HB Clinical Council Meeting

Date: Wednesday 1st June 2022

Time: 3.00pm – 5.00pm

Venue: Te Waiora Room, DHB Administration Building,
Corner Omahu Road and McLeod Street, Hastings

Members:
Dr Robin Whyman (Chair)
Brendan Duck (Deputy Chair)
Dr Andy Phillips
Dr Nicholas Jones
Dr Mike Park
Dr Russell Wills
Peta Rowden
Dr Jessica Keepa
JB Heperi-Smith
Dr Umang Patel
Dr Kevin Choy
Karyn Bousfield
Catherine Overfield
Ani Tomoana
Sarah Shanahan

Apologies:

In Attendance: Keriana Brooking, Chief Executive Officer
Chris Ash, Chief Operating Officer
Susan Barnes, Patient Safety & Quality Manager

Minute Taker:

Public Agenda

Item	Section 1: Routine	Time (pm)
1.	Karakia, Welcome and Apologies	3.00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review of Actions (public)	
5.	Annual Plan and Workplan – copy for information	
6.	HB Clinical Council Board Report – April (public) – copy for information	
	Section 2: Standing Management and Committee Reports	
7.	Chief Executive Officer's Report	3.10
8.	COVID19 Progress Report – Chris McKenna	3.25
9.	Health Pathways Update – Donna Armstrong	3.35
10.	**Section 3: Recommendation to Exclude the Public** Under Clause 33, New Zealand Public Health & Disability Act 2000	

Public Excluded Agenda

Item	Section 4: Routine	Time
11.	Minutes of Previous Meeting (public excluded)	3.50
12.	Matters Arising – Review of Actions (public excluded)	
13.	HB Clinical Council Board Report – April (public excluded) – No PubEx Report in April	
	Section: Presentations / Discussion	
14.	Chief Operating Officer Report – Chris Ash	3.55
15.	Topics of Interest – Member Issues / Updates	4.05
16.	Q3 Patient Safety and Quality Report (Sue Barnes)	4.15
17.	Medical Credentialing Policy	4.30
18.	Reflections on Clinical Council and the future	4.45
19.	Meeting concludes with refreshments	5.00

This is the final Clinical Council Meeting until further notice

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

*Showing **respect** for each other, our staff, patients and consumers*

	✔	✘
Welcoming	Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles	Is closed, cold, makes people feel a nuisance Ignore people, doesn't look up, rolls their eyes
Respectful	Values people as individuals; is culturally aware / safe Respects and protects privacy and dignity	Lacks respect or discriminates against people Lacks privacy, gossips, talks behind other people's backs
Kind	Shows kindness, empathy and compassion for others Enhances peoples mana	Is rude, aggressive, shouts, snaps, intimidates, bullies Is abrupt, belittling, or creates stress and anxiety
Helpful	Attentive to people's needs, will go the extra mile Reliable, keeps their promises; advocates for others	Unhelpful, begrudging, lazy, 'not my job' attitude Doesn't keep promises, unresponsive

ĀKINA IMPROVEMENT

*Continuous **improvement** in everything we do*

	✔	✘
Positive	Has a positive attitude, optimistic, happy Encourages and enables others; looks for solutions	Grumpy, moaning, moody, has a negative attitude Complains but doesn't act to change things
Learning	Always learning and developing themselves or others Seeks out training and development; 'growth mindset'	Not interested in learning or development; apathy "Fixed mindset, 'that's just how I am', OK with just OK
Innovating	Always looking for better ways to do things Is curious and courageous, embracing change	Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done
Appreciative	Shares and celebrates success and achievements Says 'thank you', recognises people's contributions	Nit picks, criticises, undermines or passes blame Makes people feel undervalued or inadequate

RARANGA TE TIRA PARTNERSHIP

*Working together in **partnership** across the community*

	✔	✘
Listens	Listens to people, hears and values their views Takes time to answer questions and to clarify	'Tells', dictates to others and dismisses their views Judgmental, assumes, ignores people's views
Communicates	Explains clearly in ways people can understand Shares information, is open, honest and transparent	Uses language / jargon people don't understand Leaves people in the dark
Involves	Involves colleagues, partners, patients and whanau Trusts people; helps people play an active part	Excludes people, withholds info, micromanages Makes people feel excluded or isolated
Connects	Pro-actively joins up services, teams, communities Builds understanding and teamwork	Promotes or maintains silo-working 'Us and them' attitude, shows favouritism

TAUWHIRO CARE

*Delivering high quality **care** to patients and consumers*

	✔	✘
Professional	Calm, patient, reassuring, makes people feel safe Has high standards, takes responsibility, is accountable	Rushes, 'too busy', looks / sounds unprofessional Unrealistic expectations, takes on too much
Safe	Consistently follows agreed safe practice Knows the safest care is supporting people to stay well	Inconsistent practice, slow to follow latest evidence Not thinking about health of our whole community
Efficient	Makes best use of resources and time Respects the value of other people's time, prompt	Not interested in effective user of resources Keeps people waiting unnecessarily, often late
Speaks up	Seeks out, welcomes and give feedback to others Speaks up whenever they have a concern	Rejects feedback from others, give a 'telling off' 'Walks past' safety concerns or poor behaviour

Karakia

Hei Aratākina te Hui (to start)

E Io i runga i te Rangi Whakarongo mai titiro iho mai E Io i runga i te Waitai, i te Wai Moana, i te Wai Maori Whakapiri mai whakatata mai E Io i runga i a Papatuānuku Nau mai haere mai Nōu e Io te aō nei Whakatakina te mauri ki runga ki tēna taura ki tēna tauira Kia eke tārewa tu ki te Rangi Haumie Hui E tāiki e.	The waters of life connect us to all nations of this world. Sharing skills of one another and an understanding that throughout the hui we are courageous in our decisions that set and implement decisions.

Karakia whakamutunga (to finish) Unuhia

Unuhia, unuhia te uru tapu nui o Tāne Kia wātea, kia māmā te ngākau, te wairua, Te tinana, te hinengaro i te ara takatū. Koia rā e rongo, whakairia ki runga Kia wātea, kia wātea, āe rā, kua wātea!	Release, release the sacred knowledge of Tāne To clear and to relieve the heart, the spirit, The body and the mind of the bustling path. Tis Rongo that suspends it up above To be cleared of obstructions, yes, tis cleared.

Interests Register

Dec-21

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest e.g. Organisation / Close Family Member	Nature of Interest e.g. 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
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
	Hastings Environment Centre	Board member	Sustainable Living	No	
	Ora Taiao	Executive Board Member	Health and Climate	No	
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	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	
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
Karyn Bousfield	Jonathan Black Farsight Global	Partner is Director	Organisational Psychologist/ Contractor	No	Potenital percieved - no connection on a professional level
Mike Park	College of Intensive Care Medicine (CICM)	Fellow	CPO and accreditation	No	
	ASMS	Member	Trade Union	No	
	ANZICS	Member	Professional society	No	
	Central region IHT DHB Committee	Chair	DHB network for IHT	No	
	HBDHB Medical Diirector Acute & Medical	Medical Director		Yes	Potential Pecunirary - Low level
Dr Kevin Choy	The Doctors, Hastings	GP & Director	GP	Yes	Provision of Primary Care - business
Dr Umang Patel	City Medical Ltd, Napier	GP & Medical Director	GP	Yes	Provision of Primary Care - business
	HBDHB	ED SMO/Consultant Locum	Consultant	No	
	PHO	Wife is Nursing Director		Yes	Low
Peta Rowden	Hawke's Bay DHB – Shanelle Rowden-Read	Daughter	Health Care Assistant	Yes	Low - family member
	National Directors of Mental Health Nursing (DOMHNs)	Member	Collective strategic group to positively influence nursing priorities for mental health and addiction nurses in New Zealand.	No	
	Hawke's Bay DHB Mental Health & Addictions Services – Nurse Director	Employee	Employee	No	
	Te Ao Maramatanga - College of Mental Health Nursing	Member	Professional body for practising mental health nurses in New Zealand	No	
Dr Jessica Keepa	Te Taiwhenua o Heretaunga	GP	GP	Yes	Provision of Primary Care - employee
	NZ Royal College of GPs	Member	Professional society/body	No	
	Te Ohu Rata o Aotearoa (Māori medical practitioners)	Member	Professional society		
	PHARMAC COVID-19 treatments advisory group	Member	Advisory Group	No	
	Ministry of Health COVID-19 Therapeutics TAG	Member	Advisory Group	No	
	Hawke's Bay Faculty of GPs	Member	Professional society		
Brendon Duck	HBDHB - Systems Lead for Medicine	Employee	Health Services	Yes	Potential
	Totara Health	Director	General Practice	Yes	Delivery of funded primary care services via back to back agreement with Health HB
	Totara Health - Pharmacist Prescriber	Employee	General Practice	No	
	Pharmaceutical Society of New Zealand	Advisor	Crown Agency	No	
	HQSC	Advisor	Crown Agency	No	
Catherine Overfield	Member of NZ College of Midwives	Professional Member	Professional guidance and indemnity cover	No	
JB Heperi-Smith					

MINUTES OF THE MONTHLY HAWKE'S BAY CLINICAL COUNCIL MEETING
HELD VIA ZOOM
ON WEDNESDAY, 6 APRIL 2022 at 3.00 pm

PUBLIC

Present:	Dr Robin Whyman (Chair) Brendan Duck (Deputy Chair) Dr Andy Phillips Dr Nicholas Jones Dr Russell Wills Peta Rowden Dr Jessica Keepa Dr Kevin Choy Karyn Bousfield Ani Tomoana Sarah Shanahan
Apologies:	Dr Mike Park
In Attendance:	Gemma Newland, EA to Chief Allied Health Professions Officer (minutes) Susan Barnes, Patient Safety & Quality Manager Ben Duffus, Head of Innovation and Strategic Partnership

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr Robin Whyman welcomed the group with a karakia. Apologies noted from Dr Mike Park.

2. INTEREST REGISTER

No conflicts of interest were noted for the meeting.

3. MINUTES OF PREVIOUS MEETING

The minutes of the Hawke's Bay Clinical Council public meeting held on 2 February 2022 were confirmed as a correct record of the meeting. Moved by Peta Rowden, seconded by Dr Jessica Keepa.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Quality Framework
Moving this item to Health Services Clinical Governance Group.

Item 2: HBDHB Equity Action Plan
On today's agenda.

Item 3: HealthPathways – progress update
Planned for June. Business intelligence reports to be circulated by Donna Armstrong at a later date.

Chair Dr Robin Whyman has been in discussions with CEO Keriana Brooking. It was agreed to place Clinical Council in abeyance / recess from 1 July 2022 because of the transition of Hawke's Bay District Health Board into Health NZ. The June meeting will be the last Clinical Council meeting until the regional clinical governance structures are confirmed. Health Hawke's Bay Clinical Advisory Group (CAG) and Health

Services Clinical Governance Committee (HSCGC) will continue as governance groups for primary care and secondary based health services beyond 1 July. Clinical governance groups that currently report to Clinical Council would be organised to report to HSCGC or CAG.

There was discussion regarding aged residential care representation within CAG and the need to ensure cross-system clinical governance within the health reform. Dr Russell Wills agreed it remains important to keep system-wide view of primary and secondary clinical governance programmes in place so agrees that only temporarily pausing Clinical Council is a good idea. This was supported by Dr Kevin Choy and Dr Jessica Keepa.

Clinical Council supported placing Clinical Council in abeyance from 30 June 2022 awaiting the development of regional clinical governance arrangements under Health NZ and the Māori Health Authority.

5. ANNUAL WORK PLAN

Taken as read.

6. HB CLINICAL COUNCIL BOARD REPORT – FEBRUARY (Public)

Noted. The significant work the Council had done to focus on system performance measures at its last meeting was discussed with the Board.

SECTION 2: STANDING MANAGEMENT COMMITTEE REPORTS

7. CHIEF EXECUTIVE OFFICER UPDATE

Please refer to appendix 1.

8. COVID-19 STATUS REPORT

Dr Nick Jones confirmed COVID-19 cases in the community have continued to decrease. Hawke's Bay case numbers peaked around 22 March. Hospitalisations are also tracking down with a peak of 42, there are currently 29 COVID positive patients in hospital. These trends are consistent with overall NZ rates. Welfare requests are starting to drop off after a steady response through locality hubs.

Primary care representatives confirmed rostered GPs were very busy contacting patients throughout the day as well as a rotating nursing team to support those in the community with COVID. Nurses are dealing with low risk patients and GPs with the higher risks. There was discussion of the clinical risk with telehealth involving not seeing patients in person but oximeters are provided to those at risk and patients are seen in safe practice environments if telehealth consultations identify concerns. Triaging by nurses has been effective in managing workload.

The COVID Outreach Team is available to support in-home assessments. There was discussion of how well utilised this function had been in primary care. Social support has been more of a requirement for those in contact with their GP. GPs are concerned that COVID is affecting the business as usual work in practices. There was also discussion that COVID health pathways are very long and the risk stratification was described as "clunky". Primary care facilities have had good access to rapid antigen tests. At this stage the concern is greatest for complex cases as people affected are generally older and often less familiar with IT support tools.

The recent availability of the anti-viral drug Paxlovid is expected to positively impact severe illness. There was general discussion of supply, locations of access, and the clinical access criteria (a Health Pathway is

available) which have a strong equity focus and are targeted for the most vulnerable. Paxlovid can reduce hospitalisation by up to 80%.

9. CLINICAL COUNCIL REPRESENTATIVES AND COMMITTEE REPORTS

Patient Safety and Risk Management Committee Minutes

The minutes provided for the papers were from the February meeting. Pager technology was on the agenda as well as staff workforce due to COVID impacts.

The minutes highlighted the great leadership to ensure patient safety, quality standards and audits were maintained during this busy time. Teams were commended by the group.

Safety1st went live on 1 December which will result in improved data. The programme now has ongoing work in the background to make continuous improvements and refine information collected.

Professional Standards and Performance Committee Report

Taken as read by members.

Noted was medical credentialing and document pathways.

Credentialing of medical departments is near complete.

The DHB medical credentialing policy has been updated, approved by the medical credentialing group and forwarded for final approvals by the policy and procedures committee.

The nursing and allied health credentialing committee will be reformed follow health services restructure.

The Nurse Prescribing Clinical Governance Group has been updated to include allied health prescribers, creating the Nurse and Allied Health Prescribing Clinical Governance Group. There are 27 nurses completing the HBDHB Community Nurse Prescriber pathway, after completing the education pathway they will be credentialed to prescribe in a range of medicines. These numbers in the course are evenly split between primary and secondary care nurses which is positive for the region.

SECTION 3: PRESENTATIONS / DISCUSSIONS

10. EQUITY ACTION PLAN UPDATE

An update report was tabled and taken as read, noting progress of this plan has been limited due to the COVID response. However, the progress made does allow for a good platform for the Health NZ transition. Feedback on the paper is welcomed by Dr Nick Jones and JB Heperi-Smith.

11. PAGER REPLACEMENT PROJECT

Ben Duffus presented a background and data on the project which he has led to replace the use of pagers within the hospital to new technology involving automatic contact to cellphones via an app. Work is progressing on the new technology which will utilise a live system and good visibility dashboard. Dr Grant Broadhurst is Project Sponsor. A lot of the groundwork will happen in April with rollout expected to be before the end of the financial year (30 June).

The rollout will involve linkage with RMOs. Russell Wills also suggested Switchboard Operators to be involved in the process. SMOs are best involved once the system is ready to go live.

Celo was also discussed as well as medical imaging and patient record updates.

SECTION 4: RECOMMENDATION TO EXCLUDE THE PUBLIC

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

13. Minutes of Previous Meeting (public excluded)
14. Matters Arising – Review Actions (public excluded)
15. HB Clinical Council Board Report – No February report (public excluded)
16. Chief Operating Officer Report (public excluded)
17. Q2 Patient Safety and Quality Report (public excluded)
18. End of Life Choice Act Implementation (public excluded)
19. HSCGC – Workshop Feedback (public excluded)
20. Topics of Interest (public excluded)

The meeting closed at 4.20pm

Confirmed: _____

Chair Deputy Chair

Date: _____

HAWKE'S BAY District Health Board Whakawāteatia	**April 2022 DHB CEO BOARD GOVERNANCE REPORT**
	For the attention of: **HBDHB Board**
Document Author(s)	Keriana Brooking
Date	14 April 2022
Purpose/Summary of the Aim of the Paper	To provide a monthly strategic and operational update to the Board of HBDHB.
Health Equity Framework	The penultimate version of the revised Equity Plan is now live.
Principles of the Treaty of Waitangi that this report addresses	Post Finance Risk and Audit Committee (FRAC) meeting feedback, a process has been established by Executive Leadership Team (ELT) to group review this section of ELT-produced papers to ensure all elements of the principles of Te Tiriti are explored and documented in this section for each paper.
Risk Assessment	Hawke's Bay DHB continues to carry a high degree of clinical, financial and equity risk with ongoing service demand risks in primary care, aged residential care facilities, acute services and inpatient services. From the staff to the executive, daily decisions are being made to keep our people and services safe.
Financial/Legal Impact	Nothing for noting.
Stakeholder Consultation and Impact	I have had the following interactions in this period: • Welcomed Minister Verrall who met with DHB Public Health staff and visited Te Taiwhenua o Heretaunga • Attended the Hawke's Bay Regional Leadership Group weekly meetings • Attended the Medical Leaders, Head of Department and Medical Directors monthly meeting • Attended the COVID Vaccine DHB CE leads and Ministry of Health (MoH) weekly meetings • Attended the Central Region CE's meeting • Attended the National Bipartite Advisory Group meeting • Attended the National DHB CEO meeting • As DHB CEO co-lead for Allied Health attended the National Directors Allied Health meeting • Attended the blessing for Avenue Road • Attended the farewell for National Hauora Coalition Chief Executive, Simon Royal • As acting CEO lead for Central Region COVID, attended the desk top review with the MoH of the Central Region COVID Care in the Community Response
Strategic Impact	None to note
Previous Consideration / Interdependent Papers	None to note

RECOMMENDATION:
It is recommended that the Board:
1. *Note and acknowledge this report.*

HOSPITAL SERVICES UPDATE

Unplanned Care
During March, daily emergency department (ED) attendances were relatively unchanged compared with February. The average bed occupancy at 8am for the same period was 96.5 percent, an improvement on the previous month which recorded 101.3 percent and significantly lower compared with March 2021 - when occupancy was at 106.5 percent and overall attendance numbers were 15 percent higher. Performance against the six-hour standard was 74.8 percent for the month, an improvement on the previous month (74.4 percent) and also March 2021 (73.4 percent).

The COVID Omicron outbreak affected all but eight days of March, and COVID-positive presentations in the hospital triggered the opening of the planned COVID ward and intensive care unit in Ruakopito (the Endoscopy Building). Over this period, COVID affected a range of clinical and non-clinical staff, with more than 250 people away from work at the peak. Emergency department consultants increased their workload to provide extra cover at the front of house. This enabled faster decision making and discharging of COVID patients who did not require admission.

Planned Care
Outpatient activity remained steady throughout March, whereas onsite elective productivity and delivery performance dropped significantly as a result of activating our COVID response plan. This result was an anticipated consequence of the planned response.

- A net total of 1,903 referrals were received in February. This was 68 more than January, as expected due to the holiday period. In total, 2,104 patients were provided with First Specialist Assessments in March – a level that is consistent with the planned level of outpatient work.
- The number of patients overdue against the ESPI2 measure increased by 48 patients in March. The proportion waiting four months or more for their appointment sits at 38.8 percent, up slightly from 36.5 percent in February.

In respect of elective surgery, HBDHB delivered 65.4 percent of the overall MoH production planning discharge target in March (a total of 437 discharges vs 668 plan in March). This fall in production was expected and is the direct result of the Omicron outbreak. Further, given that there were eight days of normal production, the result will be lower in April.

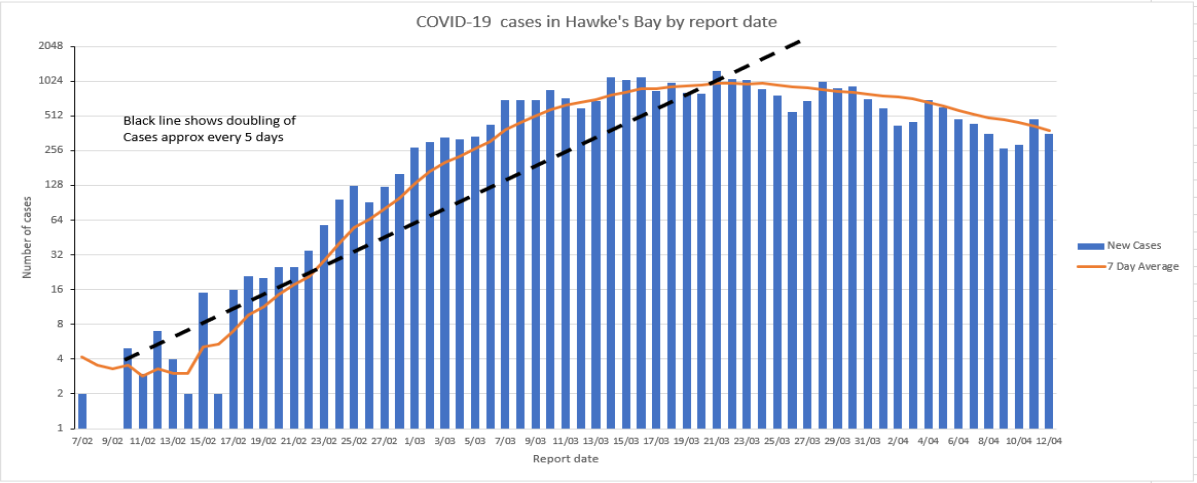
*Discharge summaries below provide an incomplete performance picture for Inter District Flows due to reporting processes and MoH data being relevant to the 20th of month following.

- Inter District Flow (IDF) activity shows 59 discharges in March against a plan of 69 discharges (85.5 percent).
- On-site activity was significantly down this month (as expected due to the Omicron response), with 274 discharges in March against a plan of 483 representing 56.7 percent of plan.
- Outsourced activity was in line against the plan with 94 discharges so far registered against the plan of 104 (90.4 percent). Again, this is an incomplete month-end position as, like IDF activity, there is a normal delay in offsite discharges being registered.
- Overall, the waiting list for surgery has increased by 183 to 2,479 with 45.6 percent of these patients waiting more than the ESPI5 measure of four months. This equates to 155 more patients compared with February (42.5 percent overdue) and is the result of a sustained number of patients listed for surgery coupled with the reduction in the number of procedures performed.

COVID UPDATE

The Government announced on 13 April New Zealand would move down to the orange setting of the COVID-19 protection framework from 11.59pm Wednesday 13 April, in time for the school holidays and Easter weekend. Nationally there is still pressure across the hospital network and some regions have not yet reached their Omicron Peak.

- The isolation period for COVID-19 cases and their household contacts is 7 days.
- Household contacts will need to have a rapid antigen test at day 3 and day 7 of their isolation period. If they become symptomatic, they should also get a test and, if the result is positive, they are required to isolate for 7 days from that point.
- Day 0 is the day someone tests positive or becomes symptomatic (whichever comes first).
- Recovered cases no longer need to self-isolate if they become a household contact within 90 days after having the virus.
- Where possible, outpatient appointments are shifting to virtual consultations, with patients being contacted directly to discuss their appointments or planned care clinical assessments.
- Vaccine passes are no longer required. There are no indoor or outdoor capacity limits and the seated and separated rule for hospitality venues is lifted. Facemask requirements in indoor settings remain unchanged.
- 16 and 17-year olds can now get a booster vaccination six months after completing their primary course (for those aged 18+ the wait time is 3 months).



RECRUITMENT AND RETENTION INITIATIVES TO SUPPORT OUR WORKFORCE IN RURAL COMMUNITIES

A previous update was provided on 15 February 2022 which noted the need for the DHB to provide additional nursing support in rural communities, with current challenges specific to the Glengarry aged residential facility in Wairoa.

A range of initiatives have been scoped to support recruitment and retention of our health care associate and nursing workforce in Wairoa. The cost estimate for all the initiatives is approximately $560,000 in operational funding. The initiatives include:

- Establishment of ongoing education fund across DHB provided and funded services and a Nurse Educator role.
- Two part-time nurse specialty roles (total 1.0 FTE) in areas requiring additional support (long term conditions and palliative care).

- Establishment of two supernumerary roles for nurse entry to practice (NETP) positions as well as travel and accommodation incentives.
- An additional clinic on wheels (two vehicles with full clinical kit to support rural healthcare delivery).

It is likely total funding requested to operationalise the plan will not be available from within existing budgets, and phasing of the initiatives will be required. The recruitment and retention initiatives for rural workforce is being piloted in Wairoa first and, pending the evaluation, will be expanded for other professional scopes and to other rural communities (Central Hawke's Bay).

It is important to note that one of the ongoing challenges in Wairoa is quality accommodation. The hostel has been noted as unsuitable either for NETP nurses who are on placement in Wairoa, or for permanently appointed staff looking for permanent accommodation. We are working closely with the Facilities team on opportunities for a refurbishment as part of capital works within this financial year (2021/22).

PACIFIC HEALTH LOCALITY PLANNING

Pacific Health is leading the development of a Pacific health locality plan for Hawke's Bay. This will guide the transition of Pacific Health into the health reforms. The plan will build on the foundational success of HBDHB's equity investment 2021 and the high rates of Pacifica COVID vaccination uptake. The plan will be led by the Pacific community, and is inclusive of Pacific workers in the Regional Seasonal Employment Scheme (RSE). Partnering for success with health services and wider agency groups will also underpin this plan. Key components of the Pacific locality plan include:

- Locality establishment
- Locality approach
- Implementation
- Funding
- Additional support

Furthermore, over the next three years, strategic resourcing provided by the Ministry of Health will be utilised to strengthen the capacity and capability development of Pacific providers and Pacific community church groups. The strategic resourcing will also be utilised to develop a Pacific mental health roadmap for implementation.

HAWKE'S BAY CLINICAL COUNCIL
MATTERS ARISING / ACTIONS

(Public)

As at April 2022

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1.	Dec-20	***Quality Framework*** Introduce framework to DLTs Launch framework	Susan Barnes	April 2022	Moving item to HSCGC
2.	Aug-21	***HBDHB Equity Action Plan*** • Report back for information on progress with the Plan	Nick Jones and JB Heperi-Smith	April 2022 (from February)	On April Agenda - completed
3.	Feb 22	***Health Pathways*** Ongoing update of progress with the programme of work	Donna Armstrong	June 2022	

Clinical Council Annual Workplan 2022

COVID

System Level Measures

Consumer Engagement

- Work with new Consumer Council on localities structure of future clinical governance
- End of Life Choice Act implementation

Clinical Effectiveness

- Clinical outcome—HRT, HQSC data DASHBOARD
- Health Pathways
- HSCGG—Monitor development of Clinical Governance Board Provider Services

Engaged and Effective Workforce

- Credentialing
- Staff experience surveys
- Quarterly invitation to People and Culture (Dashboard)
- Education and training
- Integrated Community Services

OURHEALTH HAWKE'S BAY Whakawateatia

Quality Improvement and Patient Safety

- Adverse Event Policy

Equity

OURHEALTH HAWKE'S BAY Whakawateatia	**REPORT FROM HB CLINICAL COUNCIL (Public) APRIL 2022** For the attention of: **HBDHB Board**
Document Author Document Owner(s)	Gemma Newland (Executive Assistant to Chief Allied Health Professions Officer) Dr Robin Whyman (Chair) and Brendan Duck (Deputy Chair)
Date	April 2022
Purpose/Summary of the Aim of the Paper	Provide Board with an overview of matters discussed at HB Clinical Council meeting on 6 April 2022.
Health Equity Framework	The Hawke's Bay Clinical Council works in partnership with a whole of system approach to ensure Hawke's Bay health services are achieving equity in health outcomes through the provision of services that are culturally safe, appropriate in addressing inequities and accessible to Tangata Whenua.
Principles of the Treaty of Waitangi that this report addresses:	The Hawke's Bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawke's Bay health system; committed to Te Tiriti o Waitangi and achieving equity for Tangata Whenua and other populations, in the provision of health care in the Hawkes' Bay District.
Risk Assessment	Risks associated with the issues considered by the Clinical Council include replacement of the emergency paging system with digital technology based in iPhones and delays in medical credentialing.
Financial/Legal Impact	
Stakeholder Consultation and Impact	Stakeholder engagement is the basis of discussion of issues at the Clinical Council.
Strategic Impact	None identified
Previous Consideration / Interdependent Papers	None identified
RECOMMENDATION: It is recommended that the Board: *1.* **Note** the contents of this report	

1. Clinical Governance Planning

Council agreed with the plans to temporarily suspend Clinical Council after the June meeting until regional clinical governance systems are implemented by Health NZ and the Maori Health Authority. Health Hawke's Bay's Clinical Advisory Group (CAG) and the recently formed Health Services Clinical

Governance Committee (HSCGC) will cover governance requirements for primary care and the hospital and provider services until the Health NZ governance structures are confirmed and locality planning is in place.

Susan Barnes, Patient Safety & Quality Manager has facilitated two workshops to begin the formation of the focused hospital and provider services clinical governance group in preparation for the transition to Health NZ. The Health Services Clinical Governance Committee (HSCGC) has been formed to provide clinical governance support across hospital and provider services. Terms of reference are in draft form and it is expected that any groups that currently report to Clinical Council, will report to this new committee in the interim. The committee is supported by clinicians and a Chair for HSCGC will be nominated before the next meeting.

Patient Safety and Risk Management Committee shared minutes from the February meeting. The hospital's outdated pager system was identified as a patient safety risk, but an active quality improvement project is underway and is described in this report.

The minutes highlighted the enormous pressure on leadership teams, but noted they have maintained patient safety and quality standards and audits during this busy time and were commended by the group.

Safety1st now has three months of data to use to develop reports which are proving valuable. The programme now has ongoing work in the background to make continuous improvements and refine the information collected.

The Professional Standards and Performance Committee Report noted that incomplete medical credentialing was raised as a risk issue and concerns were also noted about difficulties with access to DHB's policies, pathways and procedures on Our Hub.

The medical credentialing group is currently working with People and Culture to remediate delays in the SMOs credentialing processes before SMOs commence practice. The process is almost back up to date, and the outstanding appointments affect known SMOs with employment history at the DHB. Six new Senior Medical Officers will be joining the DHB in the next two months. The DHB medical credentialing policy has been updated and is now with the policy and procedure committee for final approval. This will ensure the medical credentialing policy and procedures are consistent with current practice.

Council celebrated 27 nurses who are now able to prescribe after completing an education pathway.

2. Pager Replacement Project

Ben Duffus, Head of Innovation and Strategic Partnership from Digital Enablement presented the pager replacement project within the hospital to Council. This project has been implemented to significantly improve the functioning of the pager system during emergencies. The new system (Cortex) will be more efficient and work through automated contact to iPhones carried by RMOs and SMOs via an app. Progressive roll out of this will be commence in May through a parallel system and then progressive retirement of the pager technology.

3. Q2 Patient Safety and Quality Report

Patient Safety and Quality data was provided to Council for the period up to 31 December 2021. Data quality remains high and there were no unexpected or outlying indicators.

Health Round Table (HRT) data was provided up to the end of December 2021. The trends identified were consistent with previous reports, and no significant deterioration in the indicators was reported.

Inequities of ethnicity were identified to be largely about access to care, rather than quality of care. Noted success stories were hip fractures being operated on within two days (incidents which are associated with a high mortality risk), a reduction in pressure injuries and hospital falls and hospital acquired infections have also decreased.

Reporting of ACC treatment injuries were discussed. A nurse coordinator is now leading this process which has resulted in positive feedback on the additional support and improved rates of reporting of ACC treatment injuries at HBDHB.

Clinical Council noted that the Health and Disability Certification audit, which was due in May, has been deferred for six months by MOH due to COVID-19. Two high risk action items from the previous certification; audit (quality systems and clinical governance and developing and implementing a robust risk framework), remain a focus of specific improvement activities.

4. End of Life Choice Act Implementation

Council received a report on experiences with the End of Life Choice Act at the DHB following its enactment on 7 November 2021. A small number of assisted dying events have occurred within the hospital in the period since November, with each proceeding smoothly. There have also been opportunities for improvement identified. Community-based assisted dying events are facilitated and governed through the Ministry of Health and not overseen by the DHB.

Council acknowledged the work Sally Houliston from the Patient Safety and Quality team has undertaken to ensure a policy and procedures for the DHB are in place and in ensuring teams in the hospital have been supported.

HAWKE'S BAY District Health Board Whakawāteatia	**May 2022 DHB CEO BOARD GOVERNANCE REPORT**
	For the attention of: **HBDHB Board**
Document Author(s)	Keriana Brooking
Date	16 May 2022
Purpose/Summary of the Aim of the Paper	To provide a monthly strategic and operational update to the Board of HBDHB.
Health Equity Framework	The penultimate version of the revised Equity Plan is now live.
Principles of the Treaty of Waitangi that this report addresses	Post Finance Risk and Audit Committee (FRAC) meeting feedback, a process has been established by the Executive Leadership Team (ELT) to group review this section of ELT-produced papers to ensure all elements of the principles of Te Tiriti are explored and documented in this section for each paper.
Risk Assessment	Hawke's Bay DHB continues to carry a high degree of clinical, financial and equity risk with ongoing service demand risks in primary care, aged residential care facilities, acute services and inpatient services. From the staff to the executive, daily decisions are being made to keep our people and services safe.
Financial/Legal Impact	Nothing for noting.
Stakeholder Consultation and Impact	I have had the following interactions in this period: • Attended the Hawke's Bay Regional Leadership Group weekly meetings • Attended the Medical Leaders, Head of Department and Medical Directors monthly meeting • Attended the COVID Vaccine DHB CE leads and MoH weekly meetings • Attended the Central Region CEs meeting • Attended the National Bipartite Advisory Group meeting • Attended the final National DHB CEO and Chairs meeting • Attended the local Bipartite Advisory Group meeting • Attended the Joint Consultative Committee (JCC) meeting between Association of Salaried Medical Specialists (ASMS) and HBDHB • Attended the launch of "Male Survivors Hawke's Bay"
Strategic Impact	None to note
Previous Consideration / Interdependent Papers	None to note
RECOMMENDATION: *It is recommended that the Board:* 1. *Note and acknowledge this report.*	

HOSPITAL SERVICES UPDATE

Unplanned Care

The hospital remained steady during April, with daily emergency department (ED) attendances relatively unchanged compared with March. The average bed occupancy at 8am for the same period was 101.9 percent, an increase on the previous month which recorded 96.5 percent. Performance against the six-hour standard was 77.9 percent for the month, an improvement on the previous month at 74.8 percent. This improvement in performance is largely the result of the changes made to enable faster decision making and discharging of COVID affected patients who did not need admission.

Planned Care

Outpatient activity reduced significantly in April. This was predominantly due to the planned operational changes made to manage the COVID surge. These included changes to rostering, re-allocation of nursing staff and a move to urgent only clinics. The successive short weeks due to public holidays also contributed to reduced numbers. Surge management was also the reason for onsite elective productivity and delivery performance dropping significantly month on month. The repurposing of Ruakopito into a COVID ward saw one theatre allocated for endoscopy (these procedures are not counted in Planned Care volumes), with another stood up for COVID-acute patients only. These changes saw only cancers and very urgent patients going through the remaining theatre capacity.

- A net total of 1,725 referrals were received in April. This was 178 fewer than March, as expected due to the public holidays in the period. In total, 1,299 patients were provided with First Specialist Assessments (FSAs) in April – this is 642 fewer patients than March, and is the lowest number of FSAs provided in a single month since May 2020 (when 1,224 FSAs were delivered due to COVID restrictions).
- The number of patients overdue against the ESPI2 measure increased by 85 patients in April. The proportion waiting four months or more for their appointment also increased month-on-month to 40.5 percent, up from 38.8 percent in March and significantly higher for the year on year compared with 26.6 percent in April 2021.

In respect of elective surgery, HBDHB delivered 52.9 percent of the overall Ministry of Health (MoH) production planning discharge target in April (a total of 287 discharges vs 543 plan in April). This decrease was an expected result of the Omicron outbreak.

*Discharge summaries below provide an incomplete performance picture for Inter District Flows due to reporting processes and MoH data being relevant to the 20th of month following.

- Inter District Flow (IDF) activity shows 28 discharges in April against a plan of 61 discharges (45.9 percent). Not all discharges will be recorded yet due to the 6-week lag time.
- On-site activity was down as expected this month due to the Omicron response, with 190 discharges in April against a plan of 396, representing 48.0 percent of the plan.
- Outsourced activity is in line against the plan with 69 discharges so far registered against the plan of 86 (80.2 percent). Again, this is an incomplete month-end position as, like IDF activity, there is a delay in discharges being registered.
- Overall, the waiting list for surgery increased in April, up by 62 to 2,541. Of these, 52.8 percent of patients have now waited more than the ESPI5 measure of four months. This equates to 366 more patients compared with March (45.6 percent overdue), the result of largely unchanged referral volumes and the significant reduction in procedures performed.

COVID UPDATE

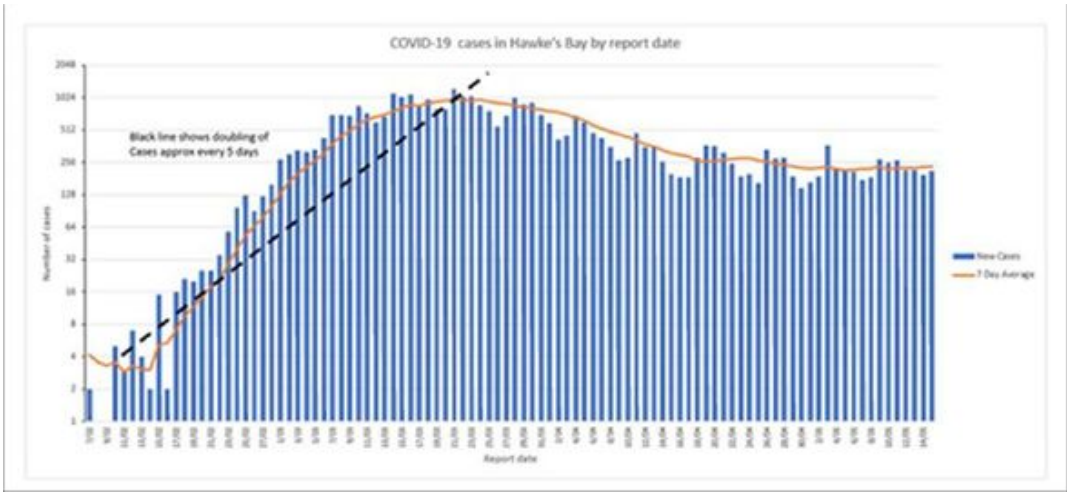
New Zealand remains in the orange setting of the COVID-19 protection framework. Key guidance is:

- The isolation period for COVID-19 cases and their household contacts is seven days.
- Household contacts will need to have a rapid antigen test at day three and day seven of their isolation period. If they become symptomatic, they should also get a test and, if the result is positive, they are required to isolate for seven days from that point.
- Day 0 is the day someone tests positive or becomes symptomatic (whichever comes first).
- Recovered cases no longer need to self-isolate if they become a household contact within 90 days after having the virus.
- Where possible, outpatient appointments are shifting to virtual consultations, with patients being contacted directly to discuss their appointments or planned care clinical assessments.
- Vaccine passes are no longer required. There are no indoor or outdoor capacity limits and the seated and separated rule for hospitality venues is lifted. Facemask requirements in indoor settings remain unchanged.
- 16 and 17-year olds can now get a booster vaccination six months after completing their primary course (for those aged 18+ the wait time is three months).
- There is now a third primary dose for 5-11 year olds who are severely immuno-compromised available by prescription only usually administered 4-8 weeks after second dose.
- New data (MoH) showing a probable small COVID spike in June and August.
- The MoH is rolling out a winter wellness campaign in June promoting all forms of vaccinations.

As at Tuesday 15 May 2022, there were 1643 active cases in Hawke's Bay. Of those, 216 were new cases including 91 in Hastings, 101 in Napier, 19 in Central Hawke's Bay and four in Wairoa. Total cases for the outbreak so far are 37,765.

As at 16 May, vaccination rates are:

- 97 percent of the eligible population has had 1 dose
- 95 percent of the eligible population has had 2 doses
- 72 percent of the eligible population (18+) has had a booster



UPDATE ON RANGATAHI (YOUNG PEOPLE) SERVICE FOR HAWKE'S BAY

Over the past three years Hawke's Bay District Health Board (HBDHB) has been working in partnership with rangatahi to design a service that they would want to use. Consultation occurred over several stages to help the DHB understand and design an appropriate service

Key points are:

- The DHB acknowledges that there has been some confusion surrounding the new service aimed to increase health and wellbeing among rangatahi.
- The new providers (a coalition) are in an establishment phase and are expected to be operational by 1 July 2022.
- The model of care is the preferred model for health and wellbeing as described by rangatahi (through rangatahi voice, health data and youth literature). More information on the solution is provided in the table below.
- A new model of care was developed, following a review of services that revealed a decline in uptake by rangatahi in low deprivation areas. Less than 50 percent of Māori and Pasifika were accessing this service (44 percent and 38 percent respectively). In addition to this, Māori and Pasifika had a lower average number of consultations than other ethnicities.
- The redesigned service is funded to provide access to a range of primary healthcare services. Rangatahi do not need to move practices or enrol in a new practice to access this service and relevant clinical information will be provided back to the registered general practice on permission of the rangatahi.
- Should rangatahi need to see a GP and choose to see the GP they are enrolled with, it will be free, or discounted, depending on how much their general practice charges.
- Eight practices will no longer receive the zero fees for under-18s scheme. This was a HBDHB initiative implemented in 2016 providing funding in addition to the Government funded zero fees for under-14s scheme. The Government's zero fees for under-14s scheme remains in place.
- All other free services for rangatahi within general practice in Hawke's Bay remain available including sexual health services and integrated primary mental health services.

The immediate benefits of the new service are that:

- Organisations in the coalition have the cultural foundations that makes it easier for rangatahi and their whānau to engage.
- Access extends to rangatahi 10 to 24-years of age.
- No rangatahi are turned away – access for all rangatahi regardless of their ethnicity or enrolment status.
- Rangatahi services will be available in Tamatea (CHB), Ahuriri (Napier), Heretaunga (Hastings) and Wairoa.
- Rangatahi who participated in consultation and co-design feel their voice is honoured because we listened and commissioned for a service aligned to what they wanted.

More information on the solution

Solution	What it looks like	What the rangatahi said
Fixed and flexible	to work around the needs of youth whether in or out of school, training, or work.	Expressed limited access to appointments and wait times and that access needs to be focused around rangatahi and not school or workforce convenience. A youth consumer test (2019) found that of 27 primary care practices, only 3 were willing to accommodate youth requiring an urgent appointment. A repeat of the test in 2021 found no change in access success.

Inclusive of health programme impacting most on rangatahi wellbeing	Inclusive of health programmes impacting most on rangatahi wellbeing – such as fitness, healthy kai, sexual health, dental care, and mental health, as well as communication and life skills support.	Limited or no access to programmes for rangatahi who need more support for problems they face. Youth want better programmes that are relevant to youth i.e. kai, life-skills study support etc.
Integrated, and co-located with social providers	A health and wider system that organises itself around the needs of youth under one kaupapa/umbrella.	Strong preference for wellbeing approaches to complement health services and messages – where they can get practical support and not just 'quick advice'.
Strong cultural foundations	Where cultural dimensions are acknowledged and valued, and where support can extend to whānau to benefit everyone in the home.	Rangatahi Māori felt the health system does not know them, they cannot trust it, and they don't feel safe. Cultural dimensions where identified as important by rangatahi because when it comes to health problems, 'when it's te ao Māori, it's easier to talk about it'.
Rangatahi led wherever possible with a highly skilled youth-responsive workforce	A model of care that is by, for, and with rangatahi; and a well-trained workforce in youth health to deliver what is required to youth.	Pasifika surveyed found racism as a key issue facing Pasifika talavou. Culturally responsive services cannot be achieved without a culturally responsive workforce that understand Māori and Pasifika youth. Rangatahi participation was identified as key to achieving this goal.

COVID-19 STATUS REPORT

HEALTH PATHWAYS UPDATE

DONNA ARMSTRONG

Recommendation to Exclude the Public

10

Clause 32, New Zealand Public Health and Disability Act 2000

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

11. Confirmation of Previous Minutes (Public Excluded)
12. Matters Arising – Review of Actions (Public Excluded)
13. Clinical Council Board Report (was no Report in April for Public Excluded)
14. Chief Operating Officers Report (Public Excluded)
15. Topics of Interest (Public Excluded)
16. Q3 Patient Safety and Quality Report (Public Excluded)
17. Medical Credentialing Policy (Public Excluded)
18. Reflections on Clinical Council (Public Excluded)

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).