Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 11 October 2018**

Meeting: **4.00 pm to 6.00 pm**

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

Council Members:

Rachel Ritchie (Chair)
Malcolm Dixon (Co-Deputy Chair)
Dr Diane Mara (Co-Deputy Chair)
Sami McIntosh
Deborah Grace
Jenny Peters
Olive Tanielu
Jim Henry
Sarah Hansen
Dallas Adams
Jemma Russell
Wayne Taylor
Les Cunningham
Gerraldine Tahere
Denise Woodhams

Apologies:

In Attendance:

Ken Foote, Company Secretary (Co Sec)
Kate Coley, Executive Director – People & Quality (ED P&Q)
Caryn Daum and Nancy Barlow – Consumer Experience Facilitators
Debs Higgins, Clinical Council Representative
Linda Dubbeldam, Health Hawke's Bay Representative
Tracy Fricker, Council Administrator / EA to Executive Director People & Quality

Public

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	4:00
2.	Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting	
5.	Matters Arising – Review Actions	
6.	Consumer Council Workplan	
7.	Chair's Report (verbal) – Rachel Ritchie	
8.	Youth Consumer Council Report (verbal) – Dallas Adams	
9.	Consumer Engagement Report (verbal) – Kate Coley	
10.	Clinical Governance Committee Representative Feedback - Terms of Reference	
	Section 2 – Presentations	
11.	IS Presentation – Anne Speden	4.30
12.	Clinical Services Plan (presentation & discussion) – Ken Foote	5.00
	Section 3 – Discussion	
13.	National Bowel Screening Programme, Indicative Equity Outcomes in Māori and Pasifika (Verbal) – Chris Ash	5.30
14.	Role of Consumer Representatives – Ken Foote	5.40
	Section 4 – Information Only (no presenters)	
15.	Te Ara Whakawaiora - Cardiovascular (National Indicator)	-
16.	**Section 5 - Recommendation to Exclude**	-
	Section 6 – General	
17.	Minutes of Previous Meeting	5.50
18.	Topics of Interest – Member Issues / Updates	
19.	Karakia Whakamutunga (Closing)	6.00

NEXT MEETING:

Thursday, 14th November 2018, 2.00-4.00 pm

Wednesday, 5th December 2018 – Joint Meeting with Clinical Council
Education Centre, Canning Road, Hawke's Bay Hospital (TBC)

Interest Register

Hawke's Bay Health Consumer Council

Jul-18

Name **Consumer Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Rachel Ritchie (Chair)	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Malcolm Dixon (Deputy Chair)	Hastings District Councillor Scott Foundation HB Medical Research Foundation Inc	Elected Councillor Allocation Committee Hastings District Council Rep		No No No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.
Deborah Grace	Isect Ltd	Director	IT Security Awareness	No	
Dr Diane Mara (Deputy Chair)	Napier Family Centre IHC Hawke's Bay Association Pacifica Women's Tiare Ahuriri Branch (Inc)	Chair Chair Branch Chair	Social Service Organisation Disability Intellectual Stakeholder Development Leadership for Pacific Women	Yes No No	Perceived/possible conflict as NFC has a small contract for PND from HBDHB
Denise Woodhams	Nil to declare				
Geraldine Tahere	Nil to declare				
Les Cunningham	Stroke Central Inc	Employee / Field Officer	Working with stroke patients and clients	No	
Wayne Taylor	Nil to declare				

MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL
HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD
CORPORATE OFFICE ON THURSDAY, 13 SEPTEMBER 2018 AT 4.05 PM

PUBLIC

Present: Rachel Ritchie (Chair)
Dr Diane Mara (Co-Deputy Chair)
Malcolm Dixon (Co-Deputy Chair)
James Henry
Sarah Hansen
Deborah Grace
Wayne Taylor
Jemma Russell
Sami McIntosh
Les Cunningham
Jenny Peters
Olive Tanielu
Gerraldine Tahere
Denise Woodhams

In Attendance: Kate Coley, ED People and Quality
Ken Foote, Company Secretary
Debs Higgins, Clinical Council Representative
David Rodgers, GP; Health HB Advisor; and member of HB Clinical Council
Shari Tidswell, Intersectoral Development Manager with HBDHB
Brenda Crene

Apologies: Dallas Adams

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

Rachel Ritchie (Chair) welcomed everyone to the meeting. A karakia/reflection was provided to by James Henry to open the meeting.

2. APOLOGIES

An apology was noted from Dallas Adams and Ken Foote (non-member).

3. INTERESTS REGISTER

No conflicts of interest noted for items on today's agenda.

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held on 8 August 2018 were confirmed as a correct record of the meeting.

Moved by Wayne Taylor and seconded Deborah Grace
Carried

5. MATTERS ARISING AND ACTIONS

Item 1: IS Update / Workshop
On workplan – Action can be removed

Item 2: Consumers on Projects
Deferred until new Consumer Experience staff are in place.

Item 3: Using Consumer Stories
On the workplan for the October meeting – Action can be removed.

Kate Coley updated members around what other DHBs are doing in the area of Consumer Stories. Some are using stories in video and written form for education and staff training purposes. Some stories have been used at the Governance level but this has not been found helpful as most/if not all consumer stories are for issues/matters best addressed at an operational level for service improvement. A number of DHBs don't use consumer stories at all but are thinking about it.

It is important to recognise there is a need to be sure about the purpose of the story 'for the particular receiving group'.
It is important to remember this is all about learning from, and not dismissing any story being told. The story reflects how the consumers feel and something needs to be done about it!

Item 4: Consumer Council Annual Workplan
Item 13 on Consumer Council agenda – Action can be removed.

Primary Care – PHO arm Consumer input:

Action: A query arose relating to a group involving consumer input under Primary Care /PHO arm. The question will be framed by Jenny and Malcolm prior to being emailed to Chris Ash directly. This will be brought back to the next meeting only if there is a need.

6. CONSUMER COUNCIL WORK PLAN

The work plan provided in the meeting papers were noted.

7. CONSUMER ENGAGEMENT UPDATE

Kate Coley provided brief update around the two new Consumer Experience Facilitator positions advertised on 31 August 2018. Two appointments have now been made. Karen the current Complaints Advisor (within the DHB) and will likely commence in mid October; the other confirmed appointment is Nancy Barlow who has experience in working for ACC and will bring other skills into the role also and will commence on 24 September.

An overview of roles will be relayed to the organisation and time will be needed to enable the new appointments to get their feet under the table.

Consumer Experience Committee reporting to Clinical Council will be framed up with the assistance of Ken Foote and Hayley Turner.

An implementation plan is being drafted for Person and Whanau Centred Care, and a meeting will be set up.

Have been advised by HQSC of a Symposium running at Te Papa on 5 October. Detail will be emailed out to consumers following this meeting. Noted the content appears to be more around patient safety.

8. CHAIR'S REPORT

Rachel Ritchie provided an update on activities and information for Council:

- The Primary Care Development Partnership (PCDP) is a new initiative and had a good positive feel.
- At the Clinical Council Meeting the day prior, Rachel asked members to start thinking about, relative to their respective areas, around Person & Whanau Centred Care (PWCC) and the elements required. The 'Consumer Experience Committee', is where the work up will occur. Seeking the types of things they see as useful to ensure the approach of PWCC is well socialised. Currently PWCC has been spoken about in governance areas mainly. Dr Russell Wills provided an example of a feedback tool. We will now build a repertoire of what tools are currently being used. This is being prepared by Kate Coley.
- Likely to meet with the Regional Consumer Council group. Graeme Norton (the first Chair of HB Health Consumer Council) has gone on to focus on building the consumer voice within DHBs nationally. Funding has and still remains a problem (via MoH and HQSC). They are now looking at funding this at CEO DHB level, as we do need a National voice ie, Consumer Councils throughout New Zealand, especially in the 'equity' area.
- HB Health Awards are coming up. Generally there is a feeling by the organisers that a Consumer voice as well as a Clinical voice should be better utilised. This will likely be implemented in 2019. Rosemary Marriott is the consumer judge – same as last year.
- Rachel will be talking with Jill Garrett regarding ASH rates, asking whether a consumer voice had been utilised when formulating the next steps.

Comments from the other members included:

- Nothing has changed within reports, when looking back over papers since HB Health Consumer Council began. We get to a stage now that Council should insist that we only accept papers that have had the **lens of Pasifika, Disability and Maori** over them. Do we bring this to the writers' attention as they are probably unaware, or take it up to the Board.
- How can we be sure the writers of reports take on board and include feedback from the committees as a further copy is not provided after the comments are made? Never sure if that has been done or actioned – feel the communication loop is not closed. From "'conceptualisation to realisation' we want to see if what is spun up in the air has landed on the ground!
- The same goes for the Pasifika community, everything is up in the air but when it comes to reality, nothing has been done which is a real shame after all these years.

9. YOUTH CONSUMER COUNCIL (YCC) REPORT

Jemma Russell provided an update opening and closing in Māori. She again conveyed Dallas Adam's apology.

Dallas had provided an email in which he acknowledged Ken Foote, Rachel, Marie Beattie and Jemma for their time on YCC's future direction and strategy plan. The Youth Consumer Council ToR outlines an enhancement strategies which will ultimately bring forth further traction and progress.

He advised of a forthcoming event YCC will lead is a **Suicide Awareness and Prevention Workshop on Wednesday 14 November on campus at EIT, Taradale**. A first for HB, this will showcase speakers such as Mike King and Rob Mokaraka. HBDHB Suicide Prevention Co-ord, Kerry Gilbert is helping YCC bring this event to fruition. This will be community driven and include other youth organisations, Police, HBDHB, EIT, YMCA, Directions Te Kupenga Hauora, and Taiwhenua. Consumer Council members are invited to attend and there is an open invitation to the community. Details will be finalised at the October Consumer Council Meeting.

Jemma reported on her attendance a month prior at the **'Involve Conference'** with the theme "Me hoki whakamuri, kai ahu, whakamua kaneke" – Looking back to move forward. What has / hasn't worked.
Dr Michelle Johansson – Michelle's research is creative, collaborative and Pasifika performance based. Through spoken work, music and dance she tells a story about her Creative PhD journey, supported and joined by music director, choreographer of the Black Friars, an Auckland based theatre group.

On the final day of the Conference the keynote speaker Dr Michelle Johansson noted her korero which resonated with Jemma. There were 10 pieces of advice when working alongside young people, Jemma shared her top 5:

1. ***"Raise the bar** – respect young people enough to expect their best, and when they bring to you less, say this is not enough, not …. You are not good enough, they have been told that enough and they are tough and it is rough but the stuff they are made of is enough.*
2. ***Believe** unfailingly in their limitless potential*
3. ***Laugh** – in laughter this is power and in humour there is humility.*
4. ***Be the grown up and own up** when you are wrong – be strong enough to fail sometimes, to ask for help sometimes, be fellable, be malleable, take the shape of the too that's needed, because ako means if they're not learning you are not teaching, and if nothing ever changes, nothing ever changes.*
5. ***You will hear stories of failure**, it is your duty to tell a new story, don't let that stuff happen again on your shift."*

As this is Maori language week … "*be encouraged to speak Māori whether it be small or whether you can speak it fluently. If you make a mistake, it's okay*!"

Members thanked Jemma for the report and also acknowledged the great contribution she had made to the Clinical Services Plan.

Additional Paper:
YOUTH CONSUMER COUNCIL REPORT AND UPDATED TERMS OF REFERENCE

The purpose of this report to seek Council approval on the future role, structure, functions, activities and support for the Youth Consumer Council (YCC).

The development plan prepared initially for discussion and now for approval includes:

- Update the YCC ToR to reflect:
  - Younger and wider membership (age 16-24 years)
  - Flexibility in meetings and communication
  - Enhanced HBDHB support
- Appoint current YCC Chair (Dallas) as a member of HB Health Consumer Council in his own right (to a current vacancy), and support him to facilitate and mentor 'new younger' leadership and membership of YCC.
- Facilitate wider engagement with HB youth health and community groups (eg Directions and YMCA), to encourage membership, participation and relationships with YCC.
- Facilitate the development of a YCC Plan that will inform/support the HBDHB Youth Health Strategy and address the priority health issues facing HB youth
- Review technology and communication options in general use by youth, that can be used to enable enhanced engagement and participation, thereby minimising the need for face to face meetings

Given that YCC is a 'committee' of HB Health Consumer Council, it is appropriate for Council to consider and approve the ToR changes and the recommended development plan, so that work can commence to implement these to gain the benefits anticipated.

Council noted the contents of this report and approved the updated Terms of Reference and the associated development plan for the Youth Consumer Council (YCC)

Moved by Wayne Taylor and seconded by Deborah Grace
Carried

One of the newly appointed facilitators will work alongside the Youth Consumer Council in future, together with Marie Beattie (Portfolio Manager, Integration).

Enhancing and broadening the scope of Youth Council's membership was discussed with suggestions to consider including: secondary school students, the unemployed, Pasifika Church groups, sports team members, and Flaxmere has a local Youth Council which may be worthwhile tapping into.

SECTION 2: PRESENTATIONS

10. AFTER HOURS URGENT CARE (6 month update)

The Chair welcomed David Rodgers (GP, member of Clinical Council and adviser to Health HB) to the meeting to discuss his paper. David was particularly interested in receiving guidance and input from consumer members around after hours urgent care going forward.

As noted in the paper the initiated system covered in the report had been operational for 9 months and had not performed as envisaged with no drop in attendances to the Hospital's Emergency Department.

It was acknowledged that the system had been pulled together hastily in response to contractual matters (to provide back to back services). It was difficult for the group to grapple with equity, access and running a General Practice business.

The 0800 number was manned by nurses and callers were given options which included an appointment with a Doctor the following day. David advised that the scope of practice nurses within General Practise has been expanded to dispense drugs. Nurses provide a free service in many practices.

Comments/Feedback:

- Consumer feedback was important at the outset but did not occur
- Make it cheaper after hours and have more nurses available.
- No system was put in place in place to obtain feedback, or follow up undertaken to obtain data on follow up appointments (whether they were attended or not, and if not – why not?).
- There was **no equity** and a **number of access** issues within the model put in place.
- The service offered appeared too sophisticated, too costly and far too confusing for consumers. It was clarified that the cost for a St Johns paramedic call-out would have been prohibitive to many at $65. As is the cost of an ambulance transfer to hospital. If attending other than your normal doctor a higher fee would have been incurred (through the current funding model).
- Communication at the outset was lacking and not done well.

SECTION 2: DISCUSSION

11. MATARIKI REGIONAL DEVELOPMENT AND SOCIAL INCLUSION STRATEGY (6 month update)

Shari Tidswell was not in attendance.

This is a long term cross sector piece of work with HB agencies. It will continue to take time to make progress and has hit some speed bumps as consumer engagement was an issue.
Business HB has taken over leadership of the group and are appointing a General Manager and will provide the administration support. The social inclusion vision paper has been completed but

not approved. Now rejuvenated with CHB and Wairoa involved also to become a regional platform. They may request common funding or apply for separate funds (by organisation). Currently the Provincial Growth Fund is understood to be funding feasibility studies.

There was brief discussion around Ngati Kahungunu (NKII) treaty settlements as it was noted that NKII is a big player. How does that relate to the social inclusion aspect? Is there a connection as Māori involvement is not visible.
Advised there are 5 Iwi groups involved in Matariki and Ngahiwi Tomoana is involved.

12. CLINICAL SERVICES PLAN (CSP)

In Ken Foote's absence, Kate Coley advised that feedback on the Clinical Services Plan closes on 31st October at noon. Information packs have been issued by email to share with your networks and your friends and family also should be encouraged to have their say.

Action: ***Individually at CSP feedback sessions consumer members have provided their input. It was decided however the Consumer Council as a group would provide joint feedback. This would be done via email amongst members, giving them time to reflect. Close off date is 31 October 2018.***

Comments/Feedback from individual members:

- P 32-33 bottom line we will need to create a learning innovative culture. Incorporate the value and behaviours in everything we do. Being respectful and being respected.
- Did not feel there was enough Person and Whanau Centred Care in the document.
- Never achieve change in services unless you have the culture of the organisation right and PWCC operationally embedded. Need to get the heart of the organisation and the sector connected.
- Feedback maybe on prioritising the nine themes noted in the presentation provided with the papers, if in fact they are included in that form in the actual draft CSP?
- The hope is that the organisation becomes more change agile and we see the change on the ground.

In addition an implementation document will developed to provide the detail. How the plan is implemented is far more important.

13. CONSUMER COUNCIL ANNUAL PLAN 2018/19

The plan had been updated and provided to members with the September papers, for approval

Consumer members approved the Annual Plan 2018/19
Moved by Wayne Taylor seconded by Deborah Grace
Carried.

Council feel the need to understand the consumer experience measures that are currently in use in the system. In the future the Patient Experience Committee will be reviewing the measures.. We have had some of them provided at Consumer Council from time to time but need to get confidence around the table that the measures are appropriate and that the the loop is closed, so that change is made following the feedback.

Consumer Council Members Portfolios / Committee Representation
Areas of Interest (for current Consumer Members) was updated - each member advised of their area of interest:

Women's health	Sami, Olive
Child health	Sami, Malcolm, Rachel

Youth health	Dallas, Jemma
Older Persons health	Jenny, Denise, Les, Sarah
Chronic conditions	James. Rachel, Les, Denise
Mental Health	Deborah, Sami, Geraldine
Alcohol and other drugs	Dallas, Les, Geraldine, Jemma
Sensory and physical disability	Sarah, Les
Intellectual and neurological disability	Olive, Diane, Les, Denise
Rural health	Deborah, Wayne
Māori health	James, Sami, Jemma, Geraldine, Wayne
Pacific health	Olive, Sami, Diane
Primary health	Jenny, Wayne, Denise, Les
High deprivation populations	Jenny, James, Denise, Sami, Geraldine, Olive, Jemma

Existing Active Groups and associated Consumer Representatives remain the same, utilising the services of the named members.

In the past Consumer Council received a number of requests for input and assistance, and it was difficult to manage with existing members at the time. Of late this has slowed and part of the reason related to the departure of the Consumer Engagement Manager. It is anticipated these opportunities will be activated with the new appointments (once they settle). New members should not feel as though they are missing out as there will be plenty of opportunities but if you are passionate and wish to be involved in any of the groups at the top of page 37 of the papers, please advise the Chair. ***Action***

14. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

Due to lack of time no updates were provided at the meeting.

The following update around the **Disability Strategy had been sent through by Diane Mara.**

I am pleased to report that the meeting went well this morning. Good to have Heather and Terry still involved. We now have some plans going forward. At our next meeting on Friday 12 October we will be matching the National Disability Strategy with a Draft DHB Strategy which will become an umbrella for development of DHB HB priorities and inclusive practices and outcomes. I am committed to having disability groups and advocates being involved and visible in the two forthcoming pieces of work: Clinical Services Plan and the Consumer Engagement Strategy. I can report next Consumer Council meeting but just thought I would let you know we are now progressing. I did a bit of "pushing" of course but what I think will be important going forward is knowing we had access to consumer engagement support (still being appointed?) as soon as possible plus what input will Consumer Council have in the development of the consultation processes/forms of consultations. I am not sure whether Shari understood that our Disability Strategy group is a sub-committee of the Council. Good progress now.

Advised by Sami McIntosh would be a Hikoi promoting Te Rao Maori and Health which would be coming from Camberley and likely to conclude at the front of the Hospital.

15. RECOMMENDATION TO EXCLUDE

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

16.1 Minutes of Previous Meeting (public excluded)

The meeting closed at 6.15pm.

Confirmed: _____
Chair

Date: _____

HB HEALTH CONSUMER COUNCIL - MATTERS ARISING (Public)

5

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	12/09/17	**Consumers on Projects** List of projects requested by Consumer Members (spreadsheet).	Chair / K Coley	TBC	Deferred until new CE Staff in place
2	13/9/18	**Primary Care – PHO Consumer input** A query arose and would be emailed to Chris Ash directly. The question will be formulated by Jenny and Malcolm and would only come back to Consumer Council if there is a need.	J Peters and M Dixon	Oct	
3	13/9/18	New Consumer members are most welcome to put their names forward to the Chair, if they wish to be part of existing project/work in progress, as noted on the top of page 37 in the September meeting papers.	W Taylor, G Tahere, D Woodhams, L Cunningham	Sept-Oct	
4	13/9/18	**Group Consumer Council feedback on the Clinical Services Plan**: This will be formulated by email amongst members noting the close off date 31 October 2018.	Consumer members	By Oct 31st	

Consumer Council Workplan as at 3 October 2018 (subject to change)	**EMT Member**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**F R A C Meeting date**	**BOARD Meeting date**
Alcohol Harm Reduction Strategy (6 monthly update) Nov-May-Nov-May	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18)	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Clinical Services Plan in final form (Summary)	Ken Foote	14-Nov-18	15-Nov-18		28-Nov-18
Health Equity Report	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
National Bowel Screening Programme, Indicative Equity Outcomes in Māori and Pasifika	Chris Ash	14-Nov-18	15-Nov-18		28-Nov-18
Te Ara Whakawaiora REVIEW	Patrick LeGeyt	14-Nov-18	15-Nov-18		28-Nov-18
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	Chris Ash	14-Nov-18	15-Nov-18		28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-Nov) each year Board action Nov 17	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Violence Intervention Programme Presentation Committees reviewed in July - once progress made, come back	Colin Hutchison	14-Nov-18	15-Nov-18		28-Nov-18
Maternal Wellbeing Programme Update (Board update action 25/7)	Patrick LeGeyt	5-Dec-18	6-Dec-18		19-Dec-18
Mobility action plan implementation - progress update on the phases	Andy Phillips	5-Dec-18	6-Dec-18		19-Dec-18
People Plan (6 monthly - Dec, Jun)	Kate Coley	5-Dec-18	6-Dec-18		19-Dec-18
Te Ara Whakawaiora - Improving First Specialist Appointment Access (previously did not attend)	Colin Hutchison	5-Dec-18	6-Dec-18		19-Dec-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Andy Phillips	5-Dec-18	6-Dec-18		19-Dec-18
Consumer Engagement Strategy Implementation Plan and presentation. Effectivenss of the strategy via regular reporting to be confirmed to Board. (previously Nov 18 now Feb 19)	Kate Coley		14-Feb-19		27-Feb-19
Ngatahi Vulnerable Children's Workforce Development - annual progress Feb 19	Colin Hutchison	13-Feb-19	14-Feb-19		27-Feb-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	Chris Ash	13-Feb-19	14-Feb-19		27-Feb-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	13-Mar-19	14-Mar-19		27-Mar-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-Mar	Andy Phillips	13-Mar-19	14-Mar-19		27-Mar-19
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Chris McKenna	13-Mar-19	14-Mar-19		27-Mar-19

CHAIR'S REPORT

Verbal

YOUTH CONSUMER COUNCIL REPORT

Verbal

CONSUMER ENGAGEMENT REPORT

Verbal

CLINICAL GOVERNANCE COMMITTEE REPRESENTATIVE FEEDBACK

Verbal

TERMS OF REFERENCE

CLINICAL GOVERNANCE

CONSUMER EXPERIENCE COMMITTEE

SEPTEMBER 2018

Purpose	Oversee the development and implementation of strategies, systems, policies, processes and actions that will contribute to the continuous improvement of consumer experience within the HB health system.
Functions	• Lead and promote a culture of continuous improvement of consumer experience within the HB health system • Consult as necessary to develop and recommend an overall integrated strategy for improving consumer experience • Develop, enhance and confirm appropriate systems and surveys to be used to gather indicators of consumer experience • Agree targets, monitor and analyse consumer 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 • Ensure decisions and recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety and experience of care for individuals; improved health and equity for all populations; best value for public health system; and improved experience of providing care)
Level of Authority	The Committee reports to, and has the authority to provide advice and recommendations to, the Hawkes Bay Clinical Council and Hawkes Bay Health Consumer Council. 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 consumer 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 a minimum of two members from each of the two Councils plus one other member
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 consumer experience survey information Decision making at meetings shall ideally be based on consensus
Reporting	A report shall be submitted to the Clinical Council and Consumer 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 both Councils.
Minutes	The minute secretary shall be a Consumer Experience Facilitator. Minutes and action plans will be circulated to all members within one week of the meeting taking place.

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TERMS OF REFERENCE

CLINICAL GOVERNANCE

CLINICAL EFFECTIVENESS & AUDIT COMMITTEE

September 2018

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 • Ensure decisions and recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety and experience of care for individuals; improved health and equity for all populations; best value for public health system; and improved experience of providing care).
Level of Authority	The Committee is appointed by, and is accountable to, the Hawkes bay Clinical Council. The Committee has the authority to provide advice and recommendations to the Clinical Council. To assist it in this function the Committee may: • Request reports and presentations from particular groups • Require Committee Advisory Groups (and/or establish other sub-groups) 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 a majority of the members appointed at the time
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)

2

	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.

OURHEALTH HAWKE'S BAY Whakawateatia

TERMS OF REFERENCE

CLINICAL GOVERNANCE

PATIENT SAFETY & RISK MANAGEMENT COMMITTEE

September 2018

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 • Ensure decisions and recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety and experience of care for individuals; improved health and equity for all populations; best value for public health system; and improved experience of providing care)
Level of Authority	The Committee is appointed by, and is accountable to, the Hawkes Bay Clinical Council. The Committee has the authority to provide advice and recommendations, to the Clinical Council. To assist it in this function the Committee may: • Request reports and presentations from particular groups • Require Committee Advisory Groups (and/or establish other sub-groups) 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 a majority of the members appointed at the time
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.

2

	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.

TERMS OF REFERENCE

CLINICAL GOVERNANCE

PROFESSIONAL STANDARDS & PERFORMANCE COMMITTEE

September 2018

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 • Ensure decisions and recommendations are consistent with the healthcare quadruple aim (the simultaneous pursuit of improved quality, safety and experience of care for individuals; improved health and equity for all populations; best value for public health system; and improved experience of providing care).
Level of Authority	The Committee is appointed by, and is accountable to, the Hawkes Bay Clinical Council The Committee has the authority to provide advice and recommendations, to the Clinical Council. To assist it in this function the Committee may: • Request reports and presentations from particular groups • Require Committee Advisory Groups (and/or establish other sub-groups) 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 Hawke's Bay District Health Board or Health Hawke's Bay Ltd.
Membership	**Membership** • Chief Medical & Dental Officer - Hospital (CMDO) • Chief Medical Officer - Primary Care • Chief Nursing & Midwifery Officer (CNMO) • Chief Allied Health Professions Officer • Executive Director People & Quality (or delegate) • Chairs (or delegate) of Relevant Advisory Groups: ▪ SMO Credentialling ▪ Nursing & Allied Health Credentialling ▪ Allied Health Professions ▪ Hawke's Bay Nursing & Midwifery ▪ Resident Medical Officer Training ▪ Hawke's Bay Clinical Research • Consumer Council representative • Senior Advisor Cultural Competency **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 a majority of the members appointed at the time
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 at times and in locations that suit the membership. Decision making at meetings shall ideally be based on consensus
Reporting	Advisory Groups reporting to the PS&PC will provide their previous meeting minutes (to be included on the quarterly agenda) along with a verbal update from each chair at the quarterly meeting. 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 EA to the CNMO and CMDO-Hospital. Minutes and action plans will be circulated to all members within one week of the meeting taking place.

Information Services

Presentation

CLINICAL SERVICES PLAN

Presentation & Discussion

NATIONAL BOWEL SCREENING PROGRAMME, INDICATIVE EQUITY OUTCOMES IN MĀORI AND PASIFIKA

13

Verbal

ROLE OF CONSUMER REPRESENTATIVES

Verbal

14

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Cardiovascular Report**
	For the attention of: **Māori Relationship Board, HB Clinical Council HB Health Consumer Council and the HBDHB Board,**
Document Owner	John Gommans, CMDO - Hospital
Document Author(s)	Paula Jones, Service Director
Reviewed by	Executive Management Team
Month/Year	September 2018
Purpose	For Information
Previous Consideration Discussions	Regular report to EMT, MRB, Clinical Council and Consumer Council for their information.
Summary	There has been a challenge within the central region in meeting the access to angiography indicator for our total population and for Maori due to CCDHB's limited ability to meet regional demand. It is doubtful that Hawke's Bay will meet these indicators without development of a local interventional cardiology service.
Contribution to Goals and Strategic Implications	Improving Health and Equity for all populations.
Impact on Reducing Inequities/Disparities	Improving Health and Equity for all populations.
Consumer Engagement	Not applicable.
Other Consultation /Involvement	Not applicable.
Financial/Budget Impact	Within operational budget.
Timing Issues	Not applicable.
Announcements/ Communications	Not applicable
RECOMMENDATION **That MRB, Clinical and Consumer Councils:** Note the contents of this report	

15

Te Ara Whakawaiora: Report from the Target Champion for Cardiovascular Disease

Author:	**Paula Jones**
Designation:	**Service Director**
Date:	**September 2018**

OVERVIEW

This report is from Dr John Gommans CMDO-Hospital and champion for the cardiovascular indicators. The report focuses on the two acute coronary syndrome (ACS) indicators, which were introduced as indicators of District Health Board (DHB) performance by the Ministry of Health in 2013/14 - high risk ACS patients accepted for angiogram within three days of admission and ACS patients who have completed data collection.

Priority	Indicator	Measure	Champion	Reporting Month
Cardiovascular	• Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. • Total number (%) with complete data on ACS forms	70% of high risk >95% of ACS patients	John Gommans	September 2018

There has been a challenge within the central region in meeting the access to angiography indicator due to CCDHB's limited ability to meet regional demand. It is doubtful that Hawke's Bay will meet these indicators without development of a local interventional cardiology service.

WHY IS THIS INDICATOR IMPORTANT?

To provide a national consistent reporting framework, all regions are required to report measures of ACS risk stratification and time to appropriate intervention using ANZACS-QI. HBDHB commenced using the ANZACS-QI system in September 2013. The DHBs actively monitor these two indicators of concern (figures 1 and 2). HBDHB actively monitors the ethnicity breakdown for these two indicators.

RECOMMENDATION:

That EMT, the MRB, Clinical and Consumer Councils:

Note the contents of this report

FIGURE 1

% of all patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days (data up to Quarter 4 2017/18).

Central Region DHB

Registry Completion Quarterly Report - Jul 2018

Central Region DHBs

Period *	Central Region DHB Performance							Regional Performance				National Performance
	Capital And Coast	Hawkes Bay	Hutt Valley	Mid Central	Nelson Marlborough	Wairarapa	Whanganui	Northern	Midland	Central	Southern	
2016/2017 Q3 (Dec 2016 - Feb 2017)	110/111 (99.1%)	83/90 (92.2%)	52/52 (100.0%)	85/86 (98.8%)	51/61 (83.6%)	31/32 (96.9%)	28/28 (100.0%)	712/724 (98.3%)	459/479 (95.8%)	440/460 (95.7%)	472/474 (99.6%)	2083/2137 (97.5%)
2016/2017 Q4 (Mar 2017 - May 2017)	114/115 (99.1%)	73/83 (88.0%)	61/62 (98.4%)	81/81 (100.0%)	62/68 (91.2%)	21/21 (100.0%)	23/24 (95.8%)	742/753 (98.5%)	511/512 (99.8%)	435/454 (95.8%)	502/508 (98.8%)	2190/2227 (98.3%)
2017/2018 Q1 (Jun 2017 - Aug 2017)	98/99 (99.0%)	80/87 (92.0%)	62/62 (100.0%)	72/72 (100.0%)	52/55 (94.5%)	33/33 (100.0%)	31/31 (100.0%)	806/809 (99.6%)	488/506 (96.4%)	428/439 (97.5%)	488/491 (99.4%)	2210/2245 (98.4%)
2017/2018 Q2 (Sep 2017 - Nov 2017)	104/104 (100.0%)	81/82 (98.8%)	63/63 (100.0%)	88/89 (98.9%)	54/60 (90.0%)	28/28 (100.0%)	34/34 (100.0%)	809/815 (99.3%)	470/500 (94.0%)	452/460 (98.3%)	489/495 (98.8%)	2220/2270 (97.8%)
2017/2018 Q3 (Dec 2017 - Feb 2018)	93/95 (97.9%)	68/69 (98.6%)	56/56 (100.0%)	61/63 (96.8%)	57/62 (91.9%)	23/23 (100.0%)	26/26 (100.0%)	759/762 (99.6%)	344/469 (73.3%)	384/394 (97.5%)	482/488 (98.8%)	1969/2113 (93.2%)
2017/2018 Q4 (Mar 2018 - May 2018)	86/88 (97.7%)	85/87 (97.7%)	68/68 (100.0%)	66/66 (100.0%)	79/84 (94.0%)	22/22 (100.0%)	37/38 (97.4%)	801/823 (97.3%)	261/523 (49.9%)	443/453 (97.8%)	432/493 (87.6%)	1937/2292 (84.5%)

Hawke's Bay DHB

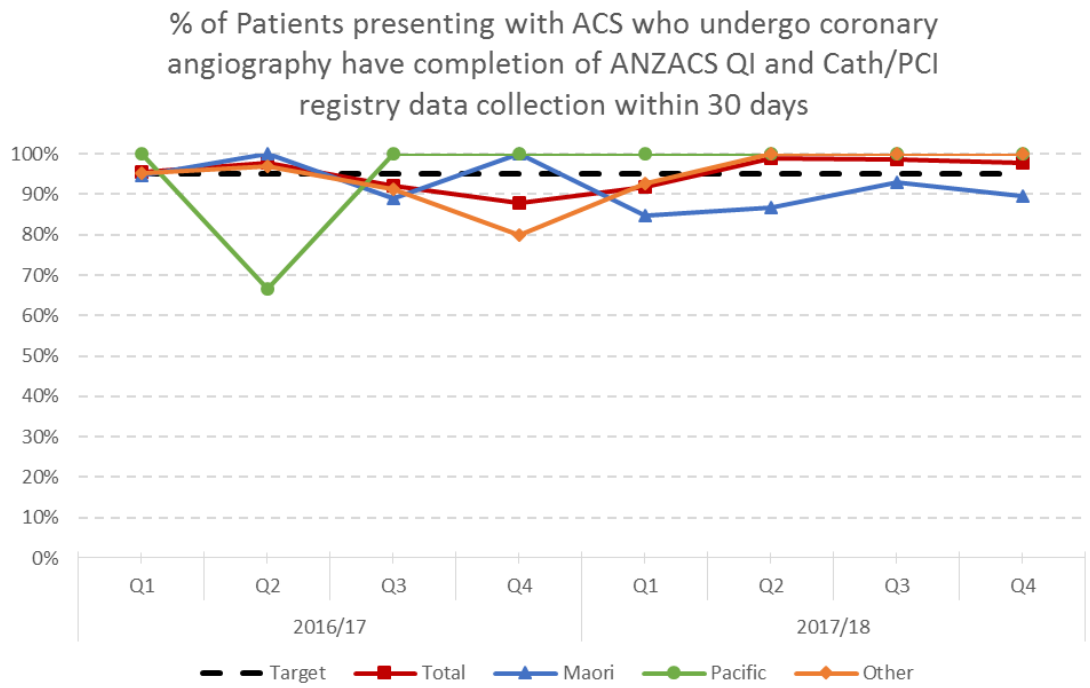

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FIGURE 1 - CONTINUED

Hawke's Bay DHB

		Target	Total	Maori	Pacific	Other
2014/15	Q1	95%	0%	0%	0%	0%
	Q2	95%	28%	13%		0%
	Q3	95%	61%	7%		0%
	Q4	95%	83%	91%	100%	81%
2015/16	Q1	95%	85%	92%	50%	85%
	Q2	95%	84%	71%		89%
	Q3	95%	100%	100%	100%	100%
	Q4	95%	99%	100%		96%
2016/17	Q1	95%	95%	95%	100%	95%
	Q2	95%	98%	100%	67%	97%
	Q3	95%	92%	89%	100%	91%
	Q4	95%	88%	100%	100%	80%
2017/18	Q1	95%	92.0%	84.6%	100.0%	92.8%
	Q2	95%	98.8%	86.7%	100.0%	100.0%
	Q3	95%	98.5%	92.9%	100.0%	100.0%
	Q4	95%	97.7%	89.5%	100.0%	100.0%

FIGURE 1 COMMENT

We have met the 95% target for the total population for five out of the last eight quarters including three of the last four quarters. The target for Maori patients has been met for three of the last eight quarters. It should be noted that there are larger variations in percentage ratings for Maori patients due to lower volumes of patients eg if we were compliant with one more patient in the last quarter or in quarter 3 2016/17 this would improve the result by 5-7% and we would have met the 95% target. The achievement of this indicator is based on local resource capacity and is ***not*** ethnicity related. Factors contributing to the variation include data being finalised on the ANZACS data registry, patients that remain as inpatients spanning more than one quarter or delays in inputting data to the registry due to lag in receiving discharge summaries from other DHBs

The recommendations of the external review of HBDHB Cardiology services carried out in December 2017 highlighted that completion of ANZACs QI registry is currently a non-dedicated FTE activity, which is at the discretion of workload within the service and suggested that resources for this important data capture for all patients are addressed in the medium to long term development of the service as this is an important national benchmark measuring compliance.

FIGURE 2

% of all patients with high risk ACS Who Receive an Angiogram within 3 days of Admission (data up to Quarter 4 2017/18).

Central Region DHB

Door to Cath < 3-Days Quarterly KPI Report by DHB - Jul 2018

Central Region DHBs

Period	Central Region DHB Performance							Regional Performance				National Performance
	Capital And Coast	Hawkes Bay	Hutt Valley	Mid Central	Nelson Marlborough	Wairarapa	Whanganui	Northern	Midland	Central	Southern	
2016/2017 Q3 (Jan 2017 - Mar 2017)	96/102 (94.1%)	50/77 (64.9%)	35/56 (62.5%)	56/76 (73.7%)	57/64 (89.1%)	18/25 (72.0%)	17/24 (70.8%)	558/716 (77.9%)	365/486 (75.1%)	329/424 (77.6%)	460/526 (87.5%)	1712/2152 (79.6%)
2016/2017 Q4 (Apr 2017 - Jun 2017)	101/113 (89.4%)	55/85 (64.7%)	48/70 (68.6%)	70/87 (80.5%)	65/65 (100.0%)	13/22 (59.1%)	20/28 (71.4%)	563/785 (71.7%)	387/517 (74.9%)	372/470 (79.1%)	414/471 (87.9%)	1736/2243 (77.4%)
2017/2018 Q1 (Jul 2017 - Sep 2017)	100/103 (97.1%)	69/84 (82.1%)	45/60 (75.0%)	58/71 (81.7%)	52/55 (94.5%)	27/34 (79.4%)	23/33 (69.7%)	604/807 (74.8%)	386/512 (75.4%)	374/440 (85.0%)	437/491 (89.0%)	1801/2250 (80.0%)
2017/2018 Q2 (Oct 2017 - Dec 2017)	97/101 (96.0%)	61/83 (73.5%)	50/58 (86.2%)	59/88 (67.0%)	55/60 (91.7%)	20/29 (69.0%)	25/29 (86.2%)	593/781 (75.9%)	385/482 (79.9%)	367/448 (81.9%)	417/485 (86.0%)	1762/2196 (80.2%)
2017/2018 Q3 (Jan 2018 - Mar 2018)	80/85 (94.1%)	37/67 (55.2%)	47/58 (81.0%)	46/63 (73.0%)	67/69 (97.1%)	14/25 (56.0%)	14/33 (42.4%)	602/775 (77.7%)	348/495 (70.3%)	305/400 (76.3%)	439/516 (85.1%)	1694/2186 (77.5%)
2017/2018 Q4 (Apr 2018 - Jun 2018)	90/99 (90.9%)	53/90 (58.9%)	53/67 (79.1%)	48/70 (68.6%)	73/75 (97.3%)	12/18 (66.7%)	16/29 (55.2%)	656/832 (78.8%)	353/470 (75.1%)	345/448 (77.0%)	376/449 (83.7%)	1730/2199 (78.7%)

The dates are based on the dates of admission. Number (%) of all ACS patients where door to cath time is between -2 to 3 days. Target is 70%. Those with < -2 days are excluded from numerator but included in denominator.

Hawke's Bay DHB

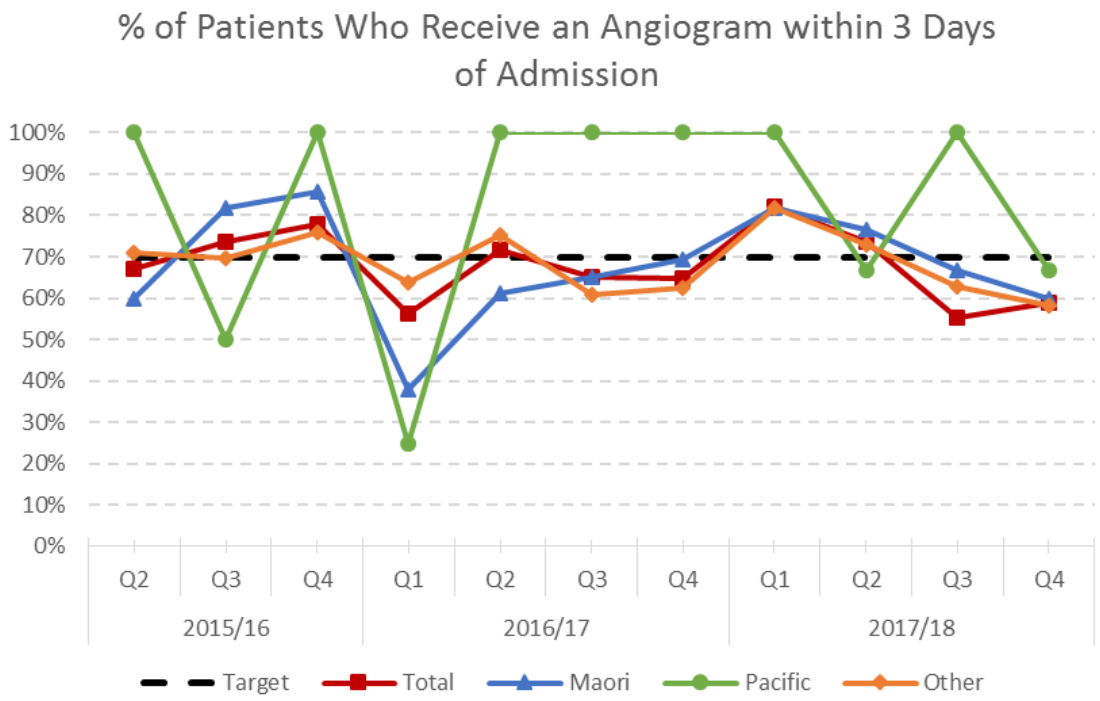

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FIGURE 2 - CONTINUED

Hawke's Bay DHB

		Target	Total	Maori	Pacific	Other
2014/15	Q1	70%	76%	91%	50%	75%
	Q2	70%	49%	33%		52%
	Q3	70%	62%	67%	50%	62%
	Q4	70%	63%	58%	50%	65%
2015/16	Q1	70%	51%	38%	50%	53%
	Q2	70%	67%	60%	100%	71%
	Q3	70%	74%	82%	50%	70%
	Q4	70%	78%	86%	100%	76%
2016/17	Q1	70%	56%	38%	25%	64%
	Q2	70%	72%	61%	100%	75%
	Q3	70%	65%	65%	100%	61%
	Q4	70%	64.7%	69%	100%	63%
2017/18	Q1	70%	82.1%	81.8%	100.0%	81.9%
	Q2	70%	73.5%	76.5%	66.7%	73.0%
	Q3	70%	55.2%	66.7%	100.0%	63.0%
	Q4	70%	58.9%	60.0%	66.7%	58.1%

FIGURE 2 comment

We have met the 70% target for three of the last eight quarters for the total population and two of the last eight for Maori. Target for Maori patients is consistent with the total performance of the quarters overall. Ethnicity is not a barrier to access to angiography once the patient has presented to secondary care. Poor performance by the HBDHB against indicators is attributed to

a) The timing of the two angiogram lists per week
b) Lack of capacity within the radiology department to extend the number of sessions offered to cardiology (although we have the ability to negotiate ad hoc short lists on a Friday if cardiologist availability and staffing allows)
c) Need to transfer the majority of patients to Wellington for angiography and CCDHB capacity to receive HBDHB patients within the timeframe
d) Regional ability to respond to peaks in demand
e) Completion of data at the time of reporting (the recommendations of the external review of HBDHB Cardiology services carried out in December 2017 highlighted that completion of ANZACs QI registry is currently a non-dedicated FTE activity, which is at the discretion of workload within the service).

The 2017 review primary recommendations include resources for the cardiology service, including angiography/PCI/Pacing addressed in the medium to long term within the service provision plan.

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR?

DATA ENTRY: HBDHB met some indicators in quarter three and four of 2017/18. This was achieved by close monitoring by the directorate leadership team in conjunction with the cardiology service. In late 2017 an external review of HBDHB cardiology services was undertaken. A subsequent strategy is being developed to implement the recommendations from this review, and will align with the cardiology service business case development.

Strategies to improve compliance to the registry data entry indicators include:

- Nursing staff, checking all incomplete forms and finalising or updating as required
- All multiple Episodes of Care (EoC) checked and corrections made as required
- Retraining on database process for staff using the system
- Month and quarter reports discussed with cardiology staff using database
- Patients transferred out from HBDHB before ACS EoC completed are followed up for database completion by CCDHB

DOOR TO CATHETER: Maintaining compliance with the door to catheter within three days indicator is challenging as there is limited access to local angiography and many of these interventions are delivered by CCDHB, which is struggling to meet demand from the region. Strategies to improve compliance include:

- Increased access to angiography suite wherever possible (resource and staffing dependant)
- Extension of the Thursday angiogram list (when possible) to capture late in the week admissions
- Ongoing partnership with flight team to 'piggyback' onto other services when possible
- Communication between CCDHB and HBDHB to support timely transfers of patients
    - Improved visibility on the Cardiac Acute Transfer Schedule (whiteboard)
    - Activation of regional response plan for 'blowout' wait lists

Since 2016, HBDHB Service Director representation has occurred in partnership with the cardiology leadership team at TAS Cardiology Regional Network meetings.

Strategies continue to ensure sustained compliance for these indicators:

- Progression with a comprehensive action plan and an initiation of formal project for the development of cardiology services in Hawke's Bay following the 2017 cardiology external review
- Cardiologist's rosters designed to ensure availability for increased coronary angiogram access.
- Locum Cardiologists support is provided when required.
- Registered nurse oversees and monitors the database in conjunction with the cardiology CNM to ensure adherence to the indicators

RECOMMENDATIONS FROM TARGET CHAMPION

The Medical Directorate leadership team in conjunction with the cardiology service will continue to monitor and review its strategies to ensure sustained compliance with both cardiovascular indicators. The service will continue to participate in TAS cardiac network activities to align with regional and national strategies.

CONCLUSION

There has been a challenge within the central region in meeting the access to angiography indicator for our total population and for Maori due to CCDHB's limited ability to meet regional demand. It is doubtful that Hawke's Bay will meet these indicators without development of a local interventional cardiology service.

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

17. Minutes of Previous Meeting (Public Excluded)
18. 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).