deliver services around the needs of individuals and whānau.
Quality and Safety Culture *Modelling a culture where equity, quality and safety are top proprieties, communicating with mutual respect and trust*	- Equity as a cross-cutting component of quality - Link between a culture of equity, improvement and improved patient outcomes	- Equity as a cross-cutting component of quality - Require and lead a culture of equity, improvement and safety to improve patient outcomes - Measure and monitor equity, improvement and safety across all HHB programmes and services. - Enact values of openness and transparency	- Equity as a cross-cutting component of quality - Live a culture of equity, improvement and safety to improved patient outcomes - The value of being open and transparent in health care and the implications for quality and safety - Reporting patient safety incidents and/or adverse events and near misses

		in health care - Provide a reliable near miss, incident or adverse event reporting system - Understand the difference between system failures and deliberate unsafe acts	- Understand the difference between system failures and deliberate unsafe acts
Leadership for improvement and change *Doing what is right and setting an example for others to follow, knowing and using the principles of change leadership*	- Current theory and practice for leadership theory and change leadership and governance - Organisational theory and management in health care including strategic planning	- The use of equity parameters to measure and monitor progress toward achieving health equity - Application of current theory, practice and tools for change leadership - Implement and sustain equitable improvement consistent with the HHB strategic plan and goals - Advance learning and development across HHB	- Understand and use improvement and change leadership tools - Measure and monitor the impact of planned improvement and change on equity - Be alert for opportunities to sustain and spread equity
Systems Thinking *Appreciating the system as dynamic and adaptive, with an awareness of the parts and their relationships to each other*	- Equity as a cross-cutting dimension of quality and quality improvement - NZ Triple Aim - The health care system as complex and adaptive and the impact of the system as a barrier and enabler to equity, improvement and quality - The function of national, regional and local health organisations	- Equity as a cross-cutting dimension of quality and quality improvement - NZ Triple Aim - The health care system as complex and adaptive and the impact of the system as a barrier and enabler to equity, improvement and quality - The health care system as complex and adaptive - Equity, improvement, quality and safety as integral system properties	- Equity as a cross-cutting dimension of quality and quality improvement - NZ Triple Aim - Build relationships and partnerships across the HB health system in pursuit of equity, improvement, quality and safety - Understand the role and potential contribution of HHB within the health system
Teamwork and Communication *Working across professional, organisational and cultural boundaries to achieve quality and safety goals*	- Communicating effectively to solve problems - Engaging in active listening	- Communicating effectively to solve problems - Engaging in active listening - How team building contributes to team functioning - How to give and receive constructive feedback - Conflict management and resolution	- Communicating effectively to solve problems - Engaging in active listening - How team building contributes to team functioning - How to give and receive constructive feedback - Conflict management and resolution
Improvement and Innovation *Using evidence to drive improvement and innovation*	- What improves equity for Māori is used to drive the development of HHB strategy - The principles of evidence-informed practice methods and tools	- What improves equity for Māori is used to inform the development of HHB policy and services, and is monitored for effectiveness in	- Equity analysis applied to all programmes and services prior to implementation and at regular intervals during services delivery - Evidence-informed practice methods and

	- Role of qualitative and quantitative data to improve system performance - Reliability, validity and limitations of measurements - Data analysis, interpretation and presentation to inform decision making - The importance of whānau narrative and feedback	- Evidence-informed practice methods and tools - Role of qualitative and quantitative data to improve system performance - Types of data, sampling methodologies, data collection and management - The reliability, validity and limitations of measurements - Data analysis, interpretation and presentation to inform decision making and how to communicate results - Requirement for a broad range of indicators to understand system performance and reliability - The importance of whānau narrative and feedback	tools - Role of qualitative and quantitative data to improve system performance - Types of data, sampling methodologies, data collection and management - The reliability, validity and limitations of measurements - Basic data analysis, interpretation and presentation to inform decision making and how to communicate results - Requirement for a broad range of indicators to understand system performance and reliability - The importance of whānau narrative and feedback
Quality Improvement and Patient Safety Knowledge and Skills *Using appropriate tools, methods and techniques*	- The current context of health care quality - Clinical and operational risk management systems - The importance of a patient safety reporting system - Harm, waste, variation and inequity as key drivers of poor quality care - Systems approach to learning from failures, including adverse event management and open communication	- The use of health equity and quality improvement tools that support the delivery of high-quality health care that is responsive to the needs and aspirations of Māori - Improvement science and patient safety methodologies and tools - Provide robust clinical and operational risk management systems - Harm, waste, variation and inequity as key drivers of poor quality care - Ensure systems approach to learning from failures, including adverse event management and open communication	- The application of health equity and quality improvement tools that support the delivery of high-quality health care that is responsive to the needs and aspirations of Māori - Report and manage clinical and operational risk - Understand role of harm, waste and variation as drivers of poor quality care - Apply a systems approach to learning from failures, including adverse event management and open communication

Issue Date: November 2017	Review Date:	Every 2 years
Approved: Wayne Woolrich	Date:	Date:
General Manager	Sign:	Sign:

CLINICAL SERVICES PLAN

Update

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THE BIG LISTEN

Presentation
(Results and Next Steps)

HAWKE'S BAY District Health Board Whakawāteatia	**Person & Whānau Centred Care**
	For the attention of: **Clinical and Consumer Councils**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Kate Coley, John Gommans and Rachel Ritchie
Month as at	December, 2017
Consideration:	For Discussion / Decision

BACKGROUND

Council Annual Plans

For some time now, both Clinical and Consumer Councils have had clear objectives around developing a 'Person Whanau Centred Care' approach and culture.

These are included within current plans as follows:

Consumer Council

- Within the context of the Purpose of:
  - "Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality"

- Specific objective:
  - "Facilitate and promote the development of a 'Person and Whānau Centred care' approach and culture to the delivery of health services, in partnership with the Clinical Council'."

Clinical Council

- Within the context of the Purpose of:
  - "Work in partnership with the HB Health Consumer Council to ensure that Hawke's Bay health services are organised around the needs of people".

- Specific objective:
  - "Work in partnership with Consumer Council to develop an appropriate 'Person & Whanau Centred Care' approach and culture".

What is Person & Whanau Centred Care?

There is no one specific definition for Person and Whānau Centred Care (elsewhere called Patient and Family Centred Care). All definitions have common themes however. A number of useful (and relevant) website reference are attached. It is recommended that these websites be accessed and scanned for a more in depth understanding of the concepts, principles, values, tools etc that exist to support such an approach.

The attachments include:

- Institute for Patient & Family Centred Care — www.ipfec.org
- Hearts in Healthcare — www.heartsinhealthcare.com
- NZ Health Quality and Safety Commission — www.hqsc.govt.nz
- The Kings Fund — www.kingsfund.org.uk

- The Point of Care Foundation www.pointofcarefoundation.org.uk
- South Central Foundation (NUKA) www.southcentralfoundation.com

Given the closer relationship being developed between HBDHB and South Central Foundation, also attached is article from Katherine Gottliel CEO, that explains the 'NUKA Model of Care' in more detail.

PREVIOUS DISCUSSIONS

'Person and Whānau Centred Care' as an approach was first discussed jointly by Clinical and Consumer Councils in early 2015. Notes from a combined sub-group of members from the two Councils are attached.

Later in 2015 (September) Consumer Council devoted some time discussing this, within the context of "Partners in Care." Copies of the introductory paper and the resultant Vision and Plan are also attached.

Last year, as Chair of the Consumer Council, Graeme Norton was asked to submit an article on his thoughts on this issue. A copy of this article is attached.

Whilst the terms for 'Person & Whānau Centred Care' or 'Patient Centeredness' are relatively new, strategies for meeting the general needs and expectations of consumer / patients are not. In early 2000 for example,a wide ranging survey of patients was undertaken, which identified what they wanted (expected) from those providing them with health care. The answers from this were reflected into a very simple "Draft Patient Charter", which unfortunately never got formally discussed nor adopted. A copy of this draft is also attached.

In summary, it would appear that discussions/actions on 'Person and Whānau Centred Care' as a total approach have stalled over the past couple of years, whilst the DHB has focussed on other areas within Transform and Sustain. Whilst this may be true for the "total concept", there has however been significant progress on many of the components/strands of such an approach, such as:

- quality improvement
- consumer engagement
- relationship centred practice
- system integration – health and social care localities
- clinical pathways
- health literacy
- clinical training developments

But is this enough?

CURRENT HBDHB ENVIRONMENT

It would appear that the current environment now provides a real opportunity to make significant progress on this 'total approach', to embed the system and cultural changes required. HBDHB is currently involved in:

- The Big Listen — Development of People Strategy with Culture at its core
- Clinical Services Plan — Identify alternatives to meeting the current and future challenges of increasing demand and consumer expectations within resource constraints.
- Transform and Sustain — Focus on organisation, service and professional integration including Health & Social Care Localities
- Enhancing relationships and mutual respect between communities / consumers / organisations / health providers / clinicians
- Commitments to co-design, clinical leadership and consumer engagement
- Development of closer strategic relationship with South Central Foundation (NUKA)

Each of these will need to be developed based on values, principles and strategies inherent in the 'Person & Whānau Centred Care' approach, to be effective. So the time appears right to promote a much more comprehensive and integrated focus on this approach, to ensure it becomes an underlying 'holistic' strategy in everything we do.

SO WHAT CAN CLINICAL AND CONSUMER COUNCIL DO?

With the mandate held by the two Councils, we are ideally placed to:

- Provide direction and advice
- Require/request/facilitate action
- Lead and advocate on implementation (where appropriate)
- Monitor and measure success
- Hold organisations and individuals to account.

The 'power' of the combined Clinical and Consumer Council voice is significant and should not be underestimated.

HOW DO WE DO THIS

Given a review and consideration of the contents of this paper and attachments, the presentations on 'Clinical Services Planning and Big Listen (to be provided earlier in the meeting), and the skills, experience and passion for this topic from members, it is proposed to Workshop and develop answers to the following questions. From this, the Chairs/Co Chairs will jointly prepare an appropriate report to HBDHB & HHB CEOs and the HBDHB Board. Depending on responses, further planning, workshops and discussions may follow:

Questions / Issues:

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

HAWKE'S BAY HEALTH CONSUMER COUNCIL
ANNUAL PLAN 2016/17

Purpose	Provide a strong viable voice for the community and consumers on health service planning and delivery	Advise and encourage best practice and innovation in the areas of patient safety, consumer experience and clinical quality	Promote and support the enhancement of consumer engagement
FUNCTIONS	• Identify and advise on and promote, a 'Partners in care' approach to the implementation of 'Person and Whānau Centred Care' into the Hawkes Bay health system, including input into: - Development of health service priorities - Strategic direction - The reduction of inequities • Participate, review and advise on reports, developments and initiatives relating to health service planning and delivery. • Seek to ensure that services are organised around the needs of all consumers	• Identify and advise on issues that will improve clinical quality, patient safety and health literacy. • Seek to enhance consumer experience and service integration across the sector. • Promote equity of access/treatment • Seek to ensure that services are responsive to individual and collective consumer needs.	• Facilitate and support the development of an appropriate Consumer Engagement Strategy for the Hawkes bay health system • Ensure, coordinate and enable appropriate consumer engagement within the health system - across Hawke's Bay - within the Central region - at National level • Receive, consider and disseminate information from and to HBDHB, Health Hawke's Bay, Consumer groups and communities. • Ensure regular communication and networking with the community and relevant consumer groups. • Link with special interest groups as required for specific issues and problems solving.
STRATEGIES	• Proactively raise and promote issues of importance and/or concern to consumers generally, for consideration and/or resolution by relevant organisations within the health system. • Engage early with project and planning teams, and standing committees, to ensure the consumer perspective is included in all outcomes and recommendations. • Review and comment on all relevant reports, papers, initiatives to the Board.	• Work with Clinical Council to develop and maintain an environment that promotes and improves: - Putting patients / consumers at the centre - Patient safety - Consumer experience - Clinical quality - Health literacy - Equity • Promote initiatives that empower communities and consumers to take more responsibility for their own health and wellness.	• Raise the profile and community awareness of Consumer Council and the opportunities / options for enhanced consumer engagement in decision making. • Ensure good attendance and robust discussions at monthly Consumer Council meetings • Co-ordinate consumer representation on appropriate committees and project teams: - Within Hawke's Bay - At Central Region and National levels

	• Ensure robust complaint/feedback systems are in place and that consumers are well informed and easily able to access these • Consumer Council members to be allocated portfolio/areas of responsibility.	• Promote a clinical culture which actively engages with patients / consumers at all levels, as 'partners in care'. • Advocate / promote for Intersectoral action on key determinants of health.	• Engage with HQSC programmes around consumer engagement and 'partners in care'. • Maintain current database and regular communications with all Hawke's Bay health consumer groups/organisations. • Provide regular updates on both the HBDHB and Health Hawke's Bay websites • Ensure Consumer Council members continue to be well connected and engaged with relevant consumer groups and communities
OBJECTIVES 2016/17	• Actively promote and participate in' co-design processes for: - Youth - Mental Health - Older Persons • Participate in the development of Health and Social Care Networks • Provide consumer perspective into Customer focussed Booking	• Promote and assist initiatives that will improve the level of health literacy within the sector and community. • Facilitate and promote the development of a 'person and whānau centred care" approach and culture to the delivery of health services, in partnership with the Clinical Council. • Promote the provision of consumer feedback and 'consumer stories'. • Monitor all 'Patient Experience' performance measures/indicators as co-sponsor of the 'patient experience Committee' within the clinical governance structure. • Facilitate a focus on disability issues	• Facilitate and support the development and implementation of a consumer engagement strategy and principles in Hawkes Bay • Establish a connection with Youth within the community • Influence the establishment and then participate in regional and national Consumer Advisory Networks.

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

FUNCTIONS	Provide Clinical advice and assurance to the Hawke's Bay health system senior management and governance structures	Work in partnership with the Hawke's Bay Health Consmer Council to ensure that Hawke's Bay health services are organised around the needs of people.	Provide oversight of clinical quality and patient safety	Provide clinical leadership to Hawke's Bay health system workforce
ROLES	Provide advice and/or assurance on: • Clinical implications of proposed services changes. • Prioritisation of health resources. • Measures that will address health inequities. • Integration of health care provision across the sector. • The effective and efficient clinical use of resources.	• Develop and promote a "Person and Whanau Centred Care" approach to health care delivery. • Facilitate service integrations across / within the sector. • Ensure systems support the effective transition of consumers between/within services. • Promote and facilitate effective consumer engagement and patient feedback at all levels. • Ensure consumers are readily able to access and navigate through the health system.	• Focus strongly on reducing preventable errors or harm. • Monitor effectiveness of current practice. • Ensure effective clinical risk management processes are in place and systems are developed that minimise risk • Provide information, analysis and advice to clinical, management and consumer groups as appropriate. • Ensure everyone in the HB health sector are aware of their responsibility for quality improvement and patient safety.	• Communicate and engage with clinicians and other stakeholders within HB Health Sector, providing clinical leadership when/where appropriate. • Oversee clinical education, training and research. • Ensure clinical accountability is in place at all levels.
STRATEGIES	• Review and comment on all reports, papers, initiatives prior to completion and submission to the Board. • Proactively develop, promote and recommend changes to improve health outcomes, patient experience and value from health resources. • Develop, promote and advise on strategies and actions that could assist with the reduction in health inequities. • Develop and promote initiatives and communications that will enhance clinical integration of services. • Provide input through representation on EMT, Alliance Leadership Team and through attendance at HB Health Sector Leadership Forum.	• Work collaboratively with the Consumer Council to design and implement a Person and Whanau Centred Care approach. • Understand what consumers need. • Understand what constitutes effective consumer engagement. • Promote clinical workforce education and training and role model desired culture. • Promote and implement effective health literacy practice. • Promote the development and implementation of appropriate systems and shared clinical records to facilitate a 'smooth patient experience' through the health system.	• Develop and maintain relevant and effective Clinical Indicator reporting and performance management processes. • Establish and maintain effective clinical governance structures and reporting processes. • Ensure safety and quality risks are proactively identified and managed through effective systems, delegation of accountabilities and properly trained and credentialed staff. • Ensure the "quality and safety" message and culture is spread and applied in all areas of HB health sector. • Promote "value-based decision-making" at all levels. This involves improving the processes by which decisions are made, so they take into consideration all three Triple Aim objectives: o Enhanced patient experience o Improved health outcomes o Better value for money • Ensure attendance at appropriate meetings/forums to provide appropriate assurance and confidence.	• Ensure all HB clinicians and other stakeholders are aware of the role, membership and activities of the Clinical Council. • Oversee the development, maintenance and implementation of a HB Clinical Workforce Sustainability Plan. • Promote clinical governance at all levels within the HB health system. • Ensure appropriate attendance/input into National/Regional/ Local meetings/events to reflect HB clinical perspective. • Promote ongoing clinical professional development including leadership and "business" training for clinical leaders. • Facilitate co-ordination of clinical education, training and research. • Role model and promote clinical accountability at all levels.
OBJECTIVES 2016/17	• Prioritise meeting time to focus on papers with significant clinical issues. • Encourage proactive presentations / discussions on innovative issues / ideas. • Ensure risk management processes provide for early Clinical Council visibility (and input) of all significant clinical issues. • Align portfolio areas of responsibility to clinical governance structure memberships (once confirmed).	• Work in partnership with Consumer Council to develop an appropriate "Person & Whanau Centred Care" approach and culture. • Monitor "Quality Dashboard" and support performance improvement initiatives as appropriate. • Promote and support ongoing enhancements to information systems relating to clinical process and consumer records. • Support a review of the "Primary Health Care" model of care. • Support and champion the development of a health literacy framework, policies, procedures, practices and action plan.	• Implement and progressively develop the proposed new Clinical Governance Committee / Advisory Group structures. • Monitor and report on the implementation of the action plan for "Governing for Quality. • Oversee and monitor the achievement of objectives within the QIPS Annual Plan.	• Enhance the profile and perceived value of Clinical Council within the sector, through improved effective two way communications. • Facilitate the development of a HB Clinical Workforce Sustainability Plan • Promote Strategies to enable the HB Clinical Workforce to adapt to meet the challenges of the future. • Support and promote the ongoing implementation of clinical leadership training and developments.

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

Transforming health care through partnerships

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Patient- and Family-Centered Care

*Patient- and family-centered care is working **"with"** patients and families, rather than just doing **"to"** or **"for"** them.*

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Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care by placing an emphasis on collaborating with people of all ages, at all levels of care, and in all health care settings. In patient- and family-centered care, patients and families define their "family" and determine how they will participate in care and decision-making. A key goal is to promote the health and well-being of individuals and families and to maintain their control.

This perspective is based on the recognition that patients and families are essential allies for quality and safety—not only in direct care interactions, but also in quality improvement, safety initiatives, education of health professionals, research, facility design, and policy development.

Patient- and family-centered care leads to better health outcomes, improved patient and family experience of care, better clinician and staff satisfaction, and wiser allocation of resources.

Core Concepts of Patient- and Family-Centered Care

- **Dignity and Respect.** Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.

Adapted from: Johnson, B. H. & Abraham, M. R. (2012). *Partnering with Patients, Residents, and Families: A Resource for Leaders of Hospitals, Ambulatory Care Settings, and Long-Term Care Communities.* Bethesda, MD: Institute for Patient- and Family-Centered Care.

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"Healthcare's focus on physical disease and bio-medicine is unbalanced. We need to pay much more attention to emotional, psychological and spiritual wellbeing and the huge importance of healing relationships."

DR ROBIN YOUNGSON "Time to Care"

{ together we can re-learn a new way of being }

This site is a hub where you can find articles, inspiration, resources and revolutions, all designed to help you be part of this movement for change, motivating others to join in and supporting each other as together we work towards our goal.

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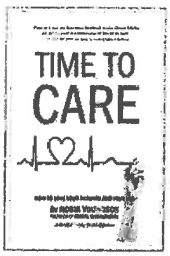
RESOURCES

Time to Care

by Robin Youngson founder of Hearts in Healthcare



"The book that launched a movement"

If you only read one book about healthcare in your lifetime, whether you are a patient or a professional, let this be the book.

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Partners in Care

The King's Fund patient- and family-centred care toolkit

30 Jun 2014 | Partners in Care

The King's Fund has released a patient and family-centred Care (PFCC) toolkit for health care professionals, to understand what a care experience is like, what needs to change, and which small improvements can make a big difference to patients, families and health care workers. The toolkit is a simple, step-by-step method for recording and understanding patient and family experiences.

The toolkit includes:

- a step-by-step guide to using the toolkit
- an overview of PFCC
- patient stories
- driver diagrams
- model for Improvement
- and more.

View the toolkit on The King's Fund website by clicking the link below.

Related links

Patient- and family-centred care toolkit (http://www.kingsfund.org.uk/projects/pfcc/?utm_source=charityemail&utm_medium=email&utm_campaign=june-2014&pubid=healthfoundation&description=june-2014&dm_i=4Y2,2KRV8,9DBSO9,9EPTA,1)

Last updated 23/11/2017

The King's Fund

Patient and Family-Centred Care toolkit

The Patient and Family-Centred Care (PFCC) toolkit (https://www.pointofcarefoundation.org.uk/resource/patient-family-centred-care-toolkit/) is now available from The Point of Care Foundation.

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What is PFCC and why is it needed?

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There is a high degree of commitment among organisations to improve patients' experience, but it can be difficult to know where to start. Patient and Family-Centred Care (PFCC) is a method of improving health care quality that changes the perspective of staff delivering care, and helps them reconnect with their values and motivation for working in health care.

What is it?

PFCC is a simple, low-technology health care quality improvement approach designed to tackle two parallel aspects of health care: processes of care and staff–patient interactions. Together, these have a profound effect on how patients and staff experience health care.

PFCC helps tackle issues in:

- the organisation of care (care 'transactions' – how care is delivered)
- 'relational' aspects of care (the human interactions that take place between patients and families, and their professional carers).

Examples of the sorts of improvements that teams have achieved include improvements in assessment processes for patients, the management of pain, and communication with patients.

The approach achieves this by focusing the attention of staff on the lived experience of care for patients and their families. Using this approach puts staff closely in touch with what it is like to be a patient, and helps build empathy into the service.

PFCC has been used to:

- improve all dimensions of quality, including clinical effectiveness
- improve patients' and families' experience of care in hospital
- support staff to provide the sort of care they would like for themselves and their families
- improve staff experience of delivering care in hospital
- build capacity to deliver patient-centred care.

The method was pioneered by Tony DiGioia at the Innovation Center at the University of Pittsburgh Medical Center (UPMC). This toolkit draws on the experience of the Patient and Family-Centred Care programme, which was run in partnership by The King's Fund and the Health Foundation. Many of the resources come from the Innovation Center at UPMC and we gratefully acknowledge their generosity in making them available.

Why is PFCC needed?

There has never been a greater focus on patients' experience as a key component of quality, nor greater acknowledgement of the value to staff of delivering excellent care. The response to the Francis Inquiry highlighted the importance of the patient experience, and the Department of Health Operating Framework 2012/13 restated the spirit of the NHS Constitution, with a key theme of 'putting patients at the centre of decision-making'. There is much to be proud of within our health care system. But we are still a long way from reliably providing an excellent patient experience.

Health care staff work in highly pressurised environments, carrying out work that is often complex, intense and emotionally challenging. Evidence shows that this has an impact on staff wellbeing, which in turn affects their ability to care for patients with compassion (see PFCC further reading).

What is different about this approach?

PFCC tackles the challenge of providing high-quality patient-centred care in a new way. Rather than blaming staff when things go wrong, it seeks to understand where care systems and processes prevent them from providing the kind of care they would wish for themselves or their families. This understanding helps staff to see where improvements are possible, and enables them to reconnect with their motivation for working in health care, promoting a new workforce culture.

When it comes to health services, improvement initiatives tend to focus either on clinical processes or on patient experience. But both are essential for high-quality health care. PFCC focuses both on processes of care (transactions) and on relational aspects of care, producing benefits for patients and staff alike. It is compatible with other service improvement initiatives, such as those in place to improve access, safety or the efficiency of care.

The approach is enacted by a multidisciplinary team, rather than individuals acting alone. It cuts across boundaries to look at care experiences from the patient's – rather than the organisation's – point of view. It also forges links between the board and frontline staff, developing commitment at executive and clinical levels.

Importantly, PFCC acknowledges the link between positive patient experience and positive staff experience – you cannot have one without the other (see PFCC further reading).

PFCC has been successful because it combines leadership support, a framework for improvement, a clear focus on a care experience, clear aims and measures, a multidisciplinary team and a focus on care seen through patients' eyes.

The clarity and simplicity of the PFCC method, with its structure and milestones, have given boards that have used it confidence that investment in the programme will yield demonstrable benefits and organisational learning that can be built on and diffused across the organisation.

What does it involve?

The resources required for PFCC consist principally of staff time to participate in the guiding council and working groups, and hands-on work on improvement projects to bring about the changes. How much time, and from which staff, will very much depend on the breadth of the care experience you work on, how much you involve frontline staff in improvement projects and how intensively you plan to deliver your goals. Widely inclusive teams build greater commitment and spread the load.

> *"The structured approach to reporting the benefits to be achieved and the focus on measurement meant that the board had a clear view of the programme delivery at key milestones in the programme.*

Lynne Wigens, PFCC Executive Sponsor, Ipswich Hospital Trust

Benefits of PFCC

Patients benefit by:

- feeling confident that the care that they receive will be of consistently high quality
- feeling that their care has been designed in a way that acknowledges its place within their broader lives.

Staff benefit by:

- becoming more engaged in their work
- developing an understanding of the current experiences from patients' point of view
- developing the skills and confidence to improve the care experience
- gaining experience in trialling practical improvements, measuring impact and spreading change
- having more time to provide individualised care, thanks to smoother and more standardised processes where appropriate.

Organisations benefit by:

- making a reality of policy commitments to improve patient-centred care
- understanding what drives patients' experiences of their services

- improving patients' experiences of care (depending on the goals chosen, PFCC may be used to improve safety, clinical effectiveness, patient-centredness, timeliness and efficiency)
- improving staff engagement, resilience and focus on patients' experience
- building capacity, so that lessons can be sustained and shared across the organisation
- building their reputation for high-quality, compassionate care.

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PFCC: Patient and Family-Centred Care toolkit

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Introduction

- More about this toolkit >
- What is PFCC and why is it needed? >
- How to use this toolkit >
- Gaining support >
- Top tips for success >

Step-by-step guide

- Step 1: Select a care experience >
- Step 2: Establish a guiding council >
- Step 3: Evaluate the current situation and develop a sense of urgency >
- Step 4: Develop working groups to carry out the improvement work >
- Step 5: Develop a shared vision for the ideal patient experience >
- Step 6: Identify individual projects and improvement teams >

Tools

- Patient and Family-Centred Care tools overview >
- Process mapping >
- Patient shadowing >

Patient stories >

Driver diagrams >

Measuring improvement >

Model for improvement >

Snorkelling >

Case studies

Case study 1: Improving the experience of children with asthma >

Case study 2: Improving the care of children with acute abdominal pain >

Case study 3: The Conversation Project >

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The Nuka System of Care: improving health through ownership and relationships

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Abstract

Go to:

Southcentral Foundation's Nuka System of Care, based in Anchorage, Alaska, is a result of a customer-driven overhaul of what was previously a bureaucratic system centrally controlled by the Indian Health Service. Alaska Native people are in control as the "customer-owners" of this health care system. The vision and mission focus on physical, mental, emotional, and spiritual wellness and working together as a Native Community. Coupled with operational principles based on relationships, core concepts and key points, this framework has fostered an environment for creativity, innovation and continuous quality improvement. Alaska Native people have received national and international recognition for their work and have set high standards for performance excellence, community engagement, and overall impact on population health. In this article, the health care transformation led by Alaska Native people is described and the benefits and results of customer ownership and the relationship-based Nuka System of Care are discussed.

Keywords: Alaska Native, wellness, self-determination, relationships, outreach, public health, quality improvement

Southcentral Foundation is a non-profit health care organization serving more than 60,000 Alaska Native and American Indian people in Southcentral Alaska. It was established in 1982 under the tribal authority of Cook Inlet Region Inc. (CIRI), one of the Alaska Native regional corporations created by Congress in 1971 under the terms of the Alaska Native Claims Settlement Act. CIRI established Southcentral Foundation to improve the health and social conditions of Alaska Native people, enhance culture and empower individuals and families to take charge of their lives. Southcentral Foundation's "Nuka System of Care" is a term that describes the entire health care system created, managed and owned by Alaska Native people to achieve physical, mental, emotional and spiritual wellness. It is inclusive of all parts of the organization – including behavioral, dental, medical and traditional services – and all the systems, processes and departments supporting the service delivery.

History

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Over the last 3 decades, Southcentral Foundation's workforce has grown from fewer than 25 to more than 1,500 employees and the operating budget from $3 million to $210 million. This growth can be attributed in large part to a change in ownership of the Alaska Native health care system – from government control to "customer ownership."

For 50 years, Alaska Native people in Southcentral Alaska received their health care as "beneficiaries" of the Indian Health Service's Native hospital. Employees were not able to be creative or innovative because it was a large, bureaucratic system centrally controlled from Washington, DC, 5,000 miles away. Patients waited weeks to get an appointment or accessed the system through the emergency room, and saw different providers each time. There was a disconnect between care for the mind and care for the body. Departments and programs acted independently. Patients were not happy and employees were not happy. Health statistics were bleak. Many patients left the Alaska Native system altogether to find better care (1). Then, in response to Alaska Native and American Indian people advocating for a voice in program planning and service delivery, Congress passed a federal law in favor of self-determination (2,3). This legislation opened the door for tribes to choose ownership over the entities delivering the services. The Alaska Native leadership of Southcentral Foundation also saw this as an opportunity for innovation – to completely redesign the tribal health care system in Southcentral Alaska based on Alaska Native values and needs. The administration and Southcentral Foundation partnered to survey the Native Community and find out what was desired.

By 1999, Alaska Native people were no longer "beneficiaries" of a government-run system, but, rather, chose to become self-determined "customers" and also "owners" of their tribally managed health care. This meant that Alaska Native people were no longer mere recipients of services, but, rather, in control of decision-making and administration. Along with this new customer-owner status came responsibilities to make informed choices on priorities for the health care system and to work to sustain it for future generations; what followed was a customer-driven overhaul of health care delivery, philosophy and values. As a result, Southcentral Foundation has today what is known as its Nuka System of Care. It addresses the challenges that health care systems around the world face – how to improve health care outcomes and customer satisfaction without skyrocketing costs.

Shared vision and mission

Go to:

Southcentral Foundation's vision is "A Native Community that enjoys physical, mental, emotional and spiritual wellness." The organization is committed to doing more than just providing treatment and health education. Southcentral Foundation's barometer for success is whether the population served is able to truly experience multidimensional wellness, and if improvements in wellness are experienced from one generation to the next.

The mission statement emphasizes getting there by working with (not doing "to" or "for") the Native Community. The aim is a Native Community that is renowned for being healthy. Southcentral Foundation measures its progress through a robust data collection effort, benchmarking with other high-performing health care organizations around the country and tracking health disparity data at the local, state and national levels.

Southcentral Foundation is intentional in the way it communicates its mission and vision to the community, workforce and customer-owners. The vision and mission provide guidance and consistency; there is a clear message and path to follow. All corporate, division, work unit, and individual goals and objectives flow out of the vision and mission's 3 "key points": shared responsibility, commitment to quality and family wellness. This framework, established by the Alaska Native board of directors, keeps Southcentral Foundation's performance evaluation and improvement efforts focused on achievement of the vision and mission. The governing board, which is composed entirely of customer-owners, sets the direction and the president/CEO creates an environment that ensures the entire workforce can both stay the course and measure progress along the way. As a result, Southcentral Foundation's data analysis and tracking ties directly back into fulfillment of the vision and mission, and achievements are shared with stakeholders in a meaningful way. For example, under the corporate goal of "shared responsibility" there are 3 corporate objectives – one of which is "achieve excellence in customer-owner satisfaction." Knowing that appointment access is a key driver of customer-owner satisfaction, departments created work plans and measurement targets around improving the availability of appointments. The data collection approach included tracking average appointment availability at 8:00 am daily, the "third next available appointment" less than 5 days out, as well as the medians and other subreports. These operational measures are available on a centralized

"data mall" and are segmented to the appropriate level to support improvement of day-to-day work processes.

Vision Statement

A Native Community that enjoys physical, mental, emotional and spiritual wellness.

Mission Statement

Working together with the Native Community to achieve wellness through health and related services.

Key Points

Shared Responsibility

We value working together with the individual, the family, and the community. We strive to honor the dignity of every individual. We see the journey to wellness being traveled in shared responsibility and partnership with those for whom we provide services.

Commitment to Quality

We strive to provide the best services for the Native Community. We employ fully qualified staff in all positions and we commit ourselves to recruiting and training Native staff to meet this need. We structure our organization to optimize the skills and contributions of our staff.

Family Wellness

We value the family as the heart of the Native Community. We work to promote wellness that goes beyond absence of illness and prevention of disease. We encourage physical, mental, social, spiritual & economic wellness in the individual, the family, the community and the world in which we live.

Service delivery

Go to:

To achieve its vision, Southcentral Foundation provides a wide range of behavioral, dental, medical and community services. These services include primary care, both in outpatient and home settings; dentistry; outpatient behavioral health; residential behavioral health; traditional healing; complementary medicine; health education and more. In addition, Southcentral Foundation has administrative programs that support direct service delivery, including human resources, information technology, compliance, grants, public relations, finance, facilities and quality assurance.

In general, Southcentral Foundation's services are provided "prepaid," based on legislative agreements and funding requirements, to members of 227 federally recognized Alaska Native tribes who live in Anchorage, the Matanuska-Susitna Valley and 55 rural Anchorage Service Unit villages. This 108,000-square-mile service area stretches about 2,000 miles from west to east, in a state that is nearly 3 times the size of Texas.

As significant numbers of Alaska Native people continue to migrate out of Alaska's rural areas to the urban centers (4), most customer-owners live in or near Anchorage, home of the Alaska Native Medical Center's 150-bed hospital and the Anchorage Native Primary Care Center, and other Southcentral Foundation owned and co-owned facilities and services. Care delivery mechanisms include ambulatory office visits, home visits, email and telephone visits, health information and education via classes and mixed media, inpatient hospital services, day and residential treatment, as well as consultation with and referral to higher levels of care. Southcentral Foundation also jointly owns and manages the Anchorage-based Alaska Native Medical Center with the Alaska Native Tribal Health Consortium (ANTHC). When advanced and complex care is required, Southcentral Foundation engages a seamless continuum of care by working in partnership with the tertiary and specialty Medical Services Division of ANTHC.

Southcentral Foundation also has experience in distance delivery of health care. Southcentral Foundation's clinical teams regularly travel to villages off the road system – accessible only by air or boat – to deliver family medicine, behavioral health, dental and optometry services. Where village clinics are in place, Southcentral Foundation clinicians also make use of electronic communication, including state-of-the-art telemedicine technology, to consult on assessment and treatment. In some cases, appropriate treatment requires Southcentral Foundation to bring customer-owners from the rural communities to Anchorage.

Relationships

Go to:

Southcentral Foundation's Nuka System of Care is based on what customer-owners really want – a primary focus on building and maintaining relationships.

Research findings have shown that relationship-based partnerships, over time, have the power to influence health outcomes (5–10). In the Nuka System of Care, one of the chief responsibilities of each provider is to work with customer-owners to establish trusting, accountable and long-term relationships. Relationships provide a better understanding of the context in which a customer lives. As a result, providers are in a better position to understand symptoms, answer questions, have meaningful conversations about risks and benefits, and work with each customer to make better health decisions. These basic principles are consistently put into practice by Southcentral Foundation's medical, behavioral, dental and traditional service providers.

However, the focus is not only on building relationships between providers and customer-owners. Southcentral Foundation's operational principles, which spell out "R-E-L-A-T-I-O-N-S-H-I-P-S," influence everything from the strategic planning process to employee hiring practices, facility design, job progressions, information support, quality improvement, financing structures, work flow across boundaries and more.

Strong and effective relationships are necessary across the organization to accomplish goals, objectives and work plans. Building a culture of trust, based on relationships, encourages shared decision-making and supports innovation and creativity.

The organization's executive leaders role model relationship-building behaviors for the rest of the workforce, including sharing personal stories, inviting inquiry and questions, admitting mistakes and celebrating successes. A 3-day mandatory Core Concepts training, led by the president/CEO, helps employees understand how their relational styles impact others, how their experiences affect how they approach and build relationships, and how to articulate and respond to story in everyday work and life.

Southcentral Foundation also depends on relationships with national, regional and local partners. The focus is more on collaboration than competition. As a result, service gaps are identified and new collaborations emerge each year.

Over a decade of performance measurement data has shown that the relationship-based Nuka System of Care has effectively broken down barriers – including barriers of space, attitude, language and time – that previously stood in the way of better health and wellness.

Operational Principles

Relationships between the customer-owner, the family, and provider must be fostered and supported

Emphasis on wellness of the whole person, family, and community including physical, mental, emotional, and spiritual wellness

Locations that are convenient for the customer-owner and create minimal stops for the customer-owner

Access is optimized and waiting times are limited

Together with the customer-owner as an active partner

Intentional whole system design to maximize coordination and minimize duplication

Outcome and process measures to continuously evaluate and improve

Not complicated but simple and easy to use

Services are financially sustainable and viable

Hub of the system is the family

Interests of the customer-owner drive the system to determine what we do and how we do it

Population-based systems and services

Services and systems build on the strengths of Alaska Native cultures

Core Concepts

Work together in relationship to learn and grow

Encourage understanding

Listen with an open mind

Laugh and enjoy humor throughout the day

Notice the dignity and value of ourselves and others

Engage others with compassion

Share our stories and our hearts

Strive to honor and respect ourselves and others

Customer ownership

Go to:

The shift to customer ownership, including the involvement of Alaska Native people in the design, implementation and control of their own programs, has produced dramatic changes in the delivery of health care services, in Alaska Native people's sense of self-efficacy, and ultimately, in health outcomes.

With customer-owners originating from more than 200 tribes in Alaska alone, Southcentral Foundation works in partnership with many different cultural groups. To ensure the organization is capturing feedback from this diverse customer base, it offers a range of options for customer-owners to be heard and responded to – some examples include personal interaction with staff, comment cards, special events, surveys, a 24-h telephone hotline and online form, focus groups and advisory committees.

Southcentral Foundation's board of directors and advisory boards are comprised solely of Alaska Native customer-owners, representing a number of different tribes. Customer-owners have also established careers at Southcentral Foundation in an increasing number of both clinical and non-clinical roles. The majority of the workforce is, in fact, Alaska Native and American Indian, including the long-time president/chief executive officer, 2 vice presidents, and over 60% of the organization's managers. Internship programs, succession planning and other workforce development initiatives are continuously grooming the next generation to take over paraprofessional, professional and leadership roles within the organization.

Alaska Native and American Indian employees also have an active role as members of Southcentral Foundation's 4 functional committees – process improvement, quality improvement, quality assurance and operations. The committees were created to be responsive to customer-owner feedback and move improvement initiatives and work plans forward without having to take ideas to the executive leadership team. The relationship-based operational principles are used to measure the alignment of any specific improvement idea. Any idea from an employee or customer-owner using the system can be put forward, and, if there is good alignment with the principles, an effort will be made to support testing that idea.

Before the Nuka System of Care, far too many Alaska Native people believed that they had no control or opportunity for input. This belief was conditioned over many decades of well-intended government-run health care that promoted the message "we will take care of you." To reverse this took a concentrated effort and empowerment on many different levels. While the system is not perfect, there have been measurable improvements. For example, a recent yearlong survey asking customer-owners about their experiences in Southcentral Foundation's clinics showed that 98.5% of the respondents agreed with the following statement: "I was given the chance to provide input into decisions about my health care." Another example – lower scores in the "Wait time to be seen by my provider" survey question initiated improvement efforts to make same-day access a priority.

The Nuka System of Care is a departure from "beneficiaries" or "patients" serving as mere recipients of tests, diagnoses, and pills. Instead, customer-owners actively share responsibility for the success of the health care system and for their family's health and wellness.

Results

Go to:

The keys to Southcentral Foundation's improvement journey and resulting success can be distilled down to: (a) customer ownership and (b) relationships. Health care leaders from around the world attend Southcentral Foundation's annual Nuka System of Care Conference to learn more about these approaches, including how they lead to the implementation of best practices such as organization-wide "advanced access," utilization of data and measurement, integrated care teams and integration of behavioral health and traditional healing into primary care.

The relationship-based, customer-owned Nuka System of Care has helped Southcentral Foundation outperform many known health care systems. It works because Southcentral Foundation redesigned the entire health care system based on the wants and wishes of its customer-owners, and, in doing so, empowered those receiving the services to share responsibility.

The results include the following:

- Prior to 1996, there was no direct primary care access. In 1996, only 35% of the local Alaska Native population had a designated primary care provider. Of those, 43% did not know who that provider was. Now, more than 95% are empanelled to an integrated primary care team. Providers know their customers' names, as well as their histories, preferences and family dynamics.
- Before Nuka, the average delay to schedule a routine appointment was 4 weeks. Now, Southcentral Foundation offers same-day access, in person or by phone or email (customer's choice).
- By implementing same-day access, Southcentral Foundation reduced the number of individuals on its behavioral health wait list (backlog) from about 1,300 to nearly zero in a year.
- Phone wait times, before Nuka, were in excess of 2 min, and are now limited to less than 30 s.
- A 36% reduction in hospital days, 42% reduction in ER and urgent care usage, and 58% reduction in specialty clinic visits have been sustained for 10 and above years.
- In 75% of the HEDIS measures (national standards), Southcentral Foundation is in the 75th percentile or better, and for many, like diabetes care, in the 95th percentile.
- Staff turnover is one-fourth of the level it was 5 years earlier.
- 25% increase in childhood immunizations.
- Customer satisfaction with respect for their cultures and traditions at 94%.

Southcentral Foundation has distinguished itself as a role model health care organization. It was Alaska's first health care organization, and 15th health care organization in the nation, to receive the Malcolm Baldrige National Quality Award. The US Congress created this award program in 1987 to identify and recognize the country's most innovative organizations, and then disseminate and share best-practice performance strategies. Southcentral Foundation also achieved the highest level of Patient Centered Medical Home™ recognition from the National Committee for Quality Assurance in 2009. The Patient Centered Medical Home standards emphasize the use of systematic, patient-centered, coordinated care that supports access, communication and patient involvement. Southcentral Foundation believes these standards could be improved by focusing on: the individual (in Southcentral

Foundation's case, the "customer-owner") and his/her family driving the system rather than the professionals; services that are woven into customers' lives built around them, rather than the medical office; and an approach that addresses the whole person and family in a well-coordinated and personal way. A better term for the Patient Centered Medical Home designation might be "customer-driven whole person care" or "customer- and family-driven integrated care provided on their terms."

Southcentral Foundation's customer-owners recognize that future generations of their families will continue to own, manage and benefit from these services. With this ownership, comes a sense of shared responsibility for the health care system's success. The people of the region are working to continuously improve the services and ensure that the decisions made are in alignment with their needs and values. Consistent with the body of knowledge on community readiness (11), by being involved, Alaska Native people are now more aware of health promotion and disease prevention options and are more interested and willing to make changes.

The value put on relationships in this Alaska Native-owned system of care provides a dramatically different care experience than what was encountered when the health system was under government control. Better relationships have meant not only healthier customer-owners, but also healthier employees and a healthier organization. These outcomes continue to attract health care professionals and government leaders from all over the world who travel far north to Alaska to learn more.

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Conflict of interest and funding

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The author has not received any funding or benefits from industry or elsewhere to conduct this study.

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Person & Whānau Centered Care – What do we mean?

Notes below from a combined sub-group of members from the Hawke's Bay Clinical and Consumer Councils – February 2015

Themes

The person

- Take time to care – being human, little courtesies like introducing yourself, creating some trust, creating an environment for partnership...
- Listen
- Respect what people are telling you
- Find out what matters; many have no or little in the way of support networks, are isolated by poverty
- Health sits in the context of broader issues/challenges for that person
- The person is often more vulnerable than in normal situations and needs more understanding of that.
- Be sensitive - reading the body language as well for indications of uncomfortableness or embarrassment which many/most people won't verbalise.

The whānau/family/caregiver/support person

- Be inclusive sooner rather than later
- Multidisciplinary includes family
- The person needs support and the "family" is a powerful aid to care

Observations

- Recap and check for real understanding – in writing please
- Health literacy is about speaking in the language of patients
- There is a lack of clear and written care planning, especially for those with long term conditions
- Use teachable moments; don't run to a timetable
- Employ people who are interested in the care of the person – this is highly variable now
- Don't be task oriented and miss the opportunity
- Speaking to the "right" person makes a world of difference
- There are no KPIs re the above – we don't value these things!

Best Practice for Effective Engagement
(developed by different group in a workshop on Engaging Effectively with Maori – February 2015)

- Ask questions
- Treat people uniquely
- Show respect
- Find out what matters to them
- Be open minded
- Give, not only receive
- Don't assume
- Don't be judgemental
- Use the language of patients (health literacy)
- Check for understanding
- Listen to learn and not just to respond
- Make authentic effort

Two Observations

The workshop could have easily been called "Engaging Effectively with Everyone"
The workshop could also have been called "Enabling Person & Whānau Centered Care"

OURHEALTH HAWKE'S BAY Whakawateatia	**PARTNERS IN CARE CONSUMER ENGAGEMENT** **The Case for Change**

Consumer engagement is an essential component of quality and safety in the design and delivery of health services.

Engaging consumers and providing person-centred care has huge benefits in treatment outcomes, prognosis, morbidity and cost savings for organisations.

Improving consumer engagement in health care is a global movement. The World Innovation Summit for Health in 2013 focused on the critical role consumer engagement plays in shaping future health services.

'The solutions to the health challenges of today and tomorrow won't come from doing business as usual; they will come from building effective partnerships and harnessing the untapped global power of ordinary people who care about improving their health. There are powerful benefits from partnering with patients, families, communities, and health care workers at all levels.

Consumers can be engaged as individuals, or collectively, with increasing power to influence quality and safety. This ranges from being given greater choice and the opportunity to provide feedback about their own health care experiences to having a meaningful voice in partnership with providers to influence the design and delivery of services.

Consumers bring unique and valuable perspectives from outside the health system 'looking in'. The health system is there for all of us as consumers; however, in the search for efficiency the consumer's experience and viewpoint can sometimes be lost. Systems naturally focus on what is being measured. If time, efficiency and clinical outcomes are being measured, that is what clinicians will focus on. Engaging consumers helps to ensure providers understand how to deliver services based on the needs of consumers.

The consumer engagement needs of people will vary from person to person. Not all consumers will want to be involved at all times. For a person who has been given a new and frightening diagnosis, being informed about different treatment options, checking that they understand their choices (assessing their heatlh literacy) and actively involving their family ay be enough for them. While all people should have an opportunity to provide feedback about their care, some may not want to take up this offer immediately. Others may want to get more involved. They may want to improve the experience of care for others by being a representative involved in service delivery, strategy and design. Or, with encouragement, motivation and skill, they may even want to represent other consumers in a governance role in an organisation

Consumer engagement is more than just a set of activities. It involves a cultural shift in organisations to welcome partnerships with consumers at all levels, from the waiting room to the board room. At the direct care level, this means working towards shared decision-making. At the service planning level, it means ensuring the results of patient experience surveys directly influence quality improvement initiatives, and that consumers are represented in expert advisory groups. At the policy and governance level, it means skilled, well-networked consumer councils will be working in parity with those in clinical governance and reporting to boards. When organisations engage with consumers as partners in care at all levels, this is true partnership.

The benefits of consumer engagement include better health outcomes, safer care, less waste, lower costs and better consumer and health provider satisfaction and staff retention. Engaged consumers have improved health literacy, are more likely to comply with treatment and medication, and are better able to self-manage long-term conditions. Equity of access to health care is also improved when consumers and communities are engaged in their own care.

Improving consumer engagement also brings enormous benefits for staff. When staff engage in compassionate, person-centred care with consumers, it has a powerful psychological influence on their wellbeing, as well as that of consumers

OURHEALTH HAWKE'S BAY Whakawateatia	**PARTNERS IN CARE CONSUMER ENGAGEMENT** **Definitions**

CONSUMER

Refers to patients and their families / whānau / caregivers / personal support persons, who have had personal experiences in the health and disability system.

The term also includes all those who might use health and disability services in the future and members of the public generally, given they are the targeted recipients of health promotion and public health messaging and services

CONSUMER ENGAGEMENT

Is a process where consumers of health and disability services are encouraged and empowered to actively participate in decisions about the treatment, services and care they need and receive. It is most successful when consumers and clinicians demonstrate mutual respect, active listening and have confidence to participate in full and frank conversation. Systems that support consumer engagement actively seek input from consumers and staff at all levels of an organisation.

PERSON AND WHANAU CENTRED CARE

Includes other terms such at:

- Patient centred care
- Patient and family/whānau centred care
- Person centred care

Person and whanau centred care at the individual level is a partnership between the clinician and the person receiving care. It involves shared decision-making, discussion treatment options and medication options, and asking questions to include the person's goals of treatment and the wishes of their family/whānau. When done well, person and whānau centred care results in people being more engaged, more health literate and better able to self-manage their own care, with whānau support as appropriate. When this extends to an organisation, person and whānau centred care involves integrated, coordinated care systems that seamlessly follow the consumer's journey through the system.

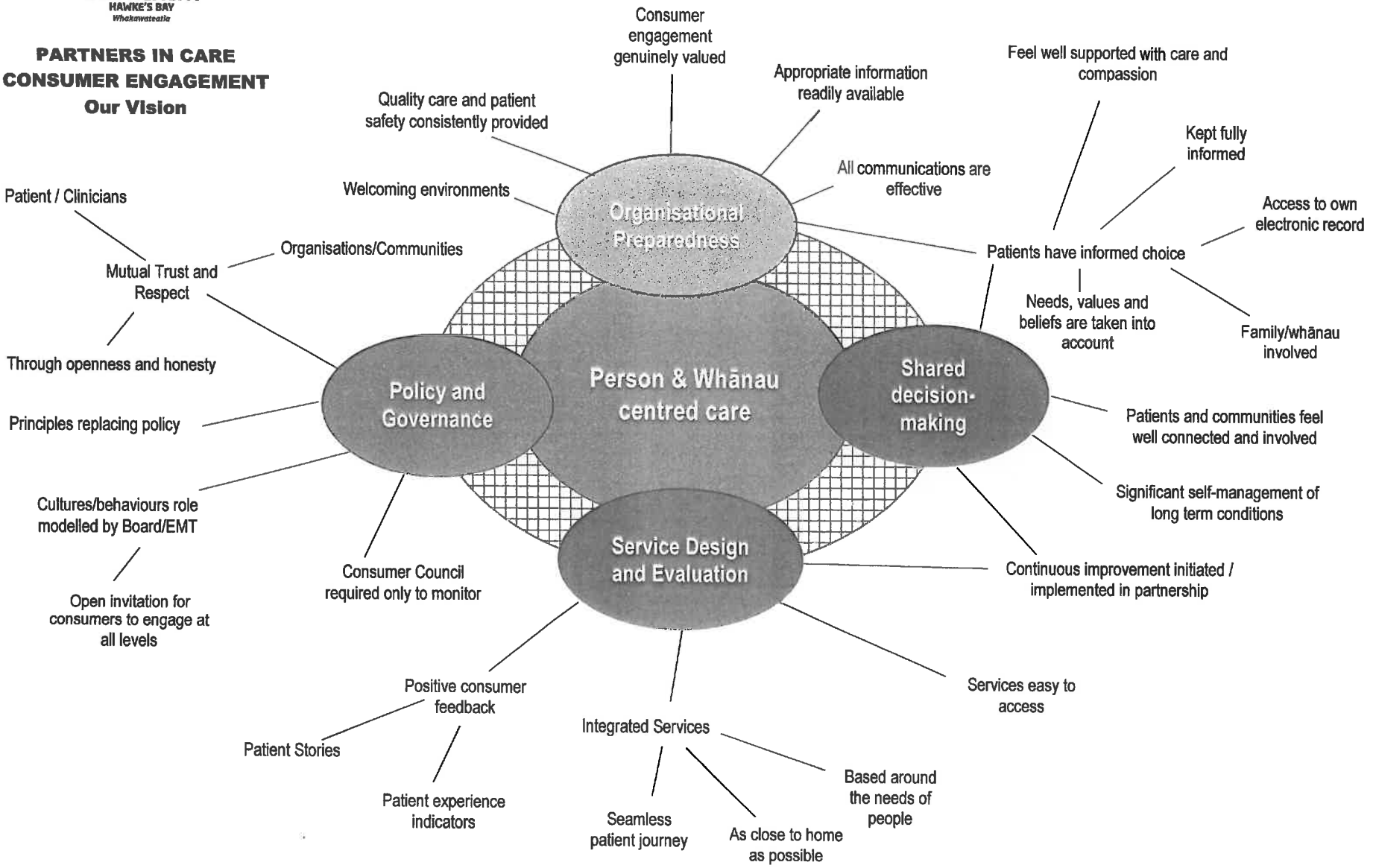
HEALTH LITERACY

Is a foundation stone of consumer engagement.

- Individual Health Literacy
  - is the skills, knowledge motivation and capacity of a person to access, understand appraise and apply information to make effective decisions about health and health care and take appropriate action.
- Health Literacy Environment
  - is the infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way that people access, understand, appraise and apply health-related information and services.

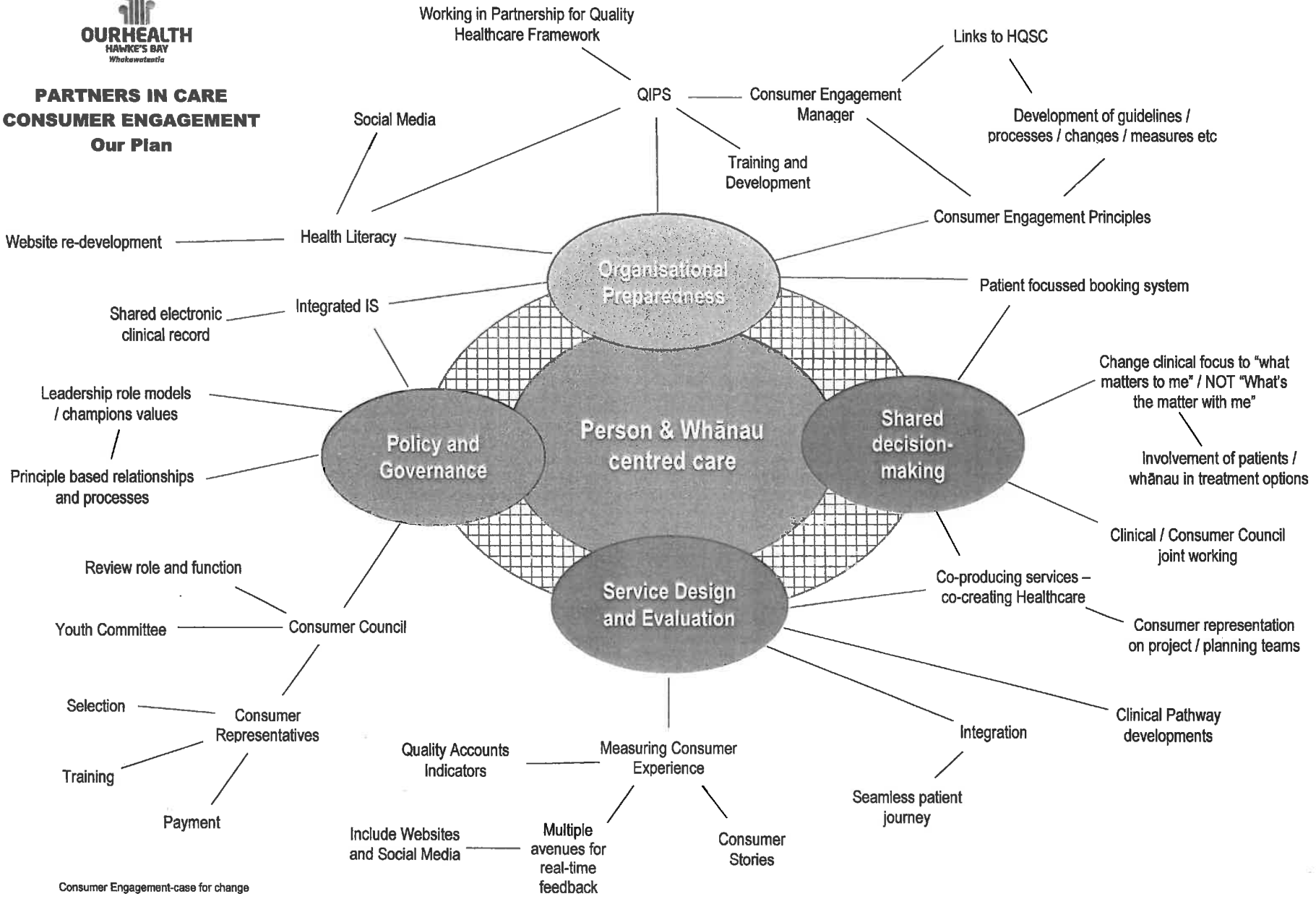
OURHEALTH HAWKE'S BAY Whakawateatia

PARTNERS IN CARE
CONSUMER ENGAGEMENT
Our Vision



OURHEALTH HAWKE'S BAY Whakawatea Ia

PARTNERS IN CARE CONSUMER ENGAGEMENT Our Plan



ROYSTON HOSPITAL

The Health Care You Should Expect

BY GRAEME NORTON

What is the relationship with your health professional like? Is it person and whanau centred? What does that mean and why does it matter anyway?

Back in 2014 the DHB board was challenged with the view that services being delivered were not patient-centred and action was needed to address this. The DHB's Consumer Council – consisting of 15 people who are a cross section of our population, each with strong links into our communities – was asked to take this issue up.

All of us around the Consumer Council table held no doubt that being supported and empowered to look after ourselves as much as possible was a whole lot better than just being told what to do or treated with indifference.

We also agreed that good care was beyond just the individual person. For the most part, we live in families or are connected in various ways, and believe a chance for better health is linked to that involvement.

But what did others think and could we come up with a set of values or behaviours that described what good care is?

So we sat around the table with our sister Clinical Council, the body of senior health sector clinicians responsible for providing a clinical view to the board. Within an hour we had come up with a set of agreed values that together added up to person and whānau centred care.

We also agreed that the living of these values within the health sector was highly variable; each of us was able to give our stories of the outstanding and the awful. When we did some subsequent research, we found that our community had been telling us pretty much the same things for at least a generation, so really there is nowhere to hide.

What are these values and behaviours that people are asking for? Here's a list

Listen:
Respect what people are telling you. You may not agree, but this is the life they live, their values and their culture.

Find out what matters:
Health sits in the context of broader issues and challenges for that person. They may have many priorities that are ahead of looking after themselves. Many are isolated by poverty, with no or limited support networks.

We are unique:
We may eat mass-produced food but we don't want mass-produced, conveyor belt care. Use teachable moments; don't run to a timetable. Together, we can find a place where we are trusted to look after ourselves with your support. Most of us resent being told what to do and that sort of 'prescription' doesn't last.

Take time to care:
Being human, little courtesies like introducing yourself, creating some trust, creating an environment for partnership.

Health literacy:
Is more about speaking in the language of patients than expecting them to learn medical language. Otherwise you are talking about me, without me.

Partnership:
Allow people to participate in decision-making on their care.

Empathy:
People are often more vulnerable than in normal situations and clinicians need more understanding of that. Be sensitive –reading the body language as well for indications of uncomfortableness or embarrassment which many/most people won't verbalise.

It's about whanau:
The whānau/family/caregiver/support person should be part of the team. Be inclusive sooner rather than later. The person often needs support and the 'family' is a powerful aid to care.

Information:
Communicate successfully by giving clear information and check for understanding. Follow it up in writing. The chances are we are unwell, anxious or off our game. We won't be taking it all in. That is, in part, why a family/support person is so critical.

Informed choice:
Enable us to make informed choices based on provided information.

Seamlessness:
Care is comprehensive, integrated and continuous. This is a topic in itself! Most of us are staggered at how not-joined-up the health sector is. We waste heaps of time

All of us around the Consumer Council table held no doubt that being supported and empowered to look after ourselves as much as possible was a whole lot better than just being told what to do or treated with indifference.

repeating the same thing to different people when they should be able to – but can't – see the information we have already provided. The way that we receive other services has revolutionised in recent years; healthcare is so 'last century' on this subject.

There are 8,760 hours in a year (ok, 8,784 this time because it's leap year). Unless you have some big health event that lays you up in hospital for a long period, the chances are you have contact with a health professional for only a very small number of those hours each year. So you are not entirely on your own but, frankly, you have more influence over how well you get on than they do. So it makes sense that you should be as well-equipped to manage your situation as you can be.

The consultant who gives you a couple of website links to better understand the diagnosis he has just given you is providing a chance for you to understand what is going on. The consultant who delivers the news in Latin and Greek may be impressing himself but is wasting your time!

I guess a lot of this comes down to being human. When I reflect on the many encounters I've had with health professionals for my own 'issues' in the last ten years as a high health user, there are standouts at both ends of the care spectrum.

You just know when you meet someone who is 'in the moment', focused on you, able to impart their care, understanding and knowledge and empower you to take control. They support your wellness at least as far as you can be well. They are like gold dust.

At the other end of the spectrum you meet some who leave you wondering why they are in a caring profession. Maybe they did care once; it's time for them to change or exit.

The Consumer and Clinical Councils are working collaboratively to enable a culture of person and whanau-centred care to become the norm across the health sector Hawke's Bay. We figure that if we can visibly demonstrate partnership it helps this positive 'infection' to spread.

The Cleveland Clinic in the U.S. has some quality videos on the subject of empathy. Here are two that are only a few minutes each and well worth a watch.

Empathy: The Human Connection to Patient Care **bit.ly/1fpWJYz**

Empathy: Patients afraid and vulnerable **bit.ly/1EETItV**

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DRAFT

HBDHB PATIENT CHARTER

Care for me

Keep me safe

Consult with me

Keep me informed

Respect me and my whanau

- **Derived from patient surveys early 2000 when asked the Question:**

  'What do you want (expect) from those providing you health care?'

- **Never formally discussed or adopted**