

Hawke's Bay Clinical Council Meeting

Date: Wednesday, 11 October 2017

Meeting: 3.00 pm to 5.30 pm

Venue: Te Waiora Meeting Room, District Health Board Corporate Office,

Cnr Omahu Road & McLeod Street, Hastings

Council Members:

Dr John Gommans Co-Chair

Dr Andy Phillips Co-Chair

Chris McKenna

Dr Tae Richardson

Dr Mark Peterson

Dr David Rodgers

David Warrington

Dr Robin Whyman

Debs Higgins

Anne McLeod

Dr Nicholas Jones

Apology: Anne McLeod

In Attendance:

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

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Welcome / Apologies	3.00
2.	Interests Register / any Conflicts of Interest with this meeting agenda	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	

	Section 2 – Workshop 1	
5.	 Whole of System Flow Data – Lisa Jones Reflection on Patient Flow presentations (today's and last month's on acute flow) 	3.05
	Section 3 – Workshop 2	
6.	 Clinical Governance Structure update (Committees and Advisory Groups) Clinical Council Workplan 2017/18 Clinical Council Annual Plan 2016/17 – for review Terms of Reference – for review 	3.45
	Section 4 – Decision	
7.	Ka Aronui Ki Te Kounga / Focussed on Quality (FINAL) "Quality Accounts" – Kate Coley	4.25
	Section 5 – Presentation	
8.	Waioha Primary Birthing Unit – Benefits Realisation – Chris McKenna / Jules Arthur	4.45
	Section 6 – Reporting Committee Updates	
9.	HB Radiology Services Committee – Mark Peterson	5.00
10.	HB Laboratory Services Committee – Andrew Phillips	
11.	HB Nursing Midwifery Leadership Council Update - including Nursing & Midwifery Dashboard - Chris McKenna	
12.	Infection Prevention Control Committee – Quarterly - Chris McKenna	
	Section 7 – Information Only (no presenters)	
13.	Gastro Review – 6 Monthly Update	-
14.	Update on Establishing Health and Social Care Localities in Hawke's Bay	-
15.	Implementing the National Bowel Screening Programme in Hawke's Bay	-
16.	Section 8 – Recommendation to Exclude the Public	

PUBLIC EXCLUDED

Item	Section 9 – Routine	
17.	Minutes of Previous Meeting	5.10
18.	Matters Arising - Review Actions (nil)	
	Section 10 – Decision	
19.	Serious Adverse Events – Annual Report to HQSC (sign off final) – Kate Coley	5.15
	Section 11 – General	
20.	Topics of Interest – Member Issues / Updates	5.30

NEXT MEETING: Wednesday, 8 November 2017



Interests Register 9 August 2017

Hawke's Bay Clinical Council

Name	Interest	Nature of Interest	Core Business	Conflict of	If Yes, Nature of Conflict:
Clinical Council Member	eg Organisation / Close Family Member	eg Role / Relationship	Key Activity of Interest	Interest Yes / No	- 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	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by	Yes	Low
Medical Officer - Primary Care)	Royal New Zealand College of General Practitioners	Board member	Southern Cross Primary Care (a subsidiary GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	ocoulation of HB. May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
Dr John Gommans (Chief	Stroke Foundation Ltd	Chairman of the Board of	Provides information and support to people	Ves	Low
Medical Officer - Hospital)	Shoke Foundation Eta	Directors	with a stroke. Has some contracts to the MOH	163	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	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Member and Chair elect of NZ Committee	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	Forum for national midwifery and maternity issues	No	
5.100.017	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	No	
	Central Region Quality and Safety Alliance	Member	workforce A network of professionals overseeing clinical governance of the central region for	No	
Dr Kiri Bird (General	Te Timatanga Ararau Trust (Iron Maori)	Partner (Lee Grace) is a	Health and Wellbeing	Yes	Low - Contract with HBDHB
Practitioner)	Gascoigne Medical Raureka	Trustee General Practitioner	General Practice	Yes	Low
	Royal NZ College of General Practitioners	Member	Health and Wellbeing	No	
	Royal NZ College of General Practitioners	Lead Medical Educator in HB	Health and Wellbeing	No	
	Te Ora Board (Maori Doctors)	Member	Health and Wellbeing	No	
	Te Akoranga a Maui (Maori chapter for RNZCGP)	Member	Health and Wellbeing	No	
	Hawke's Bay Community Fitness Centre Trust	Trustee	Health and Wellbeing	Yes	Low - May potentially request funding from DHB
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chriopractic care and treatment, primary, preventative and physiotherapy	Yes	Low
·	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Advisory	Loco Ltd	Shareholding Director	Private business	No	
Committee)	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Dr Bryn Jones employee of MoH	Husband	Deputy Chief Strategy & Policy Officer (Acting)	No	
	Pacific Chapter of Royal NZ College of GPs	Secretary			
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal
Andrew Phillips (Director Allied	Nil	Not Applicable	Not Applicable	No	- Describe relationship of Interest to
Health HBDHB) 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	Privata hucinass	Yes	Low. Provides services in primary care
		(we job share)			
	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
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	development of urgent care services.
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	the Frio.
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
Health Professional)					
	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	NZ Institute of Directors	Member	Continuing professional development for	No	
Director Oral Health)	Australian - NZ Society of Paediatric Dentists	Member	company directors Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
,	HBDHB employee Mary Wills	Spouse	Employee	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Manager	Yes	Potential, pecuniary
iwanager, rotara rieatti)	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ) Fusion Group Committee	Member Representative		No No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health		No	
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
. ,	Association of Salaried Medical Specialists HBDHB Strategy & Health Improvement Directorate	Member Employee	Professional network Employee	No No	
	National Information Clinical Leadership Group	Member	Professional network	No	
Maurice King (Community Pharmacist)	Napier Balmoral Pharmacist	Shareholder and Director	Community Pharmacy	Yes	Has various contracts with HBDHB to provide pharmacy based services. Low. Ensure position declared when
	Pharmacy Guild of NZ	Member	Representative and negotiating organisation for Pharmacy	Yes	discussing issues in this area. Negotiations on behalf of Napier Phamacy with HBDHB. Low. Ensure position declared when discussing issues in this area.
	Phamaceutical Society of NZ	Member	Pharmacy advocacy, profressional	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	standards and training. Independent Advisor	No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 13 SEPTEMBER 2017 AT 3.00 PM

PUBLIC

Present: Dr Andy Phillips (Co-Chair)

Chris McKenna (Acting Co-Chair)

Dr Mark Peterson Dr Russell Wills Dr Robin Whyman Dr David Rodgers Dr Kiri Bird

Dr Nicholas Jones Dr Tae Richardson Debs Higgins David Warrington Maurice King Jules Arthur Anne McLeod Lee-Ora Lusis

In Attendance: Dr Kevin Snee, Chief Executive Officer

Ken Foote, Company Secretary

Tracy Fricker, Council Administrator and EA to EDP&Q Graeme Norton, HB Health Consumer Council Representative

Apologies: Dr John Gommans (Co-Chair)

SECTION 1: ROUTINE

1. APOLOGIES / WELCOME / MEETING RULES

Andy Phillips (Co-Chair) welcomed everyone to the meeting.

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

The Co-Chair gave an overview of the changes to the meeting format as per the one page document provided in the meeting papers. He requested that after reflection, members provide him with feedback on the new format for the meeting.

2. INTEREST REGISTER

There were no additions or amendments to the Interest Register.

No conflicts were noted for items on the agenda.

3. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

Section 2: Workshop

- 4. After Hours Concept
- Minutes from Previous Meeting (public excluded)

Matters Arising - Review Actions (public excluded)

The first part of the public meeting closed at 3.10 pm to discuss the public excluded items, then re-convened at 3.45 pm.

SECTION 3: FOCUS ON PROVIDING QUALITY ACUTE HOSPITAL CARE 24/7

8. CONSUMER STORY OF ACUTE CARE

The Co-Chair advised that this item had been postponed until next month.

9. STAFF STORY OF PROVIDING ACUTE CARE

Chris Trow, Clinical Nurse Manager, Emergency Services provided a story on working in the Emergency Department (ED) with staff shortages due to sickness and when the ED was in "red".

Dr Russell Wills, Medical Director – Quality provided a story from an On-Call House Officer over this current winter, in a busy department.

The Co-chair thanked Chris and Russell for sharing the stories and advised that this new section of the meeting was included to bring the clinical voice into the room and was not intended for members to ask questions. These stories illustrated the challenges that staff face in providing high quality care during times of peak demand.

10. WHEN PATIENTS DETERIORATE

The Co-Chair welcomed Dr Mike Park, Head of Department, ICU and Saskia Hartemink, Clinical Nurse Co-ordinator, ICU to the meeting. Key points in the presentation included: the purpose and aims of early warning score / rapid response score, data collected from 2014-2016, issues with EWS and where to next. An overview of the patient at risk service aims and targets was also provided.

The aim is to respond to patients earlier and provide treatment that prevents further decline. This presentation demonstrated the success of the patient at risk team and intensive care unit in responding to deteriorating patients with significantly reduced mortality over recent years.

11. TRAUMA SERVICE

The Co-Chair welcomed Susan Hawken, Clinical Nurse Specialist – Trauma and Mr Albert Lo, Vascular Surgeon to the meeting. Key points in the presentation included: what is a major trauma, HBDHB comparison data for two years, alcohol and major trauma, what is happening nationally and quality improvements planned for the next 12 months.

It was noted that there is significantly greater trauma occurring in Hawkes Bay than other regions. The number of people suffering trauma from unrestrained car accidents has reduced following intersectoral work with Police. It was noticeable that there is very significant trauma occurring to middle aged cyclists in Hawkes Bay.

12. ACUTE FLOW

The Co-Chair welcomed Dr Colin Hutchinson, Medical Director, Paula Jones, Service Director – Medical and Ian Elson, Deputy Service Director to the meeting. The purpose of "FLOW" is to streamline the patient journey from home to home for acute admissions. Key points in the

presentation included: key issues, ED-6 Target – shorter stays in ED, the opportunities, 12 month view of achievements to date and moving forward – the next 12 months.

It was noted that there has been good progress with this work but that there is additional work required to provide acute care for frail older people and to implement a new model of medical care in the hospital.

13. HEALTH ROUNDTABLE VIEW OF A PATIENT JOURNEY THROUGH HAWKE'S BAY HOSPITAL

Presentation provided by Dr Gail Prileszky from the Health Roundtable (HRT) on the latest data provided by HBDHB and comparison data from other DHBs. HRT use the data to benchmark, not for performance but to show innovation, success and great ideas. The presentation provided assurance that our hospital offers safe, high quality care. Key points from the presentation included: HBDHB Hospital Standard Mortality Ratio stands at 1.01, demonstrating average performance for hospital mortality. The data also demonstrated opportunities to improve outcomes for patients at the weekends and during winter months.

SECTION 4: FOR DECISION

14. QUALITY DASHBOARD CONCEPT PAPER

Russell Wills, Medical Director - Quality spoke to this item which was around adoption of the HQSC quality dashboard for HBDHB. Issues discussed included the use of MoH vs HRT data, addition of a number of internal measures to the dashboard, the need for one consistent report, accurate coding and the importance of the relationship between coders and medical staff and having a joined up dashboard between the DHB and PHO.

The Clinical Council endorsed the establishment of the Quality Dashboard.

15. QUALITY IMPROVEMENT & PATIENT SAFETY / QUALITY ANNUAL PLAN 2017/18

The paper was taken as read. Following brief discussion, Council requested the removal of reference to "reducing inequity" to be replaced with "eliminating inequity" and that it also needs to be clear that there is authentic consumer engagement with those on the margins and our underserved population.

The Clinical Council **endorsed** the Quality Annual Plan for 2017/18.

16. IMPLEMENTING THE CONSUMER ENGAGEMENT STRATEGY

Graeme Norton advised that the document had already been discussed at Consumer Council and they had endorsed the strategy. No further discussion took place.

The Clinical Council endorsed the Consumer Engagement Strategy.

17. POSITION OF REDUCING ALCOHOL RELATED HARM

The Chair welcomed Dr Rachel Eyre, Public Health Medicine Specialist to the meeting. Dr Eyre drew attention to the recommendation for the Clinical Council to adopt the clinical governance role. Brief discussion took place that alcohol should not be treated differently to any other drug and that as a DHB we take this issue seriously.

The Clinical Council:

- 1. Accepted the progress report;
- Supported the mandate for the establishment of a steering group with wide DHB representation:
- 3. Endorsed the strategic framework and priorities and;
- 4. Agreed to the proposal that it adopts the clinical governance role

SECTION 5: MONITORING AND INFORMATION ONLY

18. TE ARA WHAKAWAIORA / HEALTHY WEIGHT (NATIONAL INDICATOR)

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

19. CLINICAL ADVISORY & GOVERNANCE GROUP REPORT (Monthly)

Dr Tae Richardson provided a verbal report from the meeting which was held yesterday. A copy of the agenda had been included in the meeting papers for information.

At the meeting there was a long discussion on governance and a framework document which had been developed by Linda Dubbeldam. The importance of having a joined up single way of working with the DHB was supported. The Whanau Wellness programme was also discussed, which is an excellent source of local data focusing on Maori and Pacific quintile 5, New Zealand index decile 9 and 10.

Action: Clinical Council to be provided with a copy of the framework document.

20. FALLS MINIMISATION COMMITTEE (6 Monthly)

The report was included in the meeting papers for information only. No issues discussed. There was acknowledgment of the leadership that Chris McKenna had provided in reducing hospital falls Nationally.

21. MATERNITY CLINICAL GOVERNANCE GROUP UPDATE (6 Monthly)

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

Jules Arthur will provide a presentation on Waioha Primary Birthing Unit – First Year Benefits Realisation at next month's meeting.

SECTION 1: ROUTINE (Continued)

22. MINUTES OF PREVIOUS MEETING / MINUTES OF ANNUAL GENERAL MEETING

The minutes of the Clinical Council meeting held on 9 August 2017, were confirmed as a correct record of the meeting with one minor change requested:

Item 7. Te Ara Whakapiri Hawke's Bay Palliative Care Outcomes on page 4 under feedback/questions, bullet point five - change the word "strong" to "not sufficient".

Moved and carried.

The minutes of the Clinical Council Annual General Meeting held on 9 August 2017, were confirmed as a correct record of the meeting.

Moved and carried.

23. MATTERS ARISING - REVIEW OF ACTIONS

Item #1 Laboratory Guidelines

The Co-Chair advised that the guidelines are still being refined by Dr Ross Boswell and that it is intended to bring this to the October meeting.

Item #2 Interests Register

The changes requested by Dr Tae Richardson and Lee-Ora Lusis have been actioned. *Item can be closed.*

Item #3 Combined Clinical and Consumer Council Minutes - July

No further issues. Item can be closed.

Item #4 Health Awards - Proposal Paper re: event being alcohol free

The proposal has been discussed at the Executive Management Team meeting. *Item can be closed.*

Item #5 Work Plan

Presentation on Waioha – First Year Findings has been deferred until October meeting. *Item can be closed.*

24. CLINICAL COUNCIL WORKPLAN

The Clinical Council Workplan was noted.

The meeting closed at 5.55 pm.

On behalf of the Clinical Council the Co-Chair thanked Dr Kiri Bird for her work for the Clinical Council and also Chairing the Laboratory Services Committee. Dr Bird commented that she had enjoyed her time on Clinical Council, the relationship building and that it had been a great learning experience.

Confirmed:	
	Chair
Date:	

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



Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	12/07/17	Laboratory Guidelines Approved in principle at July meeting. Guidelines document to be tabled for information at Clinical Council when finalised.	A Phillips	Aug/Sep	Pending
2	13/09/17	Clinical Advisory and Governance Group Report Copy of framework document by Linda Dubbeldam to be provided to Clinical Council Members	T Richardson	Oct	



WORKSHOP 1

Discussion on:

Whole of System Flow Data

Reflection on Patient Flow presentations (today's and last month's on acute flow)



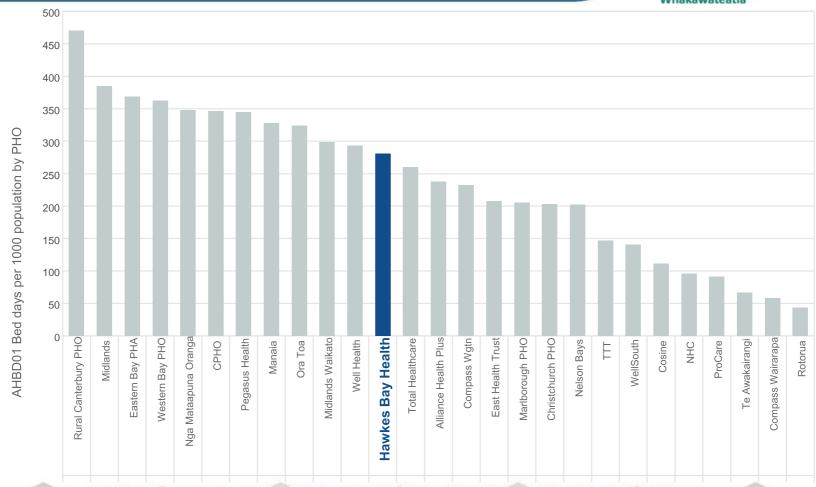


New Zealand Whole of System Report

Hawkes Bay Jan 2016 - Dec 2016

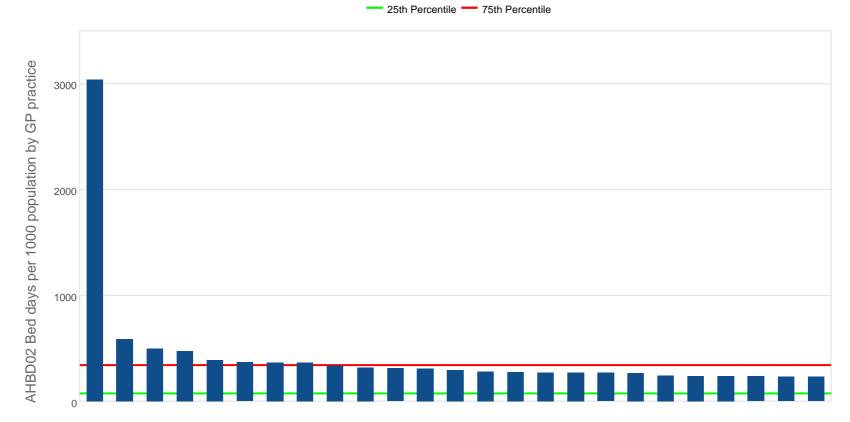
Acute hospital bed days (AHBD) per PHO per 1000 population





Acute hospital bed days (AHBD) per GP Practice per 1000 population





Top 5 MDCs by acute hospital bed days

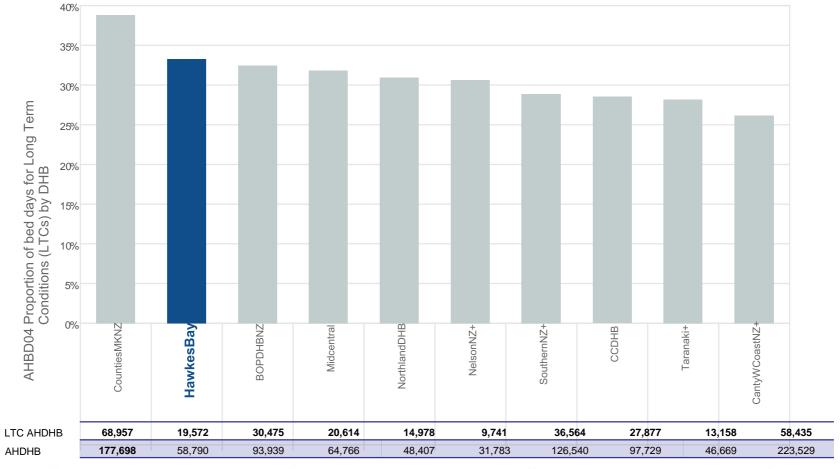


	Top 5 MDCs	BOPDHBNZ	CantyWCoastNZ+	ССБНВ	CountiesMKNZ	HawkesBay	Midoentral	NelsonNZ+	NorthlandDHB	SouthernNZ+	Taranaki+
Code	Description										
5	Diseases & Disorders of the Circulatory System	11,876 13%	25,399 11%	13,491 14%	22,477 13%	8,040 14%	8,726 13%	3,782 12%	4,528 9%	12,146 10%	4,880 10%
4	Diseases & Disorders of the Respiratory System	10,563 11%	20,769 9%	10,479 11%	20,643 12%	7,587 13%	8,994 14%	3,959 12%	5,875 12%	11,795 9%	6,084 13%
8	Diseases & Disorders of the Musculoskeletal System & Connective Tissue	12,314 13 %	26,340 12%	8,819 9%	21,543 12%	7,356 13%	7,125 11%	4,489 14%	5,291 11%	13,902 11%	4,961 11%
6	Diseases & Disorders of the Digestive System	9,872 11%	24,372 11%	10,796 11%	19,531 11%	6,778 12%	7,406 11%	4,390 14%	6,502 13%	11,495 9%	5,018 11%
1	Diseases & Disorders of the Nervous System	9,972 11%	21,030 9%	8,952 9%	12,975 7%	4,341 7%	5,534 9%	2,992 9%	4,454 9%	14,222 11%	4,087 9%

^{*} Notes: More details about acute hospital bed days in Appendix A. More details about MDC: http://health.utah.gov/opha/IBISheIp/codes/MDC.htm

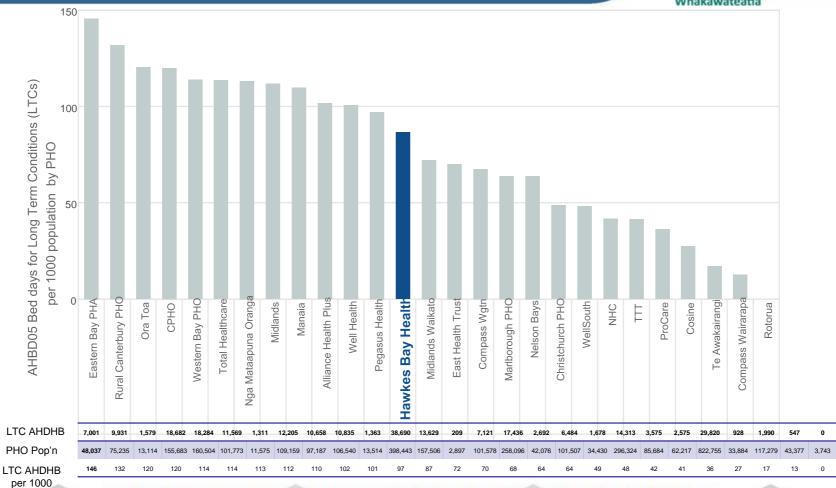
AHBD episodes with long stay conditions occupied 33.3% of the acute hospital bed days at Hawke's Bay





Acute hospital bed days (AHBD) for Long Term Conditions per PHO per 1000 population

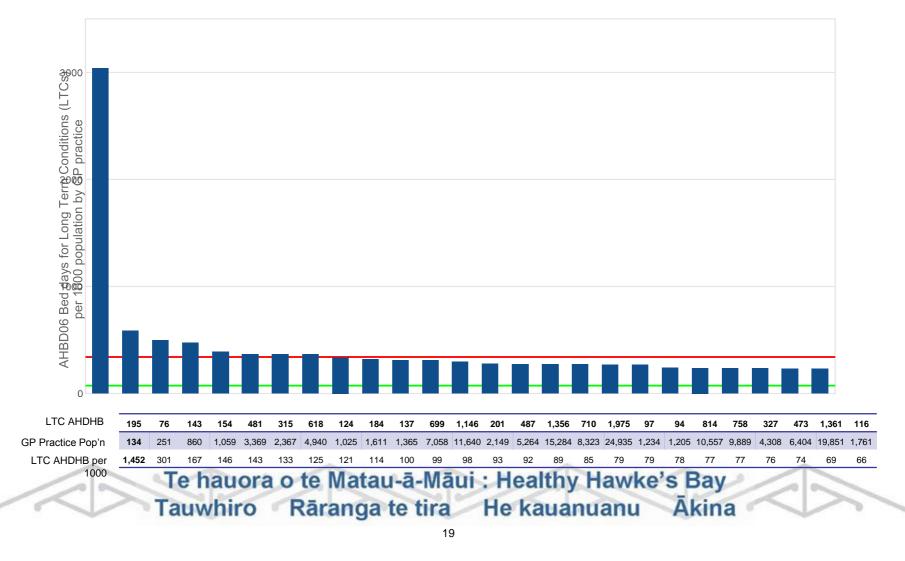




Acute hospital bed days (AHBD) for Long Term Conditions per GP practice per 1000 population

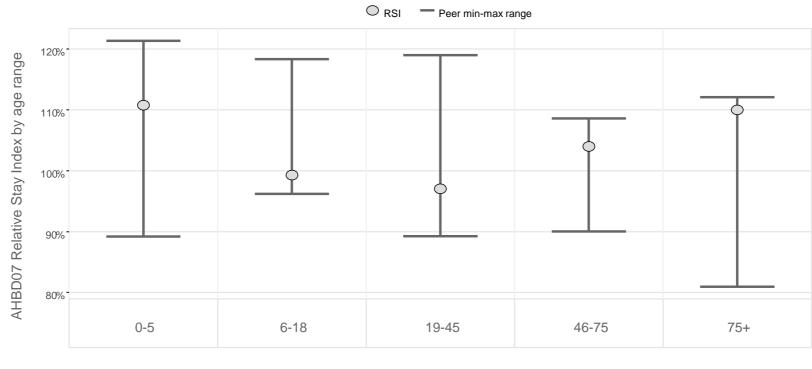


- 25th Percentile - 75th Percentile



RSI for episodes meeting the definition of acute hospital bed days broken by age band



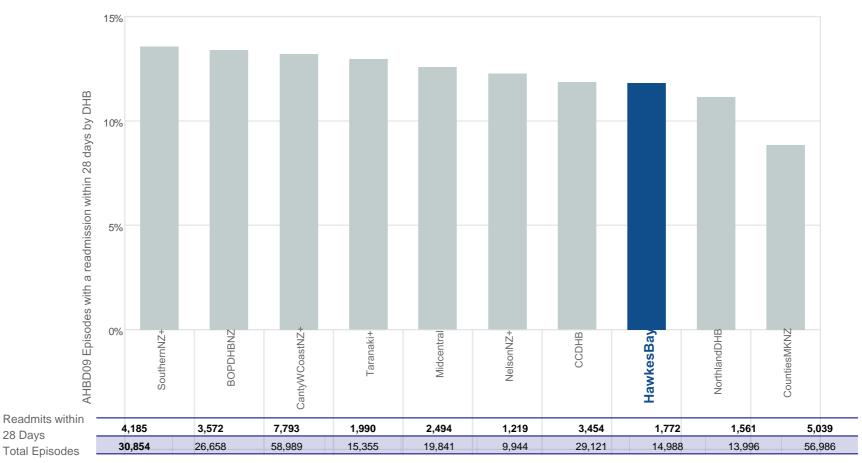


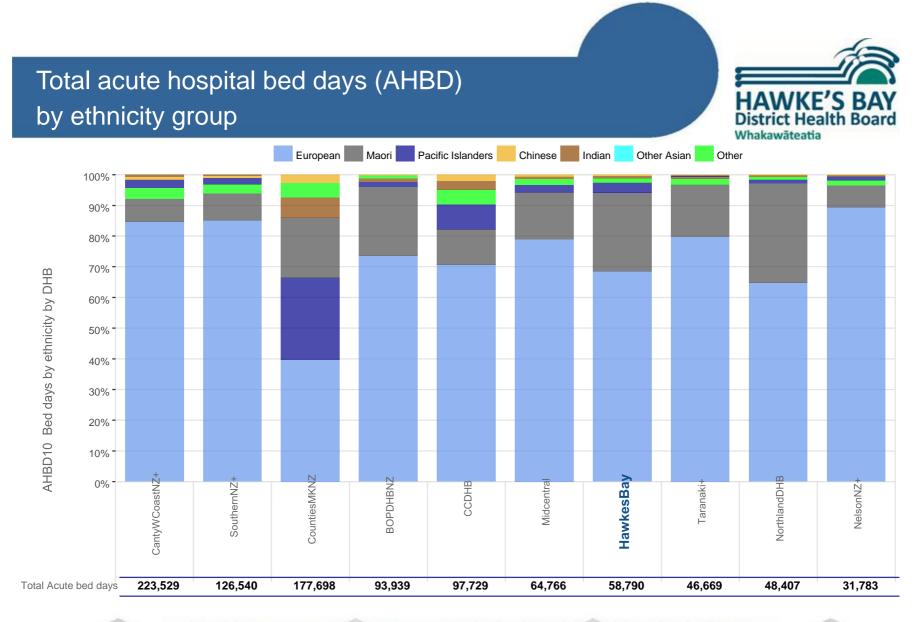
Episodes	1,562	1,118	3,191	5,396	3,721
RSI	111%	99%	97%	104%	110 %

5 % of the patients meeting acute hospital bed day (AHBD) definition returned within 7 days at Hawkes Bay

28 Days

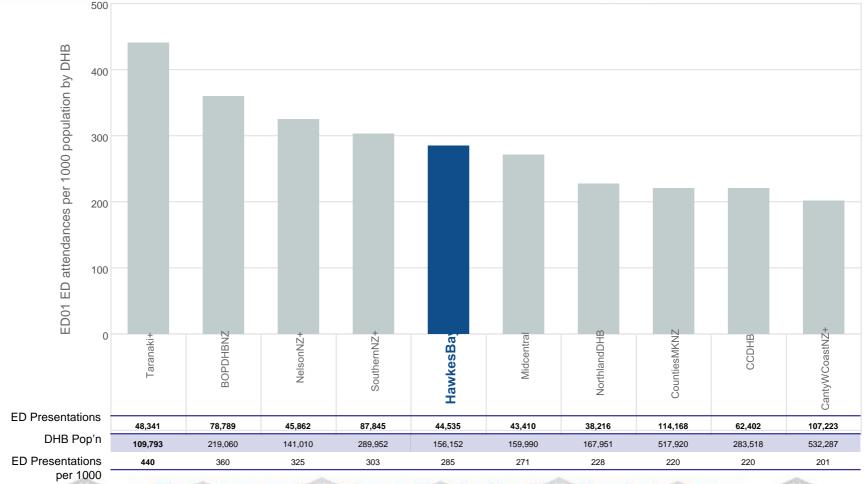






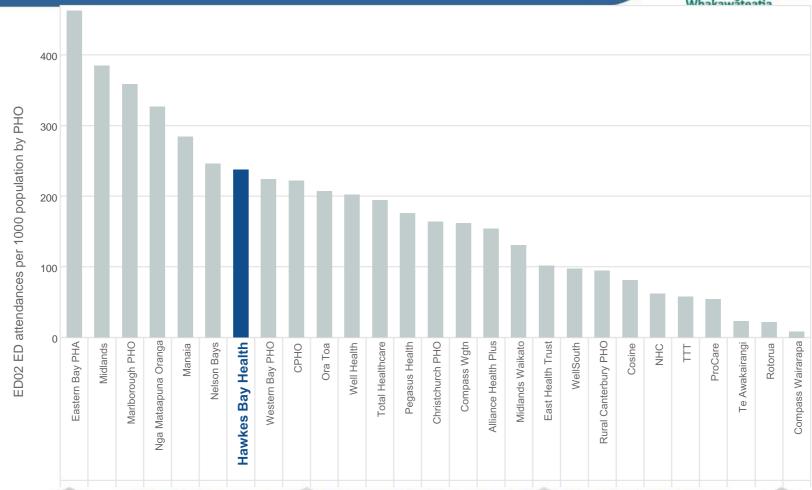
ED attendances per DHB per 1000 population





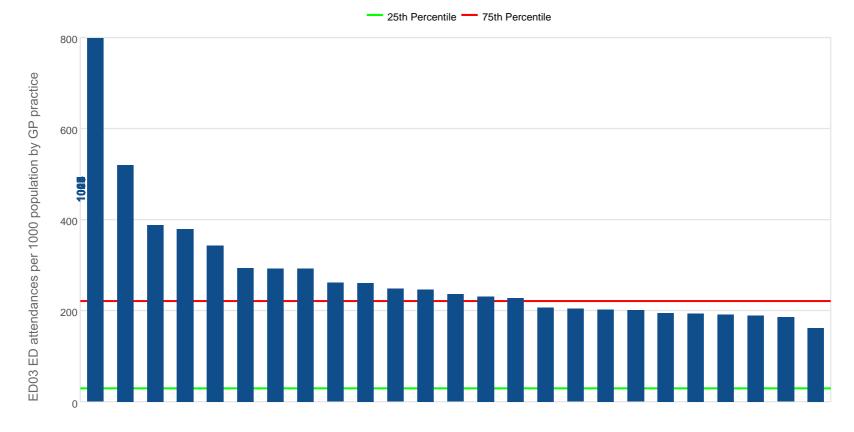
ED attendances per 1000 population by PHO





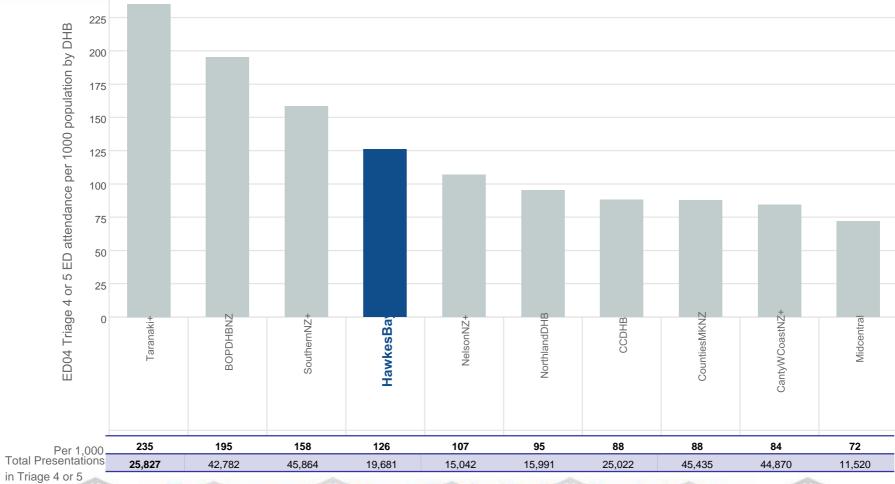
ED attendances per 1000 population by GP practice (top 25)





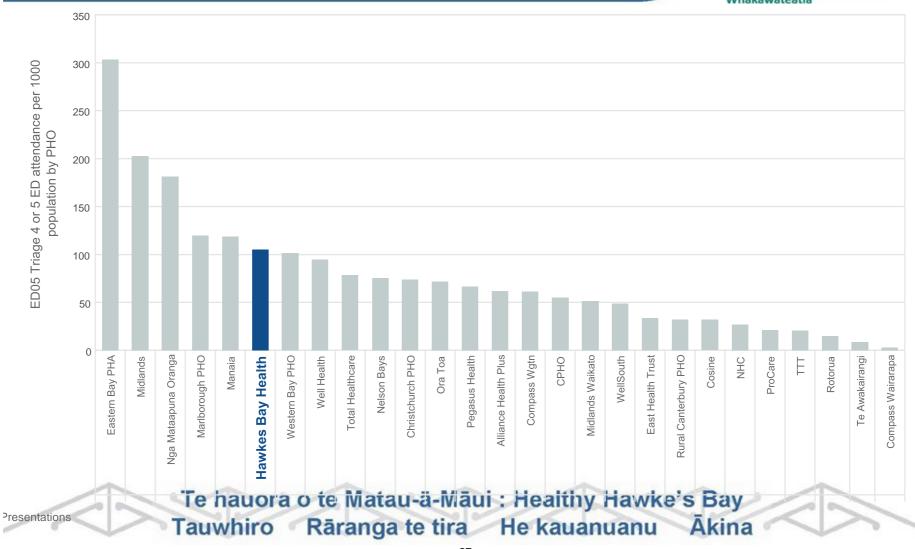
Triage category 4 or 5 ED attendances per 1000 population





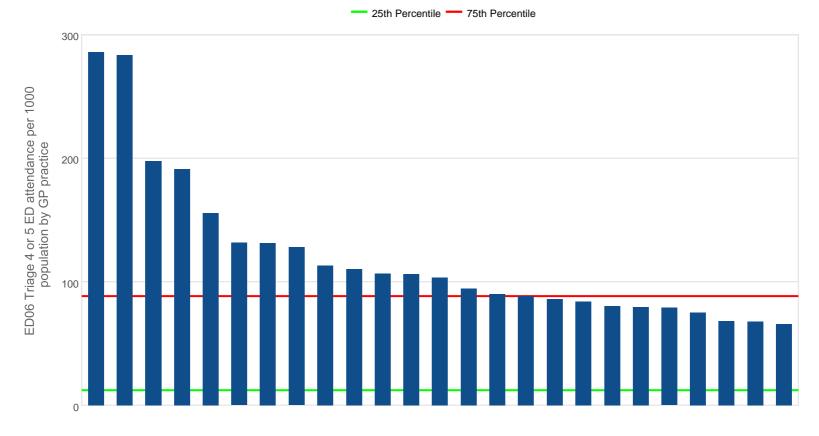
Triage category 4 or 5 ED attendances per PHO per 1000 population





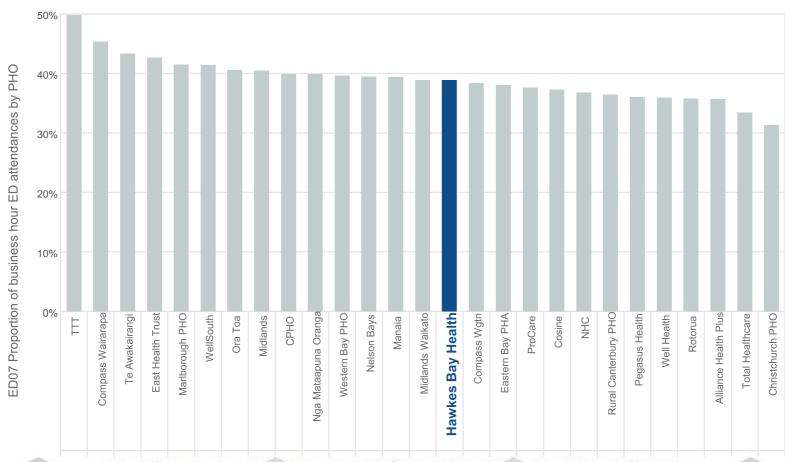
Triage category 4 or 5 ED attendance per GP practice per 1000 population





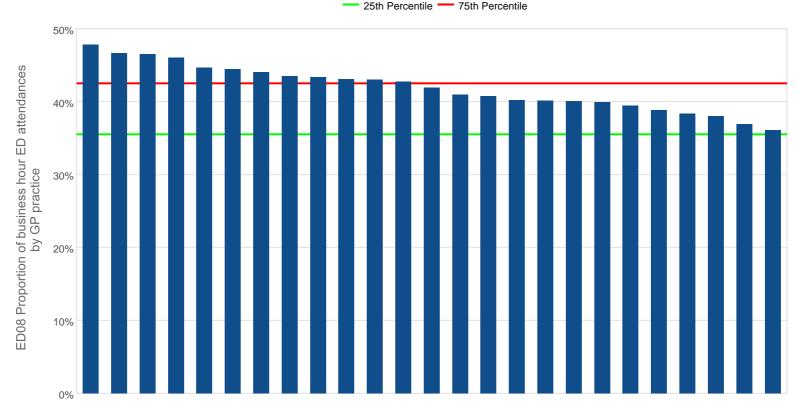
Proportion of ED attendances between 9AM and 5PM Monday to Friday by PHO





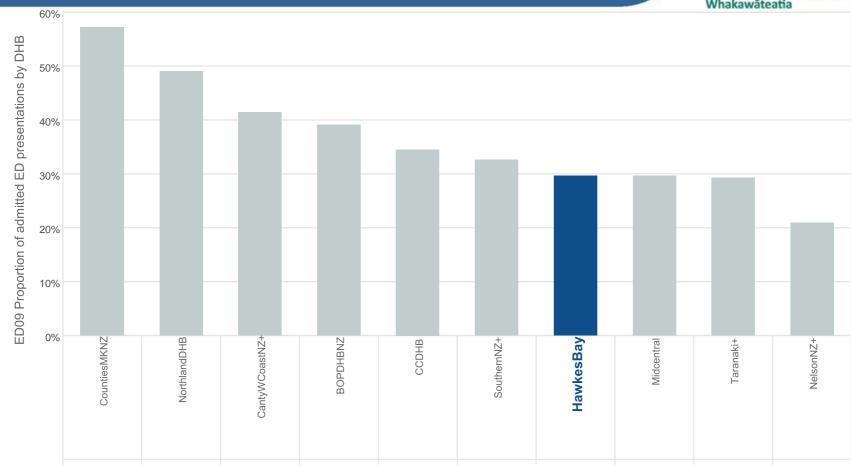
Proportion of ED attendances between 9AM and 5PM Monday to Friday by GP practice





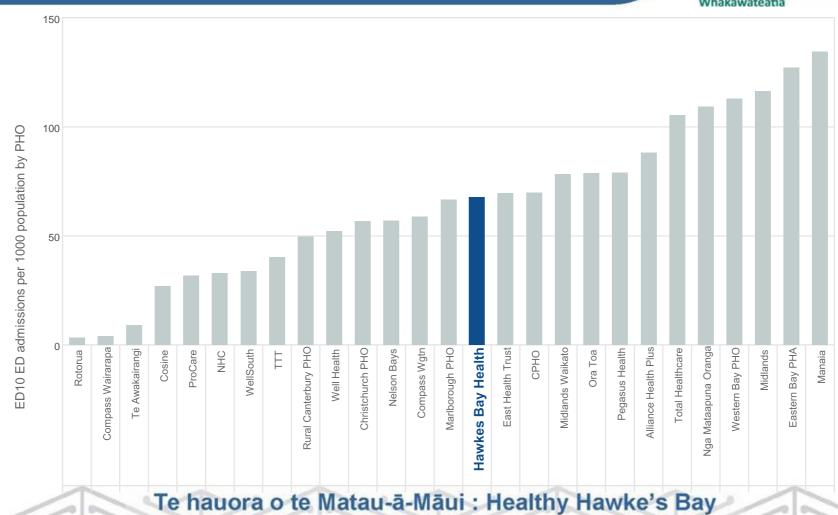
Hawkes Bay admitted 30% of ED presentations, compared to the peer group average of 36%





ED admissions by PHO per 1000 population

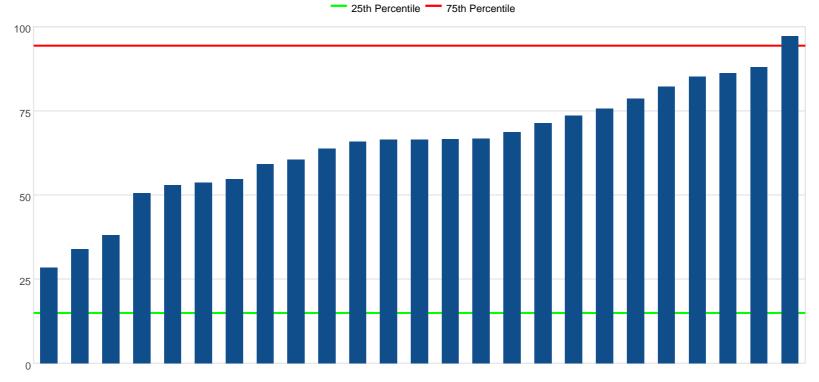




Tauwhiro Rāranga te tira He kauanuanu

ED admissions by GP practice per 1000 population

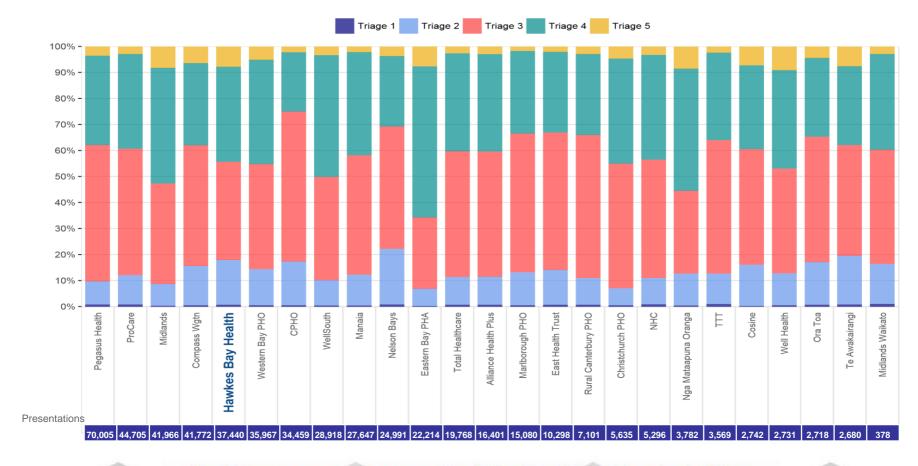




Ratio of triage categories for emergency presentations Whakawāteatia Triage 1 Triage 2 Triage 3 Triage 4 Triage 5 100% 90% -80% -70% -60% -50% -40% -30% -20% -10% -0% CCDHB HawkesBay Counties MKN. CantyWCoastNZ NorthlandDH Presentations 114,167 107,211 87,840 78,789 62,402 48,341 45,862 44,535 43,350 38,216

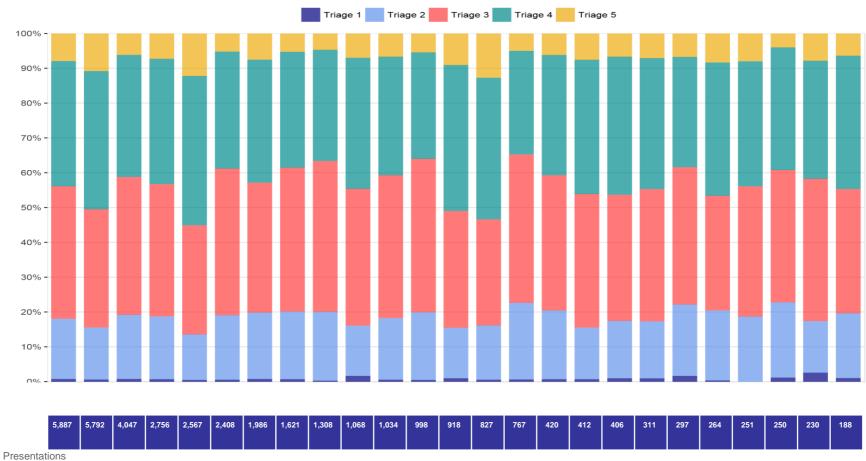
Ratio of triage categories for emergency presentations by PHO





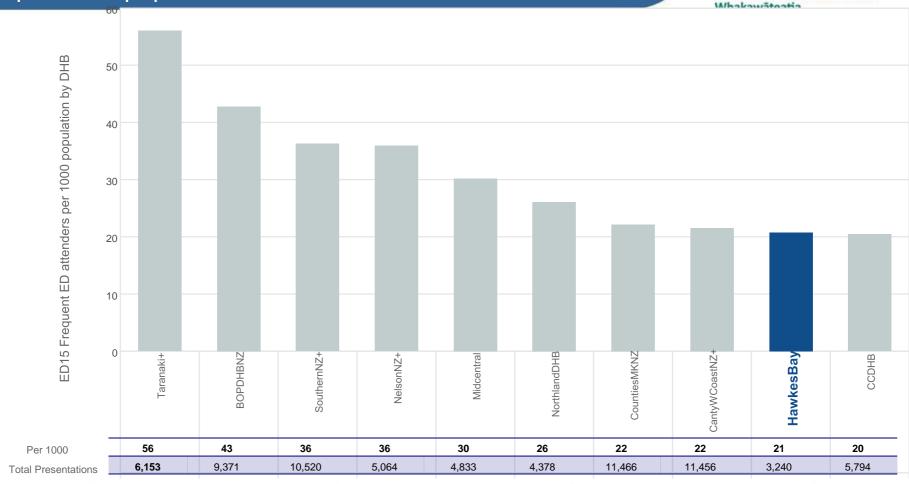
Ratio of triage categories for emergency presentations by GP





Patients with 3 or more ED attendances in 12 months per 1000 population

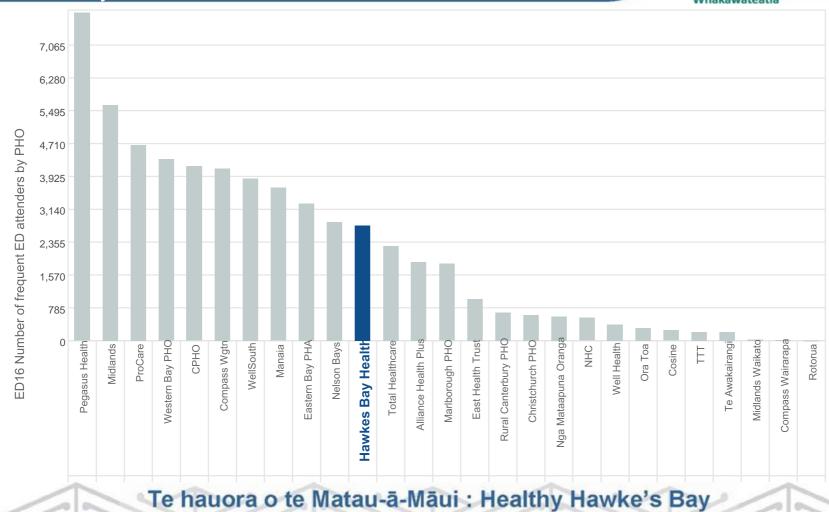




Per 1,000

Patients with 3 or more ED attendances in 12 months by PHO

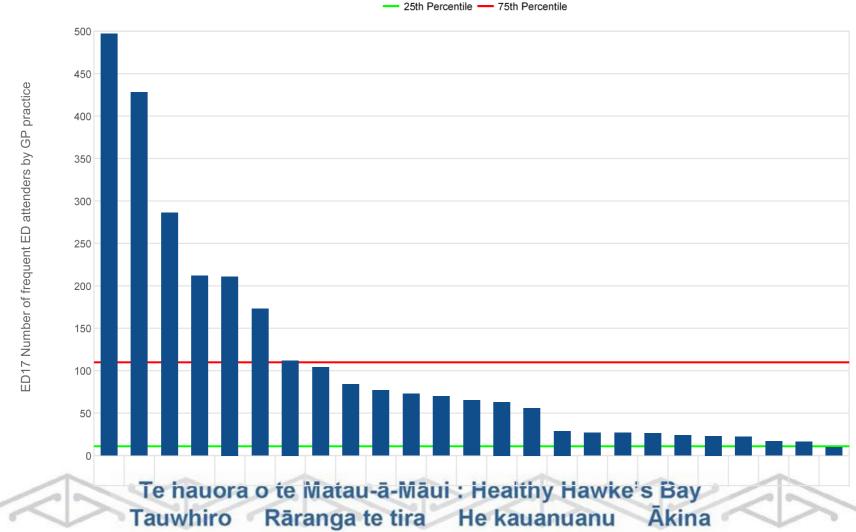


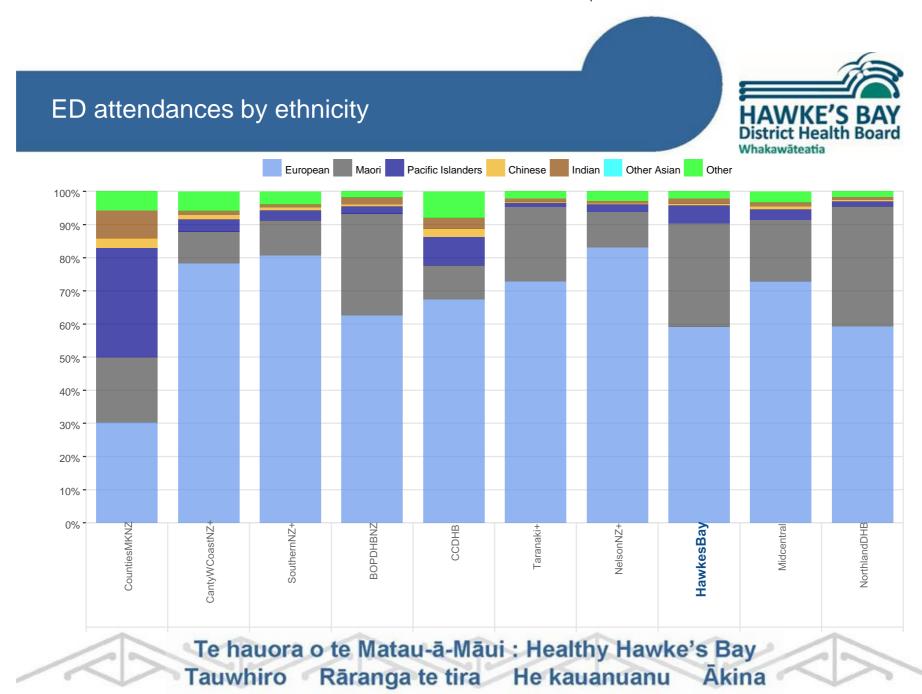


Tauwhiro Rāranga te tira He kauanuanu

Patients with 3 or more ED attendances in 12 months by GP practice







Appendix A: Acute Hospital Bed Days (AHBD)



Conditions used to define AHBD in this report:

- Inclusions:
- Inpatient episodes submitted to the Health Roundtable * Episodes discharged within the report period
- Exclusions :
- *Non-acute episodes (planned admissions)
- *Episodes discharged from Emergency Department
- *Overseas domiciled patients (code 9999)

Appendix B: Long Term Conditions (LTC)



-HEART FAILURE

- * I50 Heart failure
- * I50.0 Congestive heart failure
- * I50.1 Left ventricular failure
- * I50.9 Heart failure, unspecified
- * U82.2 Chronic heart failure

-CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

- * J43 Emphysema
- J43.0 MacLeod's syndrome
- * J43.1 Panlobular emphysema
- * J43.2 Centrilobular emphysema
- * J43.8 Other emphysema
- J43.9 Emphysema, unspecified
- * J44 Other chronic obstructive pulmonary disease
- * J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection * J44.1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified
- * J44.8 Other specified chronic obstructive pulmonary disease
- J44.9 Chronic obstructive pulmonary disease, unspecified
- * U83.2 Chronic obstructive pulmonary disease

-DIABETES

- * E10x Type 1 diabetes mellitus
- * E11x Type 2 diabetes mellitus
- * E12x Malnutrition-related diabetes mellitus
- * E13x Other specified diabetes mellitus
- * E14x Unspecified diabetes mellitus

- STROKE

- * I60x Subarachnoid haemorrhage
- * I61x Intracerebral haemorrhage
- * I62.9 Intracranial haemorrhage (nontraumatic), unspecified
- * I63x Cerebral infarction
- * I64x Stroke, not specified as haemorrhage or infarction

- CELLULITIS

L03 Cellulitis

- L03.0 Cellulitis of finger and toe
 - L03.01 Cellulitis of finger
- * L03.02 Cellulitis of toe
- L03.1 Cellulitis of other parts of limb
- L03.10 Cellulitis of upper limb
- L03.11 Cellulitis of lower limb
- L03.12 Cellulitis of upper limb
- L03.13 Cellulitis of lower limb
- L03.14 Cellulitis of foot
- * L03.19 Cellulitis of limb, not elsewhere classified
- L03.2 Cellulitis of face
- L03.3 Cellulitis of trunk
- * L03.8 Cellulitis of other sites * L03.9 Cellulitis, unspecified

- CARDIOVASCULAR DISEASE (cvD)

- I60 Subarachnoid haemorrhage
- I61 Intracerebral haemorrhage
- 162 Other nontraumatic intracranial haemorrhage
- * I63 Cerebral infarction
- * I64 Stroke, not specified as haemorrhage or infarction
- * I65 Occlusion and stenosis of precerebral arteries, not resulting in cerebral infarction
- * I66 Occlusion and stenosis of cerebral arteries, not resulting in cerebral infarction
- * I67 Other cerebrovascular diseases
- * I68 Cerebrovascular disorders in diseases classified elsewhere
- 169 Sequelae of cerebrovascular disease



Reflection on Patient Flow Presentations (today's and last month's on acute flow)



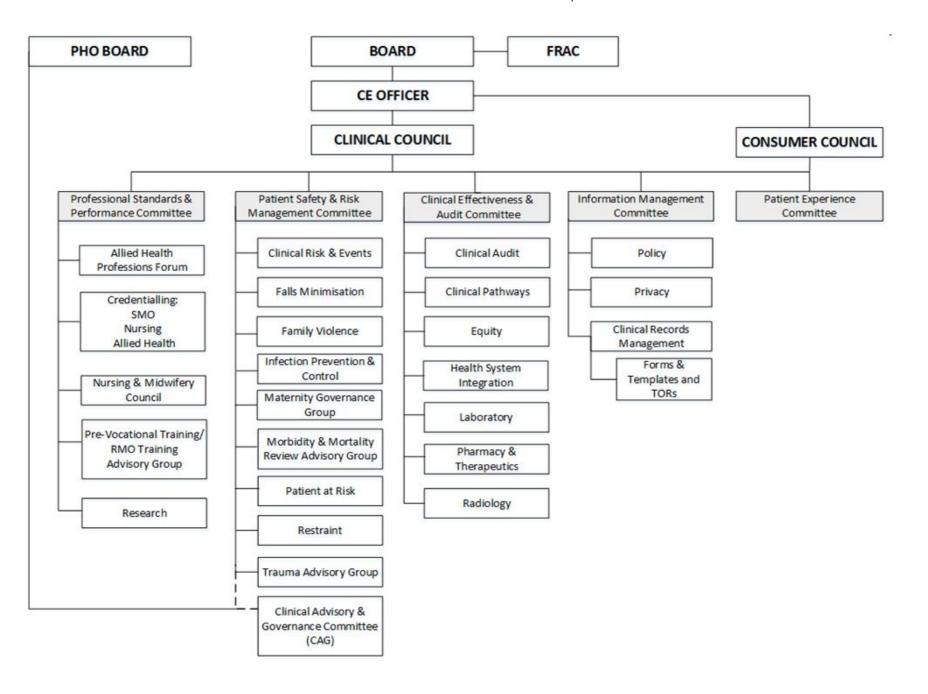
WORKSHOP 2

Discussion on:

Clinical Governance Structure update (Committees and Advisory Groups)

Clinical Council Workplan (rest of 2017 and annual)

Clinical Council Terms of Reference





CLINICAL GOVERNANCE

PROFESSIONAL STANDARDS & PERFORMANCE COMMITTEE

Purpose	To provide assurance to the Hawkes Bay Clinical Council that all essential requirements relating to credentialing, accreditation, professional standards, clinical training and research are actively promoted and maintained.	
Functions	 Lead and promote a culture of clinical professionalism, ensuring that all health professionals are appropriately credentialed, professional standards are upheld, and clinical competence is maintained Ensure that the appropriate capability and capacity exists to maintain relevant professional training accreditations. Provide oversight and forums for discussion on clinical innovation, best practice, professional training and workforce development Govern and promote a research culture, clinical research activities and implementation of appropriate research findings Ensure all relevant information, innovations, research findings and professional standards are well communicated throughout the sector Oversee, monitor and govern the activities and delegated responsibilities of Committee Advisory Groups 	
Level of Authority	 The Committee has the authority to make decisions and/or provide advice and recommendations, to the Clinical Council (as appropriate). To assist it in this function the Committee may: Request reports and presentations from particular groups Require Committee Advisory Groups (and/or establish other subgroups) to investigate and report back on particular matters Request the commissioning of audits or investigations on particular issues Co-opt people from time to time as required for a specific purpose. The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders. 	
	Delegated Authority	
	The Committee has delegated authority to:	
	 Make decisions and issue directives/guidelines on professional standards, clinical competence and research issues that: Relate directly to the function of the Committee as set out in the Terms of Reference; and Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and Are clinically and financially sustainable; and Are affordable within 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 or HHB Ltd.
Membership	Membership
	 Chief Medical Officers (Hospital & Primary Care) Chief Nursing & Midwifery Officer Chief Allied Health Professions Officer Executive Director People & Quality (or Medical Director P&Q) Chairs (or nominee) of Committee Advisory Groups: SMO Credentialling (Robin Whyman) Nursing & Allied Health Credentialling (Sally Houliston) Allied Health Professions Forum (Andy Phillips) HB Nursing & Midwifery Council (David Warrington) RMO Training (Kate Robertshaw) HB Clinical Research (John Gommans) Consumer Council representative Health Services Directorates representative Tenure
	Whilst holding a named appointment or role, or until replaced by the group being represented.
Chair	Co-Chairs – Must be members of Clinical Council - Appointed by Clinical Council
Quorum	A quorum will be two thirds of the members.
Meetings	1 hour meetings will be held quarterly at least 4 times per year, or more frequently at the request of the chair/co-chairs.
	Meetings shall be held in Feb, Mar, Aug and Nov, at times and in locations that suit the membership.
	Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical council following each meeting of the Committee.
	A formal annual report shall be submitted within 3 months of the end of each financial year (30 June)
	A precis of the annual report shall be communicated to the sector, once received by Clinical Council
Minutes	The minute secretary shall be an HR Administrator.
	Minutes and action plans will be circulated to all members within one week of the meeting taking place.



CLINICAL GOVERNANCE

PATIENT SAFETY & RISK MANAGEMENT COMMITTEE

Purpose	To provide assurance to the Hawkes Bay Clinical Council that all matters relating to patient safety and clinical risk within the Hawkes Bay health system, are effectively monitored and appropriately managed and enhanced.
Functions	 Lead and promote a culture of continuous quality improvement, patient safety, cultural competence and clinical risk management Initiate improvement projects and/or training programmes as appropriate Ensure all patient safety, cultural competence and clinical risk compliance requirements, standards and processes are met, and any corrective actions are appropriately addressed Ensure effective systems, strategies, policies, resources and procedures are in place to support quality patient safety, cultural competence and clinical risk management Ensure all relevant information, lessons learned and improvement actions are well communicated throughout the sector Oversee, monitor and govern the activities and delegated responsibilities of Committee Advisory Groups
Level of Authority	The Committee has the authority to make decisions and/or provide advice and recommendations, to the Clinical Council (as appropriate).
	 To assist it in this function the Committee may: Request reports and presentations from particular groups Require Committee Advisory Groups (and/or establish other subgroups) to investigate and report back on particular matters Request the commissioning of audits or investigations on particular issues Co-opt people from time to time as required for a specific purpose.
	The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders.
	Delegated Authority
	The Committee has delegated authority to:
	 Make decisions and issue directives/guidelines on patient safety, cultural competence and clinical risk management issues that: Relate directly to the function of the Committee as set out in the Terms of Reference; and Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and Are clinically and financially sustainable; and

	 Are affordable within 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 or HHB Ltd.	
Membership	Membership	
	Medical Director QIPS Chief Nursing & Midwifery Officer (CNMO) Chairs (or nominee) of Committee Advisory Groups: Clinical Risk & Events Falls Minimisation Family Violence Intervention Maternity Governance Infection Prevention & Control Patient at Risk Restraint Trauma Consumer Council representative Health Services Directorates representative PHO Clinical Advisory & Governance Committee representative Tenure	
	Whilst holding a named appointment or role, or until replaced by the group being represented	
Chair	Co-Chairs – Medical Director QIPS & CNMO	
Quorum	A quorum will be two thirds of the members.	
Meetings	Meetings will be held quarterly at least 4 times per year, or more frequently at the request of the chair/co-chairs.	
	Meetings shall be held at times and in locations that suit the membership	
	Decision making at meetings shall ideally be based on consensus	
Reporting	A report shall be submitted to the Clinical council following each meeting of the Committee.	
	A formal annual report shall be submitted within 3 months of the end of each financial year (30 June)	
	A precis of the annual report shall be communicated to the sector, once received by Clinical Council	
Minutes	The minute secretary shall be the QIPS Patient Safety Administrator.	
	Minutes and action plans will be circulated to all members within one week of the meeting taking place.	



CLINICAL GOVERNANCE

CLINICAL EFFECTIVENESS & AUDIT COMMITTEE

Purpose	To provide assurance to the Hawkes Bay Clinical Council (and advice and guidance to the Hawkes Bay health system) that quality clinical practice is delivered by all publicly funded health services, including diagnostic, pharmaceutical and therapeutic providers.	
Functions	 Lead and promote a culture of quality clinical practice Ensure an appropriate clinical audit programme is developed, implemented, monitored and managed, to provide an appropriate level of assurance across the sector Provide advice and guidance on what constitutes 'best clinical practice' within the HB health system Oversee clinical practice integration and equity initiatives, including clinical pathways Endorse and/or recommend guidelines and directives relating to access to and delivery of diagnostic and therapeutic services, and prescribing and delivery of pharmaceutical services Ensure all relevant information, lessons learned and improvement actions are well communicated throughout the sector Oversee, monitor and govern the activities and delegated responsibilities of Committee Advisory Groups 	
Level of Authority	The Committee has the authority to make decisions and/or provide advice and recommendations, to the Clinical Council (as appropriate). To assist it in this function the Committee may: Request reports and presentations from particular groups Require Committee Advisory Groups (and/or establish other subgroups) to investigate and report back on particular matters	
	 Request the commissioning of audits or investigations on particular issues Co-opt people from time to time as required for a specific purpose. 	
	The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders.	
	Delegated Authority	
	The Committee has delegated authority to:	
	 Make decisions and issue directives/guidelines on quality clinical practice issues that: Relate directly to the function of the Committee as set out in the Terms of Reference; and Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and 	

	 Are clinically and financially sustainable; and Are affordable within 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 or HHB Ltd.
Membership	Membership
	 Two nominated members of Clinical Council Chairs (or nominee) of Committee Advisory Groups: Clinical Audit Clinical Pathways Laboratory Pharmacy & Therapeutics Radiology Consumer Council representative Health Services Directorates representative Primary Care representative
	Tenure
	At the discretion of the body/person appointing any nominee or representative
Chair	Co-Chairs – Must be members of Clinical Council – Appointed by Clinical Council
Quorum	A quorum will be two thirds of the members.
Meetings	Meetings will be held quarterly at least 4 times per calendar year, or more frequently at the request of the chair/co-chairs.
	Meetings shall be held at times and in locations that suit the membership
	Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical Council following each meeting of the Committee.
	A formal annual report shall be submitted within 3 months of the end of each financial year (30 June)
	A precis of the annual report shall be communicated to the sector, once received by Clinical Council
Minutes	The minute secretary shall be the QIPS Patient Safety Administrator
	Minutes and action plans will be circulated to all members within one week of the meeting taking place.



CLINICAL GOVERNANCE

INFORMATION MANAGEMENT COMMITTEE

Purpose	To ensure that appropriate health information, systems and processes are readily available and well protected, to support effective and timely clinical decision making and the delivery of quality patient care, in partnership with consumers, within the HB health system.
Functions	 Liaise as necessary to ensure the benefits and concerns with existing information, systems and processes are well known, understood, acknowledged, and improvement opportunities identified Provide advice and clinical advocacy for the development, implementation and provision of improved ICT systems, processes, information and tools as necessary Ensure all health information is appropriately collected, accurate, current, stored, accessed, protected and effectively managed Ensure the HB health sector meets all compliance requirements in respect of collection, access, use, security, retention and release of health records and other relevant clinical information. Ensure all information provided to consumers is relevant, current and accurate, as well as being easy to obtain and understand Ensure all relevant health information requirements, policies, procedures and improvement actions are well communicated throughout the sector Oversee, monitor and govern the activities and delegated responsibilities of Committee Advisory Group
Level of Authority	 The Committee has the authority to make decisions and/or provide advice and recommendations, to the Clinical Council (as appropriate). To assist it in this function the Committee may: Request reports and presentations from particular groups Require Committee Advisory Groups (and/or establish other subgroups) to investigate and report back on particular matters Request the commissioning of audits or investigations on particular issues Co-opt people from time to time as required for a specific purpose. The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders.
	Delegated Authority
	The Committee has delegated authority to:
	 Make decisions and issue directives/guidelines on the collection, maintenance, reliability, storage, access, security and communication of health related information that:

	 Relate directly to the function of the Committee as set out in the Terms of Reference; and Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and Are clinically and financially sustainable; and Are affordable within current budgets. All such decisions and/or directives will be binding on all clinicians and staff who provide and/or refer to public health services funded (in whole or part) by the HBDHB or HHB Ltd.
Manakanakan	Manual annulus
Membership	Two (2) nominated members of Clinical Council Chairs (or nominee) of Committee Advisory Groups: Policy Privacy (HBDHB Privacy Officer) Health Records (HBDHB Records Manager) Consumer Council representative Health Services Directorates representative PHO representative IS representative Health Services Administration Manager Communication Service representative Tenure Whilst holding a named appointment or role, or until replaced by the group being represented
Chair	Co-Chairs – Must be members of Clinical Council – Appointed by Clinical Council
Quorum	A quorum will be two thirds of the members.
Meetings	Meetings will be held quarterly at least 4 times per year, or more frequently at the request of the chair/co-chairs.
	Meetings shall be held at times and in locations that suit the membership
	Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical Council following each meeting of the Committee. A formal annual report shall be submitted within 3 months of the end of each
	financial year (30 June) A precis of the annual report shall be communicated to the sector, once received by Clinical Council
Minutes	The minute secretary shall be provided by Education & Development Minutes and action plans will be circulated to all members within one week of the meeting taking place.



CLINICAL GOVERNANCE

PATIENT EXPERIENCE COMMITTEE

Purpose	To develop, recommend, advise and monitor strategies, systems, policies, processes and actions that will contribute to the continuous improvement of patient experience within the HB health system.
Functions	 Lead and promote a culture of continuous improvement of patient experience within the HB health system Consult as necessary to develop and recommend an overall integrated strategy for improving patient experience Develop, enhance and confirm appropriate systems and surveys to be used to gather indicators of patient experience Agree targets, monitor and analyse patient experience performance indicators Report on performance and recommend and/or initiate improvement actions Ensure all relevant information, requests for feedback and improvement actions are well communicated throughout the sector, and implemented as appropriate
Level of Authority	The Committee has the authority to make decisions and/or provide advice and recommendations to the Clinical Council and Consumer Council (as appropriate).
	 To assist it in this function the Committee may: Request reports and presentations from particular groups Establish sub-groups as necessary to investigate and report back on particular matters Request the commissioning of audits or investigations on particular issues Co-opt people from time to time as required for a specific purpose.
	The Committee's role is one of clinical governance, not operational or line management. Any issues impacting on operational performance must be addressed in partnership with relevant management and clinical leaders.
	Delegated Authority
	The Committee has delegated authority to:
	 Make decisions and issue directives/guidelines on patient experience issues (other than strategy) that: Relate directly to the function of the Committee as set out in the Terms of Reference; and Relate directly to the provision of, or access to, HBDHB or HHB Ltd publicly funded health services; and Are clinically and financially sustainable; and

	 Are affordable within current budgets.
	All such decisions and/or directives will be binding on all clinicians or other staff who provide and/or refer to public health services funded (in whole or part) by the HBDHB or HHB Ltd.
Membership	Membership
	 Four (4) Clinical Council representatives Four (4) Consumer Council representatives Health Services Directorates representative PHO representative
	Tenure
	Until replaced by the group being represented
Chair	Co-Chairs One appointed by Clinical Council from the four Clinical Council representatives One appointed by Consumer Council from the four Consumer Council representatives
	Co-Chairs of the Committee shall not be a Chair or Co-Chair of either of the two Councils
Quorum	A quorum will be two thirds of the members.
Meetings	Meetings will be held quarterly at least 4 times per year, or more frequently at the request of the chair/co-chairs.
	Meetings shall be held at times and in locations that suit the membership, and the availability of relevant patient experience survey information
	Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical council following each meeting of the Committee.
	A formal annual report shall be submitted within 3 months of the end of each financial year (30 June)
	A precis of the annual report shall be communicated to the sector, once received by Clinical Council
Minutes	The minute secretary shall be the Consumer Engagement Administrator.
	Minutes and action plans will be circulated to all members within one week of the meeting taking place.



HB CLINICAL COUNCIL WORKPLAN 2017-2018

Social Inclusion Monitoring Annual Maori Plan Q1 July-Sept Dashboard Pasifika Health Plan Q1 July-Sept 17 - Dashboard Tracee TeH Tobacco Annual Update against plan (annual) Te Ara Whakawaiora / Smoking (national indicator) Committee Reports PHO Clinical Advisory & Governance Committee (verbal) HB Clinical Research Committee Update (6 monthly) Tae Richard John Gomm 6 Dec 17 Joint Meeting Consumer and Clinical Council Venue – Havelock North Community Centre, Lantern Room	/ Ken son / J Heinz luia luia luia luia eyt / Penny
Legislative Compliance 6 monthly update (FRAC action) Recognising Consumer Participation – Review Policy FROM AUGUST Surgical Expansion Project Social Inclusion Monitoring Annual Maori Plan Q1 July-Sept Dashboard Pasifika Health Plan Q1 July-Sept 17 - Dashboard Tracee TeH Tobacco Annual Update against plan (annual) Te Ara Whakawaiora / Smoking (national indicator) Committee Reports PHO Clinical Advisory & Governance Committee (verbal) HB Clinical Research Committee Update (6 monthly) Tobacco Annual Update against plan (annual) Tracee TeH Tracee TeH Tobacco Annual Update against plan (annual) Tracee TeH Tobac	son / J Heinz luia luia luia luia eyt / Penny
Recognising Consumer Participation – Review Policy FROM AUGUST Surgical Expansion Project Social Inclusion Monitoring Annual Maori Plan Q1 July-Sept Dashboard Pasifika Health Plan Q1 July-Sept 17 - Dashboard Tracee TeH Tobacco Annual Update against plan (annual) Te Ara Whakawaiora / Smoking (national indicator) Committee Reports PHO Clinical Advisory & Governance Committee (verbal) HB Clinical Research Committee Update (6 monthly) General Material Council Venue – Havelock North Community Centre, Lantern Room	son / J Heinz luia luia luia luia eyt / Penny
Surgical Expansion Project Social Inclusion Monitoring Annual Maori Plan Q1 July-Sept Dashboard Pasifika Health Plan Q1 July-Sept 17 - Dashboard Tracee TeH Tobacco Annual Update against plan (annual) Te Ara Whakawaiora / Smoking (national indicator) Committee Reports PHO Clinical Advisory & Governance Committee (verbal) HB Clinical Research Committee Update (6 monthly) Table Tobacco Tracee TeH Tracee TeH Tobacco Annual Update against plan (annual) Tracee TeH Tracee TeH Tobacco Annual Update against plan (annual) Tobacco Annual Update against plan (annua	son / J Heinz luia luia luia luia eyt / Penny
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Annual Maori Plan Q1 July-Sept Dashboard Pasifika Health Plan Q1 July-Sept 17 - Dashboard Tracee TeH Tobacco Annual Update against plan (annual) Te Ara Whakawaiora / Smoking (national indicator) Committee Reports PHO Clinical Advisory & Governance Committee (verbal) HB Clinical Research Committee Update (6 monthly) Tae Richard John Gomm 6 Dec 17 Joint Meeting Consumer and Clinical Council Venue – Havelock North Community Centre, Lantern Room	luia luia eyt / Penny
Pasifika Health Plan Q1 July-Sept 17 - Dashboard Tobacco Annual Update against plan (annual) Te Ara Whakawaiora / Smoking (national indicator) Committee Reports PHO Clinical Advisory & Governance Committee (verbal) HB Clinical Research Committee Update (6 monthly) Tae Richard John Gomm 6 Dec 17 Joint Meeting Consumer and Clinical Council Venue – Havelock North Community Centre, Lantern Room	luia luia eyt / Penny
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Te Ara Whakawaiora / Smoking (national indicator) Committee Reports PHO Clinical Advisory & Governance Committee (verbal) HB Clinical Research Committee Update (6 monthly) Tae Richard John Gomm To Dec 17 Joint Meeting Consumer and Clinical Council Venue – Havelock North Community Centre, Lantern Room	eyt / Penny
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HB Clinical Research Committee Update (6 monthly) John Gomm Dec 17 Joint Meeting Consumer and Clinical Council Venue – Havelock North Community Centre, Lantern Room	dson
6 Dec 17 Joint Meeting Consumer and Clinical Council Venue – Havelock North Community Centre, Lantern Room	
Venue – Havelock North Community Centre, Lantern Room	nans
The Rig Listen to date (Presentation)	
The Big Listen to date (Presentation) Kate Coley	
Clinical Services Plan – First Draft (Presentation) Tracee TeHu	uia/C Burgess
Acute Flow Update John Gomm	nans
Committee Report	
PHO Clinical Advisory & Governance Committee (verbal) Tae Richard	dson
2018 Quality Annual Plan 2017/18 – 6 month review Kate Coley	
14 Feb 18 Quality Dashboard Quarterly (commences Feb 18, previously Nov 17) Kate Coley	
People Strategy (final draft) Kate Coley	
Clinical Services Plan (final draft) Tracee TeH	luia
Collaborative Pathways Update (4 monthly) Mark Peters	son/ L White
Annual Maori Plan Q2 Dashboard Tracee TeH	luia / Patrick
Monitoring	
Te Ara Whakawaiora / Access 0-4 / 45-65 year (local indicator) Mark Peters	son
Committee Reports	
HB Laboratory Services Committee (4 monthly) Andy Phillip	s / Lab Chair
HB Radiology Services Committee (4 monthly) Mark Peters	son
14 Mar 18 Establishing Health and Social Care Localities in HB (6 monthly) Tracee TeH	luia
Consumer Experience Business Case Kate Coley	
Monitoring	
Te Ara Whakawaiora / Breastfeeding (national indicator) Chris McKe	nna
Committee Report	-
Falls Minimisation Committee Update (6 monthly) Chirs McKe	

Meeting Dates	Papers and Topics	Lead(s)
11 Apr 18	Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations	Kate Coley
	Legislative omplaince (6 monthly)	Kate Coley / K Lafferty
	Monitoring	,
	Te Ara Whakawaiora / Did not Attend (local indicator)	Sharon Mason / Carleine
	Committee Report	
	HB Nursing Midwifery Leadership Council Update incl. Dashboard	Chris McKenna
9 May 18	Best Start Health Eating & Activity (6 monthly update)	Tracee TeHuia / Shari
	Committee Reports	
	PHO Clinical Advisory & Governance Committee (verbal)	Tae Richardson
	HB Clinical Research Committee Update (6 monthly)	John Gommans
	Infection Prevention Control Committee (qtly)	Chris McKenna
	Monitoring	
	Annual Maori Plan Q1 July-Sept Dashboard	Tracee TeHuia
	Pasifika Health Plan Q1 July-Sept 17 - Dashboard	Tracee TeHuia

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

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



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.	

Members appointed by tenure shall normally be appointed for three years Membership 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. A quorum will be half the members if the number of members is even, and a Quorum 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	Ka Aronui Ki Te Kounga Focussed on Quality Our Quality Picture 2017 (FINAL Quality Accounts)	
District Health Board Whakawāteatia	For the attention of: Māori Relationship Board, HB Clinical Council & HB Health Consumer Council and HBDHB Board	
Document Owner:	Kate Coley, Director Quality Improvement & Patient Safety	
Reviewed by:	Executive Management Team	
Month:	October 2017	
Consideration:	For endorsement	

RECOMMENDATION

That the Māori Relationship Board, Clinical Council, Consumer Council and HBDHB Board:

Endorse Ka aronui ki te kounga - Focussed on Quality for publication

OVERVIEW

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. Since that time HB health sector has published four sets of accounts detailing our performance against both national and local quality and safety indicators.

The Quality Accounts are annual reports to the public from DHBs about the quality of services they deliver. As they are aimed at our community the aim is to keep them as short as possible, be visual, simple 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
- Continuous quality improvement

FEEDBACK ON HB QUALITY ACCOUNTS 2016

Last year a working group was established to support the development and review of the Quality accounts publication for our community. It was a huge undertaking and presented multiple challenges. The link to last year's accounts as follows:

http://www.ourhealthhb.nz/assets/Publications/Our-Quality-Picture-2016-sml2.pdf

Previously the HQSC has reviewed all Quality Accounts providing annual feedback individually to DHB's and across New Zealand. From 2016, HQSC no longer provide feedback.

In 2016 around 400 publications and accompanying advertising posters were distributed across the community – to GP practises, health centres, public libraries, and community groups. The accounts

were advertised in local newspapers and available on ourhealth website. It has been difficult to quanitify the level of readership. Feedback from the community was limited.

The feedback from stakeholders and community that we did receive resulted in the recommendation to have a smaller, more concise document this year with increased focus on the quality improvements that have come about from community feedback and consumer engagement. A 'you said, we did" type format. Also, less emphasis on improvements and quality initiatives within services (which perpetuates the idea of working in silos) with increased emphasis on improvements as a result of working together across the sector; in particular more content from Primary care.

The publication has been developed and compiled in consultation with a cross sector steering group and through guidance provided by EMT, Consumer Council, Clinical Council and MRB.



KA ARONUI KI TE KOUNGA

FOCUSSED ON QUALITY

OUR QUALITY PICTURE 2017

Kia ora and welcome to the fifth edition of "Our Quality picture". This is a snapshot of how the health system is working to meet the needs of the Hawke's Bay community. People should be at the centre of health care and inside we focus on what we have done in the last year in response to feedback from our consumers and community.

We also recognise that providing healthcare is not without risks and sometimes people can be unintentionally harmed while undergoing care. Our aim is to reduce this harm and inside we outline our progress in this area, and how we measure up nationally against patient safety priorities and national health targets.

Kate Coley, Executive Director of People and Quality





HE KAUANUANU RESPECT ĀKINA IMPROVEMENT RARANGATETIRA 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.

ĀKINA IMPROVEMENT

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

RARANGA 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.

TAUWHIRO CARE

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

Our Quality Commitment and plades to you is

Our commitment and pledge to you is:

That as individuals, and as a health sector, we continually improve the safety and quality of health care for all

To ensure that we have a blame free culture that embraces consumer involvement

That we put the patient at the centre of everything we do and focus on continuous improvement

That we ensure all of our teams are well supported and have the skills to deliver high quality and safe patient care, every time.

Ko ā koutou whakahokinga kōrero Your 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.

Improving how we communicate with you

"He did not tell us what he was going to do. He went ahead without informing us or including us in the decision."

It is not uncommon for you to tell us, as health profesionals, that we could do better at listening to what you have to say, understanding what is most important to you and including you and your whānau in decisions about your care and treatment.

To support our staff in improving communication with consumers we started a training programme in March 2017 called "relationship centred practice" which has so far been delivered to over one hundred Allied Health Professionals (Physiotherapists, Occupational Therapists, Dental Therapists, etc.). Online learning modules and face to face training workshops were developed with consumer involvement.

The training is a sustainable, skills based training package which is aimed at providing health professionals with practical methods and strategies to improve their interactions with consumers and their whānau. This includes working in partnership, finding out what is important, what really matters to the consumer in terms of healthcare, and working together to come up with solutions.

This mana enhancing practice clearly puts the consumer and their whānau at the centre of their own healthcare - working in collaboration, building on strengths and being well supported to achieve the goals that are important in the context of their lives. It is focussed on improving the connection and quality of interactions with consumers who in turn get greater engagement and better health outcomes.

We have plans to roll this out to other health professionals in the hospital and community in 2017/18.

Staff have found this training valuable and it has allowed them to reflect on and improve their practise.

"I am much more aware of focusing on what the families want, how important it is to them and changing my approach to empower them more".

"The facilitator delivered the message effectively and simply and made me see how vital whakawhānaungatanga is, with every patient I see".

Making healthcare easy to understand

Making sure health care is easy for people to find, understand and use so that they can look after their health and wellness, is a key priority for the health system.

To do this we are committed to changing the way we deliver health care to the people of Hawke's Bay. We have taken the first step by setting principles around how we provide information such as pamphlets and letters, as well as how our health professionals talk to you about your health and wellness. This work began in 2015, through a range of online education programs for doctors and nurses working in the community.

The next step is to make sure everyone working in the sector is aware of the importance of making healthcare easy to understand. This involves working alongside our services and health professionals to help them make the changes that are needed to ensure this happens.

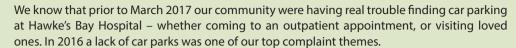
Ultimately, we want to make it as easy as possible for people to find the correct information or get to the right healthcare services, so they understand how they are best to take care of themselves.

Achieving this will take time, but people will progressively notice a difference in the way they receive information and healthcare services in Hawke's Bay.

To make this easier, we need the help of our consumers to tell us how we are doing throughout this journey and where we need to make improvements and changes. Feel free to email us at feedback@hbdhb.govt.nz with your thoughts.

This will go a long way in making sure healthcare is easy to understand to help you be well, get well and stay well.

Go Well Travel plan





"trying to find parking can take up to 30 minutes. I ended up missing my appointment".

"I had an appointment for my moko at 9am. I couldn't find a park. When I did find one we were 50 minutes late for his appointment..."

Feedback like this was not unusual. Missing an appointment is inconvenient for our patients, impacts negatively on their overall experience of care and doesn't allow us to best manage our time and resources.

We listened to you. The introduction of paid car parking in March 2017 and the promotion of alternative modes of transport has eased congestion. Patient and visitor parks are now freely available with about 30 spaces available at any given time. It is working well with plenty of positive feedback from people who are grateful to be able to easily find a park and this means a better overall experience, people attending appointments on time and less stress.

"I have used the car park twice this week for appointments, it was so nice to just be able to drive straight in and park without having to drive around endlessly. I was more than happy to pay the \$1 each time for such an easy stress free arrival".

Tom Wihapi (pictured below), is our friendly parking officer overseeing the paid parking scheme. Tom averages 15km per day on the job and is only too happy to help visitors and patients with parking queries, lost car keys or machine issues.



"It has been going very smoothly, people are very understanding of the pay scheme and visitors especially are only too happy to be able to find a car parking space."

As well as paid car parking, we have also worked with GoBay to bring you other transport options. Outpatients are making the most of the free bus transport option, with 519 trips to attend their appointments at the hospital or Napier Health in May alone. That's a staggering 122% increase on May last year!

Tom (pictured right) says he enjoys catching the bus to his hospital appointments.

If you have an upcoming outpatient appointment at the hospital or Napier Health, you too can jump on the GoBay network for free, together with a support person. Simply show your appointment letter or text reminder to the bus driver and you'll be on your way!



"It's completely hassle free, it's an easy way of getting across from Napier and I don't need to rely on anyone else."

You asked, we did

The following articles are examples of some of the things you told us through your feedback and what we are doing about it.

Youth Consumer Council

The Hawke's Bay Health system has its own youth consumer council (YCC). The first of its kind in the country!

The formation of YCC was recommended as part of the youth health strategy that was finalised in July 2016. The development of this involved lots of consultation with health system staff, community groups and youth in Hawke's Bay.

We learned that youth partnerships, leadership and collaboration across the health system was really important. YCC was initiated in late 2016 to help make this happen!

Aged between 12 and 24, the members of YCC ensure the youth voice is heard. They will also help the health system with ideas and concepts so it can be better connected with young people.

Charged with getting out and about, the council also meets with individuals in the community, other organisations and established youth groups so they can be well informed about what motivates young people to be proactive about their health. By engaging with youth face to face and interacting in different forums YCC were able to confirm their three priorities:

- Teen Suicide Awareness
- · Drug and Alcohol culture
- Mental Health

Dallas Adams, Chair off YCC and member Kylarni Tamaiva-Eria attend the monthly Hawke's Bay Health Consumer Council meetings. Whilst they found it intimidating at first they have now made positive connections and feel confident they have a platform to voice youth opinion and influence decision making in the health system. "They encourage us to have a say and that makes us feel valued" says Dallas.

Did you know?

There are 19,300 15-24 year olds in Hawke's Bay. This is 12% of the total population.

Around 2,019 (11%) youth live in rural areas and 15,984 live in urban areas (based on 2013 census)

YCC member Deveraux Short-Henare has enjoyed learning about the health system and how in his role he can influence changes to better meet the needs of youth. "I accepted the nomination because I honestly believe that youth need to be represented and have a say on what a 'youth' health system looks like and I think this group can enable that to happen". Deveraux and fellow member Tremayne Kotuhi recently represented YCC at Festival for the Future 2017. Hundreds of young innovators and influencers all gathered in Auckland to connect, explore issues, be inspired, and build ideas and skills to create the future. Tremayne came back motivated with new connections and ideas to test in Hawke's Bay.

The council has its own Facebook page, HB Youth Consumer Council ,where you can keep up-to-date with what they are up to.



Improving Outcomes for Māori

Māori don't experience the same health status as non-Māori and the health system is strongly focussed on improving health outcomes for Māori. We have a number of programmes underway to achieve this.

Te Ara Whakawaiora (the pathway to improved wellness), is a focussed Māori health improvement programme and one of the ways were are addressing Māori health concerns. It aims to gain traction, greater visibility and accelerate progress towards areas of health concern. There are a range of quality improvement initiatives including mental health, heart and diabetes care, oral health, healthy weight for children and workforce development.

Child Health improvement

In 2016/17 we have made some great gains in improving the health of our Māori children. For children under 5 years of age preventable hospitalisations has dropped by over 12%, dental conditions decreased by 8% and 94% of all 8 month old children were immunised. In 2017/18, our focus will be on reducing avoidable hospitalisations for respiratory and dental conditions, improving breastfeeding rates and access to dental treatment services as well as antenatal education programmes.

Cultural competency

We acknowledge the ethnic diversity of our community and value the cultural competency of our staff to effectively deliver health care services that meet our community's social, cultural, and linguistic needs. A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of health disparities.

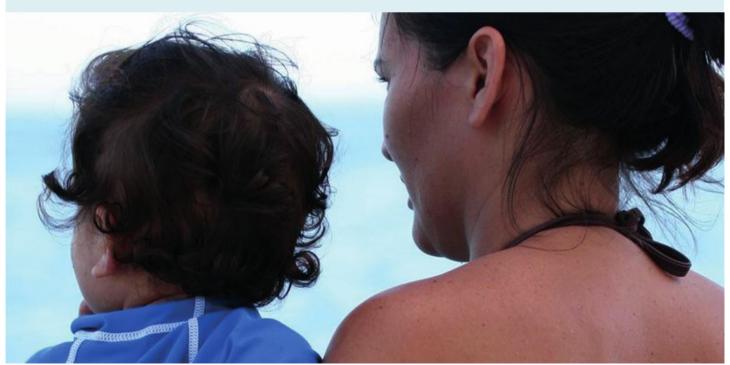
In 2016/17 bilingual signage in Māori and English were introduced and over 80 percent of our staff received training on cultural competence and cross-cultural issues. We aim to have 100 percent trained by 2017/2018. The introduction of the Ngātahi Workforce Development Programme in 2017/2018 will also ensure those organisations and staff working with high need Māori whānau and children will undergo intensive cultural competency training.

Workforce diversity

We value an ethnically diverse workforce. We aim to ensure our staff and organisation reflect the community which we serve and the growing Māori population. In 2016/2017 the Maori workforce has grown to 14.3% and we aim to increase this year on year until it is equitable with the Hawke's Bay population. A focussed Maori workforce development strategy (Turuki) has provided 38 tertiary scholarships to students studying towards health related careers and administered 162 Health Workforce NZ education grants for entry level health qualifications. In 2018 a focussed diversity workforce strategy is being developed for implementation.

Mobility Action Programme

A new exciting initiative we are introducing in 2017/18 is the Mobility Action Programme (MAP). MAP is a community based programme of care for people with a range of musculoskeletal conditions involving physiotherapy, exercise and self management programmes to be delivered across Hawke's Bay. Consumers gain benefit from improved pain management, mobility and enjoyment of life.



Staff profile

Wairoa's Rural Nurse Specialist Nervs Williams is

relishing the opportunity to make a difference in people's lives by helping them in whatever way she can. Her experiences, she says, have reinforced the importance of her role in keeping people out of hospital and delivering care in the home for rural patients.

Wairoa people are benefitting by having the opportunity to reduce travel to Hastings for procedures that can be provided by Nerys in their own home.

One experience, in particular, has had a positive impact on Nerys and listening to her recount the story of two sons who cared for their terminally ill father is touching.



"It was their Dad's dying wish to return to his papakāinga (original home)," says Nerys, who was determined to try and make that happen. With Nerys' training, the sons were able to inject medication into their Dads muscle over a period of four to five days, being fully responsible for the drug application, and providing constant attention to their Dad in the comfort of their home.

"The training was robust and this was supported by phone calls and daily visits by me to ensure the sons and wider whānau were supported well," said Nerys.

"Just as important was coordinating the wider support network including district nurses, occupational therapists and Cranford Hospice and I am proud of how well everyone pulled together to do their respective jobs with very short notice."

Improving Pacific Health

Hawke's Bay District Health Board (HBDHB) is committed to improving Pacific Health and has recently developed a Pacific Health Team to work across the DHB and within the Pacific community.

Talalelei Taufale is the Pacific Health Development Manager. Talalelei coordinates, supports and influences work within the health system ensuring quality improvements are inclusive of Pacific perspectives and approaches.

Amataga Iuli is the Pacific Health Promoter. Amataga connects and builds rapport with the different Pacific community groups to support and empower them to identify and prioritise their health and wellbeing.

Silia Momoisea and Paul Faleono are the Pacific Health Navigators, they work closely with Pacific families and consumers in the community. They support Pacific families through the health system.

In August our diverse Pacific communities gathered together to focus on growing our Pacific health workforce and improving the quality of care and access to services by Pacific people in Hawke's Bay. The Nuanua Pacific Social Gathering also included speakers from our Pacific health workforce - the result? some great discussion, information sharing and laughter!





Developed Pacific Health Action Plan.



November-Employed Pacific Health Development Manager to implement PHAP.



Pasifika Health Navigation Services Contracted to work with Pacific families.

Pasifika Health Leadership Group Established.



Nuanua Pasifika Health Workforce Group established.

Pacific Navigator role establish in Totara Health



December Pasifika Health Navigation Service Contract concludes



Pacific Health Team established- Pacific health Development Manager, Pacific Health Promoter, x2 Pacific health Navigators

Gastro Outbreak

In August 2016 Havelock North was affected by an unprecedented event in New Zealand as the town's water supply became contaminated with campylobacter, affecting over 5000 people with illness.

During the crisis the health community responded really well. The incredible work happening in primary care played a huge role in keeping people out of hospital.

Dr Peter Culham is a General Practitioner at Te Mata Peak Practice in Havelock North and was rostered on to work the weekend of 13 and 14 August (when more people were presenting with the onset of illness)

"Whilst the team at Te Mata Peak Practice were aware of increasing gastroenteritis cases, thought to be Norovirus, the district health board and Hastings District Council through media and social media statements released on Friday night made us aware we were in for something more. On the Friday night we were also called by the district health board's Emergency Manager who told us they thought there was a high chance the outbreak was likely to be Campylobacter."

"It became apparent very early on Saturday morning the outbreak was worsening. I called in extra staff and we made the early decision to try and manage the epidemic via telephone consultation".

Saturday 13 August was described by Peter as a very long and busy day. Not only was he and his team managing Campylobacter cases, but also other illnesses, as well as attending and managing the death of a patient. The DHB instituted its critical incident management structure. District Nurses were moved into retirement villages which was very helpful, and the Te Mata Peak Practice team knew they needed to do things differently to cope with the numbers of sick people.

"We improved our processes further on Sunday. We arranged afterhours telehealth support via Auckland and had extra GPs working as well as increased administration and nursing support. Our doctors and nurses provided a telephone assessment service as well as traditional face-to-face consultations. IV fluid therapy was administered on site, in homes and residential care facilities which kept people out of hospital, by the district nurses."

On the Monday Peter said the entire team, minus those who were unwell themselves, were back on deck and focussed on assessing as

many affected patients as possible. This was achieved by "deferring non-urgent work and making the most of telephone consultations." Te Mata Peak Practice was well supported by Health Hawke's Bay (The Primary Health Organisation). "They provided a clinical pharmacist and additional registered nurses to make proactive phone calls to check in on those vulnerable and at-risk people in the community; for example the elderly, diabetics (people with diabetes), and people with other medical conditions."

The incredible staff working in Te Mata Peak Practice and those that came to support them worked long into the week. Whilst numbers peaked on the Wednesday, staff were still seeing lots of patients through to the Friday night. Thankfully Peter was able to take a break over the weekend.

Innovations

Extensive use of telephone consultations helping us to assess large numbers of people, while enabling us to have face-to-face visits with the patients we were most concerned about.

Use of registered nurses to contact at risk patients via telephone. Those unaffected by the gastro outbreak were appreciative of the contact. Those affected were offered advice, telephone support or face-to-face consultations as required, to help them manage the illness with their co-existing conditions.

The DHB decision to send District Nurses into the residential care villages was another great idea.

Throughout this incident there was constant communication with the district health board and Health Hawke's Bay (PHO).

proud of our team.
Everyone pulled their
weight and worked very hard.
I believe we collaborated well
with Health Hawke's Bay and the
DHB. From this event we made
a number of innovations
which benefited our
community"





#whānau

We have 10,000 vulnerable families living in our region. #whānau was developed out of a need and desire to provide whānau with a health care service that is "real". One that is focussed on whānau, increases their access to health services and ultimately reduces inequalities in our community.

#whānau is a collaboration between General Practice Totara Health and Choices, a Maori Health Provider of 22 years. Together they have built a foundation on relationships and trust. They have identified what their strengths and limitations are and are working together to "fill the gaps" and make a difference in their community.

#whānau supports 50 vulnerable low income Māori whānau in Hastings and Flaxmere to reach their health ambitions. The #whānau team involves kaiawhina (support workers), midwives, nurses, GP's, pharmacists, nutritionists and physiotherapists.

The Kaiawhina work with whānau to develop whānau led goals and aspirations and support them to better understand their health conditions. We know that some whānau who suffer from diabetes and cancer rate their personal health as excellent. This shows that some whānau do not understand their health conditions or accept their chronic health issues as normal because other whānau members suffer or suffered from the same thing. With greater understanding, whānau realise the urgency in their care and are more appreciative of the services the #whānau team can bring to them.

This has been a very successful programme. The 50 whānau selected have achieved 100% health targets every year for the



past four years!



"It was much easier when she came along. Having health care made it easier to deal with other things".

"It got me a job... I've never worked before. I'm like, far, I've missed out on all this". "There were all these services out there but I didn't know how to access them and then [the Kaiawhina] showed up and I was like "thank you".

"I didn't know what to say so she came with me. I feel comfortable now making appointments".

"My number one was smoking. I said "I really want to quit smoking" and I no longer want to smoke. I've always tried on my own and always fail and I just didn't go and get help...".

The #whānau team are proud of their results but equally excited about the future.

They are continually improving and their work so far has taught them that they need to develop more roles and innovative tools.

They are building a new education program and their new #whānau app is intended to bring health and "other services" into the home with ease.

One Kaiawhina tells us...

"Because I have a team of experts around me, like Doctors, Nurses, Navigators, I can help whānau better. I can get support from any of them at any time. They know what I do and I know what they do. We keep in touch through the whānau files."

"Some of my whānau need a lot of help and support and so I help them. I can be at WINZ office all day helping them fill out forms. I have helped over 5 whānau get into homes and get fire places. There is a lot of poverty out there and two or three families will live together to help buy food and pay rent."

"Some of my whānau haven't been to see a doctor in years, even though they have diabetes or other chronic illness. One of my whānau, a mum of five has cancer. She hasn't been back to her doctor for over a year. I helped her come back and engage with clinicians again."

"Most of my families just don't understand how their health matters. Some just accept that having diabetes or asthma is a part of their lives, as they have always lived with it."

"I have a lot of grandparents who are looking after their mokos. I help take them to the doctor and see our School Nurse to follow up. Whatever it takes, no matter how long it's what we do."



"It feels good to be able to walk in the door and take care of whatever it is they need. Before the program, I would only want to help with the cervical smears and then come back the next day to find children that needed immunisation. That isn't a good health care service."

"Now I provide what is needed to the entire whanau. That's #WHĀNAU!"

2016 Hawke's Bay Health Awards

Teams across the health system celebrated at the Hawke's Bay Health Awards in November 2016 at the The Opera House Plaza Hastings. This was a night to recognise the collaboration and innovation taking place across our region as well as witness some new initiatives changing the landscape for future health developments.

The engAGE ORBIT team from Hawke's Bay DHB not only won the Excellence in Service Improvement Award but also took out the Supreme Award. This was in recognition of their move to a seven day allied health service which, since November 2015, has allowed the ORBIT team to see over 800 extra patients who would not otherwise have been seen. This change is likely a contributing factor to the decrease in the rate of conversion from ED presentation to hospital admission for over 65s compared to the same period for the previous year. While the number of ED presentations for over 65s has increased, the number being admitted to hospital has decreased.







and Patient Safety

ROYSTON HOSPITAL, ACURITY HEALTH GROUP LTD Ensuring adherence to the Patient Code of Rights in an age of personal mobile devices



Excellence in Innovation AVIATION HEALTH HAWKE'S BAY, UNIVERSITY OF OTAGO, SPORT HAWKE'S BAY The PIPI study - practice nurses preventing progression of prediabetes







Excellence in Provider Collaboration and Integration

HAWKE'S BAY DHB, HEALTH HAWKE'S BAY HAWKE'S BAY GENERAL PRACTICES, HOME-BASED SUPPORT SERVICES & AGED RESIDENTIAL CARE engAGE MDTs: cross sector collaboration improves for frail older people BUDDLEFINDLAY

NEW ZEALAND LAWYERS Excellence in Clinical Practice HAWKE'S BAY DHB

Perioperative Unit - Operation Productivity





Outstanding Contribution to Improving Health in Hawke's Bay

JEANETTE FRECHTLING

Hawke's Bay DHB

Ngā whāinga hauora ā-motu National health targets

KEY:

- ↑ Improved our performance against the health target.
- \checkmark Our performance against the health target has declined
- Our performance against the health target has stayed the same.

HEALTH TARGET	TARGET	OUR RESULT (2016/17)	TREND (since last year)	COMMENT
Shorter stays in Emergency Department (ED)	95%	Not achieved 93.9%	↑	Despite continued growth in people presenting to ED we have improved on last year's performance, achieving the 95% target in two quarters. We have seen a marked improvement especially for those patients who don't need to be admitted to hospital. Around 98% are assessed and treated in ED and go home within five hours. Our next challenge is improving the flow of acute patients from ED into the hospital. The FLOW program of work is starting to address some of the core issues that will help improve patient flow across the hospital.
Improved access to elective surgery	100%	Exceeded 101.3%	-	This year we achieved our elective health target, as well as the orthopaedic joint and general surgery targets. This was despite the extraordinary pressures of the Havelock North Campylobacter outbreak and two Resident Medical Officer (RMO) strikes, which saw considerable reshuffling and rescheduling of elective surgery lists. We will continue to improve access to elective surgery for our community, by creating extra theatre space through projects; such as Endoscopy and Gastroenterology building and service move, which will free up space to allow more elective surgery capacity, as well as improving patient FLOW through the hospital.
Faster Cancer Treatment	85%	Not achieved 69.3%	↑	Since January 2017 there has been a strong focus on reducing the time taken from referral to treatment for cancer. The aim has been to improve outcomes and experience for people with cancer. By working in partnership with clinical teams in Hawke's Bay and those in major centres who treat people from our community the time taken to gain treatment has significantly reduced. An action plan has been developed by the clinical teams and we are confident that there will be further improvement over the coming months.
Increased immunisation	95%	Achieved	↑	Hawke's Bay continues to be a top performer in achieving the immunisation health targets.
Better help for smokers to quit (Primary Care)	90%	Exceeded 91%	1	Health Hawke's Bay have been supporting their general practices with independent nurses contacting patients to update their smoking status and offer brief advice and cessation (stop smoking) support. Health Hawke's Bay have started to engage with workplaces to offer smoke-free support and are also in the process of organising some community events.
Raising healthy Kids* *Quarter 4 result only	95%	Exceeded 95%	N/A	The Ministry target expects that by December 2017, 95% of all obese children (98th percentile of weight) identified via a B4 School Check will be offered a referral to a health professional for clinical assessment and whānau -based nutrition, activity and lifestyle interventions. Hawke's Bay DHB currently sits at 96%. HBDHB has prioritised childhood healthy weight. This includes work supporting the national target - developing resources to support whānau with healthy eating and physical activity lifestyles, establishing an effective referral process and supporting primary care with tools.

National Patient Safety Priorities

The Health Quality and Safety Commission (HQSC) is driving improvement in the safety and quality of NZ healthcare through its quality improvement programme.

The key role of HQSC is to publish information and set targets (called quality and safety markers) to improve the quality of Health care in New Zealand.

The quality and safety markers help HQSC evaluate the success of their programmes and if the desired results are achieved. The targets help Hawke's Bay DHB monitor how we compare with other DHB's and challenge ourselves to do better.

Quality and safety markers monitor a set of care indicators which cover Falls, Healthcare associated infections, Safe Surgery and Medication Safety.

For more information look at the website www.hgsc.govt.nz

We know we are getting better in these care indicator areas because our results in the January to March 2017 quarter tells us that Hawke's Bay, compared to other DHB's, are in the top areas for three out of the five priorities. We are working hard to improve the fourth area which is the safer surgery marker and fifth area Medication safety programme.



The safer surgery marker was introduced recently and it measures levels of teamwork and communication around the paperless surgical safety checklist. We know staff are doing it – we just need to get better at proving it.

Our 2017 Falls Campaign across the whole region focussed on improving balance and strength, we had a great month working with other providers and we ended up being recognised nationally for our work. This is something everyone can do to help themselves. As we age it is harder to keep our balance and keep strong in our legs, but there are a lot of community programmes to help. Staff and visitors tried Tai Chi this year – thanks to Sport Hawke's Bay. Look at their website for a list of programmes www.sporthb.net.nz.

Other national programmes which are coordinated by HQSC and which Hawke's Bay DHB are undertaking improvement work include:

- Recognising Deteriorating Patients Getting better at identifying when someone is getting sicker while in hospital and having a plan to help them faster;
- Medication Management Helping people who are in pain and need strong medication to help them, which sometimes means they get constipated i.e. you can't have a 'poo' as often as you would normally, this is a problem so we are doing some things to stop this e.g. making sure if strong medication is needed, medicine to make you poo is also given.
- National Patient Experience Survey (in hospital) this has been running for three years now and the feedback informs national improvement campaigns. The four domains all hospitals are measured on and HBDHB scores as follows: communication (85%). coordination (85%), partnership (85%) and physical and emotional needs (88%). HQSC are now working with the Primary Health Organisation in Hawke's Bay to roll out a patient experience survey in General Practice.



National Patient Safety Priorities In hospital



Falls prevention 1: Target 90%



Surgical site infection 1: Antibiotic administration 100%



Falls prevention 2: An increase from 86% last year. Target 90%



Surgical site infections 2: right antibiotic and dose 98% (nationally approved sometimes people require something different).



Hand hygiene: Target 70% - Top DHB well done.

Medication Safety: Hawke's Bay is not yet one of the DHBs doing this project - but there is work happening to help us to get ready for when it's our turn to get involved. eg: improved technology

Let's Talk - Patient Safety Week

Patient Safety is top of mind every day in healthcare. "Let's Talk" was the theme at Hawke's Bay Hospital during Patient Safety Week in November 2016 when we highlighted better communication between patients, whānau and health professionals. We had displays to highlight the Let's Talk campaign making sure we got the attention of staff, patients and visitors to the hospital and our "what matters to you" whiteboards reinforced that whānau/family matters most.

Patient Safety Week is a Health Quality and Safety Commission initiative which we embrace every year. The theme for 2017 will be medication safety. This topic has been chosen because the patient experience survey question "Did a member of staff tell you about medication side effects to watch for when you went home?" consistently gets one of the lowest scores across all 20 DHB's in New Zealand.



CEO Dr Kevin Snee checks out a display alongside Jane Bailey, Patient Safety Advisor and Jeanette Rendle, Consumer Engagement Manager.

How to keep yourself safe when in hospital – here are our top tips:

- Talk with your doctor and nurse and tell them what you know about your illness or injury.
- Ask questions to help you understand your treatment – why you are having it, the choices, what will happen and the risks and benefits.
- **Clean** your hands often to help stop infection, and ask your visitors to clean their hands.
- Keep a list of and learn the names of the medicines you are taking, the reasons you are taking them and when and how to take them.
- **Ask** for the results of any tests you have and what happens next.
- **Get** to know your ward and make sure the call bell is always within easy reach.
- **Before** leaving hospital, ask what you and your family/whānau need to do at home.

Hand Hygiene

Hand hygiene is recognised worldwide as the single most effective way to prevent the spread of infection and improve the quality and safety of patients in our care. The 5 moments for Hand Hygiene is a programme developed by the World Health Organisation (WHO), and implemented across all New Zealand district health boards (DHBs).

HBDHB continues to achieve a high level of compliance with the 5 moments for Hand Hygiene when compared to other NZ DHBs. The quarter ending March 2017, HBDHB achieved a compliance rate of 88.7%, the highest in NZ.

On 5 May, HBDHB celebrated World Hand Hygiene Day. Wall displays across the hospital were created by enthusiastic staff members, an information board was created in the main entrance, and a competition 'guess the hands' was run that created a sense of fun and engagement with staff, patients, and visitors.





It was also a time to celebrate and thank the Hand Hygiene champions within the hospital for their passion and dedication to the programme and ultimately the positive impact it has on patient safety.



Adverse events

Adverse Events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death.

Adverse events are uncommon but taken seriously. For each event we conduct a formal review which follows the patient's journey through the hospitals systems and processes.

What we learn from these reviews is important and we recognise that each event provides an opportunity to improve the care we provide.

Adverse events 2016/17

Clinical process – 12 Medication – 2 Fall – 8

Learning from Adverse Events

Several reviews at HBDHB have led to significant improvements on the front line, examples are:

- the appointment of more senior doctors
- · reducing delays to reach definitive diagnosis
- education opportunities
- improvements to the transfer of care (handover from one health professional to another, or to a caregiver) communication information gathering tools have been developed.

"[we] would like to thank you for investigating [his] death and providing a clear report. My primary intention was to ensure any lessons that could be learnt from this tragedy would possibly prevent others having to experience this and to that end we were heartened to see the changes in DHB operating procedures.

...the family was happy to see that our concerns were taken seriously by the depth and openness of the DHB report and the remedial actions that have since been implemented".

Future Focus

The organisation has invested in a new integrated risk management system which is intended to be rolled out in 2017/18. This brings new capabilities and allows the DHB to better monitor and manage its associated risks. The DHB hopes to bring the primary care sector on board with the system in 2018/19.

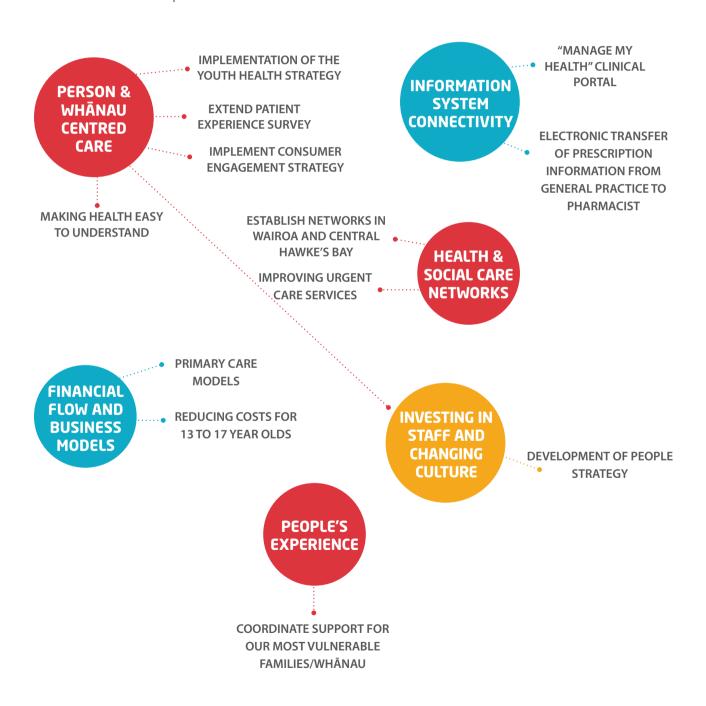
All adverse events are reported to the Health Quality and Safety Commission (HQSC). The commission is supporting DHB's to further improve their processes around event reviews. A strong focus for 2017/18 will be on more consistent consumer involvement in reporting, reviewing and learning from adverse events. The involved consumer and / or their whānau will be offered the opportunity to share their story as part of the review process.



TŌ TĀTOU ARONGA MŌ ĀPŌPŌ 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 5 year strategy Transform and Sustain which aligns to the New Zealand Health Strategy. We will support the elimination of inequity and prepare our health services for more numbers of younger Māori and growing numbers of older people and 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. To meet the needs of the Hawke's Bay population we need to continue to improve what we do.



I MŌHIO RĀNEI KOE IA RĀ... DID YOU KNOW THAT EVERY DAY...



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



person will be admitted to CHB Hospital



people will be admitted to Wairoa Hospital



new referrals are managed by child development



children will receive one of their vaccinations



6 babies will be born



21people will get their free annual diabetes check



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



operations will be completed in one of Hawke's Bay Hospital's theatres



48
people will attend a clinic appointment at Napier Health



people will be admitted to Hawke's Bay Hospital



124
People present
to HB Emergency
Department



152
visits will be made by district nurses and home service nurses



184
visits/appointments
will be made to
support people with
mental health issues



194
children will be seen for their free dental health check



1,446
people will see their family doctor

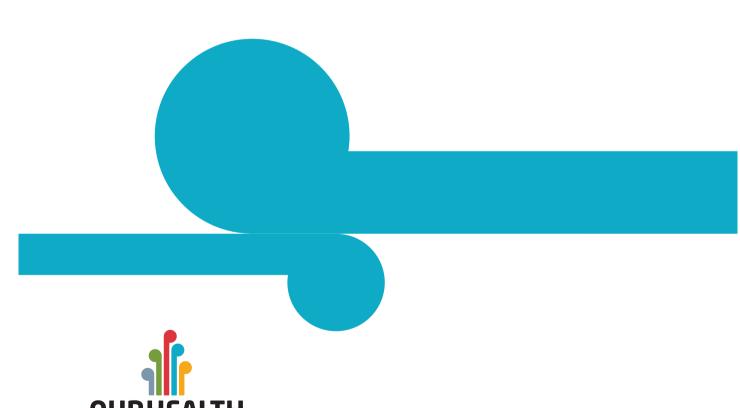


4,743 prescriptions will be filled out



5,831laboratory tests will be completed

Icons made by Freepik from www.flaticon.com



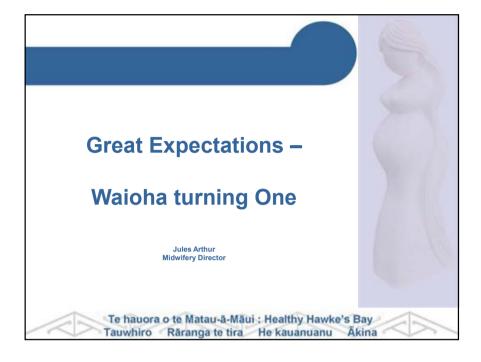
For more information visit www.ourhealthhb.nz



WAIOHA BIRTHING UNIT BENEFITS REALISATION

Presentation

HB Clinical Council 11 October 2017 - Waioha Birthing Unit - Beneftis Realisation Presentation

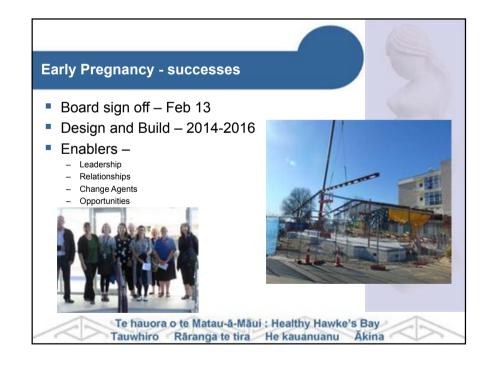


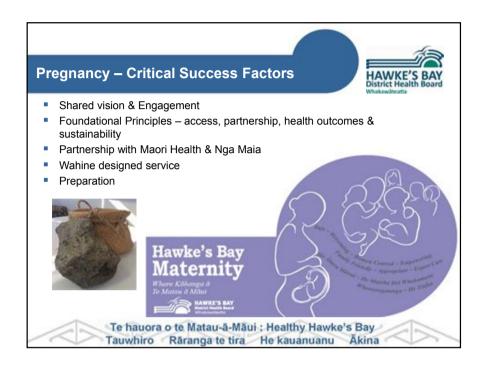
Conception – Drivers for Change

- Limited use of stand alone primary facilities
- Increasing intervention
- Declining homebirth rate
- Women's feedback
- Primary and Secondary mixed in birthing environment
- Protection of choice in place of birth
- Alignment with national and local strategies

Te hauora o te Matau-ā-Māui : Healthy Hawke's Bay Tauwhiro Rāranga te tira He kauanuanu Ākina

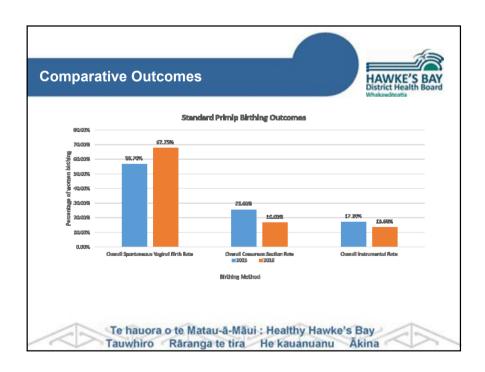
Conception – Right Place, right woman, right outcome Birthplace Study NZ Clinical indicators for Low risk 1st time mums (definition: 1st time mum, 20-34 yrs old, singleton pregnancy, head down, fit healthy and well) Environment Organisational Culture Birth outcomes Te hauora o te Matau-ā-Māui : Healthy Hawke's Bay Tauwhiro Rāranga te tira He kauanuanu Akina

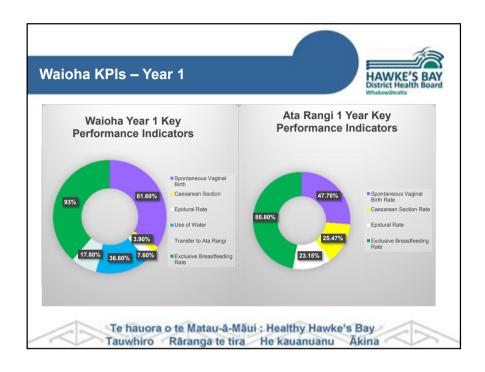


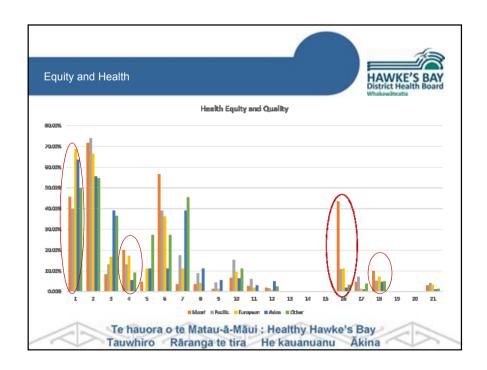




1 Year Old – How are we doing? Official opening Ceremony held March 2017 578 babies born Increasing normal birth rate Decreasing C Section rate Other improvements BFHI Accreditation achieved Model of care Engagement with Nga Maia Consumer feedback Te hauora o te Matau-ā-Māui: Healthy Hawke's Bay Tauwhiro Rāranga te tira He kauanuanu Ākina







19/09/2017

1 Year Old – How are we doing? BFHI Accreditation achieved "the facility upholds tikanga, ensuring a safe cultural model of care...whanau are seen as integral" (Annette Peri-Collier, 2017 BFHI accreditation) Model of care Engagement with Nga Maia Consumer feedback Te hauora o te Matau-ā-Māui: Healthy Hawke's Bay Tauwhiro Rāranga te tira He kauanuanu Ākina



Where to next?

- Your Birth, Your Power project
- What matters to you most feedback
- Continued improvement of primary care partnerships
- Introduction of new Maori Midwifery Consultant position
- CHB maternity resource centre

Maternity Services Hawke's Bay Video

Te hauora o te Matau-ā-Māui : Healthy Hawke's Bay Tauwhiro Rāranga te tira He kauanuanu Ākina

	HB Radiology Services Committee Report	
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: HB Clinical Council	
Document Owner:	Dr Mark Peterson, CMO Primary Care	
Document Author:	Dr Mark Peterson	
Month:	October 2017	
Consideration:	For Information	

RECOMMENDATION

That the HB Clinical Council:

Note the contents of this report of the Laboratory Services Committee Meeting held 19 September 2017

Update from Radiology Dept

- Better capacity from employment of more MRTs and roster changes
- Extended CT hours on site now to 9.30pm
- MRI scanning now 7 days, 8 hrs / day
- 2 new SMOs but lost 3
- Still to recruit new permanent radiologists
- Intermittent ability to attract locum SMOs
- Joint recruitment with TRG
- New sonographer and MR / nuclear medicine trainees.
- US waiting times now between 4 & 9 weeks and around 3 months for US injections.
- MRI target now 78% target is 85% and this expected to be reached in December.

Sharing of Images Across Sectors

This is an on-going problem but there have been some developments. The Radiology HOD has meet with the Systems Architect from IT and had positive discussions. The problem is largely that different organisations use different image archiving systems that do not link though progress is being made on enabling this.

Onsite can "push" US images on request (and do so automatically in some situations).

Hastings Health Centre reports that it is possible it might change their radiology provider as part of their building development.

It was agreed by the Committee that every effort should be made when establishing or renegotiating any contracts with external radiology organisations that ensuring image sharing should be included in the contract – **action**

Misdirected Results

This also continues to be an issue in primary care although it has improved significantly following input from IT and from Quality Improvement.

Work is now been done on a standardised referral form that will be generated from GP Practice Management Systems. This will have data fields in standardised locations on the form to assist with accurate data entry.

	Laboratory Services Committee Report	
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: HB Clinical Council	
Document Owner:	Dr Mark Peterson, CMO Primary Care	
Document Author:	Priyanka Sharma, Laboratory Systems Coordinator (meeting co-ordinator and note taker for Laboratory Service Committee)	
Month:	October 2017	
Consideration:	For Information	

RECOMMENDATION

That the HB Clinical Council:

Note the contents of this report of the Laboratory Services Committee Meeting held 18 September 2017

Laboratory Committee Membership

Dr Kiri Bird has resigned as Chair of Laboratory Committee with a new Chair being sought for this Committee.

Laboratory Testing Guidelines.

HBDHB Laboratory Guidelines are now in final draft following a review by Dr Ross Boswell, HBDHB Laboratory Clinical Director; and Shelli Turner, HBDHB Laboratory Manager. These will be circulated to the Laboratory Committee for approval.

Technology Solution: Label Project

The following was noted in July's report to Clinical Council:

At present, hand-labelling of blood tubes is required. Ross Boswell has a technology solution available with cell phone used to scan a barcode on the patient's wrist bands which after confirmation of correct patient ID, prints barcoded labels for use on tubes. The barcodes can be set up in such a way that they are recognised by laboratory analysers.

- Cost of cell phone: \$100 \$150
- Cost of label printer: \$450 per printer

A working party group and an oversight group (Chris McKenna) has been formed with IS team representation.

Laboratory Committee discussed that the project will need to align with IS strategy as it has the potential to be implemented across the DHB. Laboratory Committee support this project and will await progress updates.

Update from meeting held 18 September:

The Label Project is being managed by the Information Services team. The labelling process was presented to Product Evaluation Committee (PEC) for review. PEC have raised numerous concerns around the use of cell phones and infection control processes despite communication that the cell phone would not be touching the patient as it will be used for scanning wrist barcodes only. Furthermore, the cell phone can be placed in a clear plastic bag if working in isolation is required. The Laboratory Committee noted that Middlemore have piloted the system but are not utilising it due to their process of using pre-printed labels for tubes.

Laboratory Committee support this initiative as a pilot for HBDHB.

Paper Reports Project

Laboratory Committee have noted and approved the following:

As of 5th September 2017, HBDHB laboratory stopped delivery of paper laboratory reports to Hawke's Bay GPs who have the ability to view results via electronic reporting systems. A letter was sent prior to 5th September to practice managers and practitioners that were receiving paper laboratory reports. One piece of feedback received related to the reporting of critical results process which remains unaffected by paper laboratory reports process.

Paper laboratory reports to HBDHB locations/clinicians will continue due to current ECA system.

Preanalytical Issues – Histology Laboratory

Laboratory Committee were presented with data collated by HBDHB Histology Laboratory on preanalytical errors.

If any discrepancies (e.g.: patient name/specimen site on request form and sample do not match, specimen unlabelled etc.) are noted then the laboratory stops its process and contacts the requestor. A proforma is provided to the requestor to complete and sign, acknowledging that the requestor is responsible for error and to correct the error/provide further information. Since the proforma's implementation, histology laboratory have had to apply the above process for 1 in 3 histology specimens received. This has resulted in delayed processing time and high utilisation of resources to fix preanalytical issues as histology specimens cannot be discarded/re-collected.

Laboratory Committee provided feedback regarding community histology requests and have advised the Laboratory to report these events via HBDHB eventing system. The Laboratory Committee also support the PHO and Histology Laboratory to create a memo/guide to communicate to requestors the details Histology laboratory requests require.



HB NURSING MIDWIFERY LEADERSHIP COUNCIL UPDATE

Late Report



INFECTION PREVENTION & CONTROL COMMITTEE

Late Report

	Havelock North Gastroenteritis Outbreak Progress Report on Review Recommendations
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: HB Clinical Council & Finance Risk and Audit Committee
Document Author:	Kate Coley, Executive Director of People & Quality
Month:	October, 2017
Consideration:	For Information

RECOMMENDATION

That Clinical Council & Finance Risk and Audit Committee:

 Note the progress and actions currently completed and being undertaken to meet the recommendations of the Havelock North Gastroenteritis Outbreak Review

PURPOSE

The purpose of this report is to provide Clinical Council and FRAC with a summary of the progress being made on implementing the recommendations of the Havelock North Gastroenteritis Outbreak Review that was endorsed by Board in March 2017.

EXECUTIVE SUMMARY

This review report set out the findings of an internal review into the DHB's management of the gastroenteritis outbreak during the emergency response (12 – 23 August 2016) and the subsequent recovery period (23 August - 4 September 2016).

The report identified where the DHB excelled in its response and put forward a number of recommendations around areas for improvement. Since the internal review was endorsed the independent government inquiry Phase 1 and 2 have been completed with the recommendations from Phase 2 being considered at this time. The actions and recommendations have therefore also been updated to reflect the findings from Phase 1 of the inquiry.

Some of the key success factors identified in the review were:

- The DHB led emergency response managed through the Emergency Operations Centre was well managed and competently coordinated a sector wide response in accordance with prescribed processes.
- The DHB and Hastings District Council (HDC) shared outbreak planning sessions and joint communication strategies including Press conferences and media releases.
- The collaborative teamwork of district nurses, general practice teams, pharmacies and aged residential care facilities was a key factor in managing unwell people in their homes and preventing unnecessary admissions to hospital.
- The collaborative intelligence gathering and surveillance activities undertaken by the Population Health Service and ESR provided the EOC with an understanding of the real situation. This intelligence informed ongoing outbreak planning including strategies for the prevention of spread (cross-infection), a relapse of infection (second wave of infection) and prepare for managing potential complications of campylobacterosis.

 The decision to have 'one voice' fronting media presentations and the production of the gastroenteritis video clip provided staff and the public with consistent, open and honest messages and contributed towards gaining people's confidence that the outbreak was being well managed.

The review process also identified a number of issues of concern. These included:

- The capacity of a smaller DHB to manage a large scale event such as this outbreak presents a
 huge challenge and relies on rapid reporting of illness and activity, smart resource planning and
 deployment of specialist staff from other public health and hospital services.
- The DHBs initial response to manage the outbreak through the establishment of Population Health incident management processes, rather than activation of the EOC resulted in some confusion of roles and responsibilities.
- The absence of a mechanism for rapidly reporting real-time health alerts to the public health service.
- The timing and decision making around the outbreak led to difficulties in communicating key
 messages to both staff and the public, as well as the challenge for Hasting District Council to
 issue the boil water notice after-hours to Havelock North residents.
- External disruptors created significant challenges for the EOC, DHB and Council including the circulation of misinformation within the community.

It was agreed that the implementation of these recommendations would greatly enhance the capability and capacity of Hawke's Bay DHB and associated partners to respond to large scale outbreaks or other health emergencies in the future. Each recommendation incorporated a number of strategies for improvement.

In summary, these recommendations and strategies for improvement included:

- 1. Incorporating relevant learnings from this outbreak into the emergency response and emergency management communications strategy
- 2. Reviewing and implementing an agreed set of principles and capabilities for managing outbreak information
- 3. Strengthening public health outbreak management system
- Developing and implementing guidelines for the management of large scale (outbreak) microbiological testing
- Strengthening collaboration and integration of Primary Care, Community and Hospital Health Services
- 6. Strengthening outbreak management through shared learnings, at both local and national levels.

It was envisaged that most of the recommendations would be implemented with a 12 month period and some have already been completed, however there are a number which will require a national and regional approach, thereby requiring a longer time to develop and implement a solution.

Appendix 1 provides EMT, Clinical Council, FRAC & Board with an update on progress against these recommendations.

Appendix 1 - Action Plan Progress Report

Recommendation	Activity	Priority Responsibility	Progress Update Oct '17
1. Enhancing outbreak management and emergency response system	 a) Identify triggers for Incident Management Team initial meeting. b) Review Situation Unit processes to allow effective use of team members. c) Look at a plan for resilience of the organisation and its staff. d) Briefings and planning meetings need to be conducted separately, briefing for all staff involved (look at possibility of streaming briefings), planning for Incident Management Team on duty – process to include format and who included. e) Process manual for EOC needs to be reviewed. f) The Incident Management Team roster needs to be prominent in the EOC. g) Individuals in the Incident Management Team need some cross training to allow flexibility in placement in roles. 	Low ED of PS	Completed – triggers prepared and documented Underway - Process drafted, individuals & training needs identified To be started Completed – Format and process prepared and documented in EOC Manual Underway – currently in draft with new sections Completed – EOC board redesigned Underway – Training booked for October
2. Strengthening Collaboration and Integration of Primary Care, Community and Hospital Health Services	 a) Develop a district-wide infection prevention and control outbreak management guideline b) Early meeting of all community responders to agree action. c) The trigger for the activation of the Emergency Services Coordinating Committee needs to be examined. d) Provision of situation reports and advisories to primary care in future events to become part of standard practice. e) Telephone calls to key agencies to alert the need to read emails would assist in information dissemination. f) Investigation into health access to Population warning announcements may be useful. 	Low ED of PS & GM HHB	

Recommendation	Activity	Priority Responsib	lity Progress Update Oct '17
	 g) Process for the management and support of other agencies needs to be prepared. h) Coordination of effort needs to be addressed. i) A plan for PHO response and collaboration with the wider DHB needs to be prepared. j) Need to define roles and expectations for community staff working within primary care. k) Options for changing the model of care in general practice need to be investigated. 		Completed – process prepared and documented in EOC Manual Completed – updated EOC Manual Underway – discussions ongoing Underway – Standard operating procedure in draft
	 I) Investigate a DHB or PHO member onsite for aged residential care. m) Residential care database of all residents and those in independent living required. 		Completed – updated EOC Manual Completed - Identification of facilities with independent living undertaken, all facilities hold databases
	n) Identify mechanism to integrate primary care and community healthcare providers into HBDHB outbreak management system to enable: i. Timely notification of alerts (e.g. after-hours contact lists) ii. Integration of providers into the incident management processes when required iii. Sharing of outbreak status reports and communications.		
3. Strengthening outbreak management through shared learnings	a) Development of an interagency collaborative framework and ethos in the management of large scale disease outbreaks including: i. development of an agreed set of principles, activities and capabilities for managing large scale outbreaks ii. creating a tool for coordinating and linking key stakeholders (e.g. industries, government agencies and relevant non-government organisations)	Low ED of PS	Underway - Framework in draft, Central Region REMA commented, agency table to be populated

	Recommendation		Activity	Priority	Responsibility	Progress Update Oct '17
		c)	Rules of engagement regarding information gathering for the MoH would avoid duplication of effort. A process for the implementation of a MoH national expert group could provide this advice early in an event. Population and dissemination of lessons learnt to assist DHB's and territorial local authorities with outbreak planning responses to major events.			
4.	Strengthening HBDHB's Outbreak Management System	a) b)	Review mechanisms to better integrate and coordinate population health teams into the organisation-wide incident management processes. Review outbreak management processes including: i. Formally integrate ESR roles into the surveillance outbreak management process ii. Risk identification and mitigation strategies iii. Identify resources required for the consistent inputting of data during an outbreak event (e.g. Health EMIS) iv. Develop guidelines for workforce resource planning and defining criteria for accessing external staff resources v. Develop an outbreak timeline framework for implementation throughout the duration of an event vi. Develop a process to triage calls and manage inquiries vii. Identifying processes to understanding community resilience during an outbreak (e.g. household surveys). Moving the Population Health Service into the DHB EOC	Moderate	ED of PS & Dir Pop Health	Underway – Number of workshops with structure refined and team identified Underway - Policy review planned
		d)	environment early needs a process. A model tying together the methods of surveillance required in an outbreak event would allow better management of			

Recommendation	Activity	Priority Responsibility	Progress Update Oct '17
	surveillance. This would include the process for surveys, ESR provision of data locally and nationally and management of the data collected. e) Investigate a process for surveillance in schools and workplaces in order to allow early identification of increased absenteeism.		Underway – Meeting to discuss intelligence and surveillance planning Underway - The need for a system to support school absenteeism monitoring highlighted in submission to the Government Inquiry. Under consideration by the Ministry of Health and Ministry of Education
	f) Undertake workforce planning with the CNIDWAU to determine future resource requirements for Drinking Water Assessors. g) Identify training requirements and implement the training programme (e.g. Health EMIS, document management).		Completed – review undertaken. Identified 2.6FTE required, recruitment underway Completed - Murray Mills, MoH Regional Emergency Management Advisor will be conducting CIMS training for DHB staff in October/November
5. Outbreak Communication Strategy	a) The DHBs communication strategy is reviewed and outbreak processes are defined to: i. Facilitate an advanced (early and proactive) communication plan that includes: i identification of all agencies that need to be informed define process for health services to identify key stakeholders and inform communications team risk assessment and decision making for communication and managing external influencing factors (e.g. local elections) identify one-voice fronting all communications (management/clinical) prepare strategic communications (e.g. video-clips)	Moderate ED of CS	Underway - Healthscape database update completed Crisis communications plan developed, to be incorporated into the EPM communication policy Emergency messaging via intranet and/or internet ability secured Surge capacity for staff agreed and documented

Recommendation	Activity	Priority	Responsibility	Progress Update Oct '17
	 ii. Promote an early announcement of outbreak communication for all stakeholders (staff and the Population) that includes: consistent messaging announcement of planned information updates iii. Enable mass communication to staff and the Population that includes: the use of technologies (e.g. text messaging) maintaining current contact directories for key staff and external stakeholders iv. The communications team need to increase capacity during events in order to manage the workload particularly with the media v. Contact database data to be updated. Contact with community pharmacy needs to be by fax initially			
6. Information and Document Management Systems	 a) A review of the EOC process for filing emergency response and recovery documents is undertaken. b) Review of cascade of information process required. c) Process for preparation of advisories and fact sheets to be investigated. d) Need a process for consistent data collection – what data, from where, how collected, presentation and surveillance process. Forecasting of data requirements would allow consistency of data presentation. e) The presentation of data needs to be agreed early. f) The DHB establishes a standardised naming convention system for all emergency management events. g) An organisation information management policy is developed and implemented in accordance with the New Zealand Archives Standard and Population Records Act 2005. 	High	ED of P&Q	Completed – process documented in EOC Manual Completed – process documented Completed – process documented Underway – discussions to be undertaken Underway – discussions to be undertaken Completed – process documented Underway – policy being drafted

	Recommendation		Activity	Priority	Responsibility	Progress Update Oct '17
7.	Guidelines for the Management of Large Scale (Outbreak) Microbiological Testing	a)	Development of national laboratory service guidelines for implementation at local level.	High	ED of S & HI	Underway - Medical Officers of Health and CEO HBDHB have written to the NZ microbiological network requesting development of guidelines
8.	Additional actions arising out of the Government Inquiry State One Findings	a.	DWAs to require water suppliers to demonstrate collaboration with HBRC so as to ensure they have a better understanding of catchment risks. DWAs also to require more holistic investigations into <i>e.coli</i> transgressions.	High	ED of S & HI	Underway - Reporting is being developed in Healthscape to show an overview of transgressions over a period of time as well as those which are currently occurring. DWA's now have regular operational meetings with water suppliers in the region and this along with annual survey (which includes a specific question about source protection) and WSP's assessments is encouraging Drinking Water Suppliers to have good collaboration with HDC. The Joint Working Group is also assisting this.
		b.	HBDHB to address critical DWA shortage			Underway – currently recruiting to positions
		c.	Implement escalation and enforcement policy			Underway - currently developing this policy. Marie Scott from the Ministry of Health is assisting.
			Manage transgressions within a drinking water reticulation as potentially due to source water contamination even if source water samples are clear			Ongoing
		e.	Work with the Ministry of Education to establish a real time school absenteeism reporting system			Underway - The need for a system to support school absenteeism monitoring

Recommendation	Activity	Priority	Responsibility	Progress Update Oct '17
				highlighted in submission to the Government Inquiry. Under consideration by the Ministry of Health and Ministry of Education
	f. Establish better information exchange processes between drinking water and communicable disease teams.			Ongoing
	 g. Develop a sustainable governance framework for the Drinking Water Joint Working Group (JWG) h. Work with the JWG to identify potential untreated self-supplied dwellings and other buildings at risk from source water contamination. Provide advice or other risk mitigation measures to those supply owners. 			Underway - Terms of Reference for a governance body (Drinking Water Joint Committee) adopted by HBDHB board. We have a draft Transgression Roles and Responsibilities procedure which includes checklists to ensure the source water is considered when determining the cause of a transgression. Water transgressions are a fixed agenda item at fortnightly Communicable Disease meetings.
				JWG allocated responsibility for the resolving self-supply issues
	 i. Ensure HBDHB has intelligence capacity to provide epidemiological forecasts. 			Ongoing – working with business intelligence & public health team

	Update on Establishing Health and Social Care Localities in HB
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: Māori Relationship Board (MRB), HB Clinical Council, HB Health Consumer Council & HBDHB Board
Document Owner/Author:	Chris Ash – ED Primary Care
Document Author	Jill Garret (Change Leader Central HB) and Te Pare Meihana (Change Leader Wairoa)
Reviewed by:	Executive Management Team
Month:	October 2017
Consideration:	For Endorsement

RECOMMENDATION

That MRB, Clinical and Consumer Council

Note the contents of this paper

PROGRESS TO DATE ON LOCALITY DEVELOPMENT

Commencement of Executive Director - Primary Care

Chris Ash has commenced in the Executive Director role and the management of the localities work has been transitioned across from Tracee Te Huia, Director of Strategy and Health Improvement.

Over the next 3 months, Chris will be reviewing the existing position of the Health & Social Care Localities programme, and defining a framework within which the DHB will structure and resource its partnership with local communities.

The goals of the revitalized programme will include supporting and enabling the development of new, integrated care and support service delivery arrangements that:

- a) Better reflect local population identities, aspirations and health models (including structured support for the skills, expertise and potential already resident in those communities)
- b) Improve access by delivering the right care (from the right professional), in the right place, at the right time
- c) Target efforts to tackle inequities in health outcomes, particularly as they impact the local populations
- d) Develop a wider set of skills and integrated working within multidisciplinary and intersectoral teams, with a focus on moving to strengths-based approaches and fostering greater personal responsibility for individual and whānau wellness

Matariki – Hawke's Bay Regional Social Inclusion Strategy (SIS) and Regional Economic Development Strategy (REDS)¹

The Matariki steering group and wider stakeholder network has developed (in draft) 10 action points.

Figure 1.0 – Draft Action 2.1 relates directly to the work underway in localities.

Lead Organisation	Councils and Hapu	Ref SI 2.1		
Other Organisations	lwi, HBDHB, MSD, Oranga Tamariki, Police, TPK,	Corrections,		
Other Organisations	Social Services Providers and Community Organis	ations		
	Establish representative groups in locations across	s Hawke's Bay		
	to enable the local community and whānau to have a voice and			
	leadership in social and economic development. The groups will			
RGP action	represent key local stakeholders, who may not be directly			
	connected to Matariki REDS/ILG and; have the capacity and			
	authority to represent their community in communi	cation with		
	Matariki REDS/ILG. (Linked to 1 and 3)			

Introduction - to tell decision makers what they will need to decide

Communities across the region want to have a say in their economic and social development. An example is a recently established group is the Wairoa Community Partnership Group, created so that key local stakeholder groups can collaborate and have cohesion around responses to be developed in Wairoa. Similar groups can be established in other areas. The areas could be large e.g. Central Hawke's Bay or smaller clustered areas based on deprivation e.g. Flaxmere, Camberley, and Maraenui. This is consistent with the Social Inclusion Strategy identifying communities for targeted support and members of the community directly contributing to outcomes.

It is proposed that there is a merge of the two Matariki strategies but at this stage those discussions are in abeyance.

The change leaders of CHB and Wairoa localities have been intermittently included in the forum that oversee and contribute to the development of Matariki SIS. In their current capacity, they are finding themselves able to contribute positively to the development of locality governance structures, and to lead and influence the direction and pace of change. The change leaders involvement in all aspects of the social inclusion strategy and the wider REDs development is key to ensuring linkages are made between operational realities and strategic direction with the locality space. Ensuring continuity of their involvement and influence should be a priority of the DHB and will make a substantial contribution to future success.

Programme Governance CHB

Representation on the health liaison group, formed in July 2016, now includes a full complement of health providers within the rohe²; GP, Council, MRB, Consumer Council, Aged Care, Māori Health Provider, Nursing, Clinical Nurse Manager, Pharmacy and independent health providers.

The maturity of the group has developed over time from a focus on operational activities to one of influence and change at a governance level. Early conversations are now being had in relation to the value of this group merging with the wider social leadership group that is also functioning in CHB. The group's representation included senior management level from MoE, MSD³, tertiary education providers, senior leaders within council and the wider social sector. As required justice, fire and police are also included.

¹ REDS – Regional Economic Development Strategy

 $^{^{2}}$ Rohe – Te Reo for designated area or region

³ Ministry of Education, Ministry of Social Development

Both groups are requesting higher level data to inform priority areas whereas in the past it had been prioritised based on reactive responses to need.

The change leader is working towards the merger of these two groups in the next 8 months in readiness for the 2018-19 financial year and the development of a 3 year strategy for the locality.

With reference to the collective impact model and the five levels of relationships, the CHB locality is transitioning from cooperation to coordination, (level 3). It is anticipated by end of 2018/19 the locality will be operating at Level 4.

Figure 1.2 – Collective Impact – progressions to effective collaboration

The Five Levels of Collaboration

	1	2	3	4	5
	Networking	Cooperation	Coordination	Coalition	Collaboration
	 Aware of organisation loosely defined roles. 	Provide information to each other.	Share information and resources.	Share ideas.	 Members belong to one system.
				Share resources.	
Relationship	 Little communication. 	 Somewhat defined 	 Defined roles. 		Frequent
Characteristics		roles.		Frequent and	communication is
Characteristics	 All decisions are made 		Frequent	prioritised	characterised by
	independently.	Formal communication.	communication.	communication.	mutual trust.
			 Shared decision 	All members have a	Consensus is reached
		All decisions are made	making.	vote in decision	on all decisions.
		independently.		making.	

Source: Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. American Journal of Evaluation, 27, 3, 383-392

Locality Governance Wairoa

There has been significant progress made in Wairoa towards establishing an effective governance model that has the buy in from local leaders and government agencies. Initially the Change Leader brought together a Health and Social Care locality group that was a combination of agency leads and local individuals who had a passion for this development however further community discussions led to the Wairoa District Council introducing a community partnerships committee model that has provided the mechanism to develop a united leadership group that has assumed the responsibility to oversee and govern agreed priorities of health, social need, education and training, employment and housing.

This committee is now in place with an approved Terms of Reference and membership of local leaders and government agency decision makers. The committee is chaired by the Mayor.

It is intended that the health and social care locality plan will become one of the work streams of a wider program of action for Wairoa. The Change Leader has a lead role in supporting the Mayor and the committee to manage the community relationships and the development of the work programme.

This development is also being informed by the progress being made by Manaaki Tairawhiti – one of the three place based social investment initiatives that is underway. The Change Leader represents Wairoa at this forum and there are positive linkages, influence and learnings from the journey that Tairawhiti is undertaking towards becoming a Social Investment Board.

ACTIVITIES AND PROGRESS IN EACH LOCALITY

CENTRAL HAWKE'S BAY (CHB)

The three areas within the strategic plan that are the current focus are;

- Reducing barriers to access
- Establishing and maintaining effective communication lines
- Strengthening trust between providers

Reducing barriers to access:

Through the influence of the Rural Alliance, uptake of funded programs offered by the PHO are now being accessed by the Tukituki Medical. The programs are aimed at the high need, high deprivation populations and include SIA funded programs, High Needs Enrolment, and Whānau Wellness.

The clinical nurse manager of CHB Health Center has created pathways for transitioning care from Hastings Hospital to the health center on identification of CHB inpatients with a level of acuity able to be managed. Evidence continues to be gathered to monitor; bed utilisation rates, average length of stay with metric analysis against readmission rates. This will contribute to the 'Saving 4000 bed days target and the System Level Measure – Using Health Resources Effectively.

Establishing and maintaining effective communication lines:

Signage and communication has been a priority for the health liaison group from inception. October 3rd is the launch date for the; distribution of magnets and flyers that outline for the consumer how to access urgent and emergency care relevant to CHB residents. In addition signage has been erected within Waipawa and Waipukurau. All of the material aligns to the DHB Choose Well Strategy.

This project has required significant coordination to achieve agreement and buy in of the health providers. It has served the purpose of illustrating the importance of establishing and maintaining effective communication and relationships between the extensive health network as the foundation for future and more significant work.

The Social Leadership forum of CHB is also using the launch for the material above to trial a survey that will be used to evaluate the responsiveness of social services within CHB. This is the beginnings of the work that is coming together for both groups as indicated above under strategic leadership.

Figure 1.0 – Magnets to be distributed to every household in CHB (n=5000)



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Live Well in CHB is the brand that the Health Liaison group is using to identify the work that they are leading. In conjunction with the CHB District Council it was decided that this branding aligns with the council's strategy of "Thrive in CHB".

Strengthening trust between providers:

The increased membership- representation on the Health Liaison Group, the consistent attendance of meetings, the interest in new projects and the multi-agency involvement in those projects are all testament to the trust and confidence that is building between the providers within CHB (health and the wider social sector).

Projects currently being scoped:

- Extension of the engAGE program to include CHB a meeting was held between the Health Liaison group and the engAGE team to discuss the work that needs to be done to replicate the program within CHB, utilising existing resources and services that are working well and augmentation of services that are currently not available.
- Creation of an LMC Hub in CHB the Health Liaison group met with Jules Arthur to discuss the option of creating a hub serviced by local midwives and support workers for the benefit of the population of CHB.
- Both the Health Liaison group and the CHB Social Leadership forum are currently gathering data around the prevalence and influence of methamphetamine on the community of CHB. The intention is to scope a community based response supported by multi agencies.
- Population health and work place wellness the population health team is working on a response to creating a 'large employer' workplace wellness strategy for CHB. Initial work is underway with Silver Fern Farms, in partnership with Worksafe NZ and ACC.
- Increased utilisation of Telehealth (VC- access to outpatient and specialist input) for the
 residents of CHB is being looked at by the DHB IT team for both CHB and Wairoa. The use of
 Telehealth and virtual clinics as a mechanism for outreach provision of GP services is being
 scoped as part innovation within the CHB Rural Alliance annual plan.

> WAIROA

One of Wairoa's strongest assets is its people and the tikanga that underpins the fabric of Māori whānau and the community. The future success of any health and social transformation will need to include a strategy that encompasses the utilization of tikanga principles and values. In 2016 five Wairoa health leaders attended the NUKA training at the DHB. This group intends to utilize the learnings and experience taken from this indigenous development to support the shape and design of a tikanga based model of health care for Wairoa.

Integration activities

Ongoing activities are progressing across the General Practice Alliance network. February 2018 will see all three practices co-located on the Wairoa Health Centre site providing more opportunity for integration and consistency to occur.

Queen Street Practice, Kahungunu Executive and Te Whare Maire o Tapuwae are undertaking a "20 families" project to support the development of a one team approach to care. The cohort of patients will be those identified through general practice as pre-diabetic and a whānau led plan will be developed with each patient and their whānau, utilizing the clinical, health promotion and whānau ora skills and resources across the three providers. It is intended that the evaluation of this project will support further integrated practice across the wider health system.

A nursing review is in initial stages of planning as secondary, primary and community services are interested in further developing the rural health nursing model that enables strengthened nursing leadership in the pathways of care. This will provides further opportunity in the design of achieving a well-coordinated and one system of health care.

A co-design process is underway to develop a model for Health of Older Persons which will include introducing a variation of the Engage model into Wairoa. Key stakeholders in this process includes the Wairoa Health Centre, DHB strategic services, EngAGE, Glengarry BUPA, Aged Concern, Kahungunu Executive, Cranford Hospice and a local group of consumers and whānau.

Collaboration

The E Tu Wairoa (family violence intervention network) is making good headway with embedding the E Tu Whānau leadership model and values and have been chosen as one of the 3 communities to be involved in a national evaluation of our development and progress.

The integrated Clinical Governance committee is overseeing a major research study- He Korowai Manaaki – A Wrap Around Approach that is being undertaken by the Women's Health Research Centre University of Otago and continues to build its profile for clinical leadership in Wairoa and Hawkes Bay.

The Change Leader is working with Oranga Tamariki, Police and the DHB to establish a single triage system for referrals where there are family harm and care and protection issues. This is being modelled on a system that is already established in Tairawhiti with a view to utilizing the privacy framework and data sharing protocols.

Recommendations

The work in both of the localities is progressing well, each are well placed to embed the initiatives that are currently underway and those being scoped. It is timely that the following recommendations are addressed:

- Creating natural synergies between district and locality specific strategic direction.
- Creating formal mechanisms that link REDS⁴ and SIS⁵ with the locality work of the DHB through the roles of the change leaders
- Resourcing the coordination and administration of the work underway within each locality to free up the change leaders to operate strategically.

-

⁴ Regional Economic Development Strategy

⁵ Social Inclusion Strategy

	Implementing the National Bowel Screening Programme in Hawke's Bay
HAWKE'S BAY District Health Board Whakawāteatia	For the attention of: Māori Relationship Board, HB Clinical Council, HB Health Consumer Council & HBDHB Board
Document Owner:	Chris Ash, Executive Director of Primary Care
Document Author:	Paul Malan, Strategic Service Manager
Reviewed by:	Dr. Alan Wright, Chair, Hawke's Bay Bowel Screening Programme Advisory Group and Executive Management Team
Month:	September 2017
Consideration:	For Information

RECOMMENDATION

Māori Relationship Board, Clinical and Consumer Council & HBDHB Board:

Note the contents of this report.

OVERVIEW

The establishment of a National Bowel Screening Programme (NBSP) has been considered in New Zealand for a number of years. Budget 2016 provided funding to begin implementation of the NBSP. This will cover the design, planning and set-up phases. Additional funding has also been set aside for work that will support the IT needed for a national programme¹. Over the next year, the Hawke's Bay health sector will implement the NBSP locally. This paper is preliminary advice to governance committees about the anticipated process and timelines.

BACKGROUND

A screening pilot was launched in 2011 in Waitemata DHB, and subsequent evaluations were carried out to confirm the New Zealand approach. Waitemata DHB are now providing support and 'national coordination' functions as the national programme is being established. It is expected that a national coordination centre will be established by 2018 to manage and send screening invitations and coordinate the processing, analysis and management of completed bowel screening test results.

Hawke's Bay (HB) will need to be ready for commencement of the programme in October 2018, with systems and processes. This will coincide with completion of the new gastroenterology unit at Hawke's Bay Regional Hospital (Soldiers Memorial). New systems and processes will be in place to deliver more colonoscopies, provide clinical leadership, ensure patients are notified of results, ensure workforce capability matches requirements, provide quality assurance, maintain an equity focus and to understand and plan for the impact on surgical services, primary care and community services.

Page 1 of 2

¹ Ministry of Health: National Bowel Screening

New Zealand has one of the highest bowel cancer rates in the world. Bowel cancer is the second most common cause of cancer death in New Zealand after lung cancer. The screening programme aims to detect cancers earlier so as to provide better options for early and minimally-invasive treatments.

TIMELINE

An advisory group, with wide stakeholder representation (Appendix 1), has been set up to guide the implementation. There will be two main "phases":

Phase 1 – September 2017 to February 2018: Contribute local (Hawke's Bay) content to a business case for the Ministers of Finance and Health, who will approve the funding for the programme in Hawke's Bay.

Phase 2 – February 2018 to November 2018: Planning and establishment to implement the NBSP in Hawke's Bay. This phase includes establishing the systems and processes, completing production planning, engaging with all stakeholders, communicating with the community, integrating and testing all systems to ensure a smooth implemention, and linking in with the relevant national and regional entities.

The Advisory Group will register a project for the completion of Phase 1 and 2. Go-live is expected to be in October 2018.

FURTHER INFORMATION

For further information about the National Bowel Screening Programme please visit the Ministry of Health website at: www.health.govt.nz

ATTACHMENTS

• Appendix 1: Hawke's Bay Bowel Screening Programme Advisory Group

HAWKE'S BAY BOWEL SCREENING PROGRAMME ADVISORY GROUP

As at 14th September, 2017

The Advisory Group will be comprised of representatives of impacted services:

- General Practice (Alan Wright)
- Clinical Director, Gastroenterology (Malcom Arnold)
- Executive Leadership (Andrew Phillips)
- Executive Director Quality and Risk (Kate Coley)
- Chief Information Officer (Anne Speden)
- Acting Head of Strategic Services (Paul Malan)
- Nursing Director (Chris McKenna)
- HHB PHO representative (TBA)
- General Practice Nurse (TBA)
- Manager of Population Health (Jenny Cawston)
- Manager of Medical Directorate (Paula Jones)
- Manager of Surgical Directorate (Rika Hentschel)
- Manager of Community Directorate (Claire Caddie)
- Manager of Cancer Services (Mandy Robertson)
- Maori representation (Patrick LeGeyt)
- Pacific representation (Talalelei Taufale)
- Pharmacy and Laboratory Portfolio Manager (Di Vicary)
- Administration support (TBA)

The Advisory Group may co-opt other members from time to time as required, to address gaps in knowledge and/or expertise, and to contribute to deliberations on specific agenda items. Advisory membership may not be delegated in the event of a member's absence. If a member is absent from three consecutive meetings that member can be removed and another can be elected/appointed in their place.



Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

- 17. Minutes of Previous Meeting (Public Excluded)
- 18. Matters Arising Review of Actions (Public Excluded)
- 19. Serious Adverse Events Annual Report to HQSC
- 20. Member Topics of Interest Member issues / updates

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).