HB Clinical Council
Monthly & Annual Meeting

Date: **Wednesday, 10 August 2015**

Lunch: **12.30 pm**

Meeting: **1.00 pm to approximately 5.00 pm** (followed by refreshments)

Venue: **The Library, Mission Estate Winery, Church Road, Napier**

Council Members:

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

Apologies: Caroline McElnay, John Gommans

In Attendance:

Nick Jones (Public Health Specialist) Acting for Dr Caroline McElnay
Dr Kevin Snee, Chief Executive Officer, Hawke's Bay District Health Board
Ken Foote, Company Secretary
Barbara Ryan, Quality Improvement & Innovation Team Leader *(on behalf of Kate Coley, Director Quality Improvement & Patient Safety - on leave)*
Tracy Fricker, Council Administrator and EA to DQIPS
Graeme Norton, Chair HB Health Consumer Council
Kerri Nuku, Māori Relationship Board Member
Dr Russell Wills (Medical Director QIPS)

MONTHLY MEETING

Public Meeting

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	**1.00**
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
	Section 2 – Presentation / Updates / Discussion	
6.	Operation Productivity Presentation – Rika Hentschel (Service Director)	**1.15**
7.	Collaborative Clinical Pathways Business Case – Leigh White 7.1 Clinical Pathways Update	**1.45**
8.	Travel Plan Update Presentation – Andrea Beattie	**1.55**
9.	Draft Quality Accounts – Jeanette Rendle	**2.05**
10.	Primary Care Smoke Free (verbal) – Dr Mark Peterson	**2.10**
11.	Governing for Quality – Ken Foote 11.1 Governing for Quality – A Quality & Safety Guide for District Health Boards	**2.15**
12.	ICU Learnings Update – Chris McKenna	**2.20**
13.	Complementary Therapies Policy – Dr Andy Phillips	**2.30**
	Section 3 – Monitoring for Information (no presenters)	
14.	Te Ara Whakawaiora / Culturally Competent Workforce	**-**
15.	Te Ara Whakawaiora / Mental Health	**-**
16.	Annual Māori Plan Q4 (Apr-Jun 2016) Non-Financial Exceptions 16.1 Annual Māori Plan Q4 - Dashboard	**-**
17.	Certification – Findings and Next Steps	**-**
18.	**Recommendation to Exclude the Public**	

Public Excluded Meeting

Item	Section 4 – Routine	Time (pm)
19.	Minutes of Previous Meeting	**2.35**
20.	Matters Arising - Review Actions	

NEXT MEETING Wednesday 14 September 2016, commencing at 3.00pm Te Waiora (Boardroom), HBDHB Corporate Building

	Section 5 – Decision	Time (pm)
21.	Community Based Pharmacy Services in HB – Strategic Direction 2016-2020 – Billy Allan	**2.37**
	Section 6 – Presentation and Updates	
22.	Improving the Quality of Unscheduled Care & Acute Patient Flow (ED 6 Hours) - Colin Hutchinson (Medical Director - Acute & Medical)	**2.45**
23.	Radiology Update - Dr Mark Peterson	**3.00**
24.	Laboratory Update - Dr Andy Phillips	**3.05**
	AFTERNOON TEA (15 minutes)	**3.10**

ANNUAL MEETING

Public

Item	Section 7 – Annual Meeting	Time (pm)
25.	Welcome and Opening	**3.25**
26.	Apologies Received	
27.	Minutes of Previous Annual Meeting held 12 August 2015	
28.	Matters Arising from Annual Meeting 28.1 Annual Meeting Workshop Outcomes	
29.	Election of Chair / Co-Chairs	
30.	Review last 12 months (2015-16) Year in Summary 30.1 Attendance (for information) 30.2 Tenure (for information)	
Item	**Section 8 – Workshop** (facilitated by Ken Foote)	
31.	Review HB Clinical Council Terms of Reference	
32.	QIPS Annual Plan	
33.	Clinical Governance Committee Structure 33.1 Clinical Governance Committee Structure Flowchart	
34.	Review of Council's Annual Workplan 2015-16 (past year) Development of Annual Workplan 2016-17	

Following the meeting, platters and non-alcoholic refreshments will be available downstairs in the Bar (around 5.00 pm)

Interests Register

Hawke's Bay Clinical Council

2 August 2016

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary of	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that agrees the contract.	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
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*	

3/08/2016

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**
William Allan (Chief Pharmacist)	Pharmaceutical Society of New Zealand	Executive member	Pharmacy advocacy, professional standards and training	Yes	Low
	Pharmaceutical Management Agency (PHARMAC)	Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee)	Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML)	Yes	Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget
	Executive User Group for eMedicines programme (ITHB/HQSC)	Member (Central Region's representative)	Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines Reconciliation)	Yes	Low
	Pharmacy Steering Group (MoH)	Member	Provide advice to the Ministry on the utilisation of pharmacists within the health workforce	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	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	
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	

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	The College of Maori Nurses	Member		No	
	New Zealand Scientific Society of Diabetes	Member		No	
Dr Malcolm Arnold (SMO Physician - Gastroenterology)	NZ Society of Gastroenterology	Executive member	Provision of Gastroenteorlogy expertise throughout NZ, study of relevant conditions	No	
	NEQIP (National Endoscopy Quality Improvement Programme)	Clincal Support Lead	Standardising and improving quality of endoscopy services and training throughout the country	No	
	Endoscopy Users Group, HBDHB	Chairman	Assessing and improving provision of Endoscopy services in HB	Yes	Potential to influence budget/spending/provision of services
	Hawke's Bay Medical Research Foundation	Member of Scientific Advisory Group	Advising HBMRF on use of funds for research projects	No	
	NZ Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (since June 2015)	Chairman		No	
David Warrington (Nurse Director - Older Persons)	Havelock North Chiropractic	Wife is Practitioner and Co-owner	Chriopractic care and treatment, primary and preventative	Yes	Low
	Pilates Works	Wife is CE and Co-owner	Rehabilitation, Primary and preventative.	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality Advisory Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and Implementation	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
	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

HB Clinical Council 10 August 2016 - Interest Register

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
	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	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HBDHB CORPORATE OFFICE ON WEDNESDAY, 13 JULY 2016 AT 3.00 PM

PUBLIC

Present: Dr Mark Peterson (Co-Chair)
Chris McKenna (Co-Chair)
Dr Tae Richardson
Dr David Rodgers
Dr Robin Whyman
Dr Kiri Bird
Debs Higgins
William Allan
David Warrington
Jules Arthur

Apologies: Drs McElnay, Gommans, Arnold, Phillips, Robyn O'Dwyer and Anne McLeod

In Attendance: Ken Foote (Company Secretary)
Kate Coley (Director, Quality Improvement & Patient Safety)
Tracy Fricker (Clinical Administrator / PA to Director QIPS)
Dr Nicholas Jones (Public Health Specialist) Acting for Caroline McElnay
Graeme Norton (Chair, HB Health Consumer Council)
Kerri Nuku (Maori Relationship Board member)

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Mark Peterson (Chair) welcomed everyone to the meeting. The Chair introduced Kerri Nuku who will be the liaison representative from the Maori Relationship Board in attendance at Clinical Council. As an observer, Kerri can take part in discussions but will not have a vote. Kerri gave a brief introduction of her background and work history.

Apologies received from Dr Andy Phillips, Dr Caroline McElnay, Robyn O'Dwyer and Anne McLeod. Kiri Bird also advised she will be late to the meeting.

2. INTERESTS REGISTER

No conflicts of interests for agenda items.

One new interest received from Julie Arthur she is a member of the Central Region Quality and Safety Alliance.

Action: New interest to be added to the register for Julie Arthur.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 8 June 2016, were confirmed as a correct record of the meeting.

Moved and carried.

MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Clinical Council Member Portfolios
Deferred until August meeting.

Item 2: Alternative Health Provider - Complementary Therapies Policy
The final draft of this policy will be ready in August.

Item 3: Health Equity Update
Presentation sent out with the minutes. Item can now be closed.

Item 4: Meeting Attendance (Quorum)
The APAC Conference is being held 12-14 September in Sydney. There are a number of apologies for the September meeting. Members to ensure they advise if they are not able to attend prior to the meeting to ensure there is quorum.

4. CLINICAL COUNCIL WORK PLAN

The Chair brought attention to the Annual Plan which will be discussed at the August Meeting.

The Health Sector Leadership Forum for later this year has been cancelled and will now be held next year *(tentative date is 15 March 2017)*.

SECTION 2: FOR ENDORSEMENT

5. HEALTH AND SOCIAL CARE NETWORKS

The Chair welcomed Liz Stockley and Belinda Sleight to the meeting. Previous feedback received has been incorporated into the document. They are now looking for endorsement of the purpose, principles and geographic localities and approval of the business case.

One key change for this programme of work is that the Steering Group is now the Executive Management Team (EMT), with an operational working group which includes direct reports to EMT, members of EMT and consumers. The documents in the papers are about the overall programme and how the DHB can manage the network process and are not about how each network is going to be managed. This will be up to the networks as they develop. EMT have endorsed these papers with a strong recommendation that they want us to get on with Wairoa and Central Hawke's Bay.

Following feedback the purpose and principles document was simplified as a two page document with vision, key messages, design principles and what the service will look like for consumers. In the geographic localities proposal we are now looking at four localities Wairoa, Central Hawke's Bay, Napier and Hastings. There has been discussion on "communities of interest" where local providers and the community could work together to achieve specific aspirations for that community e.g. Flaxmere, Camberley. Providers with specific expertise could work with consumers to develop centres of excellence for a condition or life stage.

The Maori Relationship Board recommended that the HEAT Tool be applied to the document and examples provided, that are more patient-centred.

Questions / Feedback:

- The description of the reason why Wairoa and Central Hawke's Bay are being piloted first is because of their rurality and isolation. It should be an equity issue. It we look at the statistics the Pakeha living in rural isolated communities actually do better than urban Pakeha. If you

are living rurally there tends to be a higher percentage of poor Maori people in your locality and rurality is an equity issue.

- Under issues *(last bullet point on page 3)* regarding not wanting inequities between the networks - would like to see this raised more strongly. We want the same outcomes for populations experiencing inequities outside of the communities of interest.
- The rural nature of Wairoa and Central Hawke's Bay and Wairoa and the urban nature of Napier and Hastings - what about the hinterland which is quite rural but based on the Hawke's Bay District Council have we considered where they might fit? The localities are about where the population of providers is based. Consumers are already making the choice on where they go for their services and it is important that people continue to have the choice of where they want to receive their care.
- One of the challenges that comes through on reading the purpose and principles is that it is really important to be careful which consumers are engaged and involved and how that will drive the network. Looking at this from a child point of view and thinking about children and how well this is going to pick up on the needs of children and the services that children need. We are talking long term conditions that affect adults and the predominately older adult population. It is a risk in the network that is worth acknowledging. Yes – this is why it is important that this development occurs at the same time as the clinical services plan.

Following the discussion the purpose and principles paper and business case were endorsed by the Clinical Council and the Clinical Council supports the recommendation made by EMT to move forward with Wairoa and Central Hawke's Bay.

SECTION 3: FOR DISCUSSION

6. PRIMARY CARE SMOKEFREE

The Chair welcomed Liz Stockley and Victoria Speers to the meeting who provided a verbal update on the last quarter.

The results are disappointing for the overall figure for Hawke's Bay being 82%. There are some individual practices which are now over 90% which is fantastic. The Ministry of Health will now allow any interaction with a consumer in terms of providing advice to quit to be captured in general practice and attributed against the target. Previously the work had be done in general practice or by a PHO Team. The work previously being done by the Smokefree Team unless it was under the direction of the PHO, Quit Line and the work in the hospital was not being captured in this target, even though they were working with the same consumers.

There have been 14 practices which have met the target, 3 practices with no change and 5 down in coverage rates.

Four practices have started to use a reception form for consumers to complete when they come into the practice asking if they smoke and whether they would like help to quit. That form then goes to the doctor or nurse with their consultation slip and is another prompt for Smokefree advice and cessation support.

A risk going forward is that Smokefree Community Systems Co-ordinator has resigned. She has done some great work building relationships with practices.

From 1 July working as a health sector and trying to pull the work together that is being done in the different organisations and how we get it back into our patient management system is a challenge. Not sure how this will be done, we need to enhance relationships.

General discussion regarding how information is being captured and by whom. The target is with us for at least another 18 months. The Ministry has indicated they want to move to a prevalence target in the future.

7. IMPLEMENTATION OF HB CLINICAL GOVERNANCE COMMITTEE STRUCTURES

The Chair invited Kate Coley, Director QIPS to talk to her paper. The paper is high level for implementing the clinical governance committee structure which has been discussed previously. EMT looked at the paper yesterday and some minor changes have been made:

- Clinical Effectiveness & Audit – Audit changed to Clinical Audit
- Some boxes are dotted, these are the committees required to meet the Health & Disability Standards
- Clinical Advisory Group moved directly under the PHO Board
- Patient Safety and Risk Management - Risk changed to Clinical Risk
- Patient Experience – should be a joint committee with the Consumer Council
- Information Management – this area will evolve. Privacy, Policy Control and Forms and Document Control under DQIPS and OIA and Records Management under the Company Secretary.

We are looking to reduce the number of advisory committees and how often they meet from monthly to bi-monthly, they will also need administration support. This could become a business in itself and we need to ensure that what we are trying to achieve is valuable.

We now need to put some detail into the TOR for the high level committees of the Clinical Council and what sits underneath, then look at the detail of the TOR for each of the advisory groups. Recommendation that a small working group looks at the five high level clinical committees that report under the Clinical Council, their TOR and get them right, identify chairs and deputy chairs. She recommended that these committees meet on a quarterly basis. Once they are established and endorsed by Clinical Council we can then work through the other advisory groups and start to develop their TOR, which will better inform where they sit in the overall framework.

Representation on the committees will be made up of primary and secondary as well as clinical teams and consumers. Consumers should be included at this level and not have to be on every advisory group. The challenge will be timetabling meetings and having an annual reporting calendar for the reporting mechanism. Another challenge will be administration support for the committees, if we don't get the administration support the information flows are not going to achieve what we want.

To support this structure would be a quality dashboard. We want to further this conversation and get viability of that information around patient safety, clinical effectiveness and patient experience coming back to Clinical Council and shared wider.

Questions / Feedback:

- The Maternity Governance Group is not about training professionals is it a clinical governance group and is a Ministry of Health driven programme. Suggestion that should it then sit at a directorate level and report up or maybe move under Clinical Effectiveness and Audit? Does the Nursing & Midwifery Council change where it sits as well, or does the name of the stream need to change?
- It is important that this is a sector wide clinical governance structure.
- It is pleasing to see the linking of the Clinical Council and Consumer Council into the consumer experience, it is a collaborative pathway for the Consumer and Clinical Councils to work together.
- Where is equity? Also, does it make sense for CAG and Clinical Council to be separate entities? Mark Peterson advised there is a possibility in the future that they may merge. The way the structures are at the moment the PHO is still an independent organisation and the Board of the PHO still need reassurance that the things they are doing are clinically sound.
- Whatever we do the PHO is still going to need specific committees to work, just like Health Services at the hospital e.g. the Pharmacy & Therapeutics Committee the hospital still needs a sub-committees which deals with hospital only issues. The document can't cover everything

but it does ask the question of what we can do collectively across the sector to gain benefits and making clear what is just in-house internal needs.
- Look at title change for Research, Education and Training. This is really about professional performance and standards, ensuring all our clinical professionals are credentialed, trained, ongoing education and training etc. Suggest adding professionals into the title.
- Do we have a standalone equity committee or include in the TOR for all committees. We could put it in as a statement but what does it mean for each committee?
- Population level outcomes and prioritisation issues / system level measures, does it sit under clinical effectiveness or is it business of council?
- In the information management group will there be clinical representation and representation from Clinical Council? Once the structure is agreed we need to populate them. At next month's meeting we will look at who would like to be involved in each committee or take on responsibility of chair or deputy chair.

The Director QIPS advised the next steps are to look at the top level committees and bring back to Clinical Council for endorsement.

8. RENAL STAGE 4 – FACILITY DEVELOPMENT UPDATE

The Chair welcomed Megan Knowles, Project Co-ordinator, Facilities to the meeting. An update was provided on the progress of the project to date.

Key points:

- The project has a budget of $2,140,000 and is currently running ahead of schedule.
- Administration staff from Ballantyne House will be located in the old Mental Health Unit while the build is underway, they will move around November 2016.
- Tender is currently underway and will be completed by end of August.
- Project sign-off by the end of October, to enable a start construction in November.
- At this stage we have allowed for an 11 month build, expecting to be in the new facility in early 2018.

Questions/Feedback:

- Will the courtyard area have a function for staff or public? Yes this area will be fully accessible for staff and patients to use.
- Budget of $20k for signage seems excessive. All the signage for the facility will be upgraded to the new signage standard both internal and external.
- Will be remote consulting from the consulting rooms? Not at not at this stage. Currently working with IT re: video conferencing facilities.
- Will the name will remain as Ballantyne House? Yes, though it is an important point, do we call buildings by their function or a historical name linked to some distant person in this case a former hospital superintendent.

BUDGET UPDATE

The Chair advised that this is a late item added to the agenda. He welcomed Peter Kennedy, Finance Manager to the meeting who gave a short budget update following the Government budget announcements in May and how this affects the DHB.

Summary:

		$m		
Original funding envelope including IDF				**8.28**
Additional Contribution to DHB		2.34		
Pharmaceutical Investment		1.52		
Total gross funding			3.87	
less changes to base funding 2016-17				
required to be invested In pharms		-1.52		
Home community support		-1.15		
uplift in surplus for $3.00m to $4.5m		-1.50		
			-4.17	
				-0.31
Revised net funding Envelope				**-0.31**
Plus elective funding	volume			
Elective Funding core funded	78	0.34		
Elective Funding core unfunded	109			
Elective Funding regional	78	0.45		
Elective Funding additional Gen Surg and ortho	114	0.94		
Additional Elective revenue	379		1.73	
Additional Cost to deliver elective funding			-3.67	
Net additional elective costs				**-1.94**
Other unbudgeted costs				
Melanoma Drug treatment costs		-0.20		
Feasibility studies		-0.60		
				-0.80
Recurring gap covered by one off funding				**-2.74**

9. REDUCING ALCOHOL RELATED HARM

The Chair welcomed Rachel Eyre, Medical Officer of Health to the meeting. The Medical Officer of Health asked the Clinical Council for endorsement on the proposed approach of developing a HBDHB position statement on eliminating alcohol related harm and advice on the process for engaging across the DHB and sector.

The alcohol harm video was played.

Feedback:

- The idea of a position statement is powerful as it's an engagement process, we see the leadership of our people in the video. Dr Paul Quigley from Wellington presented at the Grand Round last month and talked about the good work done in Wellington how they worked with the Council around licensing, hours and data collection. Forming those relationships and how we implement the strategies is important. The best way to control alcohol is about simple strategies and access.
- Big corporations are spending billions globally we have to be realistic on how we can sell the message compared to very clever advertising agencies.
- It comes back to local community action, applications for licences and the community standing up and saying I don't want bottle shops opposite schools. Its hard graft but needs to be done. The visibility of the statement is important.
- Family violence national statistics show only 33% of Police call outs are alcohol or drug related, 60% are sober, we need to be careful about perpetuating a stereotype.
- We would be remiss as health professionals not to have a position statement but also we need grass roots community led initiatives and need the relationships and knowledge to support communities to do what they want to do in their own community.
- Need to have consistent messaging like with Smokefree and safe sleeping

Dr Nick Jones, Public Health Specialist commented that they would like advice on the process going forward to advance this, some is going to be in our own services whether it's about developing policies around intervention, access to treatment services, work in primary care as well as working with council and the community initiatives. It is too much for one person to do on their own. We don't have as much funding attached to this as we do for tobacco control. Data collection supports the advocacy and it would be good to know that there is a commitment to improve our systematic data collection around alcohol related harm in ED and in primary care, is that something the Clinical Council will support?

In Dr Paul Quigley's presentation the power they had in Wellington ED was the data, they had information on where people had drunk to show clustering to the licensing authority. Working with St John Ambulance and A&E Centres, you do need to have the commitment to collecting the data and how we resource that is a different issue. Without good data it is hard to influence the local licensing decision making, which is where we know we can make a difference. We need to work with ED on how we enable the data capture in a way that gives us meaningful information. We need a system in place to capture the data and the system in which we use it to inform decision making in the sector. IS have advised that there are no barriers for collecting the data from an IS systems perspective, it's more around a resourcing and change management process in ED.

We already know where our poorest communities are and we know they are disproportionally affected by alcohol harm so while we are collecting data we can be working with those communities, particularly if we identify community leaders and communities who are ready to be supported to move forward. You need data, you need the support of the people to use those policy levers in their favour.

What are we doing with the video? The video is on the website and we are working on video screens in ED, Napier, Wairoa and CHB. Totara Health is also doing a pilot. The video was developed primarily for the decision makers being the audience.

Brief intervention work in primary care - we have been trying to push mental health credentialing for primary care nurses and part of that training can involve brief assessment / intervention for addiction, in particular alcohol. We are looking for the PHO to come on board for clinical release time.

There was a lot of work / education with the ALAC model in primary care some time ago. It would be good to build on the model as a lot of people have gone through the training rather than introducing something new. There is also work with the Kina Trust that is happening now.

The Clinical Council supports the development of a position statement on reducing alcohol related harm.

10. LAST DAYS OF LIFE

The Chair welcomed Leigh White to the meeting who provided a summary update and asked the Clinical Council to endorse the work going forward.

The HBDHB working group has formulated a plan and tool kit based on the national guidance "Te Ara Whakapiri - Principles and Guidance or the Last Days of Life". The working group has accepted and supported a trial in aged residential care facilities. GPs are also supporting the facilities as part of the trial. After the trial, which will be for three months information will be collated and evaluated and recommendations will be made for adopting the Last Days of Life care plan across all aged residential care facilities and in medical/surgical wards. We have opted to hold off at moment in the medical/surgical ward due to the restructuring processes. We can learn some lessons from the trial in aged residential care we are assessing the tool not the care provided. Cranford has agreed to support the trial and undertake the evaluation process.

Questions / Feedback:

- Will forms be printed in colour every time? As part of the trial we will be giving colour copies to aged residential care. Some in aged residential care have said they will print in colour others have said they won't. Aim is not to have paper copies of the forms in facilities and to link it into the map of medicine
- You are missing website links for information leaflets. One of the difficulties is that they are English language resources and there are no resources in other languages if we want to have an equitable service we need to ensure our pacific population understand
- The Maori Relationship Board also mentioned that Advanced Care Planning (ACP) and EPOA should link together. This isn't part of the brief of this work but there is a gap within our local community on developing ACP. There has been a lot of work done nationally with ACP. It wasn't supported in the last budget bids. Will talk further with strategic services on where to from here
- ACP needs to be owned in the community and driven from the community. It affects the health sector ultimately, but it is a community / family conversation
- There needs to be a resource to drive it. There has been a lot of work and while it wasn't supported in the budget funding has to be found.
- The Director QIPS advised she has had a number of conversations with clinicians who are wanting to drive ACP. We can look at it from an improvement perspective. We have to get our community thinking and talking about it.

ACP does support last days of life but it is not part of it. It should be done when we are well and imbedded in the community.

Ongoing work of the last days of life care planning was endorsed by the Clinical Council.

11. TRANSFORM & SUSTAIN REFRESH

The Chair welcomed Tim Evans, General Manager Planning, Informatics and Finance and Kate Rawstron, Project Manager to talk about the transform and sustain refresh.

Tim advised the programme has been reviewed and the strategy itself and the 24 statements assessed and scored on whether they had progressed or not. Meetings were held with EMT, Health Services Leadership Team, Project and Change Managers and the Health Sector Leadership Forum and this enriched our understanding.

Six priorities where identified that we need to do better:

1. Person and Whanau Centred Care
2. Heath and Social Care Networks
3. Whole of Public Sector Delivery
4. Information System Connectivity
5. Financial Flows and Models
6. Investing in Staff and Changing Culture

25 new projects proposed:
- 9 "pencilled in" confirmed
- 21 new
- 5 "pencilled in" deleted

Each of the project ideas needs to be worked up with a terms of reference, time scale and plan of action. The Project Manager advised that being new to the organisation and coming in at the refresh time was a real opportunity to do a stock take, complete benefits mapping for the programme and the scoping of new projects. We have to have clarity about what are we going to get out of a project initiative. The stocktake, benefits and scoping will continue until September with initiation of new projects from October.

SECTION 4: REPORTING COMMITTEES / MONITORING

12. AIM 24/7

The Chief Medical Officer advised that the AIM 24/7 has been about improving our acute patient flow. It has been around for two years and has covered a lot of ground. What the steering group has decided is that it is now time to close the project and it will allow us to refocus on the things we haven't done. There will be a relaunch over the next month or so.

13. LABORATORY SERVICES COMMITTEE

Item moved to public excluded.

14. RADIOLOGY SERVICES COMMITTEE

Item moved to public excluded.

15. CLINICAL ADVISORY & GOVERNANCE COMMITTEE

Report taken as read. No issues discussed.

SECTION 5: FOR INFORMATION ONLY

16. BUSINESS CASE HEALTHY EATING AND ACTIVITY PROGRAMME

Report taken as read. No issues discussed.

17. BUSNESS CASE 2015/16 CLINICAL MIDWIFE SPECIALIST – DIABETES

Report taken as read. No issues discussed.

18. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

14. Laboratory Services Committee
15. Radiology Services Committee
20. Minutes of Previous Meeting (Public Excluded)
21. Matters Arising – Review of Actions (Public Excluded)
22. Member Topics of Interest

Moved and Carried.

The meeting closed at 5.15 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	10/2/16 8/6/16 8/6/16	***Clinical Council Member Portfolios within the Council's Annual Plan review*** Members were asked how the Annual Plan for 2016/17 may look and what Clinical Council's focus should be? Members to consider the Annual Plan in conjunction with the **"Clinical Governance Structures and Committee Review"** document (due to Council in July) refer to item 3 below.	All	July	Deferred until August meeting Agenda Item 8.
2	9/3/16	***Alternative Health Provider*** (**Complementary Therapies Policy)** New draft Policy reviewed under item 8 "Draft Complementary Therapies Policy". Revised version considering feedback to be provided for sign off.	A Phillips	July	Deferred until August Meeting as Andy is on leave
3	8/6/16	Health Equity Update presentation to be provided with the minutes	Admin		Actioned
4	8/6/16	**Meeting Attendance (Quorum)**: Members are to ensure they advise their non-attendance prior to Council meetings - especially for the September meeting (due to APAC).	All		Noted

OURHEALTH HAWKE'S BAY Whakawateatia

HB CLINICAL COUNCIL WORKPLAN 2016-2017

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Meetings 2016	Papers and Topics	Lead(s)
12 Aug	**Health Award Entries accepted up to 12 August 2016**	
14 Sept	Orthopaedic Review – closure of phase 1 Draft – Orthopaedic Review – phase 2 Draft – Family Violence – Strategy Effectiveness for noting Draft – Reducing Alcohol-Related Harm Final – Quality Accounts (co-ord with Annual Report) Draft - Event / Complaint / Hazard / Risk Management System Draft / Discussion - HB Integrated Palliative Care ***Monitoring*** Falls Minimisation Committee Update Maternity Clinical Governance Group Update Draft – Serious Adverse Events (annual) Health and Social Care Networks Update Urgent Care Project Clinical Advisory & Governance Committee (joint Aug-Sept) Te Ara Whakawaiora / Obesity (national indicator)	Andy Phillips Andy Phillips Caroline McElnay Caroline McElnay Kate Coley Kate Coley Andy Phillips Chris McKenna Chris McKenna Kate Coley Liz Stockley Liz Stockley Tae Richardson Caroline McElnay
12 Oct	Final – Reducing Alcohol-Related Harm Final – Serious Adverse Events Draft – New Patient Safety and Experience Dashboard Update - Renal – Stage 4 ***Monitoring*** HB Nursing Midwifery Leadership Council Update AIM 24/7 Update Final – HB Integrated Palliative Care Urgent Care PROPOSAL update Radiology Services Committee Infection Prevention Control Committee Qtly.	Caroline McElnay Kate Coley Kate Coley Sharon Mason Chris McKenna John Gommans Mary Wills ? Mark Peterson Chris McKenna

Meetings 2016	Papers and Topics	Lead(s)
9 Nov	ICU Learings Action Plan update Qtly Final – Developing a Person Whanau Centred Culture Endocsopy / Gastro Project Build Update Travel Plan – verbal Allied Health Professions Forum Tobacco – Annual Update against the Plan (for noting) ** ***Monitoring*** Te Ara Whakawaiora / Smoking (national indicator) ** HB Clinical Research Committee Update Urgent Care Update Laboratory Services Committee Update CAG report update Annual Maori Plan Q1	Kate Coley Kate Coley Sharon Mason Sharon Mason Andy Phillips Caroline McElnay Caroline McElnay John Gommans Liz Stockley Kiri Bird Tae Richardson Tracee TeHuia
24 Nov	**HB Health Awards presentation evening**	**Venue to be confirmed**
7 Dec	Discussion - HB Workforce Plan Final - Renal Stage 4 Draft - Orthopaedic Review – Phase 2 Quality Imprmovement Programme ***Monitoring*** Health and Social Care Networks Update Urgent Care Update Clinical Pathways Committee CAG Report	John McKeefry Sharon Mason Andy Phillips Kate Coley Liz Stockley Liz Stockley Leigh White Tae Riachardson

OPERATION PRODUCTIVITY PRESENTATION

Rika Hentschel

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HAWKE'S BAY District Health Board Whakawāteatia	collaborative clinical pathways **Collaborative Clinical Pathways (CCP) Business Case 2016/2017**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author(s):	Mark Peterson, Chief Medical Officer Primary Care Leigh White, Portfolio Manager, Strategic Services
Reviewed by:	Members of the Clinical Pathways Committee; Strategic Services Manager Primary Care - Jill Garrett; Mary Wills – Head of Strategic Services; Executive Management Team
Month:	August 2016
Consideration:	For discussion

RECOMMENDATION

That Clinical Council

Discuss the Business Case "Collaborative Clinical Pathways" as approved for new investment funding 2016/17.

Note as the spend is greater than $250,000, process 4 requires prior approval by EMT.

EXECUTIVE SUMMARY

The Collaborative Clinical Pathways funding ($347K) has been approved by Clinical Council for the 2016/17 new investment application in principle but on notice for one year. The enclosed business case outlines further development of the CCP work programme and includes new budget items (including staff recruitment/employment and remuneration).

EMT have discussed the proposal and felt it was appropriate to take stock of the current position with Clinical Pathways and has recommended that Clinical Council consider the future direction of the Pathways.

OVERVIEW

The Integration of service provision across sectors and between service providers is a long term goal for the health system. This is a response to; a population living longer, high incidence of long term conditions inclusive of co- morbidities[1] and concerns over fragmented care.

[1] Chan & Webster, 2010; Bower, 2009; Ryall, 2007

There is an expectation from the Ministry that the DHB, inclusive of the wider health sector will support both the development and implementation of CCP for the following reasons:

- Generalist and specialist services will actively support integration and "move services closer to home"
- Sector engagement with an MDT approach will focus on a person's journey through the health system by having locally developed, agreed pathways supported by clinical oversight.
- Health journeys need to be "lean" ensuring right place and right time
- Consistency of services with a focus on equity is supported through recognised and agreed pathways of care.

Clinical Care Pathways (CCP), through the utilisation of a team of clinical advisors and the online tool - Map of Medicine (MoM), defines the work of a multidisciplinary team in relation to a particular condition so as to improve workflow, enhance engagement of local services and provide consistency in the management of a long term condition within our population base. The key role of the CCP work programme is to overcome systemic, professional, organisational and cultural barriers in order to ensure flow and equitable provision of high quality, clinically effective services[2].

To achieve optimum work flow and integration of services the following have been identified as key enablers;

- Knowledge of existing provision of services – DHB-PHO-NGO et.al.
- Strengthening of inter-service relationships
- Strong clinical input into pathway development
- Trust in and use of the online tool
- IT capability and capacity within and between services

All above areas identified are required for effective and sustained uptake of the pathways. Ideally this would lead to ongoing sustained CQI cycles of improvement led by the respective MDTs. Of note there have been the frustrations with the MoM tool and its functionality in regard to single sign on through Medtech and e-referrals, which we are nearing to correct. As of June 2016 we have single sign on and currently visiting general practices to update.

Given the expansion in CCPs and their increasing predicted influence on change, it is important to continue to have dedicated resource in their development, production, implementation and socialisation. Anecdotal, feedback states that health professionals' gain value from round table discussions with a function of networking and problem solving issues relating to integration of services. Whilst this model is ideal it adds additional pressure to existing workloads and commitments of the clinical workforce. To mitigate this the following alternative model is proposed (Option 3 refer to page 12/29);

- To employ a General Practitioner, Clinical Lead with specific responsibilities for the development of the pathways
- Utilise a multidisciplinary approach inclusive of a range of appropriate health disciplines
- Dedicate a "pool" of money from which primary care clinicians can claim for time to attend meetings in an advisory capacity. This input is offset by;
    - Employment of a GP Clinical Lead and Facilitator/Editors who will be in engaged in research and development of the pathways and the creating of the initial drafts, benefits and realisation tools.
    - Reduce the integrated round the table meetings from 5 to 3.

[2] Vanhaecht, et al., 2006; Rotter et al., 2007

Collaborative Clinical Pathways Business Case 2016/207

Written by:
Leigh White
Portfolio Manager
Long Term Conditions

Table of Contents

1.0 Background

Current Situation / Problem

Hawke's Bay faces health and social challenges: increasing demand and expectations from an aging population, the increasing number of people with complex long term conditions, our large high needs population tracks pervasive inequalities both in access and outcomes, publically-funded budgets that in real terms are static, and our distance from major cities poses challenges for attracting and retaining a skilled workforce to replace the aging Specialist and GP cohort of clinicians. Rural vs urban issues also have an impact on services delivery and workforce attraction and retention.

Solutions to these challenges are multi-dimensional, but include; standardising treatment for the majority of people for which this approach is appropriate, clarifying triage and access criteria so that those who will most benefit receive treatment preferentially and ensuring that people receive treatment optimally (right service, right time, right place).

2.0 Situational Overview

2.1 *Overview*

Collaborative Clinical Care Pathways are designed to meet the needs of health care professionals, the person and their carers/family/whanau by providing an up-to-date, localised, evidence-based overview of the standard of care that can be offered following an assessment or diagnosis.

2.2 *Drivers of change*

- increasing presentation rates at Emergency Department
- need for equity of access to quality health care
- reduction of acute presentations, with corresponding reduction in unplanned care
- the need for transformational change to reduce barriers to access, reduce cost, provide effective care and enable specialist services to focus on the person with more complex needs
- shift to right level of care, right person, right place, at the right time
- improvement of the person's experience and quality of life.

Pathways are about service orientating, making the architecture fit the ground around us, some tweaking from regional to local and looking at change processes of allocating resources and priorities closer to clinicians and the person's home

2.3 *Strategic Alignment*

In 2013 HBDHB Clinical Council agreed to sponsor the establishment of CCP as a key initiative to address some of the challenges outlined in the Hawke's Bay DHB's Transform and Sustain strategic framework.

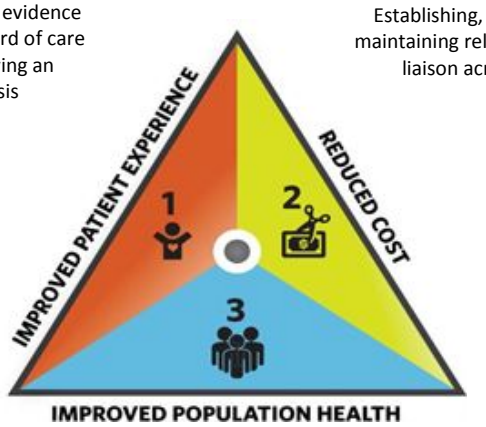
The aim of all pathway development is to target health inequities and the consequences of those inequities throughout the person's health journey. This process includes:

- an overview of known inequities
- basic data/statistics on the issue by ethnic group; not just for the total population
- an approach to addressing inequities with a focus on what individual clinicians can do
- evidence on ways to address inequities where data[3] is available.

CCP is incorporated in the Hawke's Bay DHB and Health Hawke's Bay Annual Plan and Statements of Intent and meets triple aim outcomes by:

Speeding up referrals to definite care
Proving up-to-date, localised evidence based overview of the standard of care that can be offered following an assessment or diagnosis

Lowering cots
Establishing, strengthening and maintaining relationships for better liaison across the system



Help with reducing inequities
Ensure that the person gets the right care as quickly as possible no matter which part of the **system they** access

CCP aligns to the New Zealand Health Strategy by:

- taking a population health system wide approach to addressing long term conditions (Smart system)
- taking into account the determinants of health which impact on a patients clinical journey to health and well-being (People powered)
- gaining the best value from the resources made available to the public health system through efficient flow of services and appropriate investment /disinvest (Closer to home)
- working in partnership and promoting a one team approach to care. (One team)

[3]Data includes both qualitative and quantitative data

- providing clinician led guidance informed by best practice models. (Value and high performance).

2.4 *Benefit Aims and examples*

Having clinician-led processes (setting it apart from other pathway projects) has benefits of shared ownership leading to better buy-in for implementation and partnership of vision to reduce inequities, faster referrals to definitive care, improved health outcomes, lowered costs and what is the best outcome for the person. The range of benefits fit into five categories – strategic, person, primary care, secondary care and system wide benefits.

1. **Strategic benefits.**
   Benefits should be expected when a change is conceived and then realised as a result of activities undertaken to effectuate that change. *(Refer to Appendix 5 Overview of Benefits Map Summary).*

   The CCP work programme is often challenged with what are the quantifiable and measurable improvement outcomes in terms of costs and resource.

Examples of benefits/impacts:

- *opportunities to improve how health and disability care is planned and delivered within the district to improve person access to a wider range of health services that are both closer to home and reduce avoidable hospital admissions (reduce waste, best treatment options, adding value)*
- *health professionals have access to best practice, evidence-based clinical pathways that are available at the point of care. All pathways have a standard format for their content (quality audit, evidence based (UK, NICE).strengthen primary care with an emphasis on early intervention*
- *build capability and capacity in primary care (e.g. Community Primary Options).*
- *provide equitable access to quality healthcare*
- *identify the best location for interventions, in terms of cost efficiency*
- *codify referral expectations (criteria and prior interventions) to ensure resources are focused on those who will benefit most, within budget and Government waiting time expectations.*
- *assist in attaining DHB and PHO performance targets by specifying best practice for interventions that align with governance expectations.*
- *support HBDHB vision - Tauwhiro – delivering high quality care to patients and consumers - and Raranga Te Tira – working in partnership across the community.*

2. **Benefits for the person:** Pathways specifying actions can add value to the person's journey (doing 'the right thing at the right time') however, other enablers include an improved ability to plan care that draws upon the wealth of resources and knowledge across all care settings, and access to information that engages them to take an active role in their care, including self-management and escalation prevention.

   Whilst health consumers may not directly access the CCP they can expect that expenditure and effort is focused on areas that will provide the most benefit.

   Key issues for success:

- gaining buy-in through empowerment and collaboration by ensuring there is open communication
- usability of the IT tool
- robust budgeting and cost control
- impacts that are positively on the person's experience in terms of waiting times, length of stay, access to procedures, choice and empowerment

An example: A person visiting the GP with a diagnosis of Vertigo. In many cases these types of conditions would be referred to the Emergency Department now the Map outlines options for the GP and the person. A referral can be made to a Physiotherapist (closest to the person's home) for ongoing management (Link: Vertigo Pathway).

3. **Benefits for Primary Care:** Streamlined work flows and easy access to up-to-date best practice knowledge. Having the ability of a clear criterion for referrals to specialist services whilst providing alternative actions for those who do not meet criteria is cited as a major benefit. More generally, pathways can act as a reminder of best practice for younger/locum staff regarding conditions or a set of symptoms that they may rarely see. The pathways also present opportunities for workforce development by specifying that some activities previously dealt with in the secondary sector could and should be addressed by the up-skilled primary sector.

An example: A person who presents to general practice with a Deep Vein Thrombosis (DVT). As part of socialising the DVT pathway, GPs were given clear instructions regarding not to refer to ED for a DVT ultrasound on a Friday – the Map outlines suggested process and specific management of what can occur over the weekend.

4. **Benefits for Secondary Care:** Clear criteria for referrals will facilitate quicker access for First Specialist Assessments (FSA). Pathways can change work flow, along with building efficiencies in terms of how specialist resources can be better utilised so as to effectuate outcomes at a population health level.

An example: Within a developed map: if a referral to a service is required, it will state what criteria is required from secondary care to assist with triaging.

5. **System benefits**: improved communication between primary and secondary care clinicians and the interaction of the multidisciplinary and multi-agency team development leads to enhanced cohesiveness, coordination and integration of care. What is also highlighted are any bottlenecks, unnecessary duplications with resulting agreement of streamlining and synchronisation and tailoring to fit the specific needs of demographics within our population.

An example: Copy of email from Mark (ED Consultant) regarding TIA pathway: "Hi Raewyn, this looks very comprehensive and covers all the options. Clear delineation of high risk group requiring referral to hospital and low risk group who can be managed appropriately in primary care. Also great to include the Stroke SMO contact details for discussion and also for advice regarding outpatient follow-up or investigation. Kind regards, Mark".

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2.5 *HBDHB CCP Programme*

The Collaborative Clinical Pathways programme has been in operation for over three years *(Refer to Terms of Reference Appendix 2 and Stocktake to date Appendix 3)*. MoM was selected as the preferred pathway solution for use in Hawke's Bay. Map of Medicine is a United Kingdom (UK)-based software company and is also the preferred pathway solution for eight district health boards (DHBs) in New Zealand.

Map of Medicine Value Statement

Map of Medicine enables DHBs to reduce the variation in healthcare delivered to patients and reduce the volume of inappropriate referrals across their local health economy.

Map of Medicine provides DHBs with access to a repository of evidence-based best practice care maps. Our content can be localised by DHBs to reflect local practice and referral requirements using our unique content tools, thereby driving GP adoption. This content can be delivered within the end-user clinical workflow seamless integration, all within a few clicks of the mouse. Map of Medicine also provides professional and editorial services that accelerate the speed with which DHBs can realise benefits.

The development, implementation, and refinement of collaborative clinical pathways have been clinically led, having a nominated clinical lead from primary and secondary care. The pathways cannot be developed in isolation or by one or other sectors if they are to be used effectively. It is essential that all sectors are involved in the pathway development and implementation, both from a clinical perspective and an equity issues for consumers being able to access – the best and most appropriate care in the right setting. In time utilisation of the pathways will lead to service and system wide improvements in cost reductions, improved patient experience and improved population health outcomes.

To date, progress has been significant with regards to the number of pathways developed and the enthusiasm of participants and those wanting to know more *(refer to Appendix 3: Stocktake).* We now have clinicians from a number of backgrounds (primary, secondary, home care services, private hospital) requesting to have access to the Map of Medicine (MoM). As of June 2016 we are now able to complete back-end monitoring of use *(refer to Appendix 4: Back-end Monitoring examples)* which should lead to more targeted support for staff utilising the tool and a more efficient use of the e-referral system which at times has been frustrating due to the compatibilities between MOM-Medtech and or My Practice.

Remuneration is an ongoing challenge for CCP development and implementation, as clinical input is needed but the availability of clinical advisers limited due to their own work commitments and obligations.

Some success stories:

- COPD Pathways – well adopted by the Respiratory Services. Having resilient clinical leadership by Clinical Nurse Specialist to socialise in all sectors has contributed to its success.
- DVT Pathway – relationship with Diagnostics with regards access and support if work up is complete. Our visiting Haematologist gave up time to educate at CME session which was well attended and received – *"Very well presented, accurate, relevant and engaging. Very glad I came".*
- Diabetic Pathways – we will take time to get it right – despite the time spent developing this pathway it was noted that the pathway may have been socialised but not implemented for use in primary care. Negotiation has occurred and we are working and reviewing the pathways with the aim to socialise with the specialist service CNSs who now work in primary care.
- Collegial relationship and support with Mid-central and Whanganui.
- The small team has worked hard and diligently to ensure that we are gaining standardisation of development with all pathways – we have a strong focus on health literacy and within all our pathways we have some generic (adopted) nodes, e.g. Level of Understanding and Engagement as below

The person: familiarity with medical terminology and knowledge; language of origin; hearing impairment; cultural background and belief systems; anxiety or extreme emotional intensity; issues regarding understanding and engagement.
The barriers to effective care: factors that could stop the person from getting further tests or treatments; whanau, family and social network dynamics; whanau support; family history; costs, transport, dependents; work responsibilities; community engagement and/or obligations, responsibilities; locality and geographical access to health and hospital services; socio-economic factors including source of income; appropriate support.

2.6 *HBDHB CCP Programme - Resources*

The Collaborative Clinical Pathways Team (CCP Team) is:

Responsible to:

- Clinical Pathways Committee (*Refer to Appendix 2: Terms of Reference)*
- Head of Strategic Services
- Management and co-ordination under the auspices of Strategic Services
    - Operational support by Strategic Services Manager Primary Care
    - Programme management support by Portfolio Manager Long Term Conditions

Current support:

- 0.4 (16 hours per week) FTE Health Hawkes Bay - administrator and editors responsibilities
- 0.4 (16 hours per week) FTE HBDHB - administrator and editors responsibilities
- Additional to their current HBDHB workloads: two trained editors
- Fee for Service: trained editors/facilitators
- Health personnel participation – to date has been paid on fee for service hourly rates
- Strong relationships with Mid-Central and Whanganui DHB
- Advisory: Central Region Governance Working Group
- Advisory: Chief Medical Officer Primary Care

3.0 Options Analysis

3.1 *Option 1: Build on current work – acknowledging "on notice" for one year – voluntary input by clinicians*

It is generally accepted that the current state of Hawke's Bay's health system is not sustainable in the medium-to-long term and rising costs and demands together with static budgets means that some action is required if we are to continue to meet reasonable expectations of person centred care.

Restrained funding and lack of clinical support will mean work and progress will be affected with the risk of the work ceasing, and the current system being mothballed.

3.2 *Option 2: Build on current work – acknowledging "on notice" for one year - employ GP lead*

Continue with business as usual. Current IT issues are being addressed. Work with the strong track record that MoM has in the sector and its focus on evidence-based best practice.[4] MoM has been implemented by two DHBs; Mid-Central and Whanganui DHBs, with whom we most closely work. The model of care adopted by Midlands also utilises MoM and it is model of care being closely looked at by the primary sector. All of these connections provide shared opportunities for promoting best practice models and the ability to share costs and resources.

[4] Evidence based best practice is based on the NICE guidelines which are recognised both nationally and internationally. The NICE guidelines are ……

This option includes the following:

- Appoint a GP as "CCP Clinical Lead", not a nurse. When it comes to engaging with secondary care specialists to whom to refer, it is hugely beneficial for a doctor to talk to a doctor (*Refer to Appendix 5 for draft concept).*
- Work with as few people as possible to avoid crossed wires (small facilitation and editing group).
- Reduce the integrated round the table meetings from 5 to 3 for greater efficiencies in time and resources used to complete a pathway.

Risk
Feedback states that health professionals' gain value of around the table discussion where not only do they learn off each other but they also solve the road blocks to achieve integration. If we continue with a work programme that is not supported by primary care we will continue to fail as primary care clinicians need to be intricately involved in the creation of pathways. Primary care and other health professionals e.g. Pharmacists have voiced they won't participate unless they have money to compensate them for the time they have to spend out of the workplace.

3.3 *Option 3: Build on current work – acknowledging "on notice" for one year – Employ GP lead and remuneration for other health professionals*

Continue with business as usual but this option suggests the following:

- Appoint a GP as "CCP Clinical Lead", not a nurse. When it comes to engaging with secondary care specialists for referrals, it is hugely beneficial for a doctor to talk to a doctor.
- Work with as few people as possible to avoid crossed wires (small facilitation and editing group).
- Dedicate a "pool" of money from which primary care clinicians can claim for time to attend meetings in an advisory capacity. This input is offset by;
    - Employment of a GP Clinical Lead and Facilitator/Editors who will be in engaged in research and development of the pathways and the creating of the initial drafts, benefits and realisation tools.
    - Reduce the integrated round the table meetings from 5 to 3.

3.4 Note *Appendix 6.* ***Work Plan for 2016/2017***. Adjustments may need to be made once decisions have occurred.

3.5 *Risk Profile*

Highest risk: Summative.

- Sectoral concerns and suspicions regarding the monopoly of Medtech and the interface they have with MoM in general practice.
- Potential for Primary Care to 'create hard copy resource' of maps in preference to using on line tool and therefore not keeping updated on changes and improvements (clinical and administrative)
- Lack of sustained clinical leadership and collegial DHB support; both HBDHB and from our central DHBs leading to lack of unity when working through issues.
- Friction and tensions created through poorly supported communication strategy to address-queries, use of advanced forms, IT access and engagement across and within the sectors.

Refer to Appendix 6 for Risk Analysis.

4.0 Funding Comparisons:

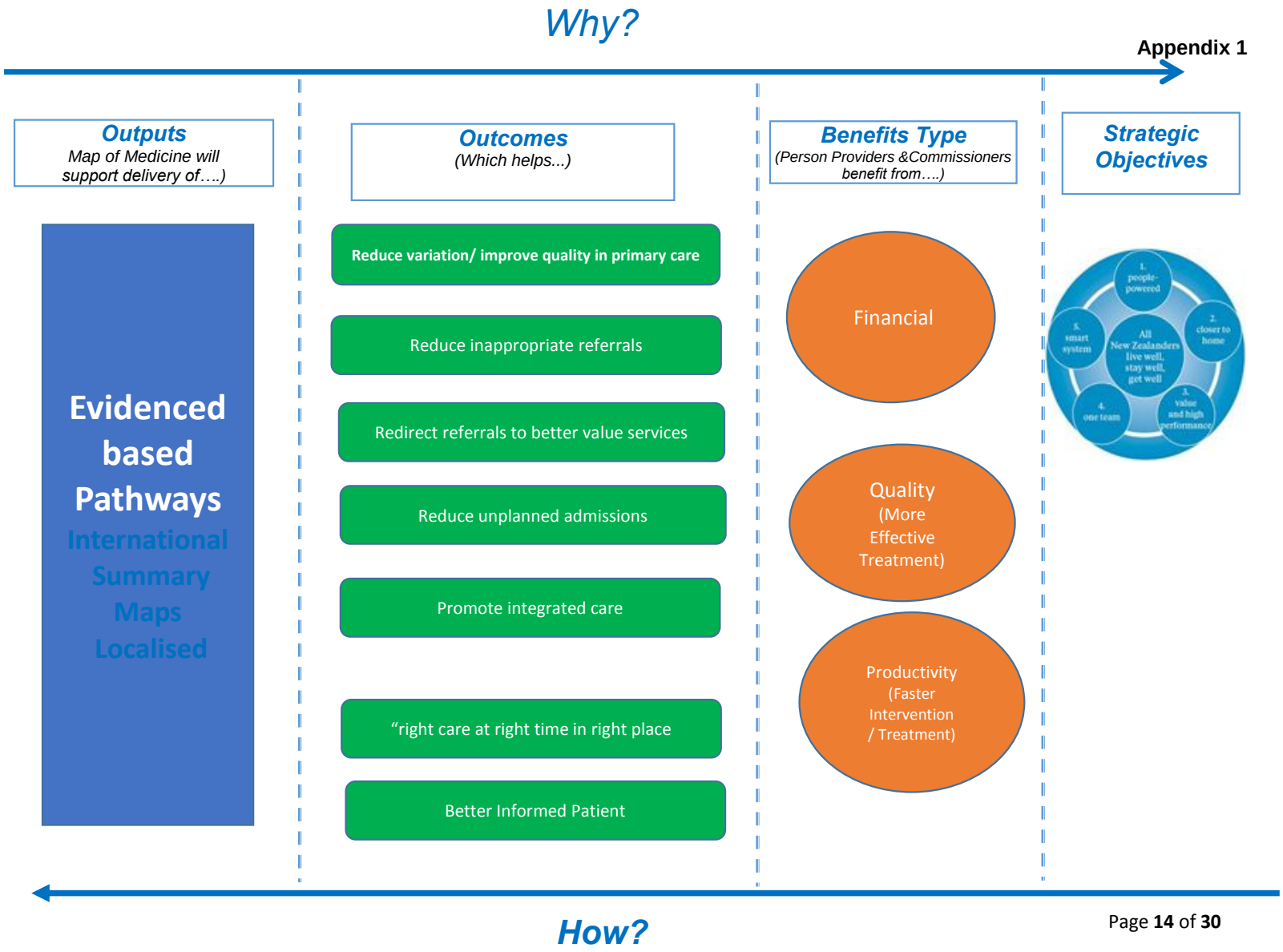
To date: 18 Published/10 Under-development *(Note 1 map can equal 1 pathway or 5 pathways in 1).*
Work Plan: to continue to maintain those and 25 new pathways per year

		Option 1	Option 2	Option 3
Bid $375k	**Internal Costs**	**Programme Costs**	**Programme Costs**	**Programme Costs**
Leadership and Management				
Clinical Pathways Project Lead	1.0 FTE			
Internal Staff Support & Other Costs		6,500	6,500	6,500
GP Champion (0.1 FTE) (Outsourced)			24,000	24,000
Project Support Costs		5,000	5,000	5,000
		11,500	**35,500**	**35,500**
Maintenance				
Editing (0.2 FTE)		26,991	26,991	26,991
Editing (outsourced)		38,400	38,400	38,400
External Facilitator/Editor (Fee for Service)		8,000	8,000	8,000
Ongoing Training		3,500	3,500	3,500
		76,891	**76,891**	**76,891**
Infrastructure				
Map of Medicine Licence Fees		60,000	60,000	60,000
Publishing Fees		26,250	26,250	26,250
Map of Medicine Annual Fee	Publishing & Support			
Software changes (Med Tech/My practice)		45,000	45,000	45,000
		131,250	**131,250**	**131,250**
Clinical Engagement				
Pharmacy, Allied Health, ARC	MDT			23,063
Hospital Staff				
Facilitation & Catering		**5,000**	**5,000**	**3,750**
Venue Hire	Hosp or Community			
Education and Socialisation		5,000	5,000	5,000
		10,000	**10,000**	**31,813**
Innovation				
Redesign, service development*		100,000	100,000	100,000
		100,000	**100,000**	**100,000**
TOTAL		**329,641**	**353,641**	**375,454**

Option 1: Status quo ($329,641)
Option 2: Add in clinical lead and reduce pathway meetings ($353,641)
Option 3: Add in clinical lead/reduce pathway meetings/ remuneration (buy-in) ($375,454)

Major risks: Implications of lack of buy-in GPs
Potential risks: Software charges, Mid-central charging for UK Publishing
***Redesign, service development** - gives the opportunity for a discretionary fund to meet inequities e.g. the person with chest infection but does not meet criteria to go to ED and cannot afford private costs

Appendix 1


Why?
Outputs
Map of Medicine will support delivery of….)
Outcomes
(Which helps...)
Benefits Type
(Person Providers &Commissioners benefit from….)
Strategic Objectives
Evidenced based Pathways
International
Summary
Maps
Localised
Reduce variation/ improve quality in primary care
Reduce inappropriate referrals
Redirect referrals to better value services
Reduce unplanned admissions
Promote integrated care
"right care at right time in right place
Better Informed Patient
Financial
Quality (More Effective Treatment)
Productivity (Faster Intervention / Treatment)
1. people-powered
2. closer to home
3. value and high performance
4. one team
5. smart system
All New Zealanders live well, stay well, get well
How?

Appendix 2

OURHEALTH HAWKE'S BAY Whakawateatia

TERMS OF REFERENCE

Clinical Pathways Committee

July 2015

Purpose	The Hawke's Bay Clinical Pathways Committee champions, co-ordinates, governs and approves the development and maintenance of specific clinical pathways on behalf of the Hawke's Bay Clinical Council (Clinical Council), and provides advice to the Clinical Council on process, resource requirements, priorities and all other relevant issues relating to the development, approval, maintenance and implementation of clinical pathways within Hawke's Bay.
Functions	The functions of the Committee are: • To advise Clinical Council on: - Priorities for clinical pathway development - System, process, structures and resource requirements to effectively implement clinical pathways in Hawke's Bay. • To approve on behalf of Clinical Council: - The development of new clinical pathways - The maintenance of existing clinical pathways. • To report to Clinical Council on: - New clinical pathways approved - Amendments to existing clinical pathway - The effectiveness, efficiency and benefits of the operation of clinical pathways within Hawke's Bay. • To engage the Hawke's Bay clinical community to gain commitment to the clinical pathways concept and programme.
Level of Authority	The Committee is a committee of the Clinical Council and has the authority to: • Approve new and amended clinical pathways for implementation • Advise, make recommendations and report to Clinical Council on general matters relating to clinical pathways. • Oversee and direct the activities of any "management" resource engaged to facilitate or support the development, maintenance and implementation of clinical pathways within Hawke's Bay.

Membership	• CMO - Primary Care • CMO - Hospital • CNO • Director of Allied Health • Head of Strategic Services – HBDHB • Health Hawke's Bay Limited - Representative • Hawke's Bay Health Consumer Council - Representative • HBDHB Māori Health Services - Representative Clinical Council will appoint the representatives of Health Hawke's Bay Limited, the Hawkes Bay Health Consumer Council and HBDHB Maori Health Services based on nominations formally received for such appointment. Members may authorise appropriate alternates to attend meetings or respond to issues on their behalf, should they be unable to do so in person.
Chairperson	CMO - Primary Care.
Quorum	The quorum will be six (6).
Meetings	Meetings will be held as required, but at least quarterly. Issues may be dealt with via email between meetings.
Reporting	The Committee will formally report to Clinical Council following each Committee meeting and, if necessary between meetings, should a decision or guidance be required.
Minutes	Secretarial support will be provided by the PA to the CMO – Primary Care. Minutes will be circulated to all members within one week of the meeting taking place.
Terms of Reference Review	These Terms of Reference are adopted by Hawke's Bay Clinical Council and will be reviewed every two years, or more frequently as required.

Appendix 3

7

Stocktake of work programme to date with comments

- ✓ Single sign on through MedTech system has been accomplished – now visiting GPs face to face to explain application and another tour around the Map of medicine framework
- ✓ Interim budget *(met and concept paper written and submitted for 2016/17 budget rounds)*
- ✓ Changes to personnel changed *(New Facilitators/Editors requiring supervision and education)*
- ✓ Technology –internal issues sorted *(International issues unresolved despite challenges)*
- ✓ Processes defined and redefined *(improving quality systems - standardisation of work practice)*
- ✓ Relationship building with Mid-central and Whanganui *(sharing of tools and knowledge)*
- ✓ Regional links with Shared Governance *(sharing, collective frustrations)*
- ✓ Relationship with United Kingdom *(trying to be supportive)*
- ✓ Impact of Service delivery to meet Annual Planning *(CCP seem to be answerable?)*
- ✓ Demand versus supply *(the work behind the scenes)*
- ✓ Faster Cancer Streams *(shared Facilitation)*
- ✓ Impact of national work *(e.g. Hepatitis C pathways – keeping abreast with timeframes)*
- ✓ Consumer input *(QA team, now resourced to capture consumer stories but need to connect as the pathways are clinical for specific disease or problem categories).*
- ✓ Māori health *(support to develop generic node)*
- ✓ Pacific health *(support to develop generic node)*
- ✓ Clinical Champions *(time limited)*
- ✓ Working groups *(bringing together a multidisciplinary clinical group but with limitations)*
- ✓ Data gaps *(don't have the data to support process, but success with support for Business Intelligence teams _ DHB and PHO)*
- ✓ Employment of Strategic Service Manager-Primary Care
- ✓ General Practice *(impact)*
- ✓ Support from IT *(assisted to work through internal process of firewalls and platforms)*

The experiences of participants – qualitative report

- ✓ *"It is good to get representatives from primary, secondary, community, pharmacists in the same room, and talking face to face."*
- ✓ *"There is potential to improve clinician understanding and communication of how each other work."*
- ✓ *"I have been approached to present our Pathways at the regional meeting next month as we have been acknowledging for our pathways."*
- ✓ *"The great thing is that it does get both primary and secondary together, and talking."*
- ✓ *" It's nice to see people face-to-face, actually, rather than email."*
- ✓ *"Looking to see how you can do something better is always a good thing."*
- ✓ *"My colleague told me that "a referral to Older Person Mental health Service was denied as incorrect information was on the referral according to what is agreed via the Map of Medicine Dementia Pathway."*

Socialisations

- ✓ Average 3 requests per week for user login/passwords to access Map of Medicine *(Multi-disciplinary – this demonstrates interest).*
- ✓ Presentations to: *(Clinical Nurse Specialist Forum; PHO Senior Nurse and Management Forums and Home Care Provider, New Secondary Care Doctors. Presentation planned for Nursing and Midwifery Council).*
- ✓ CME/CNE Sessions: *(planned for year but also planning a Cardiology evening in June and a Diabetic evening in July)*
- ✓ Updates of Maps: *(advertised within HBDHB Staff News and HHB portals)*
- ✓ Central Region Governance: *(x 2 meeting this year – review of TORs)*
- ✓ Face to face with UK: *(x 1 meeting 2016:discussion: Technology, Quality Initiatives and now initial stages working to develop Return on Investment and also back-end monitoring)*

Quality Initiatives

- ✓ Development of HBDHB Glossary of "how to do" (*commenced to assist with new staff)*
- ✓ Standardisation of nodes within the pathway (*e.g. understanding and engagement (inclusive of applying HEAT Tool , Advanced Care Planning, Consumer node inclusive)*
- ✓ Consumer input: (*work with Quality Team to gain support from focus groups – specifically high need low access client demographic)*
- ✓ Work to commence on an overarching "Self-Management Approach Pathway" based on consumerism, individualism, person-centred and empowerment. "Not all people with a long term condition need to be managed. The can manage their own health needs if educated on the "how" and "when to ask".

Pathway development	**Off track**	**On track with issues**	**On track**

There is a number of HBDHB pathways at differing developmental stages (refer to dashboard and overall summary attached). It must be noted – that a pathway may have a number of pathways within the diagnosis e.g. Asthma = 5 differing pathways.

- ✓ Shared costs: £ 166.00 (inclusive of cancer streams)
- ✓ Stand-alone costs: £ 500.00
- ✓ Annual hosting/access rights (Est: 60-70,000)
- ✓ Portfolio Manager: attendance to Maori Health Priorities Summer School and HEAT tool education

Appendix 3

Dashboard: **Collaborative Clinical Pathways progress – Update June 2016**

Pathway e.g. 1:4 – 4 pathways under one heading e.g. c/date: commencement date e.g. p/date: published date	**Shaded denotes progress to date:** 1: In developmental phases 2: Published and advertised 3: Socialised (circulated and advertised and/or educated) 4. For review	**Clinical Leads**	**Measure of success**	**Estimated costs (non inclusive of Publishing)** **(-) number of sessions** ***Shared Publish costs** ****Stand-alone Publish costs**
Last Days of Life 1:1 C/date:06/2016	1 + 2 + 3 = 4	L. Twigley M. Peterson	Support new practice	* ?
Colorectal 1:4 C/date:05/2016	1 + 2 + 3 = 4	T. Boswell D. Rogers	Align to Faster Cancer Streams	*Central Region $900 (3) to date
Lung Cancer 1:1 C/date:03/2016 P/date: 05/2016	1 + 2 + 3 = 4	L. King	Align to Faster Cancer Streams	*Central Region $360 (3) to date
Community Acquired Pneumonia C/date:03/2016	1 + 2 + 3 = 4	J. Curtis D. Smith	Reduce ASH CPO Focus Standardised prescibing	* $1656 (3) to date
Cellulitis (CPO) C/date:03/2016	1 + 2 + 3 = 4	E. Burns A Wright	Reduce ASH CPO Focus Change of prescibing	* $900 to date
Primary Care Management of Acute TIA 1:1 C/date:06/2016 P/date: 06/2016	1 + 2 + 3 = 4	C. Providence D. Rogers	Standardised referral Access to Diagnostics Standardised practice Alert for Thyrombolis	* $1800 (5) to date
Diabetes with focus on ARC – **ON HOLD**	1 + 2 + 3 = 4	T. Speeding D. Vicary	Align with ARC Guidleines currently for review	* Nil
Vertigo 1: 1 C/date:11/2015 P/date: 05/2016	1 + 2 + 3 = 4	P. Mason A. Wright	Reduced FSA Use of Physio	** $2750 (5)
Congestive Heart Failure 1:4 C/date:11/2015 P/date: 06/2016	1 + 2 + 3 = 4	K. Dyson GP The DDs	Standardised prescibing	*$1760 (4 sesions
Diabetic Foot Ulcer 1:1 C/date:11/2015 P/date: 05/2016	1 + 2 + 3 = 4	Healthy Feet Podiatrist	Align with new Podiatry Contract	*
Obstructive Sleep Assessment 1:1 C/date:11/2015	1 + 2 + 3 = 4	DHB Sleep Scientist	Support Respiratory Service Criteria Access	** $560 (4)

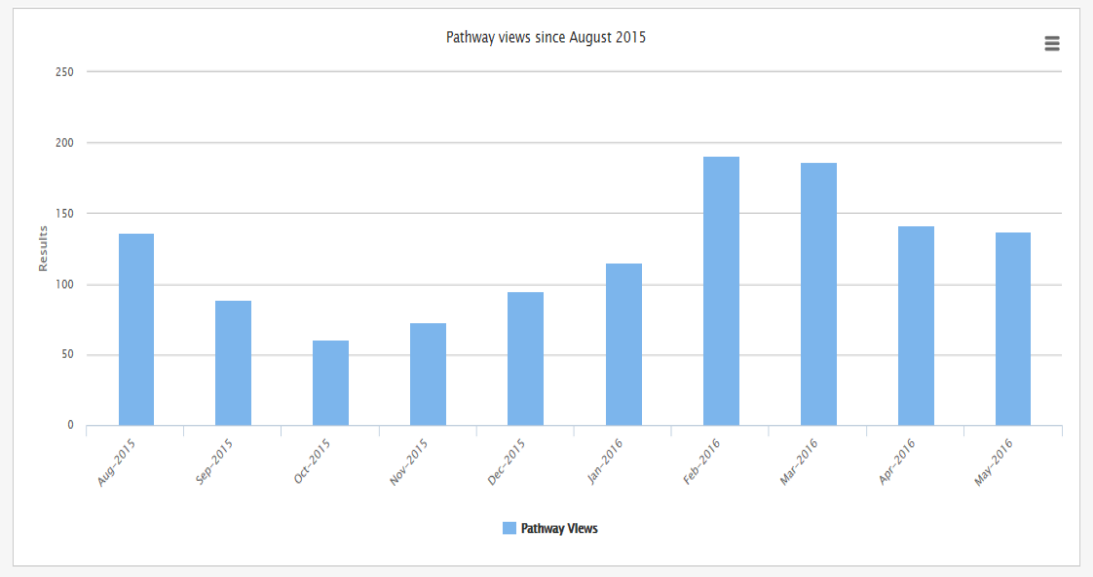
P/date: 01/2016				
Thyroid C/date:11/2015 P/date: TBC		R. Leikis N. Smuts	Reduced FSA Reduce F/Up OPD	** $2680 (4)
PVD Lower Limb 1:1 C/date:11/2015		NP: Fiona	Timeliness of referals to right place	** $1760 (4)
Urinary Incontinence 1:4 C/date:02/2016 P/date: TBC		L. Fergus N. Smuts	Standardised referral criteria to Incontinenance Service	* $2680 (4)
DVT 1:1 C/date:09/2015 P/date: 01/2016		A. Wright S. Payne	Reduced ED assessments Reduced Diagnositic access Medication Prescribing	* $1200 (4)
Services for Older Person C/date:09/2015 P/date: 12/2015		L. White M. Peterson	Cental access (Multi-Disciplianry) to support Engage Process – outcome of UCA Proesses	** Nil
Asthma **Adults:** 1:2 C/date:08/2015 P/date: 01/2016 **Children**: 1:3 C/date:08/2015 P/date: 01/2016		Paeds: N. Durnphy Adult: S. Ward	Child and Adults Reduced admissions Length of Stay Medication Prescribing	* $3170 (4) To date
Osteoporosis 1:1 C/date:08/2015 P/date: 01/2016		D. Gardner	Presented at Grand Round DEXA Medication Management	* $2760 (4)
Atrial Fibrillation 1:1 C/date:08/2015 P/date: 12/2015		K. Dyson	Reduced admissions Length of Stay	* $1870 (4)
Assessment of Chest Pain 1:1 C/date:08/2015 P/date: 11/2015		K. Dyson	Reduced admissions Length of Stay	* $1870 (4)
COPD 1:3 C/date:07/2015 P/date: 01/2016		S. Ward Breathe HB	Reduced admissions Reduce Length of Stay Reduced Spirometry Supporting Pracice – interface with GASP	* ?
Gout 1:1 C/date:07/2015 P/date: 12/2015			High number of Māori CME sessioin booked	** ?
Smoking cessation 1:1 C/date:07/2015 P/date: 10/2015		K. Moriatry	Links with multiple pathways	*?
Rhinosinusitis 1:1 C/date:07/2015			TAS Link Standardised Practice	**?

P/date: ?/2015				
Dementia 1:2 C/date:07/2015 P/date: 07/2015		E. Plesner Dr Cullen	Advanced Form CME session planned (05/16) – Capacity Assessment	*?
Diabetes 1:8 C/date:? P/date: 11/2014			Organised for Review (April)	*?
Osteoarthritic Hip/Knee 1:2 C/date:? P/date: 09/2014			On hold – changes with Orthopaedic Service – Redesign	*?
Skin Lesions 1:1 C/date:? P/date: 01/2015			On hold – Impact on Elective Services	*?
Melanoma 1: 1 C/date:? P/date: 09/2014			On hold – Impact on Elective Services	*?

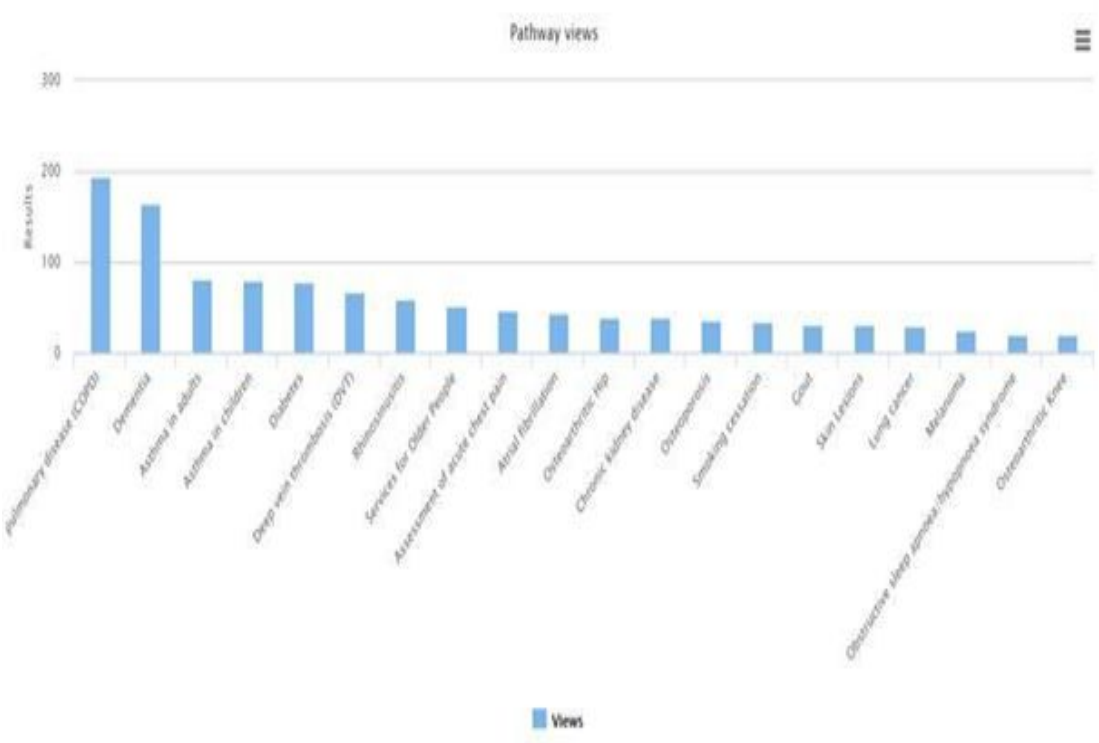
Appendix 4

Examples of back-end monitoring

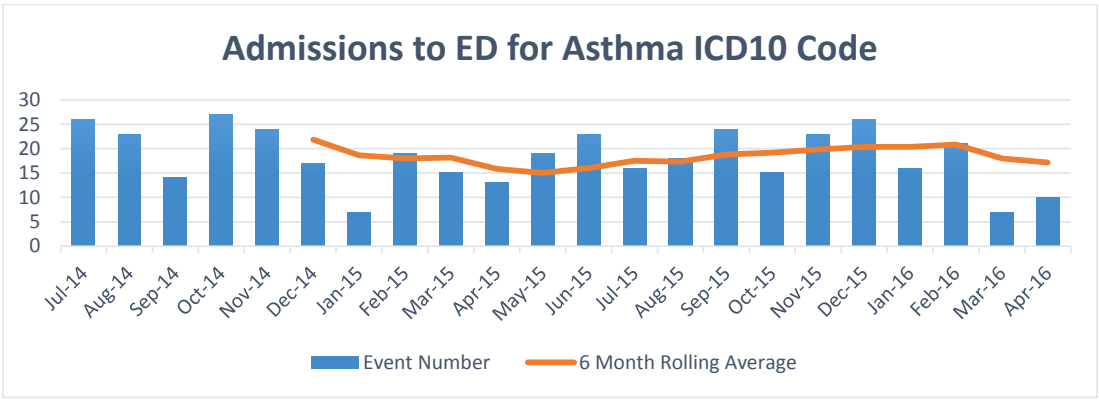
Access (number of) of pathways – 08/2015-May2016



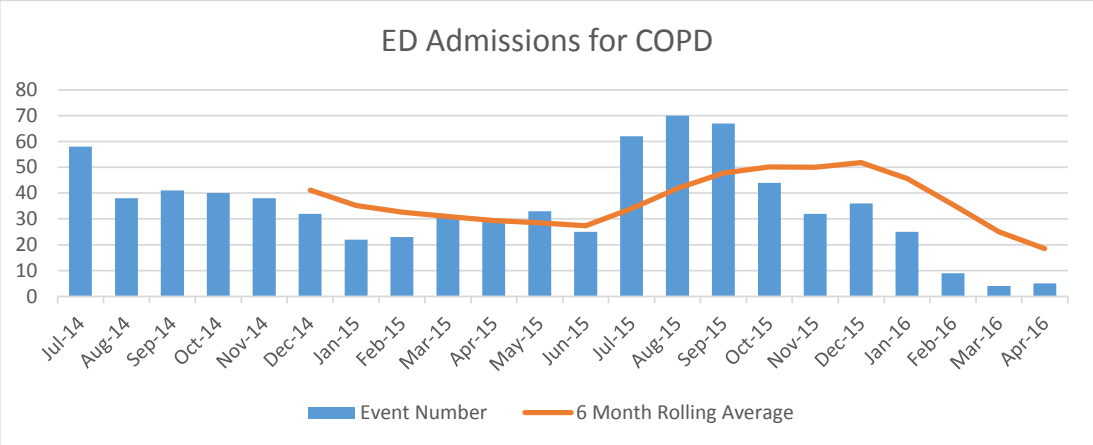
Pathway access from August 2015-May 2016 – accruing to diagnostic groupings



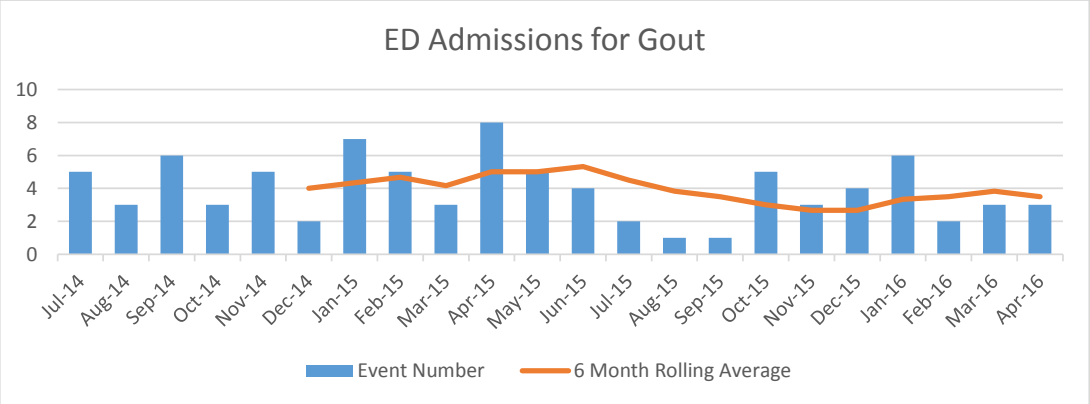
Examples of admissions for certain pathways – using HBDHB data analysis



Pathway introduced: 01/2016



Pathway introduced: 01/2016



Pathway introduced: 12/2015

Appendix 5

COLLOBORATIVE CLINICAL PATHWYAS
CLINICAL LEADERSHIP FUNDING - PROPOSAL - DRAFT

PROPOSED TIME: 0.1 FTE (4 hours per week)
PROPOSED COST: $24,000 (40 Weeks @ 4 hours per week)

BACKGROUND AND PROJECT OBJECTIVES

CCP are a key focus with aims to reduce barriers so all people are able to access the same quality care within the same timeframes, irrespective of their ethnicity, gender, locality or socio-economic status.

Pathway development to date has seen minimal engagement from general practice. General Practitioners, Nurse Practitioners and Practice Nurses play a significant role in the development and implementation process. Given the scope of the person's journey, it's essential a combination of primary and secondary care perspectives are factored into a pathway as the services are complimentary – if either is absent, it jeopardises the project and ultimately, the contractual requirements and deliverables are at risk. We've identified possible contributing factors e.g. time (too busy), financial loss (meetings held within practice hours) and other commitments (participation on other clinical pathways either current or previous).

CLINICAL LEADERSHIP ROLE INVESTMENT (General Practice)

Pathways are designed and targeted for use in general practice. Investing in a clinical leadership role to champion cancer pathways will provide multiple benefits for the person and other clinicians for example;

- improving collaborative communication, relationships and networks
- identify, improve and implement equity gaps within the system
- improving the referral process (establishing referral criteria together with consultants)
- sharing successful solutions
- professional development (working together/MOPS points)
- improving access to person support services
- identifying systemic areas of improvement and change
- promoting and educating the use of Map of Medicine as a clinical resource tool of best practice and guidance to their peers
- peer support

Criteria for role - Principal duties and responsibilities

- Compulsory attendance of all meetings
- Adherence to project timetable

- Provides active leadership, strategic direction and advice to facilitate the development, implementation and refinement of pathway/s
- Contributes to the equity analysis process and application of the HEAT Assessment Tool
- Provides skilled clinical expertise into the development of drafts and final versions of the clinical pathway/s
- Participates collectively and collaboratively work with other clinical leaders and experts to provide a clinical directorship function for the development of the pathway/s;
- Ensures clinical risk is identified and appropriately managed
- Works with the facilitator to develop and implement benefits, key performance indicators and evaluation framework
- Compulsory championing of localised pathway/s by promoting and educating clinicians in changes and benefits
- Attends and leads 1 education session to launch the pathway in the chosen education forum, this can be done with other working group members
- Compulsory attendance at the 6 month review post publication.

Appendix 6

Work Plan for 2016/17

Activities	Resources		Notes	Funding
1. Development and Socialisation	1.1	System Accountability	LTC Portfolio (0.5 FTE of current role) Support from Strategic Services Interlink with Mid-central and Whanganui	Existing staff Sundry costs (e.g. travel)
	1.2	Administration/Editing	Continue with Administrator/Editor (0.8 FTE – 0.4 PHO and 0.4 DHB) Continue with fee for Service support for facilitator/editor.	Confirm funding which will mean confirm HBDHB Administrator/Editor and review/confirm contract with PHO (due to expire October 2016).
	1.3	Clinical Leadership (Secondary)	Within current work practice, however need Secondary Service Directorate agreement to time release to assist.	Existing staff
	1.4	Clinical Leadership (Primary)	Employ dedicated GP on a 4 hours (0.1 FTE) basis with specific duties. Work on Job description (include: compulsory attendance in 2 working group meetings to develop pathway content, apply local region specifics and determine data measures for evaluation, 2-3 electronic reviews via email or teleconferences (mainly final phases), compulsory champion with their peers and wider local group, lead education session to launch the pathway in the chosen education forum)	New Funding
	1.5	Other Health Providers	Continue to build relationships with providers however with no remuneration this may cause; lack of participation, unwillingness to participate and insufficient representation from either side. Investigate other opportunities of remuneration for health professionals e.g. Utilisation of the PHO Clinical Pharmacists and Facilitators. *e.g.*	New Funding

			work with PHO with regards to nursing support and align champions to GP practices.	
	1.6	Socialisation and Change Management	Raising profile by 1:1, advertising and education. CME/CNE attainment recognised through MoM. Work with adopters/champions	Existing funding
2. MoM usability and availability	2.1	Contract with vendors to integrate technology	Inter-relationship with Med-Tech/My Practice is still ongoing.	No money set aside – potential new funding
	2.2	MoM Annual funding	Funding (£.00) can be subject to exchange rate fluctuations.	
	2.3	Continuing refining the IT compatibilities	Having a tool that is responsive and easily used will encourage use and, therefore, promulgation of best practice; workflows will be improved meaning less duplication and lost opportunities for gaining better outcomes for the person. Because of delays in the IT process this programme has not sufficiently been socialised in primary care, however, we are now progressing well with regards to looking at data that may show an impact on pathway uptake to date *(Refer to Appendix 4*).	Existing funding
	2.4	E-referral integration	It is recognised that there is some work to be done in order to gain integration between e-referrals (Healthlink forms) and the practice management system (Medtech, My Practice) in general practice. This challenge exists with other pathway applications being used in New Zealand; however we are currently in a position of negotiation to gain MoM's involvement in finding solutions **NB: This is inclusive of contributing to the development cost.**	No money set aside – potential new funding

3.0 Publishing	3.1	Pathway development costs	**Pathway Projections (June-June either requested as EOI or aligned to Annual Plan).** Note: New Pathways are approved by CCP Committee prior to work commencement. NB: There maybe 5 pathways within one. **Currently in development:** (Thyroid, PVD, Urinary Incontinence, Cellulitis, Community Acquired Pneumonia, Colorectal, Last Days of Life, Diabetes Review). **Planned to date to commence**: (Toothache, Osteoarthritis Mobility Action, and Falls with Fractures, Obesity, and Frailty (but postponed till further consultation), Dehydration (inclusive of Hyperemesis), Eczema in Children, Gestational Diabetes, and Diabetes in the Elderly). **Support alignment of Map of Medicine to key National/DHB goals:** Faster Cancer Treatments – Colorectal, Breast, Prostrate, GI, Hep C. **As per Annual Plan:** Youth Mental Health (Pathways for high prevalence conditions, Develop clinical pathways for better collaboration between primary and secondary care). Rising to the Challenge -Improve specialist support for primary care and develop care map/pathways for all levels of mental health & addictions to promote clinical collaboration. Shifting services. Agree pathways for palliative care. Diagnostics (Complete design and implementation of colonoscopy and CT colonoscopy pathway).	
4.0 Innovation	4.1	New Innovation	Opportunities to support pathway agreed outcomes with regards change of prices or new innovation e.g. paying for private echoes for small group of population	New Investment
5.0 CQI	5.1	Improvement in back-end monitoring and return on investment process.	Develop new QA process - Achieving benefits requires a clear understanding of what we are trying to achieve by developing Pathways, and a means of measuring this. To address this aspect, an Implementation and Benefits Realisation Plan is developed for each Pathway; monitoring of these Plans will be an activity conducted by the Strategic Services Group. True benefits will accrue as CCP is mainstreamed throughout the health sector	Existing funding

Appendix 7

Risk Profile

Risk	**Risk profile** 1: High, 2: Moderate, 3: Low	**Mitigation**
Financial risk • Will need new monies (2017/2018) • Funds need to follow and support • Contractual arrangements • Challenge of HEAT tool versus funding to support • Labour intensive administration and editing requirements	High	Expecting Business case for 2016/17 funding can be secured.
Lack of participation unwillingness to participate • Insufficient representation from either side. • Time limited support from Strategic team to support facilitation • Attitudes	High	Support from Steering Group and Executive level. Work around to what best fits with meeting times, facilities etc. Expert facilitation to ensure all participants have time to speak and all opinions are respected and valued. CME points for clinicians attending educational sessions.
No demonstrable or measurable improvement pathways	High	Work with Map of Medicine team on Return on Investment Process (ROI)
Business as usual concept • Remuneration is a key • Do we have the right human resource model	High	Trial a new model Business Case revisited
National and regional bodies development • Ideal is prescriptive and applies regionally not local. Adopted verbatim into Map; predominately based on clinical rather than local consumerism to achieve equity in local environment • Changes in regional personnel	Moderate	Keep abreast and ensure participation from HB. Provide alternative governance from other existing forum's for overseeing if appropriate (e.g. Directorates). Continue to keep abreast of Faster Cancer pathways.
Lack of socialisation/implementation and cost to education • General Practice expectations	Moderate	Clear implementation plans are developed as part of process. CME/CNE points

Hawke's Bay Collaborative Clinical Pathways Update June 2016

Published Pathways (update June 2016)

- Atril Fibrillation
- Assessment of Acute Chest Pain
- Asthma in Adults (Acute/Chronic)
- Asthma in Children (Wheeze in Preschool, Acute (1-15 yrs.), Chronic 5-15 yrs.)
- COPD (Suspected, Stable, Management of Acute)
- Dementia (Assessment ,Uncomplicated)
- Diabetes – (Type 1,2, Foot Ulcer)
- DVT (Lower Limb)
- Gout
- Heart Failure (Suspected, Manamgent in Primary Care)
- Lung Cancer (Suspected)

Under Development (Nearing Publication next 2-3 months)

- Community Acquired Pneumonia (Now - July 2016)
- PVD (Multi feedback closed 8 July)
- Abnormal Thyroid
- Urinary Incontinence
- Cellulitis
- Last Days of Life

Early development (Aim for Publication 3-6 months)

- Diabetes – Older Person
- Dental-Toothache
- Eczema in Children
- Dehydration

Faster Cancer Treatments **

- Colerectal (Suspected, Iron Deficiency Anaemia, Altered bowel Habits, Rectal Bleeding & Surveillance)
- Breast (Commencing development)
- Hep C (awaiting regional input)

On the List – coming up/?

- Mobility Action Pathway/Falls/Obesity
- Fraility/Self-Management

Published Pathways

- Obstructive Sleep Disorder (Suspected)
- Osteoporosis
- Lung cancer (Suspected)
- Melanoma (Suspected)
- Osteroarthritic Hip
- Osteroartic Knee
- Osteoporosis and Fracture Prevention
- Rhinosinusitis
- Services for Older people
- Skin Lesions
- Smoking Cessation ABCD
- Stroke and Transient Ischaemic Attack (Primary Care)
- Vertigo Assessment and Management

Great News

We now have single sign on for general practice – Yes taken some time – but now working (*Refer to attach, but we will also be visiting you to meet and further educate*).

Always good to hear from GPs with what pathways we should be doing and also come and help develop. Contact Leigh White: mapofmedicine@hawkesbaydhb.govt.nz

With the application of single sign on we will now be able to monitor who accesses the Maps and work out our top 5 access

Why do?

- Reduce variation
- Reduce inappropriate referrals
- Redirect referrals to better value services
- Reduce unplanned admissions
- Promote integrated care
- Right care rime time right place
- Better informed people

Forgotten your password if need to register Simply email: mapofmedicine@hbdhb.govt.nz

Update June 2016

TRAVEL PLAN UPDATE

Andrea Beattie

HAWKE'S BAY District Health Board Whakawāteatia	**Draft Quality Accounts**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Consumer Council**
Document Owner: Document Author(s):	Jeanette Rendle, Consumer Engagement Manager Quality Accounts Working Group and Service Directorates
Month:	August 2016
Consideration:	For Discussion

RECOMMENDATION

That MRB, Clinical and Consumer Council

1. Note the contents of the Quality Accounts
2. Provide feedback on the contents of the report
3. Provide guidance on the communications plan

INTRODUCTION / PURPOSE

The publication of the annual Quality Accounts was initiated in 2013, following the Health Quality & Safety Commissions (HQSC) guidance publication in July 2012 and the MOH's request that Quality Accounts should be produced annually detailing our performance against both national and local quality and safety indicators. The Quality Accounts are predominantly aimed at our community and therefore the aim is to keep them as short as possible, be visual, easy to read and understand; using photo's, images, stories, quotes, and examples to enhance the results and achievements. The guiding principles are accountability and transparency, meaningful and relevant whole of system outcomes and continuous quality improvement.

A working group was established of representatives from Consumer and Clinical Councils, Māori Health Service and Clinical teams across the sector to write a document publishing positive stories and the impacts on health outcomes of our community.

CONCLUSION / SUMMARY

The Draft publication is attached for review and feedback. Please note data is still being compiled and there are some pages in the accounts that are yet to have numbers confirmed. Proper formatting will occur after all feedback considered and changes made. Therefore feedback is requested on the overall flow of information, language and images used.

A communication plan is being developed and feedback will also be sought as to how best we communicate the accounts to our community. Feedback will be incorporated and HB Clinical Council, HB Health Consumer Council and Māori Relationship Board will be given a further opportunity for final review in September before going to HBDHB and HHB Boards.

KA ARONUI KI TE KOUNGA

FOCUSED ON QUALITY

OUR QUALITY PICTURE 2016

OURHEALTH
HAWKE'S BAY
Whakawāteatia

DID YOU KNOW THAT EVERY DAY...

6 babies will be born

11 fragile babies will be cared for in the special care baby unit

An orderly can walk on average 15km

16 people will get their free annual diabetes check

20 women will have a mammogram and a further 29 a cervical smear test

35 operations will be completed

55 children will receive one of their vaccinations

100 people will be admitted to Hawke's Bay Fallen Soldiers' Memorial Hospital

153 visits/appointments will be made to support people with mental health issues

223 visits will be made by District Nurses and Home Service Nurses

248 children on average will be seen for their free dental health check

260 people will receive meals on wheels

1,334 people will see their local family doctor

4,400 prescriptions will be written

5,256 laboratory tests will be completed

5,915 items of laundry will be delivered to the hospital

Icons made by Freepik from www.flaticon.com

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

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

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RĀRANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT
Showing ***respect*** for each other, our staff, patients and consumers. This means I actively seek to understand what matters to you.

RĀRANGA TE TIRA PARTNERSHIP
Working together in ***partnership*** across the community. This means I will work with you and your whānau on what matters to you.

ĀKINA IMPROVEMENT
Continuous ***improvement*** in everything we do. This means that I actively seek to improve my service.

TAUWHIRO CARE
Delivering high quality ***care*** to patients and consumers. This means I show empathy and treat you with care, compassion and dignity.

CONTENTS

All quotes are provided by our consumers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NAU MAI KI TĀ TĀTOU WHAKAAHUA KOUNGA
WELCOME TO OUR QUALITY PICTURE

We are pleased to share with you our fourth Hawke's Bay Health sector's quality accounts demonstrating our commitment to high quality health care, living our values and sharing with you our successes and future plans. As you will see, we have come a long way and our teams have worked hard to achieve some excellent results in meeting the Ministry's health targets and the Health Quality and Safety Commission's Quality Safety Markers; however, there is still more to do. whānau

Every day people access the health and disability services across our sector and, for some, the experience, the care, and support they receive exceeds their expectations; however in some instances we fall short. As a sector, we believe our consumers should be at the centre of health care and treat them as if they were part of our own family/whānau, so as a sector our commitment is to continually improve the safety and quality of care for all.

In these quality accounts we have focused on some of the improvements currently underway across Hawke's Bay which, we believe, will better meet the needs of our community and give us the opportunity to deliver the best care possible. At the same time we need to continue to manage the risks of providing health care and reduce incidents of unintentional harm that can occur while receiving care. These accounts show how we are meeting these challenges – showing our successes and where we need to improve and focus in the future. We welcome any feedback, as well as any suggestions for future topics.

What quality means to us?

Ākina, one of our sector values means *that we continuously look for ways in which we can make improvements and learn when things don't go as well as we planned. Achieving high quality care across the sector means the care is the right care, in the right place, at the right time, every time. We want to help develop our staff to become far more person and whānau centred, really understanding our consumers' goals and needs, working in partnership to improve the health of our communities.*

KEVIN ATKINSON

CHAIR
Hawke's Bay District Health Board

BAYDEN BARBER

CHAIR
Health Hawke's Bay - Te oranga Hawke's Bay

CHRIS McKENNA

CO-CHAIR
Hawke's Bay Clinical Council

MARK PETERSON

CO-CHAIR
Hawke's Bay Clinical Council

GRAEME NORTON

CHAIR
Hawke's Bay Health Consumer Council

OUR CLINICAL COUNCIL AND CONSUMER COUNCIL

Establishing the Hawke's Bay Clinical Council (2010) and Hawke's Bay Health Consumer Council (2013) has helped us make change across our health sector – hearing the voice of both our clinicians and consumers.

The Clinical Council is made up of a number of health professionals from across our sector, including hospital specialists, family doctors, nurses and allied health (social workers, pharmacists) to provide leadership and oversight around safety and clinical improvements.

The Hawke's Bay Health Consumer Council provides a strong voice for the community and consumers on health service planning and delivery. The Council is tasked with enhancing the consumer experience, making sure our services meet our communities' needs.

A strong sense of teamwork and working together has been established between the councils which means that all service improvements and changes must be reviewed and recommended by both councils before they are discussed and approved by the Hawke's Bay DHB Board. The key to success to date has been the commitment at board and senior executive levels to support both these councils so that both clinical and consumer voices are able to grow.

As a further advance on working together, the Clinical and Consumer councils held combined monthly meetings in the past year. They worked on deepening their shared understanding of person and whānau centered care and how to advance this way of working across the health sector.

Each of the councils' annual plans has a section they share. Consumers are increasingly routinely invited to "co-design" services with clinicians, managers and other stakeholders. Trusting relationships are being built as a result, and we are getting better at it.

2015 was the year of the consumer with the Partnership Advisory Group for mental health being the supreme award winner at the Hawke's Bay Health Awards in November. Graeme Norton, Chair of Consumer Council also won the leadership award in 2015.


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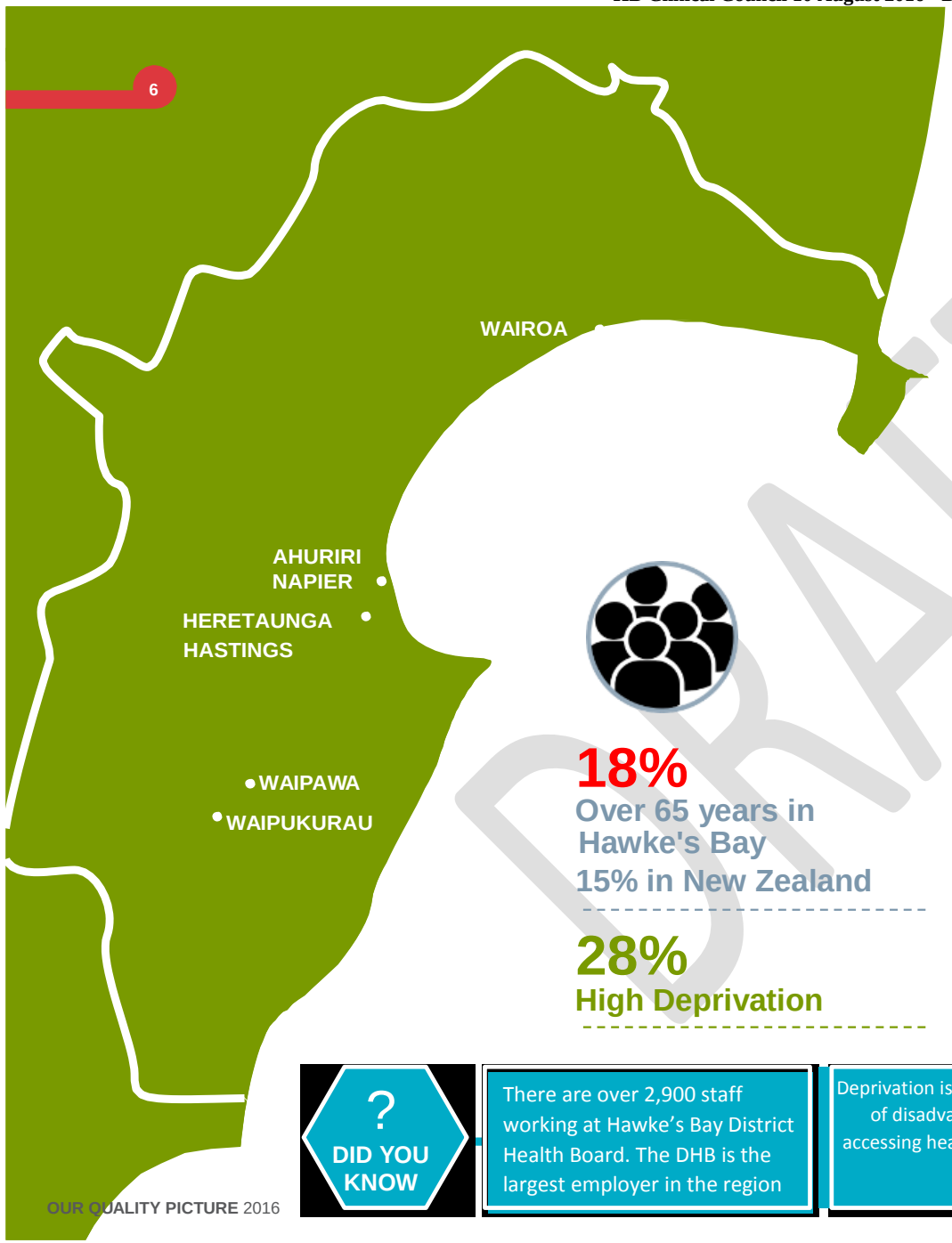

WHO ARE WE?

159,600
Hawke's Bay population 2015/16

26%
Māori in Hawke's Bay

4%
Pacific people in Hawke's Bay

18%
Over 65 years in Hawke's Bay
15% in New Zealand

28%
High Deprivation

? DID YOU KNOW

There are over 2,900 staff working at Hawke's Bay District Health Board. The DHB is the largest employer in the region

Deprivation is an indicator of disadvantage in accessing health services

The average income in Wairoa is $XX

X children are unable to attend appointments per year

TACKLING HEALTH INEQUITY

Many things in life are unequal but some things shouldn't be. Health inequities are inequalities in health that are avoidable or preventable. Hawke's Bay is a great place to live, but not everyone currently has the same opportunity to be healthy. Some parts of our community have better health than others and we need to make sure everyone enjoys the same level of health and wellbeing.

A recent update of the 2014 Health Equity Report shows that Hawke's Bay is improving in some areas.

Good progress is being made to achieve equity in the following areas:

- ✓ **Difference between Māori and non- Māori avoidable deaths almost gone.** If current trends continue there will be no difference between Māori and non- Māori avoidable death rates by 2017, largely due to disease prevention, effective treatment and/or medical care.

- ✓ **Reduction in hospital admissions for 0-4 year olds** that could have been avoided by prevention programmes and better access to treatment in primary care.

- ✓ **Reduction in teenage pregnancy** largely due to improved access to primary care contraceptive and sexual health services.

Life expectancy (how long we live) is improving but there is still significant inequity. It will take at least 50 years for Māori to have the same life expectancy as non-Māori in Hawke's Bay if current trends continue.

In the coming year, focus will be given to the areas where health equity is unchanged or worsening:

- × **Acute respiratory.** Child admissions are increasing and are associated with poor housing conditions.

- × **High smoking rates for Māori women.** Forty-three percent of Maori women giving birth in the past year were smokers. At the current slow rate of decrease it will take another fifteen years before rates are the same as non- Māori.

- × **Obesity in four year olds** has increased since 2009 with significant variation across communities. Nearly 12% of children living in places like Camberley and Tamatea are obese compared to less than 1% of four year olds in Havelock North Central or Poraiti.

- × **Oral health for five year olds.** There has been no improvement in oral health for five year olds. Māori and Pasifika children and children living in less affluent communities have significantly more dental decay.

HELPING PEOPLE STOP SMOKING

23% of all women who had a baby at the Hawke's Bay DHB facility during 2014 - 15 were current smokers.

Hapū mama who are Maori are five times more likely to be smokers. Encouraging hapū mama to stop smoking during pregnancy may also help them kick the habit for good and so provide better health benefits for mama and reduce contact to second-hand smoke by pepe.

The Increasing Smokefree Pregnancy programme is a collaboration between Kahungunu Choices Health Services, Hawke's Bay DHC Maternity Services and the Smokefree Team to provide support, education and incentives to hapū mama wanting to stop smoking. Incentives include free nappies at one, four, eight and twelve weeks if they remained smokefree. Those whānau members who smoke and are living with the hapū mama can also receive incentives at one, four, eight and twelve weeks if they remain smokefree.

RANGATAHI MAKE BETTER CHOICES

Smoking rates among Year 10 students are lower now than 15 years ago but one in four young Maori girls of this age remain regular smokers. Over 60% of Maori girls 14 – 15 years have used a tobacco product at some stage. Social supply and retail purchase are the main sources of cigarettes and tobacco for young people.

The "Breaking Cycles Challenge" engaged with Alternative Education providers in Hawkes Bay to provide education to youth aged 15-19 years old to lead healthy, active and smoke free lifestyles. The challenge was run over eight weeks with education, health, social, challenges and cessation components all factored in to the programme. The focus was smokefree and youth health, where engagement with providers once a week provided expert cessation advice and support to youth wanting help to stop smoking. In collaboration with Directions Youth Health Centre the aim was to support rangatahi to make better decisions for their health and wellbeing and create healthy lifestyles.

Kura Tutahi – ki te whakangao i ngā rangatira mo apopo

REDUCING INEQUITIES: Investing in tomorrow

Lifestyle factors such as smoking, diet and physical inactivity are the main causes of premature (early) death. Māori are doing badly in health statistics and the inequity gap is continuing to grow.

Central Health were once again the winners of the Commitment to Reducing Inequalities Award at the Hawke's Bay Health Awards in 2015. Their winning entry has a long term goal of seeing a new generation of Māori – strong, healthy and leading the way for their families/ whānau.

The biggest impact can be made when issues are addressed in children/ tamariki rather than waiting for them to become adults with poor health habits. This project aimed to improve nutrition, establish a habit of physical activity, prevent smoking uptake and access to nurse-led clinics to deliver early health care, and health promotion.

The project started out focusing on schools with the highest proportion of Māori and was later expanded to include the five kohanga in Central Hawke's Bay.

Innovations used were:

- 10 week touch rugby module for all schools to complete
- Kia Tunua – healthy cooking on a budget for children/ tamariki and their families/ whānau
- Supermarket Tour Toolkit
- Healthy Lunches Toolkit
- On-site nurse led clinics
- Social media resource (Facebook)
- Using advertising budget to become lead sponsor for Iron Māori Tamariki in Hawke's Bay

There were many success stories including The Terrace School in Waipukurau (70% Maori) which was awarded the NZ Heart Foundation's Healthy Heart Start Award (Healthy Heart Tick) for their healthy lunches programme. This is an astonishing achievement for a school which, until last year, only offered choices such as pies, sausages, and chips.

Increasing the Number of Healthy Weight Children

The best start for healthy weight children is keeping healthy during pregnancy, breastfeeding and healthy eating for our young children. The evidence suggests that getting it right from day one gives each child a good start in life and can protect against obesity throughout adulthood.

The Maternal Nutrition Programme delivers “Healthy First Foods” with Well Child Providers and gives information and practical skills to families/whānau on feeding children from six months.

Children under five who develop healthy eating behaviours are likely to maintain these over their lifetime. Also the whole whānau needs to model healthy eating and activity to support children.

The Pre School Active Families Programme, developed and funded by the DHB, is delivered by Sport Hawke’s Bay. They work with 45 families annually, providing support in the home and engaging whānau in community programmes.

Reducing the amount of sugar children consume not only supports healthy weight, it also improves oral health, concentration and overall wellbeing. “Water Only Schools” are being supported with resources, policy development and activities.

Image to be inserted appropriate to healthy eating

URGENT CARE

Emergency Department and general practice presentations continue to increase (include stat about numbers and increase on last year) and many of those who do come have coughs, colds or other minor medical conditions that would have been better treated by a nurse, family doctor or an accident and medical centre.

Last year we told you that the Urgent Care Alliance (a group of over 50 health professionals, managers and consumers across our region) was working to challenge and change the way health services are delivered, and to break down barriers like getting an appointment at short notice.

We highlighted several options we were looking at to improve some of the issues and these have been further developed in the last twelve months.

- Improved access to emergency dental treatment - As of 1 October 2016 there will be provision for 720 very low cost appointments available for anyone in Hawke's Bay who needs emergency dental treatment. Consumers can be referred by their own family doctor, by the hospital or simply walk in to Te Taiwhenua o Heretaunga for treatment.

- Communicating better with our community and helping consumers with more information so they can make better choices about where to go for treatment - This led to the implementation of the "choose well" campaign. The launch of a new health sector wide website (www.ourhealthhb.nz) supports our community with information, advice and alternatives. You may also have noticed "choose well" billboards and banners.

- Transport assistance is currently being reviewed and we expect a number of recommendations to be made in the next year to support this.

- Provision of urgent care services continues to be a priority. We are continuing to look at ways to improve access to health professionals both during and outside of normal working hours.

"I love building relationships with whānau, listening to their stories and knowing I have made a difference"

REDUCING OUR DID NOT ATTEND RATES

Rawakore means "without resources". Knowledge, transport, health literacy are examples of resources required to gain access to health services. At the DHB, we strive for equity and equal access to healthcare; however, we know there are many among us without these resources to help them on their journey.

To assist our community, the Māori Health Unit employs Kaitakawaenga to ensure that everyone is aware of their appointments, can get to their appointments, and can truly have equal access to healthcare.

Two of our Kaitakawaenga are Wirihana Raihania-White and Speedy White. Their work involves ringing people when they have appointments, visiting them in person, bringing them to appointments when needed, establishing relationships with whānau and listening to their stories. As they will tell you, "without the relationship, nothing else is possible."

Wirihana and Speedy take pride in their work every day, although they will say, "this is just what we do" to make a difference to people on their healthcare journey.

Customer focused bookings

The Customer Focused Booking project was initiated in Sept 2015. The goal of the project is to co-design a customer focused booking system that will result in improved attendance at appointments, full clinic utility, reduced waiting times and improved levels of customer satisfaction.

The project team have made good progress with placing the customer at the heart of the booking process this year and this focus will continue into 2016/17. Some of our progress is as follows:

Consumer information – we call this "demographics". The information we hold on file is not always up to date and this affects consumers being advised of an appointment. We have completed a review of our demographics form and how we collect this information, and we're getting ready to implement changes.

Online booking system – We completed a thorough review of technology solutions to support consumers being able to book and reschedule their own clinic appointments. We have chosen software we feel is the best for our systems, and we'll be rolling out a pilot within the next few months.

Text-to-remind tool – We have worked together with consumers to find out how we best use our text reminder system to meet consumer needs (see page 14). A set of recommendations are now being implemented to make this service more effective and more valuable to our consumers.

Clinic scheduling – Work to date to support our clinics running efficiently has included a review of clinic capacity and how clinics are scheduled. We continue to look at how our outpatient clinics run and changes we can make to make them even better.

Did not attend rates – There is still inequality for Maori when it comes to not being able to attend appointments. The project group will continue to monitor the data and identify issues to support system changes to promote equity and access to healthcare.

"Mum has dementia, and it is a challenge for her to manage her own appointments. Could you please send the reminder to me as her caregiver as well?

CONSUMER EXPERIENCE

Measuring what matters most to our consumers and how you experience our services is essential in improving the way we do things.

National Inpatient Experience Survey

Feedback about the care provided in our Hospital is a good indicator of how well services are working for patients and whānau. As with other District Health Boards, we send a survey every three months to a selection of adults who spent at least one night in our hospital, inviting them to participate in the survey.

330 people responded to our surveys over the last 12 months (July 2015 to June 2016) and scored us positively across the following four domains: communication, coordination, needs and partnership (see page 15).

In addition to the scores, our reporting captures lots of comments and feedback that we share with our services. This feedback has highlighted those areas we can improve – for example pain management, privacy and discharge planning.

Real time surveys

If you have visited Nga Rau Rakau, Napier & Hastings Community Mental Health, Te Harakeke Child and Family Service (CAFS), and the Home Based Treatment Team recently you may have noticed iPads placed in reception areas and staff encouraging users of the service and their whānau to take up to three minutes of their time to "tell us what you think" in an online survey. This feedback is anonymous and captures your thoughts. We are encouraging consumers to complete the survey after each appointment or interaction as we know experiences can be different each time.

178 surveys were completed between March and July 2016 with the average rating 4.01 out of 5. We received the highest rating to the question "I would recommend this service to friends and family if they needed similar care or treatment".

Workshops

In July 2016 consumers from Wairoa to Waipukurau attended a workshop reviewing the "text to remind" tool - the method used to remind outpatients of their scheduled appointments. This workshop was useful in finding out how we can best use the tool to meet consumer needs, improve the consumer experience and increase attendance of appointments.

The ultimate aims are to ensure equitable health services for all and best use of our resources.

"Whenever I was talking with staff they showed great empathy, displayed a calming sense of humour (yet) … they were professional and competent".

Results from the 2015/16 National Patient Experience Survey

Our scores have improved on last year across all four areas and in some cases are higher than the New Zealand average.

86% Felt we communicated well, and we listened to your questions

(3% increase on last year)

87% Felt you were involved in any decisions about your care and treatment

(2% increase on last year)

88% Felt you received good care and support and we treated you with dignity and respect

(3% increase on last year)

85% Felt you were given consistent information from the teams that were treating you

(2% increase on last year)

We still have room for improvement. The survey did identify areas of concern, such as discharge planning, which we will focus on improving in the coming year.

"I wasn't given info on medications prior to discharge. I felt confused about when to take them when I got home".

Image of consumer engaging with health professional

POPULATION HEALTH

We work with people and communities to prevent disease, have a safe environment and support people to be healthy and well. Population health covers areas such as reducing harm from alcohol, drugs, tobacco and hazardous substances, water safety and sanitation, promoting physical activity and healthy eating, healthy housing, sexual health, preventing disease through on-time immunisation, managing notified communicable diseases, and cancer screening.

KEY RESULTS

- Eight drinking water suppliers signed up to the Drinking Water Assistance Programme and 96 suppliers were assisted with developing water safety plans and risk management plans
- 228 homes were insulated through DHB healthy housing programmes in the last three years
- x pregnant women were helped to give up smoking
- Plans developed to increase the activity and wellness of infants and children – Hawke's Bay Healthy Weight Strategy and Best Start: Healthy Eating and Activity

OUR FOCUS 2016/2017

- Support workplaces to have healthy workplace policies
- Support schools to have policies on drinks with no sugar
- Develop a position statement on alcohol harms and outline actions to address them
- Improve the information on pamphlets given to the public on communicable disease
- Continue to address housing issues and poor insulation

Did you know?

481 communicable disease cases notified

619 liquor licence applications received

187 tobacco retailers had compliance/ education visits

123 women supported to breast & cervical screening services


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PRIMARY HEALTH CARE

Primary health care is the first place you go to for health services; often this is your general practice or health centre. The doctors, nurses and pharmacists working in our community provide a range of health services aimed to keep you well, from health promotion and screening to diagnosis and treatment of medical conditions.

KEY RESULTS

- More people have been supported to stay at home to look after their respiratory condition (breathing). This is because general practice and hospital services have worked together to support people earlier with better understanding, tools and access.
- 2,197 four year old children have received health checks before they start school. We have exceeded the target of 90% set by the Ministry of Health.
- 344 whānau (1440 individuals) were enrolled in our first Whānau Wellness Resource Programme which is a 12 month step-up programme including support to access general practice, medicines, tests and education.
- Whāriki/Stanford, a self-management programme has supported the development of Māori community champions and 81% of whānau using the programme have completed it (see page 21)

OUR FOCUS 2016/2017

- A review of systems that support patient safety continues within general practice
- Identify how primary and secondary care will work together to support better patient outcomes (system-level measures)
- Patient experience survey for primary care being developed by the Health Quality and Safety Commission is set to come to Hawke's Bay
- Improving Health Literacy - a new online training programme has been developed to support the people who work in general practice to understand more about the people that come to see them, their understanding of the health system and their health needs.

Did you know?

24,666 Cardiovascular Disease risk assessments were completed in general practice

(these forecast your risk of a Heart Attack or Stroke within the next 5 years)

710,857 (2% increase on last year) nurse and doctor consultations in general practice

6,276 Diabetic annual reviews were held in general practice

"Manage my Health allows me to access my general practice 24/7. I can use my tablet any time to book appointments or request repeat prescriptions, which is essential when my asthma medications run out. I can read the doctors notes from my consultation and email her if I need clarification. And there is no more waiting for ages for the receptionist to answer the phone".

Respiratory Programme

Managing your breathing issue is now easier because we have joined together general practice and hospital services to provide better service for patients with respiratory issues and concerns. This is called the Respiratory Programme. The solution has been to increase access to your doctor or nurse, for early diagnosis and to provide education enabling self-management and improved quality of life. Nurses have received education sessions to increase their skills for providing extended services for patients with respiratory conditions.

- More people (300% increase) are now using the Pulmonary Rehabilitation service.
- More people (225% increase) have been provided a spirometry (lung function) test at their health centre.
- The number of days people have not needed to be in hospital because of their breathing problems has been reduced by 740 days compared to last year.
- More people saw their doctor for breathing issues and were treated by their doctor reducing the need to see a specialist at the hospital; this reduced referrals from 658 in 2012 to 28 referrals in 2015.

"I feel I know better how to take care of the little lung capacity I have left… the programme has given me another ten years of productivity".

Supporting you to keep well

Consumer Portal

Did you know that you can access your own medical records and make your own appointments? Ask your practice about Manage My Health or Health 365. Currently ten practices in Hawke's Bay have access to this technology, and by the end of the year most general practices will have access to this technology.

Improving self-management of health issues in our community

Self-management has become a popular term for changing how people manage their own health. This is especially true for those with long term conditions, such as heart disease and diabetes. Health Hawke's Bay has developed a team of Master Trainers and Stanford / Whāriki Facilitators to provide group education sessions to people in their communities which aim to improve people's skills and confidence in managing their own health problems.

Support includes helping people understand their condition, developing the skills to empower good decision making, establishing goal setting and problem solving approaches. The programme supports patients being leaders in their own health and well-being, in close partnership with their medical practitioner. The Whāriki Stanford programme has been in place now for 12 months. During that time, 435 people have participated with 81% completion rate for Maori using the programme.

We have a targeted focus to support individuals and whānau to navigate the complex range of health services rolling out this coming year

Whāriki translates to "the woven mat". It is considered a special skill to be able to weave, taking time and concentration to complete. It allows contemplation and, once complete, is a great achievement.

ACUTE AND MEDICAL

We are responsible for providing safe and effective care across a number of services including:
Emergency Department, Intensive Care Unit, Radiology, Renal Services, Cancer Services, General Medicine, Cardiology, Respiratory and Palliative Care.

KEY RESULTS

- Continuing to reduce average length of stay for medical patients
- Refurbishment of ED front of house
- Dedicated team adding additional support to Patients at risk of deterioration within the hospital 24/7
- Medical Day Unit now well established and providing 6 beds for those admitted to the hospital for minor investigations and procedures

OUR FOCUS 2016/2017

- Continue to focus on flow of acute patients through the hospital
- In preparation for the National Bowel screening programme and to meet current needs in our community, plans are underway to commence building a standalone gastroenterology and endoscopy suite in early 2017
- With the appointment of a Clinical Nurse Specialist, Trauma and national data collection, we will review and optimise our trauma (serious injury) care
- Continue to focus on the right numbers of staff with the right skills at the right place at the right time.

? DID YOU KNOW

We provide a **24 hour** acute service 7 days per week

We manage around **45,000** emergency department presentations each year

We have **97** acute adult medical beds

13,342 people with injuries presented to E, 2,190 admitted to hospital, 79 with severe trauma

The most common cause of severe trauma is motor vehicle accidents

24/7 Stroke thrombolysis

In June 2016, the stroke team began providing 24/7 stroke thrombolysis (a treatment to dissolve the dangerous clots in blood vessels, improve blood flow and prevent damage to tissues and organs) to clinically eligible patients presenting to the Emergency Department with acute stroke.

Our Hawke's Bay stroke team are working closely with our Wellington counterparts, and video conferencing is being used to provide stroke expertise for patients presenting outside of working hours. This technology allows us to be in a position to offer therapy aimed at improving outcomes for clinically eligible stroke patients whenever they need it.

Emergency Department (ED) front of house

Last year we had lots of feedback from the community about how we could improve the ED waiting room. The front of house redesign project is finished, and the improvements are sure to help both staff and patients.

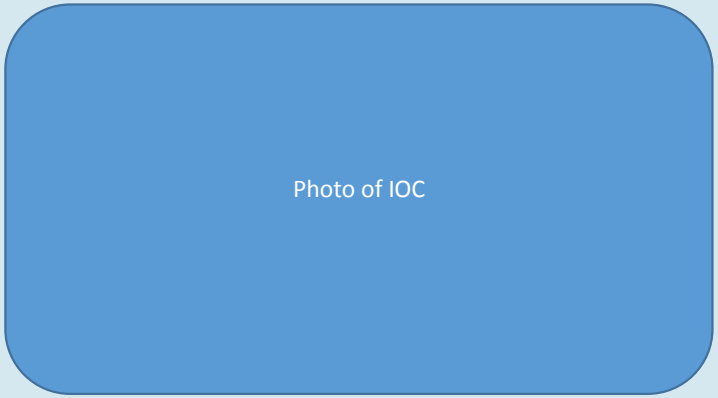
A new wall and electric doors now define ED as its own space, rather than a general thoroughfare into the hospital. This provides a clear process from the front door for patients/visitors and whanau. Increased clinical space – a new triage booth and five assessment/intervention bays – will optimise patient privacy, and commencement of interventions therefore supporting patient flow. The clear view that staff now have of patients in the waiting room will also support staff and patient safety

Integrated Operations Centre (IOC)

The Integrated Operations Centre was opened in March 2016. The main purpose of the IOC is to provide a central hub where the hospital activity is visible and patient flow across the hospital is coordinated. The IOC has become an integral part of the daily management of acute patient flow, which assists us to:

- Provide visibility of real time hospital wide activity
- Predict demand and, therefore, better manage capacity
- Alert us to areas at risk
- Manage patient flow from ED to discharge
- Support us to provide best use of our staff capacity to meet the demand

A key part of the IOC room is the three large screens, which gives us visibility of real time activity and prediction data. These screens show us at a glance what is happening and where any trouble spots are; we can then better support staff to provide high quality care and manage demand through the hospital.



"The Doctor chatted to me the day after surgery so I wasn't still foggy... and took time to answer all my questions. The Anaesthetist was calming and talked through his role and made me feel calm. The nurse kept me updated with the discharge process"

SURGICAL

We are responsible for providing surgical procedures for our consumers, whether they be elective (planned) or acute (not planned or accident) in our seven theatres, carrying out day case surgeries and caring for consumers after they have undergone surgery.

KEY RESULTS

- We exceeded the national elective health target and completed xxx surgeries, xxx more than last year
- Of these x % of people waited 4 months or less on the surgical waiting list.
- We completed xxx hip/knee joint replacements. This was {100} more than last year
- Stat about the number of breast cancer ops we did. (General statement about speed without specific number)
- Stat about average length of stay after hip/knee op – improvement on last year?
- Appointment of a Vascular Surgeon meaning consumers don't need to be sent out of the region for vascular surgery

OUR FOCUS 2016/2017

- Continue to improve the numbers of our community receiving surgery
- Updating our theatre facilities to meet the needs of the Hawke's Bay community
- Mobility Action programme – info from Dawn
- National Patient flow?
- Reduce the wait time for acute surgery by increasing our theatre opening times across the week.

? DID YOU KNOW

- **X** people are seen in the fracture clinic (Villa 1) weekly
- We do around **35** surgeries each day in our 7 Theatres
- **XXXX** patients are admitted to our 3 surgical wards yearly
- Around **XXX** people are seen at surgical outpatient clinics
- **XXX** gynae operations completed this year (?increase on previous years)

"The day before the procedure I had to come in for the pre-op meeting… I had to see 4 different people who all asked the same questions"

Spine Clinic

Not all people experiencing back pain require surgery. We now have advanced practitioner physiotherapists running a spine clinic providing assessment, diagnosis and physiotherapy treatment. This commenced in Hastings in February 2016 and in Napier in August 2016. These clinics were introduced to provide quicker service to our patients, and release orthopaedics surgeons to focus on surgery.

The clinics have been successful to date with 90% of patients being referred to the spine clinic not needing orthopaedic surgeon follow up.

Improving pre-surgery visits

In February 2016 we commenced the re-design of our pre-admissions process. These are the visits you have with us prior to your surgery to ensure you are safe and ready for surgery.

Our previous system of two different processes and multiple visits was creating confusion and frustration for staff and consumers. Consumers were experiencing significant delays and feeling like they were "double handled" with the same or similar information requested and recorded by different staff members.

We want a consumer centric, safe, efficient, consistent and streamlined process. Ultimately we will have you visit us prior to your surgery only if required, and then only once. In many cases you will only need to be seen by a specialist trained pre-admissions registered nurse. At times, the nurses are able to complete a telephone assessment so that you don't need to come in for a pre-admissions appointment.

So far we have concentrated on improving pre-surgery visits for our healthiest (low risk) patients and have commenced nurse led clinics for orthopaedic, gynaecology, ophthalmology and ear, nose and throat (ENT) specialties. Our next focus will be general surgery and neurology.

"The Spine clinic has provided me with a service that has been focused on rehabilitation catered to my specific needs. Before I began attending the clinic, I had been struggling with menial chores and pain management for around 5 months with no improvement. The clinic has helped me get back into everyday life with a degree of normality by achieving specific milestones. Being able to put my socks on in the morning is just one of those milestones achieved since attending the spine clinic."

WOMEN, CHILDREN AND YOUTH

Women, Children and Youth services provide services from early pregnancy through to whānau with children under the age of 15 in Napier, Hastings, Central Hawke's Bay and Wairoa. We support women, children and whānau through all aspects of their children's health journey from birth to teenagers providing acute and long term conditions assessment and care inclusive of audiology, and ongoing child development services. There is a particular focus on our most disadvantaged with a strong partnership with our violence intervention programmes.

- "Waioha" primary birthing unit completed
- Established Maternity Consumer engagement Reps
- Funding to support implementation of the Foetal Alcohol Spectrum Disorder (FASD) programme secured
- Audiology (hearing clinic) waitlist reduced from 2 years to 8 weeks
- Maternity Wellbeing Child Protection coordinator appointed

Teenagers living with diabetes

Last year we noticed that many of our teenagers were having a tough time following their diabetic plan. It was hard for them to follow medical treatment which ultimately impacted on their diabetes and led to many coming in to ICU and children's ward with serious health issues related to their diabetes. We submitted a bid, which was approved, for funding to employ a children's outpatient social worker who could work closely with these rangatahi. The results so far have been really positive. Relationships have been built, and education and understanding has improved. Important appointments are being attended more consistently now, and engagement with the diabetes team has lifted. Since January 2016 we have engaged with eight high risk teenagers and their whānau, the majority of whom are now participating in their diabetic plan and are starting to be more positive about their future with diabetes.

- Improving consumer engagement to help design and monitor services
- Review of patient management and access to non-acute services
- Engaging with our youth to look at ways to improve their health
- Improving Family Violence Intervention screening rates (see page 27)
- Increasing the number of births without intervention
- Continuing to improve the coordination of care for those children with complex needs
- Continuing to collaborate with children and youth agencies and providers

"Quote from woman accessing FV services"

Family Violence Routine Screening

Family violence is a serious issue in Hawke's Bay. The New Zealand Police attend a family violence callout every six minutes, and on average across the country there are ten family violence incidents per 10,000 people. In Hawke's Bay we have 52 incidents per 10,000 people. That is over five times the national average!

Violence and abuse in families has damaging physical and mental health effects. The impact of witnessing violence can be devastating for children. Hawke's Bay children are exposed to more violence than any others in the country. We know that being a victim of abuse or witnessing abuse is linked to poor health outcomes such as obesity, diabetes, heart disease and depression.

Health care providers come into contact with the majority of the population regularly and are therefore in an ideal position to assist people experiencing violence and abuse.

Our Visiting Neurodevelopmental Therapists (VNT) working in the Child Development team, are well placed to incorporate routine family violence screening questions into their everyday practice. They find that women are appreciative of being asked, and it often enhances their relationship. Recently, during a consultation for a minor developmental need with her child, one mum disclosed extensive family violence in response to the routine questioning and now works with agencies to support her and her children to move away from that situation. This will have a positive impact.

"Mum has a plan in place, has talked to family and friends and is considering moving out…"

Photograph to represent screening

"The feedback and uptake from our staff has been nothing but positive and likely to continue to grow so we are very happy how the process is going thus far. Through this relationship we can provide our patients with a level of support and follow up care that is unprecedented both in Hawkes Bay and provincial New Zealand. "- St John's Ambulance Service Acting Territory Manager.

OLDER PERSONS HEALTH

We are responsible for providing a range of services to older people in Hawke's Bay. In the last year the engAGE service has been developed to better support frail older people who live at home to remain independent. This service has three main parts:

- engAGE team meetings are held at general practices across Hawkes Bay. These meetings allow health professionals from across the hospital and community to work more closely together and learn from each other. Team members visit older people at home and work with them to make a plan to achieve their well-being goals.
- engAGE ORBIT team works at the Emergency Department to support older people to return to their home rather than having to stay in hospital. This team is now working longer days, 7 days a week. ORBIT also take referrals from St John's Ambulance and see people in their homes to complete assessments, provide equipment and co-ordinate services for older people who need a rapid response (after a fall for instance).
- engAGE Intermediate Care Beds are beds at residential care facilities in the community where older people can stay for a short period. This service can be used by people who are unwell and cannot manage at home but do not need to be in hospital OR by people who have been in hospital and are well again but not independent enough to go home. The engAGE team works with these people to develop a plan together to get them home and back to independence.

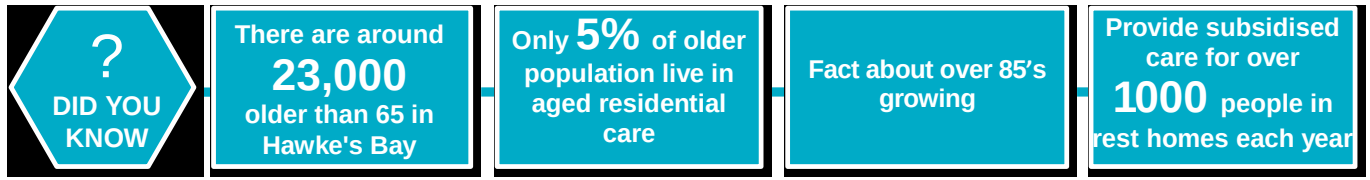
engAGE service fully functional and having a positive impact

4% increase in over 65s with no increase in hospital bed use of rest home placement

engAGE service to be developed in Wairoa and Central Hawke's Bay

engAGE ORBIT team working with Accident and Medical facilities

Evaluating the impact of the new engAGE service



"Being at home is just huge to Mum, as it is to us"

engAGE Age Well

Jessie is an 84 year old woman who lives at home alone with a supportive family.

She had three admissions to hospital in the space of a month with recurrent diarrhoea which is hard to get rid of and difficult to treat. During each hospital admission it would resolve with antibiotics but would recur when Jessie returned home.

Jessie was losing weight, becoming weak and losing confidence to be able to manage at home. Her family were extremely worried and suggested that she should move into a rest home.

Jessie was referred to engAGE for help with discharge planning and follow-up. She spent 3 weeks in an Intermediate Care Bed (ICB) located in the community with regular input from Physiotherapy and monitoring of her weight and food intake. A family meeting took place before discharge.

Jessie went home with support from engAGE and a plan in place for re-admission to an Intermediate Care Bed if she required it. Jessie has remained well and at home with no further hospital admissions.

"I'd much rather be here and have this situation in place thanks to Dr Lucy"- Jessie.

"The change in her from her last hospital release is just incredible. At home she's just Mum"- Jessie's daughter.

MENTAL HEALTH

We are responsible for delivering mental health services to people with moderate to severe mental health illness. We have community teams situated in Wairoa, Napier, Hastings and Waipukurau and a residential addiction service in Napier.

MENTAL HEALTH SERVICES
He Wāhanga Ōranga Hinengaro

KEY RESULTS

- Completion of a $22 million new building - Ngā Rau Rākau Mental Health Inpatient Unit
- Length of inpatient stay has decreased since the opening of the new inpatient unit resulting in more effective care for patients
- Ongoing implementation of a new model of care for the way services are delivered. We have established home based treatment, community resilience programmes and intensive day programmes which have decreased inpatient hospitalisations.
- Wait time for first appointment at Te Harekeke /Child and Family Service has reduced. In December 2015, 59% of people were seen within 3 weeks. In July 100% of people are seen within 3 weeks of referral

OUR FOCUS 2016/2017

- Continuing to develop and implement new services to support our consumers
- Strengthening the Community Mental Health Teams to manage and reduce the number of consumers needing acute treatment
- Recruit further staff to support our Mental Health Crisis Teams
- Continue to reduce the time children and their families wait for their first appointment with Te Harakeke/Child and Family Service

? DID YOU KNOW

X appointments with Child, Adolescent and Family Service (CAFS) per day

We have an inter-professional crisis team who are available all day, every day

We provide Maternal Mental Health specialist services for pregnant women who experience moderate to severe mental health issues

Opening of Nga Rau Rakau

On February 23, 2016, we celebrated the milestone achievement of officially opening the new mental health inpatient unit, Ngā Rau Rākau. Minister of Health, Jonathan Coleman, and Partnership Advisory Group Chair, Deborah Grace, officiated with cutting the ribbon.

The name of the new unit, Ngā Rau Rākau, means a collection of trees. By standing together, as part of the forest, Ngā Rau Rākau, the trees are protected, they are sheltered, they grow healthier, they grow stronger, they are supported and safe. And that's what developing our mental health services has been all about - growing the service, listening and transforming mental health services for Hawke's Bay people.

Home Based Treatment intervention prevents admission

Waekura Home Based Treatment prevents inpatient admissions and makes a positive difference in the life of consumers and their whānau.

A powerful case study: A young adult presented to the ED. The impression gained from the notes was that the client was recommended to be admitted to the inpatient unit.

The mental health assessment indicated moderate risk and the Home Based Team (HBT) thought this was a situation that could be managed effectively in the home setting.

The client was not keen on being admitted to the inpatient unit but needed support to cope with the impact of an upcoming significant event. Staff used multiple strengths-based, evidence-based counselling approaches which gave the family and client confidence to deal with the situation.

The client engaged well with HBT, stayed at home, was monitored at a relative's house, was visited daily by whānau, and received regular HBT clinician interventions.

The client also re-engaged with friends, built confidence, became much more resilient, and developed more positive thinking.

RURAL, ORAL AND COMMUNITY

The Rural, Oral and Community Directorate (ROC) has services located in Wairoa, Central Hawke's Bay, Napier and Hastings. Most of our services support people staying well in their community with a focus on integration and collaboration of services with primary care, Māori providers and other providers. ROC services provide a diverse range of care including: community nursing, pulmonary long term management, continence services, ostomy. Napier Health, outpatients, public health nursing, integrated sexual health services, Health Care Centre – Wairoa (HCC) – a general practice, Central Hawke's Bay Health Centre, diabetes service, endocrinology, hospital dental and community dental service (school dental service).

- Community Nurses working alongside general practices in both Napier and Hastings.
- Increase in pulmonary long term conditions group sessions for patients with breathing issues. 10 groups increased to 22 and are more accessible in the community. For the first time, the programme was implemented in Wairoa.
- Networking with health providers in the community is progressing in Central Hawke's Bay and Wairoa

- Implementing the District Nurses more closely with General Practice into Wairoa and Central Hawke's Bay.
- Involving other health providers in improving access for Māori children and whānau to dental care.
- More healthy warm homes
- Reducing hospital admissions for children.

Development of the Pulmonary Long Term Management Service

During 2014/2105 the Pulmonary Rehabilitation Service experienced a large increase in referrals to attend the Pulmonary Rehabilitation courses which at the time were offered four times a year in Napier, Hastings and twice yearly in Central Hawke's Bay. The increase in referrals was due to improved access to spirometer (lung function) services in the primary care setting.

The Pulmonary Rehabilitation Specialty Clinical Nurse identified the service could not accommodate this level of referrals and a business case was developed to alter the service model and allow for increased service provision throughout Hawke's Bay.

This resulted in the development of the Pulmonary Long Term Management Service and implementation of a new model which commenced in January 2016. This has doubled the availability of Pulmonary Rehabilitation courses in the community, and allowed the service to be offered in Wairoa as well as Central Hawke's Bay.

The programme outcomes for this patient group have demonstrated reduced presentations to the emergency department, reduced hospitalisations, improved quality of life and fitness. Patients and families have an increased understanding of their condition and improved confidence with self-management.

E Tu Wairoa – Violence Free Whānau

In 2015 Wairoa leaders decided to establish an intersectoral network with the purpose of creating a tikanga based approach to eliminating violence in our homes and community.

The network is chaired by the Wairoa Health Centre manager and to date have launched the E Tu Whānau charter with a commitment from many community members and leaders including Wairoa Mayor, Craig Little.

A programme of action has been developed and recruitment of a network coordinator is underway. The network has also secured funding to develop and deliver tikanga based programmes to address family violence.

This is an exciting collaboration of providers and community members who believe in a common goal and have worked across structures and barriers to establish a family violence intervention model that is locally grown and delivered.

NATIONAL HEALTH TARGETS

Our results

✓ **TBC surgeries delivered. That's TBC more than the target/last year.**

✗ **TBC% of people referred with a high suspicion of cancer received their first treatment within 62 days**

✓ **TBC% of eight-month olds had their immunisations on time.**

✓ **TBC% of the eligible population had their Cardiovascular Disease risk assessed in the last five years.**

✗ **93% of people spent less than six hours in the Emergency Department.**

✓ **99% of hospitalised smokers were offered advice to quit.**

✗ **TBC% of those consumers who are smokers and have a family doctor were offered advice to quit.**

NATIONAL HEALTH TARGETS - AT A GLANCE

HEALTH TARGET	TARGET	OUR RESULT	TREND (since last year)	COMMENT
Shorter stays in Emergency Department	95%	Not Achieved	↓	…
Improved access to elective surgery	100%	Exceeded	↑	This year we have continued to focus on 'Operation Productivity' and increasing Hip and Knee surgeries (pg22) to increase the number of people receiving surgery.
Faster Cancer Treatment	85%	Not achieved	N/A	…
Increased Immunisation	95%	Exceeded	↑	Hawkes' Bay DHB remains one of the top performers in this Health Target
Better help for smokers to quit (Hospitals)	95%	Exceeded	-	Hawke's Bay DHB has achieved this target for the last three years.
Better help for smokers to quit (Primary Care)	90%	Not achieved	↓	General Practice continues to have a strong focus on helping smokers to quit.
More heart and diabetes checks	90%	TBC	↑	We have maintained our performance in this area and continue to focus on priority groups who are most at risk of heart disease and diabetes.

KEY:

↑ Improved our performance against the health target.

↓ Our performance against the health target has

– Our performance against the health target has stayed the same.

www.ourhealthhb.nz

Photo courtesy of HB Today

SERIOUS ADVERSE EVENTS

In hospital

A serious adverse event is an event which has led to significant additional treatment, is life-threatening or has led to an unexpected death or major loss of function.

These events are uncommon; however with 38,715 hospital admissions in 2015/2016, we continue to focus on improving the quality and safety of the care that we provide to all our consumers so that we can prevent these events in the future.

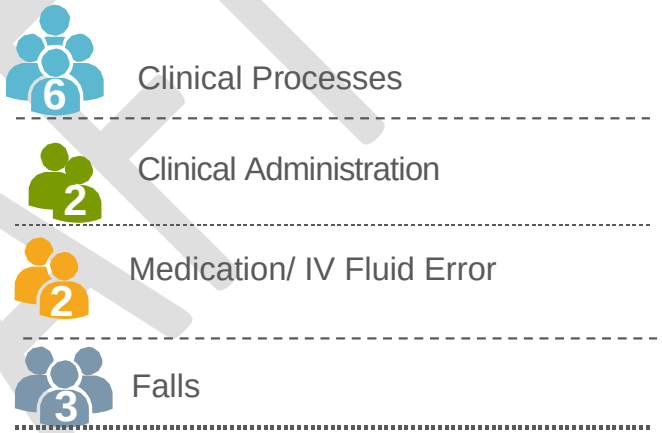
In 2015/2016 Hawke's Bay DHB had 13 serious adverse events which is an increase by two from last year.

When a serious adverse event occurs, we review our processes to try to determine the major cause, or causes that led to the event. When these causes are known, interventions are recommended to try to prevent the recurrence of the same or similar adverse event in the future. The aim is to enhance patient safety by learning from adverse events when they occur.

Did you know?

- Incidents indicate where we need improvement
- The more we report the better we will get through learning and improving
- We reported 4,168 incidents last year
- 13 of these were classified as serious adverse events
- Serious Adverse Event reviews focus on what happened? Why did it happen? What can be done to prevent it happening again?

Serious events 2015/2016



Our focus 2016-2017

- Distribute key patient safety learnings across the sector
- Develop an education programme to train reviewers of serious adverse events
- Work with PHO, GPs and aged care facilities to establish a reporting and learning programme/culture
- Upgrade our electronic risk management system

The Health Quality and Safety Commission releases an annual report titled 'Making our health and disability services safer', which is due to be released later this year. In this report we will provide more detail surrounding these events.

NATIONAL PATIENT SAFETY PRIORITIES

In hospital

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's health care through the national patient safety campaign 'Open for Better Care'. All of New Zealand's District Health Boards need to report on how well they are doing against key targets. These targets are about making sure consumers are not harmed from a fall when in our care, that we reduce the number of infections and that we make sure that when consumers have surgery that they receive the necessary medicines, and that we work as part of a team.

This is how we are doing (results for Jan-Apr 2016 unless otherwise specified):

Falls prevention 1: older consumers assessed for risk. Target 90%

Falls prevention 2: percentage of older patients assessed as at risk of falling who receive an individualized care plan addressing these risks. Target 90%

Hand hygiene: percentage of health professionals who clean their hands before and after having contact with a patient. Target 70%

Surgical site infection targets (Oct-Dec 2015):

Antibiotic administered in the hour before surgery. Target 100% (Achieved 100% in the three quarters prior)

Right antibiotic in the right dose.

Target 95%

Appropriate skin antisepsis in surgery.

Target 100%

Preventing harm from medicines in hospital

In the hospital we commonly use a group of pain killer medicines called 'opioids' (e.g. 'morphine', 'oxycodone', 'codeine'). Unfortunately these medicines can cause serious side effects like constipation. Constipation is when you haven't had a bowel motion ('poo') for three days or more. It can be painful and delay your recovery.

We introduced three things to reduce the number of patients having constipation while on opioids:

1) A patient leaflet and poster to help patients and staff describe bowel motions using the 'Bristol Stool Chart'.
2) A stamp for the patient's health record, to improve how we record each patient's bowel activity - giving us a clearer view of which patients are constipated or at risk of becoming so.
3) A 'laxative ladder' to describe the best laxatives to prevent and treat constipation.

Preventing harm from surgery in hospital

The 'Safe Surgery Program' aims to improve quality and safety of health care services provided to patients having surgery through the use of a 'surgical safety checklist'. The checklist is used to ensure patients receive the right surgery with the right preparation.

This year, a 'paperless' checklist (a poster with prompts) was introduced in our operating theatres. Theatre staff (nurses, doctors and anaesthetists) from Hawke's Bay and Royston Hospitals worked together to ensure they use the checklist in the same way. This enables staff to speak up and ask questions without fear.

Preventing harm from falls in hospital and the community

Last year we planned to take a 'wrap-around' approach to preventing falls and we've made some good progress on this since then. Representatives from HBDHB, Health Hawke's Bay (PHO), Sport Hawke's Bay, St John's Ambulance, ACC, and local Aged Care Facilities meet regularly to actively coordinate falls prevention activities across the region.

During the national 'April Falls' campaign (run in April), the group chose to highlight the falls risk associated with poor vision with 'eyes on falls', offering free eye checks.

An 8-week program called 'Upright and Active' (funded by Age Concern) introduces Tai Chi to improve flexibility and strength. Green Prescription offers individual support programmes and Kori Tinana Mo Nga Kaumatua Taster programmes is offered to kaumatua, based in marae.

We've looked into why people fall in hospital and have found poor lighting at the bedside to be a key factor. We now have an upgrade of the over-bed lighting included in the facilities' maintenance plan.

Preventing Harm from Infection

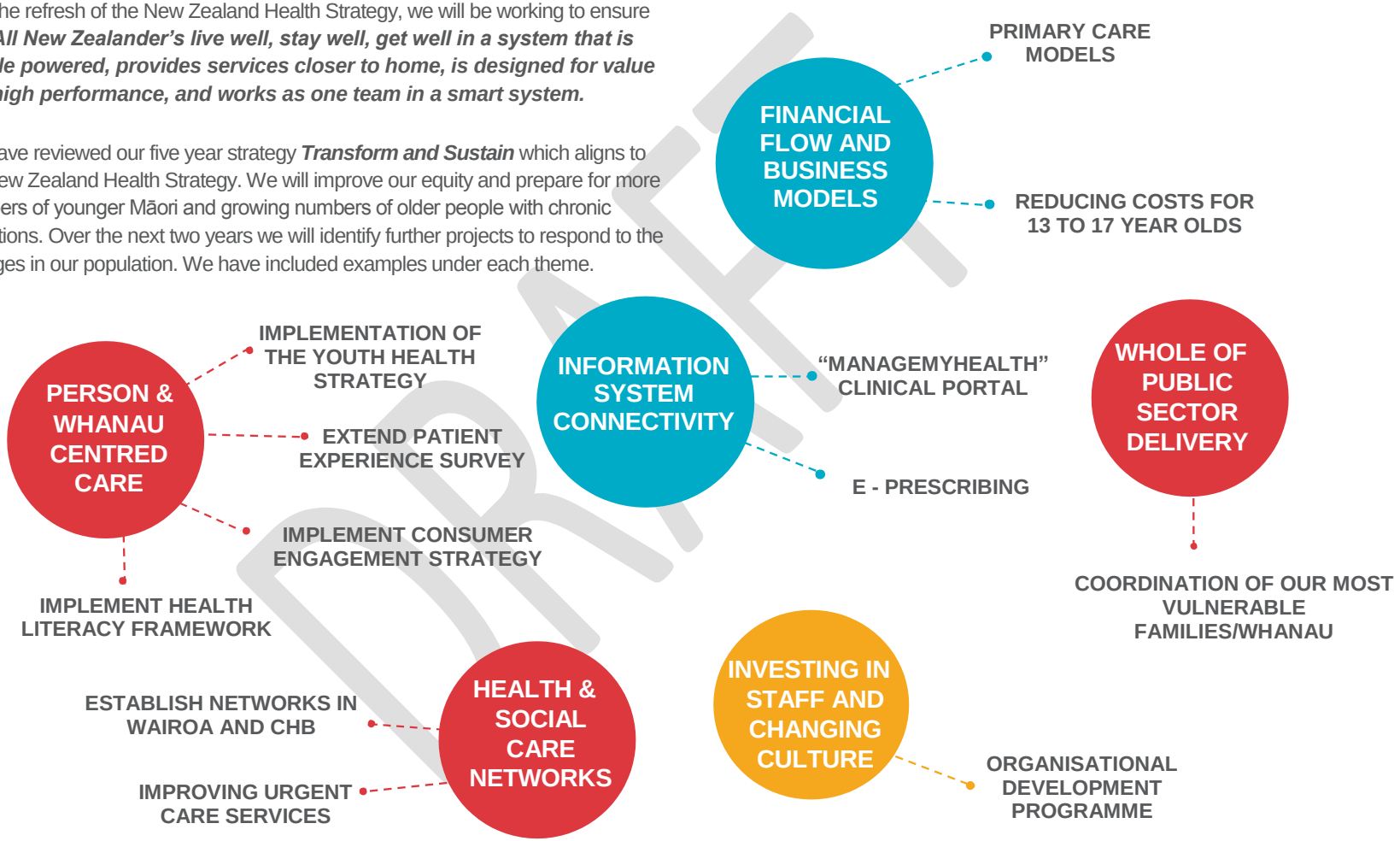
Hand hygiene is recognised as the single most effective way to prevent the spread of infection. As at June 2016 Hawkes Bay District Health Board has achieved 87.5% in the national hand hygiene programme and continues to rank amongst the top performers in NZ.

This year our focus will be the promotion of appropriate usage of antibiotics. We see this as an important patient safety issue to prevent the overuse of antibiotic and the development of multi resistant organisms. Our aim is to improve patient outcomes.

OUR FUTURE FOCUS

With the refresh of the New Zealand Health Strategy, we will be working to ensure that: ***All New Zealander's live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.***

We have reviewed our five year strategy ***Transform and Sustain*** which aligns to the New Zealand Health Strategy. We will improve our equity and prepare for more numbers of younger Māori and growing numbers of older people with chronic conditions. Over the next two years we will identify further projects to respond to the changes in our population. We have included examples under each theme.



OUR QUALITY PICTURE 2016

YOUR FEEDBACK

Consumer feedback

We welcome and appreciate receiving feedback. To improve our services we need to hear your story. Whether compliments, comments, questions or suggestions, complaints or a mixture, your feedback is valuable. It helps us see where we are performing well and where we could improve.

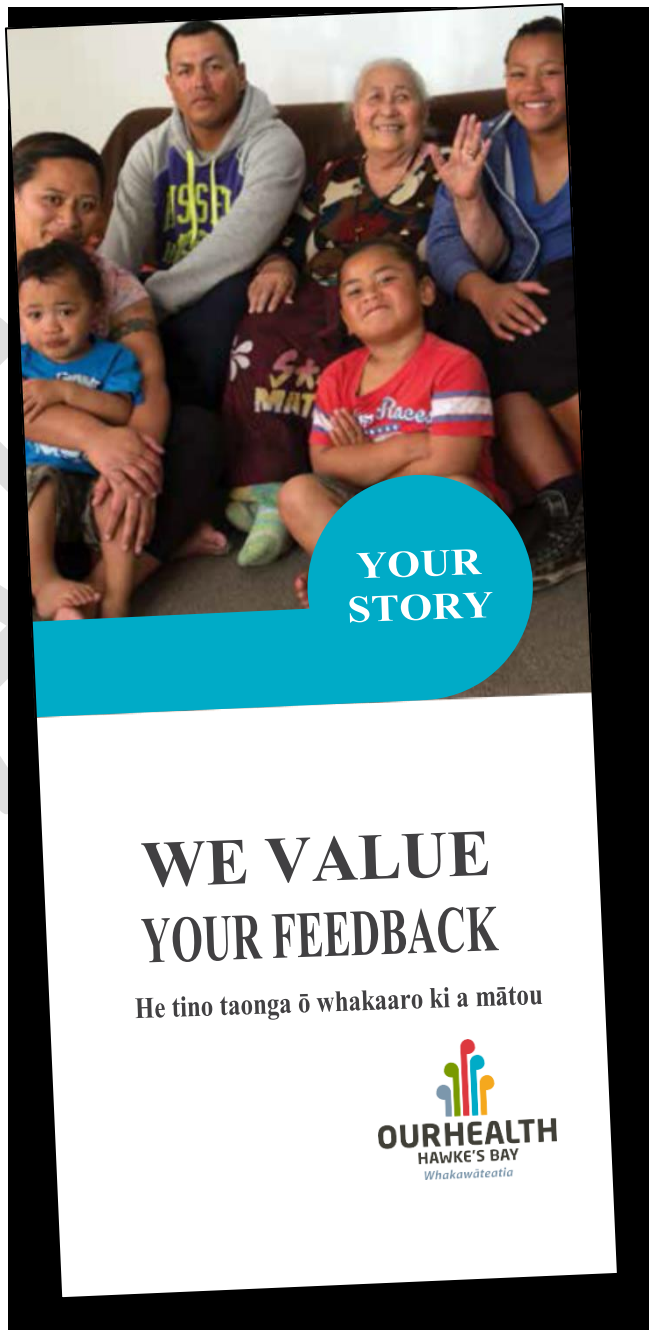
You can give feedback in a number of ways:

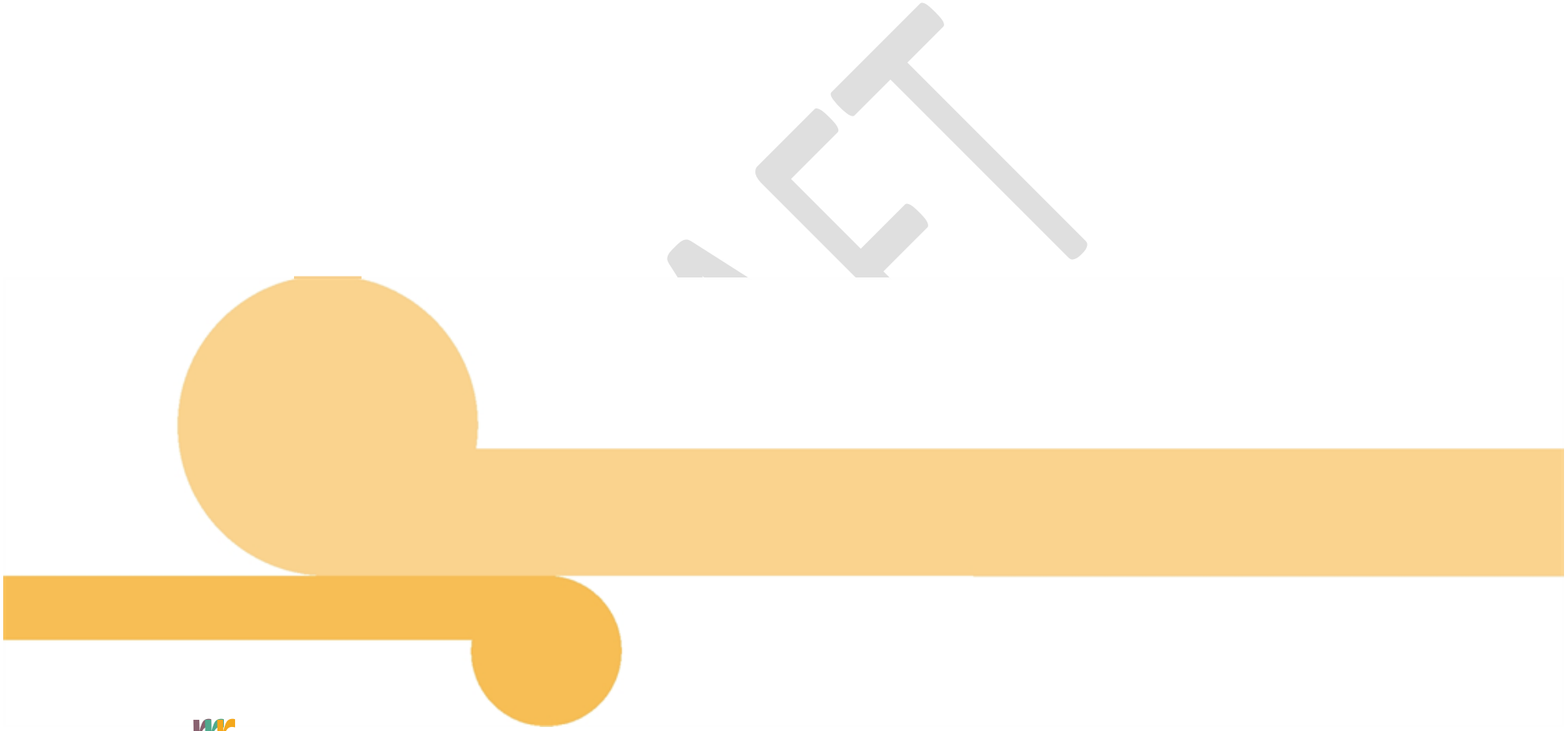
- email us: feedback@hbdhb.govt.nz
- complete an online feedback form: www.ourhealthhb.nz
- phone us: 0800 000 443
- complete a freepost feedback form which may be given to you when you visit, or which can be found in many areas across the DHB's sites.

You may receive a phone call or receive a request to complete a survey based on your experience. It is your choice to take part or not.

Then what happens?

Your feedback will be passed to the manager of the area you are providing feedback on. We will acknowledge your feedback, and if your feedback is a complaint an investigation will take place. We will let you know what we have found out and this may include what we have done to make things better, or what we are planning on doing to ensure things improve.





OUR HEALTH
HAWKE'S BAY

PRIMARY CARE SMOKE FREE (Verbal Update)

Mark Peterson

HAWKE'S BAY District Health Board Whakawāteatia	**Governing for Quality Review**
	For the attention of: **HB Clinical Council, Finance Risk and Audit Committee**
Document Owner: Document Author(s):	Kate Coley Kate Coley – Director QIPS
Reviewed by:	Executive Management Team
Month:	August 2016
Consideration:	For Endorsement

RECOMMENDATION

That Clinical Council & Board:

1. Note the contents of the report
2. Endorse the actions identified which will be incorporated into the overarching Quality Annual Plan
3. Note the opportunity for a peer review to be undertaken to confirm the DHB's self assessment

PURPOSE

The purpose of this paper is to provide Clinial Council and the Board with an assessment of the DHBs current position in relation to its quality and safety system against a recent Health Quality & Safety Commissions (HQSC) publication of February 2016 "Governing for Quality". (Attached). In undertaking this assessment the DHB will have a detailed action plan for implementation to ensure that we enable effective governance for patient safety and improving quality as part of the overarching Quality Annual Plan. Ongoing implementation and monitoring the positive impact of this Plan, should provide the Board with an appropriate level of evidence and assurance that its governance responsibilities for quality improvement and patient safety are being met.

EXECUTIVE SUMMARY

The governance of clinical quality and patient safety occurs within the context of the broader governance roles of boards, which includes financial governance, health & safety, managing risk, setting strategic direction and ensuring compliance with statutory requirements. Governance of an organisation occurs at all levels and requires a program of review and improvement of internal processes and outcomes at every level.

Clinical Governance is defined as

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

An effective system of clinical governance at all levels of the health system is essential to ensure continuous improvement in the safety and quality of care, Good clinical governance makes certain

that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement.

The DHB has both a stated commitment to quality and safety and a well-established patient safety and quality management system in place. With the establishment of the new Quality Improvement & Patient Safety Service however, there is now an opportunity to give more prominence to this commitment and refresh this system by aligning it more to the objectives of the Working in Partnership for Quality Framework, the national and regional priorities, and the priorities identified in Transform & Sustain. It also provides an opportunity to review and enhance the effectiveness of the governance structures with responsibilities for clinical quality and patient safety. This refinement and evolvement has been underway for the past year and will continue over the coming year, with the implementation of the Quality Annual Plan.

The Board is responsible for not only determining the high level patient safety and quality strategy, but also holding management accountable for the planning, delivery, monitoring and review of the overarching system. Reporting back to the Board on this through a regular process is important to ensure fulfilment of the governance role.

The key challenge as an organisation is to continue to maintain and embed the quality framework so as to ensure that patient safety and quality of clinical care is part of everyone's business and is embedded in the culture of the organisation. The focus going forward is on continuous improvement and further development of the quality framework.

This report summarises the systems and processes that are currently in place to effectively manage these issues and therefore provide assurance to the Board that they are meeting their governance responsibilities around patient safety and clinical quality. A self assessment has identified that whilst there are solid patient safety and quality systems and processes in place, there are a number of areas that are work in progress and will need to be completed to further enhance patient safety and clinical quality and the levels of assurance required:

- Implementation of a new clinical governance structure reporting through to Clinical Council that is cross sector, involves consumers and provides leadership in relation to patient safety and clinical quality

- Development of a quality dashboard and performance reporting mechanism that will provide operational teams, Clinical Council and Board with information and indicators of performance against patient safety clinical effectiveness and patient experience performance.

- Establishment of a Consumer Engagement policy and guidance document to all teams

- Continue with the building of capability of individuals ad teams around managing patient safety investigations, co-design and quality improvement methodologies.

Whilst the detailed Action Plan has been developed from a self assessment process, it is acknowledged, and therefore recommended, that this assessment and action plan be peer reviewed to ensure it's robustness and objectivity. Advice from HQSC will be sought to identify options for completeing such a review. Not only will such a review potentially add value in terms of enhancing our current systems, processes and practices, it will also provide an additional level of independent assurance to our governance structures with responsibility for these issues.

BACKGROUND

HQSC's responsibility is to drive improvement in quality and safety of New Zealand's health and disability services, aligned to Triple Aim. The intent of the February 2016 HQSC publication "Governing for Quality" A Guide for District Health Boards, is to encourage discussion and be a catalyst for further improvement and change.

The publication summarises a growing body of local and international research that suggests that effective leadership and commitment of boards will have a significant positive impact on improving quality and patient safety. This leadership and commitment of HBDHB Board was established with the development of the "Working in Partnership for Quality Strategy" in December 2013, and the investment in the development of the Quality Improvement & Patient Safety service, which works across the sector.

The HQSC publication outlines seven essentials for boards to consider to improve the quality and safety of care as follows (with a detailed checklist for an assessment to be undertaken):

- Lead and set clear goals
- Gather information and seek out patient stories
- Establish system – wide measures and monitor them
- Put a high quality and safety culture in place
- Ensure the right mix of people and encourage discussion
- Commitment to ongoing learning at all levels
- Define roles and clear accountability at all levels

Clinical Governance

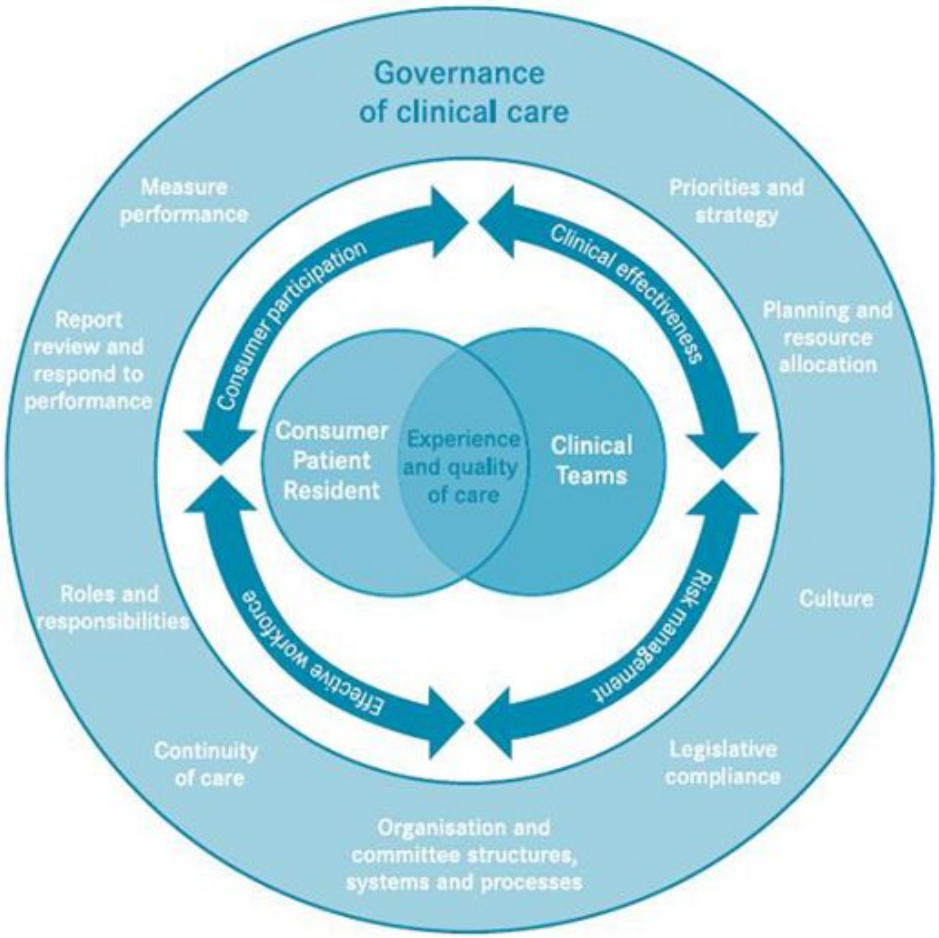
To enable the Board to achieve its quality governance responsibilities, it is essential that HBDHB operates an effective clinical governance structure.

Clinical Governance is defined as

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

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

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



[1]

This clinical governance framework is aligned to the domains of quality and identifies a number of key principles which are consistent in the HQSC publication.

These principles are:

- Strong clinical leadership & ownership
- Rigorous measurement of performance and progress, including reporting and review
- Continuous improvement of quality & safety
- Roles & Responsibilities clearly defined and understood by all
- Compliance with legislation
- Culture of committees, systems and processes to support safety and quality improvement initiatives
- Priorities and strategic direction is clear and communicated
- Focus on consumer experience throughout the continuum of care

[1] Victorian Clinical Governance Policy Framework, 2009

WHAT BOARDS CAN DO – SEVEN KEY ESSENTIALS

The HQSC 'Governing for Quality' publication identifies seven elements for boards to consider to improve quality and reduce avoidable or preventable harm. These are:

- Leadership
- Seeking out the patient voice
- Measurement & Monitoring
- Culture
- People
- Continuous Learning
- Accountability

A gap analysis has been undertaken to identify where the DHB is placed in meeting these seven essential components with a high level action plan being developed. The action plan has been developed in line with the seven key essentials and checklists and will be incorporated into the overarching Quality Annual Plan.

Leadership

Within the Governing for Quality publication leadership is described as the organisation having a clear mission, vision and strategy to improve quality and patient safety, including the setting of objectives and monitoring of performance against those.

The Hawkes Bay health sector has a clearly defined vision and strategy in Transform and Sustain which articulates the sectors commitment to achieving excellence and delivering services to meet the needs of the community. In 2013, the organisation established the Working in Partnership for Quality Framework which defines the quality and patient safety commitment, goals and strategies for the Hawkes Bay health sector, a key enabler to achieve Transform & Sustain.

The Clinical Council was established in September 2010. The purpose of this was to provide clinically led decision making and advice to the Hawkes Bay health system on resource allocation and key service changes. The Council also provides clinical leadership and oversight for clinical quality and patient safety across the sector.

Over time a number of clinical governance committees have been established, only some of which have a formal reporting and accountability line to the Clinical Council. A review of these structures is currently under way, to both enhance the coordination, accountability and communications of these committees, as well as ensure appropriate involvement of consumers and clinicians from across the sector.

The Consumer Council, established in 2013, enables the voice of consumers to be heard at all levels of the organisation, to ensure that we develop and design services that meet the needs of the sector. The Board receives monthly reports from both Councils.

The Quality Accounts have been published every year since 2013 and these provide the health sector with the ability to communicate with the community around patient safety and quality improvement initiatives across the sector.

The Quality Improvement & Patient Safety Service was established in October 2014 and is responsible for the implementation of the Working in Partnership for Quality framework reporting directly to the CEO.

Patient Stories

This is described in terms of boards reviewing progress toward safer care as part of their agenda ensuring the human face by hearing stories of patient's experience of care. This ensures that there is a focus of patient centred care.

The DHB has been sharing patient stories for the last twelve months. This followed a significant piece of work to ensure that the rationale and reasons for sharing stories was communicated to the teams. The board also ensures that the sector develops annual quality accounts which provide information to our community.

Through the diverse backgrounds and interests of its 16 members, the Consumer Council provides the consumer perspective on the setting of strategy, population health priorities, and significant decisions that impact on the sector, and has become well regarded internally and at a national and regional level. Members of the Consumer Council provide input into key strategies and projects, and the development of the Partnership Advisory Group (PAG) in Mental Health has set the standard for co-design in the future.

The Code of Rights and the role of the Health & Disability Commissioner are visible across the organisation and on the Consumer feedback form which is provided to all patients on discharge. Ourhealth website provides information and a further mechanism for patients and their families to provide feedback on the care that they have received. On admission to the DHB patients are provided with information around their safety whilst in hospital utilising the HQSC Patient Safety Card,

Within the QIPS team there is a small team (lead by the Consumer Engagement Manager) focussed on listening, managing and responding to patient complaints and feedback with the relevant clinical teams. All patient complaints and those directed through the Health & Disability Commissioner relating to the quality of care are fully investigated by the clinical teams (and external reviewers if necessary) and recommendations for improvements are tracked and implemented through the Clinical Event Committee structures in place.

The systems and processes around gathering patient feedback through complaints, feedback through website, patient stories and through projects to co-design services is evolving.

The DHB participates in the National Patient Experience survey on a quarterly basis. The survey is emailed/posted to 400 patients discharged in the previous quarter with a response rate of 20% at present.

Measurement & Monitoring

DHB Boards need to ensure that their DHBs identify organisation wide measures of patient safety, update the measures continually and make sure that they are shared across the organisation and with the community. These measures should also include benchmarks against comparable organisation as a way to monitor progress.

HBDHB continues to meet the Health & Disability Standards, and is regularly audited to ensure continuous improvement is achieved. A corrective actions plan is under development and will be monitored on a bi-annual basis. Progress reports are required for the MOH on a defined timetable and these updates are provided by the clinical teams.

The DHB has a number of risks registers by Directorates which are monitored and discussed on a monthly basis enabling the clinical teams to escalate patient safety or quality matters to the health services leadership team, which are subsequently escalated (where appropriate) through EMT, Clinical Council and to FRAC who manage these issues on behalf of the Board.

The DHB has a well-defined process for the investigation of Serious Adverse Events (SAE) that occur in the DHB, and provides education to clinical tams on a regular basis. Monitoring of

recommendations for improvement from the results of patient event investigations, SAE, HDC complaints, patient complaints and at time coronial inquests are reviewed on a monthly basis through the Clinical Events Committee. On an annual basis the DHB provides input into the national SAE release and a report is provided to the Board through FRAC and Clinical Council.

Significant clinical risks are currently reported through to the Finance, Risk and Audit Committee (FRAC) on a monthly basis and both FRAC and the Board are provided with information around Serious Adverse events on an annual basis.

Currently information around the performance of the DHB in relation to a number of quality and patient safety measures is provided from a variety of sources e.g. HQSC, MOH , however this not formally brought together. A quarterly dashboard that is shared with Board, Clinical Council and operational teams is currently being developed to address this.

There is an established clinical audit programme that all clinical ward areas undertake on a monthly basis. This includes code of rights, patient identification, VTE prevention, assessment (baseline monitoring, falls risk, pressure injury risk, family violence routine questioning), care/transition planning, and medication safety; and a bi-monthly report is provided to clinical nurse managers, service directors, nurse and midwifery directors, CMO and CNO

Culture

This relates to the need to ensure that the organisation is responsive and open with patients and their families where preventable harm has occurred. The culture of the organisation needs to be respectful, transparent and resolution focussed, whereby all staff learn from patient events and best practice and continuous improvements within teams are celebrated and recognised. It is crucial that clinicians are motivated and engaged in the quality and safety agenda.

The DHB has an established clinical leadership structure which supports clinical accountability and responsibility for quality and patient safety.

The sector has agreed values and behaviours (which are embedding), a stated commitment to quality and safety (which needs greater promotion) and recognises quality improvements through the HB Health Awards.

Whilst currently the risk management framework is under review, clinical risks are identified, discussed and escalated to the relevant levels of management and/or governance committees as necessary.

There is a well utilised event management system that enables all staff to record complaints, patient incidents, staff safety issues and near misses across the DHB. This allows the DHB to identify themes and trends in relation to patient and staff safety and look at mechanisms to make improvements.

The DHB runs a Staff Engagement survey which provides staff with the ability to provide feedback on a number of matters including patient safety and quality of care. The feedback from the survey is considered and action plans put in place to address some of the issues.

People

To tackle quality and safety issues, boards need a diverse range of skills and experience. This enables robust discussion and challenge to senior leadership teams to enable ongoing improved performance. This diversity of skills and experience also needs to exist at all levels of the organisation.

Across the Board and the organisation there is a diversity of skills and experience around quality and patient safety which ensures that robust discussions can be undertaken. In the past there have been discussions around key patient safety issues for example patient labelling errors, ICU, Radiology which has enabled improvements to be made. The Clinical Council provides a forum for clinical quality and safety matters from across the sector to be raised and discussed.

The DHB has established recruitment processes in regards to ensuring clinicians have the necessary qualifications, skills and experience to meet the requirements of the position. A number of committees are in place to ensure that ongoing credentialing and professional development of health professionals meets the legislative requirements. Credentialing of specialties is undertaken on a biennial basis, identifying any gaps and issues for the services to resolve, with an external review occurring every five years.
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Continuous Learning

Boards need to ensure that they have the capability and understanding to engage effectively with quality and patient safety issues. On a practical level this means that boards will be able to review quality and safety plans and reports; evaluate their effectiveness and consider recommendations for improvement.

The diverse skill set of the Board provides the DHB with the ability to review the quality plans, reports and recommendations to ensure that these meet the needs of the organisation. Attendance by the Chairs of the Clinical and Consumer Councils at all Board meetings ensures that additional appropriate advice is available to the Board as required.

Education sessions around clinical quality, co-design, patient safety matters are delivered on a regular basis and the DHB has invested in capability building recently utilising Ko Awatea to provide training in HBDHB.

The DHB has a defined talent mapping strategy that ensures investment and development is targeted at clinical leaders. The Transformational leadership programme has been running for the past three years and over 80 leaders from across the sector have attended the programme, with positive feedback being received from all attendees.

Accountability

The roles of boards and senior leaders in the area of safety and quality are complementary. The board sets the expectation, commitment and strategic direction, driving the organisations safety and quality culture. Senior leaders implement the strategic direction, manage operations and report on safety and quality embedding a high quality and safety culture across the organisation. It is the board's responsibility to ensure action is taken to address and remedy poor performance.

As previously detailed the sector has a clearly articulated strategy and vision, with expectations set of senior leaders to achieve the strategy. Performance monitoring against MOH targets, annual plan, and financials are provided on a regular basis and action plans are developed and implemented to address areas of concern and/or poor performance.

ACTION PLAN

Based around analysis of the seven key essentials for Boards, and also cross referenced against the checklists within the Governing for Quality publication, the following identifies a number of key actions to be undertaken.

In summary the key areas that will need to be addressed are as follows:

- Implementation of a new clinical governance structure reporting through to Clinical Council that is cross sector, involves consumers and provides leadership in relation to patient safety and clinical quality

- Development of a quality dashboard and performance reporting mechanism that will provide operational teams, Clinical Council and Board with information and indicators of performance against patient safety clinical effectiveness and patient experience performance.

- Establishment of a Consumer Engagement policy and guidance document to all teams

- Continue with the building of capability of individuals ad teams around managing patient safety investigations, co-design and quality improvement methodologies.

Key Component	Activities to be implemented
Leadership	Review of Board Induction processes to ensure patient safety and clinical quality is a key component described in position profile and governance requirements Quality Annual Plan developed & endorsed – aligned to framework, regional and national deliverables Ongoing development of Quality Accounts Implementation of cross sector clinical governance committee structure to provide assurance to Clinical Council and subsequently board around patient safety and clinical quality Ensure that Certification Standards are maintained and corrective actions improvements progressed as required Implementation of effective Risk Management Framework
Patient Stories	Development and refinement of Consumer Engagement Strategy, Policy and Guidance document Development of mechanism for sharing stories wider in the organisation Ensure recommendations from patient stories /complaints/ events/HDC are implemented, spread and sustained across organisation. Implement local patient experience survey, utilising results on a weekly/monthly basis to support teams to implement improvements Increase response rates for National Patient Experience survey Review and refresh information provided to patients on admission and discharge Quarterly report sharing of results & feedback from national and local patient experience survey Quarterly monitoring of patient complaints in regards to staff behaviours / care provided to ensure performance of individuals managed effectively

Key Component	Activities to be implemented
Measuring & Monitoring	Development of Quality dashboard, focussing on patient safety, clinical effectiveness and patient experience Ensure 'quality improvement and patient safety' is an agenda item on all 'management' team meetings. Legislative Compliance programme – reinitiated and completed on an annual basis Certification-Corrective Actions – activities and improvements progressed Development of an annual clinical audit programme of work, through the Clinical Audit Committee and Clinical Council.
Culture	Ensure clinicians fully trained in Open Disclosure best practice Implementation of the overarching Health Literacy framework across the HB health sector Establish targets for ongoing reduction of Serious Harm events Implementation of new Risk Management framework for HBDHB Reporting against HQSC Safety indicators Ensure implementation of overarching Privacy Action Plan Development of mechanism for sharing learnings wider in the organisation to enable spread of improvements. Staff Engagement survey implemented with action plans at an organisational and departmental level. Implementation of a new event, risk and feedback management system across the DHB and wider sector, ensuring all patient events, risks ad complaints are captured and providing the DHB with the ability to easily identify trends and take necessary action
People	Continue to implement building capability training strategy Implementation of cross sector clinical governance structure, with diversity of representation on these committees to provide assurance to Clinical Council and subsequently board around patient safety and clinical quality Provide a quarterly quality dashboard to ensure opportunity for discussion and debate Ensure that performance appraisals incorporate quality and patient safety as a core competence for all appropriate leaders, clinicians and clinical teams Ensure appropriate quality and patient safety conditions are included (and managed) in all provider contracts.
Continuous Learning	Implementation of cross sector clinical governance committee structure to provide assurance to Clinical Council and subsequently board around patient safety and clinical quality. Ensuring effective flow of information and sharing of learnings Develop coaching expertise in QIPS team to support clinicians around patient safety and quality improvement Continue to develop capability of all clinical teams

Key Component	Activities to be implemented
	Extend the current talent mapping strategy across the sector and wider to enable the identification of emerging talent, the development of talent pools and the implementation of a development strategy for those individuals to ensure succession plans are clearly identified and managed
Accountability	Review position profiles to ensure that responsibilities and accountabilities for patient safety and quality improvement are documented Ensure that there is clinical leadership and a multi-disciplinary approach to the review of patient events/incidents supported by the QIPS team.

PEER REVIEW

Whilst the above Action Plan has been developed from a self assessment process, it is acknowledged, and therefore recommended, that this assessment and action plan be peer reviewed to ensure it's robustness and objectivity. Advice from HQSC will be sought to identify options for completeing such a review. Not only will such a review potentially add value in terms of enhancing our current systems, processes and practices, it will also provide an additional level of independent assurance to our governance structures with responsibility for these issues.

ATTACHMENT

Publication from HQSC entitled "A Quality & Safety Guide for District Health Boards".

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

open FOR BETTER CARE
Hāpai ake te toiora

A QUALITY & SAFETY GUIDE FOR DISTRICT HEALTH BOARDS

GOVERNING FOR QUALITY

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About this guide

This guide will help district health boards (DHBs) put quality and safety at the centre of governance and drive improvement in their organisations. While the guide has been written with DHBs in mind, the principles and guidance are relevant and can be applied to all health care providers.

It includes:

- an outline of the role of boards as agents for quality and safety improvement
- the seven essential steps boards can take to improve the quality and safety of health care services:
  1. Lead and set clear goals
  2. Gather information and seek out patient stories
  3. Establish system-wide measures and monitor them
  4. Put a high quality and safety culture in place
  5. Ensure the right mix of people and encourage discussion
  6. Commit to ongoing learning at all levels
  7. Define roles and establish clear accountability at all levels
- a checklist to guide boards and assess progress.

CONTENTS

Foreword

If we are serious about improving the quality of health and disability services and reducing avoidable or preventable harm to patients, boards must engage in this imperative – it is the board that sets the priorities for a DHB and culture begins at the top.

An increasing body of evidence points to board leadership as a critical element for better, safer health care. Bader and O'Malley have made the point that boards 'can choose to be either active leaders or passive overseers in this process'.[1]

Leadership in this context requires a commitment to act, but it also requires an understanding of the issues. There is quite a lot to understanding the fundamentals of quality and safety in health care, much as there is to understanding the fundamentals of board responsibilities in respect of governance and finances. Many board members are already knowledgeble in all these areas, but for many more, education and training will be required – and for all who take on the responsibility of directorship, ongoing education is important.

The Health Quality & Safety Commission is responsible for driving improvement in the quality and safety of New Zealand's health and disability services. Our objectives have been captured in the New Zealand Triple Aim:

- Improving quality, safety and experience of care.
- Improving health and equity for all populations.
- Gaining best value from public health care resources.

Achieving these objectives requires, first, that we do the right things and, second, that we do these things right first time.

Ensuring the quality of health care is inextricably linked to ensuring the financial health of DHBs. It is vital to ensure we do the right things. The health outcomes of a population are determined by many other factors as well as health care services. Continuing to increase the funding invested directly in health care can only be achieved at the cost of other essential social requirements, such as housing, employment and education. Health care is not just about increasing production, in the sense of more procedures and consultations. If patients in New Zealand are to receive effective care that meets their needs, we cannot waste money on treatments not supported by reasonable evidence. Nor can we waste money on the costs of avoidable or preventable patient harm.

Variation in accessed health care is recognised as a problem internationally. The discrepancies in outcomes between different population groups in New Zealand is evidence that we have not yet met the needs of all New Zealanders – although progress is being made.

Governing for quality has a critical role to play in furthering these goals and getting the best possible results out of available resources – for all our populations.

There is a great deal of impressive improvement work already underway across New Zealand DHBs, and many examples of good governance. However, if we want to have truly world class services, the pursuit of excellence must continue. I hope *Governing for quality* will be a catalyst for further discussion and action in this regard. I encourage board members to use this resource to help drive quality improvement even further – and to provide feedback on its value, and on ways to improve future editions of this publication.

Professor Alan Merry ONZM FRSNZ
Chair, Health Quality & Safety Commission

1 Bader B, O'Malley S. 2006. Great Boards. *7 things your board can do to improve quality and patient safety*. Bader and Associates Governance Consultants. 6(1). URL: www.greatboards.org (accessed November 2015).

Introduction – the role of governance in improving quality and safety

Improving quality and safety is fundamental to the DHB's governance role.

It is the board, with the senior leadership team, which sets the organisation's strategic quality direction and goals for improvement. It is the board and senior leaders that model desired attitudes and values that drive quality improvement. Their approach to governance will reflect the compassionate, patient-centred, high-quality care they expect of others.

That's why boards are so instrumental in setting and championing a culture within their organisations that puts the quality and safety of consumer care at the heart of everything they do.

The board, along with senior leaders, needs to put effective governance structures in place so teams can adapt to constantly changing health care environments.

The board environment should be safe, where honest and unfiltered discussion on patient safety and quality issues is encouraged.

Board members are responsible for putting in place systems that involve patients and families/whānau in quality-of-care discussions – listening to the consumer voice. This is also essential for ensuring equitable outcomes for all.

It is the role of the board and senior leaders to set clear expectations of staff and communicate compellingly about quality and safety. The aim is to create the right environment for organisational learning.

The board needs to drive a culture where education and training are valued and readily available to all staff. Such a culture will help to create an environment where all staff have the knowledge, skills and behaviours appropriate to their role. And board members themselves need to ensure they understand quality and safety issues to fulfill their responsibilities. This guide has been developed to improve understanding and encourage discussion about these issues. If you would like a two-hour workshop on quality and safety issues at your DHB, please contact the Health Quality & Safety Commission.

Boards *do* affect quality

A growing body of international research into health organisations shows boards can make an enormous contribution to improving quality and patient safety. Effective governance and oversight by well-informed and skilled board members lies at the heart of improving quality and patient safety in health organisations.

In particular, evidence highlights the importance of strong and committed leadership. It is the board's role to make better quality of care their organisation's top priority, and to set clear and measurable goals for improvement.

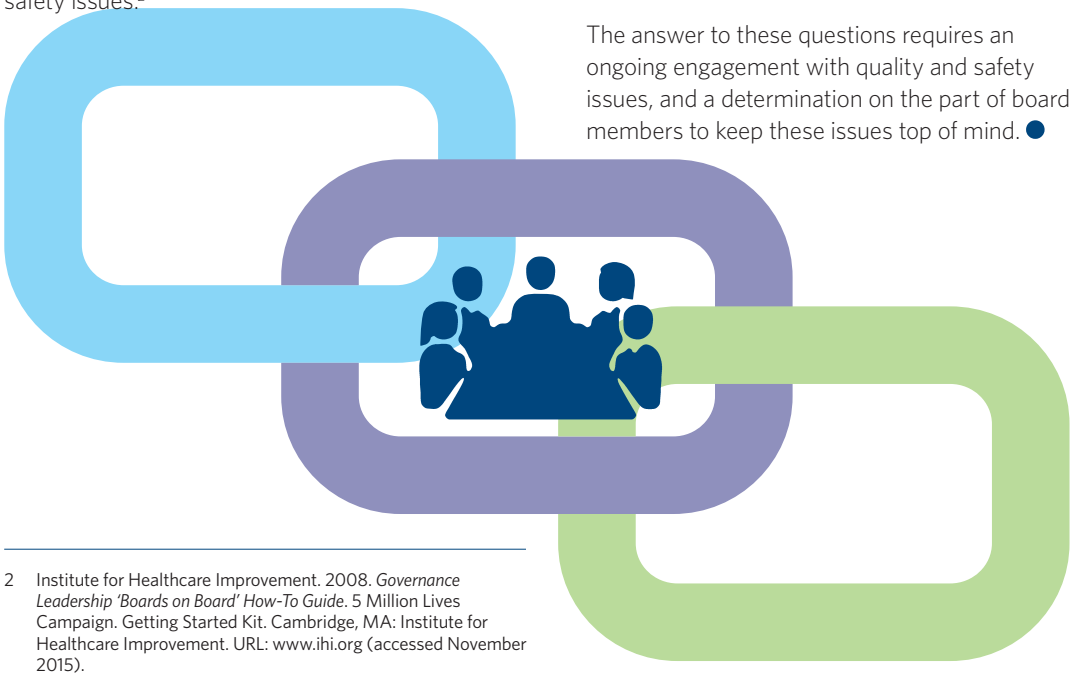
An effective board supports and expects a culture that continually strives to improve the quality and safety of care provided, and values experience, diversity and respect.

International studies recommend that boards need to allocate adequate meeting time to quality and safety issues.[2]

All board members should be able to answer these questions about quality and safety:

- How safe is your organisation?
- Is your organisation treating patients and families/whānau with respect and compassion?
- Is your organisation responsive to the cultural needs of all your patients, families/whānau and communities?
- Is patient safety improving year by year?
- Does your organisation collect robust data to measure quality and patient safety?
- Does your organisation achieve equitable outcomes for all patients, families/whānau and communities?
- Does your board report publicly against its quality and safety aims?
- How does your organisation compare with other similar organisations?

The answer to these questions requires an ongoing engagement with quality and safety issues, and a determination on the part of board members to keep these issues top of mind. ●



2 Institute for Healthcare Improvement. 2008. *Governance Leadership 'Boards on Board' How-To Guide*. 5 Million Lives Campaign. Getting Started Kit. Cambridge, MA: Institute for Healthcare Improvement. URL: www.ihi.org (accessed November 2015).

What the research tells us

Around the world, research is being conducted into the impact of board decision-making on patient safety. Evidence shows better outcomes are achieved in organisations where the focus on quality issues is paramount.

Recent research[3] involving nearly 4000 New Zealand health professionals established there is already an encouraging foundation on which to build a more robust quality and safety culture.

Key findings included:

- 77 percent agreed or strongly agreed health professionals in their DHB involved patients, families and whānau in efforts to improve family care
- 71 percent agreed or strongly agreed in their clinical area it was easy to speak up if they perceived a problem with patient care
- 71 percent agreed or strongly agreed there were people and processes in place to identify, analyse and act upon all adverse events to prevent future occurrences
- 74 percent agreed or strongly agreed their organisation had zero tolerance for patient harm anywhere in the organisation.

Overall the results of the survey provide a positive view of the existing quality and safety culture within DHBs. However, people saw room for improvement in the systems, structures and work processes across departments, work groups and with outside providers. A third of those surveyed agreed or strongly agreed 'there was little coordination of quality improvement efforts across departments and work groups'.[4]

The need for greater inspiration and leadership in these areas was also identified. Less than half of those surveyed agreed the organisation inspired them to do the best job they could every day. And nearly 60 percent of those surveyed thought there was further room for improvement in the quality of patient care.[5]

There is a challenge here for DHBs to advance quality and safety through their leadership, planning and system-level coordination.

Another three-year study[6] of New Zealand organisations highlighted that collective learning and continuous improvement are the central elements of an adaptive, resilient, high-performing organisation. The study describes organisational learning as 'a powerful and sophisticated competency' to help organisations 'adapt, survive and thrive in turbulent environments'. In this study, the specific characteristics of an adaptive organisation are identified as:

- an openness to learning, feedback and ongoing improvement
- an environment that encourages problem-solving, rather than handing out blame
- a safe culture where it is okay to admit mistakes and jointly learn from them
- an ability to pause and reflect as individuals and as a group
- an ability to listen to others and consider alternative options
- a willingness to explore untested new ideas.

3 Martin G, Mason D, Lovelock K, et al. 2015. *Health professionals' perceptions of quality survey. A report for the Health Quality & Safety Commission*. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/General-PR-files-images/Perceptions-of-quality-survey-Oct-2015.pdf (accessed November 2015).

4 *Ibid*.

5 *Ibid*.

6 Nilakant V, Walker B. 2015. *Building Adaptive Resilience, high-performing today, agile tomorrow, thriving in the future. Key findings from the Building Resilient Infrastructure Organisations Project*. Christchurch: University of Canterbury.

Other international research also demonstrates a strong correlation between high-performing health care organisations and boards that are actively engaged with quality assurance measures and issues. One US study showed 91 percent of high-performing health care organisations had boards that regularly reviewed quality data and information.[7]

Research also shows, however, that quality and patient safety is an area boards often neglect.

A study of over 5000 health care organisations in the USA described the state of health care governance as 'highly variable'.[8] Another survey of 1000 board chairs in US hospitals found 'fewer than half of the boards rated quality of care as one of their two top priorities, and only a minority reported receiving training in quality'.[9]

A national survey of health trust boards in the UK reached a similar conclusion. It found boards of governors were generally 'well-meaning but largely ineffective in helping to promote and deliver safer healthcare within their organisations'.[10] This was mainly due to a lack of awareness and understanding of the vital role of board members in assuring quality.

An Australian study[11] confirmed boards *are* key agents for change and reform in any health system. It identified the need for boards to elevate their vision beyond day-to-day processes, and give the organisation its direction, 'the purposes and values that define its actions'. The key message in this study was that board members were responsible for 'big-picture', strategic thinking that directly impacts on quality and patient safety.

7 Jha A, Epstein A. 2010. Hospital Governance and the quality of care. *Health Affairs* 29(1). URL: http://content.healthaffairs.org/content/29/1/182.full.html (accessed November 2015).

8 Institute for Healthcare Improvement 2008, *op. cit.*

9 Jha et al 2010, *op. cit.*

10 Mannion R, Freeman T, Millar R, et al. 2015. Effective board governance of safe care: A theoretically underpinned, cross-sectioned examination on the breadth and depth of relationships through local case studies and national surveys. *Health Services and Delivery Research* no 4.4. URL: http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0020/144821/FLS-10-1007-02.pdf.

11 Duckett S, Beaumont M, Bell G, et al. 2015. *Leading Change In Primary Care: Boards Of Primary Health Networks Can Help Improve The Australian Health Care System*. URL: http://ahha.asn.au/sites/default/files/docs/policy-issue/leading_change_in_primary_care.pdf (accessed November 2015).

The need to challenge outmoded views of governance

One of the main barriers to improving quality and safety is a narrow, outmoded view of governance. Too often boards are seen as only being responsible for an organisation's financial health and reputation.

As a consequence, little attention is given to establishing an organisational culture that will drive ongoing improvements in quality and patient safety.

Research in the USA has shown quality issues often receive significantly less attention at board level than financial issues. Ninety-three percent of US hospital boards put financial performance on the agenda at every board level compared with only 63 percent putting quality performance issues on the agenda at every board meeting.[12] Another telling statistic was that at low-performing hospitals, nearly half the boards did not regularly review quality measures.

Another barrier that can arise at board level is the perceived tension between financial considerations and quality improvement, as if a trade-off is required between the two. Enhancing quality does not necessarily cost more – in fact improved processes and workflows may use fewer resources and can reduce costs over the long term.

A study[13] of the link between quality improvement and health care financial performance, involving 1784 community hospitals in the USA, found quality programmes were a consistent predictor of positive financial performance. 'The longer a hospital's involved with QI (quality improvement), the higher the cash flow and the lower the cost per case.'[14]

'... [M]any of the arguments against quality improvement have been based on the premise that such programmes are expensive and divert scarce resources... This has proved not to be the case.' [15]

DHBs that effectively implement quality improvement programmes can expect to improve their financial performance. An integral part of quality improvement is therefore getting the chief financial officers of health organisations to view their role as chief quality enabler, rather than simply budget-keeper.

Board members will also be aware of the high costs of neglecting quality and safety. Examples include under-investment in regional/national electronic systems and adverse event review/investigation processes. An organisation's reputation is easily damaged by a serious failure in patient safety.

Just how damaging it can be, and the enormous costs involved, is vividly outlined in the Francis Report,[16] which many in the health sector will be familiar with. This report highlighted a whole-system failure at the Mid-Staffordshire NHS Foundation Trust. Its central message was that improving quality and safety requires the safety of the patient to be at the centre of service delivery, the first concern of professionals and the shared responsibility of all. ●

12 Jha et al 2010, *op. cit.*

13 Alexander JA, Weiner BJ, Griffith J. 2006. Quality Improvement and hospital financial performance. *Journal of Organizational Behavior* 27 (7): 1003–29.

14 *Ibid.*

15 *Ibid.*

16 www.nhsemployers.org/your-workforce/need-to-know/the-francis-inquiry

Modern view of governance

The modern view of governance is that boards have a significant responsibility to make better quality of care their organisation's first concern. This responsibility cannot just be delegated to medical staff and executive leadership – it is the boards' responsibility to ensure these delegations are acted on effectively. Ensuring patient care is safe and harm-free is at the very core of a board's legal and fiduciary responsibility.

In practice, taking responsibility for improving patient quality care means boards will:

- spend an adequate amount of board time on quality issues
- hold the chief executive accountable for quality and safety goals, and see the chief executive as the person who has the greatest impact on quality
- base the chief executive's remuneration on quality and safety performance
- participate in the development of explicit quality criteria to guide clinical staff
- review patient and family/whānau satisfaction scores annually
- set the agenda for quality
- involve clinical staff in discussions around quality, with clinical staff taking the lead.[17]

A core role of the board is to improve how quality systems function. To achieve this, boards need to actively pursue change, innovation and reform. A board is not there to maintain the status quo. It has to think and act creatively.

A board must articulate its vision of change and strike the right balance between stability and innovation. The active pursuit of change is an evolutionary process that involves board members seeing themselves as enablers. They must have a clear vision and use all means at their disposal to achieve safer care.

Research highlights[18] a number of things all boards can do to improve quality and reduce avoidable or preventable harm. These are outlined in the next section.

17 Institute for Healthcare Improvement 2008, *op. cit.*

18 *Ibid.*

What boards can do – the seven essentials

1. Lead and set clear goals

It is vital an organisation is unified around a clear mission, vision and strategy to improve quality and patient safety. This involves the board setting a clear direction and monitoring performance. The board's commitment to improving quality must be unwavering and visible to all who work in the organisation.

This vision must be communicated repeatedly to all stakeholders. Boards and chief executives will drive the right leadership culture and nurture people with the skills to lead the changes they desire.

Board members will demonstrate an energy and appetite for improvement. Studies have shown lack of will and commitment on the part of the board is a common cause of quality improvements stalling. A highly engaged board 'will be the source of will for the entire organisation'.[19]

Boards can set specific goals to reduce harm each year and make a public commitment to measurable quality improvement.

2. Gather information and seek out patient stories

Boards will review progress toward safer care as part of considering every agenda item at every board meeting. It is also important they put a 'human face' on harm data by hearing stories of patients and families/whānau who have experienced harm. Such story-telling is a powerful way of provoking fresh conversations and helps to guarantee a patient-centred approach at board discussions.

Boards will also receive detailed information from various sources to help establish patterns of harm. One idea is to report back to the board on a significant patient injury in the health care organisation. This will involve sharing the stories of the patient, family/whānau and staff involved. The aim is to illuminate the nature and source of hazards in a complex health care system.

Other potential sources of valuable information include:

- surveys of patient and family/whānau experience
- surveys of staff attitudes and perceptions towards organisational safety culture.

3. Establish system-wide measures and monitor them

Boards need to identify organisation-wide measures of patient safety, update the measures continually and make them transparent to the entire organisation and stakeholders.

A board must make sure it is getting the right information on quality of care and the reports it receives contain data that can help board members track quality improvement at the system level. These measures will also include benchmarks against comparable organisations as a way to monitor progress. An example is the rate of medical harm per 100 admissions or per 1000 patient days.

Boards should be educated to understand data in a range of formats. It is also recommended boards present their organisation's key safety data in an easily understood 'dashboard' format. Simple, visual displays are an important aspect of providing a high-level overview of performance against selected quality and safety indicators. Dashboards should be designed to include those areas that impact on quality and safety in an organisation.

19 *Ibid.*

Boards will also consider establishing a quality and safety sub-committee, chaired by a board member, which analyse quality and safety issues in greater depth than is possible at a board meeting. This is common practice when dealing with financial issues.

4. Put a high quality and safety culture in place

Boards will commit to establishing and maintaining an environment that is respectful, fair and just for all who experience pain and loss as a result of avoidable or preventable harm – patients, families/whānau and frontline staff.

Boards need to drive a culture of high quality and safety characterised by:

- respect
- transparent and open communication
- a commitment to full disclosure
- apology and support where needed
- resolution for patients and families/whānau where harm has occurred.

Boards will demonstrate the courage and commitment to confront these issues, and model expected attitudes and behaviours to the rest of the organisation. They will encourage staff members to proactively manage risk and maximise clinical safety.

In seeking a culture change, experience shows organisations should concentrate on identifying existing pockets of good practice that other groups can emulate. If people are doing good work, it's important for organisations to understand how they got there, and how staff leaders and clinicians worked together to achieve the results.

It is best to focus on delivering positive messages about change rather than negative ones. Every organisation will have examples of great culture and exceptional performance. The challenge is to replicate them. Usually it is not a matter of people not wanting to change, but not knowing how.

It is also important to celebrate learning and achievement, when quality milestones are achieved.

5. Ensure the right mix of people and encourage discussion

To tackle quality and safety issues, boards need a diverse range of skills and experience. Traditionally, for their appointed members, boards have tended to include people with a narrow band of skills, ie, people with technical, professional or financial expertise.

A more modern view is that there needs to be a broad mix of board members including those who can think 'outside the square', challenge the status quo and come up with imaginative solutions. Research shows[20] including 'mavericks' who think and behave differently from others will help efforts to achieve change.

Boards members need to be capable of ranging across multiple areas and appointments to the board should reflect this. The overall aim is to create an environment which encourages robust analysis and debate.

20 Massie S. 2015. *Talent management. Developing leadership not just leaders.* London: The King's Fund. URL: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/talent-management-leadership-in-action-jun-2015.pdf?utm_source=The+King%27s+Fund+newsletters&utm_medium=email&utm_campaign=5770588_HMP+2015-06-05&dm_i=21A8,3FOM4,FLXAAH,CALXO,1 (accessed November 2015).

An observational study[21] of four health boards in England revealed great variation in board members' level of engagement with patient safety. It described wide variation in how board debate was steered and influenced by chief executives and board chairs. The most effective discussions happened when there was reasoned and respectful questioning of management, and discussion was framed within the narrative of improving patient and family/whānau experience. This allowed improvements to be explored dispassionately in relation to culture change, rather than being seen as a personal challenge.

6. Commit to ongoing learning at all levels

A board needs to develop its own capabilities to engage effectively with quality and patient safety issues and work out the best strategies to drive continuous improvement. Boards need the skills and knowledge to lead effectively in this area.

On a practical level, board members will have the competence to:

- review quality and safety plans and reports
- evaluate their effectiveness
- consider recommendations for improvement.

Board competencies go to the heart of an organisation's health and safety culture. A recent study[22] found the competencies of board members 'appear to be linked to staff feeling safe to raise concerns about patient safety issues and also their confidence that their organisation would address their concerns'.

Keeping staff engaged and motivated is also crucial to an organisation's ability to provide high-quality care. Through senior management, the board will set an expectation for levels of education and training for all staff. It is easy to over-estimate the ability of frontline staff to improve without the right assistance. Some health care organisations develop their own programmes to build the specific skills staff require to deliver improvements.

A broader view of staff competencies is also required. In the safety and harm context, communication, consultation and relationship-development skills are as important as technical knowledge.

Leadership development is also vital to create an innovative culture. People with talent need to be nurtured so there is confident and empowered leadership at every level.

Boards will place a premium on accessing fresh ideas about improving clinical best practice. They must actively seek out new ideas that are superior to the status quo. The aim is for quality improvement to become part of business as usual.

7. Define roles and establish clear accountability at all levels

The roles of boards and senior leaders in the area of safety and quality are complementary.

A board sets the strategic leadership and direction. It drives an organisation's safety and quality culture. Senior leaders implement the strategic direction, manage operations, report on safety and quality, and implement a high quality and safety culture throughout the organisation.

21 Freeman T, Millar R, Mannion R, et al. 2015. Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England. *Sociology of Health and Illness* 38(2): 233–51.

22 Mannion et al 2015, *op. cit.*

As the diagram below illustrates, this relationship is two-way and dynamic.

More specifically, boards will set clear quality improvement targets for the executive team, and link improved performance in quality and safety to remuneration. Organisational managers will ensure quality and safety figure prominently in performance reviews and are part of day-to-day discussions.

It is the board's responsibility to ensure action is taken to address and remedy poor performance.

Assess your progress – a high quality and safety checklist for boards

Here are some questions to help your board assess the robustness of its quality and safety processes and identify areas for improvement. Working through this checklist will help your board identify gaps and initiate discussion.

Please note a separate tool, *Improving quality and safety in the New Zealand health system: A framework for building capability*, is being developed and will be made available to all DHBs.

Supporting a culture of care and compassion

1. *Supporting a culture of care and compassion will be the single most important factor in driving high quality and safety across health services.*

- What is the process for staff to raise concerns about high quality and safety? How do you ensure they can do this in a safe environment?
- What processes or systems are in place to enable referrers (eg, GPs) or other providers to provide input?
- How do you collect, monitor and analyse patient and family/whānau experience data? How do you use this data when making strategic and/or operational decisions?
- How do you ensure everyone in your organisation takes responsibility for high quality and safety in their role?
- How is high quality and safety reflected in the strategic vision of your organisation?
- How do you recognise the importance of care quality in your staff appraisal systems? What are your procedures for managing poor quality care?
- How do you ensure your staff are aware of and adhere to high quality standards and strategies in the health system?

Promoting board responsibility for high quality and safety

2. *Quality and safety in a DHB is ultimately the responsibility of the board, and will be central to the strategic vision of the organisation. In addition to this, every staff member will be aware of their responsibility in ensuring high quality and safety, whatever their role.*

- What quality and safety information is provided to the board? What else does your board do to assure itself all patients and families/whānau are receiving quality care within your responsible population?
- What priority does the board give to high quality and safety? How is this reflected in the board's work and in the education and training provided to board members?
- How do you address high quality and safety issues with your contracted providers? Whose responsibility is it in your organisation?
- What information do you collect or receive to monitor quality and safety within your contracted providers?

Communicating with and listening to patients and families/whānau

3. *Communicating with patients involves listening to them, and providing them and their families/whānau with the right information to be active participants in their own care. Communication will be respectful, understandable and caring. Patients should be able to answer several key questions to determine the quality of care they are receiving.*

4. *Listening to patients and families/whānau helps alert organisations to issues and sensitive events as well as enabling them to make improvements in the care of their patients.*

- What communication standards do you have to govern staff communication with patients and families/whānau?
- How do you encourage patients and families/whānau to give feedback (including complaints)? What proportion of your discharged patients and their families/whānau has provided feedback to you in the last year?
- How do you ensure patients and families/whānau are aware of the Code of Rights and of the role of the Health and Disability Commissioner if they do not feel they receive the appropriate standard of care?
- What is the role of the patient in their care while they are admitted? What information is given to the patients and their families/whānau to enable them to be active participants in their own care, during their time in hospital and post-discharge? How is this information given?
- How do you enable patients and families/whānau to participate in quality improvement in your organisation, and how do you share the results with them?
- How do you close the 'quality loop' and ensure lessons learnt are applied?

Effective information and monitoring systems

5. *Each organisation needs to collect data and build a comprehensive picture about quality and safety in the organisation, to enable issues and sensitive events to be identified before they escalate.*

6. *Data such as the standardised mortality ratio and clinical quality indicators, if analysed effectively, contribute to a robust data set to drive quality and safety.*

7. *The public reporting of key quality and safety data also ensures patients and families/whānau are informed about the quality of care in their DHB.*

- How do you collect, monitor and analyse patient experience data? How do you use this data when making strategic and/or operational decisions?
- How do you collect, monitor and analyse staff experience data? How do you use this data when making strategic and/or operational decisions?
- What is your early warning data set, to enable you to identify and monitor risks and pick up issues before they escalate?
- How do you collect, monitor and analyse data on adverse events?
- How do you collect, monitor and analyse data on mortality?
- Where is the information shared and discussed, and resulting actions agreed? How is progress against agreed actions measured and monitored?
- How do you ensure appropriate action is taken and is working?

Maintenance of high professional standards and confidence

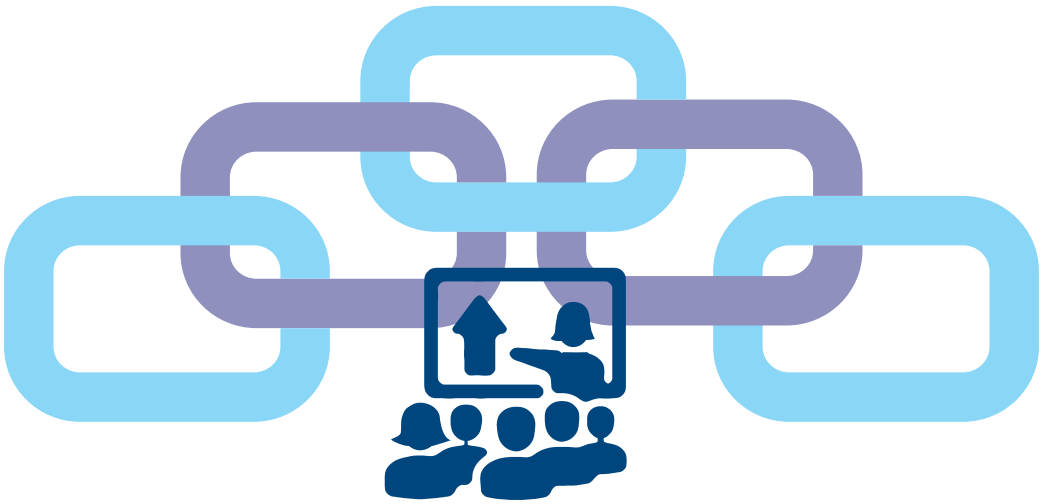
8. *High quality and safety in the health system is also maintained through law and regulation. This includes auditing services, credentialing of clinicians and a range of standards staff working in the health sector are required to meet.*

- How do you ensure recommendations from the Health and Disability Commissioner are put into practice? Whose responsibility is it to ensure this happens?
- How do you ensure your credentialing processes are robust? How often are senior clinical staff credentialed?
- How do you ensure issues raised in HealthCert and other audits are addressed? Whose responsibility is it to ensure this happens?

Strengthening clinical governance and clinical leadership

9. *Clinicians are not only responsible for the provision of high quality patient care; their leadership is also important at all levels of the system. Clinical participation in the management and governance of DHB services is essential in creating the culture needed for high quality and safety.*

- What clinical governance processes and structures do you have?
- How are clinicians represented at the board and executive leadership level?
- How does your board identify potential clinical leaders and what development processes do you have in place for them?
- What clinical audit processes do you have?
- How do you address deficiencies in practice and service, and how do you ensure your organisation learns from any issues that arise?
- How do you ensure the 'quality loop' is closed and lessons learnt are applied? ●



References and recommended reading

Australian Commission on Safety and Quality in Health Care. 2015. *Guide to the National Safety and Quality Health Service Standards for health service organisation boards.* URL: www.safetyandquality.gov.au/wp-content/uploads/2015/04/Guide-to-the-National-Safety-and-Quality-Health-Service-Standards-for-health-service-organisation-boards-April-2015.pdf (accessed November 2015).

Bader B, O'Malley S. 2006. 7 things your board can do to improve quality and patient safety. *Great Boards* 6(1). Potomac, MD: Bader and Associates Governance Consultants. URL: www.greatboards.org (accessed November 2015).

Betbeze P. 2014. *How to Jump-Start Culture Change.* Healthleadersmedia.com. URL: http://healthleadersmedia.com/print/index.cfm?content_id=310996&topic=LED (accessed November 2015).

Duckett S, Beaumont M, Bell G, et al. 2015. *Leading Change In Primary Care: Boards Of Primary Health Networks Can Help Improve The Australian Health Care System.* URL: http://ahha.asn.au/sites/default/files/docs/policy-issue/leading_change_in_primary_care.pdf (accessed November 2015).

Health Quality and Safety Commission. 2014a. *Our Vision and Values.* URL: www.hqsc.govt.nz/about-the-commission/our-vision-and-values (accessed November 2015).

Institute for Healthcare Improvement. 2008. *Governance Leadership 'Boards on Board' How-To Guide.* 5 Million Lives Campaign. Getting Started Kit. Cambridge, MA: Institute for Healthcare Improvement. URL: www.ihi.org (accessed November 2015).

Jha A, Epstein A. 2010. Hospital Governance and the quality of care. *Health Affairs* 29(1). URL: http://content.healthaffairs.org/content/29/1/182.full.html (accessed November 2015).

Mannion R, Freeman T, Millar R, et al. 2015. Effective board governance of safe care: A theoretically underpinned, cross-sectioned examination on the breadth and depth of relationships through local case studies and national surveys. *Health Services and Delivery Research* no 4.4. URL: http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0020/144821/FLS-10-1007-02.pdf (accessed November 2015).

Martin G, Mason D, Lovelock K, et al. 2015. *Health professionals' perceptions of quality survey. A report for the Health Quality & Safety Commission.* Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/assets/General-PR-files-images/Perceptions-of-quality-survey-Oct-2015.pdf (accessed November 2015).

Massie S. 2015. *Talent management. Developing leadership not just leaders.* London: The King's Fund. URL: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/talent-management-leadership-in-action-jun-2015.pdf?utm_source=The+King%27s+Fund+newsletters&utm_medium=email&utm_campaign=5770588_HMP+2015-06-05&dm_i=21A8,3FOM4,FLXAAH,CALXO,1 (accessed November 2015).

Mathias L. 2009. *The Shaping of Decision-making in Governance in NZ Public Healthcare Services.* http://leemathias.com/academic.html

Murphy J. 2014. *Supplementing HCAHPS? Ten Quality Improvement Questions for Everyone in Healthcare.* URL: www.confidentvoices.com/2014/03/06/supplementing-hcahps-ten-quality-improvement-questions-for-everyone-in-healthcar (accessed November 2015).

Nilakant V, Walker B. 2015. *Building Adaptive Resilience, high-performing today, agile tomorrow, thriving in the future. Key findings from the Building Resilient Infrastructure Organisations Project.* Christchurch: University of Canterbury.

Steward K. 2014. Exploring CQC's well-led domain. *How can boards ensure a positive organisational culture?* London: The King's Fund. URL: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/exploring-cqcs-well-led-domain-kingsfund-nov14.pdf (accessed November 2015).

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HAWKE'S BAY District Health Board Whakawāteatia	**Learnings from ICU Review 2013 – Progress Update**
	For the attention of: **Executive Management Team, HB Clinical Council and Finance Audit and Risk Committee**
Document Owner: Document Author:	Kate Coley Kate Coley
Month:	July 2016
Consideration:	For Information

12

RECOMMENDATION

The EMT, Clinical Council and FRAC:

- Note the contents of this report.

EXECUTIVE SUMMARY

At the end of 2015 an urgent request was made to EMT, Clinical Council and FRAC 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.

Incomplete and ongoing actions as at 12 July 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.	GM HR (job- sizing) ICU HoD (to structure registrar support)	Sep-16	ICU SMO job sizing in progress with aim for completion August. HoD will then work on plan for Reg training.
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.
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	PAR Team (Dec 16)	PAR Team positions advertised in July 16
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	Dec-16	Both Medical Director and HoD - ICU will try to make transfers an SMO - SMO process both ways.
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.	Dec-16	Recruitment to PAR RN underway. ICU SMO involvement to be finalised post job-sizing
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.					All other actions complete

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	Oct-16	Implementation of Operations Centre to address issues external to ICU.
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.	HSLT	Aug-16	New investment bid for increased RN resourcing rejected. Developing a plan for managing ICU at 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	HSLT	Aug-16	As 3.1
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	As 3.1 & 3.2	Aug-16	As 3.1 & 3.2
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	GM - HR	Aug-16	ICU SMO job sizing in progress with aim for completion August. New rosters will be developed
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	GM - HR	Aug-16	Await outcome of Job sizing.

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	New investment bid declined. A&M Directorate working with ICU - HoD & CNM to develop a plan for maintaining safety when at/beyond capacity. Will need to consider deferring elective surgery and flying out when workload exceeds safe staffing capacity.
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.	HSLT	Jun-16	Additional funding not approved
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	Dec-16	PAR nurse recruitment underway. The lead role will develop and implement strategy for increasing support of patient at risk.
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	Remains unresolved whilst not financially supported.
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.

Action	Responsibility	Implementation deadline	Progress Update
1. 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 & John McKeefry	Dec-16	Job sizing process documented and agreed with ASMS. ICU SMO job sizing discussions have progressed in June with a meeting to be held on July 25 to finalise the job size and agree next steps
2. Undertake a full review of the current ICU SMO rostering practices.	Colin Hutchison	Sep-16	ICU SMO job sizing in progress with aim for completion August.
3. 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 that outlines current nursing budgeted resource for ICU and HDU patient numbers and trying to determine future demand patterns and future resource requirements.
4. 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	Most recommendations that can be actioned have been. See worksheet of those incomplete.
5. Development of a TOR Guideline & process document	Kate Coley	Jul-16	Underway
6. TOR Template developed	Kate Coley	Jul-16	Draft TOR template tested with Radiology External Review. Accepted. To be finalised alongside the checklist and guidance document by end of July.
7. TOR Checklist developed	Kate Coley	Jul-16	Underway
8. 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	Aug-16	Process for approval of SMO actual hours worked and leave taken underway.
9. 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	Aug-16	Process for SMOs to record actual hours worked under development.
10. 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	Sep-16	TBC
11. 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	Work underway supported by Health Services Planner with all directorates to develop thiese plans
12. Establish effective effective mechanisms for escalation of risks to relevant governance bodies in a more consistent and transparent manner.	Kate Coley	Immediate	Significant risks currently reported to FRAC & Clinical Council. Complete.
13. Monthly meetings set up with HS Directorate teams to review directorate risks & identify any actions, escalation that needs to occur	Kate Coley	Immediate	Monthly meetings in place - Complete. Report under development as part of the enhancement to the current Risk Management Framework
14. Risks identified that are significant to be discussed with HSLG and escalated to EMT/Clinical Council/FRAC as necessary	Sharon Mason	Immediate	Ongoing
15. 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	EMT paper July to endorse implementation of preferred system. Expected full implementation to be completed by March 2017

COMPLEMENTARY THERAPIES POLICY

Dr Andy Phillips

HAWKE'S BAY DISTRICT HEALTH BOARD	**Manual:**	Clinical Practice Guidelines
	Doc No:	HBDHB/CPG/xxx
Complementary Therapies Policy	**Date Issued:**	July 2016
	Date Reviewed:	
	Approved:	Clinical Council
	Signature:	Andy Phillips, CAHPO
	Page:	1 of 17

PURPOSE

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

PRINCIPLES

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

2. All complementary therapists are bound by the Health and Disability Act and Code (2014)

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

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

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

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

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

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

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

10. Consumers have the right to access any complementary therapists they wish.

11. Hawkes Bay DHB does not accept any liability for any patient harm occurring to consumers accessing complementary therapies that are not provided by a Hawkes Bay DHB employee.

INTRODUCTION

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

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

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

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

In accordance with the above guidelines the complementary therapy:

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

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

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

SCOPE

This policy covers the following complementary therapies:

- Massage
- Aromatherapy
- Reflexology
- Indian head massage
- Hand & Foot Massage
- Relaxation
- Reiki
- Yoga
- Hypnotherapy
- Meditation
- Mindfulness

DEFINITIONS

Complementary and Alternative Medicines (CAM)

CAM is an 'umbrella' term used to describe a range of health systems, modalities and practices that may have little in common other than that they are practised alongside or as an alternative to mainstream medicine. There may however be similarities in philosophy and approach – for example, the need to take a holistic approach to health care, including the interactions between physical, spiritual, social and psychological aspects.

CAMs are considered to be any non-medically prescribed substances that a person uses with the belief that they will improve health or wellbeing. The term includes but is not limited to:

- Herbal medicines; herbalism
- Nutritional therapy (vitamins and minerals)
- Health food supplements (e.g. royal jelly)
- Colloids / cell salts
- Chinese medicine
- Rongoa Māori

The use of Complementary and Alternative Medicines is covered by a separate policy: HBDHB/IVTG/144.

Complementary therapies

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

NICE Supportive and Palliative Care Improving Outcomes Guidance (2004)

The following therapies may be practiced:

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

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

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

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

Hand and Foot Massage - see massage

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

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

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

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

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

Meditation - is a practice where an individual trains the mind or induces a mode of consciousness, either to realize some benefit or for the mind to simply acknowledge its content without becoming identified with that content or as an end in itself. The term *meditation* refers to a broad variety of practices that includes techniques designed to promote relaxation, build internal energy or life force (*qi*, *ki*, *prana*, etc.) and develop compassion, love, patience, generosity, and forgiveness. A particularly ambitious form of meditation aims at effortlessly sustained single-pointed concentration meant to enable its practitioner to enjoy an indestructible sense of well-being while engaging in any life activity.

Mindfulness - is the psychological process of bringing one's attention to the internal and external experiences occurring in the present moment, which can be developed through the practice of meditation and other training. The term "mindfulness" is a translation of the Pali-term sati, which is a significant element of some Buddhist traditions. Large population-based research studies have indicated that the practice of mindfulness is strongly correlated with well-being and perceived health. Studies have also shown that rumination and worry contribute to mental illnesses such as depression and anxiety, and that mindfulness-based interventions are effective in the reduction of both rumination and worry.

ROLES AND RESPONSIBILITIES

Hawkes Bay DHB Management Responsibilities:

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

- Where appropriate, negotiating and agreeing with local therapists the place of a complementary therapy as outlined in the protocols to support normal clinical activities, and ensuring where appropriate this is reflected in a written care plan.

- Final agreement prior to therapies being commenced on DHB premises. The management team will be responsible for the monitoring of any therapies practiced.
- Ensuring that details held on the DHB register are up-to-date and correct. They will also maintain a list of practising complementary therapists.
- Auditing practitioners compliance with this policy

Complementary Therapy Practitioners Responsibilities:

Assessment

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

Safe Practice

- The practitioner should provide written evidence of a qualification in their area of practice recognised by the sector regulator - or the relevant professional association
- Therapists will be required to practice using guidelines based on the current evidence of best practice. Any concerns that arise during treatment should be referred to the appropriate Hawkes Bay DHB health profession.
- All therapists will be required to have indemnity insurance and be a member of an appropriate professional body.
- Any essential oils used are required to be genuine, pure essential oils, of therapeutic origin and preferable of organic origin. No perfume or oils of chemical mix or origin are to be used. Carrier oils are to be cold pressed and unrefined, preferably of organic origin.

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

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

Consent:

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

Written Information:

Written information must be provided including the following:

- A description of the therapy and what that entails for the patient.

- A statement to the effect that the therapy is not an alternative to conventional therapies.
- A statement explaining that all therapists have completed relevant qualifications appropriate to their practice.

Record keeping:

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

Training Requirements:

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

They must also:

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

REFERENCES

1. Health and Disability Act and Code (2014)
2. NICE Supportive and Palliative Care Improving Outcomes Guidance (2004)
3. Ministerial Advisory Committee on Complementary and Alternative Health. 2004. Complementary and Alternative Health Care in New Zealand: Advice to the Minister of Health. Wellington: Ministry of Health. http://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/C64721A66307CAD4CC256EF200701547/$file/Complementary%20and%20alternative%20health%20care%20in%20New%20Zealand%20-%20advise%20to%20the%20Minister%20of%20Health.pdf
4. Wong A and Townley SA. Herbal medicines and anaesthesia. Continuing Education in Anaesthesia, Critical Care & Pain, 2011; 11(1): 14-17.
5. Medical Council of New Zealand. Statement on complementary and alternative medicine. March 2011. http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Complementary-and-alternative-medicine.pdf
6. bpacnz. Upfront: Traditional healing and mental health: measuring the effectiveness of rongoa. www.bpac.org.nz/magazine/2010/june/upfront.asp [Information on rongoa].
7. Ministry of Health. 2014. Tikanga ā-Rongoā. Wellington: Ministry of Health

RELATED DOCUMENTS

Hawke's Bay DHB Complementary and Alternative Medicines Policy.

KEYWORDS

Complementary Therapy
Massage

Aromatherapy
Reflexology
Indian head massage
Hand & Foot Massage
Relaxation
Reiki
Yoga
Hypnotherapy
Meditation
Mindfulness

For further information please contact
Dr Andy Phillips, Chief Allied Health Professions Officer

Appendix 1

TREATMENT GUIDELINES FOR COMPLEMENTARY THERAPIES

1.0 AROMATHERAPY

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

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

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

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

1.1 Special Precautions for patients undergoing/just completed radiotherapy

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

1.2 Special precautions for patients undergoing chemotherapy

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

1.3 Permitted Essential Oils

- There is no definitive list available of oils that are suitable for use with condition specific patient groups, and opinion differs amongst aromatherapists themselves on this issue. It is the aromatherapist's responsibility to assess each client for contraindication before choosing appropriate oil.

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

In brain tumours avoid the use of Rosemary.

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

2.0 MASSAGE

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

2.1 Clinical checklist/contraindications

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. 0 REFLEXOLOGY

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

General Precautions:

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

4.0 ACUPUNCTURE

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

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

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

Possible Risks:

- **Bruising**: This can often occur, especially if the patient is on anti-coagulants
- **Sickness**: This can be mild either during or after treatment. If severe the treatment will be stopped. The cause of sickness can be due to the body producing its own analgesic hormones. Further treatments may be continued with fewer needles and for a reduced time.
- **Dizziness/Fainting**: This is very rare, happening usually during the treatment. Stopping the treatment reverses the symptoms and future treatments are commenced with fewer needles over less time.
- **Drowsiness/Fatigue**: The patient may feel sleepy or tired during or after treatment. This should not affect their ability to drive or operate machinery. If this is a problem they may need a few hours rest in the department. The need for further treatments would be reassessed.
- **Increased Pain**: It is not unusual for patients to experience an increase in their pain either during or subsequently after treatment. This can be a positive sign but if levels continue to increase the treatment will be discontinued. A review appointment with the doctor will be given.
- **Pneumothorax:** All treatments to the thoracic area will be given with caution.
- **Allergies/Infections:** Rare occurrences.
- **Broken/bent/stick needle**
- **Allergy to swab.**

Possible Benefits:

- Decrease in the pain
- Decrease in analgesia taken
- Relaxation
- Increased sense of well-being
- Improved sleep
- Increased energy.

5.0 HYPNOTHERAPY

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

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

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

- Psychotic disorders
- Personality disorders
- Severe clinical depression.

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

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

6.0 GENERAL GUIDANCE WHEN GIVING A SESSION

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

- Aprons and gloves should always be worn when working with any immune compromised patient.
- All therapists should establish a working pressure that is comfortable for the patient at all times.
- All therapists are expected to participate in client evaluation.

Appendix 2

HBDHB REGISTER OF COMPLEMENTARY THERAPISTS OFFERING THERAPY AND CONSULTING WITH PATIENTS ON HBDHB PREMISES

Name	Qualifications	Therapies Offered	Professional Body	Indemnity Insurance	Review Meeting

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Appendix 3

COMPLEMENTARY THERAPIST AGREEMENT TO COMPLY WITH THE POLICY

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

Complementary Therapist: …… Dated: ……

Centre Manager: …… Dated: ……

Appendix 4

CONSENT FORM FOR COMPLEMENTARY THERAPY

Patient Name: ……...

Date of Birth: ……

Leaflet/Literature Provided to the Patient: YES ☐ NO ☐

I sign to confirm that:

1. I have received the information provided by the therapist YES ☐ NO ☐
2. I have understood this information YES ☐ NO ☐
3. I consent to the therapy YES ☐ NO ☐
4. I have an existing medical problem and my GP consents to the therapy YES ☐ NO ☐ N/A ☐

1. Signed: ……... Date: ……
   (Patient)

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

   Therapy Offered: ……..

2. Signed: ……... Date: ……
   (Patient)

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

   Therapy Offered: ……..

3. Signed: ……... Date: ……
   (Patient)

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

   Therapy Offered: ……..

4. Signed: ……... Date: ……
   (Patient)

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

   Therapy Offered: ……..

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora / Culturally Competent Workforce**
	For the attention of: **Maori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner: Document Author(s):	Chris McKenna, Chief Nursing Officer Andrew Phillips, Director of Allied Health John McKeefry, General Manager, Human Resources
Reviewed by:	Executive Management Team
Month:	August 2016
Consideration:	For Information

14

RECOMMENDATION:

That MRB, Clinical and Consumer Council and HBDHB Board

Note the contents of this report.

OVERVIEW

The national General Managers Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators. In September 2013, the executive management team (EMT) considered a paper from Tumu Whakarae about an approach to accelerating Māori health plan indicator performance. As a result, individual EMT members agreed to provide a championship role for the Māori Health Plan across areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from John McKeefry, Chris McKenna and Andrew Phillips, Champions for the Culturally Competent Workforce Indicators.

THIS REPORT COVERS

Priority	Indicator	Champion	Reporting Month
Culturally Competent Workforce	▪ Increase % of HBDHB staff who are Māori ▪ 100% of HBDHB staff have completed Treaty on line training ▪ 100% of HBDHB staff have completed "Effective Engagement with Māori" (EEWM) training ▪ 100% of HBDHB staff have KPI's to accelerate the improvement of Māori health	John McKeefry, Chris McKenna, and Andrew Phillips	July 2016

MRB at its June 2016 meeting identified a number of actions for consideration by EMT as below. These were discussed with MRB at its meeting of 13 August 2016 and have been considered as part of the development of this report.

a) Raise the target to Increase Māori Staff from 10% year-on-year to 25% over a five year period.
b) Present the strategy to Increase Māori staff to MRB before going to the Finance, Risk and Audit Committee (FRAC).
c) Review the current HBDHB hiring protocols and processes
d) Review the conviction policy for the HBDHB and whether a conviction that is old, is relevant now
e) Broaden the scope to the target to all disciplines, not just medical, nursing and allied health
f) Shift the responsibility of achieving the target to Hiring Managers setting KPIs for monitoring
g) Senior Management monitor the progress of the target and provide monthly updates identifying why the target was achieved, or not achieved.
h) Train Hiring Managers efficiently and effectively use the Managers Toolkit
i) Māori Health Service involved in the recruitment process form the development of position profiles, shortlisting and interview stages with a member of the team becoming a compulsory member of all hiring/selection panels.

At the July 2016 MRB meeting, MRB also identified further actions for consideration as below.

- Would like to see the midwifery workforce as part of the strategy as Māori midwifery representation is less than 2% in DHBs. Action: The General Manager, Human Resources will look into this with the Chief Nursing Officer
- MRB raised almost two years ago the issues and the need for Māori nursing students to receive formal coaching, pastoral care and Tuakana/Teina support. While EIT are still working on these student services and the DHB are partnering with EIT to develop these services, MRB were somewhat disappointed that these issues have still not been addressed
- There seems to be a gap in the Hiring/ Selection process. Recruitment panels needs strengthening to ensure they understand the need to employ more Māori and why
- Introduction Relationship Based Management Skills training is being led by Andrew Phillips (Director Allied Health HBDHB). Suggest utilising a Māori to support the training to add more value because of their first-hand knowledge and experience
- There is a lot of comprehensive work around having Māori review recruitment processes to ensure Māori priorities and realities are implemented. We should be identifying what is ***not*** attractive about the DHB rather than trying to make the DHB look attractive. The recruitment process needs to be driven by Māori. Structural issues will impinge on Māori recruitment. The barriers of the recruitment process need to be identified through forensic audits.

MĀORI HEALTH PLAN INDICATOR: Culturally Competent Workforce

% of HBDHB Staff who are Māori

Current Performance

At 30 June 2015 our Māori staff representation figure increased to 12.3% of our workforce from 8.7% in June 2012. This is off the back of increases from June 2012 (8.7%) to June 2013 (9.9%) to June 2014 (10.8%).

Unfortunately our performance has plateaued with our performance at 30 June 2016 sitting at 12.5% against a target of 14.3%. The position for all workforce groupings at 30 June 2016 is set out in Table A below. This shows for all workforce groupings the percentage of Māori staff has increased. Pleasingly there have been significant percentage increases of Māori staff representation from 2012 to 2016 in our two biggest workforces – Nursing 7.0% to 10.8% and Allied Health, 9.4% to 13.2%.
Note: Nursing workforce data is unable to be broken down into Midwifery workforce data.

Table A

Report as at 30 June last 5 years

	30-Jun-16					30-Jun-15					30-Jun-14				
	Staff	Target 14.3%	Actual	Actual %	Gap	Staff	Target 12.97%	Actual	Actual %	Gap	Staff	Target 11.78%	Actual	Actual %	Gap
Medical - SMO	142	20	2	1.4%	18	140	18	3	2.1%	15	127	15	2	1.6%	13
Medical - RMO	138	20	7	5.1%	13	119	15	4	3.4%	11	123	14	2	1.6%	12
Nursing	1,504	215	162	10.8%	53	1,453	188	147	10.1%	41	1,386	163	129	9.3%	34
Allied Health	553	79	73	13.2%	6	528	68	69	13.1%	-1	525	62	55	10.5%	7
Support	188	27	55	29.3%	-28	181	23	50	27.6%	-27	174	20	49	28.2%	-29
Management & Admin	457	65	73	16.0%	-8	440	57	78	17.7%	-21	426	50	62	14.6%	-12
Total	**2,982**	**426**	**372**	**12.5%**	**54**	**2,861**	**371**	**351**	**12.3%**	**20**	**2,761**	**325**	**299**	**10.8%**	**26**

	30-Jun-13					30-Jun-12				
	Staff	Target 10.71%	Actual	Actual %	Gap	Staff	Target 9.73%	Actual	Actual %	Gap
Medical - SMO	132	14	1	0.8%	13	128	12	1	0.8%	11
Medical - RMO	122	13	4	3.3%	9	113	11	3	2.7%	8
Nursing	1,393	149	113	8.1%	36	1,313	128	92	7.0%	36
Allied Health	527	56	53	10.1%	3	521	51	49	9.4%	2
Support	182	19	49	26.9%	-30	186	18	46	24.7%	-28
Management & Admin	420	45	56	13.3%	-11	435	42	43	9.9%	-1
Total	**2,776**	**297**	**276**	**9.9%**	**21**	**2,696**	**262**	**234**	**8.7%**	**28**

When we look at Health Services where the majority of our staff work as can be seen in Table B below, the largest gaps are in Acute and Medical and Surgical Services.

Table B

Gap by Service	Nursing	Allied Health
Acute & Medical Services	30	7
Director of Nursing (Hospital)		
Surgical Services	20	3
Facilities & Operational Support	4	1
Laboratory		8
Older Persons & Mental Health	(5)	6
Oral Rural & Community		(6)
Woman Children & Youth Service	6	1
Subtotal Health Services	**53**	**10**

Māori candidates – application shortlisting, interview appointment

Proposed Target

It is proposed by MRB that we increase the target to 25% by 2021 to mirror the population demographic for Hawke's Bay. This would see the percentage increases and gap for the next five years as below in Table C.

A 10% increase for each year would see gaps for each year through to 2021 also set out in Table C.

Table C

Increase year on year 11.82%							Increase year on year 10.00%						
Target	% Target	Emps	Target Maori	Actual	% Maori	Gap	Target	% Target	Emps	Target Maori	Actual	% Maori	Gap
2015/16	14.30%	2,970	425	366	12.32%	59	2015/16	14.30%	2,970	425	366	12.32%	59
2016/17	15.99%	2,970	475	366	12.32%	109	2016/17	15.73%	2,970	467	366	12.32%	101
2017/18	17.88%	2,970	531	366	12.32%	165	2017/18	17.30%	2,970	514	366	12.32%	148
2018/19	19.99%	2,970	594	366	12.32%	228	2018/19	19.03%	2,970	565	366	12.32%	199
2019/20	22.36%	2,970	664	366	12.32%	298	2019/20	20.94%	2,970	622	366	12.32%	256
2020/21	25.00%	2,970	742	366	12.32%	376	2020/21	23.03%	2,970	684	366	12.32%	318

This suggests that increasing the target to 25% by 30 June 2021 will be too high a target because of the sheer number of staff to be recruited and even increasing the target year on year by 10% each year will make the target harder and harder to achieve each year. A target for 2016/17 will be discussed at the FRAC meeting.

Table D

Table D below shows by workforce grouping the recruitment of Māori into the HBDHB, the turnover of Māori leaving the organisation and the total number and percent of Māori staff.

Report as at (or year end) 30 June 2016

	RECRUITMENT				TURNOVER		ACTUAL STAFFING 30 JUNE 2016				
	% Maori applied	% Maori Interviewed	% Maori Appointed	% Maori Appointed v Maori Interviewed	Maori	Total DHB	Staff	Target 14.3%	Actual	Actual %	Gap
Medical - SMO	0.0%	0.0%	0.0%	0.0%	0.0%	4.9%	142	20	2	1.4%	18
Medical - RMO	0.4%	2.0%	2.1%	100.0%	0.0%	0.0%	138	20	7	5.1%	13
Nursing	5.5%	12.3%	13.4%	58.6%	11.0%	9.2%	1,504	215	162	10.8%	53
Allied Health	11.7%	15.7%	13.8%	42.5%	5.3%	8.9%	553	79	73	13.2%	6
Support	29.3%	32.7%	24.0%	35.3%	12.2%	12.3%	188	27	55	29.3%	-28
Management & Admin	13.3%	17.0%	14.3%	29.5%	13.2%	10.2%	457	65	73	16.0%	-8
Total	**9.3%**	**14.5%**	**12.8%**	**44.4%**	**10.4%**	**9.3%**	**2,982**	**426**	**372**	12.5%	**54**

Table D shows that:
For nursing 5.5% of all applicants, 12.3% of interviewees and 13.4% of candidates appointed are Māori, 58.6% of Māori interviewed are appointed.

For Allied Health 11.7% of all applicants 15.7% of interviewees and 13.8% of candidates appointed are Māori. 42.5% of Māori interviewed are appointed.

For Support, 29.3% of all applicants, 32.7% of interviewees and 24% of appointees are Māori. 35.3% of Māori interviewed.

For Management and Administration 13.3% of applicants, 17 of interviewees and 14.3% of appointees are Māori. 29.5% of Māori interviewed and appointed.

This shows we need to increase the number of Māori applying and being interviewed for Nursing, Allied and Management and Administration roles and increase the number of Māori being interviewed and appointed for Support and Management and Administration roles.

As for turnover, Management and Administration and Nursing turnover is higher than the DHB turnover figure. This means we need to do better at reducing turnover in these areas particularly for Nursing as our biggest workforce.

Māori Staff Representation

The DHB wants to achieve Māori staff representation levels equal to the Hawke's Bay population Māori ethnicity of 25%. We want to do this to ensure we can better engage effectively with our communities and provide more jobs (and well paid jobs for Māori).

Overall we have increased Māori staff representation to 12.5% at June 2016. This has largely been achieved through our focus on increasing Māori staff representation in Nursing, increasing from 7.0% at June 2012 to 10.8% at June 2016. Increasing the target form 12.97% at June 2015 to 14.3% at June 2016 did not see a continued lift in performance. Performance at June 2015 was 12.3% only increasing to 12.5% at June 2016. We started the year with a gap of 59 closing to 54 at 30 June 2016. MRB have asked that the DHB commit to a target of 25% by 30 June 2021. This wouldrequire net increases of 109, 165, 228, 298 and 376 additional Māori staff through to 30 June 2021. Increasing the target by 10% each year through to 2021 would require net increases in Māori staff representation of 101, 148, 199, 256 and 318 each year to 30 June 2016.

EMT has considered each of these approaches at their meetings of 12 and 26 July 2016. EMT believes that it is better to commit to a realistic and achievable target for July 2017 and work with Medical, Nursing, Allied and other workforce leaders to confirm the targeted actions that need to be taken workforce grouping by workforce grouping to improve performance against the target. EMT believes a target of 30 June 2017 of 10% increase on the actual percentage achieved to 30 June 2016 of 12.5%. This would mean a new target by 30 June 2017 of 13.75%. A new target for the years' after June 2017 can be set once the targetted actions for each workforce grouping have been identified.

100% of HBDHB staff has completed Treaty on line training & 100% of HBDHB staff has completed the "Engaging Effectively with Māori" (EEWM) training.

Current Performance

We launched the newly developed package EEWM in August 2014 and it has been a success. Current training stats as at 30 June 2016 are attached as Appendix A.

To date 1925 current staff members (65.6%) have completed the EEWM training. A total of 86.3% managers have attended.

Feedback from staff attending has been positive and almost all staff feeding back through formal course feedback sheets state that they would recommend the course. We now automatically enrol all new staff onto the EEWM course and are following up with staff enrolled to make sure they attend.

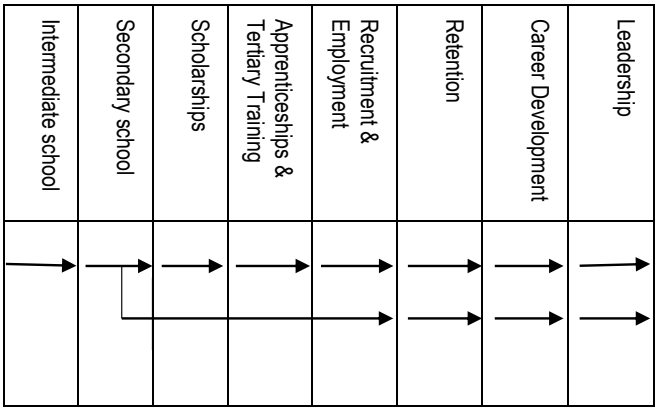
This training is under review and will be modified for internal delivery from within Māori Health Services (MHS) from July 2016 onwards.

Programme Incubator
Our Programme Incubator has been running since 2007. In the 2016 uptake, 19 schools are participating with 352 year 12 and 13 total students of which 89 (28%) are Māori. Our Earn and Learn programme targets year 11, 12 and 13 students that may not have an academic interest but are still interested in working in health. However, once employed into the DHB roles such as Orderlies, Care Associates, Laboratory Technician etc., there is an opportunity to further their career pathway through workplace training to gain national qualifications. This programme has a total of 37 students participating of which 20 (54%) are Māori.

We run our annual Health Careers Expo targeting year 10 and 11 students to get these students interested in health careers and the sciences. Most recently run in June 2016, 492 students in total attended. Ethnicity is not recorded for this.

Turuki
For Turuki we offer Health Workforce New Zealand (HWNZ) funded and other scholarships which have had a total of 79 scholarships taken up over the last three years and promote health careers to Hastings Intermediate students.

Increasing Māori Staff representation
The pipeline for Māori staff out of intermediate and secondary school into employment in the HBDHB is described below:



Students can go from secondary schooling straight into employment or into employment via tertiary training and apprenticeships.

Recruitment and Employment
We need to move our hiring managers to taking on board the challenge of recruiting more Māori staff members from understanding it in their heads to taking it into their HeARTs. We propose to introduce a number of significant new interventions including:

1. Putting in place KPI targets for Māori staff representation into hiring managers' performance plans.
2. Train up all hiring managers to EEWM and live our Values/behaviours.
3. Develop a community engagement campaign targeting local Māori through social media and events in conjunction with Communications.
4. Develop a recruitment campaign to map Māori health workers in New Zealand and Australia and target those workers to work in Hawke's Bay.
5. Understand how MHS is able to recruit high numbers of Māori and share learnings with other hiring managers.
6. Re-balance the membership of interview panels to include the hiring manager, professional lead, Māori staff member/consumer AND a community representative.

The current and proposed new actions for the tertiary training and apprenticeships and for the recruitment and employment parts of the pipeline are set out in Table E. Of the new actions identified some have been completed, others progressed and others only recently identified.

Table E

Intermediate school and secondary school student				Status
Current	Turuki – promoting health careers Incubator – promoting health careers in 19 secondary schools - targets year 12, 13 students Earn and Learn – targets 11, 12, 13 year students Health Careers Expo – targets year 10,11 students	New	Community engagement campaign to be developed including targeting Māori through social media and community events (local and national) held in Hawke's Bay).	Under development
		New	Promote new and innovative models of care that better meet community need /achieve equity e.g. EngAGE.	New
Current	Turuki – scholarships 79 Scholarships offered over last 3 years	New	KPI targets for Māori staff representation into hiring managers' performance plans.	New
Current	Tertiary Training Facebook contact with Incubator students	New	Campaign to promote HBDHB at Tertiary institutions Kanohi ki te Kanohi and on-line.	New

Recruitment and Employment				
Current	Focus on nursing with initial focus on Nurse Entry to Practice (NEtP) nursing and valuing locally trained and Māori applicants by weighting of two.	New	Work with Kia Ora Hauora to identify Māori candidates who are keen to work in the Hawke's Bay and develop ongoing relationships through their course of study.	Underway
Current	Using assessment centres to assess candidates demonstrate relationship management, EEWN skills.	New	Position profiles to be updated (key competencies and essential criteria) to include EEWM.	Completed
Current	Broadened focus to Allied Health and other roles systematically reviewing recruitment processes to audit where Māori applicants aren't recruited.	New	Update interview question template to ensure EEWM is Q2 or Q3 and also it is weighted two or higher for assessment.	Completed
Current	Job adverts include statements in Te Reo for some roles e.g. Community Health. Extend for all roles.	New	Ensure all HBDHB hiring managers complete EEWM course and can effectively assess for the competence EEWM	Ongoing (currently 86.3%)
		New	Ensure all members of an interview panel have completed EEWM and for this eventually to be a mandatory requirement before they can be involved in selection and assessment and complete Values and behaviours online training currently being developed.	Ongoing
		New	Include a Māori consumer representative on interview panel in the interim utilise Māori staff members. For targeted areas re-balance the membership of interview panels to include the hiring manager, professional lead, a Māori staff member/consumer AND a community representative.	In place for Māori staff
		New	Develop "Day in the Life" video of current Māori staff.	First video developed, five more to come

		New	Briefing of CNMs, nurse leaders, allied health leaders, other hiring managers and Union bipartite forum to confirm focus on recruiting Māori staff.	All briefings held
		New	Understand what MHS are doing well to attract Māori staff to work for their teams, "bottle" it" and extend to other DHB hiring managers and teams. Then work with these teams to develop initiatives to improve Māori staff representation in their areas.	New
		New	Provide monthly reports to hiring managers (in addition to the Māori staff representation and advise KPI performance to date) - Total no. of Māori applicants / total applicants - Total no. of Māori shortlisted / total shortlisted - Total no. of Māori appointed / total shortlisted EMT to receive monthly report.	Requires system development. Almost complete.
		New	Include question in proposal to appoint to ask "Have you appointed a Māori applicant and if not why not."	Requires system development. Almost complete.
		New	Identify unsuccessful Māori applicants and refer to other hiring managers and MHS for other potential opportunities.	Requires system development. To commence
		New	Systematic debriefing of unsuccessful Māori candidates	To commence
		New	Revise the Request to Recruit form to ask hiring managers to confirm that there is a Maori staff member or consumer on interview panels	Underway
		New	Develop a recruitment campaign to attract Māori staff to the Hawke's Bay Health Sector. Focussed on: - Mapping the talent pool of Māori Health talent in New Zealand and Australia - Developing a talent and recruitment strategy to attract Māori Health talent to work in Hawke's Bay. DHB recruitment team to provide proactive for NEtP candidates	Underway
		New	Improve EIT support for training and for application for nursing roles (tie into contract).	New
		New	Use assessment centres for other roles other than NEtP.	New
		New	Recruitment on Marae?	New
		New	Develop mid-career RN recruitment strategy	New
		New	Develop Allied Health recruitment strategy	New
		New	Work nationally to develop Allied Health career progression framework and remuneration to make Allied Health profession more attractive.	New

Retention
For retention Māori turnover has for the 12 months to 30 June 2016 been 10.4% versus the whole of DHB turnover figure of 9.3%. In previous years Māori staff turnover has been below or the same as DHB turnover.

Staff Turnover 12 months ended 30 June 2016 and reasons given by Māori staff for voluntary resignations for each workforce grouping are set out in Table F. Turnover for RMOs is 0% as all RMOs are fixed term and therefore not included in the calculation for voluntary turnover.

Table F

	DHB Turnover	Māori Staff Turnover	Number of Māori resignations	Reasons
Medical - SMO - RMO	4.9% 0.0%	0.0%	0	
Nursing	9.2%	11.0%	10	4 move to alternative position 3 not returning from maternity leave 1 retired 2 other reasons
Allied Health	8.9%	5.3%	3	1 move to alternative position 1 personal reasons 1 retired
Support	12.3%	12.2%	5	1 retired 1 relocating outside HB 1 not returning maternity leave 1 personal reasons 1 other reasons
Management & Admin	10.2%	13.2%	9	4 move to alternative position 2 relocating outside HB 1 retired 2 other reasons
Total	**9.3%**	**10.4%**	**27**	

Staff completion of exit interviews is low internationally and in New Zealand as staff feel it is too late and wonder what is the point. It is the same for the HBDHB with only a small percentage of all staff resigning for the 12 months to 30 June 2016 having completed an exit interview. Retention interviews with focus groups of Māori staff would work better and is proposed as a new retention initiative. For the HBDHB by holding focus groups with groups of Māori staff to understand what they like about working for the DHB, what they don't like and what needs to change. The feedback from these focus groups will be used to change practice within the DHB. Changing practice will lead to increased Māori staff retention.

In respect of additional retention initiatives addition we need to:
1. Revitalise the Tuakana / Teina groups in place and where this is not in place set these up by workforce grouping. This can be done post the focus groups.
2. In order to grow more Māori managers, identify aspirant Māori managers and leaders and enrol into the Basic Management and potentially Transformation Leadership programmes.
3. In rolling out our Values and behaviours team by team ensure out team leaders lead at out on our relationship based management and our Values and behaviours to ensure a supportive team environment is created.
4. Our managers to adopt flexible work practices that are family friendly and supportive and therefore better retain our Māori staff.
5. A new staff engagement survey has been selected (IBM Kenexa) and this provides an opportunity for Māori staff to feedback on a range of questions including questions based on each of our Values and new Behaviours. This survey will be run in October 2016.

Supply of Māori health workers

For each occupational group the 2016 supply of Māori Health Workforce is set out in Table G below: This shows that there will be a higher percentage of medical graduates who are Māori in five years' time but not in the interim. Nursing students across all years at 16.5% Māori which is slightly ahead of our 30 June 3016 target. For occupational therapy and physiotherapy indications are that the percentage of Māori students' graduates is low at 8% and 5%. Overall the supply of Māori health workers is not especially high and provides a challenge when wanting to increase the number of Māori applying for Nursing and Allied Health roles.

Table G

	Total Māori %
Medical	20% 2016 intake only
Nursing	16.35% for all employees
Occupational Therapy	8% (estimated)
Physiotherapy	5% (estimated)

Appendix One

Cultural Training at 30 June 2016

By percentage

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		3 yearly	Once
Medical - SMO	140	61	14
Medical - RMO	137	10	33
Nursing	1480	993	694
Allied Health	540	405	282
Support	187	96	65
Management & Admin	452	360	278
DHB Total - June 2016	**2936**	**1925**	**1366**

	Total Employees	Engaging effectively with Maori	Treaty of Waitangi
Frequency		3 yearly	Once
Medical - SMO	140	43.6%	10.0%
Medical - RMO	137	7.3%	24.1%
Nursing	1480	67.1%	46.9%
Allied Health	540	75.0%	52.2%
Support	187	51.3%	34.8%
Management & Admin	452	79.6%	61.5%
DHB Total - June 2016	**2936**	**65.6%**	**46.5%**

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In addition to the specific recruitment initiatives above, add in the Māori staff representation KPI into all managers and team leaders performance plans and reviews.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Mental Health**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and HBDHB Board**
Document Owner: Document Author(s):	Sharon Mason – Chief Operating Office (Champion) Allison Stevenson, Service Director & Simon Shaw, Medical Director
Reviewed by:	Paul Malan – Strategic Service Manager; Health Services Leadership Team; Executive Management Team
Month:	August 2016
Consideration:	For monitoring

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RECOMMENDATION

That MRB, Clinial and Consumer Council and HBDHB Board:

Note the contents of this report.

OVERVIEW

Te Ara Whakawairoa (TAW) is a report drawn from the Māori Health Plan and is reported on quarterly with champions to oversee that monitoring and reporting.

Non-performing indicators are identified by the Māori Relationship Board which require special reporting through a channel of committees and then onto the HBDHB Board.

This report is from Sharon Mason, Champion of Mental Health Services Indicators. It focuses on key indicators to improve Mental Health Services for Māori.

UPCOMING REPORTS

The following are the indicators of concern; allocated Executive Management Team (EMT) Champion and reporting month in 2015 / 2016.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Mental Health	Rate of section 29 Compulsory Treatment Orders	81.5% (per 100,000)	Sharon Mason	Allison Stevenson	August 2016
	Percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan	95%	Sharon Mason	Allison Stevenson	August 2016
	PP8 mental health wait times for non-urgent mental health or addiction services seen within three weeks (mental health provider arm), 0 to 19 years	80%	Sharon Mason	Allison Stevenson	August 2016

WHY ARE THESE INDICATORS IMPORTANT?

Use of Section 29, Compulsory Treatment Orders (CTO) is symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need. Māori are over represented in these statistics, showing that just less than half the consumers on CTO are Māori.

Monitoring the percentage of clients discharged from Child, Adolescent and Family Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) Services with a transition (discharge) plan showing the discharge to primary care with a plan in place. Showing the partnership between primary and secondary services. Consumers must have had three face-to-face contacts for a discharge plan to be generated (MoH KPI). HBDHB count all consumers discharged from CAFS Service as having a discharge / transition plan in place.

Ministry of Health monitoring of mental health wait times for non-urgent Mental Health or Addiction Services seen within three weeks, (mental health provider arm), 0 to 19 years, showing people are receiving services within acceptable timeframes of referral to face-to-face appointment. Consumers are not waiting for appointments and the services have been timely and effective in their care.

Inequality in Outcomes in Mental Health Status for Māori

- Māori have a high rate of access to Mental Health Services than non-Māori.
- Māori have 3 – 4 times higher rates of use of Section 29 compared to non-Māori on average.
- Estimated twelve month prevalence of schizophrenia for Māori (0.97%) is significantly higher than for non-Māori (0.32%[i]).
- Hospitalisation rate and readmission rate is higher for Māori (17%).

Rate of Section 29 Compulsory Treatment Orders

The Office of the Director of Mental Health reports annually on rates of Section 29 use by DHBs. The report comments that Māori have 3 - 4 times higher rates of use of Section 29 compared to non-Māori on average.

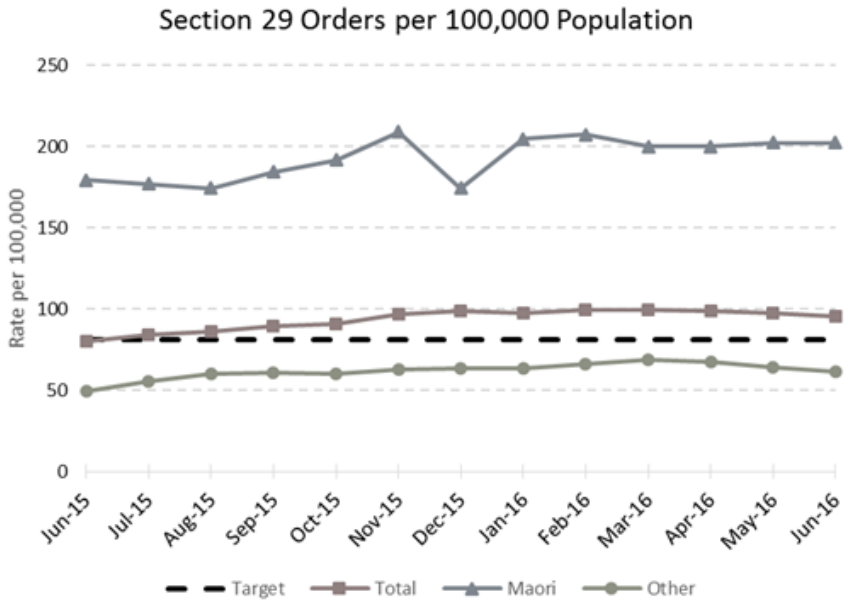
Compulsory Treatment Order (CTO) rates are symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need.

Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies including cultural and social agencies so as to provide a more holistic, integrated and comprehensive response.

No target was assigned to DHBs for this indicator through the "DHB Māori Health Plan Guidance". However, the guidance document does mention that DHBs are to "reduce the rate of Māori on the Mental Health Act". The guidance document goes on to state[ii]:

New Zealand has very high rates of compulsion under the Mental Health Act, compared with similar jurisdictions. Māori are nearly three times as likely as non-Māori to be treated under a community treatment order which represents a significant disparity. There are regional and local differences, not necessarily related to population mix, which DHBs need to understand and work to reduce. The mental health indicator also supports implementing the priority actions for Māori in Rising to the Challenge, and the Mental Health and Addiction Service Development Plan 2012-2017 including other actions in the plan that relate to addressing disparities or self-management.

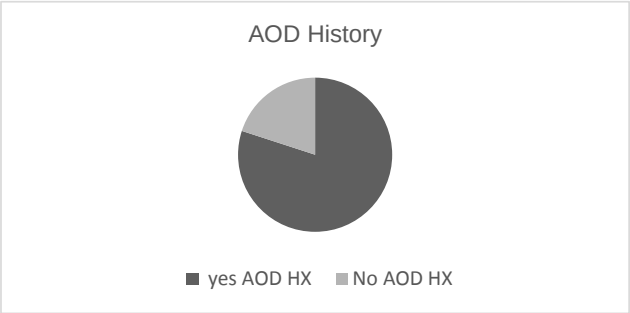
HBDHB Section 29 Orders – June 2015 to June 2016

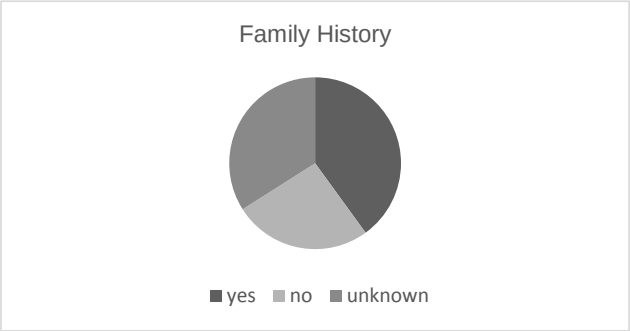


			Target	Total	Māori	Other
2015/16	Q1	≤	81.5	86.7	178.6	59.0
	Q2	≤	81.5	95.6	191.7	62.2
	Q3	≤	81.5	99.0	204.0	65.9
	Q4	≤	81.5	97.3	201.6	64.5

Audit of Fifty Random Consumer Files That Were Placed on the Community Treatment Order (CTO)

In the 2015 / 2016 Annual Plan, we signalled that we would undertake an audit of patients subject to CTO to determine factors associated with treatment under the Mental Health Act. The Mental Health Service completed the audit of fifty random files under the Mental Health Act over the past year showing the socioeconomic factors that are part of a person being place on a CTO. Some key factors examined were:

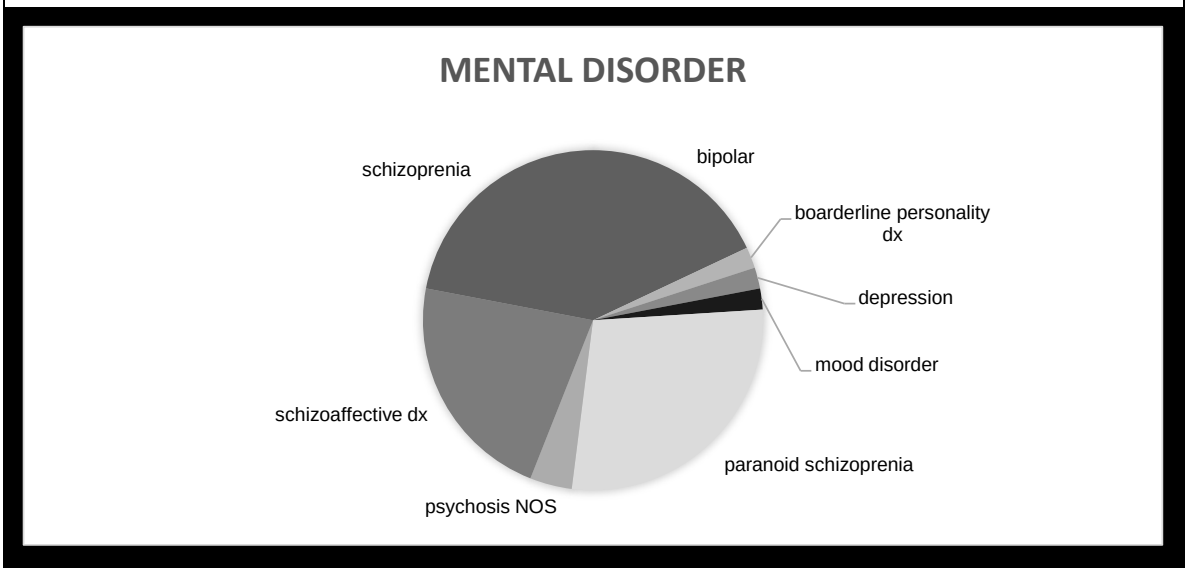
Addictions History Were addictions part of the person's history? 20% had no addictions history. 80% had an addictions history.	

Family History of Mental Illness Was there a history of mental illness within the family? 40% had a mental illness history. 26 % did not have a history of mental illness. 34 % were unknown**.**	

Work Status Was the person employed at the time of the CTO? 92% of people on CTO were unemployed. 8% were is some type of employment.	

What type of mental illness did people have who were placed under CTO?

People who were under CTO suffered from; schizophrenia 22%, bi-polar 18%, schizoaffective disorder 22% and paranoid schizophrenia 28%



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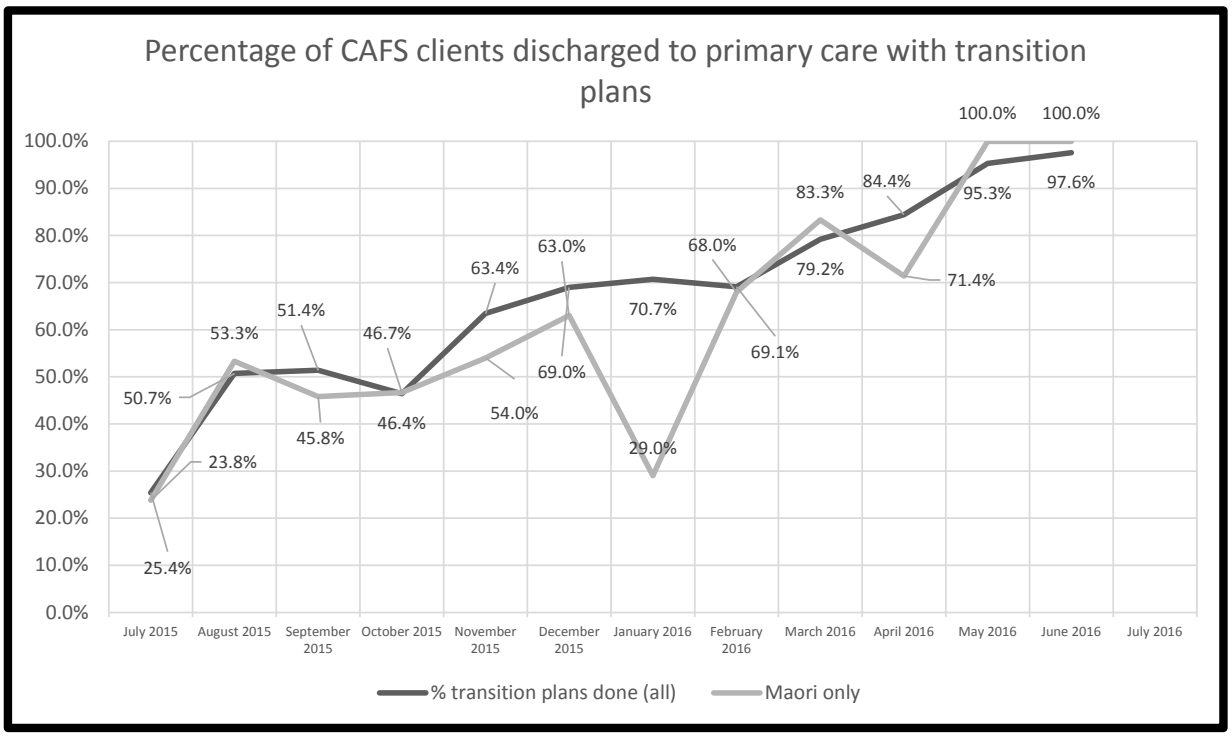
The audit shows that being placed under the CTO is not just about mental health but a complexity of social, family and health factors. In addition, differences in the population rates of these underlying factors may be a significant driver of compulsory treatment and is an important component of any attempt to reduce the rate. Currently we are analyzing the data for Māori vs non-Māori for the same content.

NUMBER 2 INDICATOR

Percentage of Clients Discharged from CAFS and Youth Alcohol and Other Drug (AOD) Services with a Transition (Discharge) Plan

This ministry measurement is after three face-to-face meetings with the child and family, a transition or discharge plan must be generated and sent to family and referrer. HBDHB counts all children and family appointment regardless of how many face-to-face contacts have been held.

The below table shows that from July 2015 to July 2016 we have increased from 23.8% to 100%.



NUMBER 3 INDICATOR

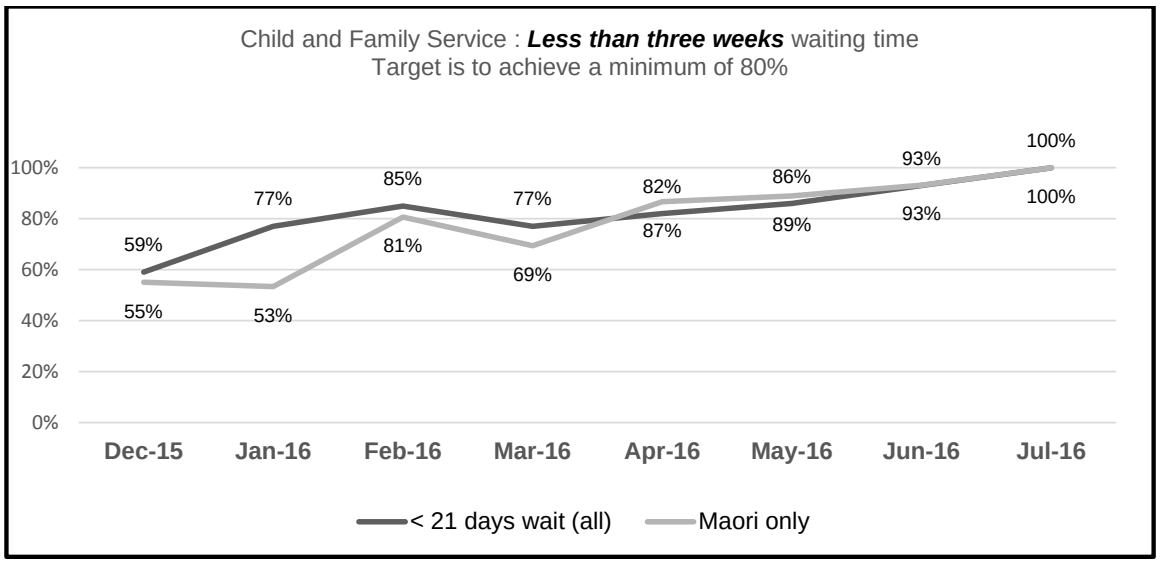
Mental Health Wait Times for Non-Urgent Mental Health or Addiction Services Seen within Three Weeks (provider arm) 0 – 19 years

This indicator shows from the time of receiving the referral from the referrer to the time the child / family are seen by a health practitioner. December 2015 at 59% to July 2016 100%.

Note: the table below is for quarter reporting and only is reported to March 2016.

	Mental Health Provider Arm									
	<3 weeks					**<8 weeks**				
12 months to	Target	Provider Arm Total	Māori	Pacific	Other	Target	Provider Arm Total	Māori	Pacific	Other
Mar-16	80.0%	67.4%	66.4%	71.4%	68.0%	95.0%	90.2%	91.4%	95.2%	89.0%

During the first six months of 2016 (i.e. Q3 and Q4), the CAFS team completed extensive work to improve the waiting time between referral and appointment. A consistent improvement from January 2016 is shown in the graph below, and the service is achieving 100% within three weeks as of July 2016.



The second component of this measure is the proportion of CAFS clients seen within eight weeks, with a national target of 95%. In December 2015 we were at 90% and in March 2016, 91.4% for Māori children and adolescents.

As explained above, the CAFS team have completed extensive work on waiting times and we are now (July 2016) achieving 100% of referrals seen within three weeks. We have been achieving 100% for Māori since April 2016 but the eight week indicator has now become irrelevant as no one is waiting longer than three weeks.

CHAMPIONS REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

Compulsory Treatment Orders
In line with Annual Plan 2015 / 2016[iii], Mental Health and Addiction Services began an audit of CTO in quarter three. That audit has given us some baseline understanding of the population under CTO. Whilst there is still work to do on further investigation of those factors, the services we are already putting in place, are a new model of care for acute and community services. This includes a shift in focus to a recovery approach that builds resilience for people with low-prevalence conditions and / or high needs and is more responsive to the wider socioeconomic factors that drive the need for intensive mental health treatment. These changes enhance access by integrating hospital and community services, strengthening collaboration with kaupapa services, and developing better primary care responses.

Transition and Discharge Planning
Over the last year we have developed a standard transition plan document / template that covers secondary mental health and addiction services. Every clinician who has primary responsibility for a case now completes the core transition document and we ensure that the primary care provider or primary referrer is prompted to make a follow-up appointment within three weeks. The completed transition plans are communicated to the primary referrer.

Reducing Waiting Times
The work that was planned to support this indicator was mostly procedural and administrative i.e. establishing prompts with appropriate policies and procedures to ensure proactive management of referrals. This was enhanced with good monitoring of results and attention to DNAs.

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

From the HBDHB Annual Plan 2016 / 2017[iv], the table below shows the activity that is planned to support the CTO indicator.

Short-term outcome		Activity	Monitoring and Reporting
Māori Health Priority	**Reduce the rate of Compulsory Treatment Orders**	Home-based treatment team increases family involvement with planning and crisis intervention by Q4.	**Rate of CTO** in Māori and non-Māori **100% of intensive service staff** trained by Q3 **Number of referrals** to specific services **SI5**: WHĀNAU ORA Key Indicator
		Ongoing daily step up step down with Ngā Rau Rākau, CMH, HBT, EMHS, Wai-O-Rua and TTOH to improve discharge and admission communication.	
		Implement intensive day programme from Q1.	
		Staff education around sensory modulation and trauma informed care to help reduce restrictive models of care.	
		Increase availability of treatment options across community mental health services.	
		Building networks within the community – increased use and referrals to NGOs within the community for follow up; meetings with NGOs and whānau/families to agree on and document plans & outcomes by Q2.	

From the HBDHB Annual Plan 2016 / 2017[v], the table below shows the activity that is planned to support transition planning:

Short-term outcome	Activity	Monitoring and Reporting
Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAFS) and Youth Alcohol and Other Drug (AOD) services	Formalise implementation of Transition Planning Checklist as standard practice in Q1. Amend discharge documentation to include standard prompt to primary referrer in Q2. Introduce "error flag" in patient administration system to prompt completion in Q3.	**PP7:** 95% of clients discharged with have a transition (discharge) plan + exception reporting
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy.	

From the HBDHB Annual Plan 2016 / 2017[vi], the table below shows the activity that is planned to support maintaining waiting times:

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Short-term outcome	Activity	Monitoring and Reporting
Improve access to CAFS and Youth AOD Services	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful by Q1.	**PP8:** 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + narrative report
	Liaise with KPI Forum stakeholders and other DHBs regarding "face-to-face" rule for first contact with children and families by Q2.	
	DNA's and joint appointments – review policy and impact of current practice by Q3. Redesign if necessary.	
	Scoping of potential for alternatives to admission for youth to be developed by Q2, e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	

PRIMARY AND SECONDAY SERVICES INEGRATION OF MENTAL HEALTH SERVICES

In March 2015, Primary Health Organisation (PHO) commissioned a review of primary mental health services and this was reviewed and completed with recommendations from the Chiplin group. The recommendations are clear about strengthening the relationships between secondary and primary care to improve and support access for clients. If availability of clinical pathways, provision of advice, joint consultations and case discussions were implemented this may reduce the increasing burden on secondary care and provide better outcomes for mental health clients in primary care.

RECOMMENDATIONS FROM TARGET CHAMPION

Activity to support these three indicators is well underway and should continue. The complexity around CTO will be better understood by further analysis of the audit results and, by sharing this information, the services will be better placed to ensure the most appropriate use of compulsory treatment. I support the intentions to increase family involvement, integrate services and service providers, and develop staff capability and to build networks.

Targets in respect of transition planning and waiting times are now all being met. This is commendable and must be maintained. The intentions in the Annual Plan will all help with ongoing

improvement but it is also recommended that the service ensure robust operational performance monitoring of these aspects of service quality in order to capture the gains.

I support the recommendations within the Chiplin report and encourage primary and secondary mental health services to implement mechanisms to allow for further integration.

CONCLUSION

Our changing models of care are designed to increase access to services, including earlier access for all people across the spectrum of need. Mental Health and Addiction Services have come a long way in the last year and it will be good to maintain that momentum and to keep improving on these and other markers of service quality.

REFERENCES

[i] Kake, Arnold and Ellis. Estimating the prevalence of schizophrenia among New Zealand Māori: a capture-recapture approach. Aust NZ J Psychiatry. 2008 Nov: 42(11):941-9

[ii] http://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package-and-review-plans/mhp-guidance

[iii] Hawke's Bay District Health Board, Annual Plan 2015/16. HBDHB.

[iv] Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.
[v] Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.
[vi] Hawke's Bay District Health Board, Draft Annual Plan 2016/17. HBDHB.

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q4 (Apr-Jun 2016) Non-Financial Exceptions Report**
	For the attention of: **Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board**
Document Owners:	Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	August 2016
Consideration:	For Monitoring

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RECOMMENDATION

MRB, Clinical and Consumer Council and HBDHB Board:

Note the contents of this report.

OVERVIEW

The purpose of this paper is to provide MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 4 on the implementation of Annual Māori Health plan. A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of Quarter 4 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indictors. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to shown a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol **'U'** *(indicated on the dashboard in red)* will be used to indicate unfavourable trend and 'F' for favourable trend *(indicated on the dashboard in green colour)* toward the annual target *(see the table below).*

KEY FOR DETAILED REPORT AND DASHBOARD

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

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2015-2016 ANNUAL MĀORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. Cervical Screening for 25-69 year old Māori women (73.2%) for this quarter is slightly lower than the 74.4% in the first quarter but still puts HBDHB on the top list on Cervical Screening performance in New Zealand. This performance also narrows the disparity gap between Māori and European by 4%. The performance is attributed to the HBDHB integrated service approach where all service providers (i.e. HBDHB Population Health, Health HB PHO (HHB PHO), general practices and Hauora Providers etc.) across the screening pathways are joined up and working together towards a common goal of attaining the national target for Māori women and addressing inequity. Furthermore, Māori women have access to free cervical smear tests and support services across the district.

   In an effort to further improve our services there has, over the years been a strong focus on continued service quality improvement e.g. improving systems and processes within primary care, improving National Cervical Screening Programme (NSCP) participant data quality on patient management systems (PMS) and the NCSP Register, compliance with NCSP policies and standards, offering client incentives, and improving access via clinical and outreach settings and support services.

2. Immunisation rates for 8 month old Māori have remained above or very near the target of ≥ 95% throughout the year with a 95.6% result in Quarter 1 and a 94.6% result in Quarter 4. Similarly, immunised rates for 2 year old Māori remained above or very near the annual target of ≥ 95% with 95.9% in Quarter 1 and 94.7% in Quarter 4. Immunisation results for 4 year olds remains above the expected target of ≥ 90% with 94% immunised in Quarter 4.

   This success is attributable to a number of factors. These range from having a champion in the executive management team; a committed, appropriate, experienced workforce; an action plan focused on bridging any gaps in service delivery; a very experienced NIR (National Immunisation Register) team; good collaboration across all immunisation providers and partners; a budget with a little leeway to try new initiatives; a service that can easily be delivered within the home; and a very effective outreach service team.

3. Ambulatory Sensitive Hospitalisation (ASH) rates overall declined from 82% in Quarter 1 to 79% in Quarter 4 following concerted work in the area of skin management through Public Holiday in early Childhood centres, Kōhanga reo and Primary Schools.. This Quarter has seen a continued focus on strengthening systems and relationships across Oral health services and providers. Resources to support self-care and management of skin have been translated in Te reo and English to support this work. To reduce DNA's at Community oral health clinics WCTO provider relationships with whānau will be strengthened coupled with funding to Tamariki ora and Plunket for advocacy and facilitation role in initiating oral health appointments and attendance. A joint analysis and review of currently contracted respiratory support services is being carried out to extend the Primary Care respiratory Pilot services to cover the 0-4 year age group.

4. Quick Access to Angiograms for Māori exceeded the expected target of ≥70% with 84.6% in Quarter 4 up from 38.5% in Quarter 1. This success is attributed to Locum Cardiologist who completed full Friday angiogram sessions for the time he was here.

Areas of progress

1. Staff completed cultural training is making good progress from 64% in Quarter 1 to 77.5% in Quarter 4. Medical staff had the largest increase of all occupational groupings from 14% in Quarter 1 to 39.6% in Quarter 4 (page 13). This progress is attributed to the growing push from EMT coupled with access to the electronic training reports by Managers and Heads of Service which enable them to keep track of their staff training.

2. Māori Breastfeeding rates at 6 weeks are 67% a 9% increase in comparison to the previous reporting period and Breastfeeding rates at 6 months shows a 2% increase.

Areas of focus

The above achievements notwithstanding, we are challenged to put more efforts in the following areas to gain traction towards targets:

1. Access to Care – Increase Patients Enrolment to the HHB PHO

The number of Māori enrolled in the HHB PHO decreased slightly by 0.3% from 95.9% in Quarter 1 to 95.6% in Quarter 4 and remains below the expected performance target of 97% (page 5). These trends are attributed to the limited availability and capacity of GPs to enrol new patients. Only 5/28 practices are enrolling new patients; 14/28 practices are enrolling new patients with conditions i.e. family member is already a patient, moved into the district from another district etc.; and 9/28 practices are not enrolling new patients at all. Furthermore, some patients are using Emergency Department (ED) for General Practice (GP) services instead of enrolling with a general practice; limited access to affordable general practice services for low income patients; and some patients moving outside of HB.

HHB PHO has been working with GPs to consider models of care that include provision of services to walk in appointments. HHB PHO has also been looking into availability of High Need Enrolment Programme via NGOs, ED, DHB and GPs with initial GP and Nurse Consultations at no cost to patients. HHB PHO feels that efforts to address health inequalities may include: support to practices to recruit general practice clinicians and staff; continue to offer the High Need Enrolment Programme; and supporting general practice to consider and implement walk in appointments.

2. Child Health - Breastfeeding

Breastfeeding rates at 3 months show a decrease of 7% from 46% in the previous reporting period to 39% this quarter. Multiple pieces of work are underway across Well Child and LMC/Midwife workforce to improve these rates. These include promotion of early engagement with services; consistent appropriate breastfeeding messages across sectors and the community; and the development of a responsive breastfeeding support service for Māori (a joint approach between the DHB Māori and Women, Child and Youth portfolios).

5. Oral Health

Pre-school oral health enrolments for Māori under 5 years of age increased from 65.3% in 2014 to 74.1% in 2015 (page 11). There is still some work to do to reach the expected target of ≥90%. We plan to update the data at the end of the calendar year.

8. Cancer Screening - Breast Screening

There has been a slight decrease from 68.4% in Quarter 1 to 67.9% in Quarter 4 and remains just below the expected target of ≥70% (page 9). This can be attributed to a number of factors including a slight increase of 25 women on the Breast Screening Aotearoa (BSA) Māori population which forms the denominator for the coverage data; increased seasonal fluctuations; and access to appointments due to holidays and availability of seasonal work. Efforts will be made on identify unscreened and under- screened women along with other approaches tailored to improve access and encourage women to participate in the BSA programme.

9. Smokefree

Māori women who are smoke free at 2 weeks post natal increased from 62% in Quarter 1 to 65.6% in Quarter 4. However, overall performance remains well below the expected target of ≥ 86% (page 7). In an effort to up these rates, HBDHB is collaborating with Choices Heretaunga in the implementation of Increasing Smoke-free Pregnancy Programme (ISPP) which is currently being used by HB midwives and LMCs to refer pregnant mothers who smoke. Acknowledging the

importance of whānau support for mothers to be smoke-free the programme has expanded its support to whānau members to live with pregnant and post-partum women.

The report also noted that advice to quit smoking for Māori pregnant women at hospital setting declined from 87.7% in Quarter 1 to 86.25 in Quarter 4 and remains below expected target of ≥90%. This is attributed to the high smoking rates among pregnant Māori women ages 20 to 29 years. We also know that most of these women either come from high deprivation areas or transient whānau so our efforts are focused on encouraging HB midwives and LMCs to refer pregnant women who smoke to ISPP, up to six months post-partum.

10. Mental Health

Māori under Mental Health Act Compulsory Treatment Orders has risen from 189.3 per 100,000 population in Quarter 1 to 201.6 per 100,000 population in Quarter 4. There remains a significant inequality between Māori and non-Māori of 104.9 per 100,000 population up from 97.7 per 100,000 population in Quarter 1 (page 12). . An audit has been carried out to better understand the issues around these rates and develop better strategies to lower them.

13. Workforce Development

Māori Workforce only grew 0.2% from 12.3% in Quarter 1 to 12.5% in Quarter 4 and did not reach the 2015-2016 expected target of 14.3% (page 13). The targeted areas for increasing the retention and recruitment of Māori of Nursing and Allied Health increased only marginally over the year. Nursing went from 10.1% to 10.8% and Allied Health from 13.1% to 13.2%. Since these are our two biggest workforce the impact of this trend is reflected across the overall performance figure for the period.

Following a significant rethink of our strategy to increase Māori staff representation we have identified actions that will make this happen. These include increasing the number of Māori applying for positions; number shortlisted and recruited for our roles and actions for better retention of our Māori staff.

An overarching Māori staff recruitment campaign is being developed with targeted actions by workforce grouping also. Focus groups discussions of current Māori staff are to be held to better understand what can be done to improve the work environment for Māori staff.

QUARTERLY PERFORMANCE AND PROGRESS UPDATE

1. Access to Care

Outcome: Increase enrolment in the HHB PHO

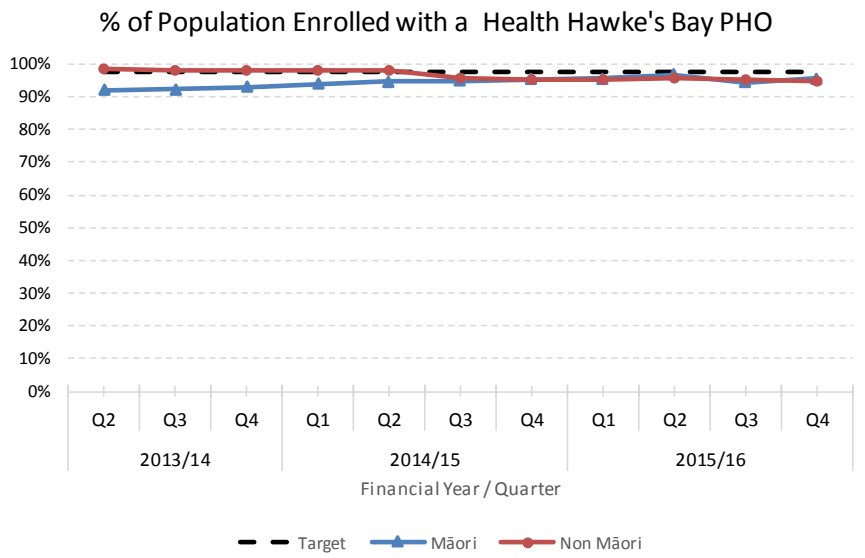
Key Performance Measures	Baseline [1]	Previous result[2]	Actual to Date[3]	Target 15-16	Trend direction
Māori	94.7%	94.5% (U)	95.6% (U)	≥97%	▲
Pacific	99.3%	86.5% (U)	88.4% (U)	≥97%	▲
Other	98.2%	96.0% (U)	96.5% (F)	≥97%	▲
Total	97.3%	95.2% (U)	95.9% (U)	≥97%	▲

Comment:

Limited availability and capacity of general practice to enrol new patients

- 5/28 practices are enrolling new patients
- 14/28 practices are enrolling new patients with conditions i.e. family member is already a patient, moved into the district from another district
- 9/28 practices are not enrolling new patients
  - Patients utilising ED for General Practice services instead of enrolling with a general practice
  - Limited access to affordable general practice services for low income patients
  - Patients moving outside of HB
  - Plan to work with General Practices to consider and review models of care

Time series



1 October 2014 to December 2014

2 October to December 2015

3 January to March 2016

2. Child Health						
Outcome: Breastfeeding of pepi improved						
Key Performance Measures	Baseline[4]	Previous result	Actual to Date	Target 15-16	Trend direction	
Infants are exclusively or fully breastfed at 6 weeks						
Māori	-	58% (U)	67% (U) [5]	≥75%	▲	**Comments:**
Pacific	-	74% (U)	82% (F)	≥75%	▲	With the combined Plunket and WCTO Breastfeeding data now being collected by the MOH more accurate breastfeeding data will be available, the new KPI card will over time show this new combined data as a trend line giving an improved picture of Breastfeeding performance for HB.
Total	-	68% (U)	73% (U)	≥75%	▲	
Infants are exclusively or fully breastfed at 3 months of age						The most recent Quarterly HB Breastfeeding data shows a 5% increase in Māori Breastfeeding rates at 6 weeks, with 3 month data showing a decline of 6% and 6 months remaining the same.
Māori	-	46% (U)	39% (U)[6]	≥60%	▼	
Pacific	-	62% (F)	63% (F)	≥60%	▲	
Total	-	54% (U)	53% (U)	≥60%	▼	Work continues on the development of a model of service provision that effectively supports Māori particularly, to sustain Breastfeeding, this is a joint approach between Māori Health and Women, Child and Youth (further details are included below)
Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)						
Māori	-	46% (U)	48% (U) [7]	≥65%	▲	
Pacific	-	57% (U)	66% (F)	≥65%	▲	
Total	-	56% (U)	58.% (U)	≥65%	▼	

4 No baseline data available

5 6 months to June 2015

6 6 months to December 2015

7 6 months to December 2015

5. Oral Health

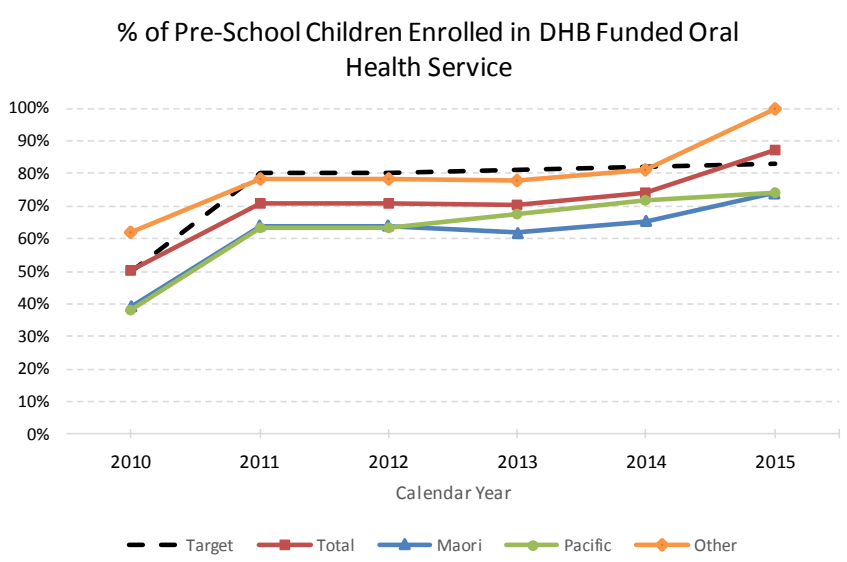
Outcome: More pre-school enrolments in the community oral health service (COHS) - 90% children under 5 years of age enrolled in community oral health services

Key Performance Measures	Baseline [8]	Previous result[9]	Actual to Date[10]	Target 15-16	Trend direction
Māori:	65.3%	74.1% (U)	-	≥90%	—
Pacific:	71.7%	74.2% (U)	-	≥90%	—
Other:	81.3%	99.8% (F)	-	≥90%	—
Total	73.9%	87.1% (U)	-	≥90%	—

Comments

This is an annual indicator which is only reported in Q3 every financial year. Health Intelligence discussing with services about the capability of reporting more frequently.

Time series



8 2013 calendar year

9 2014 calendar year

10

8. Cancer Screening

Outcome: Achieve the National Cervical Screening Programme (NCSP) national target – 80% of 25-69 years

Key Performance Measures	Baseline[11]	Previous result[12]	Actual to Date[13]	Target 15-16	Trend direction
Māori	73.8%	73.2% (U)	73.2% (U)	≥80%	—
Pacific	72.8%	70.4% (U)	71.4% (U)	≥80%	▲
Other	78.0%	77.2% (U)	77.8% (U)	≥80%	▲
Total	76.9%	76.1% (U)	76.6% (U)	≥80%	▲

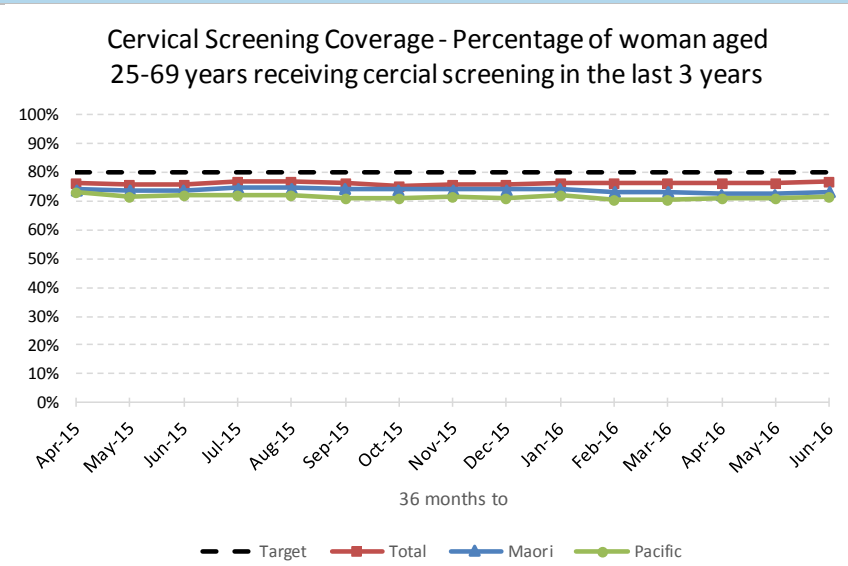
Comments:

Continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, contacting Māori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears. The uptake has been positive.

Continuing to ensure accuracy of participant ethnicity data held on National Cervical Screening Programme Register.

Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. A challenge to the sector.

Time series



Source: National Screening Unit

11 3 years to December 2014

12 3 years to December 2015

13 3 years to March 2016

Outcome: Achieve the National Breast Screen Aotearoa (BSA) national target – 70% of 50-69 years

Key Performance Measures	Baseline [14]	Previous result[15]	Actual to Date[16]	Target 15-16	Trend direction
Māori	67.2%	68.4% (U)	67.9% (U)	≥70%	▼
Pacific	79.0%	66.5% (U)	67.2% (U)	≥70%	▲
Other	77.2%	79% (F)	74.5% (F)	≥70%	▼
Total	75.8%	74.7% (F)	73.4% (F)	≥70%	▼

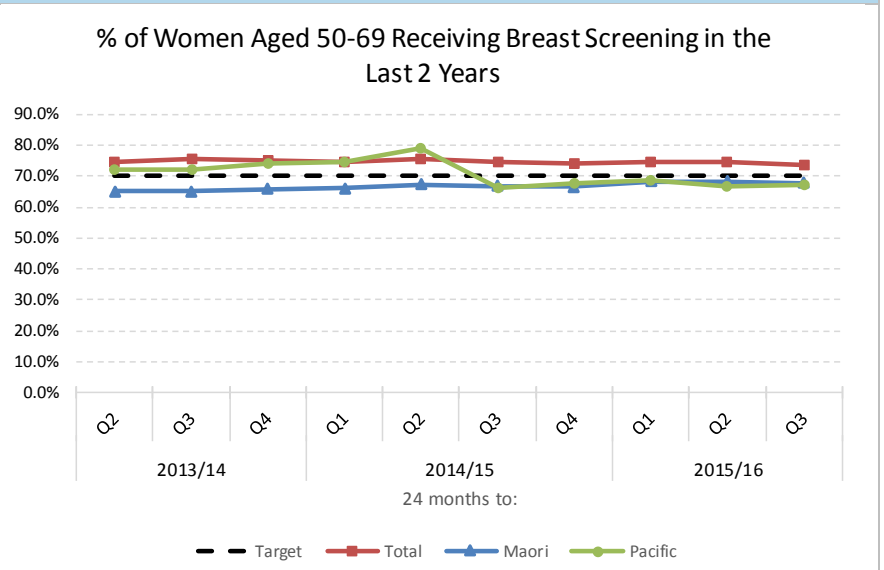
Comments:

Preparation has begun for the next mobile screening unit visit at the Cook Island Community Centre at Flaxmere on 13-27 September. BreastScreen Coast to Coast is working with Hastings-based GP practices to datamatch Flaxmere-resident clients for the upcoming visit. Invitation and recall letters will be sent out to priority group women offering an appointment for a screening mammogram. The DHB Population Screening, HHB PHO and Māori providers are working together to promote the mobile visit and offering support services to priority women.

HHB PHO and TRG Imaging facilitated an education session for GPs focused on pathology, diagnostics and treatment for breast disease.

Recent population projections released by the National Screening Unit show that in the next four years (2016-2020) Hawke's Bay's BSA eligible Māori population will increase by 8% and the Pacific population by 13%. This will be a challenge to the sector to achieve and maintain targets.

Time series



Source: National Screening Unit

14 24 months to December 2014

15 24 months to December 2015

16 24 months to March 2016

9. Smokefree							
Outcome: 90% of pregnant women who identify as smokers upon registration with a DHB- employed midwife or Lead Maternity Carer (LMC) are offered brief advice & support to quit smoking							
Key Performance Measures	Baseline[17]	Previous result[18]	Actual to Date[19]	Target 15-16	Trend direction		
Māori	100.0%	95.2% (F)	86.2% (U)	≥90%	▼	**Comments**	
Total	98.1%	96.5% (F)	88.6% (U)	≥90%	▼	HBDHB in collaboration with Choices Heretaunga have successfully implemented the Increasing Smokefree Pregnancy Programme (ISPP). HB midwives and LMCs refer pregnant mama who smoke, to this programme. On post-partum up to six months of age, woman who are still smoking can be referred to ISPP. ISPP supports pregnant and post-partum women to be smokefree at 1, 4, 8 and 12 weeks with a supply of nappies, if they have a validated CO monitor reading. Since 1 July, the programme has expanded to support whānau members who live with pregnant mama and post-partum women and pepi to be smokefree at 1, 4, 8, 12 weeks with grocery vouchers, if they too have a validated CO monitor reading.	

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17 October to December 2014

18 October to December 2015

19 January to March 2016

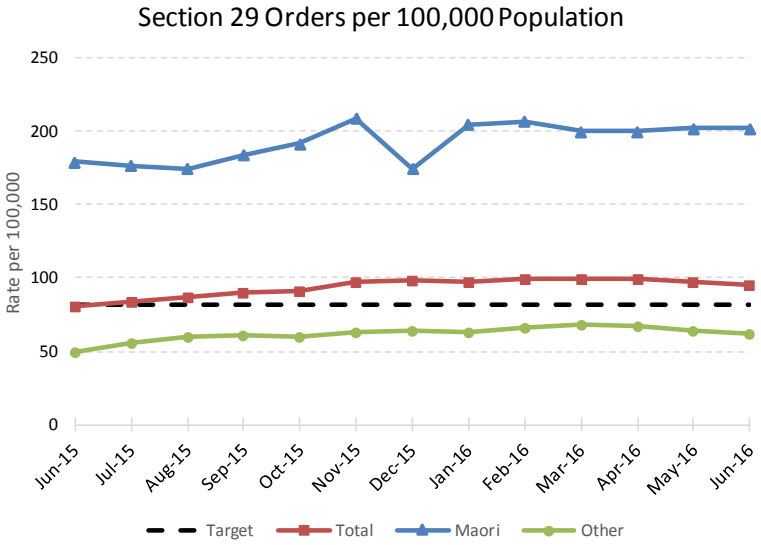
10. Mental Health

Outcome: Reduced rate of Māori under compulsory treatment orders to < 81.5 per 100,000 (total population)

Key Performance Measures	Baseline [20]	Previous result[21]	Actual to Date[22]	Target 15-16	Trend direction
Māori (per 100,000)	-	204.0 (U)	201.6 (U)	≤81.5	▲
Other (per 100,000)	-	98.9 (U)	96.7 (U)	≤81.5	▲
Total (per 100,000)	-	99.0 (U)	97.3 (U)	≤81.5	▲

Comments

We are still undertaking audits to understand the reason for the rate. First audit completed and further audit is now being undertaken.



20

21 *January to March 2016*

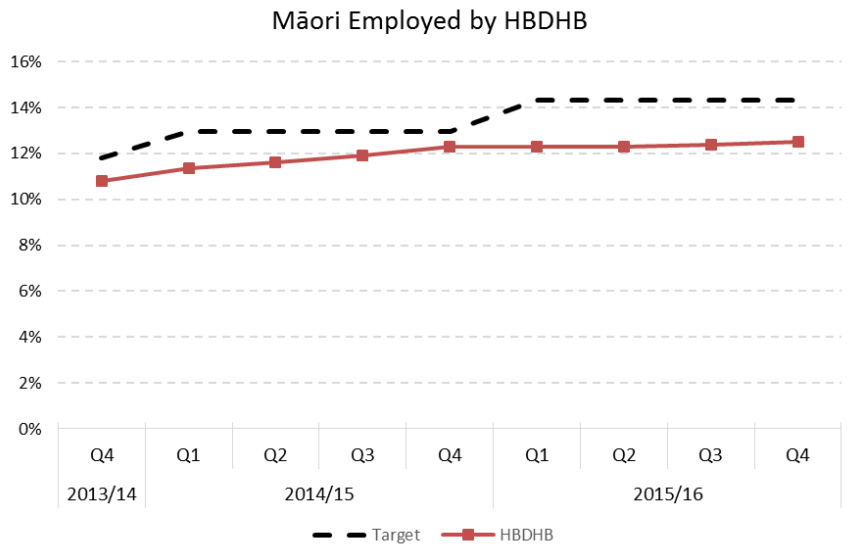
22 *April to June 2016*

13. Māori Workforce and Cultural Competency

Outcome: Increased proportion of Māori employed by 10% yearly across HBDHB. Target 15/16 year 14.3%

Key Performance Measures	Baseline[23]	Previous result[24]	Actual to Date[25]	Target 15-16	Trend Direction
Medical	2.7%	3.2%	3.2%	-	—
Management & Administration	15.7%	16.1%	16.0%	-	▼
Nursing	10.1%	10.7%	10.8%	-	▲
Allied Health	11.9%	12.4%	13.2%	-	▲
Support Staff	26.7%	30.2%	29.3%	-	▼
HBDHB	11.6%	12.4% (U)	12.5% (U)	≥14.3%	▲

Time series



Comments:

The targeted areas for increasing the retention and recruitment of Māori of Nursing and Allied Health increased only marginally over the year. Nursing went from 10.1% to 10.8% and Allied Health from 13.1% to 13.2%. Because these are our two biggest workforce the impact is going to flow through to the overall figure.

As a result of a significant rethink or our strategy for increasing Māori staff representation we have identified actions to increase the number of Māori applying, being shortlisted and recruited for our roles and actions for better retaining our Māori staff.

An overarching Māori staff recruitment campaign is being developed and targeted actions by workforce grouping also. Focus groups of current Māori staff are to be held to better understand what can be done to improve the work environment for Māori staff.

23 December 2014

24 March 2016

25 June 2016

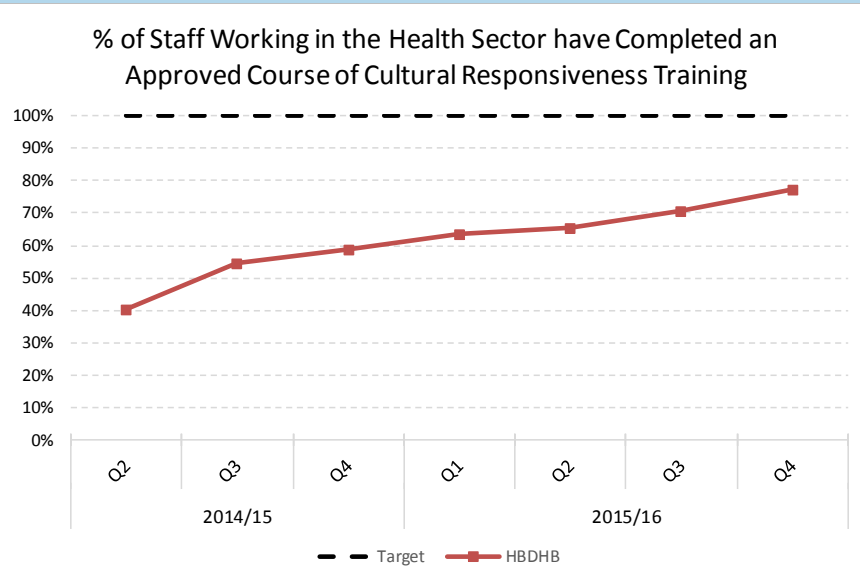
Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

Key Performance Measures	Baseline [26]	Previous result[27]	Actual to Date[28]	Target 15-16	Trend direction
Medical	9.0%	32.4%	39.6%	-	▲
Management & Administration	43.0%	82.1%	85.6%	-	▲
Nursing	41.0%	74.7%	81.4%	-	▲
Allied Health	59.0%	80.4%	85.2%	-	▲
Support Staff	12.0%	38.6%	60.1%	-	▲
HBDHB	40.0%	70.6%	77.5% (U)	≥100%	▲

Comments:

- Current report shows DHB staff who have completed EEWM training or other cultural training.
- The Education & Development Forum are establishing a communication plan to include Primary Care in EEWM training.
- Managers now have access to reports within PAL$ to monitor staff completion rates of EEWM and Treaty of Waitangi.
- The current Engaging Effectively with Māori (EEM) training sessions run to the beginning of September. There is a mandatory training report that all managers have access to and this now enables managers to follow-up on staff who have not attended EEM. This training has been rolled across the HHB PHO and NGOs.

Time series



26 December 2014

27 March 2016

28 June 2016

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q4 (Apr-Jun 2016) DASHBOARD**
	For the attention of: **Māori Relationship Board (MRB), HB Clinical Council and HB Consumer Council and HBDHB Board**
Document Owners:	Tim Evans, General Manager Planning, Informatics and Finance Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick LeGeyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team (EMT)
Month:	August 2016
Consideration:	For Monitoring

16.1

RECOMMENDATION

That MRB, Clinical and Consumer Council and HBDHB Board:

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on:

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

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

As this report is for the period ending June 2016, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

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

2015-2016 ANNUAL MAORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. HBDHB continues to have the highest percentage in New Zealand for Cervical Screening for 25-69 year old Māori women (73.2%) and the lowest disparity gap between Māori and European (4% gap).
2. Immunisation rates for 8-month old Māori have remained above or very near the target of ≥ 95% throughout 2015-2016 with a 95.6% result in Quarter 1 and a 94.6% result in Quarter 4. Similarly, immunised rates for Māori 2-year olds remained above or very near the target of ≥ 95% throughout 2015-2016 with a 95.9% result in Quarter 1 and a 94.7% result in Quarter 4. Immunisation results for 4-year olds remains above the expected target of ≥ 90% with 94% immunised in Quarter 4.
3. ASH Rates overall have declined from 82% in Quarter 1 to 79% in Quarter 4 and present a significant narrowing of disparity gap for 0-4 year old group between Māori and Other. Similarly, ASH Rates for 45-64 year old group have declined from 193% in Quarter 1 to 170% in Quarter 4 and present a significant narrowing of disparity gap between Māori and Other.
4. Quick Access to Angiograms for Māori exceeded the expected target of ≥70% with 84.6% in Quarter 4 up from 38.5% in Quarter 1.

Areas of progress

1. Staff Completed Cultural Training is making good progress from 64% in Quarter 1 to 77.5% in Quarter 4. Medical staff had the largest increase of all occupational groupings from 14% in Quarter 1 to 39.6% in Quarter 4.

Challenges

1. Breastfeeding rates at 3 months show a decrease of 7% from 46% in the previous reporting period to 39% this quarter. All breastfeeding rates at 6 weeks (67%), 3 months (39%) and at 6 months (48%) for Maori fell below the target rates of 75%, 60% and 65% for the period.
2. Māori under Mental Health Act Compulsory Treatment Orders has risen 189.3 per 100,000 population in Quarter 1 to 201.6 per 100,000 population. There remains a significant inequality between Māori and non-Māori of 104.9 per 100,000 population up from 97.7 per 100,000 population in Quarter 1.
3. Māori women who are smokefree at 2-weeks post natal increased by 3.6% from 62% in Quarter 1 to 65.6% in Quarter 4. However, overall performance remains well below the expected performance target of ≥ 86%.
4. Advice to Māori smokers in hospital who are pregnant to quit declined by 7.5% from 87.7% in Quarter 1 to 86.25 in Quarter 4 and remains below expected target of ≥90%.
5. Breast Screening has decreased slightly from 68.4% in Quarter 1 to 67.9% in Quarter 4 and remains just below the expected target of ≥70%.
6. Māori Workforce only grew 0.2% from 12.3% in Quarter 1 to 12.5% in Quarter 4 and did not reach the 2015-2016 expected target of 14.3%.
7. The number of Māori enrolled in the Health Hawke's Bay PHO decreased slightly by 0.3% from 95.9% in Quarter 1 to 95.6% in Quarter 4 and remains below the expected performance target of 97%.
8. Pre-school Oral Health Enrolments for Māori under 5-years of age increased from 65.3% in 2014 to 74.1% in 2015. There is still some work to do to reach the expected target of ≥90%.

Please note:

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

ANNUAL MĀORI HEALTH PLAN, QUARTER 4 APRIL - JUNE 2016 DASHBOARD REPORT

Access to Care
PHO Enrolment and ASH rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment	94.7%	94.5%	95.6%	96.5%	≥ 97.0%	-595		↑
0-4 years (6m)	82.0%	82.0%	79.0%	70.0%	≤ -			↓
45-64 years (6m)	100.0%	172.0%	170.0%	94.0%	≤ -			↓

Child Health
Breastfeeding rates (3m)

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data								
At 6 Weeks	68.0%	58.0%	67.0%	73.0%	≥ 75%	-		↑
At 3 months	54.0%	46.0%	39.0%	53.0%	≥ 60%	-		↑
At 6 months	59.0%	46.0%	48.0%	58.0%	≥ 65%	-		↑

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation (8 Months)	95.9%	97.7%	94.6%	95.4%	≥ 95%	-1		↑
Immunisation (2 years)	95.0%	94.8%	95.1%	94.9%	≥ 95%	0		↑
Immunisation (4 years)	-	93.2%	94.0%	92.1%	≥ 90%	11		↑
65+ Influenza (3m)	68.0%	56.5%	-	-	≥ 75%	-		

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	4.3	2.48	7.33	1.87	≤ 2.0	-2		↓

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate	65.3%	74.1%	-	-	≥ 90%	-771		↑

SUDI

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

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

Time Series Key:
Target
Actual

Cardiovascular Disease

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Heart & diabetes checks	83.9%	86.3%	-	-	≥ 90%			↑
Quick access to angiograms	66.7%	81.8%	84.6%	77.6%	≥ 70%	1.9		↑
Completion of registry data	12.5%	100.0%	90.0%	96.6%	≥ 95%	-1		↑

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs)	73.8%	73.2%	73.2%	77.8%	≥ 80%	-614		↑
Breast screening (50-69 yrs)	67.2%	68.4%	67.9%	74.5%	≥ 70%	-74		↑

Smokefree

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal	58.0%	53.0%	65.6%	79.9%	≥ 86.0%	-		↑
Pregnant smokers Brief Advice to Quit	100.0%	86.2%	81.1%	89.0%	≥ 90.0%	-5		↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000)	-	212.7	201.6	96.7	≤ 81.5	-46		↓

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.7%	3.2%	3.2%	-	≥ -			
Management & Administration	15.7%	16.1%	16.0%	-	≥ -			
Nursing	10.1%	10.7%	10.8%	-	≥ -			
Allied Health	11.9%	12.4%	13.2%	-	≥ -			
Support Staff	26.7%	30.2%	29.3%	-	≥ -			
Māori staff - HBDHB	11.6%	12.4%	12.5%	-	≥ 14.3%	-54		↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	9.0%	32.0%	39.6%	-	≥ -		
Management & Administration	43%	82.1%	85.6%	-	≥ -		
Nursing	41%	74.7%	81.4%	-	≥ -		
Allied Health	59%	80.4%	85.2%	-	≥ -		
Support Staff	12%	38.6%	60.1%	-	≥ -		
HBDHB	40%	70.6%	77.5%	-	≥ 100%			↑

Te Ara Whakawaiora Priorities

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Obesity (B4SC Healthy Weight for 4yrs)	75%	67.0%	61%	69%	≥ 75%	-62.75		↑
DNA's	16.2%	18.2%	15.20%	4.70%	≤ 7.50%	-98		↓
Oral Health (% Caries Free at 5yrs)	38.7%	36.0%	-	-	≥ 65%			↑
Bariatric Surgery	7.00	-	3.0	5.0	-	-		-

16.1

HAWKE'S BAY District Health Board Whakawāteatia	**Certification – Findings and Next Steps**
	For the attention of: **HB Clinical Council**
Document Owner/Author:	Kate Coley, Director – Quality Improvement and Patient Safety
Month:	August 2016
Consideration:	For Information

RECOMMENDATION

That Clincial Council

1. Note the contents and information within the paper
2. Note the proposed actions
3. Note a progress report will be provided in December 2016.

OVERVIEW

The purpose of this paper is to provide Clinical Council with an overview of the findings of the recent full Certification Audit undertaken in April, and to inform Clinical Council of the proposed next steps in making improvements in resolving a number of the corrective actions. These actions have ben endorsed by EMT.

Certification is our licence (awarded by HealthCERT on behalf of the MOH) to operate as a health and disability provider. It is used to provide assurance of a safe and reasonable level of service provided to our consumers as required under the Health & Disability Service (Safety) Act 2001.

Any hospital or residential disability care facility of five beds or more –is required to meet the Health and Disability Service Standards, governed by the Act. The DAA Group, a designated health and disability sector audit agency has been the audit agency that HBDHB has used in the past, and this full audit was again managed by that group.

The DHB will be audited against all of the core standards which cover the following areas:-

- Consumer Rights
- Organisational Management
- Continuum of Service Delivery
- Safe & Appropriate Environment
- Restraint Minimisation and Safe Practice
- Infection Prevention and Control

The audit was undertaken between 12-15 April and daily feedback was provided by the lead auditor and shared with the clinical teams. Over the past couple of months the DAA Group have been refining their report, following feedback from the DHB and the MOH / Health Cert have issued the DHB with Certification approval for a further 3 years expiring 6 August 2019. The next mid-point surveillance will be undertaken in October/November of 2017. Progress reports will be provided to MOH on improvements relating to our corrective actions in February 2017.

GENERAL THEMES

In general the audit was a very positive one. The 11 auditors who were onsite for the four days provided a significant amount of positive feedback on the progress that has been made since their previous visit 18 months ago. They were impressed with the organisations focus on patients and their families being involved in their care planning, the way in which teams were working in a multi-disciplinary way and that there was a definite sense of teamwork. There were a number of positive comments made around the changes in Mental Health services, Springhill, Wairoa and the general cleanliness of the environment considering the age of some of the assets.

In previous findings reports the DHB has had a mixture of medium and low risk corrective actions, whereas in this full year report we only had low risk corrective actions, again reinforcing the progress that is being made against the standards. In terms of reporting on progress in resolving these corrective actions the DHB will be required to report to the MOH in February 2017.

Whilst all of the corrective actions were identified as low risk, there is ongoing repetition to previous audit reports and therefore significant focus will need to be prioritised on progressing improvement in these areas. A copy of the full corrective actions report is attached in Appendix 1.

The areas where there will be focus are detailed below with extracts from the report summarising themes from the feedback provided by the auditors.

Area of Concern	Summary of feedback
Documentation	• Family violence screening inconsistently documented • Patient consent inconsistently documented • DNR inconsistently applied • Assessments completed not informing care plans • VTE assessment inconsistently completed • Patient goals / needs not consistently documented • Maternity EWS scores not documented • Discharge plans not fully documented • Lack of documentation re verbal handovers • Medication prescribing charting inconsistent
Privacy	• Discussions undertaken in open spaces • Triage area in ED • Health records in open areas and visible to all
Performance Appraisals	• Remain problematic – 40% completion overall • Lack of SMO appraisals
Fridge Temperatures	• Out of range results for vaccine fridges • Inpatient ward fridges not monitored • Maternity – breast milk fridge monitoring not consistent
Fire & De-escalation Training	• De-escalation training not been run for 2 years for general staff • Lack of fire evacuation practices in all areas • Record for fire training say 50% completion

NEXT STEPS

Below identifies an action plan to improve our performance in those key areas identified. These actions will be incorporated into the overarching Quality Annual Plan and reported against quarterly.

Corrective Action Finding	Responsibility	Actions to be undertaken
Documentation	QIPS & Health Services Directorates	• Undertake benchmarking exercise with other DHBs to look at their documentation / forms & processes • Working Group established to review HBDHB documentation requirements with the aim of simplification, reducing waste and increased effectiveness and efficiency for staff & patients. • Run regular Education sessions around the importance of effective documentation and the requirements under the standards and legislation for all professional groups. • Undertake regular Health record audits to identify themes, issues, good practice to inform further improvements on an ongoing basis
Privacy	QIPS Facilities	• Development of online education package for all staff • ED Front of House project implemented • Regular reminders to staff around Privacy in regards to sensitive patient conversations, handovers, family meetings etc • Work with Facilities to identify areas where health records are kept in ward areas, to try to find a simple, cost effective and pragmatic solution to improve privacy of patient information
Fridge Temperatures & Monitoring	Facilities Pharmacy	• Work with Facilities, Pharmacy & Food services to check all fridges are maintained and monitored • Implement an effective monitoring mechanism and trigger for vaccine fridges functioning outside of the required range. • Ensure all staff understand the requirements for labelling of patient and staff food in ward fridges
Fire Training & Evacuations	Security Emergency Response	• Develop annual fire evacuation plan for clinical areas. • Undertake evacuations according to plan and audit to ensure completed • Review current fire training online module & continue to monitor completion rates on a monthly basis – report provided to EMT members

Corrective Action Finding	Responsibility	Actions to be undertaken
De-escalation Training	Restraint Committee Education & Development	• Work with Restraint Committee, Education & Development and Nurse Educator Group to ensure training is run for all staff on a regular basis. • Work with CNM's to ensure as many staff can be released for training • Monitor attendance rates at training on a quarterly basis – reported to Restraint Committee
Performance Appraisals	Human Resources & Health Services	• A Performance management planning project has been established, tasked with reviewing, in partnership with Health services leaders the current performance planning system and making recommendations for improvement. • Short term actions have been identified and implemented

Appendix 1 – Certification Corrective Actions Report

Legal entity name:	Hawke's Bay District Health Board
Certificate name:	Hawke's Bay District Health Board

Designated Auditing Agency:	The DAA Group Limited

Types of audit:	Certification Audit
Premises audited:	Central Hawkes Bay Health Centre; Hawke's Bay Hospital; Springhill Treatment Centre; Wairoa Hospital & Health Centre
Services audited:	Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Children's health services; Residential disability services - Psychiatric; Hospital services - Surgical services; Hospital services - Maternity services
Dates of audit:	**Start date:** 12 April 2016 **End date:** 15 April 2016

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	PA Low			
HDS(C)S.2008	Criterion 1.1.3.1	The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.	PA Low	In mental health there are examples of staff not considering auditory privacy and arranging private rooms for meetings. Paediatrics, maternity and emergency department have physical environments not protecting visual and auditory privacy. Clinical files are not	Mental health staff proactively direct consumer meetings to private areas for auditory privacy. Paediatrics, maternity and emergency department ensure auditory, visual privacy and secure storage of patients' files	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				always being adequately protected from unauthorised access.		
HDS(C)S.2008	Criterion 1.1.3.7	Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.	PA Low	In paediatric services and maternity services family violence screening is not consistently completed in the clinical records reviewed.	Family violence training is implemented and screening preformed as per policy	180
HDS(C)S.2008	Standard 1.1.7: Discrimination	Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	PA Low			
HDS(C)S.2008	Criterion 1.1.7.2	Service providers should have an understanding of discrimination. Service providers shall demonstrate knowledge of the barriers to recovery posed by discrimination, which translates into provider systems that promote recovery.	PA Low	There were several examples observed of staff in the mental health unit using language that indicated a lack of understanding of anti-discriminatory behaviour.	Staff in the mental health service receive training on discrimination and the barrier to recovery discriminating practices pose.	180
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.4	The service is able to demonstrate that written consent is obtained where required.	PA Low	Signed written consent and discussion on the risks and benefits of treatments agreed to are inconsistently documented.	Consent documentation be completed as required.	180
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service	PA Low	Not for resuscitation forms are inconsistently completed (where	The 'Not For Resuscitation' policy clearly state	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		providers are acted on where valid.		appropriate) in several ward areas. In five of ten files this was not fully completed. Involvement of family is seldom documented.	documentation requirements and these are completed.	
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.4	There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	In several areas staff are using policies or forms that do not sufficiently guide practice (paediatrics), are not current or are in draft (mental health), or there are more than one version in use (maternity and the neonatal area).	Policies, procedures and forms are approved, up to date and only the most recent version is in use.	180
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Low			
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	Over the course of the three-and-a-half-day audit there were two examples noted of events that had not been reported through the events system and one 'near-miss' event not reported, indicating that under reporting may be an issue.	Ensure all actual and 'near-miss' events are reported and used as opportunities for improvement.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.2	Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	Credentialing processes are defined in policy but are not always completed in accordance with the specified timeframes or include all employed medical staff. Recredentialing of nursing and allied health staff does not specify the re-credentialing process or timeframe.	Credentialing and recredentialing processes are defined and completed in accordance with the policy.	180
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Performance appraisals continue to have with low rates of completion of the annual appraisal requirement and there is no systematic approach to addressing this ongoing issue. Gaps in training are noted in mental health services in relation to discrimination and stigma of mental illness. Training in restraint minimisation and enabler use is no longer occurring regularly as part of mandatory training for clinical staff (with the exception of calming and de-escalation for security and mental health staff).	Implement a system to ensure all staff requiring an appraisal (PAS) have these completed annually. Ensure general training in restraint minimisation and safe practice occurs for clinical staff on a regular basis.	180
HDS(C)S.2008	Standard 1.2.8: Service Provider Availability	Consumers receive timely, appropriate, and safe service from suitably qualified/skilled	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and/or experienced service providers.				
HDS(C)S.2008	Criterion 1.2.8.1	There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	Although staffing levels are being closely monitored in real time, and planning strategies are in place, there remain some areas in the DHB in which staff vacancies impact on service delivery and staff cover for unexpected leave is limited.	Implement processes which ensure staffing levels and skill mix meet patient demand to provide safe services over the 24-hour period.	180
HDS(C)S.2008	Standard 1.2.9: Consumer Information Management Systems	Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low			
HDS(C)S.2008	Criterion 1.2.9.7	Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.	PA Low	In the maternity service, the CTG records are not always secured in the client's file nor adequately labelled with the patient's unique identifier.	All patient information is securely stored in the record with the required unique identification details.	180
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	The assessment information does not always inform the care plan. The care plan was often used as a task sheet rather than a patient focused plan of care. Documentation completion did vary according to the method of admission (ie, acute or arranged).	All relevant aspects of assessments and re-assessments are completed in a timely manner and the results are reviewed as a multidisciplinary team to develop an integrated plan of care for each patient	180
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused,	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		integrated, and promote continuity of service delivery.				
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	In most services visited there was a lack of individual patient's goals or needs identified. In paediatric the generic plans do not comprehensively attend to all aspects of planning for the patient, in addition to a lack of goals identified through the ongoing assessment process. In mental health services five out of five 'A to D planners' were not fully completed and treatment goals were not identified by ongoing assessment in the same number of clinical notes reviewed.	Ensure the information from all relevant assessment sources is documented in detail to support an ongoing plan of care to meet the patients' needs and goals.	180
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.2	Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Evaluation of assessments and care planning is not occurring in all cases where this is required.	Ensure assessments tools are completed correctly to inform the evaluation process.	180
HDS(C)S.2008	Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.10.2	Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.	PA Low	There is no documentation occurring around verbal handover that are given between departments to provide that this has occurred and the key risks for the patients. Not all patients had a plan of care for discharge.	Transfer of care either to home or another area has a documented plan of care.	180
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Mental health, paediatrics and maternity prescribing practice does not meet best practice guidelines. Emergency medication on the resuscitation trolleys are not secured. The process around responsibilities, actions and documentation following any fridge temperatures outside the required range is not clear to those staff interviewed where this had occurred.	Medication prescribing comply with best practice. Emergency drugs in resuscitation trolleys are secured. Staff are informed of the procedure to follow should vaccine fridges be out of temperature range, to ensure the safe storage of vaccine and a robust system developed to show review of these occurrences and actions taken.	180
HDS(C)S.2008	Criterion 1.3.12.5	The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	Within the Springhill addiction service the self-administration practice does not comply with the medicine administration policy.	Self-medicating patients document when medication is taken.	180
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe	A consumer's individual food, fluids and nutritional needs are	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Food, And Fluid Management	met where this service is a component of service delivery.				
HDS(C)S.2008	Criterion 1.3.13.1	Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Food Services at CHB Health services are contracted to an external provider. The menu has not been reviewed by a dietician.	Undertake a menu review to demonstrate that nutritional requirements are met for patients at Central Hawke's Bay Hospital.	180
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	The tray line service temperatures are not being consistently monitored and recorded. In March-April 2016 results sighted indicate these are 83% complete. Patient food fridge temperature is not monitored in several patient areas, including Springhill. Breastmilk fridge monitoring in maternity is not consistently recorded. Food stored in fridges in ward areas was not always dated and covered. Staff food items were stored in ward patient fridges.	Food storage is consistent with food safety practices and guidelines.	180
HDS(C)S.2008	Standard 1.4.1: Management Of Waste And Hazardous Substances	Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.4.1.6	Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous	PA Low	Protective equipment for the face is not being used when dealing with body waste and other hazardous substances in	The use of appropriate face protection equipment is available and used in all areas where this is necessary.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		substances is provided and used by service providers.		seven of the eight sluice rooms in clinical areas.		
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	Not all equipment requiring electrical testing had been completed, with some being over one year out of date. Sanitisers are maintained, tested and labelled to indicate when the next testing is due.	All equipment requiring electrical testing and tagging is completed on a regular basis according to requirements.	180
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Low			
HDS(C)S.2008	Criterion 1.4.7.1	Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	Not all staff have completed fire training and evacuation drills as required.	Staff complete fire training and evacuation drills on a regular basis as specified in the approved fire evacuation plans and regulatory requirements.	180

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.1.8.1	The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	An evidence based project to reduce the rates of smoking in pregnancy has demonstrated an innovative, planned approach resulting in reduced smoking rates.

Code	Name	Description	Attainment	Finding

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

19. Minutes of Previous Meeting (Public Excluded)

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

21. Community Based Pharmacy Services 2016-2020

22. Improving the Quality of Unscheduled Care & Acute Patient Flow (ED 6 Hours)

23. Radiology Update

24. Laboratory Update

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).

HB Clinical Council
Annual General Meeting

2016

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL ANNUAL GENERAL MEETING HELD IN THE MANGARONGO CONFERENCE ROOM AT TE TAIWHENUA O HERETAUNGA ON WEDNESDAY, 12 AUGUST 2015 AT 2.45PM

PUBLIC

Present:	Dr John Gommans (co-Chair) Chris McKenna (co-Chair) Dr Mark Peterson Robyn O'Dwyer Dr Tae Richardson Dr Kiri Bird Dr Caroline McElnay Dr Andy Phillips Dr Kevin Snee David Warrington Jules Arthur (until 3.30pm) Billy Allan Dr Malcolm Arnold Leigh White
Apology	Dr Hannes Meyer
In Attendance:	Ken Foote (Company Secretary) Brenda Crene (Council Administrator) Kate Coley (Director Quality Improvement & Patient Safety) Graeme Norton (Chair HB Health Consumer Council) Dr David Rodgers (GP Tamatea Medical Centre)

MINUTES OF PREVIOUS ANNUAL MEETING

The signed minutes of the meeting held on 13 August 2015, were confirmed as a correct record of the meeting.

REVIEW OF PREVIOUS 12 MONTHS (2014-15)

The Year in Summary

The year in summary listing all activities Council was engaged in was provided as a record and an opportunity for reflection on what Council had focused on. In planning for the workshop, updated Terms of Reference (ToR) and work plan for 2015-16 the Chair asked Council to reflect on the areas where the biggest impacts have been. Of particular note was Council's involvement with the prioritisation of bids for allocation of new funding. The involvement of Council in this process would be used as an example of Clinical Council activity for the forthcoming joint Clinical & Consumer Council presentation to the APAC meeting by John Gommans and Graeme Norton.

The Council's rejection of the food service proposal supported by Consumer Council and the Maori Relationship Board was also a powerful reflection on Council's importance to the HB Health Sector.

It was emphasized that the Board required Council's oversight of routine clinical activity to fulfil its governance obligations, however Council's face-to-face time would be best utilised for more challenging discussions and decisions.

Matters Arising from the 2014 Annual Meeting

An overview of matters arising from the previous annual meeting held 13 August and the resulting actions were provided and acknowledged.

Attendance 2014-15

An overview the prior year's attendance was provided for information.

Review of Annual Workplan (dated September 2014)

This was not addressed at the meeting but would be reviewed subsequently.

Workshop

Following afternoon tea the chair welcomed invited participants for the Workshop, chosen to enhance input from those with expertise in fields of integration, allied health and equity.
Liz Stockley
Sonya Smith
Jeanette Fretchling
Te Pare Meihana
Bruce Green
Nicola Ehau
Di Vickery
Jeanette Rendle

The Chair reminded participants that it was now five years since Clinical Council was formed, and that we were now in a very different space as a DHB and as a HB Health Sector. The concerns that led to its creation around clinical leadership, clinical governance, performance and integration have improved significantly. Now Council is recognised as the Peak clinical advisory body in Hawke's Bay, we have visible oversight of clinical quality and KPIs, the Chairs sit at the Board table, no paper goes to the Board without our oversight, we are important participants in the HB Health Sector Leadership Forum, there is a good working relationship between the DHB and the PHO and integration is improving.

Council members then participated in a series of workshops addressing three key topics – a mixture of presentations and small group discussions with feedback.

2.45 – 3.30	Role of Clinical Quality and Governance (Kate Coley)
3.30 – 4.30	Consumer Partnerships (Graeme Norton) and Co-design/co-creation of Health (Andy Phillips)
4.30 – 5.15	Integration and workforce issues (Mark Peterson, Chris McKenna & Andy Phillips)

Clinical Council spent three hours reviewing and discussing their role from a clinical governance perspective five years on from when they were established to inform their new ToR and future work plan. A number of presentations were given, firstly on clinical governance and patient safety, the second on the development of a culture of person & whānau centred care, and the concept of co-design and co-creating health and lastly on the challenges facing the sector from a workforce perspective. There was much discussion around these new concepts and challenges and how the Clinical Council could best add value and support in these areas.

The QIPS team to provide workshop detail. **Action**

Membership of Council

Kevin Snee had indicated it was no longer necessary, or appropriate for him to be a full Council member given he was not a practising clinician and that Council reported to him, and instead would prefer to be in attendance at meetings. This potentially freed up a vacancy for a new Council position if we wanted to enhance Council diversity and expertise.

One Clinical Director vacancy had been carried for a year which would need to be addressed.

A processes had been initiated to appoint to Council a GP and Senior Nurse, replacing Dr Meyer and Leigh White. The GP vacancy had been discussed with Dr David Rodgers with an appointment imminent. Leigh White advised her last meeting would be October 2015

Once appointed and approved by the CEO, they will be endorsed by the boards of Health Hawke's Bay and HBDHB.

Chair's (Appointment / Re-appointment)

Dr John Gommans had earlier indicated that after five years as Co-Chair, it was appropriate that he stood down from the role. He nominated Dr Mark Peterson for the position of Co-Chair and this was seconded by Billy Allan.

Chris McKenna agreed she would continue for one further year as co-chair of Council.

Terms of Reference and Activity Plan

In wrapping up, Council agreed that a subgroup (of Drs Gommans, Peterson, Phillips and Chris McKenna supported by Kate Coley and Ken Foote) would review the outcomes of all discussions and produce a updated draft Terms of Reference and activity plan for consideration by the Council. **Action.**

It was noted that in future Clinical Council will be working more closely with the Quality Improvement and Patient Safety (QIPS) team together with Ken Foote, Company Secretary, for governance matters.

As part of this development there would be a joint Clinical and Consumer Council meeting – likely in September - to effectively develop a stronger governance relationship between the two councils.

Thanks to all of those in attendance, especially those who joined the Workshop and took time out of their day to enhance the quality of discussions.

There being no further business to discuss, the meeting closed at 5.35pm

Confirmed: _____
Chair

Date: _____

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HAWKE'S BAY CLINICAL COUNCIL
Matters Arising – Review of Actions
Annual Meeting

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
5	12/8/15	**Workshop detail:** To be worked up by the QIPS team.	Kate Coley	Sept	Actioned - Presentation to September Meeting.
6	12/8/15	**Terms of Reference and Annual Plan 2015/16:** A sub-group formed (Gommans, Peterson, Phillips, McKenna supported by Coley and Foote) to produce an updated draft Terms of Reference and Activity plan for consideration by Council at their September meeting.	Sub-Group	Sept	Actioned - included with September papers for discussion. ***

- Refer also to the Annual Meeting Workshop Outcomes – presentation attached.

Summary of Clinical Council Annual Meeting Workshop
September 2015

Clinical Governance

- Clinical Council accountable for clinical quality and safety across sector
- Need good clinical governance and leadership at all levels and across the sector
- Membership of the Clinical Council needs to be refreshed and diverse
- Roles and responsibilities need to be clearly defined
- Audits need to be developed and better established and utilised

Te hauora o te Matau-ā-Māui : Healthy Hawke's Bay
Tauwhiro Rāranga te tira He kauanuanu Ākina

Clinical Governance cont.

HAWKE'S BAY District Health Board Whakawātea tia

- More robust mechanisms for feeding up and feeding back in regard to monitoring – focus should be on providing assurance, sharing learnings and continuous improvement
- Health literacy key to effective and productive outcomes for all – decrease complexity and increase collaboration, improve skills
- Transitions of care – concern raised – how do we create safe and seamless transitions across the health system?

Person and Whānau Centred Care

HAWKE'S BAY District Health Board Whakawātea tia

- Push clinicians to think about what matters to the person/whānau
- Focus on building relationships and trust
- Consumer governance – can we apply same principles at every level across the sector – what does that look like?
- Building capability, understand principles of co-design /co-creating health
- Health literacy – key component
- Working together with consumers to improve outcomes – governance, service and at individual level

Te hauora o te Matau-ā-Māui : Healthy Hawke's Bay
Tauwhiro Rāranga te tira He kauanuanu Ākina

Workforce

- Need to look at how we grow leaders for the future
- Undertaking training as multi-disciplinary teams
- Co-design principles applied to our workforce challenges
- Need to create a workforce that thinks differently – flexible, outside of institutions and is one that understand that we are a 24/7 health care sector
- Workforce planning, succession, retention and recruitment strategies – need to be embedded in service and business planning

Key Themes

- Clinical governance key - need assurance, learnings and focus on continuous improvement (audits, transfer of care)
- Clarity of roles and responsibilities at Clinical Council
- Person and Whānau centred care – work together with Consumer Council to shift culture and mind-set of health sector
- Improve capability and understanding of co-design / co-creating health and health literacy
- Workforce strategy, needs to be embedded and need to take action on key challenges facing the sector

ELECTION OF CHAIR / CO-CHAIRS

Hawke's Bay Clinical Council
The past year in summary 2015/2016

Strategic Input

- Prioritisation Planning
- Integrated Urgent Care Service Level Alliance
- Integrated Urgent Care
- Hawke's Bay Health Alliance – Implications of delegations to Clinical Council
- Health Literacy Programme
- Food Services Optimisation
- Community Pharmacy Services Position Paper
- Regional Tobacco Strategy for HB 2015-2020
- Best Start Healthy Eating
- Youth Health Strategy
- Suicide Prevention and Postvention Plan
- Transform and Sustain Refresh
- 13-17 Year Old Primary Care Zero Rated Subsidy
- Health Equity

Service Development and Design Input

- Maternity Services Business Base
- Maori Health Strategy
- Mental Health Inpatient Unit
- Clinical Pathways
- General Surgery
- Theatre 7 Post Implementation Review
- Elective Services Performance
- Laboratory Services
- Transforming Primary and Community Health Care in HB
- Suicide Prevention and Postvention
- Acute Inpatient Management (AIM 24/7)
- Gastroenterology and Endoscopy Services
- Renal Services
- Pharmacy Services Strategy
- End of Life - Advanced Care Planning
- Palliative Care services
- Older Peoples Health
- Enhanced Community Services for Frail Older People
- Redesign and delivery of Muscular Skeletal Service
- Mobility Action Plan preliminaries for MoH RFP
- Respiratory Pilot
- Rheumatic Fever Prevention Plan
- Fetal Alcohol Syndrome Disorder
- Reducing Alcohol Related Harm
- Roll out of District Nursing Model of Care
- Health and Social Care Networks
- Person & Whanau Centred Care
- Bilingual Signage

Quality

- Quality Accounts
- Quality and Safety Framework
- Quality Improvement and Patient Safety Strategy
- Working in Partnership for Quality Health Care in HB
- Using Consumer Stories to Improve Quality of Care
- HB Clinical Research Committee
- Laboratory Labelling Risks Plan
- Consumer Stories for system improvement
- Complementary Therapies Policy
- Business Case for Sustainable ICU Physicians Roster
- Learnings from ICU Review 2013 and action plan
- Quality Accounts
- Quality as a Business Strategy
- Central Region Quality and Safety Alliance
- Central Region Quality & Safety Alliance
- Governing for Quality
- Quality Improvement & Patient Safety Annual Plan

Monitoring

- Maternity Clinical Governance Group quarterly reports
- Maternity Service Annual Clinical Report
- Integrated Urgent Care
- Falls minimisation
- Annual Maori Health Plan
- Pasifika Health Action Plan
- Monitoring Consumer Reports
- Monitoring Event Reports
- Consumer Council
- Customer Focused Bookings
- Health Professions Workforce
- Nursing Workforce
- Travel Plan
- Te Ara Whakawaiora / Culturally Competent Workforce
- Te Ara Whakawaiora / More Heart and Diabetes Checks
- Te Ara Whakawaiora / Obesity
- Te Ara Whakawaiora / Breast Screening
- Te Ara Whakawaiora / Cervical Screening
- Te Ara Whakawaiora / Access
- Te Ara Whakawaiora / Breastfeeding
- Te Ara Whakawaiora /Oral Health
- Te Ara Whakawaiora /Mental Health and Alcohol and Other Drugs
- Annual Maori Health quarterly dashboards
- HB Clinical Council TOR
- HB Clinical Council Annual Plan
- Operation Productivity
- Improving the Quality of Unscheduled Care & Acute Patient Flow (ED 6 Hours)

Committees and Relationship Development

- Laboratory Services Committee
- HB Clinical Research Committee
- HB Radiology Services Committee - radiology service improvement
- Collaborative Clinical Pathways
- HB Research Committee
- HB Nursing and Midwifery Leadership Council
- Clinical Quality Advisory Committee updates
- PHO Performance updates (including smoke free)

OURHEALTH HAWKE'S BAY
Whakawateatia

CLINICAL COUNCIL ATTENDANCE

2015-2016

Members	Aug	Sept	Oct	Nov	Dec	Feb	Mar	Apr	May	Jun	Jul	Mtg(s)
Chris McKenna	1	1	1	1	1	1	1	1	1	A	1	10
Dr Mark Peterson	1	1	1	1	1	1	1	1	1	1	1	11
Dr John Gommans	1	1	1	1	1	A	1	1	A	1	A	8
Dr Kevin Snee	1											1
Jules Arthur	1	1	A	A	1	A	1	1	1	1	1	8
Dr Kiri Bird	1	1	A	1	1	1	A	A	A	1	1	7
Dr Caroline McElnay	1	A	1	1	1	A	1	1	1	1	A	8
Billy Allan	1	1	1	A	1	1	1	1	1	1	1	10
Leigh White	1	1										2
Robyn O'Dwyer	1	1	A	1	1	1	1	1	A	1	A	8
Dr Hannes Meyer	A											0
David Warrington	1	1	1	1	1	1	A	1	1	1	1	10
Dr Tae Richardson	1	A	1	1	1	1	1	1	1	1	1	10
Dr Malcolm Arnold	1	1	A	1	1	1	1	1	A	1	A	8
Dr Andy Phillips	1	1	1	1	1	1	1	1	1	1	A	10
Dr David Rodgers	1	1	1	1	1	1	1	1	1	1	1	11
Debs Higgins			1	1	1	1	1	1	1	1	1	9
Robin Whyman						1	1	A	1	1	1	5
Anne McLeod					A	1	1	1	1	A	A	4
	15	12	10	12	14	13	14	14	12	14	10	

30.1

Hawke's Bay Clinical Council

Tenure as at April 2016

Tenure		Term	Expiry
Malcolm Arnold	Senior Medical / Dental Officer	1st	Dec 17
Robin Whyman	Senior Medical / Dental Officer	1st	Sep 18
Kiri Bird	General Practitioner	1st	Sep 17
David Rodgers	General Practitioner	1st	Sep 18
Robyn O'Dwyer	Senior Nurse	2nd	Sep 17
Debs Higgins	Senior Nurse	1st	Sep 18
David Warrington	Senior Nurse	1st	Sep 16
Anne McLeod	Senior Allied Health Professional	1st	Sep 18
John Gommans	Chief Medical Officer - Hospital		N/A
Mark Peterson	Chief Medical Officer - Primary Care		N/A
Chris McKenna	Chief Nursing Officer		N/A
Tae Richardson	Clinical Lead Clinical Advisory Governance Committee		N/A
Caroline McElnay	Director Population Health / Equity Champion		N/A
Jules Arthur	Director of Midwifery		N/A
Andy Phillips	Chief Allied Health Professions Officer		N/A
Billy Allan	Chief Pharmacist		N/A

Terms of Reference - Tenure

- Normally appointed for 3 years
- Ideal for one third retire by rotation each year (ie 2-3)
- Members may be reappointed but for no more than 3 terms.

Note

Members appointed by role/position do not have a finite term.

TERMS OF REFERENCE

Hawke's Bay Clinical Council

September 2015

Purpose	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system.
Functions	The Hawke's Bay Clinical Council (Council) • Provides clinical advice and assurance to the Hawke's Bay health system management and governance structures. • Works in partnership with the Hawke's Bay Health Consumer Council to ensure Hawke's Bay health services are organised around the needs of people. • Provides oversight of clinical quality and patient safety. • Provides clinical leadership to the Hawke's Bay health system workforce.
Level of Authority	The Council has the authority to make decisions and/or provide advice and recommendations, to the Boards of HBDHB and Health Hawke's Bay Limited (as appropriate). To assist it in this function the Council may: • Request reports and presentations from particular groups • Establish sub-groups to investigate and report back on particular matters • Commission audits or investigations on particular issues • Co-opt people from time to time as required for a specific purpose. The Council's role is one of governance, not operational or line management. **Delegated Authority** The Council has delegated authority from the CEOs and Boards to: • Make decisions within the mandate and scope set out in the Hawke's Bay Health Alliance – Alliance Agreement • Make decisions and issue directives on quality clinical practice and patient safety issues that: ▪ Relate directly to the function and aims of the Council as set out in the Terms of Reference; and ▪ Relate directly to the provision of, or access to, HBDHB publicly funded health services; and ▪ Are clinically and financially sustainable; and ▪ Are affordable within HBDHB's current budgets. All such decisions and/or directives will be binding on all clinicians who provide and/or refer to public health services funded (in whole or part) by the HBDHB.
Membership	Members appointed by tenure shall normally be appointed for three years whilst ensuring that approximately one third of such members 'retire by

	rotation' each year. Such members may be reappointed but for no more than three terms. Members appointed by role/position do not have a finite term. *By role/position:* • CMO Primary Health Care • CMO Hospital • Chief Nursing Officer • Midwifery Director • Director of Allied Health • Chief Pharmacist • Director Population Health • Clinical Lead PHO Clinical Advisory and Governance Committee *By Appointment (tenure):* • General Practitioner x 2 • Senior Medical / Dental Officer x 2 • Senior Nurse x 3 • Senior Allied Health Professional When making appointments, consideration must be given to maintaining a wide range of perspectives and interests within the total membership, ensuring in particular that Māori health and rural health interests and expertise are reflected.
Chair	The Council will annually elect a chair and deputy, or co-chairs.
Quorum	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
Meetings	Meetings will be held monthly at least ten times per year, or more frequently at the request of the chair/co-chairs. Meetings will generally be open to the public, but may move into "public excluded" where appropriate and shall be conducted in accordance with HBDHB Board Standing Orders as if the Council was a Board Committee. A standing reciprocal invitation has been extended to the Hawke's Bay Health Consumer Council for a representative to be in attendance at all meetings. Matters may be dealt with between meetings through discussion with the chair/co-chairs and other relevant members of the Council.
Reporting	The Council will report through HBDHB and Health Hawke's Bay Limited Chief Executives to the respective Boards. A monthly report of Council activities/decisions will be placed on the DHB website when approved.
Minutes	Minutes will be circulated to all members of the council within one week of the meeting taking place.

HAWKE'S BAY District Health Board Whakawāteatia	**Quality Improvement & Patient Safety Plan**
	For the attention of: **HB Clincial Council**
Document Owner: Document Author:	Kate Coley Kate Coley
Month:	August 2016
Consideration:	For Feedback/Discussion

RECOMMENDATION

That Clincial Council:

- Provide feedback and comment on the draft QIPS Annual Plan.

EXECUTIVE SUMMARY

With the introduction of the Working in Partnership for Quality Framework and the now fully established QIPS team there is an opportunity to develop an overarching QIPS Plan to ensure that the priorities and objectives identified in the framework are implemented.

In addition to this, a number of other priorities including HQSC programmes, the Regional Services Plan and other local drivers have been identified.

This plan is in it's first phase of development and will be shared with EMT, Clinical Council and Consumer Council for input and feedback before being presented to the Board for endorsement.

The intention is that progress against the objectives detailed within will be reported quarterly to the relevant groups.

Quality Improvement & Patient Safety

Annual Plan 2016-17

OURHEALTH
HAWKE'S BAY
Whakawāteatia

Contents

Introduction & Context

The Quality Improvement and Safety Framework developed in 2013 outlines a framework to support integrated quality improvement and performance across the Hawke's Bay health sector by providing direction and priorities. Its aim is to ensure that the entire health sector has a shared sense of direction in provision of quality care for the Hawke's Bay people.

The Working in Partnership for Quality framework breaks quality improvement and safety into four dimensions to provide a focus for our work and help us identify more readily opportunities for improvement.

WELLNESS: Improving the health of our communities.

PEOPLE'S EXPERIENCE OF HEALTH CARE: Continuously improving the safety of our services, underpinned by a culture of care and compassion.

WORKING WITH THE PEOPLE OF HAWKE'S BAY: The patient, family/whānau and carer voice as an essential component of clinical quality improvement and patient safety.

LEADERSHIP AND WORKFORCE DEVELOPMENT: Clinical quality improvement and safety is embedded within the Hawke's Bay health sector workforce and leaders.

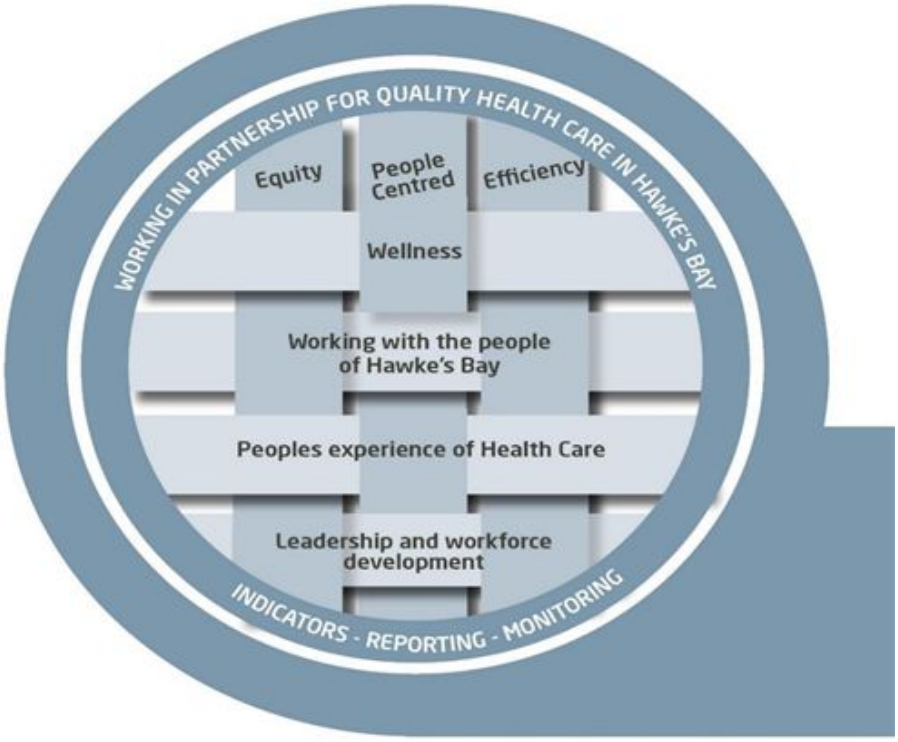
The Framework aligns to the NZ Triple Aim focussing on the three core components of Equity, People Centred and Efficiency.

.

What does success look like?

- Every person that works in the Hawke's Bay Health sector will be aware of their responsibility for quality improvement and patient safety.
- Consumers are active participants in determining their wellness and their voice is valued in decision making.
- Clinical participation in management and governance of health services is essential in creating the culture needed for effective quality improvement and patient safety.
- Clinicians are not only responsible for the provision of high quality patient care, but their leadership is also important at all levels of the system.

Working in Partnership for Quality Framework



HEALTH CARE MUST BE:

- SAFE: Avoiding harm to patients from care that is intended to help them.
- EFFECTIVE: Providing services based on evidence and which produce a clear benefit, with neither underuse nor overuse of the best available techniques.
- PEOPLE CENTERED: Establishing a partnership between clinicians and patients, inclusive of family and whānau, to ensure care respects patient's needs and preferences; and the person should play an active role in making decisions about their own care.

- TIME: Reducing waits and sometimes harmful delays.
- EFFICIENT: Constantly seeking to reduce waste.
- EQUITABLE: Providing care that does not vary in quality because of a person's characteristics

WELLNESS

Population health and prevention programmes ensure that people are better protected from accidents, ill health and disability. The programmes support people to maintain healthy lifestyles.

As part of this annual plan we acknowledge the importance of making sure that health information about conditions and services, are easily accessible and easy to understand. This will reduce barriers for access to services as well as improve equity in health services and outcomes.

PEOPLE'S EXPERIENCE OF HEALTHCARE

The health experience Hawke's Bay people have is of utmost importance. We understand that some people may be vulnerable and may be going through life changing diagnoses and treatments. It is our goal that we make this experience the best that it can possibly be.

This means we will support a culture of care and compassion, sustain an open, transparent system that will ensure those people that use the health service come first at all times.

We will ensure all those who provide care for these people, both individuals and organisations, are aware of their role in ensuring a high quality and safe service, and are accountable for what they do.

WORKING WITH THE PEOPLE OF HAWKE'S BAY

We acknowledge the people who use our services have a unique perspective of health services and are able to provide us with important information about how we design, deliver and monitor health services.

Working together with the people of Hawke's Bay includes developing and maintaining stronger partnerships to share information between all those involved to ensure that the right care, is given to the right person, at the right time and by the right person.

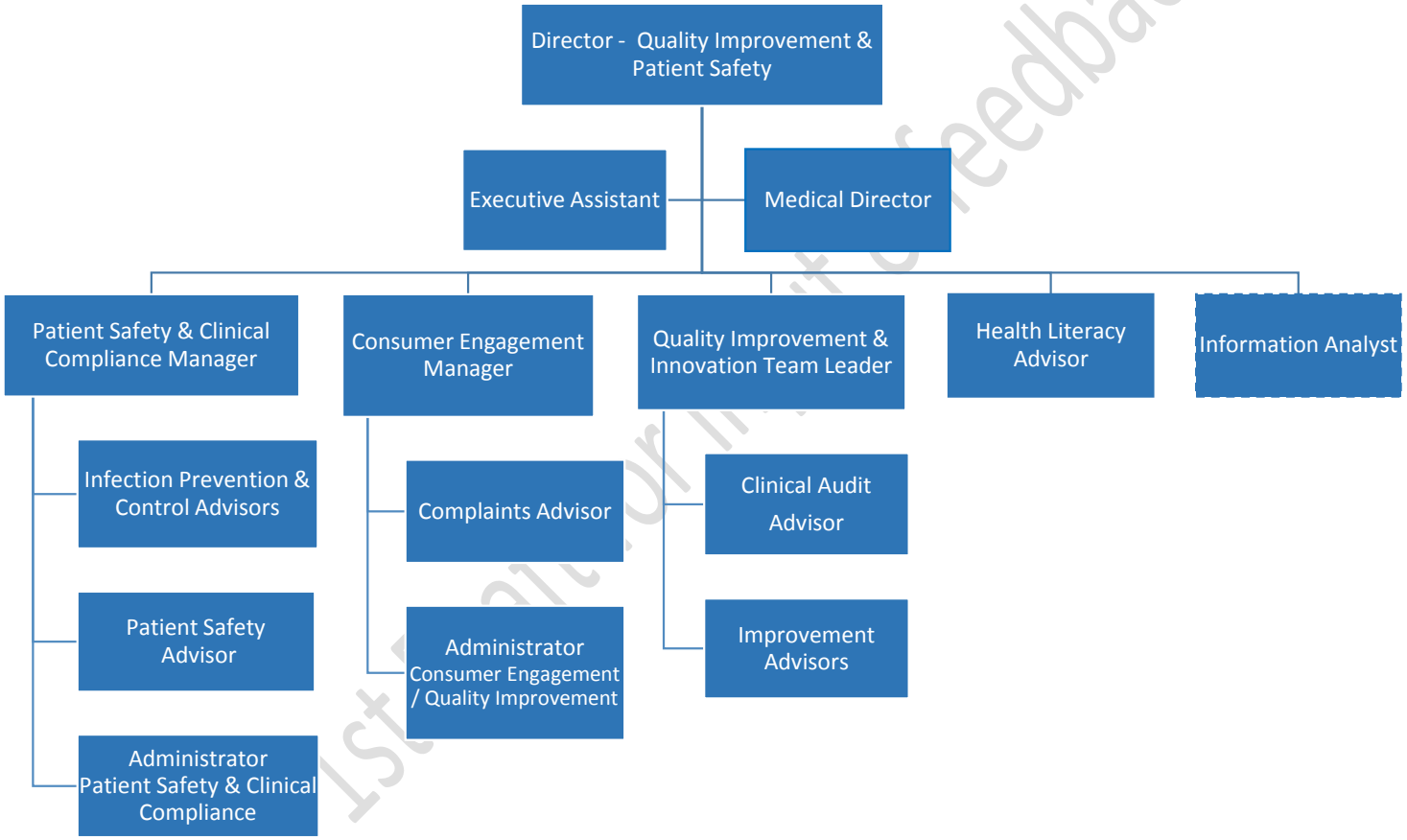
LEADERSHIP AND WORKFORCE DEVELOPMENT

Ultimately we want a health system that focuses on system wide improvements and not on individuals. We want to examine underlying contributing factors and root causes to identify changes that could be made to improve systems and process to improve quality of care.

Ultimately we want a culture of open reporting where staff are empowered to make decisions relating to quality improvement and patient safety as close as possible to the person receiving care.

Whilst the Quality Annual plan is based on the sector implementing the framework, there are also a number of national and regional priorities that are factored into the plan, including the requirements from the Health Quality and Safety Commission (HQSC), the Regional Services Plan (RSP) and the HBDHB's Annual Plan. Extracts of the RSP and Annual Plan are appendices in the plan.

Quality Improvement & Patient Safety Structure



Annual Quality Improvement & Patient Safety Programme of Activities

Framework	Objectives in Framework & Other	Activities	Measure/Target/KPI	Responsibility	Timeframe
Wellness	Ensure that our systems of communication are responsive to the people of Hawke's Bay	Development of a sector wide Health Literacy Framework/Principles	Principles endorsed by all relevant governance bodies	HL Advisor	Q1
		Implementation of Health Literacy Framework	Action plan developed and monitored on a quarterly basis	HL Advisor	Q1 – ongoing
		Support development and continual review of our health website in conjunction with Communications team	Website continually updated	HL Advisor	Ongoing
		Continue to support quality improvement initiatives such as the development of Clinical Pathways, Customer Focussed Booking and National Patient Flow.	Projects benefits realised	Consumer Engagement Manager, QI Team	Ongoing
Wellness	Improving the Communication between health professionals and the consumer	Implementation of HL Training programmes to support clinicians to understand how to best engage with consumers	Training programmes developed and utilised	HL Advisor & E&D	Q2
		Rollout of Ko Awatea training modules and review uptake from across the sector	Regular reporting completed	HL Advisor	Q2
		Continue to build awareness with clinical teams around patient centred care e.g. Patient Safety Week (November)		Consumer Engagement Manager	Q2

Monitoring & Measuring	Presentation of quality health information	Development of a quarterly sector wide quality dashboard focussed on patient safety, clinical effectiveness and patient experience	KPI's developed	DQIPS/Business Intelligence	Q1
		Communication of the dashboard to relevant governance bodies and to the sector	Quarterly report communicated & shared	DQIPS	Q2
		Publication of the annual Quality Accounts report	Report completed and positive feedback received from community and HQSC	Consumer Engagement Manager	Q2
		Review of information provided to patients on admission and on discharge, with a view to making improvements.	Plan developed and implemented with improved patient responses to national patient experience survey	HL Advisor/Patient Safety Advisor	Q3
Monitoring & Measuring	Improve HB Health Sector performance against HQSC quality safety markers	Reduce the harm from falls through an integrated approach through the falls minimisation Committee	Improved engagement across the sector leading to a reduction in falls & harm from falls	Falls Committee	Ongoing
		Ensure Falls risk assessment and care plans are completed for all admissions	HQSM achieved/exceeded consistently (90% target)	Clinical Teams	Ongoing
		Review of all falls to ensure learnings are identified and opportunities for improvement are implemented.	Recommendations/learnings shared and implemented	Falls Committee	Ongoing
		Reduce the risk of health associated infection by maintaining the achievement at or above the 80% compliance rate for hand hygiene.	80% compliance rate achieved/exceeded consistently	Infection Prevention & Control/ Gold Auditors	Ongoing

		Reduce the risk of perioperative harm with the continuation of the briefing and debriefing piece of work for every theatre list. Reduce the risk of harm from pressure injury with the establishment of a cross sector pressure injury review committee. Support the development of a pressure injury strategy and implement any learnings from pressure injury events identified. Continue to carryout medicines reconciliations to improve medication safety and report these on a quarterly basis.	Briefing & Debriefing takes place 100% of time for all surgical procedures Establishment of cross sector Pressure Injury Committee Development of programme of work Increase current % of medicine reconciliations completed	Infection Prevention Control & Improvement Advisor Patient Safety & Improvement Advisor Patient Safety Advisor Pharmacy Facilitators	Ongoing Q2 Q2 Ongoing
Leadership	Maintain and build relationships across the sector, regionally and at a national level	Implementation of quality forums within HB bringing together those responsible for quality across GP Practices, ARRC and NGOs to enable sharing of learnings and development of a programme of work to support these providers Ensure effective representation of HB on Central Regions Quality Safety Alliance to support achievement of objectives within RSP Build relationships with HQSC and Ko Awatea	Quality forums established Participation and engagement high from all areas Participate in relevant groups and influence decision making Establish training partnership Implement Improvement Network	DQIPS DQIPS DQIPS	Q3 Ongoing Ongoing

Patient Experience	Improving clinical oversight in all provider contracts	Review all current clinical provider contracts to ensure they meet the HB sectors quality and patient safety requirements. Consider the development of a mechanism to collect information to monitor quality and safety within our contracted providers.	Principles of quality applied to clinical provider contracts Ensure appropriate reporting processes	DQIPS DQIPS	Q3 Q4
Leadership	Facilitating the quality agenda through clinical and management leadership and governance structures, promoting board responsibility for quality improvement and patient safety	Implementation of new clinical governance committee's structure to ensure effective reporting to clinical council. Establishment of an annual audit programme to ensure all clinical areas undertake regular audits against key HQSM and sector wide priorities Develop and implement mechanisms to ensure learnings from patient events and incidents are shared and recommendations are fully implemented. Implementation of new risk management framework Review of current event reporting system.	Committees established, with TOR, cross sector representation and reports provided through to Clinical Council Audit Committee established, and programme of work endorsed by Clinical Council. Reports provided on a quarterly basis Mechanisms agreed, learning shared and recommendation implementation monitored by Clinical Event Advisory Groups Framework, tools and reporting mechanisms in place and utilised Business Case developed and endorsed	DQIPS/Clinical Council/Consumer Council DQIPS/CAPHO Patient Safety Advisor DQIPS/Co Secretary DQIPS	Q2 Q2 Q1 Q3 Q1

		Facilitate and lead the implementation of a new event, risk and feedback reporting system	Project plan developed and implemented	DQIPS	Q4
		Review of current quality policies and procedures to support quality improvements and safety across the Hawkes Bay health system	Policies refreshed	Patient Safety & Clinical Compliance Manager	Q2
		Ensure Privacy action plan is implemented and annual audit it undertaken to meet requirements of GCPO.	Privacy plan reported against on a quarterly basis	Patient Safety & Clinical Compliance Manager	Q1
		Facilitate and support the implementation of Certification corrective actions with all clinical teams	Progress reports provided as per MOH requirements. Corrective actions closed by MOH.	Patient Safety/ Health Services	Ongoing
		Legislative Compliance annual review undertaken	Audit undertaken Report provided to FRAC	Patient Safety & Clinical Compliance Manager/Company Secretary	Q2
Working With HB Community	Improving the process of gathering patient experience data and stories, sharing them widely across the sector	Development of an overarching Person & Whanau Centred Care strategy, encompassing Patient Experience, Consumer Engagement & Health literacy pieces of work.	High level paper developed and feedback sought before finalisation.	DQIPS & Governance Groups	Q1
			Communication & Awareness building strategy implemented		Q1
		Continue to participate in the National Patient Experience Survey	Provide HQSC with information and undertake quarterly analysis of results	Consumer Engagement Manager	Ongoing

		Development and implementation of a local patient experience survey aligned to the values of the sector Proactively seek out through focus groups, project development and quality improvement initiatives the ideas of our consumers and their whanau. Continue to share patient stories with Board and more widely across the sector.	Develop and Test questions Identify mechanism to gather data Collate information & Identify trends and themes – share with teams and identify areas for improvement Plan and implement approaches to individual projects/initiatives Mechanisms identified and implemented	Consumer Engagement Manager/Business Intelligence Consumer Engagement Manager Consumer Engagement Manager	Q2 Q1 & Ongoing Ongoing
Working With HB Community	Improving the process of monitoring consumer feedback and relevant recommendations and improvements	Share quarterly results of both national and local survey results with relevant governance groups identifying themes and areas for improvement	Information provided as part of ¼ dashboard Results shared and teams to identify improvement activities	Consumer Engagement Manager	Q2
Working With HB Community	Developing community engagement and communication channels	Identify a variety of mechanisms to engage effectively with our Community around health matters to gather their feedback and ideas	Identify provider to support effective community engagement and implement programme	Consumer Engagement Manager	Q2
Working With HB Community	Supporting the consumer voice to become part of nay	Development of a Consumer Engagement framework and guideline for all staff.	Consider all research, draft and gather feedback before finalisation and communication to all teams	Consumer Engagement Manager	Q1

	planning or redesign process	Ensure that all Project TOR require specific discussion in regards to the level of consumer engagement Continue to build capability in co-design methodology and utilising patient experience feedback to improve service design and delivery	Discuss with PMO Development of series of programmes Programmes delivered with high participation	Consumer Engagement Manager / PMO Consumer Engagement Manager	Q1 Q2 - ongoing
Leadership & Workforce	Implementing clinical leadership and building leadership capacity at all levels	Development of a programme of work to support building the capability of all teams in matters relating to Patient Safety, Consumer Engagement and Quality Improvement methodology. Continue to map talent across tier 3 and tier 4 management populations across the sector identifying potential. Extend the current talent mapping strategy to identify hidden and emerging talent Implementation of a development strategy for those identified to ensure succession plans are clearly identified and managed. Review of position profiles and performance appraisal process to ensure quality and patient safety components are included.	Annual Education programme developed and delivered Annual Mapping exercise undertaken and reports provided Tool developed and implemented, with hidden talent identified Plan implemented Position profiles & PAS templates updated	DQIPS DQIPS DQIPS DQIPS Human Resources	Q1 Q2 Q2 Q2 – ongoing Ongoing

Leadership & workforce	Improving workforce engagement	Implementation of new Staff Engagement Survey	Staff Engagement Survey run	Human Resources	Q2
		Review of information and feedback with the identification of organisational wide actions.	Reports collated and summarised for presentation	Human Resources/ EMT	Q2
		Implementation of actions	Action plans developed and progress against action monitored regularly.	EMT/HR	Q2 – ongoing
		Implementation of GEMBA Walks	Agree approach and purpose Implementation and identification of areas for improvement	DQIPS	Q2 – ongoing
Monitoring & Measuring	Ensuring that quality improvement and safety reporting and monitoring is provided and communicated effectively	Development of a quarterly sector wide quality dashboard focussed on patient safety, clinical effectiveness and patient experience	KPIs developed	DQIPS/Business Intelligence	Q1
		Communication of the dashboard to relevant governance bodies and to the sector	Report provide quarterly to relevant governance bodies and wider	DQIPS	Q1 & ongoing
		Continue to utilise benchmarking data provided by Health Roundtable (HRT) to identify further areas for improvement.	Quarterly Executive Summary shared with HS and Improvement initiatives identified and implemented	DQIPS/Business Intelligence/HS Leaders	Ongoing
		Ensure reporting of Serious Adverse Events and ACC Treatment Injury information is completed with learnings identified and recommendations implemented.	SAE Report provided annually	Patient Safety & Clinical Compliance	Q2 / Annually

Patient Experience	Ensure all Business Partners are supported to achieve their patient safety and clinical quality improvements.	Continue to facilitate a number of quality initiatives including the Bed Days and Releasing Time to Care programmes	4,500 Bed Days programme achieved Improved RSI Savings achieved	QI Team & Health Services Teams	Ongoing
		Increase collaboration and integration of QIPS team within all areas to educate, facilitate and support services to become more efficient and effective at delivering their services.	Increased & improved relationships Improved performance of services	QI Team QI Team	Ongoing
	Provision of support to projects and programmes of work	Continue to support initiatives to reduce harm, waste and variation Continue to provide expertise and advice to projects and programmes of work across sector. E.g. Operational Productivity, Aim 24/7	Benefits & savings realised Benefits of Projects realised	QI Team supporting HS QI Team supporting HS	Ongoing
Leadership & Workforce	QIPS Workforce Development	Support staff to attend training and conference opportunities to continue to build expertise and skills	Learnings shared and skills increased	DQIPS	Ongoing
		Support staff to complete annual performance appraisals and development plan to ensure staff are supported to maintain professional competencies	Performance Appraisal targets achieved	All Managers	Q1
		Ensure that all staff have annual leave plans	Annual Leave indicators achieved	All Managers	Ongoing

		Ensure that the QIPS team has opportunities to share knowledge and skill across the team through regular team meeting, quarterly sessions and annual planning day. Budget and saving efficiencies for QIPS	Planning days implemented Successes celebrated Budget savings achieved	DQIPS DQIPS / QIPS	Ongoing Q4

Appendix 1 – Extract from HBDHB Annual Plan

1.1.1 Improving Quality & Safety

Delivering consistent high quality care continues to be one of the key themes and enablers to achieving our Transform and Sustain strategy. Over the past twelve months the Quality Improvement and Patient Safety service has been evolving to support the Hawkes Bay health sectors quality improvement and patient safety framework - Working in Partnership for Quality Healthcare in Hawke's Bay. This framework identified clinical leadership and consumer partnership throughout the health sector as the most important aspect of improving quality health care and patient safety. We use our framework to align our local efforts in support of the national quality improvement work coordinated by the Health Quality and Safety Commission (HQSC). In 2015/16 we have established a new Quality Improvement and Patient Safety (QIPS) team and we appointed the Director of that service to Executive Management Team (EMT) in order to further raise the profile of quality and safety at HBDHB. With a focus on consumer engagement, the QIPS team provide support for integrated quality improvement and performance across the Hawke's Bay health sector and help clinical teams to recognise and define priority areas and to identify actions for implementation. Our focus for the coming year will be on continuing to sustain the improvements made in the past twelve months, continuing to meet the required Health and Disability Standards with our full year Certification Audit and to focus on growing the capability of our teams in regards to co-design and improvement methodologies, and enable a shift in the culture of the DHB to see consumer engagement as the norm and move to becoming far more person and whānau centred.

Short-term outcome	Activity	Monitoring & Reporting
Improve HB Health Sector performance against all National Quality and Safety markers (QSM)	QIPS team to support operational teams by supplying regular performance data from routine monitoring and audits, interpreting data and assisting with the development of improvement opportunities	HQSC quarterly QSM reporting on all targets
	Front-line ownership of improvement targets driven by directorate leadership and oversight provided by Clinical Council representing sector wide clinical leadership.	
	Continue to share consumer stories monthly with all governance bodies and present quarterly quality dashboard.	
Reduce risk of harm from falls	Cross sector integrated approach through the Falls Minimisation Committee. Includes representation from primary, aged residential care and secondary care patients and NGPs Links to activity in hospital (intentional rounding, signalling tools in wards); urgent care (fracture liaison); community (aged residential care); and primary (pharmacy, green prescription).	90% of older patients are given a falls risk assessment

	Falls risk assessments and care plans completed for all admissions.	98% of those at risk have an individual care plan completed
	Clinical Nurse managers or Nurse Directors to investigate falls events and provide feedback and learnings to Chief Nursing Officer and Falls Minimisation Committee. Focus on reducing falls in older people that result in serious harm.	
	See Health of Older People Section for activity of falls minimisation	
Short-term outcome	**Activity**	**Monitoring & Reporting**
Reduce risk of healthcare associated infection	Maintain achievement at or above 80% compliance for hand hygiene	80% compliance with good hang hygiene practice
	Maintain the right number of trained hand hygiene auditors and promote good hand hygiene practices to staff, patients and visitors. Supported by the Chief Nursing Officer's sponsorship	
	Monitor quarterly results and implement related improvements, such as implementing local improvement methodology and front-line ownership through our gold auditors	
	Continue to provide education to all staff and take part in hand hygiene initiatives e.g. National Hand Hygiene Day	
	Improve performance for clinical interventions specified by the surgical site infection improvement programme	95% of hip and knee replacement patients receive cefazolin ≥2g or cefuromine ≥1.5g as surgical prophylaxis 100% of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision
	Champions on the wards and in DSU to support the process and educate staff	
	Regularly review the results and implement necessary Quality and Safety initiatives to improve performance	
Reduce risk of perioperative harm	Achieve the old QSM threshold of all three parts of the WHO surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90 percent of operations	All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100 percent of surgical procedures, with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale, 95 percent of the time. TBC
	Checklist will be used in paperless form, as a teamwork and communication tool rather than an audit tool	
	Work with the Commission to continue to implement briefing and debriefing for each theatre list.	

Reduce the risk of harm from Pressure Injury	Establish a pressure injury review committee by December 2016	
	Support clinicians to complete ACC 45 and ACC 2152 (treatment injury claim) forms for all grades of pressure injury except grade one, to provide a more accurate picture of the incidence of pressure injuries occurring while patients are in our care	
	Report all pressure injuries grade three and above as serious adverse events to HQSC	
	Review all Pressure injury events regularly and implement improvement initiatives as required.	
	Improve classification and documentation of pressure injuries by grade in the patient record and ensure they are coded	
	Implement structured risk assessment to support clinical judgment and evidence-based prevention approaches.	
	Provide ongoing education to all staff regarding pressure injuries	
Improve medication safety	Continue to carry out medicines reconciliations and monitor and report these on a quarterly basis with an aim to spread medicines reconciliation through paper-based system	% of medicine reconciliations completed
	Support implementation of electronic medicine reconciliation platform when infrastructure available (dependent on regional programme and implementation of clinical portal) It is anticipated that this will be in 2018.	
Improve Consumer engagement and experience	Continue with initiative to capture correct patient details at 'first point of contact' working closely with the Customer Focused Booking and National Patient Flow Projects	DV4 Quarterly Reporting
	Support implementation of the Patient Experience Survey in Primary Care. Opportunities for improvement will be identified, tracked and implemented	
	Develop a consumer engagement strategy by the end of 2016	
	Support the Hawke's Bay Health Consumer Council	
	Implement a local consumer engagement survey aligned to sector wide values	

	Continue to produce a Quality Dashboard to monitor Safety, Clinical Effectiveness and Patient Experience.	
	Develop and Implement a health literacy framework	
	Co-design Collaborative clinical pathways	
Improve Quality Improvement Capability and clinical leadership	Promote Key messages and themes of Patient Safety Week 2016	Quality accounts demonstrate building of capability for quality improvement and patient safety.
	Sustain the HB sector wide transformational leadership programme	
	Implementation of training and support to all teams in patient safety, QI methodologies, health literacy and co-design.	
Produce Annual Quality Accounts	Continue to produce annual Quality accounts and circulate locally to show improvement in key quality and patient safety indicators. Utilise relevant quality data as per HQSC guidance.	
	Implement a quality dashboard by December 2016 and share regularly with Clinical Council; Finance, Risk and Audit Committee; and HBDHB Board.	
Promote Regional Collaboration for Quality and Safety Initiatives	Implement HB sector wide consumer engagement strategy	
	Participate in Central Region's Quality and Safety Alliance and quarterly Quality and Risk meetings to share learnings and build capability for improvement.	

Appendix 2 – Extract from Regional Service Plan 2016-17

Quality and Safety

Sponsor: Julie Patterson

Clinical leadership and person/family-centred care are internationally recognised as key drivers of improved patient outcomes and effective clinical governance.

Clinical governance systems within health care form the foundation of safer processes for people and their families/whānau and staff. The aim for the Central Region is to work in partnership as a region to improve the quality of care and to reduce patient harm. The Central Region Quality and Safety Alliance (CRQSA) was established June 2014, with the overarching aim of achieving consistent high quality and safety of care and positive patient experiences for people and their families/whānau.

The CRQSA provides a voice for clinical leaders across the region to positively influence planning, reduce health disparities and improve health outcomes for communities.

Partnership between the CRQSA, HQSC, ACC and Ministry of Health quality programmes has been established and will be strengthened through active participation, information sharing and collaborative initiatives that improve the health and wellbeing of communities.

Objectives

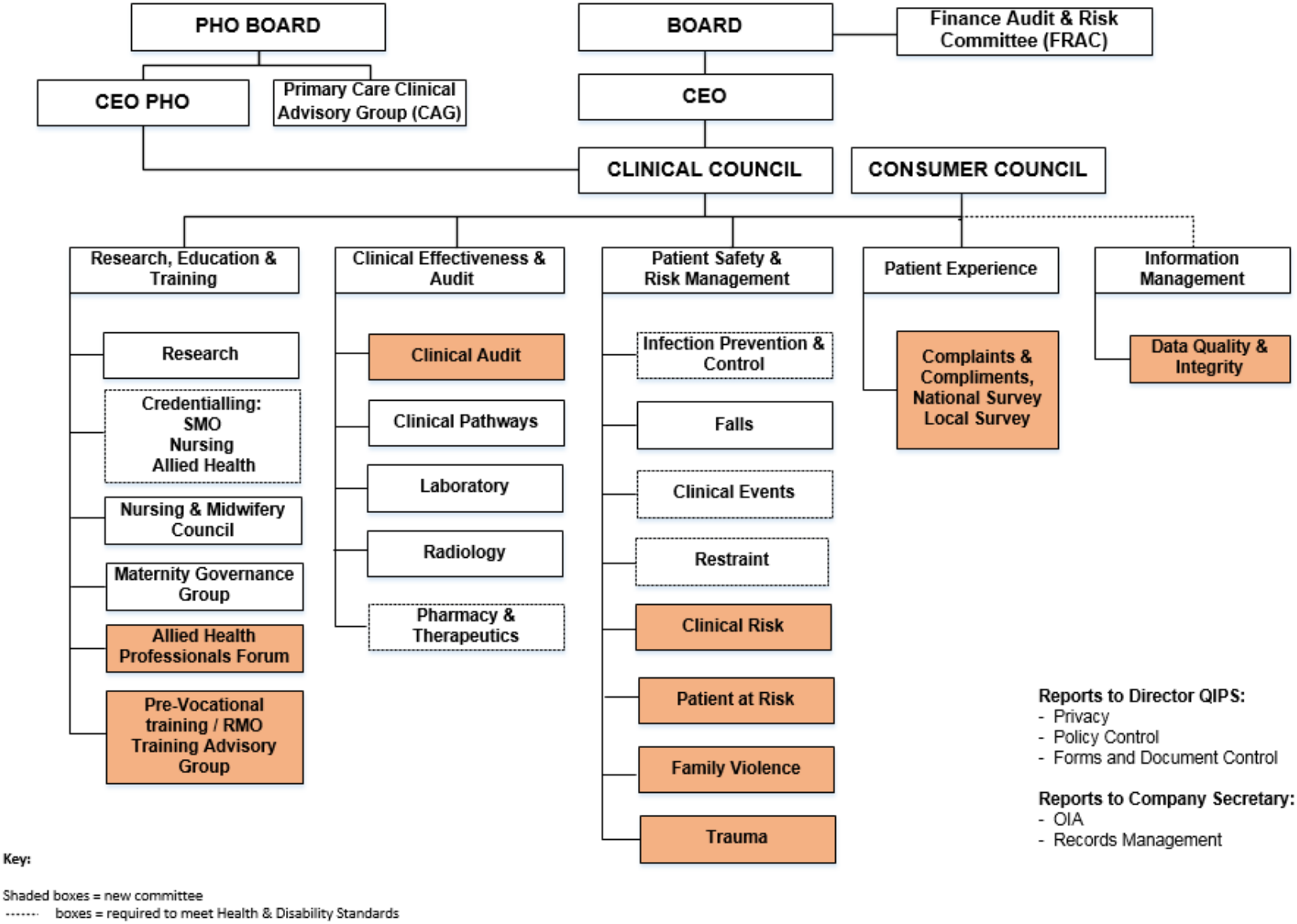
- Provide effective regional quality and safety planning, advice and recommendations to the Regional Executive Committee
- Promote the effective and appropriate sharing of quality and safety information and learnings that supports a regional perspective on patient safety issues
- Influence and support clinicians and managers to implement systems and processes that will improve the quality and safety of the care delivered

Q and S Key Actions	Milestones	Measures
Strengthen alliance with primary care participation in the Central Region	Q1: scope opportunities for further engagement points and establish relationships with PHO and DHB Clinical Governance Boards. Q2–Q3: develop and agree Future Engagement Strategy. Q3–Q4: implementation of Future Engagement Strategy.	Q1: Identifying chairs of local clinical governance boards/equivalent and sending key points from CRSQA meetings to be added to local agendas. Q2-Q3: Embed process for raising issues from local clinical governance boards to CRQSA. Q3-Q4: Maintain/increase membership of PHOs on CRQSA.
Improve patient outcomes through collaboration on areas of high patient harm with support from HQSC programmes	Q1–Q4: utilise HQSC regional data on identifying areas of improved patient outcomes/areas of risk. Q3–Q4: develop a regional shared learning framework.	To regionally mark against the national average in the quality and safety markers and outcome measures set by HQSC through sharing regional learnings. Establish a regional shared learning framework for improving patient outcomes.
Support the regional approach of person and whānau-centred care consumer partnerships with implementation of Relationship Centred Practice training	Q1: coordinate information on consumer structures and approaches utilising regional linkages on creating agreed consumer approach across the region. Q2–Q3: develop a training package to support the implementation of a person and whānau-centred approach. Q4: regional phased implementation of the Relationship Centred Practice training.	Information collected and shared on consumer groups and approaches in Central Region and available on SharePoint. Discussion item on every agenda regarding consumer input across the central region. Training package developed on the person and whānau-centred care approach. Report from HQSC regarding central region themes from adult inpatient experience survey. To provide Central Region training on person and whānau-centred care (Relationship Centred Practice training).

Continue to strengthen partnerships with the quality and safety programme of the HQSC, ACC and the Ministry to promote shared learnings	Q1: scope opportunities for shared learning events. Q1–Q4: collaborate with national partners to contribute to HQSC open book.	HQSC reports on every agenda for discussion/action. Regional contribution to HQSC 'Open Book'. Six-monthly report received from HealthCert MoH on regional learning from certification for distribution amongst quality managers. Regional collaboration on adverse event management policy development. Evidence of establishment of central region quality and safety groups such as infection control, falls events, incontinence management, pressure injury prevention, medication safety, central region quality managers, central region directors of nursing – with six-monthly updates from all groups to CRQSA.

OURHEALTH
HAWKE'S BAY
Whakawateatia

Clinical Governance Committee Structure


PHO BOARD
CEO PHO
Primary Care Clinical Advisory Group (CAG)
BOARD
Finance Audit & Risk Committee (FRAC)
CEO
CLINICAL COUNCIL
CONSUMER COUNCIL
Research, Education & Training
Research
Credentialling: SMO Nursing Allied Health
Nursing & Midwifery Council
Maternity Governance Group
Allied Health Professionals Forum
Pre-Vocational training / RMO Training Advisory Group
Clinical Effectiveness & Audit
Clinical Audit
Clinical Pathways
Laboratory
Radiology
Pharmacy & Therapeutics
Patient Safety & Risk Management
Infection Prevention & Control
Falls
Clinical Events
Restraint
Clinical Risk
Patient at Risk
Family Violence
Trauma
Patient Experience
Complaints & Compliments, National Survey Local Survey
Information Management
Data Quality & Integrity
Reports to Director QIPS:
- Privacy
- Policy Control
- Forms and Document Control
Reports to Company Secretary:
- OIA
- Records Management
Key:
Shaded boxes = new committee
------ boxes = required to meet Health & Disability Standards

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2015/16
1 September 2015

FUNCTIONS	Provide Clinical advice and assurance to the Hawke's Bay health system senior management and governance structures	Work in partnership with the Hawke's Bay Health Consmer Council to ensure that Hawke's Bay health services are organised around the needs of people.	Provide oversight of clinical quality and patient safety	Provide clinical leadership to Hawke's Bay health system workforce
ROLES	Provide advice and/or assurance on: • Clinical implications of proposed services changes. • Prioritisation of health resources. • Measures that will address health inequities. • Integration of health care provision across the sector. • The effective and efficient clinical use of resources.	• Develop and promote a "Person and Whanau Centred Care" approach to health care delivery. • Facilitate service integrations across / within the sector. • Ensure systems support the effective transition of consumers between/within services. • Promote and facilitate effective consumer engagement and patient feedback at all levels. • Ensure consumers are readily able to access and navigate through the health system.	• Focus strongly on reducing preventable errors or harm. • Monitor effectiveness of current practice. • Ensure effective clinical risk management processes are in place and systems are developed that minimise risk • Provide information, analysis and advice to clinical, management and consumer groups as appropriate. • Ensure everyone in the HB health sector are aware of their responsibility for quality improvement and patient safety.	• Communicate and engage with clinicians and other stakeholders within HB Health Sector, providing clinical leadership when/where appropriate. • Oversee clinical education, training and research. • Ensure clinical accountability is in place at all levels.

STRATEGIES	• Review and comment on all reports, papers, initiatives prior to completion and submission to the Board.
	• Proactively develop, promote and recommend changes to improve health outcomes, patient experience and value from health resources.
	• Develop, promote and advise on strategies and actions that could assist with the reduction in health inequities.
	• Develop and promote initiatives and communications that will enhance clinical integration of services.
	• Provide input through representation on EMT, Alliance Leadership Team and through attendance at HB Health Sector Leadership Forum.
		• Work collaboratively with the Consumer Council to design and implement a Person and Whanau Centred Care approach.
		• Understand what consumers need.
		• Understand what constitutes effective consumer engagement.
		• Promote clinical workforce education and training and role model desired culture.
		• Promote and implement effective health literacy practice.
		• Promote the development and implementation of appropriate systems and shared clinical records to facilitate a 'smooth patient experience' through the health system.
			• Develop and maintain relevant and effective Clinical Indicator reporting and performance management processes.
			• Establish and maintain effective clinical governance structures and reporting processes.
			• Ensure safety and quality risks are proactively identified and managed through effective systems, delegation of accountabilities and properly trained and credentialed staff.
			• Ensure the "quality and safety" message and culture is spread and applied in all areas of HB health sector.
			• Promote "value-based decision-making" at all levels. This involves improving the processes by which decisions are made, so they take into consideration all three Triple Aim objectives:
			  ○ Enhanced patient experience
			  ○ Improved health outcomes
			  ○ Better value for money
			• Ensure attendance at appropriate meetings/forums to provide appropriate assurance and confidence.
				• Ensure all HB clinicians and other stakeholders are aware of the role, membership and activities of the Clinical Council.
				• Oversee the development, maintenance and implementation of a HB Clinical Workforce Sustainability Plan.
				• Promote clinical governance at all levels within the HB heatlh system.
				• Ensure appropriate attendance/input into National/Regional/ Local meetings/events to reflect HB clinical perspective.
				• Promote ongoing clinical professional development including leadership and "business" training for clinical leaders.
				• Facilitate co-ordination of clinical education, training and research.
				• Role model and promote clinical accountability at all levels.

OBJECTIVES 2015/16	• Provide clinical leadership decision making and input into significant integration projects: Clinical Pathways, Urgent Care Alliance • Ensure HBDHB Governance/Management Work plan provides adequate time and opportunity to add value to planned initiatives/papers. • Specific portfolio areas of responsibility for 2014/15 are (first person named and underlined to take the lead): • Consumer Council Liaison **?** • Service Development o Mental Health Services **David W** o Primary and Community Healthcare **Mark** o Maternity **Jules** o Health of Older People **?** o Clinical Pathways **John** o Quality Use of Medicines **Billy** o Integrated Urgent Care Services **?** o Specialist Referrals/Advice **Tae** o Palliative Care Integrated Model of Care **?** o **Long Term Conditions** **?** Ministerial Health Targets o Shorter stays in ED **Malcolm** o Improved access to elective surgery **?** o Shorter waits for cancer treatments **Chris** o Increased immunisation **Caroline** o Better help for smokers to quit: - Hospital **David W** - Primary **Robin** o Better diabetes & cardiovascular services **Kiri** Clinical Committee Chairs o Falls Committee **Chris** o Research Committee **John** o Laboratory Services Committee **?** o Radiology Services Committee **Mark**	• Meet with Consumer Council at least twice to discuss / agree a vision and plan for the development of a "Person and Whanau Centred Care" approach. • Support a review of the "Primary Heatlh Care" model of care. • Support and champion the development of a health literacy framework, policies, procedures, practices and action plan. • Actively engage with Information Systms to develop a prioritised/achieveable plan to enhance clinical systems and shared records to support achievement of functions and roles. • Assist and support the development of a consumer engagement strategy/plan.	• Oversee the development and implementation of the Quality Improvement and Safety Framework **co-Chairs** • Further develop sector wide Clinical Indicators & Quality Accounts within the overall Quality & Safety Framework. **Caroline** • Review, realign and/or redevelop existing clinical, quality and safety "committee" structures and processes across the sector, including integrated and co-ordinated Terms of Reference and reporting requirements including linkages to HS Patient Safety Committee and CAGC **Co-Chairs** • Maintain awareness of issues raised and liaise as appropriate with HQSC. **Quality Improvement & Patient Safety**	• Enhance the profile and perceived value of Clinical Council within the sector, through improved effective two way communications. **?** • Facilitate the development and implementation of clinical leadership appointments, structures, training and development. **Co-chairs/**HR • Facilitate the development of a HB Clinical Workforce Sustainability Plan **David W/HR** • Promote Strategies to enable the HB Clinical Workforce to adapt to meet the challenges of the future. **Co-Chairs/HR**

GLOSSARY OF COMMONLY USED ACRONYMS

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

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

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

SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent
SUR	Service Utilisation Report
TAS	Technical Advisory Service
TAW	Te Ara Whakawaiora
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date