Hawke's Bay Clinical Council Meeting

Combining with Hawke's Bay Health Consumer Council

Date: **Wednesday, 9 November 2016**

Lunch **12.30 pm**

Meeting **1.00 pm to 5.30 pm**

Venue: **HBDHB Education Centre, Canning Road, Hastings**

Council Members:

Chris McKenna
Dr Mark Peterson
Dr John Gommans
David Warrington
Billy Allan
Dr Andy Phillips
Dr Robin Whyman
Dr Caroline McElnay
Jules Arthur
Dr Kiri Bird
Dr Tae Richardson
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod

Apologies:

In Attendance:

Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to Director QIPS
Kerri Nuku, Māori Relationship Board Representative

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	**1.00 pm**
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	

	Section 2 – For Discussion / Update	
6.	Learnings from ICU Review 2013 – Progress Update – Chris McKenna for Kate Coley	**1.10**
7.	Clinical Governance Structure Update – Chris McKenna for Kate Coley	**1.20**
8.	Allied Health Professions Forum – Andy Phillips	**1.30**
9.	Laboratory Specimens Labelling Improvement Initiative - Chris McKenna	**1.40**
	Section 3 – Reporting Committees / Monitoring	
10.	HB Clinical Research Committee – verbal update – John Gommans	**1.45**
11.	Laboratory Service Committee Quarterly Update – Kiri Bird	**1.50**
12.	**Section 4 – Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

13.	Minutes of Previous Meeting (public excluded)	
14.	Matters Arising – Review Actions (public excluded)	
15.	Letter received from CAG on Governance Matters – Tae Richardson	**1.55**

PUBLIC MEETING

	Combined Clinical and Consumer Council Meeting Welcome / Introductions	**2.00**
	Section 5 – Joint Discussions / Decisions	
16.	13-17 Year Old Primary Care Zero Rated Subsidy – Tim Evans / Patrick LeGeyte	**2.10**
17.	System Level Measures (DRAFT) – Tim Evans / Carina Burgess	**2.30**
18.	Alcohol Harm Reduction Position Statement – Caroline McElnay / Rachel Eyre	**2.50**
19.	Transform and Sustain Programme Refresh – Tracee TeHuia / Kate Rawstron	**3.10**
20.	Urgent Care Alliance Project End Report – Mark Peterson / Graeme Norton	**3.30**
	Section 6 – For Information - No Discussion	
21.	Travel Plan Update	-
22.	Orthopaedic Review – Closure of Phase 1	-
23.	Regional Tobacco Strategy for HB (2015-2020)	-
24.	Te Ara Whakawaiora / Smoke Free)	-
25.	Annual Maori Plan Q1 Jul-Sep 2016 - Late Paper	-
	Afternoon Tea (welcome those attending the workshop)	**3.40**
	Section 7 – Workshop: Palliative Care and Advanced Care Planning	**4.00**
26.	Palliative Care in Hawke's Bay (discussion draft)	
27.	Advanced Care Planning	
	Closure	**5.30 pm**

Next Meeting: Wednesday, 7 December 2016, commencing at 3.00 pm in the Te Waiora (Boardroom), HBDHB Corporate Building

Interests Register

Nov-16

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
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
Dr Caroline McElnay (Director Population Health & Health Equity Champion)	NZ College of Public Health Medicine	President until October 2017	NZCPHM represents the interests of Public Health Medicine specialsits in NZ, provides training of registrars, ongoing accrediation of specialists and advocacy on public health matters.	No	
	RNZ Plunket Society	National Board member	Provision of heath and social services to children under 5 years, advocacy for children	No	
William Allan (Chief Pharmacist)	Pharmaceutical Society of New Zealand	Executive member	Pharmacy advocacy, professional standards and training	Yes	Low
	Pharmaceutical Management Agency (PHARMAC)	Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee)	Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML)	Yes	Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget
	Executive User Group for eMedicines programme (ITHB/HQSC)	Member (Central Region's representative)	Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines	Yes	Low
	Pharmacy Steering Group (MoH)	Member	Provide advice to the Ministry on the utilisation of pharmacists within the health workforce	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
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)	Deputy Chair	Health and Wellbeing	No	
	Te Akoranga a Maui (Maori chapter for RNZCGP)	Member	Health and Wellbeing	No	

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	Nature of Interest **eg Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Robyn O'Dwyer (Nurse Practioner Whanau Ora)	Wairoa Health Care Center	Nurse Practitioner	General Practice	No	
	The College of Primary Care Nurses	Member	National submissions/member of nursing leadership	No	
	The College of Maori Nurses	Member		No	
	New Zealand Scientific Society of Diabetes	Member		No	
David Warrington (Nurse Director - Older Persons)	Havelock North Chiropractic	Wife is Practitioner and Co-owner	Chriopractic care and treatment, primary and preventative	Yes	Low
	Pilates Works	Wife is CE and Co-owner	Rehabilitation, Primary and preventative.	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary		No	
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	Directions Youth Health	Wife Beth involved	Assisting youth in HB	No	
	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)	The Hastings Heatlh Centre	Practice Nurse Family Violence Intervention Coordinator	Delivery of primary health care - General Practice and training of Clinicians in family violence intervention.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	LIVE (Local Initiative for Violence Elimination)	Member of management Committee	Network of agencies that provide family violence intervention services.	No	
	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	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	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	

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, 12 OCTOBER 2016 AT 3.00 PM

PUBLIC

Present:
Chris McKenna (Chair)
Dr Tae Richardson
Dr Kiri Bird
Dr John Gommans (until 4.15 pm)
Dr Russell Wills (3.10 pm)
Dr Robin Whyman
Dr David Rodgers
Dr Caroline McElnay (3.25 pm)
Andy Phillips
Debs Higgins
William Allan
David Warrington (3.30 pm)
Anne McLeod

In Attendance:
Dr Kevin Snee, Chief Executive Officer (3.45 pm)
Graeme Norton, Chair HB Health Consumer Council
Kerri Nuku, Māori Relationship Board Member (3.10 pm)
Tracy Fricker, Council Administrator and EA to DQIPS

Apologies: Dr Mark Peterson and Jules Arthur

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Chris McKenna (Chair) welcomed members to the meeting.

Apologies were noted as above. The Chair advised that she had received a number of apologies from members who would be late to the meeting and that Dr John Gommans would need to leave early.

2. INTERESTS REGISTER

No conflicts of interests for agenda items.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 14 September 2016, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: **Clinical Council Member Portfolios**
On agenda today, item #7

Item 2: **Interests Register**
New interest for Dr Mark Peterson added to the register. *Item can now be closed.*

Item 3: Complementary Therapies Policy
The Chair advised that a meeting has taken place outside of Clinical Council. Feedback provided at the last meeting has been taken into account, as well as feedback from the Maori Relationship Board meeting this morning. The final version of the policy will be tabled for information at a future Clinical Council meeting. The Chair thanked Dr Andy Phillips for the considerable amount of work undertaken to complete the policy. *Item can now be closed.*

Item 4: Mental Health Topic
The Chair advised that Graeme Norton and she have had discussion about this topic with Sharon Mason, Chief Operating Officer (COO). There are some outstanding issues that need to be resolved with Mental Health, this is to be taken off the November meeting agenda.

Item 5: Gastro Outbreak
The Chair has passed on thanks to primary care on behalf of the Clinical Council.
Item can now be closed.

Additional Item (not on agenda) - *Joint meeting with Consumer Council in November:*

The Chair suggested that a workshop around the strategic palliative care plan, advanced care and end of life planning be held. The workshop could be extended to include other staff, Lucy Fergus, Emma Merry and Cranford. Part of the palliative care process is to consult widely on the draft strategic plan. Agreement to this workshop confirmed.

Action: Chis McKenna, Andy Phillips, David Rodgers and Tae Richardson to plan workshop discussion and additional attendees to be invited.

5. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers for information.

There are a number of papers coming through for November, which need to go to the Executive Management Team (EMT) first. There are some reports which do not require a verbal update and could be a report for information only. Some reports require discussion as they need to be endorsed before going to the Board. This will be reviewed with the agenda planning by the Co-Chairs and Company Secretary.

SECTION 2: FOR DECISION

6. QUALITY DASHBOARD

Dr John Gommans advised the draft dashboard was included in the papers for feedback. The recommendation in the paper is to endorse the principle of establishing a Quality Dashboard.

The dashboard will evolve as feedback is provided. The headings on the dashboard are based around the triple aim and the content is trying to get a balance of primary, secondary and whole of sector markers. Definitions on what the indicators are will be included. We don't want duplication of other reporting.

Feedback:

- We need to get the principles and pillars right. How do the pillars of clinical governance fit into the quality dashboard and committee reporting structure? It needs to flow logically
- The scorecard and the pillars should reflect the new structure of the clinical committees

- Aggregation of individual measures with ability to drill down to areas of concern
- There is a lot of work already happening with system level measures in primary care
- Need a column on quality engagement by staff and a separate equity column
- What gets measured, gets done. What goes on the dashboard should be things that we want to actively do something about
- Data should be segregated by ethnicity e.g. under patient movements would have another heading "is equity improving" indicated by an up or down arrow
- Support system level and composite measures. This is an opportunity to look at measures which are not being done nationally which we could do locally to lead the way for meaningful system level measures with other DHBs
- Suggestion to include markers for ASH;
- Empathy with a baseline of how empathetic is our workforce
- We need measures that drive clinical practice
- When we choose the measures, need to be able to report quarterly with the ability to track and monitor changes
- Have the 7 pillars of quality sitting alongside the triple aim

The establishment of a Quality Dashboard was endorsed by the Clinical Council but there needs to be further work with the Medical Director of QIPS will oversee. Further feedback on the dashboard to be emailed to tracy.fricker@hbdhb.govt.nz.

Action: Dr Russell Wills to meet with Kate Coley, Director QIPS to discuss feedback.

7. HB CLINICAL COUNCIL ANNUAL PLAN 2016/17

The Chair advised that the Company Secretary has put the document together under the functions column are roles, strategies and objectives for 2016/17. We now need to further develop this document and link areas of interest for individual Clinical Council members to take a lead on. This document has been around since the Clinical Council started and has evolved over the years. At the AGM meeting this year there was significant feedback about prioritising the agenda, moving away from a lot of agenda items and having some proactive presentations around innovation.

It is difficult to look into detail of this document until the governance structures have been resolved and the work programme determined. Once this has been done, we need to be able to define how successful we are to provide assurance to the Board about the quality and safety of the system.

Feedback:

- Need to look at what is happening and what is in abeyance
- In terms of principles if you write a plan there must be a report to the plan. A real risk of a busy plan is there is no room for innovation. We need to innovate and set clinical direction on some aspects.
- It is maybe time to refresh the document
- Need to link the quality dashboard and establishment of the revised clinical committees work with the annual plan
- The consumer council have a leaner plan which will be signed off at the meeting tomorrow. There are specific things they will be doing in the next 12 months, a number are not responding to the system, but what they want to get done. They have identified a few key things that they want to see happen by the middle of next year, with individual consumer council members identified as the key contact with their contact details included on the plan
- These are complex systems which are not easily represented by bullet points. Pictorial ecosystems would be helpful for the complex systems
- Need a 5-year plan and set objectives for each year
- The plan needs to relate to the clinical services plan, this is a DHB priority but will take time to develop
- Need to set hard outcomes and be clear on accountability.

Following the discussion agreement that the structure of the plan needs to change as the Clinical Council has evolved and matured. The plan needs to be reviewed in conjunction with the clinical governance committee's structure and the clinical services plan.

Action: Review of the plan to take place between meetings (Mark Peterson, Chris McKenna, Andy Phillips and Russell Wills).

SECTION 3: REPORTING COMMITTEES / MONITORING

8. INFECTION PREVENTION & CONTROL COMMITTEE

The Chair advised the Infection Control Committee report to the Clinical Council 6-monthly. The brief report captures activity undertaken.

Discussion on the format of reports which come to Clinical Council. It would be helpful to have a report template similar to that which goes to the Maori Relationship Board which identifies activities, successes and issues.

Action: Develop a template for reports to Clinical Council which is consistent for all committees to use.

9. HB NURSING MIDWIFERY LEADERSHIP COUNCIL UPDATE

David Warrington commented that it has been a quiet quarter in terms of activity for the Council. The nursing and midwifery dashboard is working well, and in future will look at including it as part of this report. Legislation for RN Prescribing came into effect on 20 September and they are working through this at the moment with medical colleagues to support the process. The frequency of this report has been reviewed and changed from quarterly to 6-monthly to include the Nursing and Midwifery Dashboard.

10. URGENT CARE PROJECT UPDATE

Graeme Norton provided a verbal update. The request for proposals process was suspended at the request of the parties who had registered for the RFP on the basis that they wanted to work collaboratively with the DHB to come up with a solution. The group have had two meetings with the Emergency Department and they are working with each other on what the model would look like. These meetings have been very productive and progress has been made. The next stage is a further meeting next week and then back to the GP Collaboration Group with a view to having a model for discussion with Dr Kevin Snee, CEO on 25 October. The service needs to be improved for patients with the new model in place by April 2017.

11. RADIOLOGY SERVICES COMMITTEE

Dr Andy Phillips advised that the external review of the Radiology Service is underway. The IANZ Accreditation visit has been postponed until March/April 2017. No issues discussed.

12. LABORATORY COMMITTEE

Dr Kiri Bird, Chair of Laboratory Committee advised this is a report is about the issues identified around the use of the EasyCheck Pregnancy Test kits and the committee's recommendations for primary and secondary care regarding the use of the product.

The report outlines the background and timelines around the change from Innovacon to EasyCheck tests and the issues identified with the point of care testing and the false negative results. Page 4 of the report identifies the options for consideration. The recommendation by the Laboratory Committee is:

- Hospital – Option 3: move away from point of care testing and use blood testing by the Laboratory.
- Primary Care – Option 1: continue with the use of the EasyCheck kits until the evaluation is complete, but revert to a blood test in high risk situations.

MedSafe are currently doing an investigation and the evaluation report is due in November.

All EasyCheck kits have been removed from the hospital. The Innovacon kits previously used are available in some areas with detailed instructions on how they should be used. The gold standard is the blood test.

Concern expressed that not all of primary care are aware of this issue. Information was sent out via the PHO portal. This information needs to be resent.

The recommendations identified in the report are appropriate and they are endorsed by the Clinical Council.

Action: Information to be resent through the PHO Portal. Chris McKenna to discuss this with Wayne Woolrich.

Additional Item (not on agenda) - RMO STRIKE

Dr Andy Phillips and Dr Robin Whyman provided a brief update on the RMO Strike which is due to take place from 7 am on 18 October to 7 am, 20 October. Contingency planning is underway to ensure patient safety is maintained and we are working collaboratively with other DHBs. The next briefing meeting is being held on Monday at 1.00 pm in the Education Centre if Clinical Council members wish to attend.

SECTION 4:

13. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

14. Minutes of Previous Meeting (Public Excluded)
15. Matters Arising – Review of Actions (Public Excluded)
16. Letter received from CAG on Governance Matters
17. Topics of Interest – Member Issues/Updates

Moved and Carried.

The meeting closed at 4.25 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	12/10/16	***Workshop for Joint Meeting with Consumer Council*** Small working group to plan workshop on Palliative Care, Advanced Care and End of Life Planning for meeting.	Chris McKenna, Tae Richardson David Rodgers and Any Phillips	Oct/Nov	Completed.
2	12/10/16	***Reporting Committees / Monitoring*** Develop / update template for committees to use that report to Clinical Council.	Co-Chairs / Admin	Oct/Nov	To be actioned.
3	12/10/16	***Laboratory Committee*** Information on alert re: EasyCheck kits and recommendation for Primary Care to be sent through to PHO again for portal	Chris McKenna	Oct	

OURHEALTH HAWKE'S BAY Whakawateatia

HB CLINICAL COUNCIL WORKPLAN 2016-2017

Meetings	Papers and Topics	Lead(s)
24 Nov	**HB Health Awards presentation evening**	**The Plaza** **HB Opera House**
7 Dec 16	Draft - Orthopaedic Review – Phase 2 Discussion - HB Workforce Plan Quality Improvement Programme (presentation) Urgent Care Business Case Long Term Conditions ***Monitoring*** Health and Social Care Networks Update Clinical Pathways Committee CAG Report	Andy Phillips Kate Coley Kate Coley Mak / Graeme Tim / Leigh White Tracee / Belinda Sleight Leigh White Tae Richardson
8 Feb 17	Orthopaedic Review – phase 3 Draft Fracture Clinic – Orthopaedic Dept near ED (investigation) ICU Learnings – Action Plan update (quarterly) MRI Target Achievement (board request Sept 2016) HB Integerated Palliative Care (Final) ***Monitoring*** Te Ara Whakawaiora / Access Annual Maori Plan Q2 CAG	Andy Phillips Sharon Mason Kate Coley Sharon / Mark Mary Wills Mark Peterson Tracee TeHuia
8 Mar 17	Orthopaedic Review – phase 3 Draft ICU Learnings – Action Plan update (quarterly) Travel Plan Update ***Monitoring*** Maternity Clinical Governance Group Update (6 monthly) Falls Minimisation Committee Te Ara Whakawaiora / Breastfeeding (national indicator) Laboratory Services Committee Radiology Servcies Committee Health & Social Care Networks (6 monthly) CAG	Andy Phillips Kate Koley Sharon / Andrea Beattie Chris McKenna Chris McKenna Caroline McElnay Kiri Bird Mark Peterson Tracee / Belinda Sleight

12 Apr 17	Draft Health Equity Update Draft Youth Health Strategy Draft Suicide Prevention Postevetion Update against 2016 plan ICU Learnings Report – Action Plan update (Quarterly) ***Monitoring (work in progress – incomplete)*** Collaborative Clinical Pathways HB Nursing Midwifery Leadership Council Update & Dashboard 6mthly Te Ara Whakawaiora / Cardiology (national indicator) CAG	Caroline McElnay Caroline McElnay Caroline McElnay Kate Coley Mark / Leigh White Chris McKenna John Gommans
10 May 17	ICU Learnings Report – Action Plan update (qtly) Best Start Healthy Eatng Plan *yearly review ***Monitoring (work in progress – incomplete)*** HB Clinical Reasearch Committee Update (6 monthly) Infection Control Committee (6 monthly) CAG	Kate Coley Caroline McElnay John Gommans Chris McKenna
14 Jun 17	Orthopaedic Review – closure of phase 2 Orthopaedic Review – closure of phase 3 Quality Improvement Programme (6 monthly) Draft Health Equity Update Final Youth Health Strategy Final Suicide Prevention Postvention Update against 2016 Plan ***Monitoring (work in progress – incomplete)*** Te Ara Whakawaiora / Oral Health (national indicator) CAG	Andy Phillips Andy Phillips Kate Coley Caroline McElnay Caroline McElnay Caroline McElnay Robin Whyman

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HAWKE'S BAY District Health Board Whakawāteatia	**Learnings from ICU Review 2013 – Progress Update**
	For the attention of: **Hawke's Bay Clinical Council and Finance Risk & Audit Committee**
Document Owner: Document Author:	Kate Coley, Director Quality Improvement & Patient Safety Kate Coley, Director Quality Improvement & Patient Safety
Reviewed by:	Executive Management Team
Month:	November, 2016
Consideration:	For Information

RECOMMENDATION

That HB Clinical Council and Finance Risk & Audit Committee:

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

EXECUTIVE SUMMARY

At the end of 2015 an urgent request was made to the Executive Management Team, HB Clinical Council and the Finance Risk and Audit Committee to support a Business Case to appoint further senior consultants to ICU due to significant risks being identified in regards to SMO resourcing and an unsustainable and unsafe roster for the medical team.

A review was undertaken identifying a number of recommendations, with identified leads and timeframes for implementation. Attached is a copy of the action plan with progress updates.

Also attached is a second spreadsheet identifying the outstanding recommendations of the ICU 2013 review and progress against those that are outstanding.

ATTACHMENT(S)

A. ICU Action Plan / Progress
B. Incomplete Recommendations

A. ICU Action Plan

Action	Responsibility	Implementation deadline	Progress Update
A documented job sizing process needs to be established and agreed between the DHB and ASMS with clearly defined roles and responsibilities with an agreed timescale, with a maximum of 12 months for the work to be completed	John Gommans, Colin Hutchison + Craig Sidoruk	Dec-16	ICU SMO job sizing in progress. Further discussions and considerations and optiosn to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016.
Undertake a full review of the current ICU SMO rostering practices.	Colin Hutchison	Sep-16	ICU SMO job sizing in progress. Further discussions and considerations and optiosn to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016 with a new roster to follow thereafter.
Develop systems to ensure nurse staffing ratio's are appropriate for both ICU and HDU patients	Ian Elson/Chris McKenna	Nov-16	Draft paper being prepared for HSLT. CCDM project will be utilised to understand the issues and resourcing requirements. Expected that the results of this will be completed by March 2017.
Review all recommendations from the 2013 Review, consider and implement any that are still relevant and outstanding	Paula Jones, Colin Hutchison, Ian Elson	Nov-16	Please see separate worksheet for an update.
Development of a TOR Guideline & process document	Kate Coley	Jul-16	Complete
TOR Template developed	Kate Coley	Jul-16	Completed
TOR Checklist developed	Kate Coley	Jul-16	Complete
HBDHB is to investigate the most time effective method for effectively and efficiently reviewing and approving SMO timesheets to ensure they accurately record actual hours worked and leave taken	John McKeefry - Now Kate Coley	Aug-16	Piece of work to be undertaken as part of the DRS Unit ransition following the reconfiguration in Health Services.
Undertake a full audit of "actual hours worked" not necessarily contracted hours to determine whether SMOs / RMOs are working a significant number of hours over and above contracted hours	John McKeefry - Now Kate Coley	Aug-16	Pilot underway mapping SMO Timetables in Acute & Medical Services - actual hours worked versus contracted hours. Once pilot completed a full rollout will be undertaken as part of the DRS Unit transition.
Dependent on the results from the above audit consider and make a recommendation to EMT as to whether the DHB needs to consider ongoing tracing of actual hours worked and establishing a mechanism for identifying and escalating issues to senior leaders so that this issue is better managed.	John McKeefry - Now Kate Coley	Sep-16	Will form part of the DRS Unit transition following analysis of results of the pilot.
Each Directorate will be required to develop an annual service plan to reduce the risk of 'crises' occurring in the future	Sharon Mason	Jul-16	Completed and performance reporting provided on quraterly basis to identify any issues and risks. It will take 12 months to establish the reporting cycle.
Establish effective effective mechanisms for escalation of risks to relevant governance bodies in a more consistent and transparent manner.	Kate Coley	Immediate	Complete.
Monthly meetings set up with HS Directorate teams to review directorate risks & identify any actions, escalation that needs to occur	Kate Coley	Immediate	Complete
Risks identified that are significant to be discussed with HSLG and escalated to EMT/Clinical Council/FRAC as necessary	Sharon Mason	Immediate	Complete
Implementation of a new event system so that we will be able to triangulate information and allow us to understand where a risk is developing before it becomes critical	Kate Coley	Jan-17	Business case under development to be endorsed by year end. Implementation and upgrade to follow in first 6 months of 2017.

B. Incomplete Recommendations (as at end October 2016)

Report Recommendation (Feb 13)	Status - May 2016	Current Plan	Lead / Responsible	By When	July Update
1. ICU level					
1.8. Consideration should be made towards using the registrar more effectively. Where registrars are junior, support should be provided to enable them to manage a proportion of calls (within their ability) and to escalate others.	At time of 2013 report, majority of ICU registrars were PGY2. After accreditation - advanced trainees, now aiming for PGY3 or above. Service is now budgeted for 7 Registrars (vs 6 in 2013)	Increase in SMO numbers to support both clinical and non-clinical activity. Once new roster agreed then the support for the registrars will become more formalised.	John Gommans, Colin Hutchison & Craig Sidoruk	Sep-16	ICU SMO job sizing in progress. Further discussions and considerations and optiosn to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016.
1.9. ICU specialists should consider whether preservation of the current arrangements are of such importance that reduction of other resources (such as bedside nurses) is a preferred alternative in the case of present or future funding shortfall.	This is not the decision of ICU SMO team. Additional nursing resources not approved in recent business case. Potential review of ICU technician roles and allocation will be reviewed once flight review completed.	Will align with flight review implementation re technician support for ICU	Service Director with ICU Leadership	Oct-16	Discussions with HSLT and HR - plan to align implementation of flight review and hospital reconfiguration, alongside CCDM rollout into the ICU area to inform resourcing requirements. Expected completion march 2017.
1.11. Determine the level of care provided to groups of patients with likely poor outcome to enable best utilization of resources	Admission / discharge criteria implemented 2015	Gain consensus amonst SMO team. Support of PAR Team implementation Continue to push need for Goals of Care program at HBDHB	ICU - HoD	**COMPLETE**	Appointment made awaiting individual joining organisation.
1.17. Early discussion with colleagues around discharge plans for specific patients may reduce tension between the ICU and wards and facilitate a smooth discharge and care plan for the patient going forward.	Improved discharge planning within ICU underway including MDT meetings. Relationships between ICU and primary teams/wards improving.	Medical CD and HoD involvement in discussions with physicians group around patient care planning.	Medical Director HoD - ICU	**COMPLETE**	Undertake audit to ensure discharge planning being undertaken.
2. Hospital Level					
2.1. Continue to develop the MET team and CRN ward team to support care of the higher acuity patient on the ward.	EWS process reviewed and Rapid Response Team approach established in 2015. Additional RN fte approved in 15/16 new investment process. Business Case developed and signed off by Transform & Sustain Steering Group	Proceed with PAR Team recruitment. Work closely with ICU SMO team and Ward teams about model. Support available from ICU SMO team will be determined by outcome of ICU Job-Sizing. Paper for implementation of ALERT training prepared for CNO. Rapid Response Team now well established.	Nurse Director and ICU Leadership Team.	**COMPLETE**	
2.2. Current concerns about risk that appear to be driving a proportion of HDU admission could be addressed by a functional, integrated deteriorating patient response and supportive outreach service. Given the limited ICU medical resource, consideration should be made to making the first responder of an outreach service an experienced RN. Most services in other hospitals are based in ICU (this facilitates positive interaction between ICU and wards). Hawke's Bay should consider such a model. Further education is required to explain the basis of the deteriorating patient response system.					

Report Recommendation (Feb 13)	Status - May 2016	Current Plan	Lead / Responsible	By When	July Update
2.3. Develop an organisational approach to discharging the ICU/HDU during office hours.	As for 1.17. Ability to transfer during hours is largely influenced by ward bed availability.	Monitor and analyse ICU exit block and out of hours discharge rate.	HoD & CNM - ICU	**COMPLETE**	
3. Management					
3.1. HB Hospital need to consider value of a quality ICU service to quality care delivery at HB and maintenance of specialist surgical services	ICU SMO establishment increased. The rate limiting step in ICU is the number of RNs per shift. Bid made in new investment process for 16/17 for additional ICU RN resourcing.	Organisation clinical services plan to determine the philosophy of care for Hawkes Bay Hospital and HB ICU that determines level of service provision for Hawkes Bay. The model of care for the Hospital After Hours is still unresolved.	ICU Ops Team	Aug-16	CNM & HoD ICU to manage the day to day demands. Initiation of CCDM process in ICU with expectation of results March 2017. Aspects will inform Clinical Services plan which is expected to be completed by May 2017. the Intergrated Ops Centre and IOC manager will work with the Directorate leadership team around patient flow and capacity.
3.2. HB Hospital should clearly identify funded bed capacity and devise clear operational guidelines for when ICU reaches funded capacity. This requires administrative responsibility and should not be left to the medical and nursing staff to resolve alone.	The current level of resourcing is clear and explicit. The challenge is understanding adequacy of current resource and future impact of increased elective surgery.	As 3.1	ICU Ops Team	Aug-16	
3.3. Review number of physical beds required to meet population need and the type of service the organization wishes ICU to provide.	As 3.1 & 3.2	As 3.1 & 3.2	ICU Ops Team	Aug-16	
3.5. Serious consideration should be made to reconfigure medical cover to ICU within a structure of safe working hours and reasonable roster	Recruitment of additional Intensive Care Physician position in 2015/16	SMO job sizing under way to be completed July 2016	John Gommans, Colin Hutchison & Craig Sidoruk	Aug-16	ICU SMO job sizing in progress. Further discussions and considerations and optiosn to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016.
3.7. Significant positive change has occurred and continuing. Administration take care to facilitate positive change and beware of applying excessive financial strain during a time of transition and transformation	ICU SMO establishment increasing as a result of ICU SMO business case approval. ICU SMO job-sizing process to be completed to ensure safe and sustainable rostering.	Job sizing under way. Await outcome of job sizing project	John Gommans, Colin Hutchison & Craig Sidoruk	Aug-16	ICU SMO job sizing in progress. Further discussions and considerations and optiosn to be negotiated and worked through. Hope is to finalise this piece of work fully by end November 2016.

Report Recommendation (Feb 13)	Status - May 2016	Current Plan	Lead / Responsible	By When	July Update
3.8. Develop systems to ensure minimum nurse staffing standards are adhered to. This will ensure there is a supernumerary nurse coordinating each shift, a 1:1 nurse patient ratio for ventilated patients and a 1:2 patient ratio for HDU patients	ICU RN establishment permits 8 RN per shift. Maintaining safe staffing within this number requires occupancy to be below maximum (11 beds) and have a favourable HDU to ICU case mix. When clinical demand exceeds 8 RN/shift there is either the option to source additional RN (extra shifts or casual) or reduce clinical demands (prematurely discharge, decline elective work, defer admissions or flight critically ill people out) CNM reports monthly on casual nursing staff usage, extra shifts worked and nursing overtime in report to directorate leadership.	A new investment bid submitted to increase RN establishment. Nurse staffing shortages are recorded in event reporting system and raised with directorate leadership. Trendcare shift variance shows this in a regular report.	A&M Directorate Leadership and ICU - CNM	Aug-16	Initiation of CCDM process in ICU with expectation of results March 2017.
3.9. Fill vacant ACNM position immediately to bring it back up to 3.5 FTE	Prior attempts to reinstate 4th ACNM unsuccessful	Only half of all shifts able to be staffed by ACNM due to budgeted establishment.	ICU Ops Team	Jun-16	Initiation of CCDM process in ICU with expectation of results March 2017.
3.11. Review out of hours ward medical and nursing resources to enable better support for the deteriorating patient	Pending AIM 24/7 implementation of 'managing the deteriorating patient' work stream. PAR nurse (working during the day) will identify the at risk patients to be monitored after hours.	PAR nursing resource approved. Negotiating with ICU SMO about the level of senior medical support available.	HoD & CNM - ICU	**COMPLETE**	
3.12. ACNM office days be rostered and acknowledged as essential time to enable the team to achieve service goals, develop nursing practice and manage nursing staffs' professional development. At these times the ACNM should not routinely be pulled onto the floor for meal reliefs or to take admissions or discharges. Thus a planned roster must enable them to be completely off the floor and away from the day to day running of the unit	3 part-time ACNMs not adequate to cover 24/7 roster and provide leadership and support to clinical team. Attempts to reinstate 4th ACNM unsuccessful - not budgeted but actually need 6 fte to function effectively.	Budget application 2015/16 to reinstate 4th ACNM was not prioritised. Therefore non clinical ACNM hours are unable to be rostered due to clinical duties taking priority. When able, non clinical time is rostered. CNM frequently trying to roster non clinical as able.	HSLT	ongoing	Initiation of CCDM process in ICU with expectation of results March 2017.
4. Anaesthetic Technicians and Flight					
Reduction or loss in Anaesthetic Technician cover will leave a large gap which could lead to equipment failures and shortages, increased complications, a reduction in nursing resource and increased number of flights by third party operators (at much greater cost). At present there are not enough ICU trained flight nurses to cover a 24/7 transport service. There must also be back up transport nurse/AT for times when urgent, time sensitive, transfers are required (eg Neurosurgical, cardiac and vascular patients).	A unique arrangement exists where ICU has a role for anaesthetic techs who also provide patient transport assistance to ICU medical team. ICU clearly needs dedicated technical support and a functional flight retrieval system	Start untangliing this situation when recommendati	A&M Directorate and ICU Leadership Teams.	Oct-16	Discussions with HSLT and HR - plan to align implementation of flight review and hospital reconfiguration.

CLINICAL GOVERNANCE STRUCTURE UPDATE

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Report from Allied Health Professions Forum**
	For the attention of: **HB Clinical Council**
Document Owner:	Andy Phillips, Chief Allied Health Professions Officer
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For Information

8

RECOMMENDATION

That HB Clinical Council

Note the report from the Allied Health Professions Forum.

SITUATION

The purpose of the Allied Health Professions Forum (AHPF) is to ensure that the full potential of the Allied Health Professions is realised, engaging fully in partnership with others, to capitalise and maximise quantifiable health outcomes for the population served by Hawke's Bay District Health Board.

BACKGROUND

The Allied Health Professions workforce consists of over fifty different professional groups including Therapists, Scientific and Technical, Dental, Pharmacy, Psychology, Social Workers, Anaesthetic Technicians, Engineers, Health Promotion/Protection professionals. The AHPF is a forum for engaging with the leaders of these groups.

Terms of Reference for the AHPF are provided at the end of this document.

Standing agenda items include a strategic briefing to cascade information to all AHPs, appreciative enquiry to share lessons from work that is going particularly well, discussion of challenges in High Reliability Delivery of Quality and support required, Allied Health Educator update and report from the Primary Care Allied Health Project.

ASSESSMENT

Consistent issues discussed have included:

1. Challenges in having the right numbers of staff in place to meet current demand for current services
   - establishment
   - cover for leave
   - demand from development of other services
   - periods of high demand
   - innovations in service
   - workforce demographics

2. Supporting current staff
   - career development–advanced/expert clinicians
   - career structure-advancement in role/CASP
   - leadership roles in directorates
   - pay inequities-different MECA's, different staff groups
   - gaining funds for continuing professional development
   - lack of preceptorship and issues in competency on joining the DHB

3. Key areas for AHP development
   - Increased integration of services, trans-discipline, trans- organisation, trans-sector
   - Person and whanau-centred care; closer to home, with faster access
   - Right care for the right people, by the right people, in the right place, at the right time
   - Preventative intervention; creating an environment to maintain health and well-being
   - Empowering self-management
   - Management of long term conditions; maximizing wellness and independence, reducing avoidable hospital admissions

- Increasing cultural competency

4. Developing new staff
   - inter-professional education and training
   - funding for education and training
   - increasing Maori workforce
   - developing Assistant Practitioners-PT/OT/SW

5. Developing new service models
   - Improve access-walk in clinics
   - Move services into community, out of hospital
   - Co-design services with communities
   - Co-create health with individual patients
   - Reduce waste, harm, variation-stop doing things of limited value, start doing things of greater value
   - Work more effectively with disadvantaged populations
   - Telehealth

TERMS OF REFERENCE

Allied Health Professions Forum (AHPF)

October 2016

Strategic Goal	To ensure that the full potential of the Allied Health Professions is realised, engaging fully in partnership with others, to capitalise and maximise quantifiable health outcomes for the population served by Hawke's Bay District Health Board.
Functions	The functions of the Forum are: 1. To ensure an intentional and responsive approach to advancing allied health professions' practice. 2. To develop strategies and work-plans and working parties to take forward projects. 3. To contribute and endorse documentation pertaining to professional matters. 4. To advise the Clinical Council on professional care, therapy, clinical, scientific, technical and health management issues. 5. To be the forum for Allied Health Professions debate and professional consultation on **matters that impact clinical practice and patient care** for the organisation. 6. To provide a professional advisory forum to support management structures. 7. To support the development of interdisciplinary, multi-sector, patient focussed and outcome-based care pathways. 8. To engage with partners outside the organisation to promote understanding and effective cohesive partnership working and report back to the forum any highlights/ issues that impact Allied Health Profession Services. 9. To ensure that members of the Forum effectively represent Allied Health Profession Services to a wider audience on a uni and multi-professional basis. 10. To be a link and forum for communication with the regional and national professional advisory structures and wider networks. 11. To develop and promote, best/evidence-based practice in respect of Allied Health Professions. 12. To develop and promote, a research and development culture within the Allied Health Professions workforce.

	13. To act as a source of professional expertise, provide a coherent and coordinated forum for Allied Health Professions workforce training, development and modernisation. 14. To ensure the organisational accountabilities and responsibilities of the Allied Health Professions are met in relation to Healthcare Governance including registration with appropriate regulatory authorities. 15. To advise on the development and implementation of Health Board policies which will have a professional impact for Allied Health Profession Services. 16. To advise the organisation and assist in the effective communication and implementation of legislation, statutory guidance and professional Allied Health Professions directives.
Level of Authority	The forum is a subcommittee of Clinical Council and has delegated authority for some specified matters.
Membership	All members will ensure that their profession is represented by alternates, as required. Co-opted members will be invited to attend as appropriate.
Chair and Vice Chair	The Chief Allied Health Professions Officer will Chair the Forum. The Vice Chair will be a core member of the "Forum" and will be nominated, seconded and elected for a one year term by the members.
Quorum	Chair or Vice Chair plus 50% of members.
Reporting	Reports to Clinical Council, annually through the Forum Chair.
Meetings	Meetings will be held monthly.
Venue	Generally in the Health Services meeting room at Hawke's Bay Hospital but alternate venues may be chosen by members on a rotational basis across the geographical boundaries of the organisation.
Minutes	The Minutes of each meeting shall be submitted by the Chair to the next succeeding meeting of the Forum for their certification as a correct record of the proceedings. The Minutes are permanently retained on file in a secure location.
Terms of Reference Review	These Terms of Reference will be reviewed every two years.

HAWKE'S BAY District Health Board Whakawāteatia	**Laboratory Specimens Labelling Improvement Initiative**
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Authors:	Chris McKenna (Chief Nursing Officer) Barbara Ryan (Improvement Team Leader) and Anne Bruce (CNS IV Therapy)
Reviewed by:	Executive Management Team Member – Chris McKenna Clinical Council Member – Chris McKenna and Jules Arthur
Month:	November 2016
Consideration:	For Information

RECOMMENDATION

That Clinical Council and Consumer Council

Note the contents of the report.

OVERVIEW

This paper provides Clinical Council with an update as to HBDHB's current position following the implementation of a number of recommendations and activities that have been introduced with an aim to see better performance and a reduction in error rates in laboratory sample labelling. This paper follows two previous ones, (July 2014 and a further update in February 2015).

An improvement initiative was introduced in 2015 which has resulted in an increased awareness of the importance to correctly identify patients, the need to label specimens at the point of collection and to complete the 'Final Check', which is a mindfulness technique to check the sample labelling in front of the patient. This has resulted in a sustained reduction in the error rate from 55.4 monthly median to 41.2 despite increasing emergency department presentations and is expected to continue to decrease.

BACKGROUND

The laboratory has been reporting all incidences of unlabelled/mislabelled specimens and reports generated for all clinical areas, in order to raise awareness of this potentially serious clinical risk and highlight where ward based improvement efforts would best be targeted. Despite this, errors did not significantly decrease nor have they been sustained at a consistently low level. It appeared that simply providing information had not effected change, and it appeared that the error rate level had become the acceptable norm amongst sample collectors.

In trying to resolve this issue and reduce the number of errors and potential risk to our patients, it was recognised that any solutions needed to be multi-layered. One solution would not fix the complex issues that existed.

Following the completion of an independent observational analysis in January 2015 by Becton Dickinson (BD) – suppliers of our consumables used in blood sample collection, it was identified that

failure to properly identify our patients was a major factor in poorly labelled specimens, along with a culture of labelling specimens away from the patient or point of collection. There was also no active engagement with patients during this process.

Improvement Initiative

A number of ideas and solutions were tabled following discussions with staff e.g. nurses, midwifes, clinical educators, medical registrars and IV Link group. Solutions identified included utilising learnings from the "Did you ID me" campaign (Philadelphia), "The Final Check" Campaign (South Carolina); and the re-enforcement of the concept of labelling at the bedside and the sample labelling procedure. This highlighted the use of the three-way check (comparing patient ID, with the sample label and the request form). These initiatives were implemented through a six week campaign between August and September 2015 and was supported by the following:

- Laboratory Sample Label Collection and Labelling Procedure CPG120 developed.
- Posters/ banners in all clinical patient areas and on phlebotomy trolleys.
- Notifications on Staff notices, Hot News and Trendcare.
- Presentation at Grand-round on 1 July 2015 and through RN study days regularly throughout 2015.
- Staff education with representatives of BD who were on site to talk to staff about the campaign.
- In house education, both in small groups in all clinical areas and via the mandatory study days continued.
- Engagement with patients at the front door and in waiting areas.

A follow-up independent observational review of blood collection practices was conducted in February 2016 across three days to again look at blood collection and to see the extent of changes made.

- Wristbands were present on all (100%) patients prior to any procedures (21/21).
- All identifications were confirmed with open ended questions.
- This demonstrated greater 'buy in' for improving blood collection and sample labelling practices.

This initial campaign was further supported in 2016 by:

- Online training module developed. Staff, undertaking phlebotomy, required to pass the online learning. In June 2016 a video was made and will be added to the training module to further demonstrate the Final Check process.

- Laboratory request form reviewed and encorporated into the revised Laboratory Sample Collection Procedure (Laboratory Sample Collection and Labelling Procedure - CPG120) now includes a signed declaration that the process was completed correctly including the FINAL CHECK.

- Identification of Inpatients Day Patients Procedure CPG046 reviewed. (Identification of Inpatients Daypatients - CPG046). Agreement with Information Systems to enable one ID Band to remain on the patient throughout the admission from ED. (Reducing risk of patient ID errors).

- Individual accountability process signed off by steering group - ensuring there is a consequence to repeated labelling errors.

Results to date:

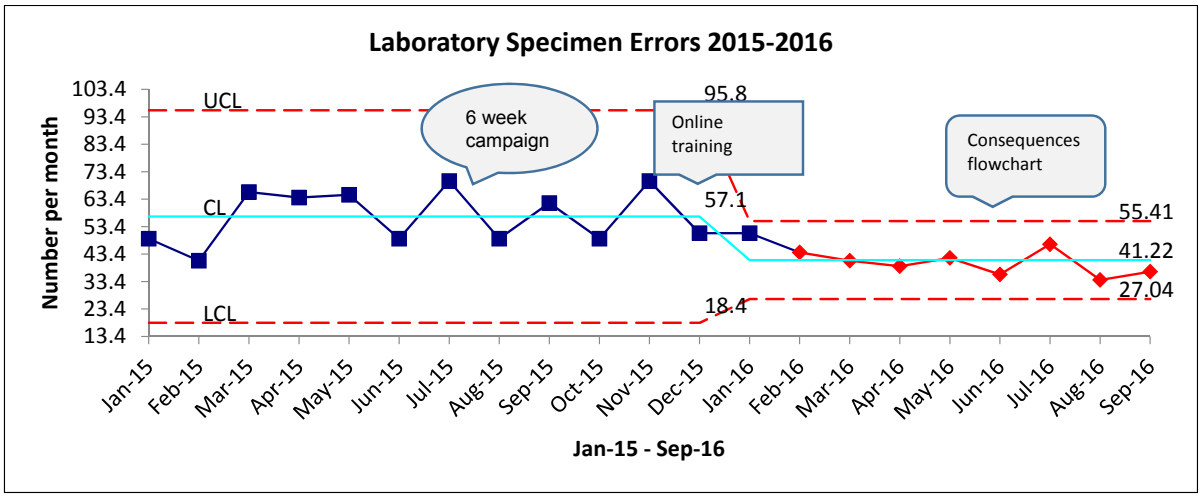
This organisation has benefited by introducing a process to support the provision of safe and excellent clinical care, by implementing a range of initiatives to highlight and improve specimen labelling at the bedside, underpinned by the principles of reducing harm, waste and patient care variation.

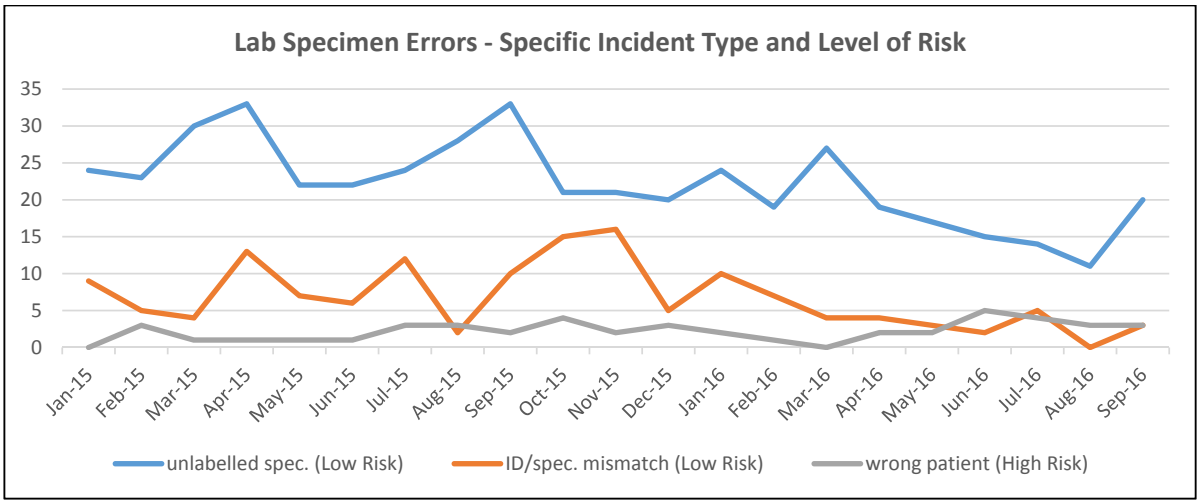
An increased acceptance of change and improvement of work practices by all clinical staff has resulted in a decrease of errors despite the increase of presentations to the Emergency Department and admissions to hospital.

This is supported by our consumer feedback which includes:

'Staff frequently checked my father's identity of Dad on several occasions…'

The number of reported events by Laboratory Staff has reduced over time. *(Refer Run chart and Specific Incident Type and Level of Risk chart below)*





HB CLINICAL RESEARCH COMMITTEE UPDATE

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Laboratory Services Committee Quarterly Update**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author(s):	Dr Mark Peterson Dr Kiri Bird, Chair
Reviewed by:	Laboratory Services Committee
Month:	November 2016
Consideration:	For Discussion

RECOMMENDATION

That the Clinical Council

Note the contents of this report.

A quarterly meeting of the Laboratory Services Committee was held on 17 October 2016. Following find a summary of the key points noted:

1. Governing body issues

- Terms of reference review invited by Clinical Council
- Membership and quorum review (e.g. Nik Krawchenko ?is he even still at HBDHB?)
- Meetings are struggling to gain quorum
- Midwife resigned
- Clinical Council need to appoint new midwife to group
- Administrator resigned Sue Larkin (minute taker and meeting coordinator).

2. Staffing changes

- Acting Laboratory Manager, Gopy had resigned
- Job advertised and now closed
- Laboratory Clinical Director, a new role sourced from Counties Manukau (Dr Ross Boswell appointed paperwork pending)

3. Accredidation Visit

- IANZ annual visit due - no issues noted by staff - Chair requested a short summary of their visit

4. Piccolo Update

- POCT Wairoa - piccolo did not add value so now working on ISTAT and LACTATE meter for Wairoa to support GPs.

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

13. Minutes of Previous Meeting (Public Excluded)

14. Matters Arising – Review of Actions (Public Excluded)

15. Letter received from CAG on Governance Matters (not discussed Sept)

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

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

HAWKE'S BAY District Health Board Whakawāteatia	**13-17 Year Old Primary Care Zero Fees Subsidy Project**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and Maori Relationship Board**
Document Owner: Document Author):	Tim Evans, GM Performance, Informatics & Finance Patrick LeGeyt
Reviewed by:	Executive Management Team
Month:	October, 2016
Consideration:	For Approval by HB Clinical Council; and For Information of MRB and HB Health Consumer Council For Endorsement by the HBDHB Board

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RECOMMENDATION

That HB Clinical Council:

1. Approve funding Eligible General Practices within the geographical area of Wairoa, Napier, Hastings and CHB to provide zero fees to their 13-17yr old population.
   - Eligible practices include those with high enrolled Māori (84.5%) and Pacific (89.6%) 13-17 year olds; and
   - cover 67.7% of all enrolled 13-17 year olds
   - costs $583,235 ($63,235 over budget)
3. Approve the requirement of general practices within programme to make 'youth friendly' changes to the model of primary care;
4. Approve the Programme Level Measures;
5. Endorse the content of this report and acknowledge that further work is required to develop an implementation plan, outcomes and evaluation framework to reach a go live date of 1 January 2017.

BACKGROUND

In May 2015 a budget investment paper, containing three investment options, was submitted to HBDHB Clinical Council for consideration. The following options were supported:

- Extend Free Primary Care for all 13-17 years olds in Hawke's Bay
  a. Ring Fence the funding for targeted access to Decile 4 & 5 to Primary Care.
  b. Reduce the amount to $500,000 per annum; proposition to come back to Clinical Council.
- Extend Free Primary Care for all 13-17 year olds in Wairoa
  a. An estimated $20,000 per annum was approved

Consultation: Following consultation with ten general practices as well as Directions Youth Health service, HHB Priority Population Committee and HHB Clinical Advisory Group; as well as targeted groups of youth from Hastings, (Camberley, Flaxmere) and Wairoa, it was agreed that a programme be introduced that addressed zero fees and changes to the model of care with associated programme performance measures.
Barriers to access: Cost is recognised as the most significant barrier to access but other areas were also identified by youth as needing to be included in the model of care.

"What Youth have told us they want"

- No cost primary health services
- Integrated (health services) with youth social services and offer 'practical' support and not just 'quick advice'
- Telehealth and preappointment options needs to offered more fully
- Walk in clinic options
- Self-selection menu of services (electronic or tick box) should be offered at reception
- Consultation times need to be more generous
- Clinic locations closer to where they live
- Staff that specialise in youth health, are younger and from a variety of cultural backgrounds
- Staff need training to be more friendly, responsive and accommodating for youth

PROGRAMME APPROACH

1. Removal of Cost
Directly fund general practices with co-payment subsidy based on a utilisation rate of 2.15 per annum costed at $25.00 per consult, inclusive of a 25% buffer for potential increases.[1]

After hours consultation subsidy is also included and will be slightly higher at $40.00 per visit (utilization rate of 0.26 visits per annum per person) as well as a pharmacy subsidy of $5.00 per item, per GP consultation (see attached paper for breakdown of funding formula calculations, options and analysis).

2. Target high need – Māori and Pacific Population Groups
Practices with the above demographic have been consulted and their feedback on model of care sought. Currently it is anticipated that 14 practices will be included in the programme, which includes two practices aligned to The Doctors Hastings.

[1] Table 1.0 provides 'indicative' funding to practices identified that fit the criteria. However it is not certain that all practices identified will participate as it is a voluntary scheme. This could reduce the overall expenditure and/or provide for a redistribution of allocated funds. Furthermore, there is a funding differentiation between VLCA practices and non VLCA practices, and reducing the co-payment subsidy to $15 per consultation for VLCA practices would reduce the overall funding request to within budget.

3. Changes to Model of Care

General practices that agree to enter the zero fees subsidy programme will be expected to adopt changes to their model of care.

The overarching principles for the model are:

- Provide a range of 'youth friendly' clinical health services, staffed by health professionals who are well trained, skilled and knowledgeable in youth health.
- Provide comprehensive and 'joined up' youth friendly care.
- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people.

4. Implementation:

- There are currently fourteen practices[2] that have indicated an interest in being part of the program of work.
- To qualify for funding each practice will need to demonstrate a commitment to improving youth health outcomes through an agreed plan – developed with each of the practices.
- The funding received by the practices is a nominal figure of $25 per consultation calculated against their enrolled 13-17 year old population, and multiplied against a utilisation rate of 2.15 visits per annum.
- Within a number of practices the following services are current and will provide a further platform to develop the model of care
    - Sexual health contract provided free of charge to the person in Napier , Hastings and Central Hawke's Bay for youth up to and including 20 year olds, and in Wairoa for youth up to and including age 24 years.
    - Whanau wellness programme provided free of charge to the person and their whanau which includes pharmacy scripts.
    - PC/ED copperative which includes an intensive case management approach
    - A number of practices have also been supported to employ social work services and kaiawhina

Where these services are in place the implementation process will ensure alignment to the best use of funding or augments what's in place as appropriate.

The sum per practice ranges from $11,933 to $83,958 per annum. (Refer Table 1.0 below)

5. Programme Outcome Measures:[3]

Reduction in acute Emergency Department presentations and admissions for -

- Self -referred but not admitted Emergency Department attendance rate (in and out of hours)
- Serious Skin Infections
- Asthma
- Mental Health (presentations & admissions)

[2] Table 1.0 – lists practices identified that meet the criteria of the programme. Shaded practices are VLCA practices (Very Low Cost Access). Many of which offer low or no fees for the 0-18/20 age group

[3] The higher level programme outcome measures provide a challenge to ensure performance indicators included in the provider contract have a clear line of sight to what's intended. This will require utlising a broad base line with practices who are not recipients of the funding and would be part of the establishmnent stage.

Individual Practice Plans - Each practice plan will:

- be co designed with the practice staff and PHO practice development team and youth
- include baseline expectations that involve changes to model of care and zero fees.[4]
- include tailored measures that will contribute to the achievement of the program outcomes.

Tailored practice measures - would be specific to individual general practices and negotiated with each practice. Options would include but are not limited to;

- Increased utilisation of primary care (> 25%) over current utilisation rates
- Youth Friendly General Practices
- Engagement in youth specific training
- Alignment of practice to recognised Youth Health Standards[5]
- Inclusion of findings from practice specific Youth Health Satisfaction Surveys in model of care design

Funding - would dictate the scope of each practice plan, however all practices will be guided to address all items listed above. (The funding formula is provided in section: 'Removal of Cost' above. Table 1.0 below illustrates funding allocations per practice based on the formula).

Resources - used to guide Best Practice for the model would include the RNZGP Measures against the Youth Friendly General Practice Audit, and the Youth Health Standards developed in Counties Manukau DHB.

6. Alignment to the HBDHB Youth Health Strategy

This proposal, through its network of providers, development of practice plans and alignment to program outcomes, supports the HBDHB Youth Health Strategy implementation The four key outcomes identified internationally and within the youth strategy aligned to creating positive youth development are:

- Healthy and Safe thriving youth engaged in healthy active lives
- Engaged and inspired youth engaged in positive relationships with peers and seniors
- Productive learning and working environments where youth can achieve as participants and leaders
- Communities that encourage inclusiveness supported through adequate resources in strength based environments.

FINANCIAL IMPACT

Although the theoretical costing of this recommended option is $63,235 over this years budget, this potential overspend is not specifically addressed in this paper because:

- Costing is based on 100% uptake by all qualifying practices – which may not be the case.
- Implementation from 1 January 2017 will have only a 50% cost impact on this financial year.
- Data gathered over the first 3-4 months of implementation will assist with the practical calculation of the budget required for 2017-18.
- Any potential 'shortfall' in 2017-18 budget can be addressed through various optons at that time.

[4] It is important to note that a number of the practices already provide zero fees.
[5] 2006 (Draft) Youth Health Standards Commissioned by Counties Manukau

Table 1.0 – Funding Allocation

Napier	Existing Fees	Total	% MPI	General consult funding	Urgent care consult	Pharmacy funding (based on $5.00 per consult)	Full Utilisation costs
The Doctors - Napier	$27.00	1400	42%	$75,250	$14,560	$16,870	$106,680
Tamatea Medical	$28.00	453	32%	$24,349	$4,711	$5,459	$34,519
Maraenui Medical (VLCA)	$11.50	417	74%	$22,414	$4,337	$5,025	$31,775
						$0	
Wairoa	**Fees**	**Total**				$0	
Wairoa Medical (VLCA)	$12.00	106	66%	$5,698	$1,102	$1,277	$8,077
Queen St Medical (VLCA)	$11.50	222	84%	$11,933	$2,309	$2,675	$16,916
Health Care Centre Ltd (VLCA)	$11.50	245	79%	$13,169	$2,548	$2,952	$18,669
						$0	
Central Hawkes Bay	**Fees**	**Total**				$0	
The Doctors – Waipawa*	$24.00					$0	
Tuki Tuki Medical	$24.00	503	29%	$27,036	$5,231	$6,061	$38,329
						$0	
Hastings	**Fees**	**Total**				$0	
Totara Health (VLCA)	$0.00	1214	65%	$65,253	$12,626	$14,629	$92,507
Medical & Injury (VLCA)	$0.00	278	65%	$14,943	$2,891	$3,350	$21,184
Hauora Heretaunga (VLCA)	$0.00	590	93%	$31,713	$6,136	$7,110	$44,958
The Doctors - Hastings	$16.00	664	36%	$35,690	$6,906	$8,001	$50,597
The Doctors - Gascoigne St* (VLCA)	$11.00					$0	
Hastings Health Centre	$18.00	1562	25%	$83,958	$16,245	$18,822	$119,024
	Total Program funding p.a.			**$411,403**	**$79,602**	**$92,231**	**$583,235**
						Total funding available	**$520,000**
Urgent Care - based on $40.00 per consult at 0.26 consults p.a.						**Variance**	**$63,235**
Pharmacy - based on $5.00 per consult @2.41 consults (0.26 + 2.15 (UC+Genral conslut rate)) p.a.							

Appendix One

(Contains all background and appendices for the initial and subsequent papers)

1. Cost as a Barrier to Access to Primary Health Care

In New Zealand primary health care is heavily subsidised and the out of pocket expense of primary health care for consumers is relatively low. NZ is in the top quartile for government funded health care in the OECD countries with just over 80% of health costs funded by general government revenues.[6] Whilst the level of out-of-pocket contributions for health care in New Zealand is bottom quartile and, despite increased funding of primary health care, cost remains the most significant barrier of access for some population groups to primary health care in NZ.

The NZ Health Survey 2013-2014 found that cost is the most significant barrier to accessing primary care service in New Zealand. Those in the more highly deprived areas, on low-medium incomes, young people aged under 25 years of age, Māori and Pacific peoples, those who use more services, and those in poorer health, are more also likely than other New Zealanders to forego visits as a result of the cost of primary health care[7]. In Hawkes Bay, the survey found that youth (15-24 years) have higher rates of unmet need for primary care than NZ national average (34% compared to 23%).

NZ research has consistently shown significant inequities in access to, and use of, services. A number of studies have particularly focused on differences between Māori and non-Māori utilisation of health services.[8] Overall, the results suggest that in many cases Māori have less access to primary health care, relative to the whole population, particularly when proxies for need (e.g., mortality, hospital discharges) are taken into account. Poor access to primary health care for Māori is considered a key factor in higher rates of illness and hospitalisations, in generating poorer health outcomes and inequalities in health. Similarly, research available on Pacific peoples' experiences of health services shows that Pacific peoples living in New Zealand generally have poorer health status than other New Zealanders; are more exposed to risk factors for poor health, and experience barriers in accessing health services.[9]

Cost also contributes to some groups seeking out free health care from HBDHB Emergency Department (ED). This can be evidenced by a significant increase in ED presentations of 17.6% over the last 5 years. ED presentations grew by 5.6% in 2015 alone. Attendances by children (5-14 years) and youth (15-24 years), increased by 10.5% and 9.7% respectfully.[10] The high utilisation rates and low conversion rate to inpatient admissions suggest ED is being used as a first level primary care health service, especially for those in close proximity to the hospital and also impoverished populations.

In October 2013, HBDHB and HHBPHO performed a survey of consumers and/or their whānau/support people, who presented at the Emergency Department, HB Hospital, between 9am

[6] Treasury Report: Improving the targeting of co-payments in primary care. June 2012
[7] Ministry of Health. NZ Health Survey 2013-2014.
[8] Evaluation of the Primary Health Care Strategy: Practice Data Analysis 2001-2005. Gribben & Cumming. 2007
[9] Ibid.
[10] HBDHB Information Services. Hawke's Bay Regional Emergency Department Trends 2011-2015

to 7pm over the period 09 September 2013 to 13 September 2013[11]. The purpose of the survey was to find out from consumers who access ED:

1. What they knew of available health services in the community
2. their experience of primary care services
3. their preference for options in accessing primary care services in the future

A total of 67 surveys were initiated with 63 being fully completed. Forty-two or 67% of respondents that answered the demographic questions identified Māori as an ethnicity. Eleven or 18% of respondents identified as Pacific and of these, six were Cook Island, four Samoan and one Tongan. Fourteen identified as New Zealander or European only. When asked what barriers prevented the respondents from accessing primary care services the majority indicated cost as a barrier, followed by transport, outstanding debts with their GP and availability of appointments.

Ambulatory sensitive hospitalisations (ASH) can be considered an indicator of reduced access to primary care. ASH related hospitalisations are potentially avoidable through preventive interventions or treatments deliverable in a primary care setting and account for around 1/5 of acute and arranged medical and surgical discharges. ASH rates amongst 0-4 years show disparities with Māori rates 1.6 times those of non-Māori rates. However this disparity has decreased as ASH rates have declined faster for Māori which coincides with the implementation of free primary care for children aged under 6. Theoretically the ASH rates for other groups of children and young people would be impacted in a similar way if access to primary care was improved.

Improved access to primary health helps prevent the early onset of long term conditions. There is growing evidence that prevention and intervention strategies applied early in life are more effective in altering outcomes, and reap more economic returns over the life course, than do strategies applied later in life. [12] Health research also confirms that risk factors for long term health conditions often present during childhood and adolescence and that targeted investment in earlier intervention at the primary care level is cost effective and has the potential to reduce some of this burden.

Improved resourcing of primary care improves population health outcomes and lowers the overall long term cost on the health system. International research also supports the focus on providing additional resources to encourage greater use of primary health care services. International research finds that primary health care in countries with stronger primary health care systems with lower costs have better health outcomes (most notably in infancy and childhood) [13].

This paper proposes a primary care zero fees approach for 13-17 year olds in Hawkes Bay that builds upon the national rollout of zero fees for under 13 year olds but is targeted towards those populations where cost is known to be a barrier to access.

2. Targeted Primary Care Funding

Over the last 15 years, primary health care funding has undergone a transformation. The Primary Health Care Strategy 2001 signalled a move away from the targeted funding approach to a universal approach, where all New Zealanders are eligible for government funding for primary health care. The PHCS emphasised capitation based funding payments based on community health and health prevention. The result has been health expenditure increase for higher income deciles more quickly than spending on lower income deciles.[14]

[11] HBDHB, Māori Health Services: Internal Report. Māori and Pacific Access to Health Services Survey. 3 October 2013.
[12] Improving the Transition Reducing Social and Psychological Morbidity During Adolescence: A report from the Prime Minister's Chief Science Advisor, May 2011
[13] Treasury Report: Improving the targeting of co-payments in primary care. June 2012
[14] Treasury Report: Improving the targeting of co-payments in primary care. June 2012

Primary health funding capitation formula and associated allocation methodologies has also been heavily criticised. It's argued that the co-payments a consumer pays to see a GP are unrelated to that consumer's ability or inability to pay, but rather to the make-up of that practice's population as a whole and to the pricing policy of the individual medical centre.

In 2015, the Primary Care Working Group (PCWG) on General Practice Sustainability provided a report to the Minister of Health detailing recommendations to improve the equitable access to affordable primary health care, workforce sustainability and shifting services closer to the community. The PCWG reviewed current targeted funding mechanisms including Community Services Cards (CSC), Working for Families Tax Credits (WFTC), deprivation and ethnicity. It found that CSC as a sole targeting mechanism had a low income threshold below the minimum wage, had a low uptake by consumers and were administratively burdensome for providers to manage. Similarly, WFTC required active application by individuals and did not cover low income individuals without children. However, PCWG found that deprivation had a strong correlation to Māori and Pacific ethnicity and therefore served as a proxy for targeting for Māori and Pacific ethnicity. The group recommended primary health funding be targeted towards a combination of CSC, deprivation and ethnicity. However, most of the components related to the recommendations, such as CSC income thresholds and primary care funding formulas, required central government policy level changes and the funding formula remains unchanged.

Given the findings of the PCWG Report require major policy changes at central government level, this paper proposes using a targeting approach focused on general practices with high Māori, Pacific and Quintile 4 & 5 enrolled populations.

3. Hawkes Bay 13-17 Year Old Population Information

HB Population 13-17 Year Olds

Hawke's Bay has proportionally more people in the more deprived sections of the population than the national average (40%) with 47% of the population living in Quintile 4 and 5 areas.[15] Of 13-17 year olds living in the HBDHB region, 5,755 (52.7%) live in Quintile 4 and 5 areas.[16]

There are approximately 11,096 children aged 13-17 years enrolled with Health Hawke's Bay PHO general practices.

- Hastings has the highest number of 13-17 year olds enrolled in general practice (5,428 or 49%).
- Māori (35.8%) and Pacific (4.9%) make up a combined 41% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.
- VLCA[17] practices make up 30% (3,248) of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.

Māori and Pacific enrolled populations are concentrated in under half of the general practices in HB.

- Just twelve general practices in HB have 85% of the total enrolled Māori and Pacific 13-17 year olds.
- High needs areas, such as Wairoa, Māori make up 77.3% of the enrolled population of general practices.

[15] Ministry of Health website: Population of Hawkes Bay DHB 2015/16

[16] Ministry of Health website: PHO Enrolment Demographics 2016

[17] Very Low Cost Access (VLCA) practices receive higher capitation rates in return for lower zero fees capped levels for standard consultations (zero fees for children 0–5 years, $11.50 maximum for children 6–17 years, $17.50 maximum for adults 18 years and over). A general practice must have at least 50% "High Needs" people (Māori, Pacific, or Quintile 5) enrolled to qualify for VLCA funding.

- In Hastings, Māori and Pacific 13-17 year olds make up 42% of the total enrolled population with 76% enrolled in just three general practices (Totara Health, Hastings Health Centre and Hauora Heretaunga[18]).
- Napier only has 13% of the HB Māori and Pacific 13-17 year olds. However, 73% of Napier Māori and Pacific population are enrolled in only three general practices (The Doctors Napier, Maraenui Medical Centre and Tamatea Medical Centre).
- General Practices with the largest 13 to 17 year old Māori and Pacific populations include Totara Health, The Doctors Napier, Hauora Heretaunga, Hastings Health Centre, The Doctors Hastings (includes Gascoigne St, Waipawa), Wairoa Health Centre, Queen Street Medical and Medical and Injury.

53% of Hawkes Bay 13-17 year olds live in Quintile 4 & 5 areas

85% of the total Māori and Pacific 13-17 year olds are enrolled in only 12 GP practices

76% of Māori and Pacific 13-17 year olds living in Hastings are enrolled in only three general practices

73% of Māori and Pacific 13-17 year olds living in Napier are enrolled in only three general practices

(See Appendix for greater breakdown of HB Population 13-17 Year Olds)

4. Primary Care Utilisation Rates

In 2015, the average GP consultations for 13-17 year olds was 1.72 consults per annum. There is very little difference between VLCA and Non-VLCA average GP consultation rates at 1.70 and 1.73 per annum respectfully. Combined GP and Nurse Consultations for 13-17 year olds is 2.15 consults per annum.

In 2015, Māori and Pacific received less average GP consultations than Asian and Other NZers. Māori and Pacific received 1.56 and 1.28 average GP consultations per annum in comparison with Asian and Other NZers which had 1.75 and 1.86 per annum. However, Māori received higher Nurse Consultations than any other ethnic group with 0.58 per annum. This increased the combined GP and Nurse average consultations for Māori to 2.13 per annum in comparison to Non-Māori 2.21, Asian 1.75 and Pacific 1.62 per annum.

The average GP consultations for 13-17 year olds was only 1.72 consults per annum

(See Appendix for further information on GP and Nurse Consultation Rates)

Utilisation Ratio Equation

When the zero fees for Under-6s and Under-13s scheme were introduced throughout New Zealand, practices experienced an initial increase of 10% in utilisation rates, which then levelled off. Experience in HBDHB which introduced consultation fees for Under-13s indicates that visits to general practice have reportedly increased on average 23 percent in the 6-12 age group in the first six months of the scheme.

The average GP consultation utilisation for 13-17 year olds is 1.72 consults per annum. This will need to have a 25% buffer included for any potential increases in utilisation. Therefore the HBDHB consultation fees subsidy for 13-17 year olds will be based on a rate of 2.15 visits per annum. The funding formula mechanism will need to be monitored to ensure utilisation do not exceed an average of 2.15 visits per year. Agreements will need to allow a review of utilisation rates annually.

[18] Hastings Health Centre, Totara Health, Hauora Heretaunga make 62% of the total 13-17 year old enrolled population of Hastings general practices

HBDHB zero fees subsidy for 13-17 year olds will be based on a rate of 2.15 visits per annum (inclusive of 25% buffer)

5. Primary Care Consultation Fees

In Hawkes Bay, consultation fees for 13 to 17 year olds range from $0 to $39. Where After Hours services are in place, the charges are usually approximately $5 more expensive per visit. Pharmacies charge a flat fee of $5 per item dispensed and may charge $1-2 extra per item after hours.

There is a geographical distinction in consultation fees costs in HB. Although the average consultation fee per person is only $17.69, there is a clear distinction between Napier and CHB with Hastings and Wairoa. In Hastings and Wairoa there are eight no cost and very low cost consultation fees practices charging between $0 – $18 per consultation. Whereas Napier has only two low cost consultation fees practice charging between $11.50 - $18 and fourteen practices charging between $20 - $39 consultation fees. In CHB the consultation fees are $24.

(See Appendix for HHBPHO GP Practice Consultation Fees)

Consultation Fees Subsidy Rate[19]

The average consultation fees for the General Practice above is only $14.70. This is impacted by VLCA practice capped consultation fees of $12.00 with three practice charging consultation fees. However in order to capture a significant section of the Māori and Pacific community, as well as Napier and CHB, General Practices, such as The Doctors Napier, Hastings Health Centre and Tuki Tuki Medical need to be included. Therefore the consultation fees subsidy must be attractive enough to include them. Therefore a consultation fees of $25.00 (GST Excl) per visit is recommended.

There is variability in the afterhours charges to people aged 13 to 17. At a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person.

It is assumed all pharmacies would accept an offer of $5.00 per item, per GP consultation (2.41 per person).

HBDHB zero fees subsidy will be $25.00 per visit

After hours fees subsidy will be $40.00 per visit

Pharmacy subsidy will be $5.00 per item

6. Option Analysis

The HBDHB Clinical Council approved funding investment for:

- All of Wairoa enrolled 13-17 year olds (estimated $20,000 per annum)
- 60% of the rest of HB enrolled 13-17 year olds (estimated $500,000)
    - Focus should be on Decile 4 & 5 populations

To achieve the Clinical Council's targeted funding allocation, three options have been developed.

Option One – Targeted Approach

[19] There is a funding differentiation between VLCA practices and non VLCA practices, and reducing the co-payment subsidy to $15 per consultation for VLCA practices would reduce the overall funding request to within budget.

- Option One provides a targeted approach towards general practices with the largest Māori and Pacific population groups (13-17 year olds).

Māori (35.8%) and Pacific (4.9%) make up a combined 41% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices. VLCA practices make up 30% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices. In Wairoa, Māori make up 77.3% of the enrolled population of General Practices. Other General Practices with significant Māori and Pacific populations include The Doctors Napier, The Doctors Hastings, Hastings Health Centre, Tamatea Medical Centre and Tuki Tuki Medical Centre with an additional 34.9% of the Māori and 26.0% of the Pacific enrolled population.

Therefore a selection criteria of General Practices with at least 30% enrolled 13-17 year old Māori patients and with over 100 enrolled 13-17 year old Māori patients has been applied. This will provide for a wider geographical coverage and ensure a capture of both high needs communities and the majority priority populations. (See Appendix for list of GP Practices)

Population Coverage
Option One provides for 84.5% of the total enrolled Māori population, 89.6% of Pacific and 67.7% of the total enrolled Health Hawke's Bay PHO population.

Option One zero fees subsidy will cover the following population and geographical areas:

- **67.7% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, Hastings and CHB,**
- **High needs communities of Wairoa, Maraenui and Flaxmere; and**
- **84.5% of Māori and 89.6% of Pacific populations**

Cost Analysis
Option One would be over the budget by $63,235 per annum and would cost an estimated $583,235 per annum.

Using local information on utilization rates in this age group, consultation fees at the different practices and the numbers of young people enrolled at each practice it is estimated that around 68% of people aged 13 to 17 years would be able to access free primary care visits during daytime hours at a price offer of $25 per visit. At the current utilization rate of 2.15 visits per person per annum the cost to the DHB to achieve 68% coverage is estimated at $411,408 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $79,602 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $92,231 per annum.

The total cost of implementing zero fees and prescriptions for 68% coverage of HB population between aged 13 to 17 years is estimated at $583,235 (GST Excl).

- **Daytime GP consultations: $411,408**
- **After Hours GP consultations: $79,602**
- **Prescription Charges: $92,231**
- **TOTAL COST: $583,235**

These costings include the estimated cost for standard general practice consultations for enrolled patients, visits to general practice by casual (non-enrolled) patients, after hours visits primary care visits, pharmacy dispensing fees but exclude ACC consultation fees and any after hour's premium levied by pharmacies.

Option Two – Generic Approach

Option Two provides a different approach where HBDHB simply set the consultation fees at $25 per consult and generically offer it to all General Practices in HBDHB region. This approach is consistent with the MOH zero fees 6-13 year old subsidy.

The rationale for Option Two is to make the zero fees subsidy for 13-17 year olds a fair offer to all General Practices and let market forces determine the uptake of the offer. The offer still needs to be attractive enough to ensure those uptake of those General Practices serving population groups where cost is a barrier to accessing primary care and who experience unequal health outcomes. If the consultation fees subsidy is $25.00 per consultation the following General Practices may accept the HBDHB offer consultation fees subsidy for 13-17 year olds.

Population Coverage
Option Two this would cover 100% of the total enrolled 13-17 year olds HB population.

Option Two zero fees subsidy will cover the total population and HBDHB geographical areas:

- **100% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, Hastings and CHB,**
- **High needs communities of Wairoa, Maraenui and Flaxmere**

Cost Analysis
Option Two would not be within budget and would cost an estimated $845,514 per annum.

Option Two provides for 100% of people aged 13 to 17 years to access free primary care visits during daytime hours. At a price offer of $25.00 per visit, with a utilization rate of 2.15 visits per person per annum, the cost to the DHB to achieve 100% coverage for daytime GP consultations is estimated at $596,410 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $115,398 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $133,706 per annum.

The total cost of implementing zero fees and prescriptions for 82% coverage of HB population between aged 13 to 17 years is estimated at $845,514

- **Daytime GP consultations: $596,410**
- **After Hours GP consultations: $115,398**
- **Prescription Charges: $133,706**
- **TOTAL COST: $845,514**

Option Two is not within budget and therefore a lower consultation fee subsidy rate should be considered.

Option Three – Generic Approach of Lower Subsidy

Option Three provides for a set zero fees subsidy offer of $20.00 per GP consultation to all General Practices in HBDHB region. A lower subsidy offer could reduce the uptake of GP practices that may accept the offer:

Population Coverage
Based on GP practices that currently charge equal or around $20 per consultation, approximately only 56.8% of the total enrolled 13-17 year olds would be covered, including 66.7% of the total

enrolled Māori population, 81.2% of Pacific and 48.2% of Other of the total enrolled Health Hawke's Bay PHO population. (See Appendix for List of GP Practices likely to accept offer).

Option Three zero fees subsidy will cover the following population and geographical areas:

- **56.8% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, and Hastings (not CHB),**
- **High needs communities of Wairoa, Maraenui and Flaxmere; and**
- **66.7% of Māori and 81.2% of Pacific populations**

Cost Analysis
Option Three would be within budget and would cost an estimated $412,662 per annum.

Option Three provides for 56.8% of people aged 13 to 17 years to access free primary care visits during daytime hours. At a price offer of $20.00 per visit, with a utilization rate of 2.15 visits per person per annum, the cost to the DHB to achieve 56.8% coverage for daytime GP consultations is estimated at $271,115.00 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $65,572.00 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $75,975 per annum.

The total cost of implementing free primary care visits and prescriptions for 56.8% coverage of HB population between aged 13 to 17 years is estimated at $412,662

- **Daytime GP consultations: $271,115.00**
- **After Hours GP consultations: $65,572.00**
- **Prescription Charges: $75,975**
- **TOTAL COST: $412,662**

Comparative Analysis

Options	Population Coverage (Percentage)					Cost	+/- Budget $520,000
	Māori	Pacific	Other	Asian	Total		
One	84.5	89.6	57.4	26.4	67.7	$583,235	+$ 63,235
Two	100	100	100	100	100	$845,514	+$325,514
Three	66.7	81.2	48.2	67.8	56.8	$412,662	- $107,338

Option One
Option One provides for:

- targeted approach towards General Practices with high enrolled Māori and Pacific 13-17 year olds
- $25.00 consultation fees subsidy
- covers 67.7% of all enrolled 13-17 year olds
- contains a high percentage of Māori (84.5%) and Pacific (89.6%) enrolled population
- wide geographical coverage Wairoa, Napier, Hastings and CHB
- Includes all VLCA practices

Option One does not provide for:

- 'fairness' with an open offer to all General Practices
- A cost structure close to budget
    - is $63,235 over budget

Option Two

Option Two provides for:

- an 'opt in' fair market approach to all General Practices
    - is consistent with consultation fees 6-13 year old approach
- $25 consultation fees subsidy
- covers 100% of all enrolled 13-17 year olds
- contains the highest percentage of Māori and Pacific enrolled population
- wide geographical coverage Wairoa, Napier, Hastings and CHB
- includes all VLCA practices

Option Two does not provide:

- a cost structure within budget
    - is $325,514 over budget

Option Two should not be considered due to the total cost being considerably outside the funding parameters.

Option Three

Option Three provides for:

- an 'opt in' fair market approach to all General Practices
    - is consistent with consultation fees 6-13 year old approach
- affordable costs structure
    - $115,534.25 under budget
- $20 consultation fees subsidy
- covers 56.8% of all enrolled 13-17 year olds
- includes all VLCA practices
- includes Clive and Havelock North

Option Three does not provide for:

- less geographical coverage
    - limited in Napier and does not include CHB
- less Māori population coverage (66.7%)
- sole focus on decile 4 & 5
    - potential inclusion of Havelock North

7. Feedback

Primary Care

Ten general practices as well as Directions Youth Health service, HHB Priority Population Committee and HHB Clinical Advisory Group were consulted over the zero fees proposition. The overwhelming majority favoured reducing costs for general practices services and a targeted approach of Māori, Pacific and Quintile 4 & 5.

Common themes from general practice included:

- Cost was a barrier to accessing primary care
- A targeted approach to Māori, Pacific and Quintile 4 & 5 was favoured
- Attitudes and behaviours of staff was a barrier for youth access
- Multidisciplinary approaches and partnerships with youth social services and youth specialist services would best suit youth health issues
- Youth health networks in each district that were accessible to all youth would improve access to youth health services

Local Consumer Feedback

HBDHB consulted with two groups of 13-17 year olds in Hastings (Camberley, Flaxmere) and Wairoa (Wairoa College) regarding the zero fees proposition. The groups were asked a range of questions related to primary care access and appropriateness.

Both groups stated that cost was the major issue and agreed that zero fees subsidy for 13-17 year olds was a good proposition. However, both groups also suggested that non-financial barriers also impacted on accessing general practice. The groups stated that the attitudes and behaviours of primary care staff were one of the most significant barriers faced in accessing services. They stated the barriers were that significant that they do not use general practice until they are extremely unwell. Furthermore they stated that school health services were difficult to access due to their limited availability and lack of privacy.

The groups of youth had many innovative suggestions for primary care to improve youth friendly services. They suggested that primary care needs:

- integrated with youth social services and offer ‘practical’ support and not just ‘quick advice’
- Telehealth and preappointment options needs to offered more fully
- Walk in clinic options
- Self-selection menu of services (electronic or tick box) should be offered at reception
- Consultation times need to be more generous
- Clinic locations closer to where they live
- Staff that specialise in youth health, are younger and from a variety of cultural backgrounds
- Staff need training to be more friendly, responsive and accommodating for youth

Youth Experience of General Practice

Most young people in New Zealand see the GP or family doctor as the main place they get health care. However, many young people report barriers or problems (such as cost, embarrassment, not wanting to be bothered or concerns regarding confidentially) to seeking health care. Often barriers are found to be particularly high for Māori, Pacific and sometimes Asian or other migrant groups; young people in higher deprivation communities and same sex attracted young people. Additionally

when young people do see GP's this is often for short term illnesses or difficulties (especially respiratory or skin care issues) not for issues that represent the main burden of disease in this age group (such as mental health and behavioural issues).

There is little research regarding the impact of General Practice care for young people. However, available evidence[20] suggests:

- Most New Zealand high school students have seen a General Practitioner (GP) within the last year.
- The majority of New Zealand high school students say GPs or family doctors are the main place that they seek health care.
- Where young people do see GPs this is often for short term illnesses and not for issues such as mental health or health risk behaviours. This is the case even when young people do have mental health difficulties and even when they would like help for them.
- GP's often report difficulties in providing youth friendly care (such as lack of training or time).
- Where young people are more familiar with their GP they report fewer barriers to accessing health care.
- GP's who have received high quality training in adolescent health have been shown to be more likely to offer high quality adolescent health care.
- There are a range of actions (such as increased utilization of trained practice nurses, routine psychosocial screening and continuity of care approaches) that may be taken to enhance General Practice care for young people; however few of these approaches have been evaluated.

8. Key Considerations for A 'Youth Friendly' Primary Model Of Care

Research, literature reviews and consultation feedback all pointed towards the need to change the model of primary care for youth to address non-financial barriers to access.[21] A systematic review[22] of factors that young people perceived to make health care youth-friendly found that:

- accessibility,
- staff attitude (respectful and supportive, honest, trustworthy and friendly),
- communication (clarity of information and listening skills of the clinician),
- medical competency, guideline driven care (confidentiality, autonomy, and well-managed transition to adult health care),
- age appropriate environments,
- youth involvement
- appropriate health outcomes were central to young people's positive experience of care.

The literature reviewed in this document suggests that to improve young people's health the health sector should:

- Provide a range of 'youth friendly' clinical health services, staffed by health professionals who are well trained, skilled and knowledgeable in youth health.

[20] Assessment of youth-friendly health care: a systematic review of indicators drawn from young people's perspectives. 2013. Ambresin AE, Bennett K, Patton GC, Sanci LA & Sawyer SM. *J Adolesc Health* 52(6) 670-81.

[21] Fleming & Elvidge. Youth Health Services Literature Review. 2010.
Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service.
The Health Status of Children and Young People in the Hawke's Bay 2015. Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago; 2016.

[22] Assessment of youth-friendly health care: a systematic review of indicators drawn from young people's perspectives. 2013. Ambresin AE, Bennett K, Patton GC, Sanci LA & Sawyer SM. *J Adolesc Health* 52(6) 670-81.

- These should provide comprehensive and 'joined up' youth friendly care.
- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people.

9. Best Practice Models and Standards

Provider Training

A transformation towards a youth friendly model of care will require specific training package for general practice. A comprehensive adolescent health training package for GP's was tested in a robust trial in Melbourne, Australia[23]. The educational programme (2.5 hours per week for 6 weeks) in the principles of adolescent health care, followed 6 weeks later by a 2-hour session of case discussion and debriefing was developed and evaluated. General Practice care for young people knowledge, attitudes and self-reported behaviours were improved following the training and were maintained at a five year follow up. A training package should be developed by Health Hawkes Bay PHO, in collaboration with general practice and youth health and social service providers, for participating general practices in the zero fees proposition.

Standards for Youth Health Care

Accreditation to standards or frameworks for youth health care can also support the hardwiring of a youth primary care model. Standards have been developed for Primary Care and other providers in numerous settings. In New Zealand the College of General Practitioners published a guide for GP's in working with young people (RACGP, 2006). This has been developed and reviewed by New Zealand practitioners and provides practical guidance for communication, screening, managing key adolescent health issues. Additionally there are local draft standards for youth health services (Kidz First Centre for Youth Health and the Youth Health Expert Working Group 2006). Other frameworks include the WHO Principles for Adolescent Friendly Care and the New South Wales Centre for the Advancement of Adolescent Health Youth Health Better Practice Framework (2005).[24] Either established standards and frameworks or the development of localised standards, in partnership with Directions Youth Health Centre, should be adopted as a baseline expectation for participating general practices in the zero fees proposition.

Viewing youth as new users of health services

The UK Royal College for Paediatrics and Child Health paper on Health Care for Adolescents (Royal College for Paediatrics and Child Health 2003) suggests that young people should be regarded as new users of health services and offered a specific appointment to meet their GP and discuss and negotiate their general practice service. This could include a discussion regarding confidentiality; the range of issues addressed by the GP and other professionals in the practice and having an opportunity to decide whether to continue with their parents GP or chose their own. If this is offered as a routine process to young people as they grow up and is explained to parents and young people in advance, such an introduction appointment could potentially address many of the identified barriers to high quality GP care for young people.

Integrated health and social services with General Practice

Research identified that school based health services, youth health centres and youth social service providers often provided more satisfactory care and support to young people than general practices do. The former services are typically provided by youth health trained nurses or social workers, youth workers or peer supporters in the first instance. It is widely acknowledged that general practice alone cannot solely address youth health related issues. Ideally, youth friendly general practice would

[23] Fleming & Elvidge. Youth Health Services Literature Review. 2010.
[24] Fleming & Elvidge. Youth Health Services Literature Review. 2010.

collaborate with other youth specific providers and offer a multidisciplinary, holistic approach, including primary care, reproductive and sexual health care, substance abuse treatment, mental health care, and education and counselling. Establishing and hardwiring collaborative relationships with local school health, youth health and youth social services should be a baseline expectation for participating general practices in the zero fees proposition.

Youth Friendly Environments
Studies demonstrate that youth want health service environments to be more youth appropriate. Youth prefer livelier décor, youth orientated reading material, and music. Youth also reported that clinic-sponsored incentives (e.g., gift certificates) would increase the likelihood that they would attend appointments. It will be recommended that participating general practices consider youth friendly environments as part of their youth friendly model of care.

Free appointments
All appointments being free or a schedule of free appointments (e.g. for an annual visit) might increase young people's use of health care. This approach has been effective for a HB sexual health clinics initiative. It is critical that people know that the appointments are free. Free appointments is a key baseline component for participating general practices in the zero fees proposition.

Flexible Appointments
Youth friendly models of care should also involve flexibility around consultations. General practices should consider walk-in clinics and telehealth appointments. Furthermore, general practice should use text reminders so young people are prompted about their appointment. It will be recommended that participating general practices consider flexible appointments as part of their youth friendly model of care.

Extended appointment times
Extended appointment times are suggested as part of providing youth friendly health services by the World Health Organisation (2002) and others. Extended appointments can allow time for explaining confidentiality, relationship building, screening and following up sensitive heath issues. This might be done by funded appointments and or by utilising non-medical health staff. Extended appointments maybe considered appropriate by participating general practices in the zero fees proposition.

Health Screening
There is considerable advocacy for routine screening for sensitive health issues among young people. This is on the basis that young people do not typically proactively disclose sensitive behaviours to health providers and yet they are often willing to, or indeed want to discuss them. Further many of these behaviours can have significant health consequence or interact with other health problems, for which the young person may be being treated. In New Zealand the year 9 assessments and opportunistic youth health screens when young people return to school clinics have been reported as a key part of the success of the HEADS Assessments. Research estimates that for every dollar spent on screening in adolescence long term health costs are reduced by a greater amount.[25] It will be recommended that participating general practices consider a health screening and assessment approach as part of their youth friendly model of care.

A baseline requirement of general practices within the Zero Fees 13-17 Year Old programme will be to make 'youth friendly' changes to their model of primary care

[25] Fleming & Elvidge. Youth Health Services Literature Review. 2010.

10. Measuring Benefits

Successful implementation of the project will show significant improvements within the NZ Triple Aim as follows:

Triple Aim Outcome Profile

Dimension	Measure
1. Improved Quality/Safety / experience of Patient Care	• Improved access to primary care including better information to Manage my own health (Health Literacy) • Early detection of health risks and access to treatment
2. Improved Health & equity for all populations	• Decreased burden of disease across the population • Increased equity of health status including Māori, Pacific, Low deprivation populations
3. Best Value for Public Health system resources	• Decreased cost of disease management associated with Long term conditions across the system

Population Health Measures

The Zero Fees Proposition for 13-17 Year Olds will implement a set of Programme Measures as well as Individual Tailored Measures for participating general practices.

The New Zealand Child and Youth Epidemiology Service provide a set of "Top 20" Indicators of Child and Youth Health indicators (see Appendix Four).[26] Most relevant to the zero fees proposition are:

- Most Frequent Causes of Hospital Admission and Mortality
- Primary Health Care Provision and Utilisation
- Exposure to Cigarette Smoke in the Home

Furthermore, the Otago University and New Zealand Child and Youth Epidemiology Service Health Status of Children and Young People in the Hawke's Bay 2015 Report provides Ambulatory Sensitive Hospitalisation (ASH) rate indicators and relevant, in terms of significant incidences, attributable to access to primary health care for 13-17 year olds.

Programme Measures

Therefore the health indicators within the Programme Measures for the Zero Fees 13-17 Year Old proposition include a reduction in acute Emergency Department presentations and admissions[27] for:

- Self -referred but not admitted Emergency Department attendance rate (in hours and out of hours)
- Serious Skin Infections
- Asthma
- Mental Health (presentations & admissions)

Non-clinical indicators for the Programme Measures for the Zero Fees 13-17 Year Old proposition include:

[26] Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service

[27] ASH Rates and ED Presentation baseline data yet to be determined by HBDHB

- Increased utilisation of primary care (≥ 25%) over current utilisation rates
- Youth Friendly General Practices
    - Free consultations, Youth specific training, Accredited to Youth Health Standards, Flexible consultations, Youth Health Satisfaction Surveys

Individual Tailored Measures
Individual tailored indicators would be general practice specific related to the clinical and non-clinical programme indicators. These would require breakdown of HBDHB and PHO data to determine specific health indicators directly attributable to access to primary care. The tailored measures would be negotiated with each practice and the scope of the plans would be based on the level of funding they are likely to receive. However there would be baseline expectations that include changes to model of care and zero fees.

Health Hawkes Bay and HBDHB will develop 0-18 year old population profiles for each general practice that opts in for the 13-17 year old primary care zero fees subsidy. Each general practice will be asked to provide a plan on how they will improve their responsiveness to their youth population. Depending on the general practice population profile they could be asked for a population health plan on how they will respond to health issues.

11. Risks

Unintended Consequences

The following potential unintended consequences have been identified:

1. Patient Flight – Some patients and their whanau could leave their General Practice to enrol in a practice with consultation fees.
2. Lack of Capacity - General Practices providing consultation fees could be inundated with enrolment requests impacting on their capacity to deliver quality health care.
3. Funding Sustainability - funding could be compromised if General Practices that have opted into the consultation fees subsidy grow their enrolled population beyond the ability of the funding parameters.

Risk Analysis

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
Activity increase leads to reluctance of General Practices to participate	Med	Hi	Identify optimal practices and also Work with consider existing VLCA (very low cost access practices)
Ability of selected practices to provide an optimal 13- 17 year old service as per requirements identified.	Med	Hi	Work with selected practices to find optimal ways to meet the requirements

12. Implementation

Project Approach
The 13-17 year old primary care zero fees subsidy is being implemented under the formal HBDHB project management methodology. The project has a terms of reference with a project manager, governance committee and project team.

Implementation by Health Hawkes Bay
The implementation of the13-17 year old primary care zero fees subsidy project will be a partnership between HBDHB Strategic Services and Health Hawkes Bay. HBDHB and Health Hawkes Bay will visit each eligible general practice and discuss the programme detailing the 13-17 year old primary care zero fees subsidy and model of care expectations. HBDHB will contract Health Hawkes Bay to contract with general practice. It will build upon current transformation work with general practice being carried out by Health Hawkes Bay.

Procurement
HBDHB Contracts will manage the procurement process. A letter of offer will be sent to the targeted general practices detailing the zero fees subsidy including criteria and expectations.

HBDHB and Health Hawkes Bay will provide a population profile for each general practice including significant health issues for 13-17 year olds. Each general practice will be asked to submit a proposal on what new services or service model they intend to implement to improve access to primary care services for 13-17 year olds. The service plan should cover objectives, targets and measures for areas such as addressing significant health needs, reducing ASH rates and ED admissions as well as detailing the provision of any additional 'youth friendly' services.

HBDHB Māori Health, Strategic Services and Health Hawkes Bay must approve and sign off the service plan before funding is released.

Timeline:

High Level Milestone	**Date of Completion**
EMT paper - Preapproval SG - EMT / Clinical Council	October 2016
Implementation	
Preparation for Go Live _ systems/ processes as per plan completed – Contracts developed and agreed	October – December 2016
Go Live	1 January 2017

Appendix Two

Implementation of 'Zero Fees' For Children Under 13 Years

In July 2015 the Government invested $90 million nationally over three years to make doctors' visits and prescriptions free for children aged under 13 years at any time of the day or night. The intent is to remove cost as a barrier to access to primary care services by replacing the zero fees made by patients to general practices, Accident and Medical centres and pharmacies with government funding.

The zero-fee visits for children under 13 policy was an 'opt in' approach where general practices could choose whether or not to provide 'zero fees' to under-13s. Those that opt in receive an additional subsidy of around $45 per annum from the Government. (The General Medical Subsidy (GMS) rate for casual visits for 6–12 year olds remains unchanged, helping to incentivize enrolment with a regular practice and continuity of care). Nationally, 96% of general practices with enrolled children aged 6 - 12 have opted in to the zero-fees for under-13s scheme, and 98% of practices with enrolled under-sixes offer zero-fee visits.

Utilization rates for zero fees for under-13s have been modelled on existing average utilization rates of an average of 2.2 visits per year. The Government subsidises an additional $44 - $45 for 'Zero Fees Under 13 year olds' over and above the $94.28 - $99.48 (non-Access Practices) and $117.31 - $125.33 (Access Practices) first contact non-high user card subsidy.

In Hawke's Bay practices, Health Hawkes Bay report an increase of 23% in utilization rates for the 6-12 year old group.

Appendix Three:

HEALTH HAWKES BAY ENROLLED POPULATION 13-17 YEARS

There are approximately 11,096 children aged thirteen to seventeen enrolled with Health Hawke's Bay PHO general practices. Māori and Pacific make up 35.2% and 4.8% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.

Health Hawkes Bay - 2015 Calendar Year 13-17 Enrolled Population by Ethnicity

Ethnicity	HEALTH HAWKES BAY Patients
Asian	292
Māori	3,905
Other	6,362
Pacific	538
Total	**11,096**

Around 3,215 of those are registered with one of the eight Very Low Cost Access practices (VLCA)[28] with Health Hawke's Bay PHO general practices.

Health Hawkes Bay - 2015 Calendar Year 13-17 Enrolled Population by Age and VLCA/Non-VLCA

Age	HEALTH HAWKES BAY Patients	VLCA Practices	Non-VLCA Practices
13	2,205	685	1,521
14	2,221	674	1,547
15	2,272	659	1,613
16	2,168	604	1,564
17	2,230	594	1,637
Total	**11,096**	**3,215**	**7,881**

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Primary Care Utilisation Rates

In 2015, the average GP consultations for 13-17 year olds was 1.72 consults per annum. There is very little difference between VLCA and Non-VLCA average GP consultation rates at 1.70 and 1.73 per annum respectfully. Combined GP and Nurse Consultations for 13-17 year olds is 2.15 consults per annum.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations

Age	HEALTH HAWKES BAY Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	2,205	1.68	1.40	0.28
14	2,221	1.89	1.50	0.39
15	2,272	2.05	1.66	0.39
16	2,168	2.42	1.92	0.50
17	2,230	2.70	2.13	0.57
Total	**11,096**	**2.15**	**1.72**	**0.43**

[28] *Very Low Cost Access (VLCA) practices receive higher capitation rates in return for lower zero fees capped levels for standard consultations (zero fees for children 0–5 years, $11.50 maximum for children 6–17 years, $17.50 maximum for adults 18 years and over). A general practice must have at least 50% "High Needs" people (Māori, Pacific, or Quintile 5) enrolled to qualify for VLCA funding.*

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations Non-VLCA Practices

Age	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	1,521	1.57	1.38	0.19
14	1,547	1.77	1.49	0.28
15	1,613	1.97	1.68	0.29
16	1,564	2.22	1.88	0.35
17	1,637	2.61	2.17	0.44
Total	**7,881**	**2.04**	**1.73**	**0.31**

For VLCA the average combined GP and Nurse Consultations were slightly higher at 2.42 per annum than Non-VLCA practices 2.04 per annum. This is primarily due to VLCA practices having a higher nurse consultation average rate of 0.71 in comparison to Non-VLCA average rate of 0.31.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations VLCA Practices

Age	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	685	1.93	1.43	0.50
14	674	2.16	1.51	0.65
15	659	2.24	1.61	0.64
16	604	2.93	2.03	0.91
17	594	2.94	2.01	0.93
Total	**3,215**	**2.42**	**1.70**	**0.71**

In 2015, Māori and Pacific received less average GP consultations than Asian and Other NZers. Māori and Pacific received 1.56 and 1.28 average GP consultations per annum in comparison with Asian and Other NZers which had 1.75 and 1.86 per annum. However, Māori received higher Nurse Consultations than any other ethnic group with 0.58 per annum. This increased the combined GP and Nurse average consultations for Māori to 2.13 per annum in comparison to Non-Māori 2.21, Asian 1.75 and Pacific 1.62 per annum.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Average Consultations of Enrolled Population by Ethnicity

Ethnicity	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
Asian	292	2.01	1.75	0.26
Māori	3,905	2.13	1.56	0.58
Other	6,362	2.21	1.86	0.35
Pacific	538	1.62	1.28	0.34

Appendix Four

Primary Care Subsidy and Zero Fees Structures

Primary Care Subsidies

The Government currently subsidises first contact primary care for 13 - 17 year olds between:

- Access Practices
  - $63.65 - $117.31 for Males
  - $115.65 - $125.33 for Females
- Non-Access Practices
  - $63.65 - $94.28 for Males
  - $99.48 - $115.65 for Females

Primary Care Subsidy Rates by Age – High User Card, Access Practices, VLCA, Under 14 Yrs & Under 6 Yrs

Age Group	Gender	First Contact				Vlca	Free Under Sixes	Free Under 13s
		Access Practices		Non Access Practices				
		Huhc	Non Huhc	Huhc	Non Huhc			
5 - 14	Female	$379.5048	$125.3340	$379.5048	$99.4860	$52.2740	$2.4168	$45.0256
	Male	$379.5048	$117.3144	$379.5048	$94.2880	$51.6556	$2.2616	$44.8704
15 - 24	Female	$365.5776	$115.6512	$365.5776	$115.6512	$29.6752	N/A	N/A
	Male	$365.5776	$63.6512	$365.5776	$63.6512	$16.3328	N/A	N/A

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Primary Care Consultation Fees

In Hawkes Bay, consultation fees for 13 to 17 year olds range from $0 to $42 (GST Incl). Where After Hours services are in place, the charges are usually approximately $5 more expensive per visit. Pharmacies charge a flat fee of $5 per item dispensed and may charge $1-2 extra per item after hours.

There is a geographical distinction in consultation fees costs between Napier and CHB with Hastings and Wairoa. In Hastings and Wairoa there are eight no cost and very low cost consultation fees practices charging between $0 – $18 per consultation. Whereas Napier has only two low cost consultation fees practice charging between $11.50 - $18 and fourteen practices charging between $20 - $39 consultation fees. In CHB the consultation fees are $24.

General Practices with the largest 13 to 17 year old Māori and Pacific populations include Totara Health, The Doctors Napier, Hauora Heretaunga, Hastings Health Centre, The Doctors Hastings (includes Gascoigne St, Waipawa), Wairoa Health Centre, Queen Street Medical and Medical and Injury.

Health Hawkes Bay Practices - Enrolled Population Consultation Fees for 13-17 Year Olds

Napier	Fees	Māori	Pacific	Other	Asian	Total
The Doctors - Napier	$27.00	546	40	773	41	1400
Carlyle Medical	$27.00	76	8	355	6	445
Central Medical	$28.00	50	1	151	2	204
Shakespeare Road Medical	$20.00	29	2	31	3	65
Greendale Medical	$30.00	43	1	241	8	293
HB Wellness Centre	$27.00	14	2	35	6	57
Tamatea Medical	$28.00	133	10	307	3	453
Taradale Medical Centre	$39.00	93	8	640	28	769
Dr Luft	$30.00	24	0	26	1	51
Dr Craig	$25.00	16	1	59	0	76
Dr Hendy	$25.00	6	1	26	3	36
Dr Harris	$18.00	15	1	3	0	19
Maraenui Medical	$11.50	249	60	107	1	417

Wairoa	Fees	Māori	Pacific	Other	Asian	Total
Wairoa Medical	$12.00	70	0	36	0	106
Queen St Medical	$11.50	184	3	31	4	222
Health Care Centre Ltd	$11.50	189	4	49	3	245

Central Hawkes Bay	Fees	Māori	Pacific	Other	Asian	Total
The Doctors – Waipawa*	$24.00					
Tuki Tuki Medical	$24.00	141	3	354	5	503

Hastings	Fees	Māori	Pacific	Other	Asian	Total
Totara Health	$0.00	616	175	399	24	1214
Medical & Injury	$0.00	147	33	66	32	278
Hauora Heretaunga	$0.00	485	64	33	8	590
The Doctors - Hastings	$16.00	206	31	394	33	664
The Doctors - Gascoigne St*	$11.00					
Hastings Health Centre	$18.00	336	59	1102	65	1562
Te Mata Medical	$15.00	51	5	718	20	794
Mahora Medical	$27.00	8	3	67	2	80
Dr Jolly	$24.00	16	0	50	1	67
Dr Wakefield	$24.00	8	1	41	0	50
Clive Medical Centre Ltd	$21.00	27	0	97	5	129

VLCA Practices

* Enrolled population included in The Doctors Hastings total population

Appendix Five

Recommended "Top 20" Indicators of Child and Youth Health[29]

Individual and Whanau Health and Wellbeing	Socioeconomic and Cultural Determinants	Risk and Protective Factors
Most Frequent Causes of Hospital Admission and Mortality	Children in Families with Restricted Socioeconomic Resources	Breastfeeding
Low Birth Weight: Small for Gestational Age, Preterm Birth	Household Crowding	Overweight and Obesity
Infant Mortality	Educational Attainment at School Leaving	Exposure to Cigarette Smoke in the Home
Oral Health	Primary Health Care Provision and Utilisation	Immunisation
Injuries Arising from Assault in Children		
Total and Unintentional Injuries		
Serious Bacterial Infections		
Lower Respiratory Morbidity and Mortality In Children		
Selected Chronic Conditions: Diabetes and Epilepsy		
Disability Prevalence		
Self-Harm and Suicide		
Teenage Pregnancy		

Appendix Six

[29] Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service

Consumer and Primary Care Consultation

Consumer Consultation – Youth Questions

Youth Questions

1. If you had to look after the health of young people, what would a good health service look like?
    a. What are the key features?
    b. Where, when, who and how?
2. What is working well at the moment? Why?
    a. What isn't working well?
    b. What would you change?
    c. What would you keep?
    d. What would you stop?

Primary Care Consultation - Questions

- Proposition of zero fees for 13-17 Year Olds (Decile 4-5)

Questions:

1. What do you think would improve access to primary care for young people Dep 8-10
2. What else other than financial barriers would enhance young people engaging proactively with general practice?
3. Do you think general practice is the best place for young people to access health services?
4. If you had to look after the health of young people, what would a good health service look like?
    a. What are the key features?
    b. Where, when, who and how?

OURHEALTH HAWKE'S BAY Whakawateatia	**Improvement Plan for System Level Measures DRAFT**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author(s):	Tim Evans, GM Planning Informatics and Finance Carina Burgess, Head of Planning; and Wayne Woolrich, Business Services Manager (Health Hawke's Bay)
Reviewed by:	Executive Management Team
Month:	November, 2016
Consideration:	For Approval subject to changes required by MoH

RECOMMENDATION

That MRB, Clinical and Consumer Council:

1. Note the System Level Measures Framework and what is required from the DHB and Health Hawke's Bay
2. Note the process carried out to formulate the draft
3. Provide any comments or feedback on the draft
4. Approve the contents subject to any changes required.

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OVERVIEW

The Systems Level Measures Framework has been introduced to encourage the Health System to work as one team to achieve outcomes. Hawke's Bay DHB and Health Hawke's Bay are required to develop a joint Improvement Plan for the 2016/17 year. The draft plan is attached which has been developed following two joint primary and secondary workshops and subsequent meetings to refine the plan. The Plan has been submitted to the MoH for review. Early feedback suggests that changes are required in the Patient Experience of Care section. A verbal update will be provided once more detail is known.

BACKGROUND

The System Level Measures (SLM) Framework has evolved from the Integrated Performance and Incentive Framework (IPIF). Unlike IPIF, SLM is focused on whole system outcomes.

System Level Measures for 2016/17

The SLMs were announced on the 1st April 2016. These were set by the Ministry of Health after consultation with the sector.

The four new System Level Measures to be implemented from 1 July 2016 are:

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds (i.e. Keeping children out of the hospital)
2. Acute hospital bed days per capita (i.e. Using health resources effectively)
3. Patient experience of care (i.e. Person centred care)
4. Amenable Mortality rates (i.e. Prevention and early detection)

The following two System Level Measures will be developed during 2016/17 including definitions and identification of data sets:

5. Number of babies who live in a smokefree household at six weeks post natal (i.e. Healthy start)
6. Youth access to and utilisation of youth appropriate health services (i.e. Teens make good choices about their health and wellbeing).

IMPROVEMENT PLAN

The DHB is required to jointly develop an improvement plan which outlines the activities and contributory measures that will lead to achieving the targets on the System Level Measures. The draft has been developed following two joint primary and secondary workshops. Subsequent meetigns took place to refine the information gathered during those sessions. Targets, contributory measures and activity are set by the DHB/PHO but the System Level Measures are non-negotiable. The improvement plans are to be signed off by District Alliances

INCENTIVE PAYMENT

The MoH give Health Hawke's Bay a sum of money if, as a system, we achieve the locally set SLM targets (excluding amenable mortality) as well as two Health Targets: Better Help for Smokers to Quit – Primary Care and Increased Immunisations. How this funding is then devolved to Primary Care is a local decision.

Two capacity and capability payments and one 'at risk' performance payment will be paid to PHOs:

- Payment 1: 25% capacity and capability payment up front in quarter one (15 July 2016)
- Payment 2: 50% capacity and capability payment in quarter two once the Ministry approves the district alliance's improvement plan (15 December 2016)
- Payment 3: 25% performance payment in quarter one 2017/18 based on quarter four 2016/17 performance (15 September 2017).

ATTACHMENT

DRAFT Hawke's Bay System Level Measures Improvement Plan 2016/17

APPENDIX

Hawke's Bay System Level Measures Improvement Plan 2016/17

17

DRAFT

Insert Note of agreement from HHB and HBDHB

1. Background

The Integrated Performance and Incentive Framework (IPIF) began in 2012. The aim of IPIF was to drive stronger integration across the health system, improve quality and ensure long term system sustainability. IPIF was implemented in 2014 with primary care financial incentives directly linked to performance against the primary care National Health Targets (Better help for smokers to quit, Immunisation and More Heart and Diabetes Checks) and the cervical screening coverage.

The development of the overall IPIF framework was paused during the refresh of the Strategy. In May 2015 the Minister of Health decided not to introduce new performance measures in 2015/16 as he wanted more aspirational measures developed that looked at the performance of the system rather than just primary care. The Minister also wanted to change the focus from looking at outputs and processes to outcomes. The refresh of the Strategy provided the opportunity for this work and has built the case to extend and evolve the IPIF concept of System Level Measures.

The Ministry of Health (the Ministry) has been working closely with the sector to co-develop a suite of System Level Measures that provide a system wide view of performance. These measures have evolved from an initial list of over 100. The new measures engage the health sector more broadly (professions, settings and health conditions) than the previous measures.

The performance of individual clinicians and/or provider organisations, through health activities and processes, are measured by contributory measures. These individual groups must work as one team to improve system level performance. The System Level Measures for introduction in 2016/17 also resonate with the care closer to home, people powered and smart system themes of the Strategy.

The System Level Measures to be introduced rely on the contribution of a wider group of providers. In 2016/17, the focus is on the contributions and performance of DHBs and PHOs. The contribution of the wider groups will be seen over the next 18 months as the Ministry and the DHBs include System Level Measures in a wider range of contracts.

Health Hawke's Bay and the District Health Board are required to work together to develop an improvement plan for the System Level Measures Framework and report against it throughout the year.

2. Development of the Improvement Plan

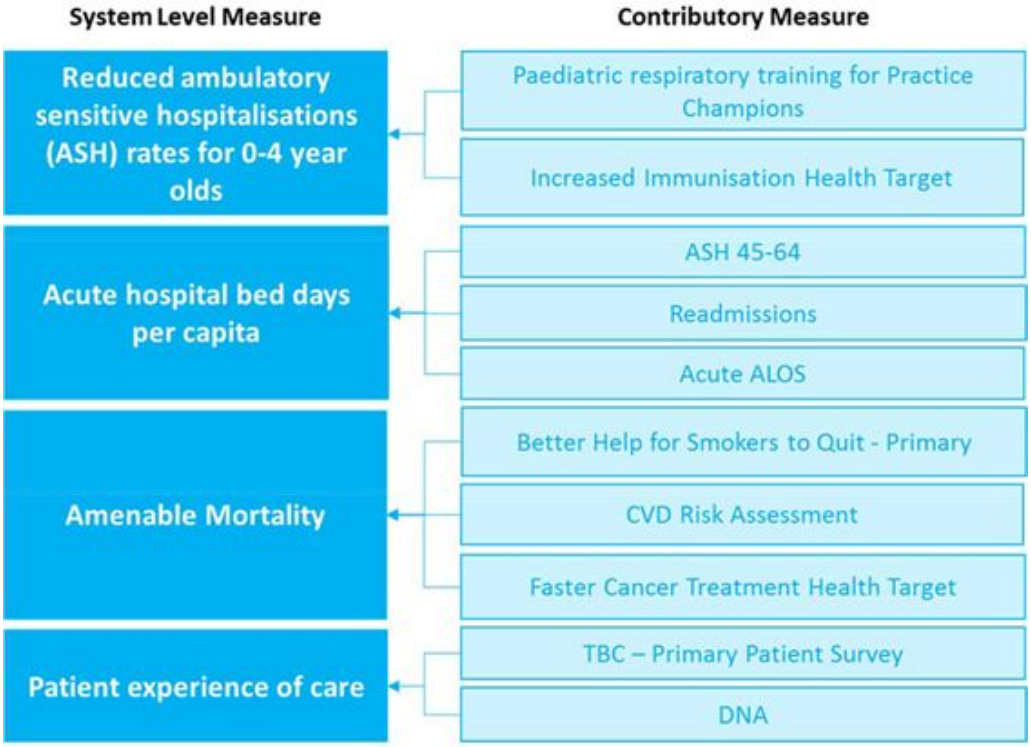
Health Hawke's Bay ran two workshops in conjunction with the Hawke's Bay District Health Board which were attended by both primary and secondary managers and clinicians. The first was also attended by Dr Peter Jones and Kanchan Sharma from the Ministry of Health who explained what SLMs were and what was expected in 2016/17.

The workshops delivered clear themes which were further refined with representatives from primary and secondary care and various governance committees.

In the first year, our aim is to get everyone on board with the concept of System Level Measures and the idea of working together as a whole system. As we move forward we will look to challenge the system more to achieve the desired outcomes.

3. System Level Measures and Contributory Measures

Below is a diagram outlining the System Level Measures and Contributory Measures agreed by Health Hawke's Bay and Hawke's Bay District Health Board. The activities and targets are detailed in the section below.



4. Detailed Improvement Plan

Keeping Children out of Hospital

Measure	Ambulatory Sensitive Hospitalisation 0-4
Target	TBC
Baseline	12 months to March 2016 Total = 4,725, Māori = 5,336, Other = 3,768

Contributory Measures

Paediatric respiratory training for Practice Champions

Measure	% of Respiratory Practice Champions attending Paediatric Respiratory training offered by DHB		
Target	100%		
Baseline	0%		
Numerator	Number of respiratory practice champions that have attended training		
Denominator	Number of respiratory practice champions (n=35)		
Data Source	PHO		
Rationale for Inclusion	Respiratory infections and Asthma are the most common causes of ASH in 0-4 year olds. The gap between Māori and non-Māori ASH rates for Asthma is increasing. Ensuring appropriate support and treatment at a young age sets a foundation for future healthy lungs.		
Activities	**Activity**	**Lead**	**By when**
	DHB to provide training on paediatric respiratory conditions to respiratory practice champions in primary care.	Service Director WCY	End Q4
	Hawke's Bay's existing respiratory programme to expand to include children as well as adults	HHB Health Programmes Manager	Ongoing
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agreed Improvement Plan		
Q2	Systems in place to deliver training		
Q3	50%		
Q4	100%		

Increased Immunisation Health Target

Measure	% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.		
Target	≥95%		
Baseline	Oct 2015 to Dec 2015 Total = 93.3%, Māori = 92.6% Pacific = 100%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Data supplied from Ministry from NIR		
Rationale for Inclusion	Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children, particularly for the most vulnerable groups. The changes which are required to reach the target immunisation coverage levels will lead to more efficient health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better co-ordinated.		
Activities	**Activity**	**Lead**	**By when**
	Continue to facilitate successful Hawke's Bay Immunisation steering group quarterly and use this group to monitor coverage rates, equity and outreach activity.	DHB Imms Coordinator	Quarterly
	Continue to implement strategies in the Immunisation Action *Plan 'Improving Childhood Immunisation On Time Rates in Hawke's Bay'*. - Identify overdue children through access to Dr Info, monthly Karo reports and quarterly benchmarking across practices. - After three recall attempts, refer children to outreach immunisation services - Check immunisation status for all children presenting at paediatric inpatients and outpatients, and offer immunisation where required.	DHB Imms Coordinator	Quarterly
	Use Datamart reports regularly to measure the coverage rates by ethnicity and deprivation status, identifying increasing numbers of declining or opt-offs or other gaps in service delivery. Tailor the response to data appropriately using the variety of access options available.	DHB Imms Coordinator	Quarterly
	Health Hawke's Bay to support practices to review, audit and manage their Patient management systems for the systematic and timely review of children.	PHO Performance manager	Quarterly
	Health Hawke's Bay and HBDHB to work collaboratively on promotion of Immunisation week in Q4 2017	DHB / PHO	Q3
	Immunisation team to maintain working relationships with age appropriate services such as Tamariki Ora, Plunket, community oral health services and Before School Checks to ensure efficient use of resources for tracking children and appropriate service provision.	DHB Imms Coordinator	Quarterly
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agreed Improvement Plan		
Q2	95%		
Q3	95%		
Q4	95%		

Using Health Services Effectively

Measure	Acute Bed Days Per Capita
Target	<350.6
Baseline	12 months to March 2016 Total = 350.6, Māori = 338.5, Other = 356.2

Contributory Measures

Readmission Rates

Measure	Waiting on MoH to confirm the Measure for 2016/17		
Target	TBC		
Baseline	TBC		
Numerator	TBC		
Denominator	TBC		
Data Source	TBC		
Rationale for Inclusion	An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of care, in the hospital and/or primary care, ensuring that people receive better health and disability services. Readmission rates should be monitored along with average length of stay when aiming to reduce bed days		
Activities	**Activity**	**Lead**	**By when**
	4000 bed days activity - TBC		
SLM Funding Arrangement			
SLM Proportion of Funding			
Milestones			
Q1	Agreed Improvement Plan		
Q2	TBC		
Q3	TBC		
Q4	TBC		

Average Length of Stay

Measure	Inpatient Average Length of Stay (ALOS) for acute admissions		
Target	≤2.35		
Baseline	12 months to Dec 2015 Total – 2.55		
Definition	The standardised ALOS for acute discharges in any medical or surgical specialty, expressed as the ratio of the observed (actual) to predicted ALOS, multiplied by the nationwide acute inpatient ALOS. The DHB observed ALOS, and the nationwide acute inpatient ALOS, are both defined as the total bed days for acute medical or surgical inpatients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for acute inpatients during the 12 months to the end of the quarter.		
Data Source	National Minimum Dataset (NMDS), Ministry of Health		
Rationale for Inclusion	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, the DHB will impact on the Ministerial priority of improved hospital productivity. This will be achieved through freeing up beds and other resources so the DHB can both provide more elective surgery and reduce length of stay in the emergency department.		
Activities	**Activity**	**Lead**	**By when**
	Improve communication to patients about their admission and things they need to know, to ensure family / support people are involved and engaged in the process.	Improvement advisor Team Leader	
	Improve patient information in all adult wards including CHB and Wairoa.		
	Electronic Whiteboards in all adult inpatient areas.		
	Criteria Based Discharge - Promote timely discharge, reduce delays across the seven day week. Currently formally introduced in one medical ward this now needs to be enhanced to include a seven day week service and to be introduced to surgical areas and across all medical areas.		
	Increase Knowledge/ access to EngAGE intermediate beds and flag early.		
	Communicate to multidisciplinary teams options for supported discharge via one document and flowchart		
	Identify solutions to gaps if identified.		
SLM Funding Arrangement	Nil		
SLM Proportion of Funding	Nil		
Milestones			
Q1	Agreed Improvement Plan ≤2.52		
Q2	≤2.46		
Q3	≤2.41		
Q4	≤2.35		

ASH 45-64

Measure	Ambulatory Sensitive Hospitalisation rate per 100,000 population for 45-64 year olds		
Target	≤3,510		
Baseline	October 2014 to September 2015 Total = 3,510, Māori =6,310, Other = 2,812		
Numerator	Number of ASH admissions for 45 - 64 year olds		
Denominator	Number of 45 - 64 year olds		
Data Source	Data will be released by the Ministry of Health quarterly		
Rationale for Inclusion	Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting. Determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure. It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers. ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This indicator can also highlight variation between different population groups that will assist with DHB planning to reduce disparities		
Activities	**Activity**	**Lead**	**By when**
	Develop a clinical pathway for Cellulitis to standardise practice by Q1	CPO coordinator (HHB)	Q1
	Implement and socialise the recently developed clinical pathway for Congestive Heart Failure by Q2	Manager – Cardiology (DHB)	Q2
	Secure sustainable funding to continue to provide nurse led respiratory clinics. The clinics are a joint Health Hawke's Bay and HBDHB initiative which has proven to be effective at encouraging self-management resulting in clinical, financial and organisational efficiency. A reduction in hospital admissions resulting from acute exacerbations of chronic respiratory disease has been noted and may be attributable to the respiratory project. This is currently a pilot so sustainable funding will embed the programme into the community.	Strategic Service Manager – Primary Care (DHB)	Q1
	Develop a reporting structure by Q2 which provide reports to general practices to show their admission rates to hospital and emergency department attendances. This will allow the DHB and PHO to identify practices where admission rates for particular conditions are high and work with the practice to identify causes and solutions.	Strategic Service Manager – Primary Care (DHB)	Q2
	Following allocation of funding through new investment prioritisation process, appoint a Congestive Heart Failure nurse practitioner to work in the community alongside primary care with the aim of supporting Heart failure patients to self-manage and avoid hospitalisations	Manager – Cardiology (DHB)	Q4
	Clinical Nurse Specialist and Breathe HB will provide two Respiratory training sessions in Primary Care by Q4	Strategic Service Manager – Primary Care (DHB)	Q4
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agreed Improvement Plan		
Q2	≤3,510		
Q3			
Q4	≤3,510		

Prevention and Early Detection

Measure	Amenable Mortality
Target	Reduce
Baseline	Amenable mortality deaths, age standardised rates, 0-74 year olds 2013 (provisional) = 102.3

Contributory Measures

Better Help for Smokers to Quit - Primary

Measure	% of PHO enrolled patients who smoke that have been offered help to quit smoking by a health care practitioner in the last 15 months		
Target	≥90%		
Baseline	Jul 2014 to Sep 2015 Total = 81.2%, Māori 80.8%, Pacific 75.7%, Other 75.7%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Supplied to the Ministry of Health through the PHO performance programme (PPP) system		
Rationale for Inclusion	Tobacco is a key contributor to health inequity in Hawkes Bay. Our prevalence of tobacco use is higher than the national average and we believe that reducing tobacco consumption remains the best opportunity to improve Māori health, improve equity and reduce amenable mortality.		
Activities	**Activity**	**Lead**	**By when**
	Continue to offer GP Practices and their staff training, support and guidance on Smokefree systems, processes and policy development	DHB Smokefree manager	Q4
	Provide benchmarking data and audit support for high level leadership and governance structures to manage performance of the 'Better help for smokers to quit' Health Target in primary care. Encouraging the identity and development of Smokefree champions in practices where appropriate.	DHB Smokefree manager	Quarterly
	Review the forms used in the primary care Patient Management System to explore the possibility of mandatory Smokefree fields.	PHO Performance manager	Q4
	Fund independent nurses to contact patients and offer them smoking brief advice and cessation support.	PHO Performance manager	ongoing
	Fund general practices for additional resource to contact patients and offer them smoking brief advice and cessation support.	PHO Performance manager	ongoing
	Coordinate and fund a 'text to remind' campaign with Vensa Health	PHO Performance manager	Q3
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agree Improvement Plan 90%		
Q2	90%		
Q3	90%		
Q4	90%		

Cardiovascular Disease Risk Assessment

Measure	% of the eligible population who have had their cardiovascular risk assessed in the last five years.		
Target	≥90%		
Baseline	5 years to Dec 2015 Total = 90.3%, Māori 86.3%, Pacific 87.0%, Other 91.7%		
Numerator	PP20 Definition		
Denominator	PP20 Definition		
Data Source	Supplied to the Ministry of Health through the PHO performance programme (PPP) system		
Rationale for Inclusion	According to our Health Equity Report, ischaemic heart disease is the leading cause of avoidable mortality in Hawke's Bay across all ethnicities. However, the potential years of life lost rates for Māori and Pasifika are four and three times higher respectively than the non-Māori, Non-Pasifika population highlighting a significant equity issue. To reduce the risk of developing CVD, five yearly risk assessments should be carried out on the eligible population.		
Activities	**Activity**	**Lead**	**By when**
	Support practices to carry out PMS audits with a particular focus on those who are coming due for Cardiovascular Risk Assessment (CVRA). Including those coming into the cohort, those that are due and those that will require rescreening	PHO Performance manager	Quarterly
	Provide data to assist Practices to manage the total cohort of their screened population and allow internal benchmarking. Where appropriate, the General Practice facilitation team will work with practices to improve those outliers' performance	PHO Performance manager	Quarterly
	Specific outreach nursing services will target workplaces where there is a high volume of Māori men in the work place and offer incentives such as prize draws.	PHO Performance manager	Quarterly
	Meet with key high needs community stakeholders to develop a plan to increase CVDRA for Maori, Pacific and quintile 5.	PHO Performance manager	Q3
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agree Improvement Plan		
Q2	90%		
Q3	90%		
Q4	90%		

Faster Cancer Treatment Health Target

Measure	% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by June 2017.		
Target	≥90%		
Baseline	6 months to Dec 2015 Total = 77.6%, Māori 78.6%, Other 76.7%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Data to be supplied by DHBs		
Rationale for Inclusion	Cancer is one of the leading causes of amenable mortality. Cancer services span the continuum from prevention and screening, through treatment and follow-up care. The National Health Target 'Faster Cancer Treatment' (FCT) takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. Cancer treatment is provided by HBDHB through our own provider and in collaboration with a number of other providers. For example, all radiation treatments are provided for Hawke's Bay patients by MidCentral DHB, while some surgical treatments are outsourced from Capital & Coast, Hutt Valley and Auckland DHBs. There is local provision of outpatient-based chemotherapy plus coordination of all Hawke's Bay patients across and through all networked services. This requires a high level of inter-district collaboration to ensure that services are integrated and seamless for patients.		
Activities	**Activity**	**Lead**	**By when**
	Participate in and comply with reviews of current service provision against the tumour standards within the Central Region. Implement any recommended actions from the reviews.	Manager – Oncology	Ongoing
	Work with the local radiology department to support implementation of regional or local outcomes of their review.	Manager – Oncology	Ongoing
	Review the Breast cancer referral pathway to reduce time delays within referral management	Manager – Oncology	Ongoing
	Work with Central Cancer Network (CCN) to investigate and scope future development of multi-disciplinary meetings and processes. Project report to be prepared June 2016.	Manager – Oncology	Ongoing
	Implement the prostate cancer management and referral guidance by Q4	Manager – Oncology	Q4
	Work with the central region to standardise data interpretation	Manager – Oncology	Ongoing
SLM Funding Arrangement	Nil		
SLM Proportion of Funding	Nil		
Milestones			
Q1	Agree Improvement Plan		
Q2	≥90%		
Q3	≥90%		
Q4	≥90%		

Person & whānau Centred Care

Measure	Implement the Patient Experience of care survey in at least 3 practices by end of June 2017
Target	≥3 practices
Baseline	0 practices

Contributory Measures

National Enrolment Service

Measure	Percentage of general practices live on National Enrolment Service (NES) by end June 2017		
Target	90%		
Baseline	11%		
Numerator	Number of general practices live on National Enrolment Service (NES) by end June 2017		
Denominator	Number of general practices (n=29)		
Data Source	PHO		
Rationale for Inclusion	The NES has been developed to provide a single definitive source for all national enrolment and identity data. The NES is an enabler for the Patient Experience Survey.		
Activities	**Activity**	**Lead**	**By when**
	Dedicated Health Hawke's Bay personnel allocated to be responsible for on-boarding practices in tranches as advised by the MoH.	Health and Social Care IT Liaison (HHB)	Q1
	Health Hawke's Bay provide General Practice with NES and PES education		Ongoing
	Practices on boarded at the rate recommended by the MoH.		Ongoing
	Health Hawke's Bay maintains an active risk management plan to mitigate against any risks associated with not reaching its target of 90% of practices on boarded		Ongoing
	Health Hawke's Bay works with the MoH, patients first and the HQSC to ensure that the PES software is tested and available to General practice in a timely manner		Ongoing
	Risks are escalated to Health Hawke's Bay Clinical and Governance Advisory Group for advice.		Ongoing
SLM Funding Arrangement	TBC		
SLM Proportion of Funding	TBC		
Milestones			
Q1	Agree Improvement Plan		
Q2			
Q3	50%		
Q4	90%		

DNA

Measure	Did Not Attend (DNA) Rate		
Target	≤7.5%		
Baseline	October 2015 to December 2015 Total = 8.1%, Māori = 14.9%, Pacific = 18.3%, Other = 5.3%		
Data Source	Internal		
Rationale for Inclusion	Māori and Pacific people have DNA rates that are 3-4 times higher than those of other people in Hawke's Bay and therefore are not gaining the benefit of timely health advice or treatment. These rates have remained stubbornly poor both locally and nationally for many years despite numerous initiatives to make a difference. A high DNA rate suggests there are significant numbers of people whose health may be adversely affected through not receiving timely and appropriate health care advice or treatment. It may also indicate access, systems or other reasons that may be limiting people's ability or willingness to attend. DNA is an important measure of person centred care.		
Activities	**Activity**	**Lead**	**By when**
	TBC		
SLM Funding Arrangement	Nil		
SLM Proportion of Funding	Nil		
Milestones			
Q1	Agree Improvement Plan		
Q2	≤7.5%		
Q3	≤7.5%		
Q4	≤7.5%		

5. Beyond 2016/17

Ambulatory sensitive hospitalisation rates for 0-4 year olds

Dental conditions are one of the leading causes of ASH 0-4. In 2016/17 we will form a working group to look into possible joint initiatives to reduce the number of children being hospitalised for dental conditions. If successful, this could lead to a possible contributory measure in the coming years.

Acute hospital bed days per capita

We have a programme of work being coordinated in the DHB to reduce bed days. Over the year the DHB will further align with primary care in this initiative.

Patient experience of care

From 1st July 2017, the Patient Experience Survey will be carried out in Primary care so we will have GP practices on boarded and data to analyse.

Amenable mortality

During the SLM workshops there were discussions on how we could measure CVD risk management rather than just assessment. This will be further explored in 2016/17.

Youth access to and utilisation of youth appropriate health services and Number of babies in smoke-free households at six weeks post-natal

We will continue to engage in discussions on the development of these SLMs over 2016/17

HAWKE'S BAY District Health Board Whakawāteatia	**Alcohol Harm Reduction Position Statement**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: **Document Author(s):**	Dr Caroline McElnay, Director Population Health Dr Rachel Eyre, Medical Officer of Health
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For Endorsement

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

1. Note the contents of this Position Statement.
2. Seek endorsement to go to Board for adoption.

18

D R A F T

POSITION STATEMENT ON REDUCING ALCOHOL-RELATED HARM

Hawke's Bay District Health Board Position

Although alcohol is a legal drug consumed and enjoyed by many people, the Hawke's Bay District Health Board recognises that alcohol–related harm is a significant health issue for our community that must be addressed.

Harmful alcohol consumption is a major risk factor which contributes to the physical, mental and social ill-health in our community and to Māori: non-Māori health inequities in Hawke's Bay. This health and social burden is borne not just by drinkers but often by others.

The Hawke's Bay District Health Board recognises that the widespread promotion of and accessibility to alcohol has a significant role to play in people's drinking behaviour. Similarly, the DHB understands that the strongest measures to reduce alcohol-related harm operate at a policy level and include increasing price, reducing availability and reducing advertising.

Hawke's Bay District Health Board commits to taking a leadership role in reducing alcohol-related harm in our community. The first steps involve the DHB developing a high-level Strategy and a more detailed Implementation (and Communication) Plan to take action in collaboration with our stakeholders and community.

OUR VISION

"Healthy communities, family and whānau living free from alcohol-related harm and inequity"

The Core DHB Values that underpin the *process* for developing the DHB's Strategy and plans to address alcohol-related harm are:

Rāranga te tira -Working in partnership across the community

The improvement of Māori outcomes will require Iwi defined and led strategies

Community engagement & ownership will be critical to change attitudes to alcohol – related harm

Tauwhiro - High quality care

Effective strategies need to be evidence informed

Population-based prevention strategies are the most effective and efficient, where possible to deliver at the local level

Improving early intervention support & treatment has an important role

He kauanuanu - Showing respect to staff, patients and community

A harm minimisation approach is realistic for many people, accepting that target groups need tailored advice and strategies

Systems thinking is critical to develop strategies which work synergistically

Akina - Continuous improvement

DHB leadership entails being a role model, e.g. holding alcohol-free events within our health system and thus leading the way towards moderation in the community

Relies on strengthened intelligence through improving health system data collection

DRAFT

The Hawke's Bay District Health Board is committed to supporting our government's National Drug Policy 2015-2020[1] to:

- reduce excessive drinking by adults and young people
- protect the most vulnerable members of our community when it comes to alcohol-related harm e.g. children and young people, pregnant women and babies (Foetal Alcohol Spectrum Disorder)
- reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes
- support the safe and responsible sale, supply and consumption of alcohol
- improve community input into local alcohol licensing decisions
- improve the operation of the alcohol licensing system.

Further to the above, the Hawke's Bay District Health Board is committed to:

- reduce and eliminate alcohol and other drug-related harm inequities – particularly for Māori, young people, pregnant women and others who experience disproportionate alcohol-related harm in our community.

NEXT STEPS

The Hawke's Bay District Health Board will undertake the following next steps as a priority.

1. Identify the appropriate capacity and resource to lead the development of an Alcohol Harm Reduction Strategy and Implementation.

2. Identify a governance and management structure to guide and provide an accountability mechanism for the 'Coordinator', and Strategy/Plan delivery.

3. Support high-level Champions within our health system and in the community to act as spokespersons and be credible role models to help shift staff, community, whanau, family and individual attitudes to reduce harmful alcohol consumption.

4. Identify the best way to input into the review and delivery of the Napier City and Hastings District Councils' Joint Alcohol Strategy to limit availability and promote safe, responsible drinking.

5. Establish the best method to engage the relevant departments across our DHB and PHO, and to engage with Iwi, Pasifika, young people and community (building on existing groups -Safer Communities, Māori NGOs etc), to develop appropriate strategies and to provide support.

6. Consider the development of a local Alcohol Coalition of NGOs and other agencies, akin to the Hawke's Bay Smokefree Coalition to build support at a community level.

7. Identify service gaps and priority objectives for local DHB action to include:
   - improved systems for health data collection/screening and brief intervention (e.g. in the Emergency Department, Maternity and Primary Care)
   - appropriate clinical referral pathways and treatment services
   - support for strong, consistent health messaging (such as no drinking in pregnancy).

[1] http://www.health.govt.nz/system/files/documents/publications/national-drug-policy-2015-2020-aug15.pdf

KEY OUTCOMES

Consistent with the National Drug Policy the key outcomes our District Health Board is striving for, include:

- Reduced hazardous drinking of alcohol
- Delayed uptake of alcohol by young people
- Reduced illness and injury from alcohol
- Changed attitudes towards alcohol and reduced tolerance for alcohol-related harms

August 2016
Position Statement Review date: October 2017 and on a 3 year cycle thereafter.

LINKAGES

National Drug Policy Framework (2015-2020) (Inter-Agency Committee on Drugs, 2015)

Rising to the Challenge - The Mental Health and Addiction Service Development Plan (2012-2017)

Hawke's Bay District Health Board: Health Equity in Hawke's Bay (McElnay C 2014), *Health Equity in Hawke's Bay Update* (McElnay C 2016) *Youth Health Strategy* (2016-2019), *FASD Discussion Document* (December 2015), *Intimate Partner Violence Intervention* (Reviewed September 2016) *Mai, Māori Health Strategy* (2014-2019), *Māori Health Annual Plan* (2016 – 2017).

HAWKE'S BAY District Health Board Whakawāteatia	**Transform & Sustain Programme Refresh**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner:	Tracee Te Huia, GM Maori Health
Document Author(s):	Tracee Te Huia & Kate Rawstron, Project Management Office Manager
Reviewed by:	Transform & Sustain Steering Group, Executive Management Team
Month:	November, 2016
Consideration:	For Discussion

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

1. **Note** the contents of this report.
2. **Endorse** the proposed new projects.

OVERVIEW

The Transform & Sustain Programme was initiated back in 2013 and is now more than half-way through its five year horizon. Whilst the overarching Transform & Sustain Strategy will not require refreshing until the second of 2017, a mid-point refresh of the programme of projects (that underpin of the strategy) is critical to ensure that we remain on track to delivery against all of our key intentions as planned.

The paper includes:

- The refreshed Transform & Sustain programme workplan
- High-level outline for each of the new proposed projects
- Programme success criteria
- Key next steps

BACKGROUND

The refresh of the Transform and Sustain programme workplan was kicked off with an evaluation of the outcomes achieved at the 'half-way point'. This review highlighted five priority areas where outcomes had not yet been achieved as intended.
These priority areas, plus a sixth that was added subsequently, were identified, validated and endorsed by a wide range of stakeholders as summarised below:

- Project Management Office identified 24 outcome statements from Transform & Sustain document
- EMT members scored each statement as doing well/ making some progress/ not yet making change - scores are aggregated

- Health Services Leadership Team identifies the 8 outcomes with 'least progress' - these are mapped against the EMT scores
- There is a strong degree of consensus and 'five areas' emerge to which EMT add 'organisation development' as a sixth area
- These six priority areas are validated with front line project leaders and change managers
- 'World Café' exercise held at Waipatu Marae with wider health sector leadership forum to confirm priority areas and to gather input to inform future project plans
- List of 21 proposed new projects, across the six priority areas, is generated
- EMT members assigned to a priority area to work with the Project Management Office to establish full programme of work

(Refer Transform & Sustain Refresh 2016 – July 2016).

DEVELOPMENT OF THE REFRESHED PROGRAMME WORKPLAN

Taking the information gathered during the 'World Café' exercise and the list of proposed projects, a benefits mapping exercise was undertaken for each priority area. The purpose of this exercise was to ensure a clear relationship exists between the identified problem statements, business outcomes and objectives, and to ensure the proposed projects aligned to this and would deliver the desired set of business outcomes and benefits. Each session included three nominated EMT members and was facilitated, and outputs documented, by the PMO Manager.

Overall these sessions were very productive, generating a lot of good robust challenge and discussion, and for the majority of priority areas this resulted in a number of refinements to the list of proposed projects.

In addition to the project changes, this exercise also highlighted the high degree of working dependencies between projects within a single priority area but also across priority areas. In recognition of this, and programme lessons learned thus far, it was agreed that a single EMT member should be assigned as SRO to all projects under one priority area, and that a priority area would be managed as a workstream under the programme.

It is important to note that further lessons, learned during the first half of Transform & Sustain, have also been applied at a project level and will continue to be applied as new projects are initiated and stood-up as part of the refresh activity.

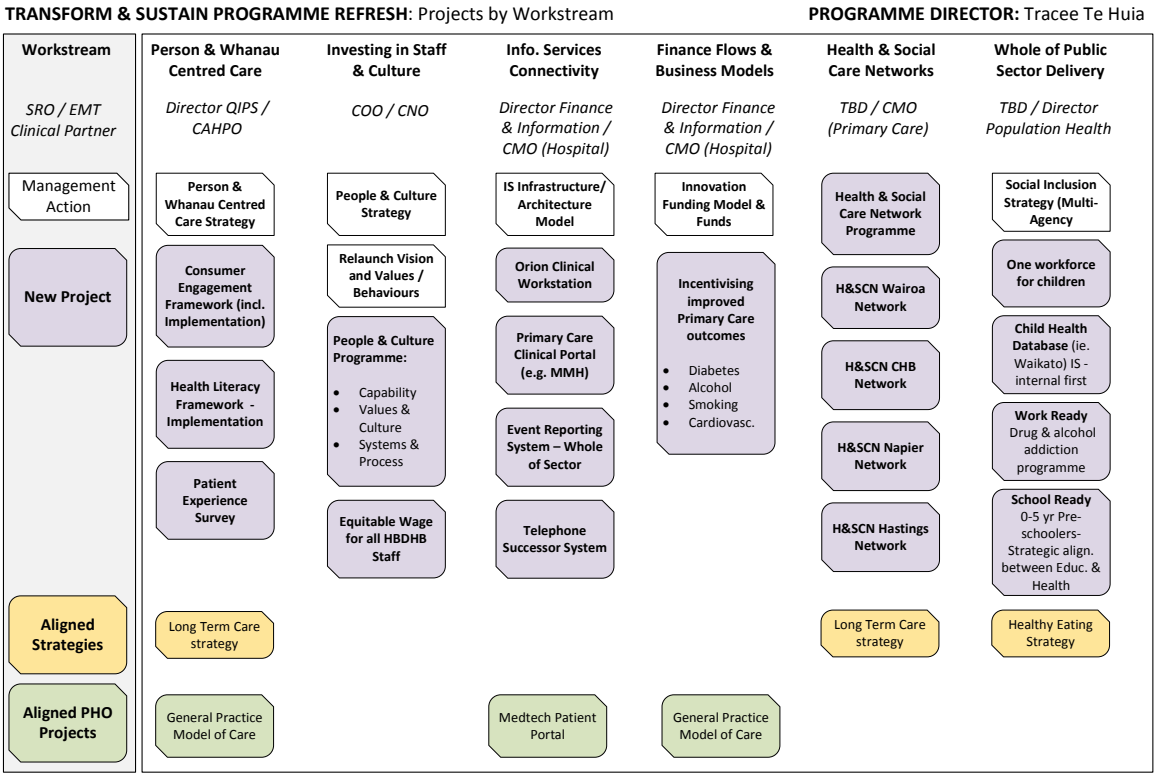
Following the documentation of outputs from the benefit's mapping sessions, one further review, by workstream, of the proposed projects was undertaken with the nominated workstream SRO before final review by the Transform & Sustain Programme Director and Transform & Sustain Steering Group.

CLINICAL LEADERSHIP

By moving to a workstream management structure (with a single SRO per workstream) this enables increased management and alignment to operational functions however, it does not enable the desired level of clinical partnering. As such a 'EMT Clinical Parter' role will be established at the workstream level to partner with the workstream SRO. Clearly defined roles and responsibilities for this role, and that of the workstream SRO, are currently being developed.

In addition to this new role, the programme will also ensure clinical leadership is maximised at a project level (e.g. within project roles such as Project Sponsor, Steering Group membership etc.), ensure clinical leadership is distributed across the team and development opportunities for future leaders identitied.

The final list of 19 proposed projects, by workstream, is shown on the next page.



***QIPS** = Quality Improvement & Patient Safety / **CAHPO** = Chief Allied Health Professions Officer / **COO** = Chief Operating Officer / **CNO** = Chief Nursing Officer / **CMO** = Chief Medical Officer*

19

Further detail on each of the projects can be found in the following tables.

It is important to note, however, that this information should be viewed as indicative only at this time. Once the programme workplan has been approved each project will undergo full scoping, as per the prescribed HBDHB project methodology, with any significant new investment approved via the normal prioritisation and funding processes.

WORKSTREAM: Person & Whanau Centred Care – Director QIPS / CAHPO

Key Intention	**Project**	Short Description	Dashboard KPI
2	**Patient Experience Survey**	To develop and implement a local patient experience survey, and set of processes to utilise results alongside the National Patient survey, to support continuous improvement.	Patient Experience
2	**Consumer Engagement Framework (CEF)**	Design and implementation of a CEF to ensure the voice of the consumer is utilised in the right way on a consistent basis across the health sector, through the application of a co-design model.	Patient Experience
3	**Health Literacy Framework (HLF) - Implementation**	Implementation of the HLF (Action Plan & detailed Implementation Plan), this project includes: - Stanford Programme; empowering self-management - Relationship centred practice; clinical engagement tool - Health Passport - Review of all info provided to consumers/patients	Patient Experience

WORKSTREAM: Investing in Staff and Changing Culture – GM HR / CNO & COO

Key Intention	**Project**	Short Description	Dashboard KPI
Enabler	**People & Culture Programme**	A 2-5 year programme of work to change the culture of health sector focusing initially on the 'hospital'; the programme will be planned and implemented on a rolling 12-mth basis and is made up of the 3 strands: **Capability** - Workforce development (CI) - leadership (including Maori leadership development) - Talent Mapping and succession planning - Training Hub **Values & Culture** - Behaviours - creation of a Healthy at Work Programme (incl. nurse-led assessment clinics) - Resilience / kindfulness / mindfulness - Employee Brand - Staff Engagement Survey **Systems & Process** - BAU - Better, Smarter, Faster - Staff discounts / confidential budgeting services	KPI - Better staff engagement KPI - Culturally competent workforce KPI - Better staff retention KPI- Improved hospital workforce productivity
Enabler	**Equitable Wage for All HBDHB Staff**	To establish a training route for DHB staff, paid below the living wage, to attain the living wage, this project will include: - framework and processes i.e. appraisals - training programme tailoring for each staff group	KPI - Improved hospital workforce productivity KPI - Better staff engagement KPI - Better staff retention KPI - Reduced infant mortality KPI - Fewer premature deaths KPI - Fewer women smoking in pregnancy KPI - Reducing Rheumatic fever

WORKSTREAM: Financial Flows and Business Models – Director Finance & Information / CMO (Hospital)

Key Intention	**Project**	Short Description	Dashboard KPI
11	**Incentivising improved Primary Care outcomes**	Establishment of new funding flows to target evidence based interventions within Primary Care, initial focus will be on reducing ASH rates in particular those issues relating to: - Diabetes - Alcohol - Smoking - Cardiovascular	KPI - Care close to home KPI - More treatments out of hospital

WORKSTREAM: Information Services Connectivity – Director Finance & Information / CMO (Hospital)

Key Intention	**Project**	Short Description	Dashboard KPI
Enabler	**Orion Clinical Portal**	Implement an enhanced version of the regional standard clinical workstation, standardise and document associated business processes.	KPI - A safer hospital KPI - Improved hospital workforce productivity
Enabler	**Primary Care Clinical Portal**	Implementation of a system which allows clinical access to a single Primary Care Record, is centred on the patient and facilitates multi-disciplinary recording & patient management.	KPI - Care close to home KPI - Fewer premature deaths
Enabler	**Event Reporting System**	Upgrade of the current system (RL6 solution) and subsequent roll out to the community.	KPI - Patient Safety
Enabler	**Telephone Successor System**	Design and implementation of a replacement system for the current switchboard and Wi-Fi telephone system that enables both current and enhanced functionality e.g. mobile devices.	KPI – More efficient building

WORKSTREAM: Health & Social Care Networks – SRO TBD / CMO (Primary Care)

Key Intention	**Project**	Short Description	Dashboard KPI
8	**Health Social Care Network - Overarching Programme**	Establish a framework that supports community-led redesign of health and wellness services, based on the needs and aspirations of the local population. There is a focus on collaborative working practice across health and social service providers.	KPI - Reduced Readmissions KPI - Emergency Department Waits KPI - Fewer premature deaths KPI - Care closer to home KPI - More treatments out of hospital KPI - Better staff engagement
7	**HSCN - Wairoa**	Design and implement a network with locality based planning and delivery of services - includes: - Health Needs Assessment - Asset Mapping - MSD profiling	
7	**HSCN - CHB**		
8	**HSCN - Napier**		
8	**HSCN - Hastings**		

WORKSTREAM: Whole of Public Sector Delivery – SRO TBD / Director Population Health

Key Intention	Project	Short Description	Dashboard KPI
4	One Workforce for Children	Identify and address the gaps in knowledge and skills of the vulnerable children's workforce in Hawke's Bay in order to work effectively with families and improve outcomes (particularly for tamariki and rangatahi Māori and their Whānau) including: - benchmark skills against the Children's Action Plan Core Competency Framework and relevant registration bodies - aggregate the results up to each service, each sector and as a region - design, deliver and evaluate a training programme to address the skills gaps identified, and assess the impact on outcomes for children and families	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions
4	School Ready	Through the strategic alignment between Education and Health sectors, developing an integrated view of services provided/ aimed at Pre-schoolers (0-5yrs) to ready children for the best possible start to schooling.	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions
4	Work Ready	A drug & alcohol addiction programme providing a health service response to current addiction issues within our population who would otherwise be available to work.	Living healthier and longer lives
4	Child Health Database	To evaluate, recommend and implement the preferred solution to combine the various child health databases into a single repository (i.e. Waikato model)	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions

Currently there are 23 projects in-flight; of which 14 are planned to be in closure or closed by the end of the year. A further 4 projects ('next phase' or from the capital master plan) are either in the process of starting up or are planned to start in early 2017. Combined with the 19 new proposed projects this brings the total number of projects to 32:

23	-	14	+	4	+	19	=	**32**
In- flight Projects		Closing		Other Projects		Refresh Projects		**Total Projects**

A draft Transform & Sustain Programme workplan, based on the planned and estimated projects timeframes, can be found in **Appendix 1**.

KEY ASSUMPTIONS / KEY RISKS

- Resource availability e.g. Project Manager resource, IS support, funding
- Necessary Clinical engagement and availability of subject matter experts
- Feasibility of the planned programme of change and ability for the health system to absorb this schedule of change
- The number of new projects to be scoped and stood-up in the next 3-6 months
- Alignment with PHO and Primary Care programme of change

TRANSFORM & SUSTAIN PROGRAMME SUCCESS CRITERIA

As we move into the second half of the Transform & Sustain Programme it is critical that we continue to remain focused on delivering transformational change that meets the original objectives as outlined in the 11 key intentions and delivers sustainably business outcomes and benefits.

Whilst it is important that appropriate structures and discipline are applied at an individual project level, it is the collective change to the way we 'do business' across the sector that will ultimately determine the success (or otherwise) of the programme.

This means that by December 2018:

- Our staff are happier; they feel valued and supported, and are more resilient
- Consumers have a voice; they are engaged consistently across the health sector, co-design is just how we do things and consumers own their own health plans
- Our primary and secondary clinicians, and patients, have access to the same patient information, interventions are faster, and paper has been removed from our processes
- Patients are happier, safer and receiving more treatment in the community
- Communities have increased ownership of the services delivered in their locality
- The HBDHB is leading the way on building intersectoral relationships with a multi-agency programme of work in-place and visible

KEY NEXT STEPS

09/11/16 Workplan reviewed and endorsed by:
- Clinical Council
- Consumer Council
- MRB

16/11/16 Refresh update at Bi-partite meeting

30/11/16 Review and endorsement of workplan by FRAC

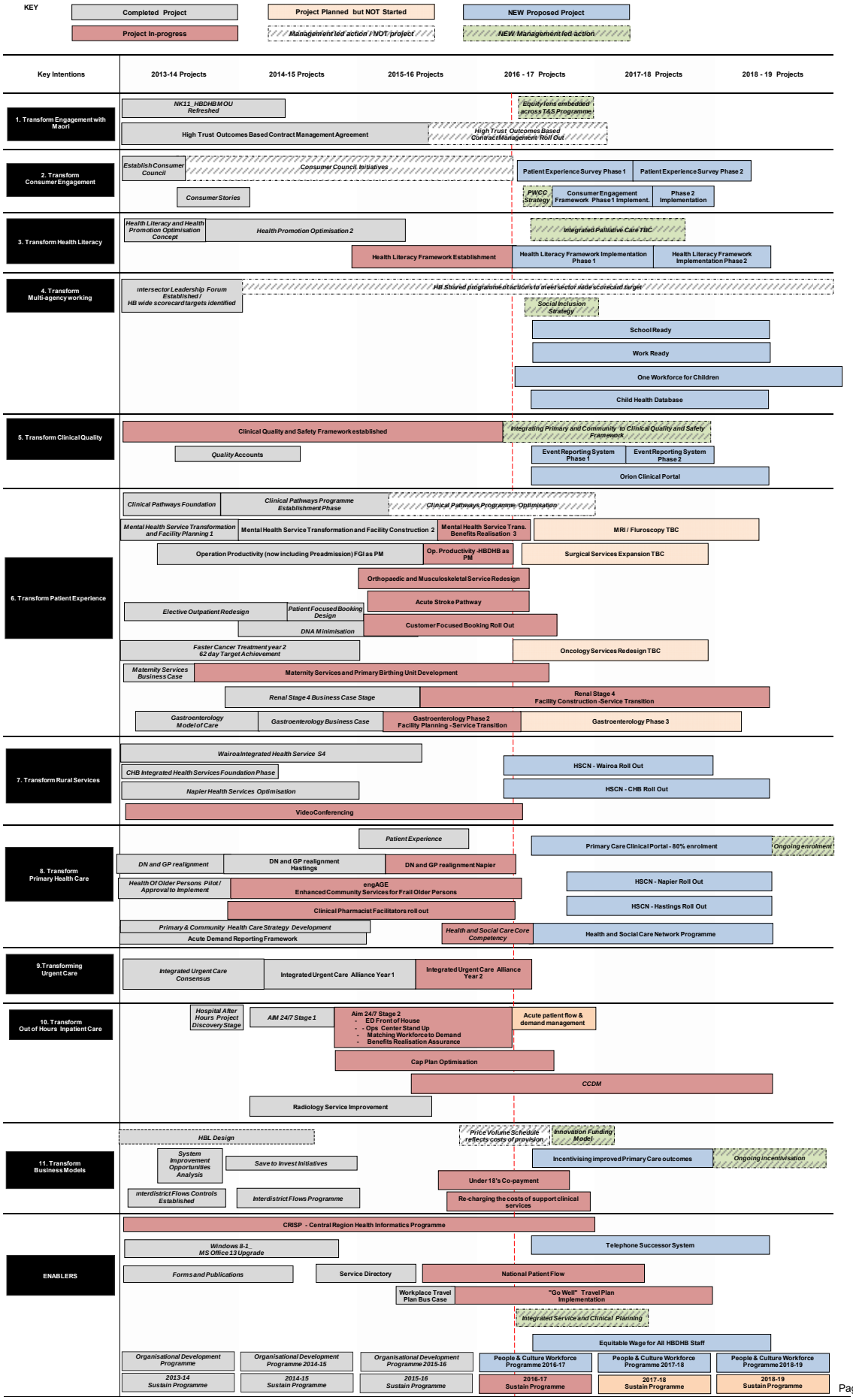
30/11/16 BOARD approval of workplan – *alternative date December Board meeting*

Post approval:

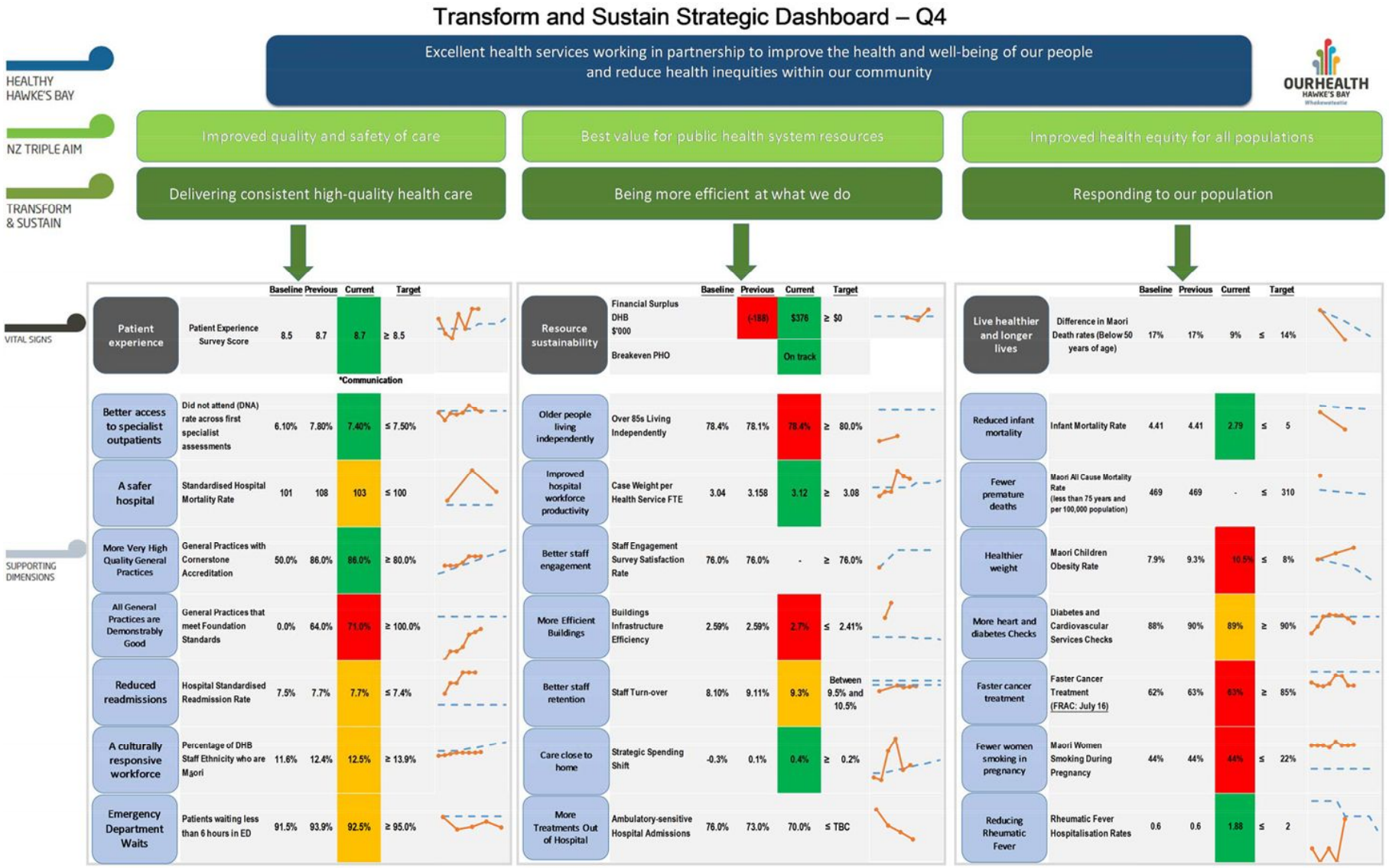
Dec 2016 Syndication with PHO/ HSLT / Service Directorate / Unions

Feb 2017 T&S Refresh launched – *exact date TBC*

APPENDIX 1: TRANSFORM & SUSTAIN PROGRAMME WORKPLAN DRAFT



APPENDIX 2: Strategic Dashboard Q4 2014/2015



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APPENDIX 3: Benefit Mapping Session Attendees

PRIORITY AREA	ATTENDEES			
Investing in Staff and Changing Culture	Tracee Te Huia	Kate Coley	Chris McKenna	
Person & Whanau Centred Care	Tracee Te Huia	Kate Coley	Andy Phillips	
IS Connectivity	Tim Evans	John Gommans	Chris McKenna (apologies)	
Financial Flows & Business Models	Tim Evans	Tracee Te Huia	Ken Foote	Allison Stevenson
Health & Social Care Networks	Tracee Te Huia	Liz Stockley	Mark Petersen (apologies)	Belinda Sleight
Whole of Public Sector Delivery	Kevin Snee	Tracee Te Huia	Caroline McElnay	

APPENDIX 4: Transform & Sustain Key Intentions

1. Transform Engagement with Maori
2. Transform Consumer Engagement
3. Transform Health Literacy
4. Transform Multi-agency working
5. Transform Clinical Quality
6. Transform Patient Experience
7. Transform Rural Services
8. Transform Primary Health Care
9. Transforming Urgent Care
10. Transform Out of Hours Inpatient Care
11. Transform Business Models

OURHEALTH HAWKE'S BAY Whakawateatia	**Urgent Care Alliance – Project End Report**
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author:	Mark Peterson Project Sponsor and Graeme Norton, Chair Jonathan Amos (Project Manager)
Reviewed by:	Executive Management Team and the Finance Risk & Audit Committee (October)
Month:	November, 2016
Consideration:	For Approval by HB Clinical Council For Information of HB Consumer Council

RECOMMENDATION

That HB Clinical Council:

1. Approve the options of the final two work streams from the Urgent Care Alliance Urgent Care Project

2. Note the current status of the remaining project work streams (page 5), the legacy of the Urgent Care Alliance and its transition into the future service arrangements (page 10)

Urgent Care Project
Project End Report

OURHEALTH HAWKE'S BAY
Whakawateatia

choose well

Contents

URGENT CARE PROJECT RECOMMENDATIONS

That Clinical Council:

1. **Approve the options of the final two work streams from the Urgent Care Alliance Urgent Care Project**
   There are a number of options for the two remaining work streams that the Urgent Care Project has produced and that the Urgent Care Alliance supports. **Please see the summary of future options on page 10.**

2. **Note the current status of the remaining project work streams (page 5), the legacy of the Urgent Care Alliance and its transition into the future service arrangements (page 9)**

Previous Papers	**Approved by Clinical Council**
Urgent Care Alliance – Guiding Principles and Mandate	11th March 2015
Urgent Care Alliance – Project Terms of Reference	11th March 2015
Urgent Care Alliance – Staged Work Plan	13th May 2015
Urgent Care Alliance – Year End Report	9th December 2015
Urgent Care Alliance – Monthly Performance Reporting	Monthly ongoing

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1. PURPOSE OF THIS REPORT

This Project End Report describes the conclusion of the Urgent Care Project that was established and led by the Urgent Care Alliance in 2015/16. The project is coming to an end in December 2016 but the work it set in motion is continuing as the majority of the Urgent Care work has been handed over as business as usual. There are however the last two remaining work streams with options that need to be endorsed.

It is important for the reader to separate the Urgent Care Alliance from the Urgent Care Project that it established, as the project is coming to an end with this report, but the UCA itself and the work it has begun is continuing in various settings throughout the health sector in Hawke's Bay.

This report also sets out the legacy arrangements for the future of the UCA itself, as it transitions into future service arrangements beyond that of the Urgent Care Project. This report is NOT a business case. It is intended that any business cases will follow in the normal business case financial cycle of the DHB as indicated below.

2. BACKGROUND – Consumer at the heart of the project

What is Urgent Care?

Urgent Care can be simply stated as: 'I am unwell, and I need advice or treatment now'.

This reflects the fact that someone has a health need and just wants to see a provider. A provider description of Urgent Care is: 'Urgent care is the range of services available to people who have, or perceive they have an urgent need for advice, diagnosis, treatment or care'.

In May 2015 Clinical Council approved the Staged Work Plan. This plan set out the key priority areas that had been selected by stakeholders for the Urgent Care Alliance (UCA) to address. This plan also set out the 2 year project timeline for addressing these priority areas. These 11 priority areas were chosen to have maximum impact on the provision of Urgent Care for the people of Hawke's Bay.

The UCA and the stakeholders *(including General Practices, Māori Health Providers, NGOs, Pharmacists, Rural Health Providers, Dentists, Aged Residential Care Providers, St John, HHB and HBDHB etc. see Appendix for a full list)* **placed the consumer at the heart** of the Urgent Care project. Each of the options contained within this report sets out to address at least one or all of the following:

Now – Consumer experience

- **Inequity** - Urgent Care services that are available to people are different depending on where a person lives and, for many, cost is a barrier to access.
- **Confusing, fragmented and unclear** – Urgent Care services are not always clear to the consumer
- **Lack of integration** – A persons experience varies from service to service as some services work well with each other and others less so
- **Increasing demand from people** for existing Urgent Care services could be managed better within existing resources

2.1 What is the problem we are trying to solve?

Having established the Urgent Care issues that the people of Hawke's Bay face (see above) the UCA and Stakeholders agreed the following priority areas to help address them. A project work stream was created for each priority and a stakeholder working group set up to analyse the issues. The first key stage for each working group was to consider the key urgent care issues facing the population within each priority in greater detail. Nine of these work streams have now been completed (or suspended) by the Urgent Care Alliance and only 2 remain for final endorsement by Clinical Council in this report.

Work streams	Work Stream outcome at project end
1. GP/ED Working Group	Handed over - now Urgent Care RFP process
2. Oral Health	Handed over – Business case to be submitted
3. Public Communication	Handed over – Business as usual
4. St John service provision	Suspended
5. Transport Assistance	Handed over – Business as usual
6. Person Centred Urgent Support Pathways	Handed over – Business as usual
7. Timely Access to Data	Handed over – Business as usual
8. Affordable Access	Merged into RFP
9. **Advanced Practitioner Workforce**	**See Options for endorsement**
10. **Aged Residential Care**	**See Options for endorsement**
11. Greater Treatment in Pharmacies	Suspended

2.2 The future for the consumer - What will be different?

The following sets out what the project is seeking to achieve for the people of Hawkes Bay in the future:

Future – Consumer experience

The people of Hawke's Bay will:

- be well informed about their care choices – **choose well**
- for those people who need targeted financial assistance, be supported to enable access to services
- have access 24/7 to telephone or technology based advice - locally responsive, nationally supported and backed
- have formalised continuity of access to primary care services 24/7 – in hours and out of hours
- have a care response which is integrated – **right response, right door, right time**

2.3 Lessening the need for Urgent Care

To reduce demand for Urgent Care we need to work earlier with consumers who are at risk of developing conditions that would put them at risk in the future. There are a number of pieces of work underway to increase consumer's ability to manage their own health and access health services earlier. An example is coordination of health literacy initiatives and working with consumers at risk of developing Long Term Conditions. Whilst this work is not directly within the remit of the Urgent Care Project we recognise that this work is crucial to reducing demand for Urgent Care in our population.

2.4 Future financial implications

This report sets out the case for the final series of options to help support Urgent Care in Hawke's Bay. Some of these options have financial implications in the future should they be approved at this stage. The Urgent Care Alliance has an approved budget in principle that it can make claims against subject to approval of individual business cases by Clinical Council and HBDHB Board. It must be noted that the UCA is not asking for the approval of any business cases at this stage. Should any options with financial implications be approved within this report a full business case will be developed.

This is to allow the consideration of any/all financial bids within the same time frame to allow the HBDHB Board to allocate its set budget with the correct financial considerations.

3. CURRENT STATUS OF THE WORK ON URGENT CARE

3.1 Urgent Care RFP - Handed over – Strategic Services

Status - Ongoing

The Urgent Care Alliance proposed that a Registration of Interest/Request for Proposals (ROI/RFP) process be run by the DHB/PHO to assess if there was sufficient interest and resource to set up a new Urgent Care Service for Hawke's Bay. This was endorsed by Clinical Council/Board.

At this point the UCA then transferred the responsibility for running the ROI/RFP to the DHB and following a successful ROI an RFP is ongoing with a group of respondents jointly working with the DHB to pull together a proposed new service.

The RFP itself is currently suspended with a finish date of the 31st October. This is to allow the respondents and the DHB to work jointly on a solution. The latest stage of which is for a detailed clinical model to be developed jointly between General Practice clinicians and clinicians from Hastings Hospital Emergency Department before being proposed for the final Urgent Care Service model.

The RFP process, chaired by the head of Strategic Services and reporting to the DHB chief executive and board through FRAC is being intensively worked on and closely monitored. All parties fully understand that significant progress is required in appropriate, consistent and affordable service provision "right door, right service, right time" in Hastings and with implications for Napier from this work. The current timeline requires sign off by end of calendar year and services in place April 2017.

3.2 Oral Health – Handed over – Strategic Services

The Oral Health stakeholder group was formed and proposed 6 options to Clinical Council at year end. Since that date the group has progressed to business as usual meeting less frequently but still addressing Urgent Oral Health. Recently they have produced an oral health advisory pamphlet following a request from the Winter Planning Group. This pamphlet is designed to provide consumers presenting at the Emergency

3.2.1 Handed over – Strategic Services

Status - Suspended

Complete an Oral Health Pathway to enable sector wide health services to understand the full range of options available to them for Oral Health treatment of the people of Hawke's Bay.
- Recently EMT reviewed the functionality of the pathways software 'Map of Medicine' and as a result the creation of new pathways has been suspended. Along with this development of new pathways were looked at and it was decided that the lower volumes of consumers that would benefit from this meant that it would meet the threshold of a priority pathway. Therefore at the moment of writing this report it is looking unlikely that this clinical pathway will be completed.

3.2.2 Handed over – Strategic Services

Status - Ongoing

Increase engagement with the Ministry of Social Development (through their Regional disability advisor) to fully understand the current picture of spend on the provision of special grants for Urgent Oral Health treatment and potentially develop new innovative treatment packages. – The group will continue to look at ways of working more closely with MSD.

3.2.3. Handed Over – Māori Health services

Status - Completed

A contract variation with Te Taiwhenua O Heretaunga (TTOH) oral health service to provide additional capacity for access to urgent care. – The dental contract at TTOH has been adjusted to focus far more heavily on providing walk-in appointments. The levels of uptake of this new service will be monitored by Māori Health Services. The Emergency department at Hasting Hospital have been advised and are advising clients with Community Service Cards to seek treatment at TTOH. The recent introduction of the Toothache advisory pamphlet also provides clear advice to consumers about how to seek treatment through this service.

Status - Ongoing

Handed Over – Strategic Services - Business Case

Options 4, 5 and 6 that were put forward by the Oral Health Group will be merged into a business case to be submitted as part of the annual budget review process. These are:

3.2.4 Provide additional funding for existing emergency dental contracts to allow for a more consistent level of treatment over the 2 year periods of the contracts.

3.2.5 Create an additional Dental Practitioner post within the Oral Health Services at HBDHB for the provision of a relief of pain clinic.

3.2.6 Provide seed funding to encourage a private dentist to set up a relief of pain clinic in a primary health care setting.

Status - Ongoing

3.3 Public Communication – Handed over – Communications Team

The Urgent Care Alliance co-designed a new campaign 'choose well' which is the public face of Urgent Care demonstrating to members of the public how to prioritise their treatment. The 'choose well' campaign is now business as usual for the DHB Communications Team. An annual ongoing budget of $50k has been transferred to the team from the UCA budget to underwrite a continuous strategy for the foreseeable future. The team continue to develop the 'choose well' message utilising many approaches including:

- The Our Health Website
- Billboards
- Banners
- Radio adverts
- Social media promotions
- Posters and postcards etc.

Choose well recently received praise from the media with the Hospital Emergency department seeing fewer presentations when compared to the same period last year.

3.4 St John Service Provision - Suspended

Status - Suspended

St John are running an Urgent Community Care scheme in Horowhenua that they felt could be pursued in Hawke's Bay. Two options were put forward to Clinical Council at the end of 2015 with a provision for the UCA to look into the detail behind the Horowhenua scheme in early 2016. When the UCA reviewed the information on the St John UCC Horowhenua scheme it was found that although the scheme had some positive impacts there were a number of issues with the pilots including:

a. UCC inducing demand from patients
b. Not seeing enough patients (fewer than 10 per day across both pilots) at a cost of $1.5m per annum

When the UCA asked for more up to date evidence unfortunately St John were not in a position to provide more information. As a result the UCA took the decision to suspend these options going forward until new evidence to support the options emerges. To date St John have been unable to provide further supporting evidence.

St John are still an important stakeholder in the Urgent Care process and will be widely consulted with when the Urgent Care RFP produces a new proposed Urgent Care service.

3.5 Transport Assistance – Handed over – Strategic Services

Status - Ongoing

The Urgent Care Alliance created a Transport Assistance stakeholder group from the DHB/PHO and transport providers Red Cross and St John etc. Together the group quickly discovered that the lack of integration between the different services provided and contractual arrangements presented a number of issues. This led to the following recommendations being endorsed by Clinical Council:

3.5.1 A strategic approach to consumer transportation issues across both the DHB and PHO at a strategic sector wide level should be considered. Although out of scope for the Urgent Care Project itself, many opportunities exist (Travel Plan, Health and Social Networks etc.) for this work to go forward.

3.5.2 Once adopted, there are a number of potential Urgent Care options a strategic approach could consider.

As a result of this work the responsibility for the strategic direction of transportation was handed over to Strategic Services to consider. Since this hand over the entire portfolio of services has been mapped out across providers and a series of meetings and discussions have been undertaken. These include discussions with, HHB PHO, St John, Red Cross, Wairoa Health Centre and the Regional Council who provide Go Bus subsidised transport for consumer of health care services. The aim of this work was to address improving the delivery of transport services to consumers and better support consumer attendance to appointments.

This work is currently being aligned with the new Operations Directorate which is seeking to reduce the fragmentation of Transport Services within the DHB through the centralisation of responsibility for transportation. It is expected that once in place this new service will work closely with Strategic Services and transport providers to further integrate existing transportation provision. This could be achieved through the use of a transportation forum or other such mechanism which could then consider the Urgent Care transportation needs of consumers in the future based upon the recommendations of the Urgent Care Alliance.

3.6 Support Pathways – Handed over – EngAGE Steering Group

Status - Completed

This priority was developed by discussions with stakeholders around the timeliness and navigation of support packages that are available for consumers. There were concerns amongst stakeholders that consumers aren't getting the correct care or support packages and when they are getting them they aren't put in place quick enough in certain areas.

To address this the Support Pathways stakeholder group identified a series of principles that resulted in the following priorities:

3.6.1 EngAGE Steering Group be expanded to include a wider group of support providers (including Options, ACC etc.) and be regularly maintained into the future. This is to strengthen links between the services, enhance integration and develop existing knowledge. This group to explore at Urgent Care Issues with support pathways once existing gaps are fully mapped and understood.

3.6.2 Complete a Care Pathway for older people to enable Clinicians to understand the full range of support options available to consumers and enable a timely support package for the individual.

Since these options were approved by Clinical Council the EngAGE service has been established. The EngAGE Steering Group have acted upon the principles outlined by the Support Pathways Stakeholder Group and ensured that all services that co-ordinate support packages for consumers are aware of how they work and they have now established the:

- EngAGE response Team
- EngAGE Multi-disciplinary Teams x6, and
- EngAGE intermediate care services

Each of these services places the consumer at the centre and engages with all services to ensure that care packages are put in place in a timely manner

The care pathways for older people are also nearing completion with the following areas being addressed on Map of Medicine:

- Services for older people
- Falls and older people
- Osteoporosis and fracture prevention

3.7 Timely Access to Data – Handed over – Information Services

Status - Ongoing

When identifying its priorities the immediacy of consumer medical data for clinicians was identified as a major barrier for Urgent Care. When the stakeholders were consulted it quickly became apparent that there is a large amount of strategic change occurring with health and consumer data systems. As a result the stakeholder group put forward the following option which was endorsed by Clinical Council:

3.7.1 Feed the identified gaps and options produced by the Urgent Care Project into the wider strategic change that is taking place with Information Systems

The stakeholder group produced a series of gaps and options that reflected the need of systems to be timely, easy to use, linked up and have common access and sharing of information. These principles have been taken forward by Information Services and informed the rollout of a number of IT programmes including:

- The local implementation of the National Enrolment Service
- The involvement of HBDHB in the MOH led Single Patient Record
- The rollout of the Manage My Health Patient Portal
- Provider Portal – EngAGE
- District Nurse / General Practice alignment work

Recently an IT Governance Group has formed through the PHO and this group will be responsible for guiding further strategic level progress within the Primary sector and its connections to the Secondary sector systems.

Status - Ongoing

3.8 Affordable Access – Merged into the RFP

The recommendations for affordable access to consumers endorsed by Clinical Council will be taken forward by the new providers of the Urgent Care Service. It is expected that as part of their proposal any respondents to the Urgent Care RFP must address mechanisms to maintain affordability for consumers. This could be in the form of targeted fee reductions to certain groups such as community service card holders or other mechanism.

3.9 Advanced Practitioner Workforce – Options for endorsement by Clinical Council below

3.10 Aged Residential Care – Options for endorsement by Clinical Council below

Status - Suspended

3.11 Greater Treatment in Pharmacies - Suspended

At the beginning of 2016 the Urgent Care Alliance set out its stage two work streams including Greater Treatment in Pharmacies. Representatives from the UCA met with representatives from Pharmacy Services and discussed the potential of setting up an Urgent Care Pharmacy Stakeholder Group. It was agreed that due to the sensitivities around the contract negotiation and the intentions by the DHB to establish a single pharmacy stakeholder group it would be sensible to suspend the Greater Treatment in Pharmacies Urgent Care work stream until the wider stakeholders group was formed. At the point of writing this report a pharmacy stakeholders group has yet to be formed due to complications in agreeing its format etc.

4. The future of the Urgent Care Alliance

With the completion of the work of the final two work streams and the resultant options for endorsement by Clinical Council the responsibility for delivering them will be handed over to the DHB and PHO staff and the UCA will transition into a new phase.

It has been proposed that the group will meet on a quarterly basis linked to the new committee structure that is currently being adopted by Clinical Council with its function to act as an interface between acute secondary service provision and general practice primary service provision.

An example of its future role could be in the roll out of the new acute patient flow model and linking this new model into the primary sector through a reconnection of patients with their primary patient 'home'.

The newly named Urgent Care forum will be supported the Strategic Services Manager Primary Care.

5. OPTIONS FOR TWO REMAINING WORK STREAMS FOR APPROVAL

	Name	UCA Lead	Options	Financial implications for project	UCA supported Option/s
Project Work Streams					
9	Advanced Practitioner Workforce	Leigh White / Jill Lowrey / Graeme Norton	a. The DHB and PHO to support a new model of care to allow the greater use of 'Triage, Assess, Advice' model led by nurses in our primary sector providers.	No	✓
			b. The DHB and PHO to support the principle of ring fenced funding (utilising the co-payment model) for nurse led Urgent Care clinics – For Nurse led clinics to succeed in the primary sector the stakeholder group felt that it needs to be financially viable and a reasonable co-payment charge should be supported.	No	✓
			c. The DHB and PHO to support raising the public and professional perception of the nursing and midwifery workforce – A much greater emphasis should be placed upon the role of nursing and midwifery in Urgent Care and this should be publicised by the DHB and PHO through the use of targeted nursing and midwifery health promotion initiatives. The stakeholder group acknowledged that midwifery currently provide Urgent Care services, but it was felt that greater links need to be established to help integrate the midwifery workforce into primary care.	No	✓
			d. The DHB to fund a primary Nurse Educator – In order for the workforce to change and adapt to the growing demand for Urgent Care it needs to be properly educated in the correct models of care. To achieve this the stakeholder group feels that a dedicated primary nurse educator be established. This role could potentially support and train Aged Residential Care (ARC) residential nursing staff in Urgent Care techniques (see Urgent Care Aged Residential Care Options). This is in line with the the Transform and Sustain Refresh priority – • Investing in Staff and Changing culture (equipping staff for a changing world).	Yes	Subject to Business Case
			e. Local expertise from senior nurses to support Workforce Development – The new function of the primary nurse educator could be supported by establishing a network of senior nurses. This network can to help to support, teach and transfer their skills to the workforce.	Yes	Subject to Business Case
10	Age Residential Care	Leigh White/	1. Raising the profile and understanding of ARC within the DHB - There needs to be a cultural change between ARC and the DHB where staff are encouraged	No	✓

		Graeme Norton	and supported to understand the roles each play and the support each sector provides for residents. The opportunity exists with the role out of the Transform and Sustain refresh. In particular two of the priorities - • Whole of Public sector delivery (delivering effectively with public sector partners). • Investing in Staff and Changing culture (equipping staff for a changing world). The Urgent Care ARC stakeholder group wants ARC placed within these priorities as a key partner of health service delivery. The levels of care and the needs of the residents in Aged Residential Care (ARC) is changing. The knowledge and relationships between nursing and other clinical and management staff within ARC and both primary and secondary care need to be strengthened to reflect this.		
			2. Fund an ARC Nurse Educator – In order for the workforce to change and adapt to the growing demand for Urgent Care the workforce needs to be properly educated in the correct models of care. To achieve this the ARC stakeholder group feels that a dedicated nurse educator should be established. This role could also potentially support and train Primary Sector nursing staff in Aged Residential Care techniques (see Urgent Care Nursing and Midwifery Workforce Care Options). This is in line with the Transform and Sustain Refresh priority – • Investing in Staff and Changing culture (equipping staff for a changing world).	Yes	✓
			3. Local expertise from senior nurses to support Workforce Development – The new function of the nurse educator could be supported by establishing a network of senior nurses. A key issue facing ARC clinical staff is the ability to make ethical decisions for their residents. This network can to help to support, teach and transfer their skills to the workforce.	Yes	Subject to Business Case
			4. Involved in the review of EngAGE services (Clinical expertise gap to support RN's) - The stakeholder group felt that it was important that ARC is represented at any review of the new engAGE service.	No	Subject to Business Case
			5. After Hours arrangements with Age Residential Care needs to be addressed by new Urgent Care Service - When a new Urgent Care Service is established for Hawke's Bay, the ARC stakeholders group would like the new provider to work closely with the ARC sector to explore the Urgent Care needs of the sector especially with their out of hours provision.	No	✓

HAWKE'S BAY District Health Board Whakawāteatia	**Travel Plan Update**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner: Document Author(s):	Sharon Mason (Chief Operating Officer) Andrea Beattie (Property and Service Contracts Manager)
Reviewed by:	Executive Management Team
Month:	November, 2016
Consideration:	For Information

RECOMMENDATION

That MRB, Clinical and Consumer Council:

Note the contents of the report

OVERVIEW

The purpose of this report is to provide an update on progress since the previous update in August 2016.

UPDATE

In early September the first of the Go Well personnel started with HBDHB. This means there is now a dedicated and focussed resource to drive the implementation of the travel plan.

Engagement with the working groups and other staff stakeholders has continued with regular meetings taking place. A representative of Sport Hawke's Bay has now joined the working group.

A Go Well update was presented to staff including a few external stakeholders at the monthly Transform and Sustain seminar in October.

Bus Services

On 26 September, new and improved bus services commenced. Our partnership with Hawke's Bay Regional Council means our communications teams are working closely around developing messaging and promoting these services.

A proposal is currently in development around extending free bus transport for patients, and will be presented to the travel plan steering group in November.

Parking Management Controls

The request for proposals process to identify appropriate and suitable parking management control equipment closed in late September. After completing evaluations and vendor interviews a preferred vendor has been selected. The parking controls team has elected to implement the parking controls in a phased manner, commencing with pay and display equipment, with considering being given to adding barrier arms to some parking areas in future.

Parking Improvements

A new car park with approx. 40 parks in currently being constructed beside the Diabetes Service off McLeod Street.

The proposed car park remarking and signage updates are currently being finalised and we expect work to start on this shortly.

Cycling

A number of new cycle stands are now in place, and planning has commenced around the construction of a second secure bike store on the Hospital site.

Discussions are also underway with our landlord about providing a secure bike store for our corporate office staff.

HAWKE'S BAY District Health Board Whakawāteatia	**Orthopaedic Review – Closure of Phase 1**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author(s):	Andy Phillips and Sharon Mason Carina Burgess and Andy Phillips
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For Information

RECOMMENDATION

That Māori Relationship Board and Clinical and Consumer Councils:

- Note the progress to date in the Orthopaedic Review and the Closure of the First Phase.

PURPOSE

This paper gives a brief overview of the work that has been carried out to redesign Musculoskeletal and Orthopaedic Services and notes the closure of the first phase.

OVERVIEW

It is evident that there are a large number of people in the community living with pain and disability caused by musculoskeletal conditions. This number is expected to rise as the population of Hawke's Bay ages and the incidence of osteoarthritis increases.

This paper describes the first phase of work to review and fundamentally redesign musculoskeletal and orthopaedic services to meet the needs of people in our community.

Initial work demonstrated the lack of threshold setting for surgical candidature and inconsistencies with prioritisation between surgeons, and delays experienced by patients along the pathway from referral to surgery. These concerns were focussed on hip and knee conditions joints but public feedback, staff concerns and workforce planning also highlighted the back, spine and acute orthopaedic pathways as other areas for review and redesign.

The redesign of Musculoskeletal and Orthopaedic services was set out in three phases. The first phase, now complete involved increasing surgical capacity and making conservative treatment options available. The second phase will involve the co-design of a long term plan to effectively manage demand and align capacity over two to five years. The third phase will address 'third horizon' issues over ten years that will require innovative approaches.

In 2015 a project was initiated to review Orthopaedic Services. The objective of the project was to reduce pain and disability to patients in our community from musculoskeletal conditions by reviewing and co-designing musculoskeletal services. A paper outlining the programme and actions for Phase One was presented to Clinical Council and the Board resulting in funding being approved for additional surgical capacity and a non-surgical intervention programme.

The initiatives completed in the first phase included:

- Implementing non-surgical treatment options by increasing physiotherapy and other allied health resource.
- Implementing a new pathway for back pain patients offering an alternative non-surgical treatment option.
- Improved patient communication and collaborative services within the DHB.
- Reducing wait times throughout the pathway.
- Setting thresholds for surgery based on data for orthopaedic scoring and Oxford score.
- Increasing surgical capacity to deliver on the major joint replacement target.

Non-surgical Treatment Programme

Non-surgical assessment and treatment is now being provided by physiotherapists for those being referred to the orthopaedic department for hip, knee or back pain. Following assessment, patients who do not meet the threshold for surgery and/or those who are assessed as being likely to benefit from non-surgical interventions are offered physiotherapy or other allied health treatment and management.

1. Spine Clinic

The spine clinic delivered by Advanced Practitioner Physiotherapists was launched on 15th February 2016. Since then, there have been 333 referrals, 171 directly to the clinic and 162 were originally referred to Orthopaedic FSA by their GP and were redirected to the Physio Spine Clinic. All of these patients had complex worsening symptoms lasting between six months and forty years with average duration of eighteen months. Many had previous spinal surgery. A proportion of these are still undergoing treatment but discharge data has been collected for 50% of the referrals.

Total Referrals all sources	Discharge Data collected	Discharge Outcomes				
		Fully resolved or minimal signs and symptoms	Managing symptoms successfully	Did not access of did not complete	Inappropriate referral – discharge or referred on	Referred to FSA
333	165 (50%)	43%	18%	23%	3%	14%

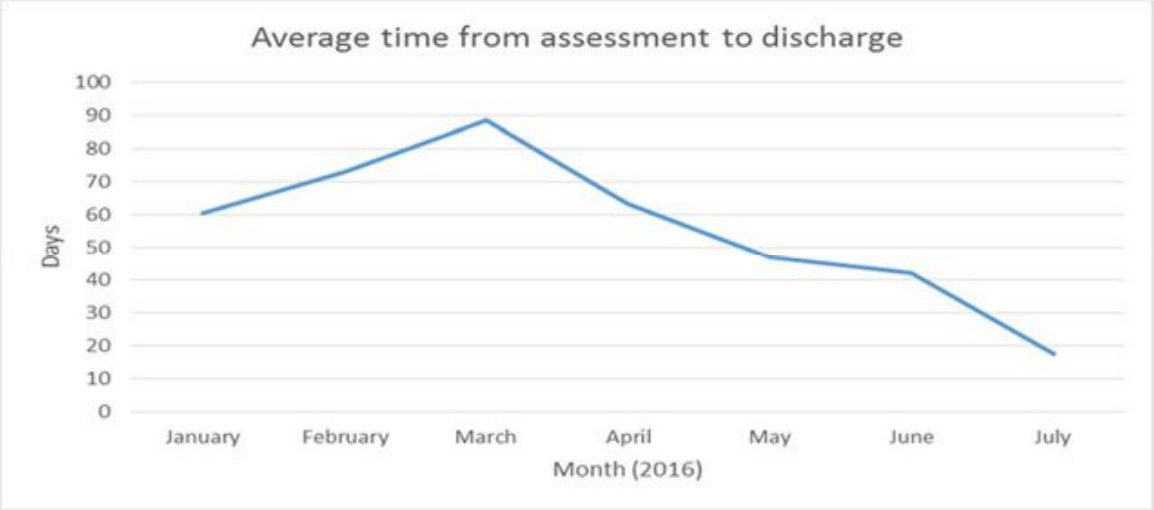
Of the 162 patients originally referred to Orthopaedic FSA by their GP and redirected to the Physio Spine Clinic for assessment and treatment, only 14% were referred back to Orthopaedic clinics.

Intercepted FSA referrals	Discharge Data collected	Discharge Outcomes		% of patients 'Highly Satisfied' with the service
		Managed within the spine clinic	Referred back to FSA	
162	97	86%	14%	93%

Of the patients seen in Spine clinic, 76% had improvement in symptoms, 20% had no change whilst one patient had worsening of symptoms and was referred for Orthopaedic treatment.

Access and Timeliness:

The waiting time from referral to assessment had increased as the number of referrals to the clinic is increasing. GPs are now referring directly to the clinic.



With two advanced practice therapists now in post, patients are being followed up and discharged more promptly. One therapist is averaging three treatments per referral and the other four treatments per referral.

The clinic is primarily based in Hastings, and 94% of assessments have been carried out in Hastings, 4% in Napier and 1% in Waipukarau.

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Patient Outcomes:

New outcome measuring tools were researched, trialled and developed over the six month period. New reports generated in August 2016 include percentage change data and client satisfaction recording. The data from these reports below show an improvement across all outcome areas – reduced pain, and increased function and self-management. The results also show a reduction in the STarT back score which is a measure of the risk factors for back pain disability. Of the 33 discharged patients using the new outcomes tool, 73% scored 10/10 on the patient satisfaction score.

Patient based average outcome scores (discharged patients)			
Average Reduction in Pain % change	**Average Improvement in Function % change**	**Average Improvement in self-management Ability % change**	**Average Improvement in STarT back score % change**
23.6%	12.5%	30.0%	14.8%

Patient Satisfaction score	**Frequency %**
1-5 Low	0
6	3
7	3
8	15
9	6
10 High	73

Communication and Education:

The spinal clinic has been promoted through letters to GPs and information pamphlets. GPs are now referring directly to the spine clinic rather than to FSA. Attendance is improving as patients are now better informed of the clinic and assessment process and are therefore willing to engage.

A number of resources have been made available such as back facts booklets, education packs for all referrers and an education tool which is widely available in GP practices and the community.

2. Hip and Knee Pathway

In March 2016 funding was made available to:

1. Expand the hip/knee scoring clinic to allow 6 and 12 month rescore by physiotherapist.
2. Establish multi-disciplinary education and exercise programme (MEEP) team to provide treatment to patients who had not met criteria for FSA and therefore had been declined hip/knee joint replacement surgery.

The aims were to provide treatment to:

- Improve patient satisfaction around arthritis surgical process.
- Increase self-management through greater patient knowledge of arthritis and utilisation of medications.
- Slow clinical decline of joints through better muscle strength/ posture.
- Support patients with activities of daily living through access to equipment.

FTE was provided primarily for physiotherapy to lead the programme of multi-disciplinary education and exercise [MEEP] and be the major speaker. Occupational Therapy, Social Work and Pharmacy disciplines each gained 0.3 FTE to provide educational segments of sessions.

Following early piloting of group programmes that was not successful, a change was made to individualised treatment and education provided by the physiotherapist alone, who had the ability to refer to other discipline as required.

The physiotherapist works with patients individually covering education topics of all the disciplines along with specific training in posture, gait, and muscle strengthening. Strengthening was provided as home programme along with access to supervised gym and/ or gym sessions.

Outcomes:

- Patients now have 6-12 month re-scoring to ensure they can access orthopaedic specialist appointment if required, rather than being referred back to Primary Care.
- The wait time for physiotherapy assessment has reduced to ten days from the previous 4-12 weeks.
- Patients report significant satisfaction in having access to gym and pool session in a safe environment which fits their level of activity, and where they gain individualised physiotherapist guidance.
- Arthritis New Zealand now use the pool after hours and this provides a community link to which patients can transition.

Individualised treatment and education format 17 June to 30 September 2016:

- 105 patients attended 188 individual sessions.

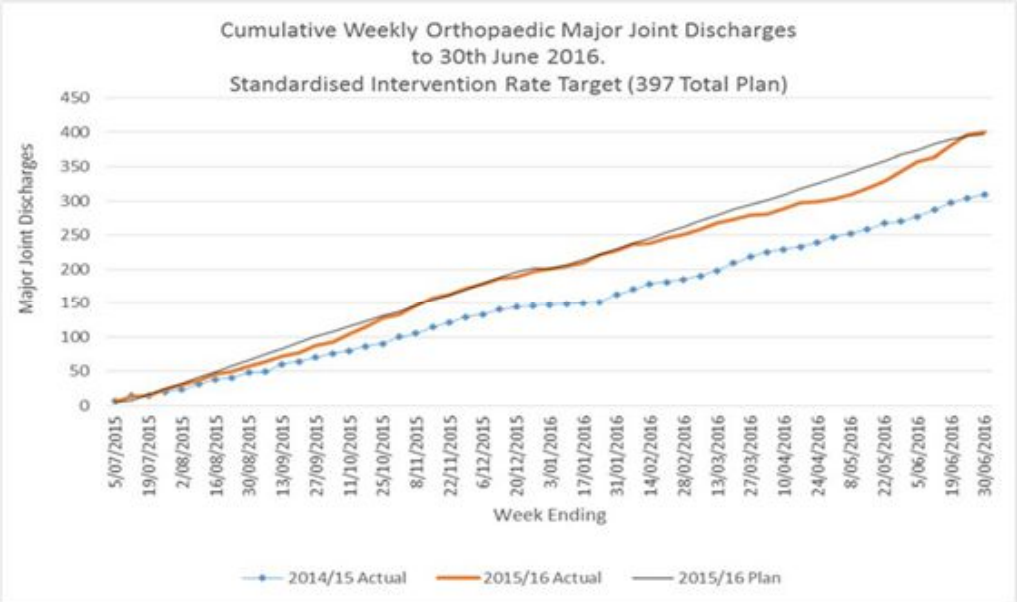
Areas for development:

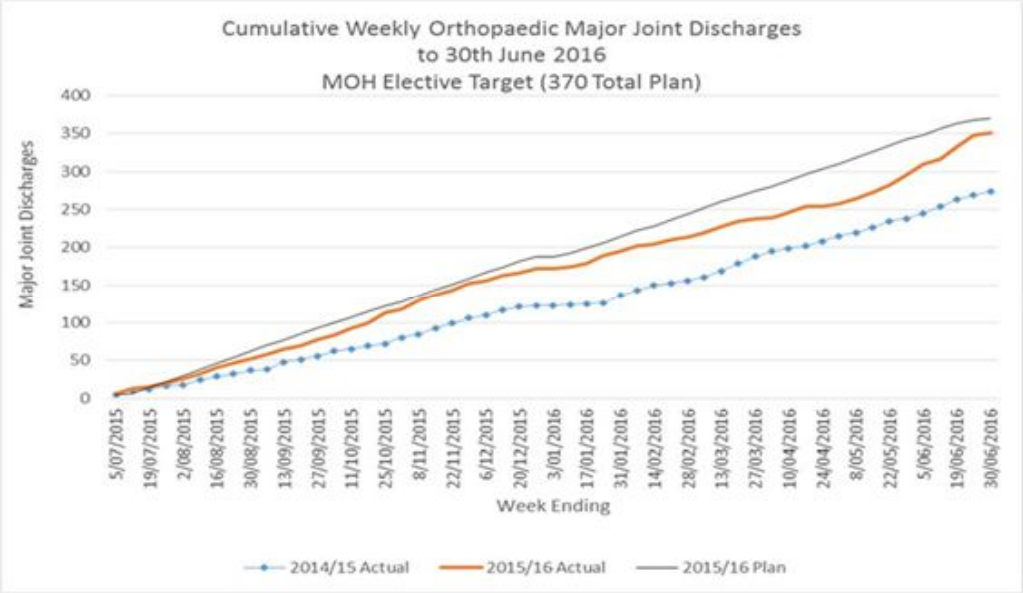
- There will be a focus on making clinics more accessible across Hawke's Bay, especially in Wairoa and Waipukarau.
- A triage tool and referral pathway has been developed using the StarT Back Tool, Keele University. This will be rolled out within the DHB and in the community to educate on when to refer to limit unnecessary referrals. Examples of when this will most useful are:
  - Use in ED to limit hospital admissions.
  - Use by HBDHB staff in ENGAGE, ORBIT, and prior to internal referrals.
  - Triage by general practitioners.
- Professional development of at least one new staff member to up skill over the next year to work within the clinic.
- Provide opportunities for current advanced practitioners to share data and success stories to support HBDHB initiatives nationally and internationally.

- Investigation of potential for physiotherapists to treat patients currently treated by radiologists with image guided injection of joints.
- Implementation of shoulder pathway.

Surgical Capacity

In 2015/16 there were 91 additional Orthopaedic Major Joint Replacement discharges than in 2014/15. The standardised intervention target of 397 was met as we delivered 400 discharges in the year. The elective target however was not met as only 351 of the 400 were elective surgeries (target 370) and the remaining were acute. We ended the year at 94.9%.





Outsourcing was required throughout the year. Fifty surgeries were outsourced to Royston and the majority of these occurred in the last three months. Going forward, outsourcing will be more planned.

Following an External Review of Orthopaedics the business case for an 8th orthopaedic surgeon has been approved and is being recruited to.

Additional orthopaedic surgical acute lists on a Sunday commenced on 23 October 2016 and have been evaluated as a success.

System Changes – Referral to Discharge

During the initial stages of the project it was determined that there were many delays in the process from referral to discharge. Many of these have been resolved and others are being addressed through the National Patient Flow (NPF) project which is targeted at orthopaedics and other surgical specialties. We have worked with the NPF project team to develop a referral pathway for effective data capture.

Patient Experience

Patient letters have been rewritten so that they are more informative and better explain the process. These have been developed in conjunction with the Consumer Engagement Manager. In the hip and knee pathway, following scoring, there is a set threshold for FSA. If the threshold is not met the decline is immediate rather than waiting three weeks which is what was happening previously.

Mobility Action Programme

The Ministry of Health is investing $6million over three years to improve diagnosis and treatment for people with musculoskeletal health conditions. The focus is on early intervention, community based, multidisciplinary community services.

HBDHB, with Health Hawke's Bay and Iron Māori, were successful in securing $380,000 of this funding to deliver the Mobility Action Programme. The proposal was based on a Whānau Ora, community model to improve access to services for people in high deprivation areas. The service offers walk in clinics located in targeted communities for early intervention to reduce pain and disability and support people to remain in work and live independently. Iron Māori will act as the hub of the Mobility Action Programme coordinating services from Community Physiotherapists, Mananui lifestyle collective and Long Term Conditions Programme (Stanford Model).

Co-designed Clinical Pathways

A Hip and Knee osteoarthritis clinical pathway was developed in early stages of the clinical pathways work. This pathway was published but not socialised. In the second phase of the programme a new pathway will be co-designed by consumer groups, NGOs and staff from November 2016.

Outstanding Issues for Resolution from the First Phase

Whereas additional funding of $60,000 was agreed for Coordinated Primary Options work, this has not eventuated. This funding was granted to support a GP with Special Interest in muscular skeletal treatment to provide additional management and treatment including joint injections for patients who had completed physiotherapy treatment and been referred for Orthopaedic FSA but declined for surgery due to not meeting the threshold. This service will be implemented once the GPSI is in post.

HAWKE'S BAY District Health Board Whakawāteatia	**Regional Tobacco Strategy for Hawke's Bay, 2015–2020 update**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Shari Tidswell, Team Leader/Population Health Advisor Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by:	Exeuctive Management Team
Month:	November 2016
Consideration:	For information

RECOMMENDATION:

That the Māori Relationship Board, Clinical and Consumer Council:

Note the contents of this report.

OVERVIEW

In November 2015 the Regional Tobacco Strategy for Hawke's Bay, 2015–2020 was endorsed by the HBDHB Board with a yearly report to be provided to the Board and Committees. This is the first annual update of the Strategy with particular focus on progress towards the three objectives through monitoring of the six key indicators:

Indicator 1a: Smoking prevalence (particularly Māori)
Indicator 1b: Smoking prevalence in pregnant women (particularly Māori women)
Indicator 1c: Lung Cancer Incidence
Indicator 2a: Prevalence of Year 10 students who have never smoking (particularly Māori students)
Indicator 2b: Prevalence of Year 10 students living with one or more parent who smokes (particularly Māori students
Indicator 3a: Number of tobacco free retailers

BACKGROUND

The Health Equity Report 2014 identified tobacco use as the single biggest underlying cause of inequity of death rates and ill-health in Hawke's Bay[1]. Smoking is still more prevalent for Māori than any other ethnic group in New Zealand[2] and is more common in areas with a significant Māori population and in areas of deprivation. Pregnant women who are Māori or who live in a Quintile 5 area are five more times more likely to be smokers than non-Māori or women living in a Quintile 1 area[3].

[1] McElnay C 2014. Health inEquity in Hawke's Bay. Hawke's Bay District Health Board.
[2] Ministry of Health. 2011. Māori Smoking and Tobacco Use 2011. Wellington. Ministry of Health.
[3] McElnay C 2016. Health Equity in Hawke's Bay. Hawke's Bay District Health Board

While rates of tobacco use have declined over the years, the decrease for Māori in particular is not sufficient to reach equity nor to reach the national 2025 Smokefree target of smoking prevalence being less than 5%.

The Regional Tobacco Strategy for Hawke's Bay 2015-2020 goal is for communities in Hawke's Bay to be smokefree/auahi kore – with Hawke's Bay whānau enjoying a tobacco free life. The Strategy has a strong commitment to reducing the social and health inequities associated with tobacco use and has three objectives:

- Cessation – help people stop smoking
- Prevention – preventing smoking uptake by creating an environment where young people choose not to smoke
- Protection - creating smokefree environments

The main source of information on smoking rates comes from the NZ Census but this will not be updated until 2018. The Ministry of Health funded ASH (Action on Smoking and Health) year 10 tobacco use survey and we have preliminary results for 2015. This survey is an annual questionnaire of approximately 30,000 students from across New Zealand. It is conducted in schools throughout the country and is one of the biggest surveys of its kind. It provides valuable and robust insight into rates of youth smoking. HBDHB also collect smoking data on pregnant women engaging with our services, this included over 90% of women giving birth. We are able to report the data quarterly.

WHAT'S HAPPENED IN ONE YEAR?

OBJECTIVE 1: HELPING PEOPLE TO STOP SMOKING

Te Haa Matea (Stop Smoking Services, Hawke's Bay)

At the same time HBDHB adopted the Tobacco Strategy, the Ministry of Health announced the end of 32 Aukāti Kai Paipa services and six national smokefree advocacy groups at 30 June 2016. The formation of 16 regional Stop Smoking Services and one national smokefree advocacy group commenced on 1 July 2016. Hawke's Bay is fortunate to have one of the regional Stop Smoking Services. Te Haa Matea is a partnership between Te Taiwhenua o Heretaunga (Lead), Te Kupenga Hauora o Ahuriri, Choices Kahungunu Health Services and HBDHB. Te Haa Matea's mission is to help whānau stop smoking and 'breathe easy'. One of the goals of Te Haa Matea is to support and encourage 1,337 Hawke's Bay residents to stop smoking (and stay stopped) each year until 2025. Of these, 39% (516 per annum) will need to be Māori[4].

HBDHB are contributing specifically to Te Haa Matea outcomes by providing project management for the development of the new service, cessation services in Wairoa, providing cessation programmes for pregnant women and providing support for workplace cessation programmes. HBDHB also provides leadership for the Smokefree Coalition which coordinates and delivers health promotion activity.

Choices Kahungunu Health Services and HBDHB have been running a successful Increasing Smokefree Pregnancy Programme (ISSP) with Wāhine Hapū since 2014. ISSP is set to expand to all partners of Te Haa Matea, providing wider coverage with more resources and greater access for pregnant women. The resources include nappy incentives to Wāhine Hapu who can validate being smokefree at weeks 1, 4, 8 and 12. Whānau who live in the same household will receive food vouchers to the value of $30.00 if they can validate being smokefree at weeks 1, 4, 8, and 12. This is creating a smokefree environment for the new baby and whānau.

Te Haa Matea cessation support has expanded to include smokefree clinics in workplaces i.e. Trade and Commerce (Rangatahi and Young Adults), Silver Fern Farms in Central Hawke's Bay, Tumu Timbers in Hastings and Lighthouse / Wit in both Napier and Hastings.

[4] HBDHB. Tobacco Control Plan 2015 – 2018.

Rates of Smoking for Māori Women Remain High

Assisting women to stop smoking remains a priority. For Māori women giving birth this year, 37.6% were smokers (2016 data for women giving birth in HBDHB services). A review of the Smokefree Pregnancy Programme in 2015 recommended early engagement at confirmation of pregnancy is necessary to give brief advice and offer cessation support. Most Wāhine Hapū get confirmation of pregnancy from their general practitioner. A suite of Wāhine Hapū resources has been developed to remind GPs to conduct ABC with Wāhine Hapū and refer her onto ISPP as soon as possible. The distribution of Wāhine Hapū resources will occur at the same time as the Maternity "Early Engagement" project, whereby a collaboration approach between Maternity and the Smokefree Team will talk with all GPs in the Hawke's Bay region over the next six months.

HBDHB have funded Directions Youth Health Service to develop and deliver a programme to support young Māori wāhine to remain smokefree, working with year 8, 9 and 10 students to co-design the programme. In addition the Smokefree Team's Māori Support Worker is using a range of support tools including FaceBook to promote smokefree lifestyle before pregnancy. Having smokefree wāhine is critical in reducing smoking during pregnancy and reducing smoking rates.

Smokefree Education, Training, Cessation Support

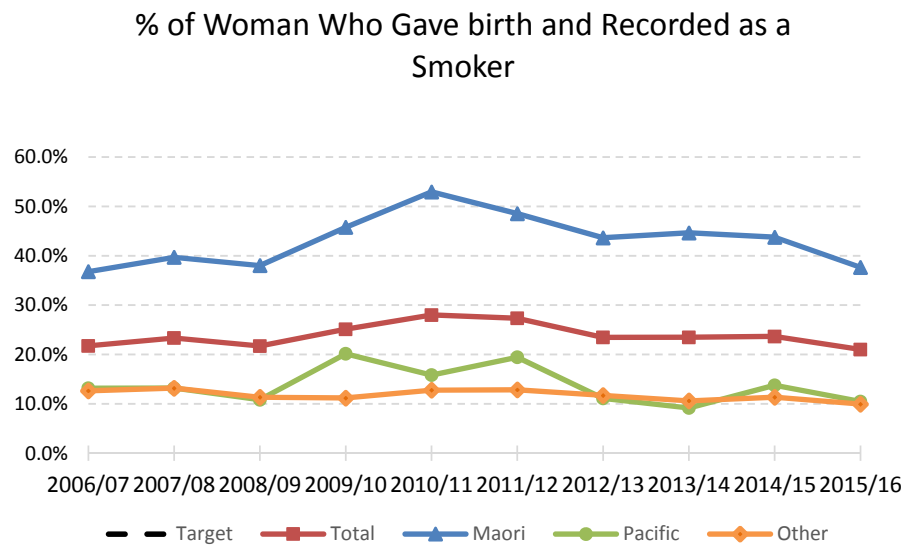
The Smokefree Team continues to support primary and secondary care clinicians with: -

- Understanding Nicotine Replacement Therapy (NRT) medicines
- How to chart NRT for patients
- How to complete Quit Cards
- Confidence in NRT conversations and
- Completing the "Helping People Stop Smoking" Ministry of Health training.

This year, the above mentioned training was extended to clinical staff at Royston Hospital and Te Taiwhenua o Heretaunga. We will continue to provide smokefree education and training in clinical and community settings.

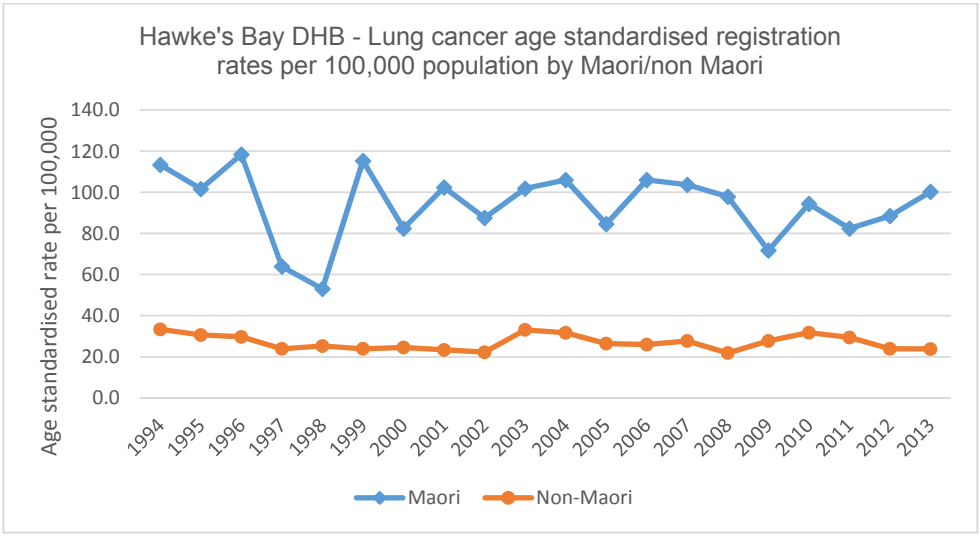
Indicator 1a: Smoking prevalence (particularly Maori)
No update on prevalence until 2018 census. Current data has smoking rates at 18% for non-Māori and 47.4% for Māori in Hawke's Bay. Please refer to the HB Tobacco Strategy for details.

Indicator 1b: Smoking prevalence in pregnant women (particularly Maori women)
The data below provides a time series from 2007 to June 2016 and illustrates a decrease in smoking rates for pregnant women from 2011. There is a significant reduction between 2015 to 2016 from 23.7% to 21% with the reduction of Māori women even greater from 43.7% to 37.6%. The delivery of the ISPP, greater engagement in healthy lifestyles programme (i.e. Maternal Nutrition), increases in the price of cigarettes and increased education/awareness have all contributed to this improvement.



Indicator 1c: Lung Cancer Incidence

Overall rates for lung cancer continues to decline slowly from 54 per 100,000 in 2004 to 31 in 2013, reflecting the reduction in the smoking population. However, the gap between Māori and non-Māori remains. This reflects the higher prevalence of smoking for Māori in Hawke's Bay.



OBJECTIVE 2: PREVENTING SMOKING UPTAKE

Young people who smoke may acquire the habit and become addicted before reaching adulthood, making them less able to quit smoking and more likely to have a tobacco-related health problem.

Te Haa Matea provide smokefree clinics and education in workplace settings, trade training establishments and teen parent units to target young people. These include Tumu Timbers, Silver Fern Farms (CHB), Wit/Lighthouse, EIT Hawke's Bay, Trade and Commerce and both Teen Parent Schools. The Smokefree Team's Māori Support Worker is working with rangitahi as outlined above.

Indicator 2a: Prevalence of Year 10 students who have never smoked (particularly Maori students)
The annual ASH survey shows that there has been a gradual increase in the number of Māori students who have never smoked. The percentage of all Māori year 10 students across New Zealand who never smoked was 16.2% in 2000 increasing to 59.2% in 2015. In 2015, Hawke's Bay noted 73% of year 10s, 54.33% of Māori year 10s and 50.95% of Māori wahine year 10s have never smoked.

This is a significant improvement. Anecdotally we are told that price increases were a major contributor with "family and friends not supplying young people due to the cost". This social supply remains the leading source of tobacco for this age group.

Indicator 2b: Prevalence of Year 10 students living with one or more parent who smokes
This information is sourced from the census so will not be available until 2018.

OBJECTIVE 3: CREATING SMOKEFREE ENVIRONMENTS

Hawke's Bay DHB continues to visit all retailers at least once a year to deliver reminders on the legislative requirements, encourage a smokefree policy and check compliance. A review of the Controlled Purchase Operations was completed this year and retailer education increased with the delivery of national resources.

A second visit by a Population Health Advisor or Smokefree Health Promoter is to encourage retailers to not sell tobacco. Three retailers located in Napier, Putorino and Wairoa become tobacco-free in the past year. Two articles were published in local newspapers that promoted retailers becoming tobacco free; "Hawke's Bay Retailers Care about Our Kids and Whānau".

An increase in burglaries at dairies and retail outlets has become a concern with cigarettes and cash targeted. Visits to all retailers located in Napier and Hastings during August and September 2016 confirmed this but did not provoke any retailer to not sell tobacco. Comments below are from three dairies who were burgled.

> *"That's the risk the shop owner has to take"*
>
> *"I wouldn't stop selling because it's 60% of my business and when customers buy tobacco they also buy on impulse and that's what boosts my business."*
>
> *"Shaken by the experience, I get nervous when it's dark but selling tobacco supports the business".*

Support Legislation and Policy Change for Smokefree Environment

As a member of the HB Smokefree Coalition, HBDHB supported a coordinated submission to the joint Council Smokefree Policy (Napier and Hastings). Feedback from the joint committee reviewing submissions was that the information and constructive approach used in the submission was instrumental in achieving the changes to the policy. The new policy has extended smokefree environments to include bus stops, frontages of Council building, cafes and wider coverage in parks. HBDHB have supported awareness raising for these changes including signage and advertising.

Submissions on plain packaging and e-cigarettes aim to influence law change to further discourage smoking by reducing advertising and brand power, also providing other cessation support opportunities.

Indicator 3a: Number of Tobacco Free Retailers
In the past year, three retailers have stopped selling tobacco, which is a reduction. HBDHB has a process of visiting tobacco retailers to ensure compliance with the law and discuss becoming a tobacco free retailer. The decision to continue to sell is an economic one.

CONCLUSION

- It is exciting to have HBDHB involved in the development of Te Haa Matea in Hawke's Bay. All Smoking Cessation Services working collaboratively in all settings will help us achieve the Aotearoa Smokefree 2025 goal.

- Programmes led by and contributed to by HBDHB are seeing successes in supporting the reduction in smoking especially for Māori wāhine, as noted in the smoking data for pregnant women and improvement in never smoked for year 10 Māori wahine.

- The passing of legislation requiring tobacco products to have plain packaging this month is expected to further reduce smoking intiation. Tobacco products will no longer look attractive; as design and appearance has been a powerful marketing tool to initiate smoking for young people and encourage smokers to continue smoking.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Smokefree**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For information

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

Note the contents of this report.

OVERVIEW

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

MĀORI HEALTH PLAN INDICATOR: Smokefree

- 95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking
- 90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months
- 90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking
- 90% of young pregnant Māori women are referred to cessation support
- 95% of pregnant Māori women who are smokefree at 2 weeks post natal

WHY ARE THESE INDICATORS IMPORTANT?

Most smokers want to quit, and there are immediate and long-term health benefits for those who do. The risk of premature death from smoking decreases soon after someone quits smoking and continues to do so for at least 10 to 15 years. There are valuable interventions that can be routinely provided in both primary and secondary care.

These targets are designed to prompt doctors, nurses and other health professionals to routinely ask the people they see whether they smoke. The health professional is then able to provide brief advice and to offer quit support to smokers. There is strong evidence that brief advice from a health professional is highly effective at encouraging people to try to quit smoking, and to stay smokefree. Research shows that one in every forty smokers will make a quit attempt simply as a result of receiving brief advice. In the Health Equity Report 2014, tobacco use was highlighted as the single biggest underlying cause of inequity of death rates and ill health in Hawke's Bay.

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THESE INDICATORS?

95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking

During the period 28/5/2015 to 25/06/2016, 98% of patients aged 15 years and over coded as given brief advice and help to stop smoking. The Smokefree team continue to provide ABC, Helping People Stop Smoking, Nicotine Replacement Therapy (NRT) educational support to clinical staff ward by ward, in the hospital. It is important that patients who smoke within the hospital setting are:

- Charted NRT to manage their addiction
- Offered a referral for cessation and behavioural support on discharge

90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months

		Target	Total	Maori	Pacific	Other	Non Maori
2015/16	Q1	90.0%	81.2%	80.8%	75.7%	75.8%	81.5%
	Q2	90.0%	75.0%	74.5%	70.7%	75.8%	75.4%
	Q3	90.0%	77.6%	76.4%	71.9%	79.1%	77.6%
	Q4	90.0%	81.3%	80.3%	75.3%	83.1%	81.3%

During the period 1 July 2015 – 30 June 2016, 81% PHO enrolled smokers were given brief advice and help to quit. The likely reasons for not achieving this target are:

- Incorrect patient contact details
- Timeliness of ABC conversations. Due to workloads and/or patient priorities, the ABC is not done
- ABC completed verbally, ABC documentation not completed
- No confidence in carrying out ABC
- Few clinical staff have completed the "Helping People Stop Smoking" MoH training

The Smokefree Community Systems Coordinator 0.7 FTE supports the PHO and General Practices in finding solutions to achieve the 90% PHO enrolled smokers; provided with brief advice and help to quit target. There had been a three month period whilst this role was recruited to which left a gap in support to the PHO and General Practices. However, this position has now been filled and will work closely with both the PHO and General Practices to provide sustainable solutions for our whānau and communities.

90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking

	Month (3 months to)	Target	Total	Maori
2013/14	Q1	90.0%	93.2%	0.0%
	Q2	90.0%	96.3%	94.3%
	Q3	90.0%	87.9%	85.4%
	Q4	90.0%	94.5%	95.2%
2014/15	Q1	90.0%	100.0%	100.0%
	Q2	90.0%	98.1%	100.0%
	Q3	90.0%	98.6%	97.9%
	Q4	90.0%	96.9%	95.2%
2015/16	Q1	90.0%	90.3%	87.7%
	Q2	90.0%	96.5%	95.2%
	Q3	90.0%	88.6%	86.2%
	Q4	90.0%	89.0%	81.1%

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death at infancy.

Encouraging pregnant women to stop smoking during pregnancy may also help them to kick the habit for good and provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

91.1% of all pregnant women in Hawke's Bay who identified as smokers were offered smoking brief advice and support to quit (1 July 2015 – 30 June 2016). In the same period, pregnant Māori women who identified as smokers passed the target in one quarter and were below 90% in three quarters. Therefore, overall in the year for Māori, 87.55% were offered smoking brief advice and support to quit.

90% of young pregnant Māori women are referred to cessation support

There is no specific data on referrals of young Māori women to cessation support other than what is collected in (3) above HBDHB and Choices Kahungunu Health Services continue to support Wāhine Hapū and their whānau to be smokefree in the Increasing Smokefree Pregnancy Programme (ISSP). ISPP newly named Wāhine Hapū results for January to December 2015 were:

- There were 502 not smokefree pregnant women booked to HBDHB service, 69% were Māori, 28% European, 2% Pacific island and 1% other.
- Total of 318 stop smoking referrals were made for antenatal women (238), postnatal women (34) and whānau (46). 212 (67%) identified as Māori.
- Of the 318 referrals received to stop smoking services, 103 opted on to a three month stop smoking programme. 63 identified as Māori. 31 (30%) of those who opted on to the programme were smokefree at 4 weeks and 27 (26%) remained smokefree at 12 weeks.

As noted above the ISPP now has incentives to encourage whānau members of the pregnant, postnatal women to increase the chances of the women to be smokefree and to improve the health outcomes of foetus and baby. In conjunction, opportunistic peer to peer support is provided to midwives and lead maternity carers on the ward to increase their confidence with smoking cessation. House Officer and Registrar smokefree training occurs twice a year.

In addition, the Smokefree Māori Support Worker is working with young people to encourage smokefree lifestyles before pregnancy.

95% of Māori women who are smokefree at 2 weeks post-natal

	Target	Total	Maori	Pacific	High Deprivation
Jul - Dec 13	86%	79.0%	58.0%	94.0%	68.0%
Jan - Jun 14	86%	79.0%	62.0%	96.0%	70.0%
Jul - Dec 14	86%	73.0%	53.0%	81.0%	64.0%
Jan - Jun 15	86%	79.9%	65.6%	97.7%	72.6%

Data for Māori women smokefree at 2 weeks is sourced from. To ensure considerable opportunity is given to women to be smokefree, the ISPP includes postnatal women and their whānau. Although most women referred to the ISSP are pregnant, 11% of women are postnatal.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THESE INDICATORS?

The tobacco control realignment saw the end of 32 Aukati Kai Paipa in New Zealand on 30 June 2016. Hawke's Bay was successful in the bid to be one of the new Stop Smoking Services in New Zealand. Te Haa Matea is a partnership between Te Taiwhenua o Heretaunga (Lead), Te Kupenga Hauora o Ahuriri, Choices Kahungunu Health Services and HBDHB. It is estimated Hawke's Bay has approximately 23,000 smokers in the region. To be able to achieve less than 5% of smokers by 2025, Hawke's Bay needs to help 1,337 people stop smoking each year. This is the goal of Te Haa Matea – to enrol 1,337 people per year and encourage and support as many as possible to be smokefree in 4 weeks.

Te Haa Matea is committed to working together to achieve this goal by:

- Hospital referrals to the Te Haa Matea Hub for follow-up.
- Support PHO and General Practices.
  - Working with the PHO to add a Te Haa Matea referral pathway to Med Tech. (Quitline currently is the only referral pathway).
  - Te Kupenga Hauora is working with Maraenui Medical Centre in helping patients to stop smoking. Te Haa Matea wants to work with other General Practices.
- Expanding the ISPP from an initiative between Choices Kahungunu Health Services and HBDHB to Te Haa Matea partners. This means all partners can work with Wāhine Hapū and her whānau to create a smokefree home environment and better health outcomes for all. The ISPP provides incentives at 1, 4, 8 and 12 weeks validation smokefree of nappies for the Wāhine Hapū and food vouchers for her whānau. By expanding ISPP to Te Haa Matea, we want to achieve a wider coverage of smokefree whānau.
- Te Haa Matea Stop Smoking Practitioners are holding smokefree clinics in youth training establishments e.g. Trade and Commerce, Hastings.

HBDHB along with various stakeholders continues to implement the Regional Tobacco Strategy with particular focus on young Māori women smoking rates and looking at opportunities to work better together with hauora providers.

RECOMMENDATIONS FROM TARGET CHAMPION

There needs to be ongoing focus on achieving the targets for PHO enrolled smokers and Māori pregnant women. The Smokefree Systems Coordinator role that had been vacant for three months has now been filled and this role needs to continue to work closely with the PHO and general practices to support practices to achieve this target.

Ongoing work with LMCs and general practices needs to ensure that there is equity in referring pregnant women to cessation services.

More work is required to define the target group of "young Māori pregnant women" and ensure appropriate services. The expansion of the Increasing Smokefree Pregnancy Programme has potential to be effective but this needs to be evaluated and other programmes considered as required.

Most of the indicators for this area are process indicators – the exception being the percentage of Māori women postnatal who are smokefree. These process indicators are based on the assumption that by inquiring about smokefree status and making referrals to cessation services there will be a reduction in smoking rates. We must ensure that these process targets are being met but also that a wide population health approach is also being taken to reduce smoking rates in our priority groups. This approach is outlined in the Regional Tobacco Control Plan.

CONCLUSION

Achieving these targets continue to be challenging. However I am excited with the development of Te Haa Matea in Hawke's Bay and note the increased focus on working together and support for primary care and smokefree pregnancies. Working collaboratively in all settings will help us achieve the Aotearoa Smokefree 2025 goal.

HAWKE'S BAY District Health Board Whakawāteatia	**Palliative Care in Hawke's Bay**
	For the attention of: **Māori Relationship Board, HB Clinical and HB Health Consumer Council**
Document Owner: Document Author(s):	Chris McKenna Director of Nursing Mary Wills Head of Strategic Services
Month:	November 2016
Consideration:	For feedback

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council:

1. Provide feedback on the draft plan
2. Note that further consultation with the community will follow.

OVERVIEW

The attached draft plan has been developed with a combined clinical steering group involving primary and specialist palliative care. The initial draft plan has been shared with Consumer Council to check the content is on the right track before broader engagement and feedback.

The MRB meeting and Council Workshop on 9 November will discuss the paper and the broader issues of end of life and advance care planning.

Following this, consultation workshops will be planned with key stakeholders and the community. This will shape the resulting work programme and where these will be led from.

All people who are dying and their family/whānau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way

(NZ Palliative Care Strategy 2001)

Palliative Care in Hawke's Bay

Our vision and priorities for the future 2016 – 2026

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Executive Summary

"You matter because you are you, and you matter to the last moment of your life. We will do all we can, not only to help you die peacefully, but also to live until you die"
Dame Cicely Saunders

Dying is a normal part of the human experience and affects people regardless of age. Whenever a person dies in Hawke's Bay, there are impacts for their family/whānau, friends, work colleagues and the community in which they live. Many people would prefer to die in their own home, cared for and surrounded by their loved ones. [24] Others will die in hospice, hospital or aged residential care, by choice or by necessity.

The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poorly supported dying, with inadequate symptom control and failure to meet the needs of those who are dying as well as those who care for them, may lead to a complicated bereavement process for those left behind. In contrast, high quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and surrounding community.

The quality of care provided in the Hawke's Bay region to those at the end of life is everyone's responsibility. Death is not a subject that should be avoided or concealed. It is one of the great certainties of life, and involvement in caring for those people who are dying can, not only strengthen family relationships, encourage compassion and resilience, and promote positive connections in the community, enhance respect for health and life, and reduce community fears about death and dying.

We will extend the ways we receive patient feedback and hear what is important to patients and family/whānau. As the numbers of people needing palliative care grows rapidly over the next 10 years, we will need to be culturally responsive in our practice. This will be supported by shared leadership, working as one team and with agreed priorities for the next 10 years.

We will recruit and train staff in palliative care. This includes sustainable medical staff and replacement of our retiring nursing workforce. Allied health and family support team members will work with primary care to provide a multidisciplinary response for patients with dementia and who are frail. Our focus on education and training will develop the next generation of palliative care practitioners in primary and specialist palliative care.

We will agree how services provide access 24 hours a day 7 days a week. As the national strategies for Health of Older people and Palliative Care are implemented in Hawke's Bay, we will invest in sustainable specialist palliative care services and education and training. This will be supported by technology, shared information across services and using information to inform service improvement.

Our six priorities for the future will improve care for people and their family/whānau. To achieve this requires us to work together as one team to strengthen the foundations on which our vision is built.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Our six priorities:

1. **Each person and their family/whānau will have their individual needs as the centre of care**
2. **Each person gets fair access to high quality individualised care**
3. **Comfort and wellbeing maximised**
4. **Care is seamless**
5. **The community is involved**
6. **People are prepared to care**

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Introduction

In today's society, people are increasingly expressing the importance of choice and independence as major components of dignity in advancing illness and old age. Most of us expect to make decisions, not only on how we live our last years, months, weeks and days of life but also on how and where we die.
With advances in chronic disease management, single disease approaches for planning end of life will make less sense as functional decline towards end of life could be very hard to predict. This will have wide reaching implications for the co-ordination of care, health and social needs, predictions of future outcomes, referrals and patient, family/whānau experience and choice.

Increasing numbers of people with neurodegenerative conditions like dementia suggests an increasing need for early participation in planning for, and conversation about dying if we are going to be able to provide quality care to those at end of life.

Palliative care is recognised as a speciality that focuses on patient centred care, but as future demands for services increase, more than ever we will need to ensure we continue to place the patient and their family/whānau needs and goals at the centre. Our response to needs will have to be tailored so that we are providing just the right amount of support to empower and enable individuals to achieve their goals and to live their lives until they die. Services will need to ensure that they are providing a culture of enablement alongside our care. This will enable people greater choice, independence and dignity in advancing illness and/or old age.

For Hawke's Bay the level of need for palliative care is hard to predict. There is literature stating that for most people their palliative care needs can be met through good primary palliative care provided by general practitioners, hospitals, aged residential care, district nurses and Māori health providers without the need for direct care provision of specialist palliative care. [18;20]. Providing palliative care needs to be a core part of everyone's practice.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

What is palliative care?

Palliative care is the care of people who are dying from active, progressive diseases or other conditions that are not responsive to curative treatment. Palliative care embraces the physical, social, emotional and spiritual elements of wellbeing–tinana, whānau, hinengaro and wairua – and enhances a person's quality of life while they are dying. Palliative care also supports the bereaved family/whānau. 13.

The principles of palliative care are that it:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may also be suitable sometimes when treatments are being given aimed at extending quality of life.

It should be available wherever the person may be located. It should be provided by all health care professionals, supported where necessary, by specialist palliative care services.

Palliative care should be provided in such a way as to meet the unique needs of people from particular communities or groups. This includes but is not limited to: Māori, children and young people, immigrants, those with intellectual disability, refugees, prisoners, the homeless, those in isolated communities and lesbian, gay, transgender and intersex people. 16.

Palliative care will be delivered by both primary palliative care and specialist palliative care providers working together as one team.

Primary palliative care (PPC) refers to care provided by general practices, Māori health providers, allied health teams, district nurses, aged residential care staff, general hospital ward staff as well as disease specific teams e.g. oncology, respiratory, renal and cardiac teams. The care provided is an integral part of usual clinical practice. Primary palliative care providers assess and refer people to specialist palliative care services when the needs of the person exceed the capability of the primary palliative care provider. [7.]

Specialist palliative care (SPC) is palliative care provided by those who have undergone specific training or accreditation in palliative care/medicine, working in the context of a multidisciplinary team of palliative care health professionals.

Specialist palliative care may be provided by hospice or hospital based palliative care services where people have access to at least medical and nursing palliative care specialists.

Specialist palliative care is delivered in two key ways:

- Directly – direct management and support of the person and family/ whānau where more complex palliative care needs exceed the physical, spiritual or social resources of the primary provider. SPC involvement with any person and the family/ whānau can be continuous or episodic depending on the changing need.
- Indirectly – to provide advice, support, education and training for other health professionals and volunteers to support the primary provision of palliative care.

Future need

Like all of New Zealand, and the World, the increasing numbers of people dying and the changing patterns of illness means the number of people who could benefit from a palliative approach to care is increasing. We will need to manage resources and ensure that we have the right people equipped to care and support the needs of those with a life limiting condition.

Evidence is showing us that in the next 20 years we will have more people dying. They will be living with and dying from not only malignant conditions such as cancer, but chronic conditions and multiple comorbidities, including dementia. Their longevity will be frequently compromised by fragility and disability.[10.]

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

For New Zealand the estimates are:

- Projected deaths will increase by almost 50 percent (from 30,000 to 45,000 per annum in 2038).
- Deaths will reach 55,500 per annum by 2068. This is the result of people living longer than before, coupled with an absolute increase in numbers due to the "baby boom" generation (born between 1946 – 1965) entering their older years.
- There will be rapid ageing of those deaths. In 20 years over half of the deaths will be in the age group 85 years and older. Deaths at the oldest ages will be predominantly women.
- Over the last decade deaths from circulatory system conditions have been declining and deaths from other conditions, including respiratory conditions, dementia and frailty, have been proportionally increasing.

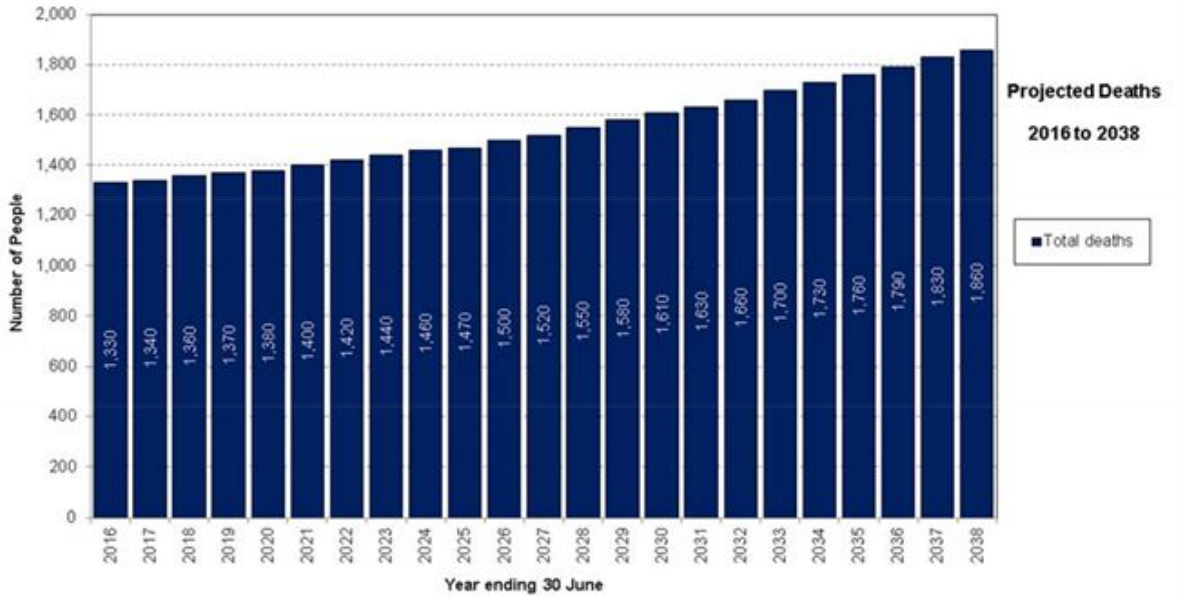
For Hawke's Bay our data is showing us:

- The number of deaths per year will increase by over 500 people. From 1,330 predicted for 2016 to 1,860 by 2038. See graph 1.
- People in the 84-94 age group will more than double from 420 in 2016 to 870 by 2038. See graph 2.
- We will also see an increase in the 95 years and over age group with increases from 100 in 2016 to 200 by 2038.
- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty plus barriers to access caused by cultural differences and lack of resources means that they are likely to require more support to achieve equitable outcomes.
- The estimated number of people dying who are likely to benefit from palliative care services is 822 in 2015 rising to 927 in 2025.
- The Hospice NZ Palliative Care Demand Model suggests that Cranford Hospice could possibly have been involved with 822 deaths in 2015 based on population data. They were actually involved in 663 deaths. There may be an unmet need of approximately 160 patients currently per annum.

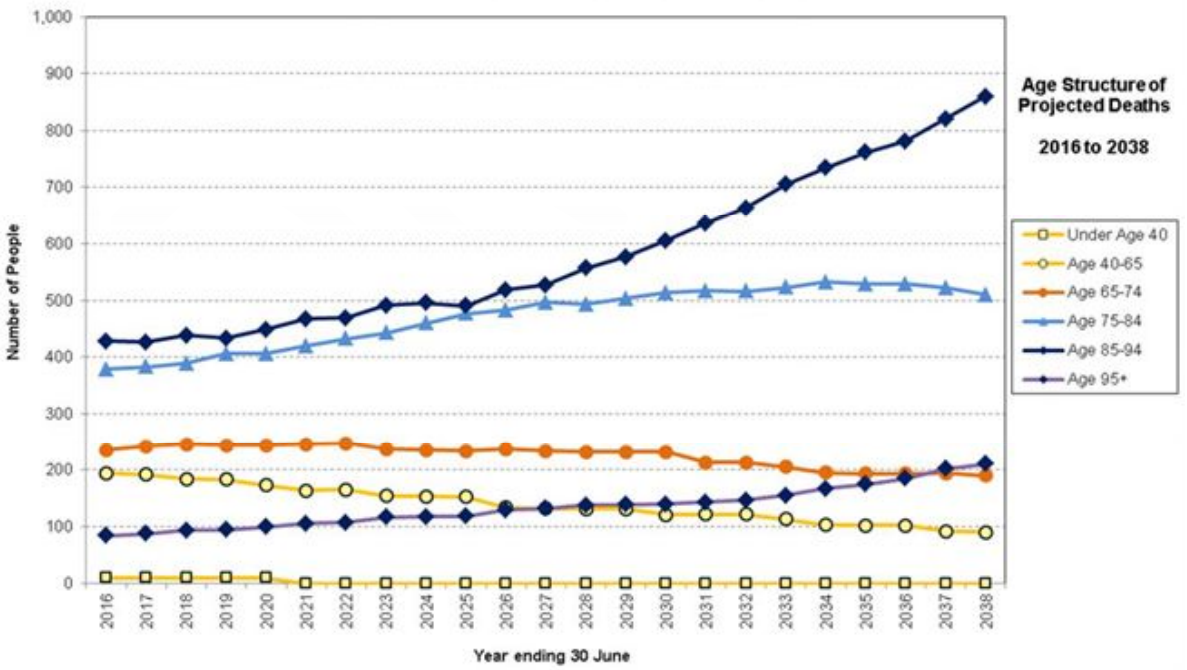
Uptake of specialist and primary palliative care services by Māori (15.8%) and Pasifika (1.1%) was in line with their younger population profiles in 2014. However, it is not known whether the experiences of those groups is equitable, or whether they receive similar number of contacts per person as other non-Maori, non-Pasifika people.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Graph 1 : Number of projected deaths in Hawke's Bay 2016 to 2038



Graph 2 : Estimated change in age of death in Hawke's Bay from 2016 to 2038

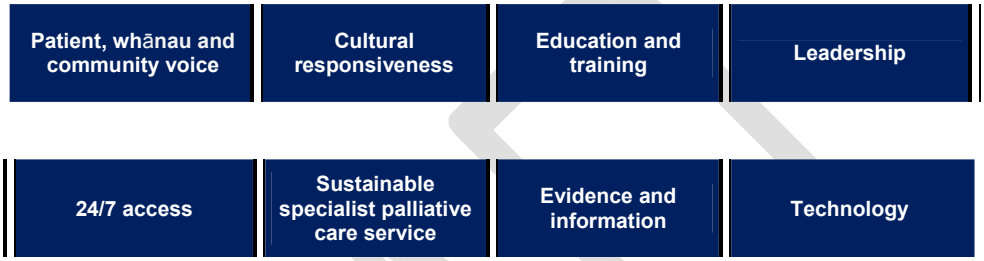


Acknowledgement: This document was developed using the National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020. www.endoflifeambitions.org.uk.

Foundations on which our vision is built

"All people who are dying and their family/whanau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way" [13].

To realise our vision we have identified eight foundations that need to be in place to meet our commitments to palliative care in Hawke's Bay. They are necessary for each and underpin the whole. These foundations are prerequisites for success in providing quality palliative care to our community now and into the future.



1. Patient, Whānau and Community Voice

Systems for palliative care are best designed in collaboration with people who have had personal experience of death, dying and bereavement. We need to ensure that we are listening to the voices of patients, family/whānau, carers and communities in all that we do.[3] We need to engage communities in their own care design and how health services are delivered. Patients and whānau have told us they need better information so they are aware of support and can access it when they need it.[21]

2. Cultural responsiveness

We will provide culturally responsive care that is mindful of the beliefs and values of patients, family/whanau. This will include considering how to provide palliative care for the growing numbers of Māori and Pasifika who will need these services. Whānaungatanga, kanohi ki te kanohi, wairuatanga, and the availability of Māori kaitakawaenga are all important for effective communication with Māori patients and their family/whānau. [11]

3. Education and Training

To have palliative care as everybody's business there is a large education programme that needs to be implemented. We will need to educate patients, family/whānau, carers and primary palliative care providers in palliative care. With increasing demands on time we will need to look at a range of methods to teach appropriate knowledge and skills in end of life care. They include face-to-face, e-learning, simulation, reflective learning, health promotion, telemedicine, case studies, death reviews, mentoring and supervised clinical practice. We also need to look at ways to educate and train our informal workforce, unpaid volunteers and carers so they too are well equipped to provide hands on care and support. We will need to understand death and dying and advance care planning.

For PPC providers core elements will include:

- Identifying patients who need palliative care
- Breaking bad news
- Conversations with patients and their family/ whānau around advance care planning
- Providing care according to patient and family/whanau needs
- Basic symptom management
- Psychosocial support
- Knowledge of when to refer to specialist palliative care

These should be routine aspects of care delivered by any PPC health practitioner.

With a greater focus on primary palliative care, we will need a sustainable and sufficient specialist workforce to provide advice, support and education to PPC providers. They will also be educated, trained and equipped to manage and care for those who will need complex palliative care management including those with dementia and frailty.

There needs to be a focus on increasing opportunities for introducing and training students in all disciplines in palliative care.

4. Leadership

Shared leadership with clear responsibilities will deliver our vision and priorities. A business case will describe the priorities for investment so that services are planned to meet Hawke's Bay population needs.

Clinical leadership must be at the heart of this strategic vision to ensure that each person and their family/whānau receives the care they need, at the right time, by the right people. They must be committed to the priorities and are key in ensuring outcomes are met. As the Ministry of Health finalises the Palliative Care Strategy and Health of Older People Strategy, we will link new national priorities to our agreed local priorities.

5. Access 24 hours, 7 days a week

Every person at the end of life should have access to services 24 hours, 7 days per week (24/7). In times of distress, uncontrolled pain and other symptoms cannot wait for office hours. People need to know who to contact, no matter what the time. PPC providers, especially GPs, are providing the majority of care. They need to be resourced to meet the demands, with access to 24/7 advice and support from SPC. For those who experience complex symptoms, the SPC nursing and medical team needs to be able to provide advice, care and support to those in need.

In Hawke's Bay we have a PPC programme that is intended to support patients who have a life limiting condition. The funding allocated to this programme is focussed on providing patients with dedicated care led by their primary health care team that works to moderate symptoms, pain, physical stress and the mental stressors associated with serious illness. The goal of this programme is to support planned care to improve the quality of life for both patients and their families.

A patient is offered access to this programme when they meet criteria and when there is a sense of need to provide palliative care therapies when no cure can be expected and when there is an expected length of life of six months or less. We will plan for sustainable funding past 30 June 2017.

6. Sustainable Specialist Palliative Care Service

Specialist palliative care is a vital foundation if we are to realise our vision and our priorities. Our specialist service needs to be equipped and resourced to meet the needs of complex patients, family/whānau, increased education needs, support of primary palliative care providers, advice and support 24/7.

There is a national shortage of palliative medicine specialists, an ageing nursing workforce and the low use of allied health teams.[24] Allied health professionals are commonly part of the palliative care multidisciplinary team in other countries (e.g. United Kingdom) but are not always in New Zealand.

SPC has been working hard since 2011 to build its workforce for the future needs with the introduction of advanced trainee positions, the introduction and expansion of clinical nurse specialists in hospice and hospital and the development of a nurse practitioner role. There is still work to do to ensure that we have a sustainable workforce that is well educated and equipped to meet needs.

In 2016 Cranford Hospice was successful in its submission for Ministry of Health innovation funding. The following roles have been established, based on feedback from General Practice and Aged Residential Care.

The existing Aged Residential Care Palliative Care Resource Nurse position increased from 0.6 to 1.2 full time equivalent. The Aged Residential Care liaison nurse will support and teach skills in palliative care.

A new 0.9FTE Palliative Care Nurse Practitioner supports primary care and rural services. This role works within General Practice with an emphasis in the first instance on rural populations in Central Hawke's Bay and Wairoa. The focus of this role will be to develop the skills, capacity and systems/processes required in primary care to deliver high quality primary palliative care. The Nurse Practitioner will support a primary care training programme and establish a process for regular case review with practices.

A new Caregiver Support Coordinator provides support to family/whanau caring for palliative patients by mobilising existing support services and volunteer networks.

Alongside new innovation and new roles the core clinical team positions need development to meet current and future demands.

Our specialist medical workforce is an urgent priority. We do not have a sustainable medical workforce to meet required needs. With increasing complexity of patient and family/whānau needs and population growth we need to plan to increase resources.

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This is not unique to Hawke's Bay. In 2014 the national Palliative Medicine and Training Coordination Committee surveyed District Health Boards and reviewed work force projections for Senior Medical Officer positions. They found 12 Senior Medical Officer positions were vacant and over the next five years to 2019, vacancies due to retirement would increase this to 30.[10.]

The current medical, nursing, allied health, family support workforce is summarised in Appendix 1. Proposed roles and FTEs are described for 2026, to be able to cope with an increased demand for clinical care provision, advice, mentorship, supervision, rural support and education.

Over 50% of our SPC nursing workforce are eligible for retirement in the next 2 to 5 years. In the last few years we have been successful in recruiting for positions, as more nurses are considering palliative care as a speciality. These nurses will need time (2 to 3 years) to specialise and train. As half of our experienced workforce retires in the next 5 years providing support, mentorship and training will be challenging.

We have proposed increases in the nursing workforce to meet the increased need for complex care provision, an increase in inpatient beds at Hospice from 8 to10, increased education and mentorship of primary care providers and training new specialist nursing staff. Staff, services and facilities will respond to the growing numbers of people with dementia and frailty.

To provide a holistic approach to care, SPC has also been growing its family support team and allied health team. This team will almost double to be able to meet demands in the community, especially with increased frailty, the need for a rehabilitative approach and patients living for longer with multiple comorbidities. As interdisciplinary teams develop further with primary care we will improve our communication and systems so we coordinate with new services such as engAGE services for frail older people.

To respond to the needs of the Hawke's Bay population, we will integrate Cranford Hospice and the Hospital Specialist Palliative Care team (HPCT) to form one specialist palliative care service for Hawke's Bay. This integrated service will provide quality clinical care at Cranford Hospice, within the community, and an in-reach consultation liaison service to the Hawke's Bay Fallen Soldiers Memorial Hospital. The service will use the same management support, human resources and clinical guidelines across all care settings. There will be one single point of entry to SPC, and care will be more seamless no matter what bed you are in or which setting that bed is placed in. SPC will be delivered equitably, with greater care coordination and with opportunities for workforce development. There will be rotation of staff across hospice, community and hospital areas.

7. Technology

Care planning conversations need to be effectively recorded and appropriately shared through electronic systems. Electronic systems will need to support wider access to information, extended information context and new functions, such as write access by multiple sources. Access to Advanced Care Plans, pre-emptive charting and crisis plans must be maximised. [19].

8. Evidence and Information

We need to ensure that data and evidence, including people's accounts of their experience of care are used effectively to inform learning, improvement. We will improve the collection, analysis, interpretation and dissemination of data related to palliative and end of life care. This will include evidence relating to needs, provision, activity, indicators and outcomes.[19].

1 Each person and their family/whanau will have their individual needs as the centre of care

"On one occasion the hospice nurse arrived after he was discharged from hospital and worked through the discharge summary to make sure we understood the plan"
Wife of patient

What we already know

- People are unique, they want to be listened to, respected and involved in their care.
- People and their family/whānau require care. The needs of all individual members need to be identified and addressed.
- Leaders and care professionals need to be innovative in how they ask, record and work to support choices, particularly with limited resources.
- People, family/ whānau want to be involved in their care. They should be given all the information, advice and support they need to make decisions about it.
- Advance care planning gives everyone a chance to say what is important to them, ahead of time. It helps people understand what the future might hold and to say what treatment they would and would not want. It helps people, their families and healthcare teams plan for the future and end of life care .14.
- Having conversations about death, dying and end of life requires compassion, knowledge, experience, sensitivity and skill on the part of the health professional involved. A series of conversations may be needed to determine the goals, values and wishes of the person and their family/ whānau in order to reach decisions about the appropriate plan of care.

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The building blocks we need in place

Enablers for person centred care

Care must be delivered by systems that are carefully and consciously designed to ensure people retain control and are active participants in their care. Whenever possible care must be respectful of the person's values and preferences 16.

Access to social support

There is a mix of health, personal and social need at the end of life and afterwards which requires skilled assessment and available resources, delivered in an appropriate environment.

Meaningful conversations

People should have the opportunity to say what's important to them and be well informed about dying, death and bereavement by the right people in the right way at the right time .14.

Clear expectations

People and their family/whānau should know what they are entitled to expect as they reach the end of their lives.15.

Integrating the philosophy

The philosophy of person centred care is promoted and integrated into models of care across the health and social sectors.

Good end of life care includes bereavement

Caring for the individual includes understanding the need to support the unique set of relationships between family, friends, carers, other loved ones and their community, and includes preparations for loss, grief and bereavement.

2 Each person gets fair access to high quality care

"The hospital palliative care team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept a referral"
Consumer feedback

What we already know

- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty in this population and the barriers to access caused by cultural difference and lack of resources means that they are likely to require more support to achieve equitable outcomes .11.
- We cannot identify and predict when every person will die. The population is ageing and chronic conditions and co-morbidities will increase, making this even more difficult.
- Adults living in Wairoa and Central Hawke's Bay had fewer face to face contacts with SPC than in urban areas. They did not receive a corresponding increase in GP contacts, suggesting an inequity between urban and rural service delivery. 22.
- There is substantial data available regarding the palliative population. This needs to be standardised and used appropriately to identify the needs of the Hawke's Bay population and inform decision making. 23.
- Access to good and early palliative care can improve outcomes, not only with regards to quality of life, but also life expectancy 15; 18
- The way messages relating to the likely outcomes of medical conditions are communicated to people, affect their transition from curative to palliative care and willingness to accept referral to specialist palliative care.
- A public health approach recognises and plans to accommodate those disadvantaged by the economy, including rural and remote populations, tangata whenua, the homeless, lesbian, gay, bisexual, transgender and intersex communities.
- "Until recently, almost all assessments of the quality of palliative care focused on care structures and processes rather than on outcomes. Outcome measures are widely used in palliative care research to describe patient populations or to assess the effectiveness of interventions, but they are not, as yet, always incorporated into routine clinical practice". 2.

The building blocks we need in place

Person centred outcome measurement

With a consistent data set, improvement can be tracked and action taken to ensure all providers are accountable for enabling fair access to quality care.

Using data

"Well-organised data collection can help us to target different population groups and track their progress towards better outcomes, access and wider goals shared with other agencies. Information we collect can improve our understanding of the cause and effect relationships between health and other social services, the effectiveness of different ways of working, and the value for money offered by different interventions" 13

Unwavering commitment

To achieve equity and access, provision and responsiveness requires unwavering commitment to local contracts and sustainable funding.

Referral criteria

A clear referral process is designed to ensure limited resources are appropriately allocated to serve those most in need. Other barriers to access are proactively evaluated and reduced to ensure an equitable service.

Community partnerships

Local plans should include partnerships between different faith groups and cultural communities, as well as the diverse organisations that support children and young adults, people living with different life shortening illness, and those managing the difficulties of older age.

Population based needs

Palliative care needs for the Hawke's Bay population should inform service design and resource allocation.

3 Comfort and wellbeing maximised

"The hospice doctor was the first to look at my whole picture, she asked "what sort of person are you? Do you want to know anything? She was the first to work with my interest in other therapies"
Patient feedback

What we already know

- What matters most to people at the end of life is good control of pain and other symptoms and being accompanied by but not a burden to their family/whānau. 10.
- People want to be considered as a whole. We need to care for physical, spiritual, family and mental health needs.
- Many people approaching death are fearful of being in pain or distress. Dying and death can be a powerful source of emotional turmoil, social isolation and spiritual or existential distress. 15
- The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poor support and inadequate symptom control may mean we fail to meet the needs of those who are dying, as well as those who care for them. This may lead to a complicated bereavement process for those left behind.
- A rehabilitation approach to palliative care is central to the person-centred ethos of hospice care, and promotes a culture that helps patients to thrive, not just survive, when faced with uncertainty and serious illness. 8.
- "The benefits of this rehabilitative approach are huge, not only for patients and their families but for hospices too, as they seek to respond to the challenges of supporting more people living longer with chronic conditions". 8.
- Members of the interdisciplinary team offer a diverse range of skills in the provision of emotional, social, psychosocial, cultural, religious and spiritual support, and it is recognised that all team members play a vital role.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Recognising distress whatever the cause

"Promptly recognising, acknowledging and working with the person to assess the extent and cause of the distress, and considering together what might be done to address this is important. This must be available in every setting." **15**

Skilled assessment and symptom management

Attending to physical comfort and pain and symptom management is the primary obligation of health professionals at this time of a person's life. Their skills to do so must be assured and kept up to date. **15**

Addressing all forms of distress

The experience of suffering associated with physical symptoms may be caused or made worse by emotional or psychological anguish or social or spiritual distress. Addressing this requires professionals to recognise, understand and work to alleviate the causes.

Priorities for care of the dying person

The delivery of care is respectful, individualised and tailored to the person who is in their last days of life. This includes acknowledgement of physical, spiritual, social, mental and cultural factors important to each individual and their family/whanau. Mechanisms to incorporate these factors into the delivery of care are prioritised as decided by the person, wherever they may be dying.

Specialist palliative care

Specialist palliative care is available to those people whose assessed needs exceed the capability of the primary palliative care provider. Specialist palliative care is responsible for supporting primary palliative care to achieve improved outcomes for patients and their family/whānau.

Rehabilitative palliative care

Rehabilitation aims to improve quality of life by enabling people to be as active and productive as possible, with minimum dependence on others, regardless of life expectancy **8.**

Fit for purpose facility

A suitable, well located facility will ensure that everyone has access to expertise and care. It also provides a hub for community engagement.

4 Care is seamless

"It feels like the nurses are all up with the play, we don't have to repeat the story each time, it quickly felt like they really know us"

Patient feedback

What we already know

- People report not having a clear understanding of the role of the multiple health services involved in their care.
- Feedback indicates that lack of coordinated care and services increases the stress experienced by the patient, their carer/s, family and whānau. The alleviation of this would add significantly to their quality of life.
- People feel supported and safe with 24 hour advice available. The quality of the advice directly influences the level of trust people have with a service as a whole.
- Poor communication and failure to share information about the person who is dying is a recurrent theme when care is not good enough. **15**.
- Primary palliative care professionals, including aged residential care staff report the increased confidence and increased ability to provide quality of care when access to specialist advice is available.
- High quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and the surrounding community. **19.**
- People at the end of life with high levels of health, support and palliative needs require flexible packages of quality home nursing and support services to enable them to die at home, and to support their family and whanau at this time.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Systems for shared records

Health records for all people living with a life-limiting condition must include documentation of their assessed needs, as well as their preferences for end of life care. The person must have given their informed consent and the records should be shared electronically with all those involved in their care.

Clear roles and responsibilities

People living with life limiting conditions may have different services involved in their care. It is essential that people and their families know who and where to turn to for advice in times of change or crisis.

A system-wide response

Coordinated services need to be responsive to need in the community. These systems must include enabling dying people and their family/whānau access to 24/7 advice and support.

Continuity in partnership

Communication between service providers and consistent knowledge across settings, facilitates the smooth and timely delivery of quality care.

5 The community is involved

What we already know

- Talking about death, dying and bereavement is avoided in most community groups.
- Many members of the community do not understand what palliative care is.
- People who are dying and bereaved people often feel disconnected or isolated from their communities and networks of support. 15
- Globally there is much known about helping to nourish compassionate and resilient communities, and how to build capacity to provide practical support. 15
- Death, dying and loss affect everybody.
- The majority of people living and eventually dying from life-limiting conditions spend the greater part of their time at home being cared for and supported by family members, friends and neighbours.
- Many people feel unprepared when faced with the experiences of life-limiting conditions, death and bereavement and are uncertain about how to offer support and assistance.
- The experience of death, dying and bereavement can bring additional personal, health and social costs to those left behind. Much of this is preventable and/or relievable if the right supports are available in the right place at the right time. 9.
- The use of volunteers maximises community engagement and promotes partnerships between agencies and the community. Volunteers add value to the patient and family experience and complement the work of paid staff.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Compassionate and resilient communities

In a compassionate community, people are motivated by compassion to take responsibility for and care for each other with collective benefit.
http://www.charterforcompassion.org/index.php/shareable-community-ideas/what-is-a-compassionate-community

Public awareness

A community will be in the best position to care when they are comfortable with death and dying, can understand the difficulties people face, and know what help is available.

Practical support

Practical support, information and training are needed to enable families, neighbours and community organisations to help.

Volunteers

To meet our commitment, more should be done locally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their family/whanau and communities. **15.**

6 People prepared to care

"People didn't focus on physical symptoms – hospice staff were able to see the whole picture"

Consumer feedback

What we already know

- The recruitment and retention of palliative care medicine specialists in urban and provincial areas is a major issue. 12. This is also an issue for Hawke's Bay. 12.
- We have an ageing specialist palliative care nursing workforce.
- The demand for palliative care services, and thus workforce, will increase slowly over the next ten years but thereafter will increase more rapidly in line with the ageing population. 12.
- There is a growing need for a workforce that is culturally competent to accommodate diverse personal, cultural and spiritual customs and values. 10.
- Feedback suggests that the relationship people have with their GP and practice nurse is extremely important.
- The ageing population and emphasis on integrated care means that home and personal caregiver roles are becoming an increasingly critical part of the palliative care multidisciplinary team.
- Much of palliative care is provided by family members as informal carers. Reliance on informal carers and the volunteer workforce will only increase and we will need to support them to undertake potentially more complex roles. 10.
- A primary palliative care workforce works best when it is well-informed, educated and supported by specialist palliative care in caring for those with life-limiting conditions.
- Specialist palliative care services will need the capability and capacity to be able to provide care, support and educate others to meet projected demands and complexities of care.
- In order to meet identified needs of patients and their family/whanau we need a diverse range of skill and expertise within the interdisciplinary team.
- Staff can only compassionately care when they are cared for themselves. They must be supported to sustain their compassion so that they can remain resilient. This allows them to use their empathy and apply their professional values every time. 15.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Knowledge base

Only well-trained competent and confident staff can bring professionalism, compassion and skill to the most difficult, and intensely delicate, physical and psychological caring. 15

Support and resilience

Dealing with death and dying can be challenging. The potential impact of providing end of life care should not be minimised by clinicians, the team or the health service. 1.

Sustainable workforce

A sufficient formal and informal workforce is needed to provide the necessary hands-on support, advice and education, now and into the future.

Using technology

Professionals have to adapt to new ways of learning and interacting with the people that they are supporting and they need help and guidance to do so. Technology can also play a significant role in enhancing professional's self-directed learning and development. 15.

Clinical governance

Specialist and primary palliative care services will lead and co-ordinate a single system of care.

HOW WE PLAN TO STRENGTHEN OUR FOUNDATIONS AND MEET OUR PRIORITIES

OUR PRIORITIES

Each person and their family/whānau will have their individual needs as the centre of care

Enablers for person centred care	Access to social support	Meaningful conversations	Clear expectations	Integrating the philosophy	Bereavement Support

Each person gets fair access to high quality care

Using data	Unwavering commitment	Person centred outcome measurement	Population based needs	Referral criteria	Community partnerships

Comfort and wellbeing is maximised

Recognising distress	Skilled assessment & symptom management	Priorities for care of the dying person	Addressing all forms of distress	Specialist palliative care	Rehabilitative palliative care	Fit for Purpose Facility

Care is seamless

Systems for shared records	Clear roles and responsibilities	System-wide response	Continuity in partnership

The community is involved

Compassionate communities	Public awareness	Practical support	Volunteers

All staff are prepared to care

Knowledge base	Support and resilience	Using technology	Sustainable workforce	Clinical governance

ACTIONS REQUIRED

- Patients and family members know where to go for palliative care and are connected to services
- Information, education and visibility in the community on innovative ways to increase awareness and community culture around death and dying.
- Health and support workforce is skilled and informed to be able to support conversations around death and dying.
- Integration of Cranford Hospice and Hospital Palliative Care Team to form one specialist palliative care service.
- Specialist medical workforce developed to meet minimum recommended requirements.
- Training and supervision systems in place to support the development of SPC workforce.
- Confirm sustainable and responsive after hours primary palliative care arrangements
- Specialist palliative care provide education and support the efforts of primary palliative care providers in delivering patient care.
- Develop and expand nurse-led initiatives and expert roles such as the Nurse Practitioner.
- Last Days of Life (Te Ara Whakapiri) Pathway is developed and implemented across the region.
- Increase the role and size of the allied health and family support services.
- Research and evaluation outcomes are used to inform best practice.
- New purpose built facility for specialist palliative care. Increase from 8 to 10 inpatient beds as per recommendations (MOH 2013).
- Information technology systems accessible across primary and specialist settings. Palcare or other system.
- Look for opportunities to expand volunteer and informal support services in the community.
- Continued involvement in national data work – to develop measurable patient outcomes.
- Implementation of a rehabilitative approach to palliative care.

OUTCOME MEASUREMENTS

1. Increase in satisfaction with care by family members surveyed after death using a standard questionnaire relating to comfort and wellbeing. Measure baseline then increase by x to y by 2026.
2. National palliative care outcome measures are implemented and used for data collection and evaluation by 31 December 2017.
3. 95% of referrals to specialist palliative are accepted, reflecting appropriateness.
4. 70% of GP practice have access to the electronic patient management system Palcare by 1 July, 2018 and 70% of hospital by 1 July 2021.
5. Monitor access to SPC compared to our population profile & then adapt services to respond:
   - - Death by ethnicity in HB.
   - - Access by area reflects deaths in each area.
   - - Access by condition reflects deaths by condition.
6. The proportion of people dying in their preferred setting will be 90% by 31 December, 2018.
   - The proportion of people dying in hospital will decrease by one third from 34% to 21% by 31 December 2018
7. 100% of aged residential care facilities and hospital wards have implemented the Last Days of Life Care (Te Ara Whakapiri) Plan supported by Specialist Palliative Care services.
8. People with palliative care needs living in aged residential care facilities have care plans reflecting individual needs and best practice via documentation peer review.
9. New SPC facility built by 31 December 2019.
10. One specialist palliative care team for Hawkes Bay providing hospice, community and hospital in-reach consultation-liaison services by 1 July 2018
11. 20% nursing staff under the age of 50 by 2021.
12. Increase the proportion of Maori nurses to reflect the population in Hawke's Bay from 8% to 24 by 2026.
13. SPC FTE medical staff increased from 3.2 to 6.4 by 31 December 2018

FOUNDATIONS

Patient, whānau and community voice	Cultural responsiveness	Education and training	Leadership	24/7 access	Sustainable specialist palliative care service	Evidence and information	Technology

Appendix 1

Table 1: Current & Proposed Medical Workforce

Role 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Palliative medicine specialist (Hospital 0.5; Hospice 0.5)	1.0	Palliative medicine specialist	2.0
Medical officer special scale Advanced trainee (currently in Hospital)	1.8 0.4	Medical officer special scale or GP with special interest, or advanced trainee or registrar physician training. (Covering community, hospice inpatient unit and hospital services)	3.0
		House officer trainee Hospital & Hospice	1.0
Medical Director	0.4	Medical Director	0.4
TOTAL	**3.6**		**6.4**

This FTE does not include 30% non-clinical time as per contracts or leave requirements.

Table 2: Current & Proposed Nursing Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Nurse Practitioner Candidate	0.9	Nurse Practitioner	0.9
Clinical Nurse Specialists Hospital 2.0; Hospice 2.8	4.8	Clinical Nurse Specialists Hospital 2.0; Hospice 3.0	5.0
Aged Care Liaison Nurses	1.2	Aged Care Clinical Nurse Specialist	2.0
Registered Nurses inpatient unit and community nurses	18.2	Registered Nurses inpatient unit and community nurses, new graduate position	21.8
Education	0.5	Education	2.0
	0.8	Enrolled Nurse	0.8
		Health care assistants	3.0
TOTAL	**26.4**		**35.5**

Table 3: Current & Proposed Allied Health & Family Support Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Counsellor	1.0	Counsellor	2.0
Social Worker	1.0	Social Worker	2.0
Pastoral Care	0.8	Pastoral Care	1.0
Carer Support Coordinator	1.0	Carer Support Coordinator	1.6
Music Therapist	0.4	Music Therapist	0.6
Kaitakawaenga	0.8	Kaitakawaenga	1.0
Cultural Advisor	0.2	Cultural Advisor	0.2
Pharmacist	0.5	Pharmacist	0.8
Occupational Therapist	0.6	Occupational Therapist	1.0
		Physiotherapist	1.0
TOTAL	**6.3**		**11.2**

References

1. Australian Commission on Safety and Quality in Health Care. (2015). National Consensus Statement: essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC
2. Bausewein et al. (2016). EAPC White Paper on outcome measurement in palliative care: Improving practice, attaining outcomes and delivering quality services. Palliat Med. 2016 Jan;30(1):6-22. doi: 10.1177/0269216315589898. Epub 2015 Jun 11.
3. Boon, A. (2012). Excellence through Patient and Family Centred Care; Literature Review. Wellington: Health Quality and Safety Commission
4. BPAC. (2016). Providing palliative care to Maori. As retrieved from: http://www.bpac.org.nz/resources/campaign/palliative/palliative_maori.asp
5. Canadian hospice Palliative care Association. (2013). Innovative Models of Integrated Hospice Palliative Care, the Way Forward Initiative: An Integrated Palliative Approach to care.
6. Heatley, R. (2008). Carers' services guide. London: Help the Hospices
7. Hospice New Zealand. (2011). Hospice New Zealand standards for the care of people approaching the end of life. Wellington: MoH
8. Hospice UK. (2015). Rehabilitative palliative care: enabling people to live fully until they die – A challenge for the 21st century.
9. Kellehear, A. (1999). Health Promoting Palliative Care. Melbourne: OUP
10. Ministry of Health (2016). Review of Adult Palliative Care Services, DRAFT June 2016
11. Ministry of Health. (2014). Palliative Care and Māori from a Health Literacy Perspective. Wellington: Ministry of Health.
12. Ministry of Health. (2011). Palliative Care Workforce Service Review; Health Workforce New Zealand. Wellington: Ministry of Health
13. Ministry of Health. (2001). New Zealand Palliative Care Strategy. Wellington. MoH
14. Northern Regional Alliance. (2016). Advance Care Planning asks "What matters to you?" as retrieved from: http://www.advancecareplanning.org.nz/
15. National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020. www.endoflifeambitions.org.uk.
16. Palliative Care Subcommittee, NZ Cancer Treatment Working Party (2007) New Zealand Palliative Care: A Working Definition. [Online]. Available from: http://www.moh.govt.nz/moh.nsf/pagesmh/2951/$File/nz-palliative-care-definitionoct07.pdf.
17. Palliative Care Council of New Zealand. (2012). New Zealand Palliative Care Glossary. Wellington: Ministry of Health
18. Temel, J.S, Greer, J.A, Muzikansky, M.A, Gallagher, E.R, Admane, M.B, et al (2010). Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer. N Engl J Med 2010; 363:733-42
19. The Scottish Government. (2015). Strategic Framework for Action on Palliative and End of Life Care 2016-2021. Edinburgh: The Scottish Government.
20. Quill, T.E., & Abernethy, A.P. (2013). Generalist plus Specialist Palliative Care — Creating a More Sustainable Model. N Engl J Med; 368:1173-1175March 28, 2013DOI: 10.1056/NEJMp1215620
21. Layden, Connelly, Sandeman, Hekerem, Alexander, McLoughlin & Tyrrell. (2014). Understanding palliative and end of life care through stakeholder and community engagement. BMJ Support Palliat Care 2014;4:117-118 doi:10.1136/bmjspcare-2014-000653.39
22. Palliative Care Council. (2013). Needs Assessment for Palliative Care: Summary Phase 2 Report: Palliative Care Capacity and Capability in New Zealand June 2013
23. McLeod, H. (2016). Hospice New Zealand Data Project Plan
24. Gomes, Calanzan, Gysels, Hall, Higginson Heterogeneity and changes in preferences for dying at home: a systemic review 12:7 BMC Palliative Care 2013 12:7

Consumer feedback 2015 – 2016

This information is from written and verbal feedback. Quotes are adapted to maintain confidentiality

PRIMARY PALLIATIVE CARE

Almost all mentioned their GP – always expressed strongly, whether good or bad This is a very important relationship. Majority spoke positively about their GP, the sense of support, advocacy and availability. Practice nurses mentioned occasionally, positive addition to sense of support.

Criticisms related to communication:

- of prognosis and introduction of the idea of referral to Hospice
- availability, the need to be able to access as needed and not to have to see other GPs who don't know them
- concentration on physical / medical needs of the patient

SECONDARY PALLIATIVE CARE

Some people reported satisfaction with the service they were provided if/when admitted. Of those that met with the HPCT, all but one was positive and the communication provided relief and more confidence and understanding of hospice.

Several negative experiences expressed of communication from specialists / doctors regarding diagnosis and prognosis. These were all expressed with quite a bit of emotion. Mostly related to 'abruptness' or suddenness of the message. Some felt that this was even "rude" and left them with negative feelings including an inability to ask questions. Many left not knowing what 'palliative care' was and afraid to accept the referral.

Many felt the doctors at the hospital were only interested in one aspect of them and this was a barrier to quality care.

I can tell my GP anything, she is a great advocate

The Hospital Palliative Care Team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept referral

It is hard to get the same GP so we have to "start again" each time - this stopped us talking about Long Term Care like we wanted to. GP is there for/focuses on "medical matters"

SPECIALIST PALLIATIVE CARE

The majority of those visited described having strong beliefs about Hospice as a 'place to die' and were unhappy about the referral, some saying that this meant they refused referral initially and later regretted this once they learned what it is really about.

All felt that Cranford Hospice staff were great and there were no complaints or criticism about this. Often people felt supported and safe with the 24 hour advice available.

People didn't focus on physical symptoms – most were more interested in talking about the general feeling of psychosocial support and several mentioned that the Hospice staff were able to see the 'whole picture'.

Actually coming into the Hospice building for an appointment was universally a positive experience and reduced fears / barriers to accepting admission if needed.

People talked about the need to keep 'living' and things like vague appointment times were interruptions to that.

When they decide they can't do anything medically for you, you are off on your own, they don't want to know you….

My out-patient appointment made all the difference, they linked everything together

Cranford people are non-intrusive; responsive and great for advice

When we ask for a visit – the response is always "yip, no problem"

The doctor was the first to look at the "whole picture"

WORKSHOP

ADVANCED CARE PLANNING