Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 13 April 2016**

Meeting: **3.00pm to 5.30pm**

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

Council Members:

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

Apologies:

In Attendance:

Kevin Snee, Chief Executive Officer
Ken Foote, Company Secretary
Kate Coley, Director of Quality Improvement & Patient Safety
Tracy Fricker, Council Administrator
Graeme Norton, Chair HB Health Consumer Council

HB Clinical Council – Agenda

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	**3.00**
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	
	Section 2 – Decision	
6.	Detailed Business Cases for 15/16 Investments - Chris McKenna A: Palliative B: Cardiac C: Patient at Risk	**3.15**
	Section 3 – Review	
7.	Best Start Healthy Eating (Draft) – Caroline McElnay and Shari Tidswell	**3.30**
	Section 4 – Reporting Committees	
8.	Urgent Care Alliance Quarterly Update – Graeme Norton	**3.45**
9.	Radiology Services Committee – Mark Peterson	**4.00**
10.	Laboratory Services Committee – Dr Kiri Bird	**4.05**
11.	Clinical Advisory Governance Group (February and March 2016) - Tae Richardson	**4.10**
12.	Clinical Pathways Committee Update – Leigh White	**4.15**
	Section 5 – For Information / Discussion	
13.	AIM 24/7 Quarterly Update – John Gommans	**4.25**
14.	Transform and Sustain Refresh (draft)	**4.30**
15.	Prioritisation Process preliminary discussion – Peter Kennedy	**4.40**
16.	**Section 6 – Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 7 – Routine	
17.	Minutes of Previous Meeting (public excluded)	
18.	Matters Arising – Review Actions	
	Section 8 – Decision	
19.	Learnings from ICU Review 2013 – Kate Coley	**5.10**
	Section 9 – General	
20.	Topics of Interest - Member Issues / Updates	

NEXT MEETING IS A QUARTERLY being held Wednesday 11 May 2016, with lunch at 12.30pm
VENUE: Takarangi Conference Room, Te Taiwhenua o Heretaunga, 821 Orchard Road, Hastings

Interests Register

14 March 2016

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
Dr Mark Peterson (Chief Medical Officer - Primary	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary of	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Immediate Past President and a current Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Member and Chair elect of NZ Committee	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ	Yes	Low
Dr Caroline McElnay (Director Population Health & Health Equity Champion)	NZ College of Public Health Medicine	President until October 2017	NZCPHM represents the interests of Public Health Medicine specialsits in NZ, provides training of registrars, ongoing accrediation of specialists and advocacy on public health matters.	*No*	
	RNZ Plunket Society	National Board member	Provision of heath and social services to children under 5 years, advocacy for children	*No*	
William Allan (Chief Pharmacist)	Pharmaceutical Society of New Zealand	Executive member	Pharmacy advocacy, professional standards and training	Yes	Low
	Pharmaceutical Management Agency (PHARMAC)	Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee)	Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML)	Yes	Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget
	Executive User Group for eMedicines programme (ITHB/HQSC)	Member (Central Region's representative)	Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines Reconciliation)	Yes	Low
	Pharmacy Steering Group (MoH)	Member	Provide advice to the Ministry on the utilisation of pharmacists within the health workforce	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
Dr Kiri Bird (General Practitioner)	Te Timatanga Ararau Trust (Iron Maori)	Partner is a Trustee	Health and Wellbeing	Yes	Low - Contract with HBDHB
	Te Taiwhenua o Heretaunga	General Practitioner	General Practice	Yes	Low - TToH contract with HBDHB
	Royal NZ College of General Practitioners	Board Member	Health and Wellbeing	No	
	Te Ora Board (Maori Doctors)	Deputy Chair	Health and Wellbeing	No	
	Te Akoranga a Maui (Maori chapter for RNZCGP	Chairperson	Health and Wellbeing	No	
Robyn O'Dwyer (Nurse Practioner Whanau Ora)	Wairoa Health Care Center	Nurse Practitioner	General Practice	No	
	The College of Primary Care Nurses	Member	National submissions/member of nursing leadership	No	
	The College of Maori Nurses	Member		No	
	New Zealand Scientific Society of Diabetes	Member		No	
Dr Malcolm Arnold (Medical Director / HOD)	NZ Society of Gastroenterology	Executive member	Provision of Gastroenteorlogy expertise throughout NZ, study of relevant conditions	No	
	NEQIP (National Endoscopy Quality Improvement Programme)	Clincal Support Lead	Standardising and improving quality of endoscopy services and training throughout the countrv	No	
	Endoscopy Users Group, HBDHB	Chairman	Assessing and improving provision of Endoscopy services in HB	Yes	Potential to influence budget/spending/provision of services
	Hawke's Bay Medical Research Foundation	Member of Scientific Advisory Group	Advising HBMRF on use of funds for research projects	No	
	NZ Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (since June 2015)	Chairman		No	
David Warrington (Nurse Director - Older Persons)	Havelock North Chiropractic	Wife is Practitioner and Co-owner	Chiropractic care and treatment, primary and preventative	Yes	Low
	Pilates Works	Wife is CE and Co-owner	Rehabilitation, Primary and preventative.	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality	Loco Ltd	Shareholding Director	Private business	No	

HB Clinical Council 13 April 2016 - Interest Register

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Advisory Committee)	Dr Bryn Jones employee of MoH	Husband	Role with Ministry of Health as Chief Advisor in Sector Capability and Implementation	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
Andrew Phillips (Director Allied Health HBDHB)	Nil	Not Applicable	Not Applicable	No	Nil
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	Directions Youth Health	Wife Beth involved	Assisting youth in HB	No	
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.
	National Advisory Committee of the RNZCGPs	Member	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins	The Hastings Heatlh Centre	Practice Nurse Family Violence Intervention Coordinator	Delivery of primary health care - General Practice and training of Clinicians in family violence intervention.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	LIVE (Local Initiative for Violence Elimination)	Member of management Committee	Network of agencies that provide family violence intervention services.	No	
Anne McLeod	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	

**MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL MEETING
HELD IN THE HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE
ON WEDNESDAY, 9 MARCH 2016 AT 3.00 PM**

PUBLIC

Present:
Chris McKenna (Co-Chair)
Dr Mark Peterson (Co-Chair)
Dr John Gommans
Dr Tae Richardson
Dr Andy Phillips
Dr David Rodgers
Debs Higgins
Dr Malcolm Arnold
Dr Robin Whyman
Dr Caroline McElnay
Robyn O'Dwyer
Billy Allan
Jules Arthur
Anne McLeod

In Attendance:
Dr Kevin Snee (Chief Executive Officer)
Ken Foote (Company Secretary)
Graeme Norton (Chair HB Health Consumer Council)
Tracy Fricker (PA to Director QIPS / Clinical Council Secretary)

Guests:
Hans Snoek, GP and Clinical Director Te Awakairangi Health Network (PHO)
Sisira Jayathissa, Acting Chief Medical Officer, Hutt Valley DHB (HVDHB)
Helen Pocknall, Executive Director of Nursing and Midwifery, HVDHB
Saira Dayal, Public Health Medicine Specialist, HVDHB

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Chris McKenna (Chair) welcomed the guests from Hutt Valley District Health Board (HVDHB) who are visiting Hawke's Bay District Health Board to understand how our Clinical Council works. HVDHB are in the process of establishing a Clinical Council.

Apologies received from Kiri Bird and David Warrington.

2. INTERESTS REGISTER

No conflicts of interests for agenda items. No new interests disclosed.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 10 February 2016, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: Alternative Health Provider
New draft Complementary Therapies Policy reviewed and feedback provided. This document will be further reviewed and brought back to Council for sign off. Timing to be determined.

Item 2: Changes to Interest Register
Ken Foote (Company Secretary) advised that a declaration will be sent to David Rogers and Robin Whyman to register their interests.

Item 3: Customer Service Training
Kate Coley (Director, QIPS) is working with Education and Development and liaising with external provider on a roll out plan for this training for primary care. Update to be provided at the April meeting.

Item 4: Clinical Council Member Portfolios
Carried forward to the April meeting. Members to email areas of interest to the Company Secretary.

5. CLINICAL COUNCIL WORK PLAN

Updated work plan included in the papers. The work plan requires further discussion re: prioritisation, which items need to be received for information only or comment and items which do not need to be tabled at Clinical Council. The Clinical Council can make decisions on their own workload/workflow.

The Chair advised that the Health Sector Leadership Forum Workshop will be held in May *(tentatively 17 May)*. This is part of Clinical Council work and includes members from DHB Board, PHO Board, Clinical Council, Consumer Council and Maori Relationship Board. It would be good to have increased representation from Clinical Council members than what was at the October meeting.

In May the Clinical Council and Consumer Council meetings will be combined. The meeting will be held at Te Taiwhenua o Heretaunga.

SECTION 2: REVIEW

6. DAVANTI IS REVIEW

The Chair welcomed Tim Evans, General Manager – Planning, Informatics and Finance (GM PI&F) to the meeting.

Davanti Consulting conducted a review of HBDHB's Information Services Department (IS) in October 2015. The GM PI&F presented the findings and recommendations from the review.

The GM PI&F requested endorsement of the actions going forward and feedback from the Clinical Council before he presents the report to the DHB Board on 30 March.

General discussion and feedback from Clinical Council members:

- Culture change. Structure of clinical governance and advisory committee and an IS advisory group makes sense to provide high level clinical input across the whole sector.

- Is the need for governance strategic or operational? More at the strategic end to point in the right direction and to do the big things. For operational setting service agreements, standards

etc it is important to have a mechanism for making sure what the customer wants, setting the targets and performance management. This needs to involve clinicians, users and a wider group of stakeholders.

- There is scepticism from clinical staff about IS. Two aspects – big picture of over promising and under delivering and also about IS being an "blocker" and not an enabler e.g. not emailing clinical information or using iPhones to take clinical pictures and getting in the way of what clinicians want to do. What does not come across in the paper is that this is about a health service and delivering health care to people. The marketing of this to clinicians will be a key factor to get engagement. Clinicians need to see that this is going to make a difference for them clinically.

- The talk is about not more investment, but the report talks about underperforming in areas. Are we confident in reallocating people that these same people will be able to deliver the performance we want? The GM PI&F commented it is his plan to be more involved with IS going forward. There is a need to make what we currently have work better, changing the culture in IS and having mechanisms for performance management and promoting the right behaviours.

- The document does not look at the regional view and is Hawke's Bay centric. GM PI&F advised this is included in the wider report. We didn't have a strategic agenda as we were going to have regional programmes for our IS systems and a national infrastructure. From a regional scale we need to get clinical work station in and standardise business process around it.

The GM PI&F advised that he will be seeking approval from the Board on 30 March to establish a small steering group to get the restructure underway. The review report has been shared with the IS Department staff.

Any further feedback to Tim Evans by 24 March (tim.evans@hbdhb.govt.nz).

The general approach is accepted by the Clinical Council.

SECTION 3: INFORMATION AND COMMENT

7. MOH MOBILITY PLAN

Andy Phillips, Chief Allied Health Professions Officer (CAHPO) gave a presentation on the Mobility Action Programme (MAP).

The aim of MAP:

- To support people with musculoskeletal conditions to fulfil their health potential and increase independence
- Achieved through improved access to high quality advice, assessment, diagnosis and treatment
- To include self-management education programmes
- To include rehabilitation programmes to improve function, ability to carry out daily activities and improve function

Proposed Hawke's Bay Bid to MAP:

- Community based Physiotherapy 'walk in' clinics
- Self-care programs including Stanford and Maori variant
- Clinics based in areas of high deprivation including Wairoa, Maraenui, Takapau, Flaxmere, Waipukarau
- Clinics also run in conjunction with Arthritis NZ sessions
- Clinics also in workplaces of large employers

- Walk in clinics provide physio assessment and treatment, free of charge
- Links with Green Prescription and Iron Maori
- On completion, information sent to GP including recommendation for onward referral to Orthopaedics as appropriate

Benefits from Proposal:

- Improve access to assessment and treatment of musculoskeletal conditions for people in high deprivation areas
- Better outcomes in terms of reduced pain and disability
- Support people to remain in work and living independently
- Better patient experience
- Reduce demand for Orthopaedics FSA
- Early intervention in musculoskeletal conditions
- Potential to reduce demand by delaying need for orthopaedic operations/potential for reduced number of revisions

The CAHPO advised that we are still at the formative stage and working up an expression of interest around the principles. Further discussions will be had with the steering group if we choose to go through to the RFP stage.

Questions / feedback from Clinical Council members:

- What is the cost of programme? Would be around $350,000 for two years.

- Is there an evaluation? There will be a national evaluation, and we may want to have some additional items in the evaluation to fulfil the aims of the programme, some things we want to add locally to better inform the success of this programme and to compare with other programmes.

- If successful do we have to continue to fund? No. All of these programmes are not researched - it is more about implementation, they are ideas that have run well in other parts of New Zealand or internationally. We want to know from a New Zealand context what are the issues in implementation and at the end of it there will be an evaluation of 1the 2 programmes that provide information to DHBs to commission an ongoing programme or not.

- There may not be an obligation to the Ministry to fund but there is an obligation to our patients. Need to be careful of setting up expectations.

- If it was successful we would continue. We need to understand at the outset what criteria we could commit to. Expectation of patients that the programme will continue.

- The unmet demand most likely will exceed the supply – how do we ration it and properly target and how do we ensure that private physiotherapy services are not undermined? This is additional work for them, people who cannot afford to access their services currently. This programme should help to answer these questions.

- Will there be criteria to meet for the walk in clinic before they can access the free service? Yes. Will be targeted and need to be certain what it is for and not just any physio condition.

- How do we support people who will never meet the criteria for hip replacements and keep them in the workplace and independent? Partnering with employers, one of the barriers with employers is once you are unable to do the job you are employed to do, they can exclude you from the workplace and if the injury occurred outside of work they are under no obligation to take you back until you are fit to do the job again. If we are looking at partnering, not just with ACC but with non ACC providers like AON, talking about how we might have people in the workplace for non-work related injuries.

- As the DHB is one of the biggest employers in Hawke's Bay, will there be a walk in clinic for staff? Not the main objective of this and would need some thought. There would be benefits to keep our own staff at work. Will look at this in terms of partnering with employers.

- Will the evaluation for long term arthritis and disability measure qualities of life for individuals or groups? Yes, types of evaluation will include SM12 and pain scores. The challenge it not to make the evaluation unfeasibility large and impossible for people to understand the questions.

Any further feedback can be emailed to andrew.phillips@hbdhb.govt.nz.

8. DRAFT COMPLEMENTARY THERAPIES POLICY

The first draft of the policy is included in the papers. Andy Phillips, Chief Allied Health Professions Officer (CAHPO) advised that the policy is at a formative stage and is for complementary therapists who are practising on DHB premises. He is not aware of any complementary therapies being practiced by HBDHB employees. He will look further into whether any of the therapies under the scope of the policy are practiced by HBDHB employees. There is a complementary medicines policy to be referenced in this policy and he has not yet included information on Osteopathy and Chiropractic treatment.

The CAHPO requested feedback on the principles and whether he has the Clinical Council's requirements right.

Feedback from Clinical Council members:

- Good information in the policy, homeopathy is not covered. A lot of personal choice is involved and the placebo affect. The principles are right.
- In maternity complementary therapies are used all the time and we are long overdue to have a policy on where we stand. It should be supported and used in partnership and alongside conventional medicine.
- We don't have a register as it currently stands or sight qualifications.
- What consultation will be had in the community, they will have a perspective on this. The DHB has the right to set the terms of its own policies. It may need to be refined so it does not turn into a barrier.
- No problem with the purpose of the document. We have an obligation to guard against charlatanism while at the same time people have the right to ignore our health advice and seek other advice from whoever they want, but this would not be in the remit of the document. The document doesn't acknowledge the Pacific communities indigenous use of health massage, particularly the Samoan culture. There is also no mention of meditation and mindfulness which should be incorporated.
- Need to specifically mention in the Purpose that this policy is for DHB premises.
- Would it be more helpful regarding the safety aspect, to state what is not acceptable rather that what is acceptable e.g. for aromatherapy what oils are not acceptable.
- The principles are very good. Need to add that any health practitioner practising is bound by the Health & Disability Commissioner for anything they do and are as liable as HBDHB.

Any further feedback can be emailed to andrew.phillips@hbdhb.govt.nz.

The Chair acknowledged the CAHPO for the work undertaken so far on this complex and far reaching issue.

9. DRAFT ANNUAL PLAN STATEMENT OF INTENT

The Chair welcomed Carina Burgess, Acting Head of Planning to the meeting. An update was provided on progress of the first draft of the HBDHB Annual Plan and refresh of the statement of intent 2016/17. The refresh will focus on incorporating the NZ Health Strategy and how we will measure the implementation and impact of transform and sustain, projects going on and vision and values dashboard.

The first draft of the annual plan is due to the Ministry by 31 March. There has been good engagement with the PHO, Maori Health, the providers and Population Health and good working groups on each of the sections. Good accountability on all of the actions. All reviewed through rather than just being rolled over to the next year.

New or increased focused areas:

- Reducing childhood obesity has been introduced as a National Health Target
- Reducing Unintended Teenage Pregnancy is a National Priority
- The focus for Stroke has extended to cover timely transfer to inpatient rehabilitation
- Increased emphasis on plans to shift services into the community e.g. Health and Social Care networks, District nursing, engAGE, Pharmacy Facilitators etc.

Less focus:

- More Heart and Diabetes checks is no longer a health target but remains a priority
- Nationally there is less focus on child and maternal health activity such as antenatal education and LMC enrolment. However, these remain as activities relating to outcomes such as increasing breastfeeding rates and reducing SUDI in our Annual Plan.

Local Maori Health Priorities:

- Māori Workforce
- Obesity
- Alcohol and other drugs – NEW

The draft was supported by the Clinical Council. The Chair commented that the draft is comprehensive and more succinct.

10. ANNUAL MĀORI HEALTH PLAN Q2 (OCTOBER-DECEMER 2015) DASHBOARD

The Chair welcomed Patrick Le Geyt, Programme Manager, Māori Health to the meeting. The contents of the report were noted including the achievements, areas of progress and challenges.

General discussion regarding cultural training. There was a 5% increase for medical staff this quarter. Is the target for SMOs or RMOs? RMOs are only here 1 or 2 years and have cultural training at their universities. Need clarification on what we are monitoring. Other health professionals also do training as undergraduate and post graduate. Do we capture this? Are we only counting the DHB training, are their other options that are appropriate. If people have had training elsewhere we need to understand the quality of that training. Patrick advised he will gain clarification on how this target is being measured. The DHB training is being evaluated to inform development of the next stage.

We need to inform doctors that this training will meet the requirements of their colleges, some in primary care find it hard to find appropriate courses.

The Chair commented that the essence of this course is confidence for this organisation, otherwise we have many health professions opting out.

Action: Clarification on the measure for the cultural training target.

11. TE ARA WHAKAWAIORA / BREASTFEEDING

Dr Caroline McElnay, Director – Population Health advised that the draft paper will also be going to the Maori Relationship Board and the Consumer Council for information before the DHB Board. There have been issues with the data in the past but they have now landed on a baseline for a comparison going forward. We are not meeting the target, increasing breastfeeding rates is a significant ongoing challenge. The rates at six weeks have increased for Maori, but there is a significant drop at three months. We need to look at this issue in a different way.

Questions / comments / feedback from Clinical Council Members:

- It's around culture, women are most influenced by their partners, family and community on how we feed our babies in the best way. Will not change overnight.
- Is the Baby café being well supported by consumers? Yes, they have become a go to place for women who have significant problems with breastfeeding rather than an every-day service.
- Having a choice, family violence is a factor and these women are busy surviving. Some partners don't like seeing breastfeeding, jealousy issue.
- There is an 88% success rate on discharge from hospital, then there is a drop off.
- Maternal age - younger mums start well but don't continue.
- Our health providers are remiss at times and don't look at weight charts well, babies on the 25 percentile, the perception of what is abnormal in terms of weight gain is not very good amongst some of our health providers.
- Can we look at how money for breastfeeding initiatives is being used (approximately $600 per woman) and look at doing something different.
- Social economic is a huge factor. The need to return to work, accessibility of being able to express milk in workplaces. What are we doing for those that are not at work, at home on benefits?

Any further feedback can be emailed Caroline McElnay caroline.mcelnay@hbdhb.govt.nz.

SECTION 3: REPORTING COMMITTEES

12. URGENT CARE ALLIANCE UPDATE

Dr Mark Peterson (Co-Chair) provided an update on the Urgent Care Alliance (UCA). Work is currently in hiatus, awaiting responses from the expressions of interest for taking part in the urgent care discussion (due back on 21 March). The two meetings held with health providers generated good discussion on both out of hours cover and urgent care during the day time.

Graeme Norton (Chair Consumer Council) advised that we are in the middle of the process now. It has generated a lot of conversations behind the scenes on how parties may collaborate. The proposal will come out of this. The service change proposal was circulated last year. It has given some steer to the group which was formed to develop the proposal. Good conversations are taking place in secondary services on how they might align differently.

Decision making is in May, process will be as long as is takes to get the processes in play. There is a timeline but we are uncertain as to what will come and will be able to provide a better update in April. What is the contingency if there are no suitable RFPs? The judgement at the moment is that we are likely to have a satisfactory response.

Kevin Snee (CEO) advised that he had seen responses on our Facebook page which mainly are around two issues, the cost of going to the GP and being able to access their GP when needed. There is a need for a radical change in thinking inside and outside of the hospital.

John Gommans (CMO) commented having had a record day in ED this week and increased growth month on month for the last 9 months through the ED, trying to plan how we manage this in the hospital depends on what happens in primary. Very keen to hear answers if we improve primary care what impact will this have on ED has to be part of the thinking. We don't want to have a bigger ED with more staff. That is not the right message.

The Chair Consumer Council commented there is some opportunity for improvement with structural change, but also need behavioural change. This is not a short term activity. A group visited the Midland region people who could not get a same day appointment with their GP. They were rung back within one hour by a medical practitioner and they found that 70% could be dealt with over the phone and did not need to come in. This is an example of a different practice, which results in a different outcome.

13. LABORATORY SERVICES COMMITTEE

Dr Kiri Bird was not at the meeting to provide an update. Deferred until April meeting.

14. FALLS COMMITTEE REPORT

Chris McKenna, Chief Nursing Officer and Chair advised there is a lot activity going on across the sector. No questions or issues raised.

15. MATERNITY CLINICAL GOVERNANCE GROUP UPDATE

Jules Arthur, Midwifery Director provided an update from the Maternity Clinical Governance Group. The Early engagement pilot, initial findings are really positive, working with our primary care colleagues.

No issues raised.

SECTION 4: GENERAL BUSINESS

16. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

No new member issues.

Caroline McElnay (Director Population Health) advised that the Youth Strategy will be coming back to Clinical Council and will be a draft strategy. If anyone in the Clinical Council has a particular interest in youth services they should contact Nicky Skerman, Population Health Strategist who is currently out doing consultation. There has been good consumer input.

John Gommans (CMO) commented that the recent visit by Jonathan Coleman, Minister of Health opening new Mental Health Unit was successful. The Minister was impressed with our consumer involvement and the presentations he attend around Aim 24/7, Clinical Council, productivity, engage in the community and the networks. He left with a very good impression on what we are doing at HBDHB.

17. RECOMMENDATION TO EXCLUDE THE PUBLIC

Recommendation by the Chair to move to the public excluded section of the meeting.

Approved.

The meeting closed at 4.50 pm

Confirmed: _____
Chair

Date: _____

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

Action No	Date issue raised	Action to be Taken	By Whom	By When	Status
1	09/09/15	**Alternative Health Provider** Item raised by David Rodgers will be investigated by Andy Phillips and a Draft Policy for the DHB regarding alternative providers will be produced.	A Phillips	Mar	Actioned
	9/3/16	New draft Policy reviewed under item 8 "Draft Complementary Therapies Policy". Revised version considering feedback to be provided for sign off.	A Phillips	?	Timing to be advised
2	9/3/16	Changes to the interest register have subsequently been advised and updated for Drs Whyman and Rodgers	B Crene	Mar	Actioned
3	10/02/16	**Customer Service Training** Update on future training sessions for HBDHB and PHO staff.	K Coley	Apr	Verbal update
4	10/02/16	**Clinical Council Member Portfolios** Members to email Ken/Brenda with areas of interest to be added to the plan.	All	Apr	
5	9/3/16	**Annual Maori Health Plan Q2** Clarification on the measure for the cultural training target sought for a response to April meeting.	T TeHuia / P LeGeyte	Apr	HR advise that Cultural Training is mandatory for all staff to attend.

HB CLINICAL COUNCIL WORKPLAN 2016-2017

Title of the Paper	Council meeting date	EMT Member
Investment / Disinvestment Prioritisation (1-3pm)	**11 MAY 2016**	
Orthopaedic Review - closure of phase 1 (from April to May)	**QUARTERLY**	Andy
Best Start Healthy Eating (FINAL)	**Venue: TTOH**	Caroline
Health Equity Update late paper to EMT and presentation	**Takarangi Room**	Caroline
Youth Health Strategy (DRAFT)		Caroline
PRELIM Quality Accounts regarding content (2 pager)	***Timing:***	Kate
New Patient Safety & Experience Report FOR May (precedes Dashboard in Jun)	*12.30pm lunch*	Kate
HB Intersectoral Group (Priority Plan) DRAFT	*1.00pm mtg*	Kevin Snee
Food Services Internal Review - DRAFT	*4.00pm Consumer*	Sharon
Travel Plan (Quarterly updates from May 16 - May/Aug/Nov/Mar17) verbal	*6pm close*	Sharon
Endoscopy Service Transition / Unit Development Update		Sharon
Customer Focussed Bookings		Sharon
Integrated Shared Patient Care Record - moved to May per Tim variation 18/2		Tim
Transform and Sustain Refresh (final)		Tim
HB Integrated Palliative Care (Discussion Draft)		Tim
Annual Maori Plan Q3 Jan-Mar 16 EMT version goes into committee papers		Tim
FINAL Annual Plan and Statement of Intent		Tim
HB Clinical Research Committee Update (May-Nov)		John G
Clinical Governance Structures / Committees Review		Kate
Quality Improvement Programme (EMT Prelim discussion - Preso to Clinical)		Kate
Urgent Care Monthly Project Report (provided to PMO)		
CAG Report (meeting on 3 May 2016) – tabled		Mark / Chris
HB Health Sector Leadership Forum	**17 MAY Venue: Waipatu Marae 8.30am-3.00pm**	
Youth Health Strategy (FINAL)	**8-Jun-16**	Caroline
Suicide Prevention Plan Update prior to MOH CFA website	8-Jun-16	Caroline
NEW Patient Safety and Experience Dashboard Q3 Jan-Mar 16)	8-Jun-16	Kate
Health Literacy FRAMEWORK	8-Jun-16	Kate / Ken
Health and Social Care Networks Update (Mar-Jun-Sept-Dec-Mar 17)	8-Jun-16	Liz
Te Ara Whakawaiora / Oral Health	8-Jun-16	Sharon
Food Services Internal Review - FINAL	8-Jun-16	Sharon

IS Review/Restructure Update Qtly Update - June + Sept + Dec 16	8-Jun-16	Tim
Infection Prevention Control Committee - Quarterly / reporting from June 2016	8-Jun-16	Chris
HB Nursing Midwifery Leadership Council Update (June-Oct))	8-Jun-16	Chris
Urgent Care Monthly Project Report (provided to PMO)	8-Jun-16	
Endoscopy/Gasto Build - Project Build Update (FRAC request 30/3/16)	8-Jun-16	Sharon
Alcohol (DISCUSSION)	**13-Jul-16**	Caroline
DRAFT Developing a Person Whanau Centred Culture	13-Jul-16	Kate
AIM 24/7 Update (Quarterly -Apr/July/Oct/Feb17 /Apr17)	13-Jul-16	John G
Quality Annual Plan (same time as "Governing for Quality")	13-Jul-16	Kate
Governing for Quality (same time as "Quality Annual Plan")	13-Jul-16	Kate
Urgent Care Alliance Update Quarterly (Apr/Jul/Oct/Feb 17)	13-Jul-16	
Radiology Services Committee	13-Jul-16	Mark
Laboratory Service Committee (March July November, March 17)	13-Jul-16	Mark
CAG Report (meeting on 14 June 2016) – written due 4 July	13-Jul-16	Mark / Chris
Renal Stage 4 SEEKING GUIDANCE	13-Jul-16	Sharon
DRAFT Quality Accounts (annual) - coordinate for issue same time as Annual Report	**10-Aug-16**	Kate
Event / Complaint / Hazard / Risk Management System	10-Aug-16	Kate
Travel Plan (Quarterly updates from May 16 - May/Aug/Nov/Mar17) VERBAL	10-Aug-16	Sharon
Annual Maori Plan Q4 Apr-Jun 16 EMT version goes into committee papers	10-Aug-16	Tim
Urgent Care Monthly Project Report (provided to PMO)	10-Aug-16	
Clinical Pathways Committee (4 monthly Apr-Aug-Dec-Apr 17)	10-Aug-16	Mark
CAG report (meeting on 26th July 2016) – no report this month - combined aug/sept	10-Aug-16	Mark / Chris
Operation Productivity Update	10-Aug-16	Sharon
Orthopaedic Review - phase 2 DRAFT	**14-Sep-16**	Andy
Family Violence - Strategy Effectiveness - for noting	14-Sep-16	Caroline
Alcohol (DRAFT)	14-Sep-16	Caroline
FINAL Developing a Person Whanau Centred Culture	14-Sep-16	Kate
FINAL Quality Accounts (annual) - coordinate for issue same time as Annual Report	14-Sep-16	Kate
NEW Patient Safety and Experience Dashboard Q4 (Apr-Jun 16)	14-Sep-16	Kate
Health and Social Care Networks Update (Mar-Jun-Sept-Dec-Mar 17) Board6monthly	14-Sep-16	Liz
HB Integrated Palliative Care (Final)	14-Sep-16	Tim
IS Review/Restructure Update Qtly Update - June + Sept + Dec 16	14-Sep-16	Tim
Falls Minimisation Committee Update (Mar-Sept)	14-Sep-16	Chris
Maternity Clinical Governance Group Update (Mar-Sept	14-Sep-16	Chris
Infection Prevention Control Committee (Sept-Dec-Mar-Jun)	14-Sep-16	Chris
DRAFT Serious Adverse Events (annually)	14-Sep-16	Kate

Urgent Care Monthly Project Report (provided to PMO)	14-Sep-16	
CAG Report (meeting on 6 September 2016) – tabled/verbal	14-Sep-16	Mark / Chris
Alcohol (FINAL)	**12-Oct-16**	Caroline
HB Nursing Midwifery Leadership Council Update (June-Oct))	12-Oct-16	Chris
AIM 24/7 Update (Quarterly -Apr/July/Oct/Feb17 /Apr17)	12-Oct-16	John G
FINAL Serious Adverse Events (annually)	12-Oct-16	Kate
Urgent Care Alliance Update Quarterly (Apr/Jul/Oct/Feb 17)	12-Oct-16	
Radiology Services Committee	12-Oct-16	Mark
Te Ara Whakawaiora / Smoking (national indicator) - same dates as Tobacco Plan	**9-Nov-16**	Caroline
Tobacco - Annual Update on Progress against the Plan (for noting) - same as TAW	9-Nov-16	Caroline
Travel Plan (Quarterly updates from May 16 - May/Aug/Nov/Mar17) VERBAL	9-Nov-16	Sharon
Annual Maori Plan Q1 Jul-Sept 16 EMT version goes into committee papers	9-Nov-16	Tim
Allied Health Professions Forum	9-Nov-16	Andy
HB Clinical Research Committee Update (May-Nov)	9-Nov-16	John G
Urgent Care Monthly Project Report (provided to PMO)	9-Nov-16	
Laboratory Service Committee (March July November, March 17)	9-Nov-16	Mark
CAG Report (meeting on 11 October 2016) - written due mon 31 OCT	9-Nov-16	Mark / Chris
Endoscopy/Gasto Build - Project Build Update (FRAC request 30/3/16)	9-Nov-16	Sharon
HBDHB Workforce Plan - Discussion Document (Dec 16 - final in March 17)	**7-Dec-16**	John McK
NEW Patient Safety and Experience Dashboard Q1 (July-Sept 16)	7-Dec-16	Kate
Health and Social Care Networks Update (Mar-Jun-Sept-Dec-Mar 17)	7-Dec-16	Liz
IS Review/Restructure Update Qtly Update - June + Sept + Dec 16	7-Dec-16	Tim
Infection Prevention Control Committee (Sept-Dec-Mar-Jun)	7-Dec-16	Chris
Urgent Care Monthly Project Report (provided to PMO)	7-Dec-16	
Clinical Pathways Committee (4 monthly Apr-Aug-Dec-Apr 17)	7-Dec-16	Mark
CAG Report (meeting on 29 November 2016) – tabled/verbal Rpt DUE 30 NOV	7-Dec-16	Mark / Chris
Renal Stage 4 FINAL FOR ENDORSEMENT	7-Dec-16	Sharon
Orthopaedic Review - phase 3 DRAFT	**8-Feb-17**	Andy
Annual Maori Plan Q2 Oct-Dec 16 EMT version goes into committee papers	8-Feb-17	Tim
AIM 24/7 Update (Quarterly -Apr/July/Oct/Feb17 /Apr17)	8-Feb-17	John G
Radiology Services Committee	8-Feb-17	Mark
Urgent Care Alliance Update Quarterly (/Feb -May 17)	8-Feb-17	
NEW Patient Safety and Experience Dashboard Q2 (Sept-Dec 16)	**8-Mar-17**	Kate
Health and Social Care Networks Update (Mar-Jun-Sept-Dec-Mar 17) Board6monthly	8-Mar-17	Liz
Travel Plan (Quarterly updates from May 16 - May/Aug/Nov/Mar17) VERBAL	8-Mar-17	Sharon
Falls Minimisation Committee Update (Mar-Sept)	8-Mar-17	Chris

Maternity Clinical Governance Group Update (Mar-Sept)	8-Mar-17	Chris
Infection Prevention Control Committee (Sept-Dec-Mar-Jun)	8-Mar-17	Chris
Urgent Care Monthly Project Report (provided to PMO)	8-Mar-17	
Laboratory Service Committee (March July November, March 17)	8-Mar-17	Mark
AIM 24/7 Update (Quarterly -Apr/July/Oct/Feb17 /Apr17)	**12-Apr-17**	John G
Urgent Care Monthly Project Report (provided to PMO)	12-Apr-17	
Clinical Pathways Committee (4 monthly Apr-Aug-Dec-Apr 17)	12-Apr-17	Mark
HB Clinical Research Committee Update (May-Nov)	**10-May-17**	John G
Urgent Care Alliance Update Quarterly (/Feb -May 17)	10-May-17	Mark
Orthopaedic Review - closure of phase 2	**8-Jun-17**	Andy
Orthopaedic Review - closure of phase 3	8-Jun-17	Andy
NEW Patient Safety and Experience Dashboard Q3 (Jan-Mar 17) MAY	8-Jun-17	Kate
Infection Prevention Control Committee (Sept-Dec-Mar-Jun)	8-Jun-17	Chris
HB Nursing Midwifery Leadership Council Update (June-Oct))	8-Jun-17	Chris

HAWKE'S BAY District Health Board Whakawāteatia	**Detailed Business Cases for 2015/16 Investments (A)**
	Position Title/s: - Palliative Care Medical Registrar (# 94) - Palliative Care CNS cover (# 44) - RNs Medical subspecialties Villa 6 and - NHC Outpatients (# 43)
For the attention of:	**HB Clinical Council**
Document Owner: Document Author(s):	Mandy Robinson Mandy Robinson, Penny Pere
Reviewed by:	Acute and Medical Directors, Executive Management Team
Month:	April 2016
Consideration:	For approval

RECOMMENDATION

That HB Clinical Council:

1. **Approve** the businesss case for the 2015/16 new investment. 2015/16 application numbers 94, 44, 43 were prioritised by clinical council to be combined to one business case and to go through approval process 3 for investment approval.

2. **Approve** funding of $124 thousand this financial year (2015-2016) and an annual budget of $198 thousand thereafter as outlined below:
   a. Palliative Care advanced trainee registrar (0.4 FTE) at a cost of $40,000 in the 2015 - 2016 year (one-off). Total cost for position $67,000 less $27,000 funded by Health workforce NZ (HWNZ).
   b. Palliative Care Clinical Nurse Specialist cover (0.5 FTE). 2015-16 year $47,000 and ongoing annual budget of $47,000.
   c. Villa 6 registered nursing increase of 1.43 FTE at a cost of $37,000 for the 2015-16 year for medical subspecialties, Oncology services and Napier Health Centre (NHC) outpatient clinics. Ongoing annual budget of $151,000.00 (1.94 FTE).

OVERVIEW

As part of the 2015/2016 new investment application process, Clinical Council has prioritised the following three applications for investment to be grouped together to a business case for further consideration and approval through process three investment approval process, to EMT and clinical council:

- palliative care advanced trainee Registrar 0.4 FTE
- leave cover of 0.5 FTE for Palliative Care Clinical Nurse Specialists (CNS)
- registered nursing (RN) increase of 1.43 FTE for Villa 6 nursing resource to work across:
  a) Medical subspecialties

b) Oncology services
c) Napier Health Centre (NHC) outpatient clinics.

This document outlines how the prioritised funding of $198 thousand from the Clinical Council decision, will be distributed across the three cases.

It was presented to EMT and is now presented to Clinical Council for consideration and approval.

BACKGROUND

Executive summary for the business case

Advanced Trainee post in Palliative Care Medicine

The palliative medicine workforce is integral to efficient, multidisciplinary care across a range of District Health Board services and conditions. Hospital based palliative care often focuses on supporting patients at an early stage of their illness when there is uncertainty regarding palliative requirements, for example; patients on renal dialysis, patients in Intensive Care or High Dependency Units, patients with a chronic disease being admitted multiple times. Specialist palliative care can be required at various stages across the patient's journey and when in place, often decreases the need for acute interventions.

Palliative Medicine has been identified as a vulnerable medical specialty by the Health Workforce New Zealand (HWNZ) and widely acknowledged as a critical workforce. The Ministry of Health has urged DHBs to consider filling palliative medicine trainee positions as able (correspondence from Ministry of Health available). An advanced trainee working between Cranford Hospice and Hawke's Bay District Health Board (HBDHB) was considered. Accreditation status from the Royal Australasian College of physicians was sought and approved, effective from June 2015 for a maximum of one year.

Due to the time it would have taken to go through a full business case proposal and recruitment process, plus the fact that a suitable trainee was living locally and seeking a part time position, a decision was made to appoint to this role in October 2015 at a cost of $40 thousand absorbed by Acute and Medical Directorate until funding was secured. We have funding via Health Workforce NZ of $27,000 (the pro rata amount for part time position).

An advanced trainee in palliative medicine will:

- contribute to the national workforce critical shortage
- improve medical support for patients will palliative care needs in the hospital, community and hospice
- provide opportunity for integrating palliative care with other medical sub-specialties e.g. renal, oncology etc.
- strengthen education, knowledge, skills and attitudes across the hospital, community and hospice

Palliative Care CNS 0.5FTE

The Palliative Care CNS roles are a critical component of the acute palliative care team based in the hospital. They work closely with the consultant Monday to Friday monitoring the current list of palliative care admitted patients and assessing the new referrals. The CNS role is an essential link between the clinical nursing and speciality teams with the palliative care consultant and with Hospice services.

The palliative care consultant is a part time specialist role and the advanced trainee role is present two days/week. Therefore the CNS palliative care roles need to provide a level of consistent and reliable service for the patients, their families and the clinical staff. The nursing team has a well-

structured training and education programme for all the staff and particular study days for those who are interested in expanding their palliative care knowledge.

The implementation of Te Ara Whakapiri, the principles and guidance for the last days of life, is a nationwide change replacing the Liverpool Care Pathway. The CNS nurses will have a central role implementing this change in the clinical environment. The path encompasses the experience of a person and their whanau/family at the end of life. The advanced care planning process which is now part of the clinical care environment is the opportunity for an individual to develop and express preferences for care with an understanding of their current and anticipated health status and the options available for care. The Palliative Care CNS enable the Advanced Care Plan (ACP) to be facilitated and respected within the acute environment. They work closely in partnership with the individual and their whanau/families to ensure the final days are, as the person wishes.

The future for the Palliative Care team lies within integration across the HBDHB sector with Hospice and Community providers especially in the Aged Residential Care sector. There needs to be a sound and reliable basis within the hospital environment to build on the opportunities for integration.

The current CNS team is 1.5 FTE. This bid is to increase the team to 2.0 FTE. The team is then made up of three staff who cover the leave of each member and ensure the presence of two expert nurses in the acute environment Monday to Friday. The peer support and collegial benefits with two people working in tandem, mitigate the isolation of single staff members and ensures continuity and communication when the medical team is not present. The additional resources required to implement Te Ara Wkakapiri are not available and the CNS nursing team will be required to develop an implementation plan to facilitate the change in the clinical areas.

Villa 6 Registered Nursing (RN) for Oncology and Medical sub specialties

The Oncology and Medical sub specialty services out of villa 6 have increased recently with; new clinics in NHC, a second Neurologist, an increase in Dermatology and skin lesion services, increased volumes in medical oncology and haematology and associated developments in the chemotherapy protocols, as well as increased demand for blood transfusions and venesections. There has been no increase in budgeted registered nursing FTE. . Most of the increased clinics have been supported with additional unbudgeted RN hours.

a) Medical and Radiation Oncology and Haematology

The provision of chemotherapy treatments, the management of bone biopsies and the monitoring and care of venesection patients are routine responsibilities of the nursing team in Villa 6. There are changes to the chemotherapy protocols which increase the number of attendances. The radiation oncology clinics are increasing to weekly rather than fortnightly. The haematology patient demand is increasing to the level that MidCentral District Health Board are looking at options to increase support to weekly rather than fortnightly, through the visiting clinic arrangements. Increased support for the consultants and registrars will facilitate efficiencies within the clinics' structure and process.

b) Medical Subspecialties - Infectious Disease RN and Dermatology

The structure and schedule of the clinics for Infectious Diseases has altered and led to an increase of out-patients clinics as a result of AAU roster changes. It is important to have strong nurse support to monitor the clinical status of patients between visits. This is a specialised area with succession planning required.

An increase in the Dermatology consultant FTE resource plus the service change within the skin lesion service and has meant more RN time required to support the medical clinics, minor surgery clinics and the outpatient referral processes. At this time the reinstatement of clinics at rural sites is on hold.

There are three senior staff for whom Villa 6 need to undertake succession planning. Full training and supervision is required to facilitate a smooth transition so that service delivery is not

compromised. Oncology and Haematology specialist nurses require supervised training of approximately 9 – 12 months. The clinic nurses for Infectious Diseases will be a member of the chemotherapy team who also has a medical subspecialty portfolio.

BENEFITS AND OUTCOMES

Benefit of this new position triple aim profile	Outcome	Measure
1. Improved quality, safety, patient care	• In patient referrals prioritised and initial assessment same day. (Palliative Care) • Patients and family have clear understanding of health status and options. (Medical Oncology, Haematology, Palliative Care) • Particular ACP requests are respected. (Palliative Care) • Single point of contact for patients and families with CNS established, (Palliative Care), and with Villa 6 RNs. (Medical Oncology, Haematology, Dermatology & Infectious Diseases). • Optimum experience of care	• <LOS palliative care (PC) inpatients • Consumer feedback • ESPI target compliance (Medical subspecialties)
2. Improved population health outcomes, equity	• Communication and relationships with Hospice and Community providers are consistent and have value.(Palliative Care) • Opportunities for engagement and partnerships are identified and explored. (Medical Oncology, Haematology, Dermatology & Infectious Diseases). • RN clinics for non-complex follow-ups (Dermatology & Infectious Diseases). • Full clinic schedules facilitating patient focused scheduling.	• Hospice, Primary care, and Aged Care sector provide positive feedback (Palliative Care) • Access to Palliative Care service reflect equity provision of care. • <DNA rates
3. Best value for health system	• All in patients are assessed and care plan documented same day as referral.(Palliative Care) • Transitions of clinical care to community and hospice are efficient and non-disruptive.(Palliative Care) • Acute presentations and/or admissions for patients may be reduced with improved communication pathway and an integrated model of care. (Dermatology, Infectious Diseases and Palliative Care)	• Shorter First Specialist Assessment (FSA) and Follow Up (FU) waiting times • Reduced casual nursing and additional nursing hours over budget • Clear and consistent documentation in Human Resources (Palliative Care)

FINANCIAL INVESTMENT, IMPLICATIONS AND SERVICE DELIVERY

Palliative Care advanced trainee	**$000's**	
	full time	pro rata (0.4 FTE)
Salary cost	125	60
On costs	25	7
Other operational costs		
total costs	150	67
less HWNZ funding		27
Estimated funding required & requested		40
Palliative Care CNS	**$000's**	
Salary cost	$47	
On costs		
Other operational costs		
Capital costs (please set out what capital purchase are required)		
Office accommodation found	Yes	
Information technology requirements identified (please stipulate what is required)	in place	
Medical and Oncology RNs	**$000's**	
Salary cost	$ 37 (2015-16) $151 (ongoing)	
On costs		
Other operational costs		
Capital costs (please set out what capital purchase are required)		
Office accommodation found	Yes	
Information technology requirements identified (please stipulate what is required)		

ESTIMATED TIMELINE

Provide an estimated milestone plan for the implementation phase of this project.

Milestones	Completion Date
Palliative Care Advanced Trainee	In place June 2015 - June 2016
Palliative Care CNS 0.5FTE	April 2016
Villa 6 RN increase	April 2016

Hawke's Bay
District Health Board
Position Profile / Terms & Conditions

Position holder (title)	Registered Nurse - step 2 *(as per the NZNO/DHBs Nursing & Midwifery Multi Employer Collective Agreement)*
Reports to (title)	Nuse Manager Oncology & Medical Subspecialities
Department / Service	Villa 6, Acute & Medicine Directorate
Purpose of the position	▪ The nurse works in partnership with patients and their families / whanau and collaborates with the multi-disciplinary team, to provide quality nursing care that is safe, cost effective and in accordance with professional, organisational standards, policy and procedure. ▪ To provide nursing care in line with the Nursing Council of New Zealand (2007) Competencies for the Registered Nurse Scope of Practice. ▪ To support the delivery of the Hawkes Bay Health Sector vision and organisational wide KPI's e.g. MOH targets, financial targets. ▪ To recognise and support the delivery of the Hawkes Bay Health Sector vision.

Working Relationships

Internal	External
▪ Patients/Consumer/Tangata Whaiora ▪ Service Management team (ie, Nurse Director, Clinical Director, Service Director) ▪ Wider Organisational Nursing team (ie, Nurse Educators, Clinical Nurse Specialists, Nurse Practitioners, Registered and Enrolled Nurses) ▪ Chief Nursing Officer ▪ Allied Health Staff ▪ Medical Staff ▪ Other team members (ie, Care Associates, Nursing students) ▪ Relevant advisory groups/committees	▪ Families/whanau and caregivers ▪ General Practitioners ▪ Practice Nurses ▪ Primary health providers ▪ Health agencies ▪ Rural Health centres ▪ Mid central DHB ▪ Cancer Society HB

Dimensions

Expenditure & budget / forecast for which accountable	Nil
Challenges & Problem solving	The nurse working the Oncology service and medical sub speciality is required to become proficient in the management of chemotherapy and to focus on one of the medical sub speciality teams from an Out Patient perspective. The Villa 6 nursing team is a small team with very good relationships across the speciality teams and clinical roles associated with service delivery. The nursing roles are supported with preceptors, mentors and particular education to develop the competencies required to work in the Villa 6 environment.
Number of staff reports	Nil
Delegations & Decision	Registered Nurses practice are responsible for direction and delegation as outlined in the Nursing Council of New Zealand guidelines: ▪ Guideline: Responsibilities for direction and delegation of care to enrolled nurses (May 2011) ▪ Guideline: Delegation of care by a registered nurse to a health care assistant (May 2011)
Other Indicators	Nil


Our vision
HEALTHY
HAWKE'S BAY
TE HAUORA O
TE MATAU-Ā-MĀUI
Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.
Our values
Tauwhiro – delivering high quality care to patients and consumers
Rāranga te tira – working together in partnership across the community
He kauanuanu – showing respect for each other, our staff, patients and consumers
Ākina – continuously improving everything we do

Key Accountabilities

PROFESSIONAL RESPONSIBILITY Has knowledge and judgement in professional, legal, ethical responsibilities and cultural safety. Is accountable for own actions and decisions, while promoting an environment that maximises client safety, independence, quality of life and health.	
Tasks (how it is achieved): Accepts individual responsibility and professional judgement for position requirements and decision making. Demonstrates responsibility, accountability and commitment in nursing practice and to the nursing profession. Applies the Treaty of Waitangi to nursing practice, assisting patients to gain appropriate support cultural needs and preferences. Demonstrates a clear understanding of direction and delgation when delegating work to others i.e. enrolled nurses, nursing students, care associates. Seeks guidance from senior RN's when required. Recognises and manages risks to provide care that best meets the needs and interests of patients. Demonstrates individual responsibility for professional development.	**How it will be measured (KPI):** Evaluated through feedback on: ▪ 100% legislative compliance ▪ Working within ethical guidelines, Code of Health and Disability Service Consumers' Rights, HBDHB Professional Nursing Standards, Policies, Protocols and Guidelines. Evidence of competence by: ▪ Self assessment against all Nursing Council RN competencies (illustrated through the Nursing Professional Development Recognition Programme [PDRP] at level 2) ▪ Three yearly review against all Nursing Council RN competencies.

MANAGEMENT OF NURSING CARE Is responsive to client needs in relation to assessment and managing care, supported by nursing knowledge and evidence based research.	
Tasks (how it is achieved): Demonstrates competence and autonomy of practice in the clinical setting providing nursing care to patients with a range of needs. Utilises nursing knowledge and skills through reflective practice and professional judgement to provide competent care and advice. Completes timely systematic holistic asessments to determine actual and potential risk problems. Recognises recurring patterns related to monitoring and patient responses/conditions and is able to problem solve utilising assessment/monitoring data. Utilises assessment skills and nursing interventions to assess patient responses to treatments and adapt approaches to accommodate any changes. In partnership with the patient, family / whanau, develops an individualised plan of care to achieve the desired outcomes. Implements and coordinates the interventions to deliver the plan of care. Evaluates and records progress toward attainment of desired outcomes and revise the plan of care as necessary.	**How it will be measured (KPI):** Evidenced through confirmed assessment on PDRP. Evaluated through evidence of competence by: ▪ Self assessment against all Nursing Council RN competencies (illustrated through the Nursing Professional Development Recognition Programme [PDRP] at level 2) ▪ Three yearly review against all Nursing Council RN competencies. Evaluated through documentation audits. Evaluated through patient/family feedback. Timely completion of trendcare data & complaince with inter-rater reliability testing (in areas utilising this system)

Maintains clear, concise, timely accurate and current documentation within a legal and ethical framework. Actualises all patients in Trendcare (if applicable within ward / unit). Takes action in situations that compromise the patients safety and wellbeing. Participates in health education, ensuring the patient understands relevant information related to their care.	

INTERPERSONAL RELATIONSHIPS Provides interpersonal and therapeutic communication with clients, other health professionals, including documentation.	
Tasks (how it is achieved): Demonstrates respect, empathy and interest in the patient. Participates in building clinical capacity and capability of nurses to meet the patient/consumer/tangata whaiora needs in an efficient and effective manner. Demonstrates competence in applying the principles of teaching and learning in association with patient/client care. Contributes to the development of nursing knowledge within the work area. Communicates effectively with patients and members of the health care team.	**How it will be measured (KPI):** Evaluated through evidence of competence by: ▪ Self assessment against all Nursing Council RN competencies (illustrated through the Nursing Professional Development Recognition Programme [PDRP] at level 2) ▪ Three yearly review against all Nursing Council RN competencies. Contribution to work area teaching sessions Evaluated through: ▪ Feedback from patients/families ▪ Feedback from team members including students.

INTERPROFESSIONAL HEALTH CARE and QUALITY IMPROVEMENT Evaluates the effectiveness of care and promotes a nursing perspective within the inter-professional activities of the health care team.	
Tasks (how it is achieved): Providing guidance and support to all team members including nursing students. Maintains and documents information necessary for continuity of care. Develops discharge plans in consultation with the patient and other team members. Contributes to the coordination of patient care to maximise health outcomes. Participates in quality systems, including standards of practice and service standards. Demonstrates an understanding of quality improvement principles with translation into nursing practice.	**How it will be measured (KPI):** Evaluated through evidence of competence by: ▪ Self assessment against all Nursing Council RN competencies (illustrated through the Nursing Professional Development Recognition Programme [PDRP] at level 2) ▪ Three yearly review against all Nursing Council RN competencies. Evaluated through feedback from team members including students. Evaluated through: ▪ Participation in the Quality Improvement processes ▪ Timely completion of trendcare data & complaince with inter-rater reliability testing (in areas utilising this system).

PATIENT SAFETY	
Tasks (how it is achieved):	**How it will be measured (KPI):**

Demonstrates the use of patient safety mechanisms to identify near misses. Participation in multi-disciplinary meetings and systems	Evaluated through evidence of competence by: ▪ Self assessment against all Nursing Council RN competencies (illustrated through the Nursing Professional Development Recognition Programme [PDRP] at level 2) ▪ Three yearly review against all Nursing Council RN competencies. Evaluated through: ▪ Timely utilisation and completion of patient safety tools e.g., Event Report, Medication Errors, Falls, EWS ▪ Evaluated through documentation audits ▪ Feedback from team members

OCCUPATIONAL HEALTH & SAFETY	
Tasks (how it is achieved): Displays commitment through actively supporting all health and safety initiatives. Ensures all staff/colleagues maintain adequate safety standards on the job through consultation, training and supervision. Ensures own and others safety at all times. Complies with policies, procedures and safe systems of work. Reports all incidents/accidents, including near misses in a timely fashion. Is involved in health and safety through participation and consultation.	**How it will be measured (KPI):** Evidence of participation in health and safety activities. Demonstrates support of staff/colleagues to maintain safe systems of work. Evidence of compliance with relevant health and safety policies, procedures and event reporting.

Key Competencies

CUSTOMER SERVICE	
Tasks (how it is achieved): Open and responsive to customer needs. Demonstrate an understanding of continuous quality improvement.	**How it will be measured (KPI):** Demonstrates a commitment to customer service and continuous quality improvement, through interaction with patient/clients and other customers. Identifies customer needs and offers ideas for quality improvement. Effective management of customers/situations.

HONOURING TREATY OF WAITANGI OBLIGATIONS	
Tasks (how it is achieved): Demonstrates understanding of the principles of the Treaty of Waitangi. Ensure the principles of partnership, protection and participation are applied to day to day work.	**How it will be measured (KPI):** Evidence of the principles applied in work practice.

Ensures procedures do not discriminate against Maori.	

Essential and Desirable Criteria: Qualifications / Skills / Experience

Essential	
Treaty of Waitangi Responsiveness (cultural safety)	Demonstrates the ability to practise nursing in a manner that the health consumer determines as being culturally safe, and to demonstrate ability to apply the Treaty of Waitangi to nursing practice.
Qualifications (eg, tertiary, professional)	Registration with the Nursing Council of New Zealand as a Registered Nurse.
Business / Technical Skills (eg, computing, negotiating, leadership, project management)	Provides evidence to meet the Nursing Council of New Zealand (2007) Competencies for the Registered Nurse scope of practice and (2012) Code of Conduct for Nurses.
Experience (technical and behavioural)	▪ A current practising certificate with the Nursing Council of New Zealand, with evidence of meeting continuing competence requirements. ▪ Level 2 portfolio as assessed via an approved Nursing Professional Development Recognition Programme (PDRP) ▪ Demonstrated time management skills ▪ Demonstrated ability to work within a team ▪ Excellent communication skills Shows commitment to, and demonstrates the behaviours of the health sector: ▪ Tauwhiro (delivering high quality care to patients and consumers) ▪ Rāranga te tira (working together in partnership across the community) ▪ He kauanuanu (showing respect for each other, our staff, patients, and consumers) ▪ Ākina (continuously improving everything we do) ▪ Recent acute experience in either surgical or medical services.
Desirable	
	▪ IV Certification ▪ Cannulation ▪ Experience with chemotherapy management

Recruitment Details

Position Title	As per the requisition
Hours of Work	80 per fortnight
Salary & Employment Agreement Coverage	In accordance with the DHB's / NZNO Nursing & Midwifery Multi Employer Collective Agreement (MECA) $50,940 - $63,528 gross per annum according to qualifications and experience pro rata for hours worked (only include if the position part time).
Date	Date position profile received and used for recruiting

Hawke's Bay
District Health Board
Position Profile / Terms & Conditions

Position holder (title)	Clinical Nurse Specialist – Palliative Care
Reports to (title)	Nurse Director – Acute & Medical and Elective & Surgical Services Nurse Manager Oncology & medical Subspecialties
Department / Service	Acute & Medicine Directorate
Purpose of the position	The Clinical Nurse Specialist – Cancer Nurse Coordinator (CNS/CNC) will provide advanced care coordination from point of referral through to diagnosis, treatment & beyond for the identified patient population. The patient population are those patients included within the HBDHB environment who have been referred to Palliative Care Services for assessment and care. To improve overall access and timeliness for care and treatment by Palliative Care services through consistent and robust processes. To improve the experience for patients including their family and whanau, at the end of life. The role will have a strong focus on equity of access to support our high-risk populations. This role will be involved in both direct care delivery and in support of other health professionals in the management of this patient population. This role will lead innovative practice within the population group to improve patient flow across the sectors (acute care, hospice, community and ARC). This role will act as a change agent to identify, review and improve systems and processes using quality improvement best practice methodology. To promote and role model excellence in nursing practice, that results in improved clinical practice and health outcomes for the identified population group.

Working Relationships

Internal	External
• Patients/Consumer/Tangata Whaiora • Director of Nursing • Service Management team • Wider Organisational Nursing team (i.e., Nurse Educators Clinical Nurse Specialists, Nurse Practitioners) • Allied Health Staff • Medical staff and clinical teams for each of specialist services • Admin staff and IS/IT teams • Diagnostic clinical teams, laboratory and radiology • HBDHB Cancer specialties and MDM teams	• Families/whanau and caregivers • Primary health care providers, GPs • Other health providers / Maori Health providers • NGO's & other relevant community health & social service agencies • Cranford Hospice and staff • Regional Cancer Treatment Service (RCTS) - Medical Oncology, Radiation Oncology & Clinical Haematology cancer treatment teams • Central Cancer Network (CCN) • Other Central Region & nationwide DHB service providers

Dimensions

Expenditure & budget / forecast for which accountable	NA
Challenges & Problem solving	• The development and establishment of an extensive network including HBDHB providers, clinical staff, MDT members, external providers of services, diagnostic teams, and relevant management personnel. • Enabling an effective continuum of care for cancer patients requires the development and maintenance of relationships, credibility and the ability to identify the appropriate clinical need. • Identifying multidisciplinary strengths and weaknesses and implementing change in services for patients and families to reflect best practice and influencing outcomes with consideration of individual requirements and expectations. • Effectively initiating and facilitating change processes to improve standards in clinical practice and patient outcomes in conjunction with key stakeholders and with reference to the expectations associated with Palliative Care . • Ensuring equity of access for high risk groups.
Number of staff reports	Nil
Delegations & Decision	• The role has accountability for coordinating care for any patient referred to the Palliative Care service. • The key function is advanced clinical coordination of the patient care and internal HBDHB processes that enable continuity of care. • The CNS ensures decision making is undertaken by the most appropriate clinician at the correct point in the patient pathway.
Other Indicators	• To engage and work towards an integrated model of care.


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Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.
Our values
Tauwhiro – delivering high quality care to patients and consumers
Rāranga te tira – working together in partnership across the community
He kauanuanu – showing respect for each other, our staff, patients and consumers
Ākina – continuously improving everything we do

Key Accountabilities

PROFESSIONAL RESPONSIBILITY	
Tasks (how it is achieved): • Accepts responsibility for the provision of specialist care and expertise, which meets the standards of the professional, ethical and relevant legislated requirements. • Provides nursing leadership within the multi-disciplinary meeting (MDM) environment (once MDM established) by providing leadership and direction for the teams that provide direct care delivery. • Accountable for researching, evaluating, developing and implementing standards of nursing practice, developing evidence based practice including clinical protocols and guidelines. • Responsible for communicating to Nurse Director, Service Management and the wider clinical team practice changes, which are based on best practice evidence. • Responsible for communicating to Nurse Director, Service Management and wider teams of clinical risks facing the services that deliver cancer care and recommending plans for addressing areas of concern. • Achieves and maintains recognition of expert (Level 4) of practice on the HBDHB Nursing Professional Development and Recognition Programme (PDRP). • Participates in professional activities to keep abreast of current trends and issues in nursing. • Maintains own knowledge of best practice relating to the management of cancer pathways, and promotes this across the HBDHB and the Central Region networks. • Establishes formal and informal networks on a local, regional and national level.	**How it will be measured (KPI):** Evaluated through annual performance appraisal and successful assessment of PDRP with: • Evidence of process and pathway development • Evidence of relationship development within HBDHB and across Palliative Care Network • Demonstrates responsibility and risk management to provide care that meets standards. • Evidence of maintaining a significant presence in clinical areas as a resource, role model, coach and advocate. • Positive staff feedback regarding assistance, support and communication. • Demonstrates ongoing maintenance of Level 4 PDRP. • Engages in postgraduate level education (or equivalent).

MANAGEMENT OF NURSING CARE	
Tasks (how it is achieved): • Establishes a coordinated and standardised referral processes for patients. • Responsible for providing specialist care and expertise through direct care delivery to clients which supports the delivery of Palliative care and HBDHB financial sustainability. • Leads case management of patients with complex needs and identified high service users within the multidisciplinary team, as required. • Provides advice in complex clinical issues across settings and disciplines including the community. • Facilitates patients to develop and understand their clinical status, to enable the patient's decision making and acceptance of self management. • Records contacts within the hospital setting and documentation of patient visits through HR and clinical letter documentation. • Records contacts in the community and documentation of patient visits within the shared patient file. • Role models excellence in clinical practice, patient management processes and maintenance of the therapeutic environment.	**How it will be measured (KPI):** Evaluation through annual performance appraisal and successful assessment of PDRP with: • Clearly described referral processes developed and implemented for patients with confirmed cancer and/or those with high suspicion. • Assessment, planning, implementation and evaluation of care for complex and high service user's patients. • Demonstrates strong clinical involvement in supporting implementation of national tumour standards. • 100% compliance of using established referral and exit criteria • 100% compliance with clinical documentation of client progress e.g. pathways, treatment plans, community visits, clinical record, letters, and clinical photography

• Accountable for researching, evaluating, developing and implementing standards of nursing practice, developing evidence based practice. • Develops and provides expert resource to patients, families, nurses and multidisciplinary team in planning and evaluating care. • Works with within the MDM and primary health organisations / NGO's to ensure equity of access for high risk groups	• Develops processes for collection and utilisation of key clinical indicators related to service quality and timeliness. • Positive staff and patient / family feedback. • Researching, evaluating, developing and implementing standards of nursing practice. • Development of patient information resources.

INTERPERSONAL RELATIONSHIPS & CONSULTATION ***(Clinical Advice to Health Professionals)***	
Tasks (how it is achieved): • Liaise with all other relevant clinical staff with a cancer care focus to develop coordinated pathways for patients with confirmed cancer. • Provides expert clinical leadership, by providing leadership, advice, support and development to other staff providing direct care delivery with regards to cancer coordination within HBDHB health sector and the Central Region. • Establishes and maintains effective communication between services across the wider HBDHB setting including primary providers and NGO services. • Communicates effectively with members of the health care team, including using a variety of effective communication techniques, employing appropriate language to context and providing adequate time for discussion. • Establishes and maintains effective interpersonal relationships with others, including utilising effective interviewing and counselling skills and establishing rapport and trust. • Provides advice and practical assistance to nursing staff and carers in a timely manner. .	**How it will be measured (KPI):** Evaluated through annual performance appraisal and successful assessment of PDRP with: • Evidence of attendance and participation at senior clinical meetings within local health sector and across Palliative Care Network • Evidence of review, development and support of changes to clinical practice with providers. • Feedback from patients and members of the health care team regarding effective communication, assistance and support. • Evidence of working as a change agent by influencing attitudes and behaviours through the introduction of new ideas and approaches to nursing practice. • Evidence of working collaboratively across multi-disciplinary teams at HBDHB.

INTERPROFESSIONAL HEALTH CARE and QUALITY IMPROVEMENT	
Tasks (how it is achieved): • Maintains and promotes quality and safe practice in line with risk management policies. • Participates in quality improvement activities identifying, monitoring and reporting nurse sensitive clinical indicators. • Facilitates the development, implementation and review of best practice guidelines, procedures and policies to provide guidance and increase consistency of care across the sector. • Participates in projects and working parties (as delegated) to address organisation wide clinical issues, including implementation of recommendations and project outcomes. • Works with nursing staff to continuously improve nursing practice and patient outcomes. • Facilitates forums as appropriate or in conjunction with other services to progress and improve health care and quality of clinical practice. • Identifies opportunities and efficiency gains that will enhance the clinical provision of the service. • Participates in complaint and event reviews (as delgated). • Contributes to risk management activities within the service.	**How it will be measured (KPI):** Evaluation through annual performance appraisal and successful attainment of PDRP with: • Evidence of development and audit / monitoring of key clinical indicators. • Evidence of development and/or participation in audit activity associated with MDM processes. • Evidence that clinical and organisational risk is being monitored and processes for escalation are developed. • Evidence of leadership in participating, attending and implementing set project outcomes • Evidence of resolving consumer complaints and event reviews.

ADVANCED CLINICAL ASSESSMENT & DIAGNOSTIC REASONING	
Tasks (how it is achieved): • Demonstrates advanced clinical knowledge and skills in cancer nursing and advanced clinical care coordination • Supports all members of the MDM teams to develop clinical competencies that facilitate appropriate care. • Maintains clear and concise documentation which meets HBDHB documentation standards. • Establishes a method of triaging for service / referrals for specific specialty patients. • Supports the implementation of patient assessment tools and systems. • Use of advanced clinical assessment skills to identify individuals or patient populations at risk and plan necessary interventions.	**How it will be measured (KPI):** Evaluated through annual performance appraisal and successful assessment of PDRP with: • Evidence of development of consistent and robust referral management process for all patients referred.. • Evidence of a high level of documentation of clinical assessment and diagnostic reasoning in the patient's health record. • Evidence of working with and supporting clinicians with case reviews. • Evidence of leading and participating in local, regional or national benchmarking.

EDUCATION, REFLECTIVE PRACTICE and PEER REVIEW	
Tasks (how it is achieved): • Demonstrates utilisation of evidence to inform best practice, which is disseminated across the sector. • Collaborates with clinical, diagnostic, and allied health team members to facilitate the development, implementation and evaluation of team education, utilising evidence based clinical pathways, nursing standards of practice and protocols, to improve patient outcomes, as delegated. • Foster and participate in peer review and reflective practice processes. • Participates in strategic planning activities related to workforce development for the sector.	**How it will be measured (KPI):** Evaluated through annual performance appraisal and successful assessment of PDRP with: • Evidence of contributing and supporting the advancement of specialty practice education through facilitation and participation in peer review, journal club activity. • Evidence of the utilisation of best practice in any practice changes. • Contribute to evaluation of the cancer care coordination roles.

CRITICAL THINKING	
Tasks (how it is achieved): • Accesses and utilises relevant policy, organisational, national strategic and policy documents and reports to progress the effectiveness of services. • Critically reviews policy and programme information related to Palliative Care to ensure HBDHB meet the service objectives and performance measures.. • Provides information, feedback and submissions relating to service delivery and capacity within the sector as required. • Presentation of business case development and writing as delegated.	**How it will be measured (KPI):** Evaluated through annual performance appraisal and successful assessment of PDRP with: • Evidence of critiquing of and integration of contemporary literature for service development. • Demonstration that HBDHB continues to meet Palliative Care requirements and measures. • Demonstration of written material to a high standard e.g. documents, policies, business cases etc.

PATIENT and FAMILY EDUCATION	
Tasks (how it is achieved): • Providing information and advice to patients to facilitate decision making regarding treatment decisions.	**How it will be measured (KPI):**

• Develops the role as the single point of contract for patients for Palliative Care.. • Development of educational material e.g. handouts etc for consumers for health literacy of specific conditions. • Supports and participates in specific educational programmes for patients and their family members eg. Advanced care planning.	Evaluated through annual performance appraisal and successful assessment of PDRP with: • Evidence of educating family / whanau to self-manage. • Evidence of effective after-hours management for patients requiring support and information. • Evidence of involvement in educational programmes. • High levels of patient/family/whanau satisfaction reported.

OCCUPATIONAL HEALTH & SAFETY	
Tasks (how it is achieved):	**How it will be measured (KPI):**
• Displays commitment through actively supporting all health and safety initiatives. • Ensures all staff/colleagues maintain adequate safety standards on the job through consultation, training and supervision. • Ensures own and others safety at all times. • Complies with policies, procedures and safe systems of work. • Reports all incidents/accidents, including near misses in a timely fashion. • Is involved in health and safety through participation and consultation.	• Evidence of 100% participation in health and safety activities. • Demonstrates support of staff/colleagues to maintain safe systems of work. • Evidence of compliance with relevant health and safety policies, procedures and event reporting.

Key Competencies

CUSTOMER SERVICE	
Tasks (how it is achieved):	**How it will be measured (KPI):**
• Open and responsive to customer needs. • Demonstrate an understanding of continuous quality improvement.	• Demonstrates a commitment to customer service and continuous quality improvement, through interaction with patient/clients and other customers. • Identifies customer needs and offers ideas for quality improvement. • Effective management of customers/situations.

HONOURING TREATY OF WAITANGI OBLIGATIONS	
Tasks (how it is achieved):	**How it will be measured (KPI):**
• Demonstrates understanding of the principles of the Treaty of Waitangi. • Ensure the principles of partnership, protection and participation are applied to day to day work. • Ensures procedures do not discriminate against Maori. • Strong emphasis on reducing disparity across all tumour streams. This involves understanding most risk populations and developing strategies across local health sector to address disparity.	• Evidence of the principles applied in work practice. • Specific monitoring of outcomes by ethnicity is developed and reported. • Health services across the local sector are involved in addressing identified disparity.

Essential and Desirable Criteria: Qualifications / Skills / Experience

Essential	
Qualifications (eg, tertiary, professional)	Registration with the Nursing Council of New Zealand as a Registered Nurse.
Business / Technical Skills (eg, computing, negotiating, leadership, project management)	Provides evidence to meet the Nursing Council of New Zealand (2007) Competencies for the Registered Nurse scope of practice and (2012) Code of Conduct for Nurses.
Experience (technical and behavioural)	• A current practising certificate with the Nursing Council of New Zealand, with evidence of meeting continuing competence requirements: • Evidence of completion of a postgraduate diploma and working towards a Clinical Masters degree. • Commitment to the Hawke's Bay District Health Board Nursing Professional Development Recognition Programme (PDRP), evidenced by portfolio submission 6 months after commencement of employment. • Excellent facilitation and co-ordination skills. • Demonstrated effective ability in written and oral communication. • Knowledge of and a demonstrated ability to achieve continuous improvement outcomes. • Demonstrates sound analytical skills. • Agent for change and ability to work collaboratively and influence at a regional and national level • Current New Zealand driver's licence.
Desirable	• Clinical experience in oncology/cancer nursing • Proven ability to function in a nursing leadership role. • Experience as a clinician in a community environment. • Knowledge of adult education and teaching principles. • Ability to motivate others towards a common goal.

Recruitment Details

Position Title	Clinical Nurse Specialist - Cancer Nurse Coordinator
Hours of Work	As negotiated
Salary & Employment Agreement Coverage	In accordance with the NZNO/DHB's Nursing & Midwifery Multi Employer Collective Agreement (MECA) Grade 4 Step 1 Senior Nurse scale $78,094 gross per annum according to qualifications and experience pro rata for hours worked
Date	Date position profile received and used for recruiting

HAWKE'S BAY District Health Board Whakawāteatia	**Detailed Business Cases for 2015/16 Investments (B)**
	Position Title: **-** Specialty Clinical Nurse -Cardiac Rhythm Management (#64)
For the attention of:	**HB Clinical Council**
Document Owner: Document Author(s):	Gay Brown Gay Brown and Penny Pere
Reviewed by:	Acute and Medical Directors, Executive Management Team
Month:	April 2016
Consideration:	For approval

RECOMMENDATION

That HB Clinical Council:

1. **Approve** the business case for the 2015/16 new investment application process. Application number 64 was prioritised by clinical council to go through approval process 3 for investment approval.

2. **Approve** recruitment to the new nursing position of Specialist Clinical Nurse, Cardiac Rhythm Management, 1 FTE salary of $89,777. $24,443 this financial year (2015/16) and full annual cost thereafter of $89,777.

OVERVIEW AND PURPOSE

As part of the 2015/2016 new investment application process, Clinical Council has prioritised the application for investment number 64, Specialty Clinical Nurse, cardiac rhythm management to go through approval process 3 for investment approval.

There is an increasing number of the Hawkes Bay population with, and requiring, pacemakers and implantable cardiac defibrillator (ICD). As at February 2016 in Hawkes Bay there are around 600 patients with pacemaker, over 140 patients with ICDs and 20 patients with reveal monitors. These numbers are growing year on year due to the aging population. People are surviving longer with cardiac conditions requiring an implantable cardiac device to maintain their quality of life.

The position of Speciality Clinical Nurse, Cardiac Rhythm Management will provide specialist nursing care for cardiac arrhythmia patients requiring implantable cardiac devices. The nurse will provide a support service for patients requiring complex cardiac devices pre and post procedure, patients requiring long term arrhythmia management and will enhance the existing cardiac pacing service at present staffed by a Cardiac Clinical Physiologist. The nurse will be the key point of contact for clinicians and patients.

This business case outlines how the proposed investment of $89,777 will be allocated to the new position of specialty clinical nurse (SCN), cardiac rhythm management (CRM).

It was presented to EMT and is now presented to Clinical Council for consideration and approval.

BACKGROUND

Executive summary for the business case

HBDHB is experiencing a steady increase of patients with, and requiring, permanent pacemakers (PPM) and ICD's (50-60 yearly). Since the establishment of the pacing service in Hawkes Bay in 2014, there is an acknowledged gap in patient care pre and post insertion of devices. Patients transferring to Capital and Coast (C&C) DHB for insertion of these devices are reliant on information, education and support from C&C staff. Care for patients post insertion of devices, is currently provided by the Clinical Physiologists around their core service of technical monitoring patient devices. This is sub optimal patient care and is better provided and managed by an experienced registered nurse.

Current service for these groups of patients:

- Patient diagnosed as requiring ICD or pacemaker or other cardiac device
- Patient referred to C&C DHB. Information and education given to patient and family at this time is dependent on Cardiology ward inpatient staff time, knowledge and experience, outpatient staff knowledge and experience, or primary care provider knowledge
- When in Wellington for procedure, patient may or may not see a CRM specialist clinical nurse
- Patient returns to Hawkes Bay and seen by clinical physiologist for technical follow-up
- 3 – 6 monthly technical checks with clinical physiologists in Hawkes Bay

The new position of Speciality Clinical Nurse Cardiac Rhythm Management will provide specialist nursing care for cardiac arrhythmia patients including those requiring implantable cardioverter defibrillators (ICD's), cardiac resynchronisation (CRT) devices, permanent pacemakers (PPM), implantable loops recorders, holter analysing and other specific cardiac investigations. The nurse will work directly with patients and whanau providing support and clinical expertise for patients requiring complex cardiac devices and patients requiring arrhythmia management. The SCN will enhance the existing pacing service at present staffed by Cardiac Clinical Physiologists.

The focus is on care delivery and community support, providing nursing care and expertise, both in direct care delivery and in support to other staff and community providers in the management of cardiac patients with cardiac devices. The nurse will be the key point of contact for clinicians across the district, and patients, providing support and information resources.

BENEFITS AND OUTCOMES

Benefit of this new position triple aim profile	Outcome	Measure
1. Improved quality, safety, patient care	• patients seen within recommended follow up times • decreased anxiety of patients waiting to be seen or wanting advice (through SCN contacting patients and whanau/family) • point of contact established • improved experience of care • continuity of care pre and post procedure • SCN will liaise with primary care provider on follow up and monitoring requirements	• ESPI targets met • MoH target • Consumer feedback • Follow up waiting times within target • Primary care feedback
2. Improved population health outcomes, equity	• improved experience of care through pre and post procedure support • point of contact for hospital and primary clinicians, and patients • planning for end of life deactivation of device • stronger links with primary care through stronger communication channels, education and training provision • Contribution to the development of clinical pathways and protocols within the Cardiac Service.	• primary care feedback • consumer feedback • fewer referrals for specialist clinics are declined or returned to referrer •
3. Best value for health system	• fewer presentations and/or admissions for patients who may require intervention and/or monitoring • reduced LOS for this group of patients • continuity of care pre and post procedure	• shorter FU waiting times • reduced LOS • reduced readmissions

FINANCIAL INVESTMENT, IMPLICATIONS AND SERVICE DELIVERY

	$000's
Salary cost	24 (2015/16) 89,777 (ongoing)
On costs	
Other operational costs	
Capital costs (please set out what capital purchase are required)	
Office accommodation found	Yes
Information technology requirements identified	nil additional

FINANCING THE POSITION/S

The position will be funded by the 2015-2016 approved budget bid

ESTIMATED TIMELINE

Milestones	Completion Date
funding confirmed	March 2016
position advertised	March 2016
recruitment completed	April 2016

Hawke's Bay
District Health Board
Position Profile / Terms & Conditions

Position holder)	Specialty Clinical Nurse – Cardiac Rhythm Management
Reports to	Clinical Nurse Manager; Cardiology Service
Department / Service	Acute and Medical Directorate
Purpose of the position	▪ The Specialty Clinical Nurse will work directly with patients with pacemakers & ICD's to enhance health outcomes by providing assessment, care and education as part of the Cardiology Service. ▪ The focus is on care delivery, community support providing nursing care and expertise, both in direct care delivery and in support to other staff and community providers in the management of cardiac patients with cardiac devices. ▪ Contributes to the development of clinical pathways and protocols within the Cardiology Service. ▪ To support the delivery of organisational wide KPI's e.g. MOH targets, financial targets. ▪ Advocate for services and projects that will assist in the achievement of the government's objectives which is inclusive of *The New Zealand Health Strategy*[1], *The Primary Health Care Strategy*[2], *He Korowai Oranga Maori Health Strategy*[3], *The Pacific Health and Disability Action Plan*[4], and *The Disability Strategy*[5], *Ministry of Health targets*[6]

Working Relationships

Internal	External
▪ Patients /Consumer /Tangata Whaiora ▪ Service Management team (i.e., Nurse Director, Clinical Director, Service Director) ▪ Wider Organisational Nursing team ▪ Chief Nursing Officer ▪ Allied Health Staff ▪ Medical Staff ▪ Other team members (i.e., Care Associates, Nursing students) ▪ Relevant advisory groups / committees	▪ Families/whanau and caregivers ▪ General Practitioners ▪ Practice Nurses ▪ Primary health providers ▪ Health agencies ▪ Rural Health centres

[1] Minister of Health. (2000). *The New Zealand health strategy*.
[2] Minister of Health. (2001). *The Primary health care strategy*.
[3] Minister of Health & Associate Minister of Health. (2002). *He korowai oranga – Maori health strategy*.
[4] Minister of Health. (2002). *The Pacific health and disability action plan*.
[5] Minister for Disability Issues. (2001). *The New Zealand disability strategy: Making a world of difference – Whakanui oranga*.
[6] Ministry of Health (Nov 2009)

Dimensions

Expenditure & budget / forecast for which accountable	Nil
Challenges & Problem solving	Will maintain professional and courteous relationships with all external and internal stakeholders at all times.
Delegations & Decision	Registered Nurses practice are responsible for direction and delegation as outlined in the Nursing Council of New Zealand guidelines: ▪ Guideline: Responsibilities for direction and delegation of care to enrolled nurses (May 2011) ▪ Guideline: Delegation of care by a registered nurse to a health care assistant (May 2011)
Other Indicators	The individual will be an active participant in quality projects, audits, completion of organisational documentation (e.g. falls assessment) and, completion of patient active database.


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Ākina – continuously improving everything we do

Key Accountabilities

PROFESSIONAL RESPONSIBILITY	
Tasks (how it is achieved): • Accepts individual responsibility and professional judgement for position requirements and decision making. • Provides clinical leadership by providing support and development to other staff providing direct care delivery. • Demonstrates responsibility, accountability and commitment in nursing practice and to the nursing profession. • Applies the Treaty of Waitangi to nursing practice, assisting patients to gain appropriate support cultural needs and preferences. • Demonstrates a clear understanding of direction and delgation when delegating work to others i.e. enrolled nurses, nursing students, care associates. • Recognises and manages risks to provide care that best meets the needs and interests of patients. • Achieves and maintains clinical practice at proficient level of the Nursing professional development and recognition programme (PDRP) and works towards expert level. • Participates in professional activities that keep abreast of current trends and issues in nursing. • Demonstrates individual responsibility for professional development, including postgraudate education and maintenance of all required HBDHB competencies e.g. manual handling, fire, infection control etc . • Establishes formal and informal networks on a local, regional and national level.	**How it will be measured (KPI):** Evaluated through ongoing feedback and annual performance plan by the Clinical Nurse Manager regarding: • Evidence of maintaining a significant presence in clinical areas as a resource, role model, coach and advocate. • Evidence of nursing practice meets standards and policies consistent with best practice. • Positive staff feedback regarding assistance, support and communication. • Ongoing maintenance of level 3 PDRP. • Evidence of engagement in relevant postgraduate studies.

MANAGEMENT OF NURSING CARE	
Tasks (how it is achieved): • Utilises nursing knowledge and skills through reflective practice and professional judgement to provide competent care and advice. • Utilises assessment skills and nursing interventions to assess patient responses to treatments and adapt approaches to accommodate any changes. • In partnership with the patient, family / whanau, develops an individualised plan of care to achieve the desired outcomes. • Implements and coordinates the interventions to deliver the plan of care. • Evaluates and records progress toward attainment of desired outcomes and revise the plan of care as necessary. • Maintains clear, concise, timely accurate and current documentation within a legal and ethical framework. • Contributes to the development of clinical pathways (as required), which aligns with nursing processes and care delivery models. • Role models excellence in clinical practice, patient management proceeses and maintenance of the therapeutic environment. • Develops and provides education and resources to patients, families, nurses and multidisciplinary team when planning and evaluating care.	**How it will be measured (KPI):** Evaluated through ongoing feedback and annual performance plan by the Clinical Nurse Manager regarding: • Assessment, planning, implementation and evaluation of care for patient / families, including discharge planning. • 100% compliance of using established referral and exit criteria. • 100% compliance with clinical documentation and encounters. • Positive staff and customer feedback. • Working collaboratively alongside other multi-disciplinary teams to improve the care of patients. • Development of specific patient information resources.

INTERPERSONAL RELATIONSHIPS & CONSULTATION	
Tasks (how it is achieved): • Provides leadership, advice, support and development to other staff providing direct care delivery with regards to the specific patient population. • Establishes and maintains effective communication between services across the wider DHB setting. • Establishes and maintains effective interpersonal relationships with others, including utilising effective interviewing and counselling skills and establishing rapport and trust. • Provides advice and support across settings and disciplines. • Provides advice and practical assistance to nursing staff and carers in a timely manner. • Ensures patients and families have a clear understanding of the impact of their health issue, the treatment, and follow up care. • Provides advocacy support to patients and their families.	**How it will be measured (KPI):** Evaluated through ongoing feedback and annual performance plan by the Clinical Nurse Manager regarding: • Evidence of development of effective communications across the sector. • Evidence of attendance and participation at senior clinical meetings. • Evidence of participating with and working collaboratively alongside other multi-disciplinary teams to improve the care of patients. • Feedback from patients and members of the health care team regarding effective communication, assistance and support. • Is visible and available to support the wider health care team.

INTERPROFESSIONAL HEALTH CARE & QUALITY IMPROVEMENT	
Tasks (how it is achieved): • Identifies opportunities and efficiency gains that will enhance the clinical provision of the service. • Participates in quality improvement activities identifying, monitoring and reporting nurse sensitive clinical indicators. • Contributes to the development, implementation and review of best practice guidelines, procedures and policies to provide guidance and increase consistency of care across the sector. • Works with nursing staff to continuously improve nursing practice and patient outcomes. •	**How it will be measured (KPI):** Evaluated through ongoing feedback and annual performance plan by the Clinical Nurse Manager regarding: • Evidence of development and/or participation in audit activity. • 100% compliance with agreed HBDHB nursing and clinical quality standards • Provides monthly and annual report of service provision.

PATIENT & FAMILY EDUCATION	
Tasks (how it is achieved): • Assess the health literacy of patients and their family to ensure they have a clear understanding of the impact of their health issues, the treatment required and follow up plan. • Involvement with discharge planning, education and health promotion as required supporting effective discharge. • Development of educational material.	**How it will be measured (KPI):** Evaluated through ongoing feedback and annual performance plan by the Clinical Nurse Manager regarding: • Evidence of educating family / whanau to self-manage. • Evidence of effective discharge planning to prevent readmission. • Evidence of involvement in educational programmes.

OCCUPATIONAL HEALTH & SAFETY

Tasks (how it is achieved):	How it will be measured (KPI):
• Displays commitment through actively supporting all health and safety initiatives. • Ensures all staff/colleagues maintain adequate safety standards on the job through consultation, training and supervision. • Ensures own and others safety at all times. • Complies with policies, procedures and safe systems of work. • Reports all incidents/accidents, including near misses in a timely fashion. • Is involved in health and safety through participation and consultation.	• Evidence of 100% participation in health and safety activities. • Demonstrates support of staff/colleagues to maintain safe systems of work. • Evidence of compliance with relevant health and safety policies, procedures and event reporting.

Key Competencies

CUSTOMER SERVICE	
Tasks (how it is achieved): • Open and responsive to customer needs. • Demonstrate an understanding of continuous quality improvement.	**How it will be measured (KPI):** • Demonstrates a commitment to customer service and continuous quality improvement, through interaction with patient/clients and other customers. • Identifies customer needs and offers ideas for quality improvement. • Effective management of customers/situations.

ENGAGING EFFECTIVELY WITH MĀORI	
Tasks (how it is achieved): • Demonstrates knowledge and understanding of local tikanga and Māori culture sufficiently to be able to respond appropriately to Māori. • Is visible, welcoming and accessible to Māori consumers and their whanau. • Actively engages in respectful relationships with Māori consumers and whānau and the Māori community. • Actively seeks ways to work with Māori consumers and whānau to maximise Māori experience. • Actively facilitates the participation of whānau in the care and support of their whānau member.	**How it will be measured (KPI):** • Accelerated health outcomes for Maori. • Evidence of positive feedback from Māori consumers and whānau, and colleagues. • Evidence of collaborative relationships with Māori whānau and community/organisations. • Evidence of whānau participation in the care and support of their whānau member.

HONOURING TREATY OF WAITANGI OBLIGATIONS	
Tasks (how it is achieved): • Demonstrates understanding of the principles of the Treaty of Waitangi. • Ensure the principles of partnership, protection and participation are applied to day to day work. • Ensures procedures do not discriminate against Maori.	**How it will be measured (KPI):** Evidence of the principles applied in work practice.

Essential and Desirable Criteria: Qualifications / Skills / Experience

Essential	
Treaty of Waitangi Responsiveness (cultural safety)	Demonstrates the ability to practise nursing in a manner that the health consumer determines as being culturally safe, and to demonstrate ability to apply the Treaty of Waitangi to nursing practice.
Qualifications (eg, tertiary, professional)	Registration with the Nursing Council of New Zealand as a Registered Nurse.
Business / Technical Skills (eg, computing, negotiating, leadership, project management)	Provides evidence to meet the Nursing Council of New Zealand (2007) Competencies for the Registered Nurse scope of practice and (2012) Code of Conduct for Nurses.
Experience (technical and behavioural)	• A current practising certificate with the Nursing Council of New Zealand, with evidence of meeting continuing competence requirements: • Commitment to the Hawke's Bay District Health Board Nursing Professional Development Recognition Programme (PDRP), with a currently assessment proficient portfolio (as a minimum) and requirement for portfolio submission six months after commencement of employment. • Demonstrated time management skills. • Demonstrated ability to work within a team. • Proven ability to work within a multi-disciplinary team. • Demonstrates proficiency and autonomy of practice, requiring minimal guidance. • Demonstrated effective ability in written and oral communication. • Knowledge of and a demonstrated ability to achieve continuous improvement outcomes. • Skills to perform CPR & physical ability to carry out manual handling requirements. • Cardiac specialty knowledge including implantable cardiac devices. • Working knowledge of IT office applications e.g. word, excel, power point. • Current New Zealand driver's licence. Shows commitment to, and demonstrates the behaviours of the health sector: ▪ Tauwhiro (delivering high quality care to patients and consumers) ▪ Rāranga te tira (working together in partnership across the community) ▪ He kauanuanu (showing respect for each other, our staff, patients, and consumers) ▪ Ākina (continuously improving everything we do)
Desirable	
	• Advanced Life Support level 5 • Vision and innovation for specialty practice • Experience with project / change management.

Recruitment Details

Position Title	Specialty Clinical Nurse Cardiac Rhythm Management
Hours of Work	80 hours per fortnight
Salary & Employment Agreement Coverage	In accordance with the NZNO/DHB's Nursing & Midwifery Multi Employer Collective Agreement (MECA) Senior Nurse Scale, Grade 2 $70,873 to $73,652 gross per annum according to qualifications and experience.
Date	February 2016

HAWKE'S BAY District Health Board Whakawāteatia	**Detailed Business Cases for 2015/16 Investments (C)**
	Position Title/s: Registered Nurse - Nurse Led Hospital Wide Patient at Risk Services (previously referred to as 'Early Warning Signs of the Deteriorating Patient).
For the attention of:	**HB Clinical Council**
Document Owner: Document Author(s):	Dr Mike Park Andrea Fail
Reviewed by:	Acute and Medical Directors, Executive Management Team
Month:	April 2016
Consideration:	For approval

RECOMMENDATION:

That HB Clinical Council

Approve funding for the implementation of the Nurse-Led Hospital Wide Patient at Risk Service seven days per week from 0800 – 1630. The position was approved by Clinical Council in the 2015/16 new investment process.

Approve recruitment for a 1.7 fte RN for which the cost will be $33,189 in (2015/16) and full annual cost thereafter of $132,755.

OVERVIEW

As part of the 2015/2016 new investment application process, Clinical Council prioritised the application for investment number 288 - 'Nurse-Led Hospital Wide Patient at Risk Services' previously referred to as '*Early Warning Signs of the Deteriorating Patient',* to go through the Process 1 approval process. The document provides the business case requirements for that recruitment process, giving the background, purpose and benefits and outcomes for this new position. Attached position profile provides further detailed information on this nursing position.

It is to be noted that the title of the service was reviewed and changed to align nationally and reflect the wider hospital focus for this service rather than being focused on ICU. This change does not alter the original intent or function of the position approved by Clinical Council.

The Taleo recruitment approval process is underway, with this final approval from the Transform and Sustain Steering group being sought.

BACKGROUND AND OVERVIEW

The HBDHB Transform and Sustain Programme 2013-2018 describe a strategy to think and work differently across one system. Transforming out of hours care is one of the key intentions of this programme. In July 2014 Joy Farley produced a report titled 'The Hawkes Bay Hospital after Hours Project: Stage One – Discovery'. The report challenged us to address two questions in relation to the care of the deteriorating patient after hours – Who knows where the sickest patients are? And who is in charge of them?

The report recommended more formalised outreach (now titled Patient at Risk) services – based on ICU Head of Department and senior nursing leadership, strengthened escalation processes for deteriorating patients and clarification about ICU being the lead clinical department for the hospital for the out of hours period" (Pg.9)1.

In August 2014, the Acute Inpatient Management 24/7 [AIM 24/7] project was initiated to address the recommendations of Hospital after Hours Report. *Management of the Deteriorating Patient* was an identified work stream under AIM 24/7. A pilot was undertaken by an Intensive Care Physician and experienced ICU RN to explore the synergy between the proposed Patient at Risk Service and a Goals of Treatment Workstream. A decision was made by the AIM 24/7 Steering Group to approach these as two separate but related pieces of work. As a result there was a full business case produced to direct the development of the Nurse-Led Hospital Wide PAR Service which is summarised in this paper.

PURPOSE

Do we have a problem in HBDHB?

- The Standard Mortality Rate [SMR] data for HBDHB Fallen Soldiers Memorial Hospital, as demonstrated in the Health Round Table (HRT) published statistics[2] place our hospital in the lower rankings for after hours' and weekend's SMR comparative data.
    - 34% increase rate of dying if admitted on a Sunday
    - 35% increase rate of dying if admitted as a surgical admission at the weekend
    - 17% increase rate of dying if admitted as a medical admission at the weekend

What has this DHB done so far to manage this?

- In August 2013 a revised track and trigger system called the Early Warning Score System (EWSS) was introduced along with a Rapid Response Service (RRS) with the purpose of detecting patients earlier in their deterioration and allow early assessment and intervention.

Are the EWSS and RRS working?

- The EWSS audit suggests that patients who deteriorate are seen and referred earlier to the ICU team. However, the EWSS has created more work for both ward based teams and the Intensive Care Team. Efficiencies and effectiveness has not been fully realised due to the lack of education and support to both ward based teams with regards to using the EWSS and also the RRS team with regards to improving assessment and management skills.

Are the EWSS and RRS enough?

- Audit data reveals that almost half the Rapid Response Team (RRT) trigger activations occur within the first 24hrs of admission (this is much higher than the NZ average of 20% Psirides et al).
- The current EWS System is a reactive service that responds to the patient only once deterioration has occurred.
- On-going missed opportunities
    - Audit data shows that a medical officer had seen 1 in 4 of RRS patients within 2 hours prior to the patient's deterioration. Often, the nurse at the bedside would notice the patient's deterioration long before the EWS triggered a response. This would therefore

[1] The Hawke's Bay Hospital After Hours Project: Stage 1 – Discovery. July 2014

[2] Appendix Three

be an opportunity for the PAR service to intervene making the PAR service be a proactive service rather than the reactive RRS.

What are other DHBs and Healthcare Providers doing?

- There are national and international directives to provide improved flexible and timely response for patients who are at risk of clinical deterioration in hospital.
- The creation of a service that directly targets patients at risk in this hospital singles an alignment to the NZ Health Quality and Safety Commission who have developed a business case for investing in a quality improvement programme to reduce harm caused by clinical deterioration.
- There are also drivers to reduce inefficiencies through so called overtreatment, such as ordering investigations and commencing therapies which will give no benefit. The "Choosing Wisely" campaign is an example through education and support that is showing healthcare providers where efficiencies can be made. It is estimated that in the US 30-40 cents of every dollar spent on health is due to overtreatment.

Is a Patient at Risk (PAR) service with Goals of Treatment consistent with the HBDHB's vision?

- Both the Transform and Sustain Programme[3] and the AIM 24/7 Steering Group report[4], reaffirm and promote this area as an important clinical risk and quality initiative for HBDHB that is aligned with the Triple Aim.

How will the PAR service work and what are the aims?

- Assess and intervene at an earlier point of the patient's deterioration compared to the RRS. The provision of this service would allow the surveillance of all patients scoring an Early Warning Score [EWS] of 3 or above. Early assessment, interventions and documentation of clinically agreed multidisciplinary care plans would occur. The PAR team would:
    - Optimise and stabilise the patient's condition,
    - Commence early technological interventions to support organ function and facilitate admission into ICU/HDU quickly when required.
    - Facilitate earlier discharges from the HDU.
    - Identify patients with irreversible deterioration.
    - Support the quality of care at end of life.
    - Reduce out of hours SMR.

How will the PAR service reskill ward based teams?

- The PAR service would
    - Provide education and support to maintain and manage patient care on the ward.
    - Help train all ward staff in the recognition and treatment of the deteriorating patient.
    - Through observation and audit the PAR service will highlight any deficit in practice and education.
    - Educate through role modelling, bed side teaching and simulation.

Why should the PAR service run during day time hours when the data shows that the out of hour's period is the problem?

[3] Appendix One

[4] Appendix Two

- By working day time hours, the PAR team will have:
    - Communication access to all the primary team Registrar and SMO staff.
    - Allow the multi-disciplinary team [MDT] to produce clinical plans for the patients deemed at risk of deterioration before they deteriorate in the after-hours period.
    - Draw interventions and clinical planning for patients back into daytime hours away from after-hours crisis management. In the event of further deterioration, there would be a clear and appropriate plan to support the patient by the current after-hours medical and nursing teams. This would require a verbal and written handover to both the afterhours medical and Clinical Resource Nurse team. This day time cover would provide optimum impact to ensure a decrease of clinical risk and a rise in quality improvement around patient experience.

What will success look like?

- The outcomes generated by the PAR team will be by improving the quality of care HBDHB delivers:
    - A reduction in demand versus capacity pressure in ICU
    - A reduction in SMR rates afterhours and on the weekends.
    - A reduction in LOS in hospital and ICU
    - A reduction in waiting time for patients requiring an ICU bed
    - A reduction in readmission rates to ICU
    - A reduction in patients transferred from ICU after 1800
    - Averted ICU admissions from wards through PAR interventions.

What are the costs?

- The key risk associated with the business case is the financial impact on investment in a PAR nursing team.
- A nurse led team is a less costly financial investment than increasing workload hours for physicians. The PAR team will work to stabilise and optimise a patient's condition thereby reducing the costs associated with technical escalation of care.
- The reduction in LOS and the effect of averted admissions would save an estimated $2500 per HDU patient day and $4000 per ICU patient day, which would offset salary costs built into budget for the PAR team.

What are the Risks?

Insufficient education and training

- Communication failure.

  An important area of risk is the communication between hospital staff and patients and families and the care delivered surrounding end of life. A Healthcare Commission Report in 2007 revealed that 54% of the 16,000 hospital complaints received were about care surrounding a death. Talking to patients and families about deterioration and end of life care can be seen as a difficult conversation to have. This will be compounded by the fact that a high proportion of RMOs in this DHB are at the beginning of their training. Without the education and support there is high risk that patients and their whanau will complain if communication is not done well. Risk of increasing overtreatment costs

- Risk of over treatment

EWSS audit data shows that the EWS identifies not only patients who have a reversible deterioration but also patients who have irreversible deterioration. If the PAR and RRT are not educated and supported by senior clinicians there is a risk that inappropriate escalation of therapy could occur. This could lead to worse outcomes for the patient and increased inefficiencies through overtreatment. An unsupported PAR and RRT service could increase HDU/ICU demand to unsustainable levels.

BENEFITS AND OUTCOMES

Benefit of this new position triple aim profile	Outcome	Measure
1. *Improved quality, safety, patient care*	• Early recognition and escalation of deterioration. • Commence early technological interventions to support organ function and facilitate admission into ICU/HDU quickly when required. • Facilitate earlier discharges from the HDU • Reduce crisis management when deterioration occurs after hours • Identify patients with irreversible deterioration. • Support the quality of care at end of life • Reduce RRT activation, cardiac arrest calls and preventable mortality after hours.	• A reduction ICU demand • A reduction in SMR rates afterhours and on the weekends. • A reduction in LOS in hospital and ICU • A reduction in waiting time for patients requiring an ICU bed • A reduction in readmission rates to ICU • A reduction in patients transferred from ICU after 1800 • Averted ICU admissions from wards through PAR interventions.
2. *Improved population health outcomes, equity*	• Support the quality of care at end of life – increase patient/whanau involvement in decision-making • Reduce LoS and therefore create hospital flow and capacity • Provide a safer 'acute hospital' for our population	• Reduction in ICU occupancy • Reduced LoS in ICU & HDU • Increase in the number of people having end of life plans of care.
3. *Best value for health system*	• Facilitate earlier discharges from HDU • Identify patients with irreversible deterioration and prevent expensive futile treatment. • Support the quality of care at end of life • Intervene earlier and more effectively in the deteriorating patient	• Reduced ICU demand • Reduced ICU LoS • Reduce RRT activation • Averted ICU admissions

FINANCIAL INVESTMENT, IMPLICATIONS AND SERVICE DELIVERY

	$000's	$000's
Salary cost	$33,189	132,755
On costs		
Other operational costs		
Capital costs		
Office accommodation found	Yes	Yes
Information technology requirements identified		

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HAWKE'S BAY District Health Board Whakawāteatia	**DRAFT Best Start: Healthy Eating** A plan for Improving healthy eating and activity for children in Hawke's Bay
	For the attention of: **HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Author(s):	Dr Caroline McElnay, Director Population Health Shari Tidswell, Team Leader/Health Promotion Advisor, Kim Williams and Tracy Ashworth, Population Health Advisors
Reviewed by:	Executive Management Team (EMT)
Month:	April 2016
Consideration:	For discussion and feedback

Recommendation

That the HB Clinical Council and HB Health Consumer Council:

1. Note request for detail on the community and stakeholder engagement is followed up
2. Review and provide feedback on the Plan.

OVERVIEW

The purpose of this report is to respond to request for further detail on how the HBDHB has engaged with stakeholder and community to identify how to address childhood obesity and improve health equity. This detail is summarised in the draft 'Best Start: Healthy Eating, A plan for improving healthy eating and activity for children in Hawke's Bay' attached. This Plan brings together a summary of the sources informing it's development, a clear goal – "improving healthy eating and active lives for Hawke's Bay children" and the activities needed to achieve this goal. We are seeking discussion and feedback on our engagement.

BACKGROUND

Evidence supports a focus on early years for the greatest opportunity to achieve healthy weights across the lifespan. This early intervention needs to include, changing the obesogenic environment to a healthy eating one through; leadership, role modelling, consistent messaging, supporting healthy eating settings i.e. schools, workplaces and events, and working with retailers, to make healthy choices easy. We will make the greatest gains by having an equity approach targeting Pasifika, Māori and high deprivation communities. Stakeholder and community input noted that prevention and intervention activities need to be part of a healthy lifestyle changes which support whānau to achieve their health goals and uses a whole community approach.

Currently, a third of our population are obese, with higher rates for Māori (48%) and Pacific (64%) populations. Obesity is the second leading risk to health in the Hawke's Bay. Rates have been increasing. Obesity leads to a range of disease including; heart disease, diabetes and cancer and these incur high, medium and long term costs to individuals, whānau, communities, the health sector and wider social services. (Detailed data is presented in the Equity Report)

Increasing rates of obesity are contributed to our lifestyle - we are consuming more of the calorie rich nutrient poor food which is easily available and cheap. The cause is simple, the

solution is complex. Stakeholder and community feedback noted culture, economics, access, knowledge, family structure, working patterns, government policy and genetics all have a part to play in the choices we make in what and the amount we eat. To reverse the obesity trend we need strong leadership, community engagement and to support whānau lifestyle changes.

What does the evidence show as effective?

- Healthy weight gain for pregnant women – this supports healthy birth weights for babies.
- Healthy first foods - early behaviours are influential on our long term health, children who are breastfed maintain healthy weight over their lifetime. Toddlers who eat healthy develop healthy eating habits over their lifetime.
- School based programmes which support healthy eating and activity - children who are physically active and eat a healthy diet continue to be active and less likely to be obese.
- Children influence the whānau and community – e.g. community feedback and the results of Waikato's Project Energise.
- Environments which support healthy eating choices and activity – settings (schools, churches) where the healthy choice is easy are effective in changing behaviours.

The benefits of healthy eating and activity are far reaching including positively impacting on oral health, mental health and injury prevention. It can also reduce risk of cancers and other disease later in life.

What did the stakeholder and community input say?

The input from these groups and people reinforced the evidence, with following overarching themes. Focus needs to be wider than the individual and include whānau and the environmental influences. Equity issues need to be addressed. Community and whānau engagement in programme design and delivery is critical in achieving sustainable outcomes. Finally build on existing effective initiatives to gain the benefit of existing networks, skill and community linkages.

What are the planned objectives?

Objective	Description
1. Increase healthy eating environments	Addressing the environment by increasing healthy food choices in settings that children engage with including education, marae, events and communities. Also advocating for changes in marketing, retail and councils.
2. Develop and deliver prevention programmes – via food literacy, maternal nutrition, physical activity and implementing policy	Implementing programmes which support healthy eating and physical activity for pregnant women, support breastfeeding, encourage healthy first foods, support whānau with healthy lifestyle changes and school programmes which reinforces healthy eating messages and engage whānau.
3. Intervention – support people to have healthy weight	Screening programmes identifying weight issues early and address weight gain via education, increased food literacy and whānau programmes. Screening during pregnancy, and under five confer the greatest benefits over a lifetime.
4. Provide leadership in healthy eating	A population wide improvement in healthy eating requires a cross sector approach, the HBDHB is ideally placed to provide leadership and support key stakeholders in promoting healthy food environments, prevention programmes and early intervention.

This Plan provides an evidenced-based approach to increasing healthy weights for children in Hawke's Bay and will be delivered with community partners in order to support whānau engagement. Finally, the HBDHB has a role in leadership and will need to advocate for changes nationally and locally to develop an environment which supports healthy lifestyle changes. The Plan is attached.

Best Start: Healthy Eating

A Plan for Improving healthy eating and active lives for children in Hawke's Bay (DRAFT)

2016-2020

Prepared March 2016

Table of Contents

Executive Summary

Best Start: Healthy Eating Plan

The purpose of this Plan is to bring together a summary of the sources informing the development, the goal - "improving healthy eating and active lives for Hawke's Bay children" and the activities needed to achieve this goal. The informing sources include summaries of the:

- reports, plans and strategies which inform the context for childhood obesity
- key evidence and input from key stakeholders, including community

The activities fall into four objectives developed from the informing sources.

- Increasing healthy eating environments, by increasing healthy eating choices and physical activity opportunities.
- Developing and delivering prevention programmes which include food literacy, maternal nutrition, implementing policy and physical activity.
- Interventions which support children to have healthy weight.
- Providing leadership in Hawke's Bay for health eating.

These objectives have indicators which will help us measure progress toward our goal and this progress will be reported annually. The Plan is informed by the principles of reducing inequity, engaging with whānau and Pasifika communities, health leadership and sustainable change.

How can we achieve healthy weight children in Hawke's Bay?

- Evidence supports a focus on early years to achieve the greatest opportunity for healthy weights across the lifespan
- Promoting healthy food environments, through leadership, role modelling, consistent messaging, supporting healthy eating settings i.e. workplaces and events, and working with retailers, to make healthy choices the easy choice.
- We will make the greatest gains by having an equity approach targeting Pasifika, Māori and high deprivation communities.
- Stakeholder and community input noted that prevention and intervention activities need to be part of healthy lifestyle changes which support whānau to achieve their health goals and use a whole of community approach.
- We need a greater focus on healthy eating behaviour change while supporting existing physical activity initiatives. We noted a wide range of activity based programmes in HB and only a few healthy eating programmes, so the Plan's emphasis is on nutrition to address this gap.

This Plan outlines activities that will support whānau and communities to engage with programmes and interventions which support health weight.

What is the situation we aim to change?

Increase the number of health weight children

Over a third of our Hawke's Bay population is obese with higher rates for Māori (48%) and Pasifika (64%) populations. Obesity is the second leading risk to health in the Hawke's Bay. Rates continuing to increase over the past decade. Obesity leads to a range of diseases including heart disease, diabetes and cancer and these incur high medium and long term costs to individuals, whānau, communities, the health sector and wider social services. (Detailed data has been presented in the

Equity Report[1]). We can change this trend by focusing on increasing the number of healthy weight children.

Create a healthy eating environment
Children are consuming more calorie rich, nutrient poor food which is easily available and cheap. While the cause may seem simple the systems we need to change to reduce obesity are complex: culture, economics, access, knowledge, family structure, working patterns, government policy and genetics all have a part to play in the choices we make in what and how much we eat and what we feed our children.

Make the healthy choice the easy choice
Unlike tobacco, where the message is simple, "don't start smoking or quit", food, exercise and healthy weight messages are dependent on a range of factors i.e. age, gender, type of activity. Therefore the key is to make changes to our wider community which means influencing our employers, retailers, food manufacturers, education sector, government departments, whānau and iwi, to provide environments which support healthy eating and activity in a daily lives.

What has been shown to work?

- Healthy weight gain in pregnancy supports healthy birth weights for babies.
- Introduction of appropriate 'first foods' develops healthy eating behaviours and supports life time healthy eating Healthy first foods – Breastfeeding strong evidence in supporting healthy weights for both mother and baby. Toddlers who eat healthy food and appropriate portions develop healthy eating habits over their lifetime.
- School based programmes which support healthy eating and activity - School aged children who are physically active and eat a healthy diet continue to be active and maintain healthy weights.
- Children influencing the health behaviours of whānau and community - the best example in New Zealand are the outcomes of Waikato's Project Energise and safety belts.
- Making the healthy choice the easy choice is effective in changing behaviours. Where children only have water they drink water i.e. water only events and schools
- The benefits of healthy eating and physical activity are far reaching including positively impacting on oral health, mental health and injury prevention and reducing chronic diseases

[1] HB DHB Equity Report. http://www.ourhealthhb.nz/assets/Strategy-Documents/13676-HealthEquity-Report-PRINTlr.pdf

Context

The greatest health benefit comes from prevention and early intervention so a focus on the childhood years provides the most resiliency across the lifespan.

There are a number of contextual plans, documents and strategies which inform this plan.

International

The World Health Organisation's "Ending Childhood Obesity Report[2]", developed comprehensive recommendations to address childhood obesity. It calls for governments to take leadership and for all stakeholders to recognise their moral responsibility in acting on behalf of the child to reduce the risk of obesity.

National

Since the retraction of the Healthy Eating Healthy Action Strategy in 2009, there has been no overarching strategy for obesity prevention or maintaining healthy weight available to support DHB planning. In 2015 the Ministry of Health released the "Childhood Obesity Plan[3]" which includes broad population approaches, increased support and targeted initiatives. This will be implemented at a local level via DHB's, schools, sports trusts and community organisations. The six action areas identified are:

1. Increasing awareness and making healthy choices easier i.e. health star rating
2. Supporting healthy weight gain in pregnancy and childhood
3. Reducing the risk of progression to obesity in adulthood
4. Slowing the progression of obesity related complications, such as diabetes and heart disease
5. Maximizing the effectiveness and efficiency of obesity treatment
6. Monitoring trends in obesity and its complications and evaluating prevention intervention programmes

Local

Locally we have plans and organisations supporting healthy eating lifestyles and delivering activities. They include active transport plans which promote walking and cycling, and community-led healthy lifestyle programmes, such as, Iron Māori and Patu Aotearoa, and community gardens including those based in schools and marae. The HBDHB supports a range of these initiatives via funding, resources and expertise. Healthy eating practices have also been implemented in, workplaces such as the HBDHB, schools with sugar free drinks policies and events promoting healthy food. These plans and activities help make the healthy choice easier, however Hawke's Bay rates of obesity are increasing. Further action is needed including building on the effective programmes/ activities currently delivered, extending the environmental influences, having a greater focus on nutrition, increasing the leadership supporting healthy eating and coordinating activity strategically.

To support strategic coordination and alignment across these contexts, a HB Obesity Prevention Strategy (Appendix A) using a lifespan approach was adopted in 2015. This Plan has been developed to respond to the childhood part of the lifespan. The Plan outlines the evidence, stakeholder and community views, alignment and framework used to achieve the goal of "improving healthy eating and activity for children in Hawke's Bay".

[2] **World Health Organization 2016 "Ending Childhood Obesity" http://www.who.int/end-childhood-obesity/en/**
[3] Ministry of Health, New Zealand, "Childhood Obesity Plan" http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan

Evidence

Obesity is an equity issue, with 25% of Pasifika and 19% of Māori children being obese at 4 years compared to 12% for other ethnicities, inequity starts early. (HB Data)

Current data

Obesity is the second leading risk factor to health in New Zealand (after tobacco-use). It is linked to a range of diseases with high health and non-health costs. One third of New Zealand's population is obese compared to an average OECD obesity rate of 17%; in fact only three OECD countries rate higher (United States, Mexico and Hungary) and our closest neighbour Australia, has a 25% rate[4].

Obesity is unfairly distributed in New Zealand with rates for Māori children twice and Pasifika three times the total populations rate, and children living in our most deprived areas are more likely to be obese than those living in our least deprived areas (one and a half times and three times respectively)[5]. This inequity profile is reflected in Hawke's Bay with 19% of Māori and 25% of Pasifika children aged 2 – 14 years are obese compared to 12% for non-Māori[6]. B4 School Check data also shows total four year old obesity prevalence is 4.2%, while Māori rates are 6% and Pasifika nearly 14%, and 6% of four year olds in quintile 5 were obese compared to 1.8% for quintile 1.

Obesity impacts

At a societal level there is also an impact for our health system, it has been estimated that medical costs attributed to excess weight and obesity in 2006, were NZ$686 million[7]. There are other costs including infrastructure costs required by organisations to adjust for obese clients and staff. The impact of obesity goes beyond poor health outcomes, reduced quality of life and reduced life expectancy, the New Zealand Institute of Economic Research report identified obesity impacted on a wide range of areas including lower wages, increased sick leave, lower school education achievement, poorer mental health and barriers to public infrastructure i.e. plane seat being too small[8]. These impacts effect whānau and the community economically and socially.

Addressing childhood obesity

Addressing childhood obesity is particularly important as overweight children are more likely to develop adult obesity that continues throughout their lifetime[9] because pre-conditions for obesity are set very early in life[10]. The familial influence is the biggest influence on dietary intake and level of physical activity for children, therefore any approach needs to be cognisant with whānau

[4] OECD. (2013). "Overweight and obesity", in OECD Factbook 2013: Economic, Environmental and Social Statistics, OECD Publishing.

[5] Ministry of Health. (2015). *Tatau Kahukura: Maori Health Chart Book 2015*. (3rd edition). Wellington: Ministry of Health

[6] Ministry of Health. (2015). *Annual update of Key Results 2014/15: New Zealand Health Survey*. Wellington: Ministry of Health.

[7] La A, et al. (2012). Health care and lost productivity costs of overweight and obesity in New Zealand. Aut NZ J Public Health 2012;36(6):550-6.

[8] New Zealand of Economic Research, The Wider Economic and Social Cost of Obesity, January 2015

[9] Sundborn, G., Mwerriman, T.R., Thornley, S., Metcalf, P., Jackson, R. (2014). An 'End-Game' for sugar sweetened beverages? Pacific Health Dialog. Vol 20 (1).

[10] Morton, S.M.B., Maternal nutrition and fetal growth and development, in Developmental Origins of Health and Disease, P.D. Gluckman, Hanson, M.A., Editor. 2006, Cambridge University Press: Cambridge. P. 98-130.

acceptance and involvement. Furthermore, education provides a logical setting for approaches to enable healthy eating and activity environments for children.

Children spend approximately one third of their waking hours during the school term in a structured school environment that has close links with whānau. Evidence shows that early intervention programmes delivered in this setting are particularly effective because behaviour change is reinforced across the wider school and home environment. The food environment has changed over time, access to fast foods and sugary drinks has increased, while the availability of fresh foods has decreased. Exposing children to food marketing on the journey to and from school, at school and during screen time impacts on whānau ability to make healthy food choices.

The food environment forms part of the largest and most significant impact on increases in obesity - the "obesogenic environment". This is the complex influences in the environment which influence our lifestyle and eating behavior. There is strong evidence to show that advertising high calorie low nutrition food to children increase consumption by children. Auckland University conducted a review of supermarkets in 2015 to assess their food content. 60% of food did not meet Ministry of Health Healthy Eating Guidelines[11] (low in sugar, salt and fat). If our main food source i.e. the supermarket, has mostly unhealthy food it is likely you will be eating unhealthy food.

Healthy public policy is one of society's most powerful mechanisms for environmental change. Parallels for obesity prevention efforts can be drawn to tobacco control. For example, limiting marketing on television, creating smokefree spaces and increasing taxes on tobacco products, changed the environment, influenced people's decisions, and consequently smoking rates dropped. Sustained advocacy for similar interventions could provide the catalyst for change in the obesity epidemic[12].

There is evidence that brief interventions can support at least short-term improvements in behavioral change and body weight if they combine: both physical activity and nutrition components, are delivered by appropriately trained practitioners, encourage self-monitoring, foster support networks, and are flexible enough to respond to individual circumstances[13].

The health sector needs to develop and deliver evidence based information and education campaigns to raise awareness of the health problems related to poor nutrition, overweight and obesity in a format that is appropriate for the groups and settings most vulnerable. This can only be achieved through appropriate and meaningful engagement with priority groups and settings group engage with to determine the current levels of health literacy and appropriate way to communicate key messages. Only a well–informed consumer is able to make rational decision.

[11] Ministry of Health, "Healthy Eating Guidelines"
[12] http://www.hsph.harvard.edu/obesity-prevention-source/policy-and-environmental-change/
[13] Cavill N et al. Brief interventions for weight management. Oxford: National Obesity Observatory, 2011.

Stakeholder and Community Input

Engagement with community, whānau and settings children engage with is vital

To gain further local knowledge and engagement we sought input from stakeholders and community to help us understand the issues from their perspective and how they feel these issues can best be addressed. Overall this input aligned with the evidence and reinforced the need to continue to engage whānau in development and delivery, use consistent messages, build on existing effective programmes and support settings children engage in to provide healthy eating environments. We have noted that physical activity is supported in a wide range of ways including schools, sports clubs, dance groups, community facilities and out of school programmes, but there needs to be more support for healthy eating. (Appendix B notes the source documents for the summaries below)

The **Maternal Nutrition programme** has ensured feedback and consultation occurs throughout development and delivery. Providing an opportunity for participants to inform the programme's development. Key themes identified were:

- A supportive and trusting relationship between advisors (program supports) and participants is a key facilitator of programme success. This relationship is about the needs and priorities of participants being listened to and embedded within a plan that will work for their lifestyle.
- Program design needs to reflect a wellbeing approach by promoting a holistic view that is about participants investing in their own health and the things (food, exercise, etc.) that will benefit their wellbeing. This decentralises nutrition and exercise, and prioritises the women and their babies in a way that is well placed to ensure the sustainability of any changes women make.
- The majority of responses indicated significant flow-on effects to the whānau with respect to increased physical activity and healthy dietary changes.

Stocktake of healthy eating and activity initiatives offered to Hawke's Bay primary schools, used consultation to provide, an overview of healthy eating and activity initiatives offered and explored the views of stakeholders. Key theme identified were:

- Healthy eating and beverage policies must be better understood by their users and consistently implemented across settings
- All food and beverages provided in schools must meet New Zealand Food Nutrition Guidelines
- Access to sugary food and beverages and high fat, processed foods on the journey to/from school and within the environment undermines school healthy eating ethos
- Food security is a contributing factor
- Sustainable healthy eating behaviour change is transferrable across the wider school community and the home environment
- Whānau should feel empowered to participate in programme development, activities and desired outcomes
- A school-based physical activity programme that encourages whānau participation is needed for ***all*** children
- Programme components must have the capacity to be tailored to local needs

Consumer Council input comes from a workshop session with Council representatives in January 2016. Identified key enablers for change:

- Using belief structures, key groups/stakeholders including Government
- Strengthening connections
- Culturally appropriate modes

Initiatives, approaches and key messages identified:

- Well-being literacy, coordinated pathways
- Using points of influence i.e. pregnancy, parenting, education curriculum
- Promoting incidental exercise, hooks to engage
- Doing our best for our children, translate healthy into everyday life
- Work with whānau and make the healthy choice the easy choice

The overall view was to work at a range of levels from individuals to whānau, settings, communities and politically to create the greatest gains.

Maori Relationship Board Feedback

During 2015 support was given for the Strategy i.e." the strategy is a very comprehensive plan that exhibits a number of activities" and "supportive of the current strategy in term of its focus". There were further recommendations including engaging whānau, HBDHB showing leadership, engaging with the community, speaking to the right people and work more closely with Maori. These have been picked up in the development of this Plan. Further feedback was sought to develop this Plan in March 2016 and members provided to following direction (meeting minutes March 2016).

- We need an equity lens on this strategy, how are we watching for any unintended consequences.
- The strategy is a starting point but there is a need to have teenage youth involved who are our future parents and leaders, nutrition advice to Maori homes and communities needs to be included.
- Investigate the cultural aspect of food because part of 'Manaaki' (a Māori custom) is to feed the people.
- It would have been useful to see the local information, the geographical spread and if we are improving or not. It would also be valuable to see where we align with other DHB initiatives, what they are doing and how do we measure against them.
- This is not just a DHB issue it is a community issue so we need to involve hapū and iwi.
- The issue is that sugary and takeaway foods are more affordable so obesity ties into the living wage discussion. Addiction ties into obesity.
- We need to stop siloing the issues that are bad; addiction, sexual health, oral health, obesity, smokefree, and suicide etc. It's about employing the whānau into good lifestyles. When we change the whānau environment we change the way they look at themselves and opt for good decisions as a by-product.

Overall the stakeholder and community input reinforced the evidence, with following overarching themes:

- Focus needs to be wider than the individual and include whānau and the environmental influences.
- Equity issues need to be addressed.
- Community and whānau engagement in programme design and delivery is critical in achieving sustainable outcomes.
- Build on existing effective initiatives to gain the benefit of existing networks, skill and community linkages.

Alignment

Leadership is critical and all stakeholders needs to use their influence

Hawke's Bay DHB is well placed to lead healthy eating. To lead we need to engage across a wide range of stakeholders including private sector, government bodies and community organisations, to deliver the complex and multi-factorial solutions required for obesity reductions. Recognizing and acting on obesity is crucial – particularly in childhood so we can slow progression of a greater burden of disease.

To be responsive to whānau and our communities healthy eating will be incorporated with wider healthy lifestyle programmes and be supported in an environment which makes the healthy choice the easy choice. The Plan works with providers who have existing whānau relationships, uses settings which influence wider community and whānau, and aligns with national resources, programmes and messages.

The Obesity Prevention Strategy (Appendix A) provides a lifespan approach to support coordination and alignment, for services, messages, initiatives and monitoring. The table below uses the Strategy age groups and this Plans key outcome areas to show where this coordination and alignment occurs for health services supporting child healthy weights.

Strategy Groups	Environment	Prevention	Intervention	Leadership
0-4 years	Advocacy to change marketing practices Policy support for ECEs-MoH Licensing Criteria	Resources to support breastfeeding, first foods – maternity services, Well Child/ Tamariki Ora Early engagement with LMC and oral health services Messages- media community	Workforce development/screening tools/resources- midwives, Well Child/ Tamariki Ora, and B4 School Check. Clinical pathway- pediatric dietetic services	Breastfeeding Strategy National Obesity Plan Primary care- general practice and LMCs NCTD Well Child/Tamariki Ora network Maori Health Plan TAW targets
5-12	Policy support for schools Advocacy-Health Promoting Schools programme	Consistent messaging –Health Promoting Schools, nutrition programmes, Fruit in School, PHNs	Supporting whānau based programmes- Sport HB, Iron Maori, community providers General practice Secondary services	MoE, principals, school boards National Obesity Plan
13-18	Policy support for schools- MoE	Food literacy workforce development- PHNs, teachers, community workers	School clinics General practice	HB Youth Health Strategy National Obesity Plan

Plan Framework

As outlined earlier, this Plan was informed by:

- Evidence, which clearly shows nutrition is the key in healthy weight, change needs to be lifestyle and must have a whānau and community approach and best outcomes are achieved when focusing on early intervention and early years.
- Stakeholder and consumer input, supports the evidence with issues such as food literacy, environmental and economic influences being and, whānau engagement and a cross sector approach all being required to support lifestyle changes.
- Our local Strategy provides a structure to align the wide range of national and local activity needed for sustainable change.

Goal: Improving healthy eating and active lives for children in Hawke's Bay

Guiding values

- Reducing health inequity in our Hawke's Bay communities, use an equity lens to review and deliver this plan
- Improving Māori health outcomes
- Engaging the Pasifika communities
- Enable cross sector leadership
- Approaches and activities support and engage whānau and communities
- A sustainable population health approach

As illustrated by the values, this Plan has a strong commitment to reducing the social and health inequities associated with poor nutrition and weight gain.

Objectives

Objective	Description
1. Increase healthy eating environments	Addressing the environment by increasing healthy food choices in settings that children engage with including education, marae, events and communities. Also advocating for changes in marketing, retail and councils.
2. Develop and deliver prevention programmes – via food literacy, maternal nutrition, physical activity and implementing policy	Implementing programmes which support healthy eating and physical activity for pregnant women, support breastfeeding, encourage healthy first foods, support whānau with healthy lifestyle changes and school programmes which reinforces healthy eating messages and engage whānau are shown to prevent the health risks associated with weight gain by maintaining healthy weight.
3. Intervention – support people to have healthy weight	Screening programmes identify weight issues early and address weight gain via education, increases food literacy and whānau programmes. Screening during pregnancy, and under five confer the greatest benefits over a lifetime.
4. Provide leadership in healthy eating	A population wide improvement in healthy eating requires a cross sector approach, the HBDHB is ideally placed to provide leadership and support key stakeholders in promoting healthy food environments, prevention programmes and early intervention.

Objectives, Indicators and Actions

Objective 1: Increase healthy eating environments

Indicator 1a: Increase the number of schools with healthy eating policies

Indicator 1b: Increase the number of settings including workplaces, churches and marae with healthy eating policy

What the data shows

There is limited data for the region, monitoring this objects will require the collection of baseline data for each indicator using the schools data in HealthScape and surveying other settings.

Activity to deliver objective one			
	What	**How**	**When**
Current activity	• Work with setting to increase healthy eating including education, school, workplaces, events, Pasifika churches, marae • Support national messaging • Advocate for changes in marketing and council planning	• Healthy eating policies in 5 ECE centres, key events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae of reviewed with NKI Inc. • Communication plan implemented for national messages • Submissions made	July 2017
New actions	• Support education settings to implement healthy eating- early childhood, primary schools secondary schools, including establishing a base measure for monitoring • Engage cross sector groups to gain support and influence to increase healthy eating environments • Investigate food security for children and their whānau identifying issue for Hawke's Bay	• 50% increase in schools with water only policy annually • Deprivation 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually • Establish a group to influences changes in the environment across HB. • Partner with Auckland University to establish a baseline for the HB food environment and monitor annually	Reported annually to 2020
Key partners	Ministry of Education, School Boards, Principals, School communities (including whānau), Iwi, Employers, Councils, Event organisers		

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

Indicator 2b: Number of healthy weight children at 4 years remain stable or improves

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 68% for total population, 58% Māori and 74% Pasifka (December 2015 Ministry of Health)
- 76.5% of Hawke's Bay four year olds are healthy weight, 65.2% Māori and 66.9% Pasifika (2014 Before School Check data, Health Hawke's Bay)

Actions and Stakeholders			
	What	**How**	**When**
Current activity	• Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating programmes/policies • Supporting health promoting schools	• Breastfeeding support resources provided via Hauora • All Well Child/ Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/ Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools healthy promoters are up-skilled to implement healthy eating approaches	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers • Supporting healthy pregnancies, via education and activity opportunities • Support the development of whānau programme (building on existing successful programme) • Develop food literacy resources and deliver across a range of programme and settings • Support healthy eating programmes and approaches in schools	• Deliver training to LMCs, Well Child Providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation, Healthy First Foods, B4 School Check resources • Contract and support local provider/s to deliver the Maternal healthy eating a activity programme • Contact and support local provider/s to deliver whānau based programmes i.e. Active Families • Deliver key messages for whānau with 2 – 3 year olds • Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources. • Support the co-designed programme for deprivation 9/10 communities	Reported annually until 2020
Key partners	Hauora providers, Early childhood education providers, schools, principals, Boards, Ministry of education, workplaces, Iwi, Councils, LMCs, Maternity Services, Heart Foundation, Sport HB, Iron Maori		

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referral to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI over 21

Indicator 3b: Increase food literacy training to targeted workforce including midwives, Well Child/ Tamariki Ora, education workforces, social services and Before School Check practitioners.

What the data shows

- 55 HB children were identified with BMI over 21, of these, 47 were referred to interventions including Pre-school Active Families and the remaining 8 were given advice. Of the referrals 55% were Māori, 29% other and 19% Pasifika. (2015 B4 School Check Clinical Data- Health HB)
- 57 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops and 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH)

Activities and Stakeholders			
	What	**How**	**When**
Current activity	• Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5's • Paediatric dietetic referrals	• Monitor the screening and responding referrals • Fund Active Families Under Five and monitor implementation. Investigate extending to further providers. • Monitor referrals and outcomes	July 2017 Maori Health Targets - 6 monthly to the Board
New actions	• Support screening in maternal programme, Well Child/ Tamariki Ora and B4 School Checks • Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways. • Develop a clinical pathway from well child /primary care to secondary services • Support child health workforce, to deliver healthy conversations	• Support training for health profession completing screening an annual opportunity maternal, Well Child/ Tamariki Ora and B4 School Checks • Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals. • Healthy Conversation training delivered.	Annually until 2020
Key partners	Well Child/Tamariki Ora, Primary care, GPs, LMCs, Strategic Services, Oral Health Services, Paediatric Services, LMC's, Maternity Services.		

Objective 4: Provide leadership in healthy eating

Indicator 4a: Monitor the implementation of the HB DHB Healthy Eating policy

Indicator 4b: Engage support from key partners

What the data shows

Hawke's Bay District Health Board policy is compliant with MoH requirements Dec 2015. Obesity responses have been workshopped with cross sector leaders and presented at the Intersectorial Forum in 2015.

Activities and Stakeholders			
	What	**How**	**When**
Current activity	• Share information, evidence and best practise and healthy weight data with key community partners • Show leadership by establish the HBDHB healthy eating policy and implementing the Healthy @ Work workplan	• Regular updates provided via Maternal, Well Child/ Tamariki Ora and B4 School Check forums. Regular meetings with community providers • Review and monitor the HB DHB Health Eating Policy and support the implementation of the Health @ Work work plan	July 2017
New actions	• Lead an equity focus by applying an equity lens to review this plan and delivered activity • Align DHB Healthy Eating policy with national food and beverage guidelines for DHBs • Developing a process for a cross sector approach to support healthy eating environments in Hawke's • Influence key service delivery stakeholders to maintain best practise and consistent messaging for healthy eating • Continue engagement with community particularly key influencers for Maori and Pasifika i.e. marae and church leaders	• Equity report written and finding used to refine this plan to improve response to equity • Reviewed policy reflects the guidelines • Framework/ process implemented for cross sector approach and inter-agency activity reported • Hauora, general practise, LMC's, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities with NKI Inc. including Waitangi Day celebrations and policy/ guidance document development and engagement with Pasifika church leaders	Ongoing until 2020
Key partners	Iwi leaders, NKI Inc. staff, community leaders, governments department leaders, local authorities leaders, non-government organisations leader, private sector leaders, Pasifika community leaders, Ministry of Health		

Monitoring process

It is proposed that implementation of this Plan will be informally monitored via the Population Health Advisors Team and formally monitor via reporting on the HBDHB Annual Plan and to governance committees via key target measures and an annual report on activities.

There are also a number of aligned monitoring and reporting pathways for healthy weight:

- Nationals targets- including B4 School Check, breastfeeding rates (quarterly reporting)
- Population Health Core Plan six month and annual reporting
- Reporting on alignment with national guidelines for DHB Healthy Eating policy
- HB DHB Māori Health Target- healthy weights at 4 years
- Maternal Nutrition Programme outcomes frame work (evaluations) reporting to MoH 6 monthly
- Schools Programme outcomes (evaluation), Population Health Plan
- Health Promoting Schools reporting framework

Data limitations:

- Data for over 5s is limited and not consistent
- Engaging with schools data is yet to be explored
- There is no baseline data for the healthy eating environment including food security
- There are time lags in data from the Ministry of Health so impact of current activity cannot be show for 12 month for breastfeeding and B4 School Checks

Delivery mechanism

The annual plans detail the activities, outcome measures and who is responsible for activities being achieved. We deliver these activities with community partners i.e. Well Child/Tamariki Ora providers. Each of the activities is included in annual planning for HBDHB, particularly in the Population Health Service Annual Plan where the (Appendix C):

- advocating for healthy eating environment and policy is part of the health promotion section
- develop and delivery of whānau based programmes is included in the maternal nutrition and health promotion sections
- support tools and workforce development for screening and referrals for interventions appear in the maternal nutrition section and health promotion sections
- information sharing and policy leadership is in the health promotion section
- consistent messaging and alignment national messages is in the health promotion sections
- developing a cross sector model is in the health promotion section

While we, HBDHB, have a leadership role we need to partner with local government, schools, workplaces, community providers and Ngāti Kahungunu Iwi Incorporated to support healthy eating environments. As such delivery detail will be outlined in these organisations plans and contracts.

Finally timing of deliver is dependent on funding sources, as they become available new action can be initiated. For example the HB DHB are will negotiate with MoH in 2017 for funding associated with the National Childhood Obesity Plan, Population Health has secured another year of Maternal Nutrition funding from the MoH and are completing a business case for EMT to funding a school aged programme.

Appendices

Appendix A: Obesity Prevention Strategy

Summary document previously presented to HBDHB Board

Appendix B: Stakeholder Feedback

Full report are available on request for:

- Schools Stocktake Feedback
- Maternal Nutrition and Active Families Evaluation (client and stakeholder feedback)
- Minutes from Consumer Council workshop
- Maori Relationship Board meeting minutes (June 2015, September 2015 and March 2016)

Appendix C: Population Health Annual Plan

Available on request and has been presented to the HBDHB Board as part of the Annual Plan approval process.

OURHEALTH HAWKE'S BAY Whakawateatia	**Urgent Care Alliance Update**
	For the attention of: **HB Clinical Council and Finance Risk and Audit Committee (FRAC)**
Document Owner:	Graeme Norton UCA Chair
Document Author:	Jonathan Amos (Project Manager)
Reviewed by:	Executive Management Team
Month:	April, 2016
Consideration:	For Information

8

RECOMMENDATION

That Clinical Council and FRAC:

Note the contents of this report.

OVERVIEW – Urgent Care Alliance First Quarter 2016 Update

This update provides a summary of the work of the Urgent Care Alliance (UCA) since the year-end report in December 2015. It is intended that these quarterly reports provide a more in-depth overview than the monthly progress reports that are regularly received by EMT/Clinical Council.

It is not intended that these quarterly reports replace the monthly progress reports that will be submitted as normal to EMT/Clinical Council but supplement them with further details for members of EMT and Clinical Council.

BACKGROUND

The UCA took its year-end report through EMT/Clinical Council and Board last December. It set out all the options for each of its priority areas (**see Appendix**). Since December work has concentrated on a these key areas:

- **Urgent Care Service Change Proposal** – Registration of Interest/Feedback/Request for Proposals
- **Refinement of the Oral Health options**
- **Handover of a number of work streams** to services to pick up as business as usual
- **Initiation of the four new Stage Two work streams**

URGENT CARE SERVICE CHANGE PROPOSAL

In December the Urgent Care Alliance put forward its options to set out an Urgent Care Service Change Proposal for feedback with stakeholders and begin a Registration of Interest process with service providers. So far the following has taken place:

- UCA approved the outline timeframe and ROI/RFP process to secure new Urgent Care Service provision in Hawke's Bay - December
- Urgent Care Strategic Group established to set out process detail, oversee process and ensure minimal conflict of interest - January

- Engagement of McHale Group Public Sector Assurance to ensure that ROI/RFP process follows correct probity procedure - January
- Service Change Proposal issued to stakeholders for an 8 week period for feedback - January
- Registration of Interest (ROI) process published on Government Electronic Tenders Service (GETS) for an 8 week period - January
- Two Face to Face meetings held with potential providers as key stage of ROI to establish a high level model of Urgent Care for Hawke's Bay - February
- Strategic Group in the process of developing Model of Care for Request for Proposals – March/April
- Weighting and Criteria for RFP developed by Strategic Group – March/April
- ROI closed on 21st March. Strategic Group confirmed that there is sufficient interest from providers to proceed with RFP in April/May

A paper outlining the next stages of the RFP process and the proposed new service model of urgent care that will feature in the RFP will be taken to a closed session of EMT (to avoid any conflicts of interest) in the next few weeks. Once discussed, the RFP will be issued to the providers that have registered in April/May.

REFINEMENT OF ORAL HEALTH OPTIONS

The Oral Health work stream produced a number of key options for year-end that the UCA requested be refined in 2016 for further consideration. The stakeholder group met in February to refine these options. The group continued with its development of the non-cost options (**see Appendix for detail of options**). They have agreed to provide a full business case for options 4 and 5 whilst dropping option 6 as unrealistic at this point in time. Therefore a business case will be prepared for the UCA on the following costed options:

- Provide additional funding for existing emergency dental contracts to allow for a more consistent level of treatment over the 2 year periods of the contracts
- Create an additional Dental Practitioner post within the Oral Health Services at HBDHB for the provision of a relief of pain clinic

HANDOVER OF WORK STREAMS

Following their successful completion a number of work streams have been handed over to services to introduce the options agreed as business as usual processes. These include:

- Public Communication – The 'choose well' campaign will become more than just a one off campaign it will be extended to become a standard key public communication message of the Our Health Alliance
- Transport Assistance – The option put forward to consider the transportation of patients at a more strategic level jointly between the DHB and PHO was reviewed and accepted by both organisations. Currently a review of Transport provision is underway by Strategic Services
- Support Pathways – The options put forward by UCA were accepted by the EngAGE Steering Group representatives and will be built into future service provision
- Timely Access to Data – The options detailed within the Year End report were presented back to Information Services and will be reflected within upcoming recommendations on new strategic level IT systems
- St John Service Provision – Due to a lack of current capacity at St John the UCA decided to suspend any further work on this work stream until further notice. St John have been informed and understand this decision

INITIATION OF THE FOUR NEW STAGE TWO WORK STREAMS

Work is underway for the four new work streams chosen by the UCA as key priorities for 2016. These are:

- Advanced Practitioner Workforce – Both the Nurse and Midwifery Leadership Council (HBNMLC) and the Primary Health care Nurse Leadership Group have been approached and asked to nominate suitable stakeholder representatives to join a stakeholder group that can set out principles and options over the coming months for the role of Nurses and Midwifes in Urgent Care. It is expected that this stakeholder working group recommendations will form the basis for a series of recommendations to the HBNMLC to further to position of staff in the provision of these services.
- Aged Residential Care – A request for stakeholders to join this work stream will be issued shortly.
- Greater Treatment in Pharmacies – Following the recent Pharmacy Forum work is underway to establish a joint stakeholder group with the DHB and local pharmacists to consider the issue of expanding the availability and scope of services that local pharmacists can provide.
- Affordable Access – Since agreeing this as a priority last year it has become a far more pressing issue across both DHB and PHO service provision. It is expected to become an important aspect of the upcoming Urgent Care Service Proposal RFP. However work is underway outside of the UCA that may take this issue forward under Health and Social Care networks.

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

A budget has been approved 'in principle' by EMT/Clinical Council/Board, however there are no financial implications as yet. It is expected that the following Work Streams will produce a business case with a number of a costed proposal for UCA Leaders approval to ensure funding is targeted appropriately.

- Urgent Care Service Change Proposal – RFP
- Oral Health

In addition, business cases may emerge from the 2016 work streams

ATTACHMENTS

See Work Stream progress chart below.

	Urgent Care Project - Outline timeline for UCA consideration												
		January	February	March	April	May	June	July	August	September	October	November	December
1	**Urgent Care Health services Change Proposal**	ROI / Feedback underway	Face to Face Meetings	RFP developed / Feedback ends / Registration ends	RFP finalised / RFP Evaluation Group formed / RFP issued	RFP ends / RFP Evaluation Group recommendation report drafted	Decision Paper on proposals	Negotiation and contracting / Plan for implementation	Negotiation and contracting / Plan for implementation	Commence implementation (existing contracts may alter this date)			
2	**Oral Health**		Oral Health Group met review options	Cost options narrowed / Pathway work / MSD work	Onoging - Pathway work / MSD work	Business Case preparation?	Decision on Business Case - UCA / Next years budget bids	Handover to group	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion Report			
3	**Public Communication**	Monitor website usage	Review success of campaign	Handover ongoing responsibility for Choose Well / Agree KPI / UCA Monitoring	Ongoing budget agreed	Completion Report							
4	**St John service provision**	UCA reviewed the progress to date on this work stream and made a decision to suspend unitl further notice from St John											
5	**Transport Assistance**	UCA Handover / DHB decision taken to support strategic review	UCA to support review	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report								
6	**Support Pathways**	UCA Handover to engAGE working group	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report									
7	**Timely Access to Data**	UCA Handover to Information services	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report									
8	**Advanced Practitioner Workforce**		Met with Nurse Midwife Leaders Council and asked them to help recruit more nursing staff to form a sustainable workstream	Set Principles	Develop Options	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to ???	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report		
9	**Aged Care Residential**			Establish Work Stream Group / Set Principles	Develop Options	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to ???	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report		
10	**Greater Treatment in Pharmacies**		Attended Pharmacy forum / Establishing Work Stream Group	Set Principles / Role of Pharmacy facilitators / One health?	Develop Options	Develop Options	Decision paper drafted / Establish if a business case is required	Decision paper	UCA Handover to ???	Agree ongoing UCA monitoring of progress of Working group towards UCA aims	Completion report		
11	**Affordable Access**		Review evidence of priority area so far	UCA to review Affordable Access definition. Decision to build into RFP weighting and criteria taken by Strategic Group									

URGENT CARE – STAGE ONE YEAR END REPORT – SUMMARY OF FUTURE OPTIONS

	Name	UCA Lead	Options	Financial implications for project	UCA supported Option/s
GP/ ED Working Group					
1	GP in Hours / GP Out of Hours / Rural	Alison Bennett / Hannes Meyer / Brad Sandleback / Graeme Norton	1. A Health Service Change proposal (see Appendix) to be considered and then sent out with a supporting commentary to all appropriate Consumer Groups and Primary and Secondary Care staff in Hawke's Bay in early 2016 for feedback.	Yes - 2016	✓
			2. An Expression of Interest (or similar) process will follow the feedback seeking proposals from the Health Sector that meet the principles contained within the Health Service Change Proposal		✓
Project Work Streams					
2	Oral Health	Leigh White / Graeme Norton	1. Complete an Oral Health Pathway to enable sector wide health services to understand the full range of options available to them for Oral Health treatment of the people of Hawke's Bay.	No	✓
			2. Increase engagement with the Ministry of Social Development (through their Regional disability advisor) to fully understand the current picture of spend on the provision of special grants for Urgent Oral Health treatment and potentially develop new innovative treatment packages	No	✓
			3. A contract variation with Te Taiwhenua O Heretaunga (TTOH) oral health service to provide additional capacity for access to urgent care.	No	✓
			4. Provide additional funding for existing emergency dental contracts to allow for a more consistent level of treatment over the 2 year periods of the contracts	Yes	Subject to Business Case
			5. Create an additional Dental Practitioner post within the Oral Health Services at HBDHB for the provision of a relief of pain clinic	Yes	Subject to Business Case
			6. Provide seed funding to encourage a private dentist to set up a relief of pain clinic in a primary health care setting.	Yes	Subject to Business Case
3	Public Communication	Graeme Norton	1. The Choose Well campaign be expanded and supported further by contributions from the UCA operational budget (alongside other key partners).	No	✓
			2. That the Urgent Care Alliance be closely linked with the work of the upcoming Health Literacy framework as it matures.		✓
4	St John service provision	Carleine Receveur	1. St John Urgent Community Care – Napier / Hastings – On hold until we have the information from St John to make an informed decision	Yes	N/A
			2. Urgent Community Care in Central Hawke's Bay – On hold until we the information from St John to make an informed decision	Yes	N/A

URGENT CARE OPTIONS FOR FURTHER CONSIDERATION BY THE HEALTH SECTOR

	Name	UCA Lead	Options	Financial implications for project	UCA supported Option/s
5	Transport Assistance	Nicola Ehau	1. A strategic approach to consumer transportation issues across both the DHB and PHO at a strategic sector wide level should be considered. Although out of scope for the Urgent Care Project itself, many opportunities exist (Travel Plan, Health and Social Networks etc.) for this work to go forward.	No	✓
			2. Once adopted, there are a number of potential Urgent Care options a strategic approach could consider (see detail document).		✓
6	Person Centred Urgent Support Pathways	Leigh White	1. EngAGE Steering Group be expanded to include a wider group of support providers (including Options, ACC etc.) and be regularly maintained into the future. This is to strengthen links between the services, enhance integration and develop existing knowledge. This group could then consider Urgent Care options (see detail document)	No	✓
			2. Complete a Care Pathway for older people to enable Clinicians to understand the full range of support options available to consumers and enable a timely support package for the individual.		✓
7	Timely Access to Data	Alison Bennett / Hannes Meyer / Carleine Receveur	1. Feed the identified gaps and options produced by the Urgent Care Project into the wider strategic change that is taking place with Information Systems	No	✓

Urgent Care – Stakeholders

Contact Name	Contact Organisation / Occupation
Abby Mackinlay	HBDHB - Graduate Accountant
Alex Chan	Raureka Pharmacy
Alison Bennett	GP Taradale
Angela Fuller	HBDHB - Radiology Manager
Beverley Te Huia	Choices - Integration Coordinator Totara Health
Brad Sandleback	HBDHB - Emergency Consultant
Brendan Hutchinson	St John
Carleine Receveur	HBDHB - Strategic Services Manager
Carol McAllum	HBDHB Clinical Director - Palliative Care
Chris Petersen	Health HB - Health Intelligence Team Manager
Claire Caddie	HBDHB - Acting Service Director Women Children and Youth
Colin Dykes	Hastings Health Centre - GP
Colin Jones	Hastings Health Centre - GP
David Rodgers	GP Napier
Diana Triplow	Aged Care Association
Graeme Norton	Chair Consumer Council / UCA
Grant Murray	Colwyn House - Facility Manager
Hayley Anderson	Hastings Health Centre - CEO
Hannes Meyer	GP Hastings
Hugh Findlay	City Medical - CEO & Medical Director
Jeff Petrie	Health HB PHO - Office Manager and Assistant to the CEO
Jenny Peters	HB Health Consumer Council
Jo Aston	HBDHB - Associated Nurse Manager
John Trewick	HBDHB - ED Fast Track MOSS
Karyn Foley	InterRAI Lead Practitioner
Katie Durbin	Cranford - CNS
Kiriana Bird	Hauora Heretaunga - GP
Lee Allsop	The Doctors Napier - Manager
Lee Foley	Options - Referral Co-ordinator
Leigh White	HBDHB - Clinical Nurse Specialist - Gerontology
Lisa Jones	HBDHB - Population Health Intelligence Manager
Mereana Tumohe	HBDHB - Senior Dentist
Nicki Lishman	MSD - Regional Health Advisor / Consumer Council
Nicola Ehau	Health HB - Head of Health Services
Patrick Le Geyt	HBDHB - Māori Programme Manager
Peter Culham	Te Mata Peak - GP
Phillipa Story	HHC GP / ED Consultant
Rachel Ritchie	HB Health Consumer Council
Rob Ewers	Manager - Central Health
Rob Kanagaratnam	HB NZDA branch president
Robin Whyman	HBDHB - Clinical Director Oral Health
Sandra Jessop	Totara Health - GP
Sara Mason	HBDHB - CNS Pulmonary
Sarah Shanahan	HBDHB - EngAGE Team Leader
Sharon Payne	HBDHB - Nurse Practitioner ED Fast Track
Steph Boston	HBDHB Clinical Nurse Manager - Transportation
Susan Hunter	Clinical Manager - Access Health
Te Pare Meihana	Manager - Wairoa Health Centre
Teresa Loughlin	Otatara Heights, Taradale - Owner
Tim Bishop	Bishop and Kay Family Dental Centre
Tim Klingender	Flaxmere Pharmacy
Tina Godbert	Hauora Heretaunga - Dentist
Weitske Cloo	HBDHB - Acting Service Director Oral, Rural and Community

Radiology Services Committee Report to Clinical Council

April 2016

Recommendation: That Clinical Council note the contents of this report.

9

The Radiology Services Committee met on 13 March 16.

Items agreed are summarised below:

There was on-going discussion about "out of town" referrals, primarily by specialists engaged by Accident Compensation Commission (ACC), and the need for these referrers to provide appropriate details to the Radiology Department. A letter has been sent to ACC to remind them of this requirement.

National Radiology Access Criteria for ultrasound were agreed. These will be socialised with General Practice in a CME event around the middle of the year (this has been booked in the Health HB education programme).

It was agreed that there was a need for radiology input in to Clinical Guideline development. It should be noted this may not have been as good as it might have been in the development of some of the guidelines to date.

The second draft of the Hospital Imaging Guidelines has gone out to SMOs via the Chief Medical Officer Hospital, for the input of the relevant departments. Once finalised these will come back to the Radiology Committee and then through to Clinical Council.

Dr Mark Peterson
Chairperson

HB Laboratory Services Committee Report to Clinical Council

April 2016

Recommendation: That Clinical Council note the contents of this report.

Specimen Labelling

Audits around the new process .

Weekly reviews and no increase in mislabelling.

An online training programme through Ko Awatea is currently being set up to up skill those who have mislabelled specimens.

Laboratory Testing Guidelines

Hawkes Bay DHB have used existing Laboratory Guidelines from Waikato Hospital and adapted them to Hawkes Bay. The aim is to reduce duplication of tests and to encourage thought around what and why we are ordering a test, with benefits of reduction in expense coupled with good patient experience (reduction of multiple blood tests). Ash to seek advice from some specialities in regards to specific tests.

Electronic ordering

In the near future will prevent unnecessary tests - June/July 2016 due update.

Clinical Information

Another reminder to include relevant clinical information on request forms

Antenatal bloods

Antenatal bloods to include HbA1c automatically.

Dr Kiri Bird
Chairperson

HEALTH HAWKE'S BAY
Te Oranga Hawke's Bay

Clinical Council Report Clinical Advisory and Governance Committee

Date:	10 February 2016	Time:	5.30pm
Item	**Notes**		
4. Presentations 4.1 Foundation Standards 4.1.1 Foundation Standards Presentation	Victoria Speers, Bobbie Cameron & Michele McCarthy provided an update on activity with general practices around Foundation Standards. Eight practices are on the journey for Foundation Standards with one practice audited this year and two have audit dates booked. This is significant work for a six month period. MoH deadline is 1 July 2017.		
4.2 Primary Care Options	Draft paper for HQSC Board shared with PHOs for feedback on proposed quality activity processes and foci for primary care. Feedack from PHO Leadership Team and CAG Committee will be forwarded to HQSC. Key messages are recognision of primary care limited capacity for new quality activities, a focus on small projects, ensure sustainable funding, and for HQSC to consider asking what primary care quality activities are currently underway and work beside them, rather than add new quality activities to general practice.		
4.3 Significant Events Sharing	Kaye Lafferty provides significant event that was across general practice, after hours and secondary care. Committee provided background to the event, how the event was investigated and what the learnings were. Discussion was around establishing a process for sharing these learnings with primary care. Committee members noted there was still a feeling of 'blame and shame' when events were shared wider; if events were shared wider there was a need to support non-DHB employees involved in the event, and could the DHB provide RCA services to a general practice for a specific event.		
5. Discussion papers 5.1 HPV General Practice action plan – discussion	This discussion was prompted by a request from Hastings Health Centre for support after receiving the MoH HPV General Practice Action Plan. It was acknowledged that this plan had been circulated by MoH directly to general practice, without linking with PHOs. The Committee agree and acknowledges the challenges to carrying out the action plan in light of there currently being no clear lines of communication between schools and general practice to notify general practice when girls have their HPV at school. The current communication required manual loading of data into the general practice PMS; an electronic solution is required.		
5.2 DCIP	The Committtee endorsed the anticipated approach for a proposed district-wide Diabetes Services. The paper also sought advice and guidance around quality improvement, diabetes care improvement planning and how to engage general practice with change management process. Discussion included advice to manage referrals to Stanford from the central system.		
6. Decision papers 6.1 General Practice Score Cards (2015)	The General Practice Quality Score Card 2015 was presented to the Committtee. The indicators for the Score Card are IPIF performance, Cornerstone Accreditation, Nurse PDRP engagement and GP vocational registration. Decision to include He Taura Tieke in 2016 Quality Score Card – deferred to March meeting.		
6.2 Prescribing in a shared electronic environment	Deferred to March		
6.3 Brief Update	Endorsed for circulation to general practice via our Clinical Update newsletter.		
7. Information papers 7.1 Patient Dashboard 7.2 DHB Contract Reporting 7.2.1 B4SC 7.2.2 Mental Health 7.2.3 IT Joint 7.2.4 CPO – 7.2.4.1 Primary Care Says Ahh 7.2.4.2 Sexual Health	The paper responds to questions raised by the committee in September 2015 when they endorsed the Dashboard enhancement for Hepatitis B. These papers are copies of reports submitted to HBDHB for listed contracts.		
8. General business 8.1 Survey-CAG Committee December 2015	All Survey results from December 2015 regarding prioritization of proposed clinical pathways and feedback to Clinical Council Chair: Deferred to March		
Additional Agenda Items 5.3 Health and Social Care Networks Programme Brief	Deferred to March meting		
7.3 Cranford Hospice-Service Development Proposal Template	Acknowledged		

Clinical Council Report

Clinical Advisory and Governance Committee meeting March 2016

Date:	15 March 2016	**Time:**	5.30pm
Item		**Discussion**	
4. Presentations and Guests 4.1 Significant Events Sharing		Kaye Lafferty joined the meeting to discuss a significant event investigation that involved a patient being burnt and requiring skin graft treatment as a result of a personal hot water bottle being filled during an ED presentation. It was agreed that reminding general practice and community pharmacy teams the risks of hot water bottles, including medicine safety (transdermal patches) would be timely with approaching winter.	
4.2 HBDHB policy: Anticoagulated Dental Patient – management		Dr Robin Whyman joined the meeting to discuss the updated DHB policy for hospital and community based dentists on the management of patients undergoing dental procedures while taking either anticoagulant or antiplatelet medicines. Discussion included the value in sharing the DHB policy with general practitioners and community pharmacists. It was suggested that general practitioners are mindful that management of medicine changes also includes communication with the patient's community pharmacist and the challenges of a medicine to be temporarily stopped when provided in compliance (blister) packaging.	
4.3 CPO-Clinical Lead		Dr Alan Wright joined the meeting to discuss the CPO programmes, in particular the new service specifications for the two CPO engAGE pathways. It was noted by Dr Wright the challenges a general practitioner may face to provide 27/4 care particularly in Hastings / Havelock North. It was agreed that general practitioners should be made aware of this requirement when provided the contract. Discussion also centered around the difficulty with ARRC staff administering medicines brought in by a patient that is not in compliance packaging.	
4.4 CarePlus Redesign		Ms Haley Petkovich provided the Committee with an update of the CarePlus Redesign progarmme outlining those practices with contracts and those in development. Reporting as begun. Challenges around reporting where raised with the Committee together with examples of excellent reporting and a case study (reporting requirement).	
5. Decision papers 5.1 General Practice Scorecard (He Taura Tieke)		The Committee endorsed the addition of an indicator for cultural competence in Māori responsiveness to the General Practice Quality Score Card 2016. He Taura Tieke is the current place holder being a self assessment tool for use by General Practice teams.	
5.2 Prescribing in a shared electronic environment		The Committee endorsed the content for the 2016 Best Practice book which highlighed the importance of accurate electronic records. The Committee welcomed this paper and the important issues it raised.	
5.3 Brief Update		Endorsed for sharing with General Practice and wider.	
6. Discussion papers 6.1 Health and Social Care Networks Programme Brief		Acknowledged and agreed with the direction of travel. Discussion was around what these networks will 'look like' and challenges engaging with health professional groups when the 'how' could not be described.	
7. Information papers 7.1 Foundation Standards		Risk analysis and mitigation plan provided – Committee acknowledge this well written paper which covered all questions raised at the February meeting presentation.	
7.2 IPIF – Q2 report		Acknowledged	
7.3 HHB Annual Plan Reporting		Acknowledged	
7.4 DHB Contract Reporting 7.4.1 CVD Contract		Acknowledged	
7.4.2 Cervical Smears		Committee acknowledged how well general practice is doing with the contract and asked that general practice be acknowledged for their hard work.	
7.4.3 Pharmacy		Acknowledged	
8. General Business 8.1 Mobility Action Programme (MAP)		Dr Andy Phillips presented that MAP and asked for feedback to be provided directly to him electronically.	
8.2 Sexual and Reproductive Health Action Plan Sector Engagement Meetings		Ms Catrina Riley provided email from College of Nurses sharing communication from Ministry of Health regarding Sexual and Reproductive Health Action Plan Sector Engagement. Committee acknowledged the value in nurse representation at these sector engagement meetings and asked the HBDHB consider funding release time for a Hawke's Bay Nurse Practitioner or a Priority Population nurse working in primary care to be on this reference group.	
Next Meeting		03 May 2016, 5:30-7.30pm	

OURHEALTH HAWKE'S BAY Whakawateatia	collaborative clinical pathways For the attention of: **HB Clinical Council**
Document Owner:	Dr Mark Peterson
Document Author:	Leigh White, Portfolio Manager of Long-Term Conditions
Reviewed by:	Not applicable
Month:	April, 2016
Consideration:	For Information and Discussion

RECOMMENDATION

That HB Clinical Council

Note the contents of this report

PATHWAY PROJECTIONS	**2014-2015**	**2015/16**	**2016/17**	
				ON TRACK
	3	**26**	**25**	

Overall risk

Risk of fragility (breakdown in process and funding) which could open up the programme to vulnerability.

Budget Priorities	**Off track**	**On track with issues**	**On track**

- ✓ Concept Paper written and submitted for 2016/17 budget rounds
- ✓ PHO Editor (20 hours per week) – working well
- ✓ HBDHB Editor (up to 20 hours per week) – advertised through HR processes, position in place (March 2016) till review - end of June 2016
- ✓ Fee for Service Editors and Facilitators (x 2 –utilised as required for support as back-up)
- ✓ Education has occurred for Clinical Facilitators/Editors – 6 personnel (3 external/ 4 in-house)
- ✓ Split Central Region (Mid-central/Whanganui) HR employment of Faster Cancer Streams Facilitator – in place since January 2016
- ✓ HBDHB Primary Service Manager commenced end March 2016
- ✓ Ongoing costs of HR personnel to attend planning sessions – cost variables
- **Work Planned**: Business case to develop if successful with budget bids – unsuccessful will cause fragility of success of work plan

High Challenges/Risks

Off track	On track with issues	On track

- ✓ Culture change – all or nothing – the how to and time!
- ✓ Behind the "scenes" workload – labour intensive for editors
- ✓ Changes to Mid-central and Whanganui personnel teams may cause delay in publishing
- ✓ Promotion/Socialisation (time/Primary Care overwhelmed with the number of education sessions)
- ✓ Challenges of dis-investment (best practice recommended changes impacting on primary care with no financial support e.g. increase access for reassessments)
- ✓ Clinical Champions (reduced to 2 – David Rogers/David Gardner)
- ✓ Human Resource participation into the planning of pathways – low numbers/buy-in
- ✓ Data – limited with differing diagnostic coding and non-standardisation of coding (e.g. READ codes)
- ✓ **Work Planned**: Address issues as they occur

Technology

Off track	On track with issues	On track

- ✓ Ongoing cost implications (licence/publishing)
- ✓ Incompatibility of platform technology – Internet Explorer – better relationship by both sides (UK/Central Region) working to resolve issue (one click does not prevent GP access)
- ✓ Integration - opportunity of sidebar – investigating – currently in Midlands but feedback - slows "other" computer processes
- ✓ Internal DHB firewall and platform may be a factor – working through this process with IT and UK
- ✓ Direct links-Hyperlinks inserted for referral / outbox documents in medtech for GPs (explore options)

Socialisation

Off track	On track with issues	On track

- ✓ Average 6 a week requesting user login/passwords to access Map of Medicine (Multi-disciplinary – this demonstrates interest
- ✓ Presentation to Clinical Nurse Specialist Forum; PHO Senior Nurse and Management Forums and Home Care Provider.
- ✓ Presentation planned for Nursing and Midwifery Council
- ✓ Regular meetings with PHO personnel
- ✓ One to one – Hastings Health Centre/Taradale Medical Centre/Greendale –all supportive to work alongside
- ✓ CME/CNE Sessions planned
- ✓ Updates of Maps advertised within HBDHB Staff News and HHB portals
- ✓ Central Region Governance – x 1 meeting in last quarter
- ✓ Face to face with UK – x 1 meeting (discussion: Technology, Quality Initiatives)

Quality Initiatives

Off track	On track with issues	On track

- ✓ Development of HBDHB Glossary of "how to do" commenced to assist with new staff
- ✓ Logic Model to support Provenance Certificate being trialed for implementation
- ✓ Standardisation of nodes within the pathway e.g. understanding and engagement (inclusive of applying HEAT , advanced care planning)
- ✓ Consumer input – work with Quality Team to gain support from focus groups – specifically high need low access client demographic
- ✓ Work to commence on an overarching " Self-Management Approach Pathway" based on consumerism, individualism, person-centred and empowerment – not all people with a long term condition need to be managed they can manage their own health needs if educated on the "how" and "when to ask".

Pathway development	Off track	On track with issues	On track

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

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

Attachments

- One page snapshot of current and predicted
- Dashboard of progress (note estimated costs)

Hawkes BayColloborative Clinical Pathways

Published Pathways

- Hip and Knee (Service Review/Elective Service- under review)
- Rhinosinusitis (Standardised best practice)
- Smoking Cessation (Support practice)
- Dementia (Reduced inappropriate referrals/advanced form)
- Diabetes (plan to review /not socialised)
- Skin Lesions (Service Review/Elective Service- under review)
- Respiratory/COPD (CNS Champion/drive change of practice)
- Asthma (Child/Adults) (CNS Champion/drive change of practice)
- Atrial Fibrillation (not socialised)
- Chest Pain (not socialised)
- Obstructive Sleep Assessment (Support practice)
- Osteoporosis (medication management/DEXA)
- Gout (medication management)
- Older Health Services (information of service delivery)

Under development – nearing publication next 2-3 months

- CHF (Standardised best practice)
- Lower Limb Ulceration (Reduced inappropriate referrals)
- Diabetic Ulcer to foot (Reduced inappropriate referrals)
- Abnormal Thyroids (OPD – FSA/F/Up)
- Vertigo (Use of Physio management)
- Community Acquired Pneumonia (CPO/< ED visits)
- Stroke (change of practice/Stroke Unit)
- Urinary Incontinence (standardised referrals)

Faster Cancer Treatments – meet timelines

- Lung (in progress)
- Colorectal (in progress)
- Breast (planning stages)

Early development (aim publication 3-6 months)

- Cellulitis (CPO, medication management)
- Diabetes – Older Person (reframe current policies)
- Last Days of Life (implement national changes)
- Early Pregnancy (Hyperemesis)
- Dental – Toothache (UCA/< ED presentations)
- Self-Management Approach Pathway

OURHEALTH HAWKE'S BAY
Whakawateatia

Opportunity 2016

- Unilateral Hearing Loss (TAS)
- Cancer Stream (Breast)
- Sore Throat (CPO RH Fever, Say Ah)
- Epilepsy (OPD – FSA/F/Up)
- Iron Infusions (medication management)
- Falls (multi-sectoral)
- Advanced Care Planning (link to other)
- GORD (Paediatricians)
- Delirium (standardised practice)
- Depression (Support practice)
- Renal Colic (standardised practice)
- Heavy Menstrual Bleeding (CPO)
- Urinary Tract Infections (CPO)
- Accelerated Chest Pain (standardised practice)
- Obesity (national objective)
- Hepatitis (Central Region)

CME Sessions booked

- Stroke (Feb 2016)
- DVT (March 2016)
- Asthma (March 2016)
- Capacity/Dementia(April 2016)
- Gout/Vertigo (May 2016)

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

Pathway	Shaded denotes progress to date: 1: In developmental phases 2: Published and advertised 3: Socialised (circulated and advertised and/or educated) 4. For review	Clinical Leads	Measure of success	Estimated costs (non inclusive of Publishing) (-) number of sessions *Shared Publish costs **Stand-alone Publish costs
Last Days of Life C/date:03/2016		C. McCullum M. Peterson	Support new practice	* ?
Colorectal C/date:03/2016		T. Boswell D. Rogers	Align to Faster Cancer Streams	*Central Region $900 (3) to date
Lung Cancer C/date:03/2016		L. King	Align to Faster Cancer Streams	*Central Region $360 (3) to date
Community Acquired Pneumonia C/date:03/2016		J. Curtis D. Smith	Reduce ASH CPO Focus Standardised prescibing	* $1656 (3) to date
Cellulitis (CPO) C/date:03/2016		A. Burns A Wright	Reduce ASH CPO Focus Change of prescibing	* $900 to date
Stroke C/date:02/2016		C. Providence D. Rogers	Standardised referral Access to Diagnostics Standardised practice Alert for Thyrombolis	* $1800 (5) to date
Diabetes with focus on ARC		T. Speeding D. Vicary	Align with ARC Guidleines currently for review	* Nil
Vertigo C/date:11/2015		P. Mason A. Wright	Reduced FSA Use of Physio	** $2750 (5)
Congestive Heart Failure C/date:11/2015		K. Dyson GP The DDs	Standardised prescibing	*$1760 (4 sesions
Diabetic Foot Ulcer C/date:11/2015		Healthy Feet Podiatrist	Align with new Podiatry Contract	*
Obstructive Sleep Assessment		DHB Sleep Scientist	Support Respiratory Service Criteria Access	** $560 (4)
Thyroid C/date:11/2015		R. Leikis N. Smuts	Reduced FSA Reduce F/Up OPD	** $2680 (4)
Lower Limb C/date:11/2015		NP: Fiona	Timeliness of referals to right place	** $1760 (4)
Urinary Incontinence C/date:02/2016		L. Fergus N. Smuts	Standardised referral criteria to Incontinenance Service	* $2680 (4)

12

CPO (DVT) C/date:09/2015	1 + 2 + 3 = 4	A. Wright S. Payne	Reduced ED assessments Reduced Diagnositic access Medication Prescribing	* $1200 (4)
Older Health Service C/date:09/2015	1 + 2 + 3 = 4	L. White M. Peterson	Cental access (Multi-Disciplianry) to support Engage Process – outcome of UCA Proesses	** Nil
Asthma C/date:08/2015	1 + 2 + 3 = 4	Paeds: N. Durnphy Adult: S. Ward	Child and Adults Reduced admissions Length of Stay Medication Prescribing	* $3170 (4) To date
Osteoporosis C/date:08/2015	1 + 2 + 3 = 4	D. Gardner	Presented at Grand Round DEXA Medication Management	* $2760 (4)
Cardiac (Atrial Fibrillation) C/date:08/2015	1 + 2 + 3 = 4	K. Dyson	Reduced admissions Length of Stay	* $1870 (4)
Respiratory/COPD C/date:07/2015	1 + 2 + 3 = 4	S. Ward Breathe HB	Reduced admissions Reduce Length of Stay Reduced Spirometry Supporting Pracice – interface with GASP	* ?
Gout C/date:07/2015	1 + 2 + 3 = 4		High number of Māori CME sessioin booked	** ?
Smoking cessation C/date:07/2015	1 + 2 + 3 = 4	K. Moriatry	Links with multiple pathways	*?
Rhinosinusitis C/date:07/2015	1 + 2 + 3 = 4		TAS Link Standardised Practice	**?
Dementia C/date:07/2015	1 + 2 + 3 = 4	E. Plesner Dr Cullen	Advanced Form CME session planned (05/16) – Capacity Assessment	*?
Diabetes	1 + 2 + 3 = 4		Organised for Review (April)	*?
Osteoarthritic Hip	1 + 2 + 3 = 4		On hold – changes with Orthopaedic Service - Redesign	*?
Skin Lesions	1 + 2 + 3 = 4		On hold – Impact on Elective Services	*?

HAWKE'S BAY District Health Board Whakawāteatia	**AIM 24/7 Update Report: Acute Inpatient Management**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author(s):	Dr John Gommans, Chief Medical Officer Jeff Petrie, Assistant GM Primary Care
Reviewed by:	Finance, Risk and Audit Committee (in March)
Month:	April, 2016
Consideration:	Monitoring

13

RECOMMENDATION
HB Clinical Council:

Note the contents of this report.

OVERVIEW
This report provides an update on progress with AIM 24/7 since the last EMT update in October 2015.

AIM 24/7 is currently in Stage 2 – The Next Steps, which is focussed on achieving and sustaining a 24/7 Hospital, is progressing well. The current focus of the project and ongoing work can be identified under four core areas:

- Matching Workforce to Demand
- AAU Model of Care - addressing the recommendations of the TAS AAU review
- Management of the Deteriorating Inpatient – establishment of a hospital wide nurse lead 'Patient at Risk Service'
- Integrated Operations Centre

With many of the project work streams being either completed or remaining partially open for reporting purposes only, a concentrated effort has been made to progress the work needed to ensure the Hospital's workforce is matching acute demand.

Matching Workforce to Demand
Stage one of the AIM 24/7 Matching Workforce to Demand work stream was about *setting the scene* – understanding acute demand and verifying current resource allocation.

A Matching Workforce to Demand workshop was held on 19 November - an outcome of which was the development of a list of preliminary options that were identified as being able to improve patient care and flow. These options were developed and strengthened based on data analysis and clinical recommendations. An Action Plan was then brought together and endorsed by the AIM 24/7 Steering Group, with prioritised actions to advance the options (attached as Appendix A). Stage two is now about working with clinical leaders in key acute areas (ED, AAU and ICU) to enable progression and implementation of the Action Plan for better resourcing 24/7.

AAU model of Care
The TAS report for the review of the AAU model of care, refreshed in 2014 as part of the 24/7 project, was endorsed by the AIM 24/7 Steering Group on 26 February 2016. The report identified six recommendations for improvement of the AAU model of care. The AIM 24/7 Steering Group agreed

that the recommendations will now be pulled through to an action plan with governance overview from the AIM 24/7 Steering Group.

Management of the Deteriorating Inpatient
Dr Emma Merry, Andrea Fail and Dr Mike Park have been working on developing a business case for the roll out of a hospital wide, nurse led, Patient at Risk Service. The aim of the service is to achieve early anticipation and detection of disordered physiology of patients at a stage before organ failure is established, through the initiation of early preventative therapies. The business case will be presented to the EMT for endorsement on 22 March 2016.

Integrated Operations Centre
The Coordinated Operations Service work stream of AIM 24/7 has been moved to report on an operations level to the Chief Operating Officer. A key achievement of this stream over the past three months has been the development of the Integrated Operations Centre, which will become operational by the end of March 2016. The Centre will be a central hub for the coordination of hospital activity and patient flow, and will enable teams to use real-time information for clinical and operational decision making across the organisation.

The AIM 24/7 Steering Group has agreed to refresh the Group's membership to better reflect the goals of the current project work as outlined above. This process will be completed by 17 March 2016.

Maintaining effective communications with all AIM 24/7 stakeholders continues to be a priority to ensure project engagement and to assist with highlighting project achievements. Anecdotal feedback collated by project leadership note staff are acknowledging the positive outcomes that have been achieved to date and moral is building. Attached as Appendix B is the February 2016 AIM 24/7 communication for your information. Dr John Gommans also presented an AIM 24/7 update to staff at the 26 February Transform and Sustain seminar.

Update on Progress
An update on the progress of current activities and achievements over the last four months are provided below:

Remaining work streams and current focus	**Current activities and key achievements**
Matching Workforce to Demand	*Current activities:* Action Plan - Each action has been updated to include current status, assigned lead, agreed timeframe for completion and financial implication. Monthly meetings have been scheduled with the action leads and John McKeefry in order to maintain momentum and accountability. *Key achievements:* • Agreed goals established at the November 2015 workshop: - To deliver safe and high quality patient and whanau centred care. - Acute clinical activity and volumes are consistent across both weekdays and weekends - need similar core clinical staffing (staff providing patient care) across weekdays & weekends - Acute clinical activity across weekdays and weekends is sustained between 1100 and 2200 - core clinical staffing should reflect this. - Experienced clinical leadership is required on site in the weekends and evenings • Following the November 2015 workshop - Secondment of Jill Lowrey in a Patient Flow Coordinator role - 3 month contract for GP to be based in ED to support the interfacing between primary care and ED - Approval of ED and ICU SMO expansion. - Approved action plan to progress the matching of workforce to demand.

Addressing the recommendations of the TAS AAU review report	*Current activities:* • Recommendations of the report will now be pulled through to an action plan with governance overview from the AIM 24/7 steering group. *Key achievements:* • Final draft TAS AAU evaluation received and reviewed by senior leaders • AIM 24/7 Steering Group endorsed the AAU Review Report and agreed for the report to be changed from draft to final and made freely available. • Recommendations adopted that require improvement and attention over the next year are: 1. Clinical Governance 2. Clinical Leadership within AAU 3. Relationship with ED 4. Partnerships with Primary Care 5. Measures of success 6. Reframing the Patient Journey • AIM 24/7 Steering Group endorsed a draft proposal requesting approval for a dedicated AAU physician team (including AAU Clinical Leadership role) and roster model to support the TAS AAU Model of Care Review report recommendations.
Management of the Deteriorating Inpatient – Establishment of a hospital wide nurse lead 'Patient at Risk Service'	*Current activities:* • The business case for the establishment of a hospital wide nurse led 'Patient at Risk Service will be reviewed by the Health Services Leadership Team prior to approval by AIM 24/7 Steering Group and EMT on 22 March 2016. *Key achievements:* • Exploration of options for delivering a patient at risk service completed. • Business case outlining an options analysis and proposal for implementation (including education component). • Socialisation of concept at steering group level and Transform and Sustain session February 2016.
Integrated Operations Centre (formerly described as Coordinated Operations Service)	*Current activities:* • The Integrated Operations Centre will become operational in March and will be located on the second floor of the hospital tower block. Currently undergoing physical set up at centre location. *Key achievements:* • Coordinated Operations Service proposal completed and submitted to EMT. Planning of change management process under way. • Socialisation of centre's purpose and aims to staff through Transform and Sustain session February 2016.
Other activities	• AIM 24/7 update presented to the HBDHB in November 2015. • AIM 24/7 progress and current focus presentation by Dr John Gommans to Minister Coleman February 2016. • AIM 24/7 update presented by Dr John Gommans at February Transform and Sustain session.

ATTACHMENTS:

Appendix A - Matching Workforce to Demand Action Plan
Appendix B - AIM 24/7 February Staff Update
Appendix C - Dashboard of AIM 24/7 Key Performance Indicators with commentary – February 2016
Appendix D - Hospital Analysis - February 2016

Appendix A

DRAFT ACTION PLAN – Matching Workforce to Demand

No. Impact	Action	Who	By when	HBDHB Financial Implications		
				N/A	In 16/17 Budget	New invest.
1. ED	ED SMO business case to be progressed (EMT approved 8/12/15)	Paula Jones	Complete			
2. ED	Senior nurse led Minor Emergency Clinic (MEC). This will include Fast Track extension, through: • Maintenance of the current MEC nurse 10 hour shift but start earlier to allow MEC to be available from 0900 hours (paper completed, not yet approved). Will require reduction of MOSS hours by ?????? ASMS have been given an early heads up. • Add an additional 8 hour RN shift in MEC between 1430 hours to 2300 hours	Chris Trow	1 July 16			✓
UPDATE	11/2/16 Point one: Paper prepared by Ian Elson and Chris Trow, no response to date. Point two: Additional 8 hour RN shift in MEC between 1430 hours to 2300 hours not highest priority at present, unsure if this will solve any problems.					
3. ED	To support improved integration between ED and Primary Care provision of a GP (0.1 FTE) to work alongside ED and Primary Care (three month contract, through to 31 March 2016? Hannes Meyer).	Sharon Mason/Liz Stockley	In progress Review for extension ?	✓		
UPDATE	11/2/16 Hannah Meyer is working alongside Jill Lowrey and the ED team for a 3 month period.					
4. ED	Implement staggering of start times for the ACNs to strengthen nursing leadership in ED/AAU for longer periods. Note: Has been trialled since. Will be reviewed by ??????	Chris Trow	1 July 16	✓		

I:\Projects\AIM 24_7\7. Matching Workforce to Deman\Action Plan 2016

UPDATE	11/2/16Trialled further with no significant improvement.	Recommendation that action is removed				
5. ED	Develop pathways for referred surgical acutes that present via ED, which include surgical patients referred from GPs, surgeon's clinics and/or private rooms. Manage the compliance to this pathway.	Rika Hentschel/ John Rose/Kerri Cooley	1 July 16	✓		
UPDATE	11/2/16 In consultation with Grant Broadhurst and his colleagues developed a pathway for admission of acute 'arranged' pts. (above 24 hours and less than 7 days). Direct Admission to Patient acute Attached form plus pt. information leaflet.Surgical Inpatient Caarranged admission As you can see the pt. can be seen/booked on a theatre acute list if required/go home/ present back on nominated day directly to ward A4. With this planned approach the ward will have a nominated bed available, theatre will have early notification and ED will not be utilised. Most importantly- the patient has a clear pathway and arrives into hospital with a plan (and a bed!) which should be timely and produce the best outcome. The e forms are with Chris Lord for finalising at present so we will begin a 'trial' of this process within the next few weeks- though unofficially already started.					
6. ED	Multi service agreement adherence to be led by Clinical leaders.	John Gommans	Ongoing	✓		
UPDATE	11/2/16 Work in progress.					

7. AAU/ED	Provision of 1.4 additional FTE Administrator to be rostered during 11302000 per day, 7 days per week float between AAU and ED, due to the increase in ED volumes, and changes in processes between ED and AAU, the introduction of the Medical Day Unit and improved customer engagement as per ED Front of House work.	Waiariki Davis	1 July 16			✓
UPDATE	11/2/16 Waiariki Davis is manager of this area (admin). Note: Requires Steering Group support to proceed.		Requires follow up and clarification			
8. Radiology	Note the business case from the Radiology Service Improvement Project regarding extending the CT/MRI/Ultrasound workday to support improved access to diagnostics which has an impact on improved patient flow.	Angela Fuller Iain Morle	1 July 16			✓
UPDATE	11/2/16 These budget bids are being prepared for inclusion in the 2016/2017 budget round.					
9. AAU	AAU - ensure all pre-review recommendations are implemented:					
	☐Develop a process to stream selected groups of patients through ED/AAU more effectively.	Paula Jones/Colin Hutchison/Ian Elson	31 March 16		✓	
	☐Electronic whiteboard that highlights all patients in the system across the 'hot floor', particularly between AAU and ED (from draft AAU review)	Chris Trow	31 March 16			✓
	☐Implement Rapid Rounds in AAU, at 1100 each day, including weekends. Note: to include as part of patient flow review.	Colin Hutchison /Chris Trow	31 March 16	✓		
	☐ Agree process for rapid telephone access to specialist (medical and surgical) advice for primary care, and communicate.	Paula Jones/Colin Hutchison/Ian Elson	31 March 16	✓		

	• Rapid access to specialist clinics – look at booking/referral process and keep slots in outpatients free for semi-urgent referrals to reduce impact on ED and AAU. • Develop nurse led discharge process from AAU (Note from draft AAU review)	Paula Jones/Colin Hutchison Paula Jones/Colin Hutchison/Ian Elson	TBC 31 March 16	✓ ✓		
UPDATE	11/2/16 AAU draft review is with physician team and clinical leader for comment and next steps. To be tabled at February Aim 24/7 Steering Group meeting.					
10. AAU	☐Post AAU review - ensure recommendations are considered, and if agreed implemented.	Sharon Mason	1 July 2016		✓	✓
UPDATE	11/2/16 AAU draft review is with physician team and clinical leader for comment and next steps. To be tabled at February Aim 24/7 Steering Group meeting.					
11. ICU	ICU SMO Business case (Phase 1) to be progressed (EMT approved 8/12/15)	Paula Jones	Complete		✓	
12. ICU	Flight review – ensure recommendations are considered, and if agreed implemented.	Sharon Mason	31 March 16			✓
UPDATE	11/2/16 TAS team are pulling the key stakeholder group together to review final draft of paper and final validation the information they have captured is correct. Expect to table paper in March					
13.	Surgical assessment response – review the Registrar roster to ensure that there is adequate cover, and manage response rates.	Rika Hentschel/ John Rose/ Kerri Cooley	1 July 16			✓
UPDATE	11/2/16 This is being constantly monitored in ED. John is not sure whether					

	there is any ongoing monitoring within our service. The introduction of the General Surgical registrar night roster should have an impact on waiting times overnight.					
14.	Surgical and Orthopaedic registrars are rostered and available to respond to need.	Rika Hentschel/ John Rose/ Kerri Cooley	31 March 16	✓		
UPDATE	11/2/16 Both specialties have a registrar rostered at all times for managing acutes. This means they are available for seeing patients in ED but they also have responsibilities (in theatre and to the wards?). This is work in progress.					
15. ICU	ICU RN resourcing to be reviewed due to the consistent clinical activity and volumes across both weekdays and weekends in ICU, consideration needs to have the same or similar core clinical staffing (staff who provide patient care) team across weekdays and weekends.	Colin Hutchison / Ian Elson	1 July 16			✓
UPDATE	11/2/16 These budget bids are being prepared for inclusion in the 2016/2017 budget round.					
16. AAU/ED	Patient flow leadership role - 1 FTE Temp	Sharon Mason	Completed	✓		
UPDATE	11/2/16 Jill Lowery secondment. Ends 31 July 2016.					

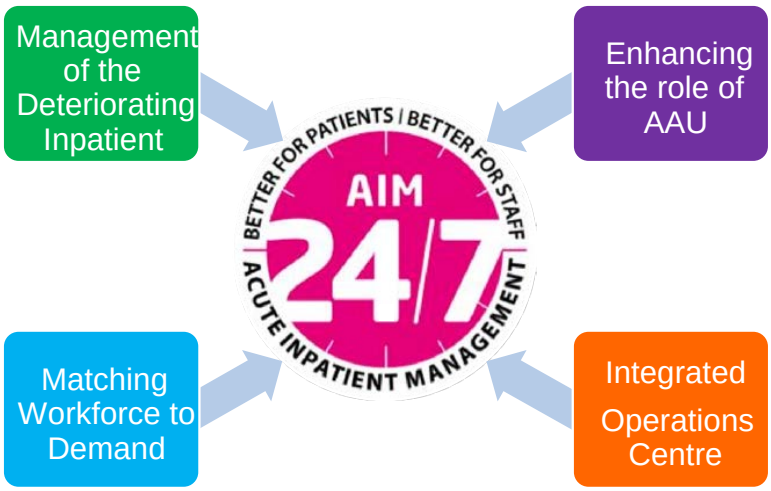
Appendix B

Update – Next Steps 29 February 2016

AIM 24/7 Better for patients, better for staff

The Next Steps – Stage 2

The next steps of AIM 24/7 builds on the work done in the first phase but with a focus on making sure we deliver high quality care to our acute patients across the whole hospital on a 24/7 basis. There are four key projects designed to help us achieve this; matching workforce to demand, management of the deteriorating inpatient, enhancing the role of AAU and creating an Integrated Operations Centre. Brief updates on all four projects are included in this newsletter.



Integrated Operations Centre

In phase one we focussed on understanding the data and information we needed; creating daily operation meetings to manage our patient flow, staff and resourcing requirements, addressing issues as they arose; and establishing evening multidisciplinary handovers. Initially ably led by Carleine Receveur and more recently by Jill Lowrey, who has worked on the location of the new Integrated Operation Centre (IOC) and who needed to be co-located there.

The AIM 24/7 Steering Group is pleased to announce that the IOC will become a reality next month on the second floor of the hospital tower block, just outside A2 (the physio room). This room is currently being gutted and will form a central hub for the IOC where patient flow can be better co-ordinated. This new centre will be crucial to helping us manage, in real time, the flow of acute patients throughout the hospital, helping to

prevent bed blockages, manage the flow from the Emergency Department and help us make the best use of our staff capacity to meet demand. All of this will be assisted with data from Capacity Planner, Trendcare and ECA to support forecasting and planning on an hour by hour, day by day, and weekly basis.
Essential to this is giving visibility to the data as it is gathered through a number of large screens that will be housed in the operation centre room and will show us at a glance what's happening and where any trouble spots are so we can better support staff to provide high quality care and manage demand through the hospital.

Managing the Integrated Operation Centre move is Jill Lowrey who points out where the new screens will shortly be placed after the physio room is gutted to house the Integrated Operations Centre.

Matching Workforce to Demand

The Hospital-After-Hours report clearly identified the peak periods and flow patterns of acute presentations to the hospital, and the mismatch with our staffing both in numbers and seniority. A lot of work is happening with this project and many of you will have been involved in the November workshop held to explore the issues and look to a way forward to address these. At the workshop the below key principles were agreed if we were to meet our primary goal: to deliver safe and high quality patient and whanau centred care.

1. Acute clinical activity and volumes are consistent across both weekdays and weekends, therefore the hospital needs similar core clinical staffing (staff providing patient care) across weekdays & weekends.
2. Acute clinical activity across weekdays and weekends is sustained between 1100 and 2200, therefore core clinical staffing in the hospital should reflect this.
3. Experienced clinical leadership is required on site in the weekends and evenings.

Since the workshop an action plan has been developed. The most obvious changes include approval for an increase in the number of Emergency Physicians working a shift system (rather than call back after hours) and recruitment is underway. When in place it will mean a specialist ED Physician is physically on site leading the department and supervising patient care in evenings and on weekends. Similarly the number of Intensive Care specialists is being increased to help maintain high quality care to those who present with severe trauma or illness or for patients who deteriorate on the wards. The project is also looking at nursing and allied health staff plus the role of key support services including laboratory, radiology, orderlies, administration and transport.
We now also have a GP in ED as part of a three month pilot working four hours a week to help us understand and help resolve some issues with the interface between primary care and the Emergency Department, and are also looking to appoint a patient flow coordinator.

Management of the Deteriorating Inpatient

Andy Fail and Emma Merry have spent much of the last six months exploring options for providing a 'Patient at Risk' service, often called an Outreach Service, to help ward staff better manage inpatients who are deteriorating; similar to that provided in other hospitals across Australia and New Zealand. These are usually nurse-led services provided by a pool of nurses with enhanced skills and training, often from an ICU background and supported by their ICU specialist colleagues. The goal of this new service is to identify early those patients at risk of deteriorating and intervene to help prevent any deterioration and potential need for intensive care admission. The business case for this service is currently being finalised and I look forward to updating you on its progress in the next issue.

Enhancing the role of the Acute Assessment Unit (AAU)

Acute admissions to Medicine outnumber all other acute admissions to the hospital combined. The AAU plays a key role in managing those patients with acute medical problems requiring rapid review or admission. Under AIM 24/7 additional resources were put in place and a model of Physician-led services trialled Monday to Friday in-hours including the Physicians holding the GP phone. A recent review by TAS (Technical Advisory Service) of this AAU model of care showed a 25percent increase in patients managed within AAU in the first six months compared to the same time the previous year, and that about 40percentof all acute medical admissions are now managed via AAU. The review also identified areas for improvement and attention over the next year regarding:-

1. Clinical Governance
2. Clinical leadership within AAU
3. The interface and relationship with ED
4. Partnerships with primary care
5. Data - the measures of success so it is easy to track the gains of the benefit of the unit 6. The patient journey – to ensure clear pathways and reduce double handling of patients.

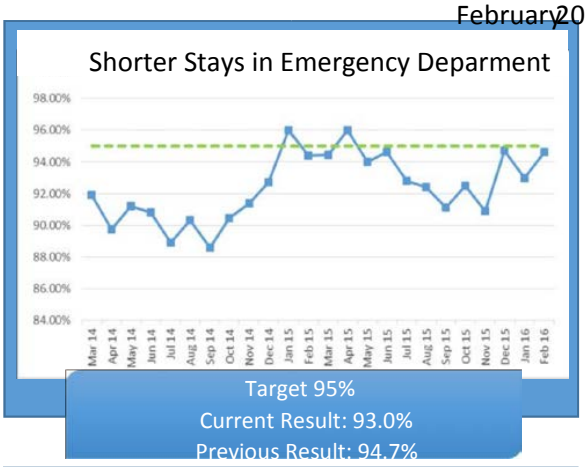
The work on this is ongoing and we will update you in the next newsletter.

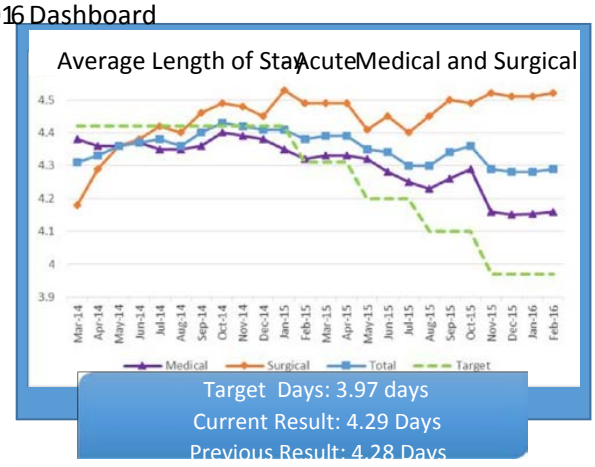
I look forward to updating you on our progress as we continue the next steps on our journey towards a 24/7 Hospital that is better for patients and better for staff.

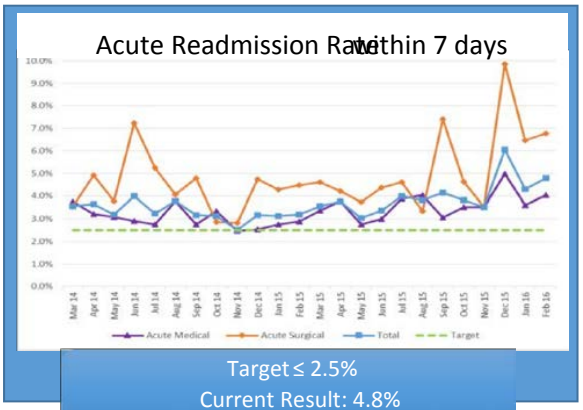
DR JOHN GOMMANS
Chief Medical Officer - Hospital

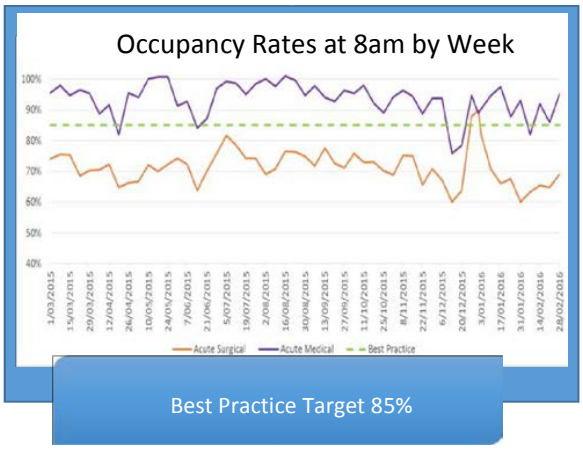
Appendix C

February 2016 Dashboard



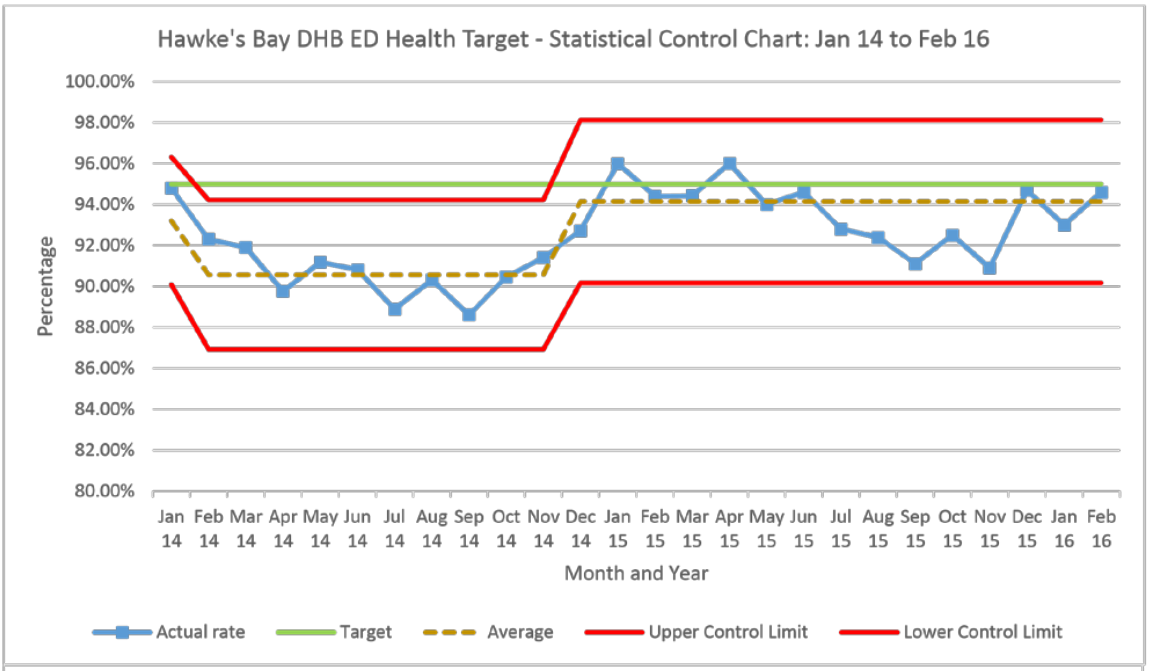


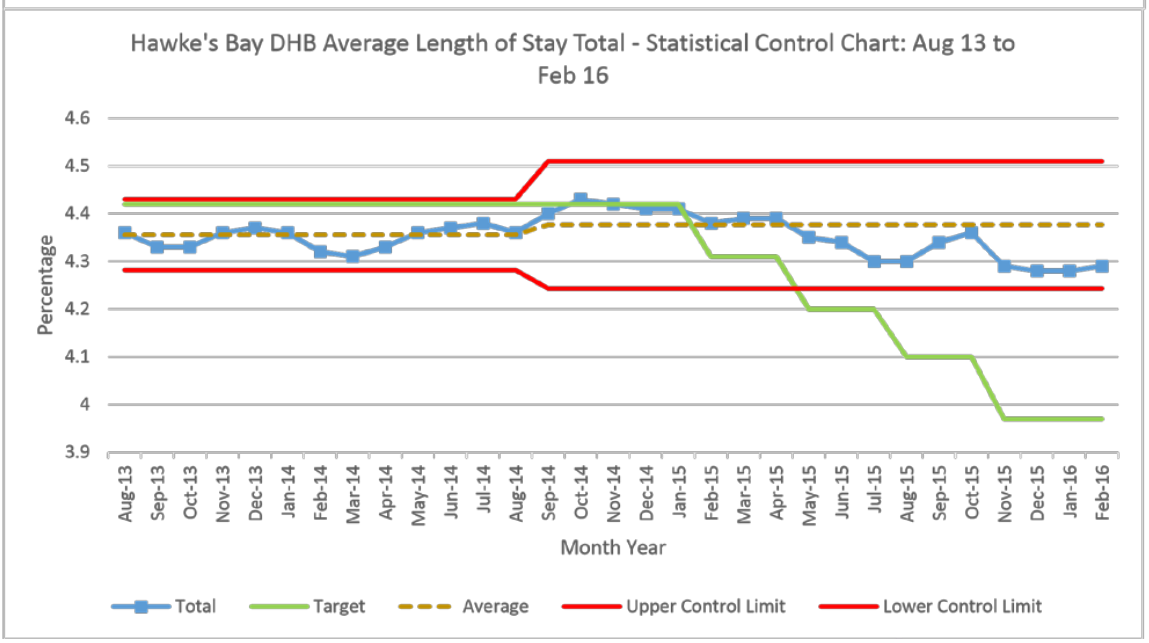




Appendix C AIM 24-7 Dashboard - Feb 16_19A28DC

AIM 24-7 Dashboard February 2016





13

AIM 24-7 Dashboard February 2016

Dashboard - Explanatory Notes Occupancy Rates at 8am

The ideal occupancy rate is deemed to be around 85% to manage day to day fluctuations in presentations and ensure sufficient beds are free to enable patients with specific needs to access beds/nurses most suited to their needs. This data must be interpreted with some caution as 8am may not reflect overcrowding and access block at other times. Also when occupancy is high the data may not fully compensate for use of unresourced overflow beds in acute wards and AT&R Unit, use of A2 beds or outlier patients (e.g. medical patients in surgical beds).The increased winter demand in 2015 combined with an emphasis on maintaining elective surgical performance is reflected in the high occupancy rates shown and there have been numerous periods of 'access block' to ward beds when patients have been unable to transfer out of AAU or ED to free up assessment beds for new patients. This situation would previously have had major adverse impacts on hospital efficiency and ED6 Target measures, which have been somewhat minimised by the actions of AIM 24/7.

Average Length of Stay – Acute Medical and Surgical

The average length of stay (LOS) in medicine has reduced indicating more efficient processes due to the actions initiated by the General Medicine and AAU Models of Care, and the Return to the Community work streams. However, surgical LOS has increased partly reflecting new appointments of vascular and general surgeons undertaking more complex procedures.

Shorter Stays in Emergency Department

The Shorter Stays in ED Target requires 95% of presentations to be seen, treated and either discharged or admitted within 6 hours. It is a measure of how well acute demand is managed and reflects whole of hospital functioning. Steady improvements occurred from initiation of AIM 24/7 in September 2014 and the 95% target was achieved for the first two quarters of 2015 calendar year. However the 9-10% growth in ED presentations from winter 2015 to present day have challenged the hospital's resources and processes and performance against the target has fallen.

Acute Readmission Rate within 7 days – Acute Medical and Surgical

This indicator was designed to monitor risk of unintended adverse harm (i.e. unplanned early readmission) as a consequence of AIM 24/7 efforts to reduce the average length of stay. Results show small increases in medical readmissions rate in recent months during the period of increased ED presentations. Surgical readmission rates have fluctuated significantly but are under Operation Productivity and not part of AIM 24/7.

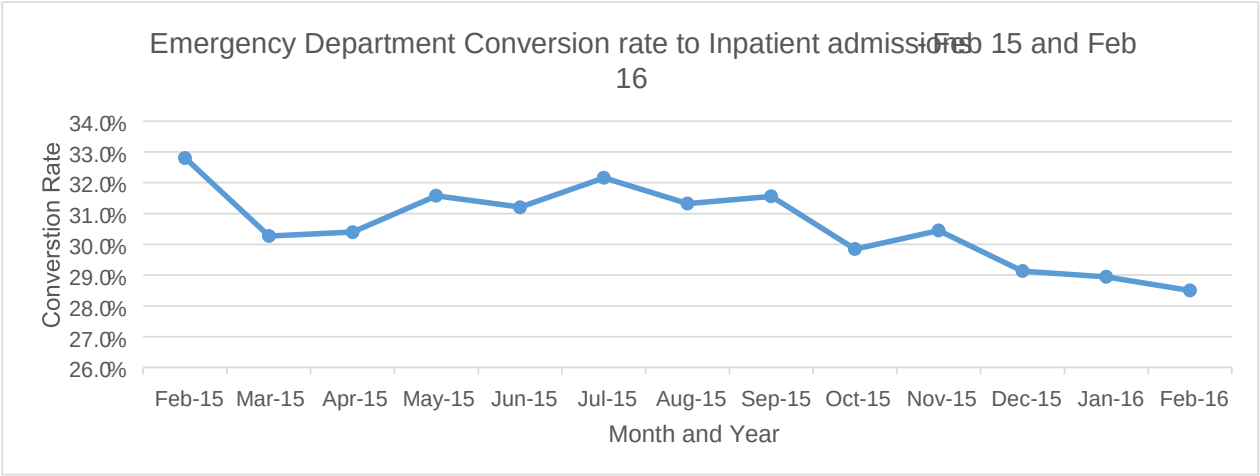
Appendix D

Business Performance and Intelligence

Hospital Analysis – February 16

Comparison of February 2015 and 2016

Emergency Department



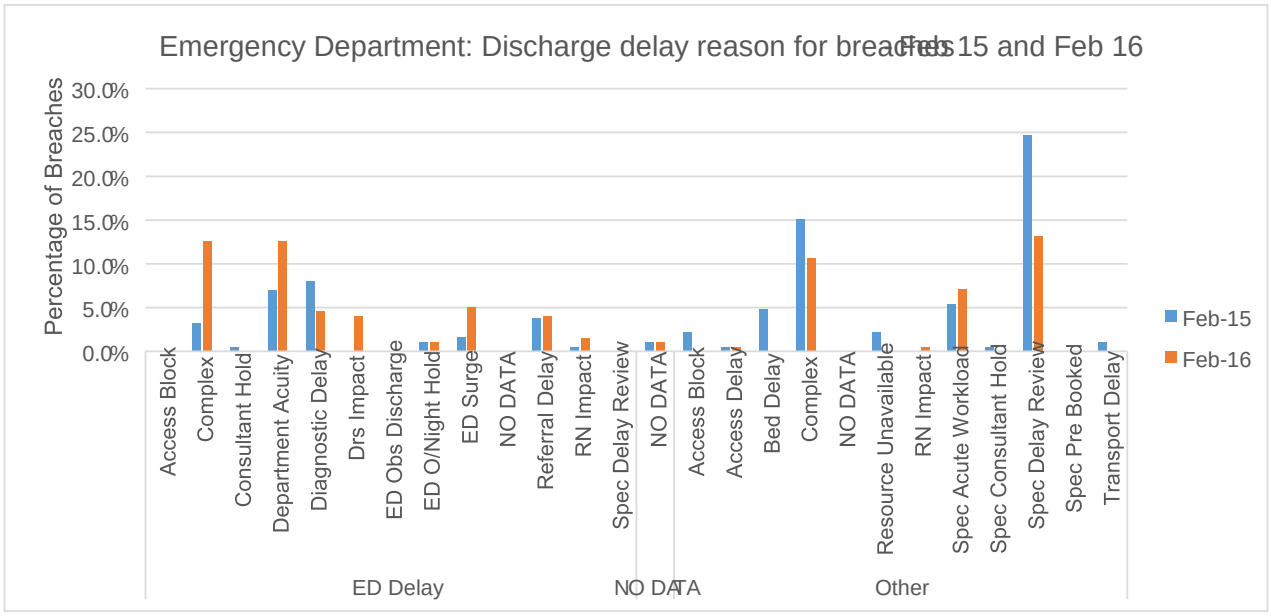
	Presentations	Admitted as Inpatient	Conversion Rate	ED Breaches	ED Health Target
Feb-15	3,311	1,086	32.8%	186	94.4%
Feb-16	3,663	1,044	28.5%	198	94.6%
Variance	10.6% (352)	-3.9% (-42)	-4.3%	6.5% (12)	0.2%

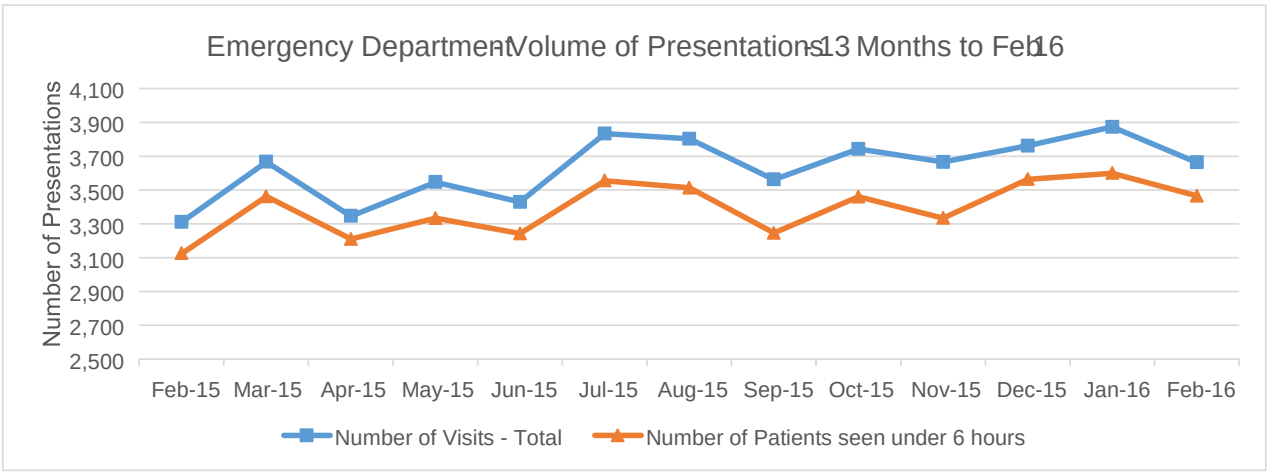
Comment:

Presentations to Hastings Regional Hospital for February 16 increased by 10.6% (352 presentations) on February 15 to 3,663 presentations. Patients admitted as inpatients decreased by 42 events to 1,044 for February 16, with the conversion rate decreasing to 28.5% for February 16. ED breaches increased slightly by 6.5% (12 more events) which translated to ED Health target of 94.6%, an increase of 0.2% on February 15.

Hastings Regional hospital performance increased with more presentations through the door, a lower conversion rate but more breaches comparing February 16 to February 15. This translated to a health target result for shorter stays in ED of 94.6%, (target of 95%), an increase on February 15 result of 94.4%.

Further Analysis:



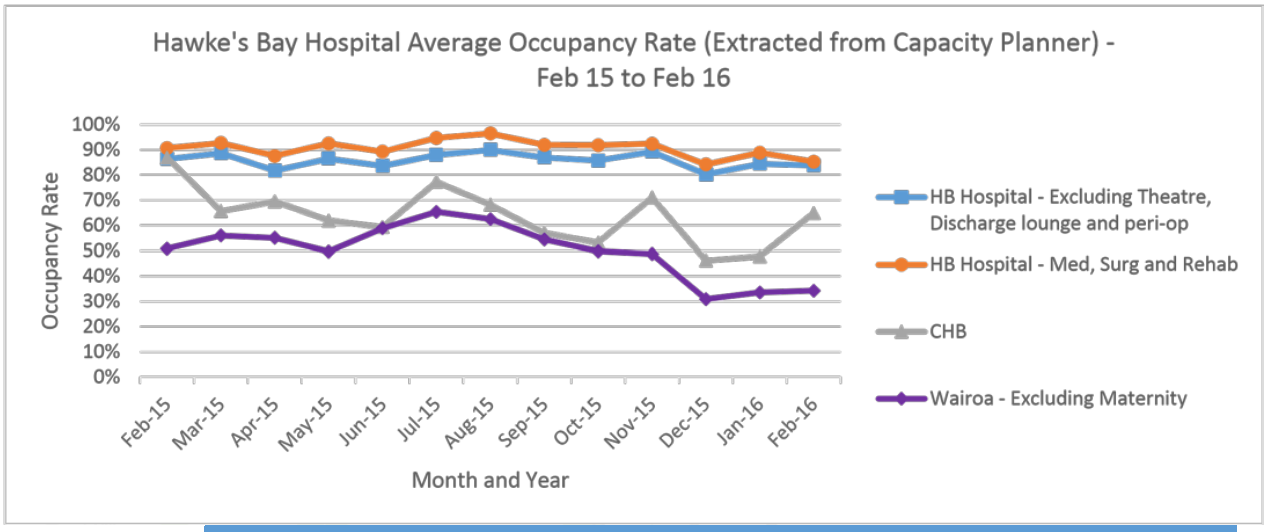


The two graphs above show the volume of presentations to Hawke's Bay Regional Hospital Emergency department and the discharge reason for breaches in February 2015 and 2016.

The discharge delay reason is categorised into two categories; ED Delay and Other. ED Delay is something that ED had control over that attributed to a delay. Other means the reason for delay was outside of ED's control that attributed to the delay. The main discharge delay reason for breaches is specialist delay in review 13.1%, 26 events (Feb 15: 24.7%, 46 events), which has decreased by almost half compared to February 15. There has been a significant increase in the number of breaches due to complexity within ED, ED department acuity, ED surge and doctors impact; with an increase to 34% of all breaches for February 16 (68 breaches) compared to 11.8% in February 15 (22 breaches).

When specialist delay for review is broken down to specialty, there is a substantial decrease in breaches for February 16 compared to February 15.

Average Occupancy Rate



	Feb-15		Feb-16	
Specialty of Breaches due to Specialty delay review	Number of Events	% of Events	Number of Events	% of Events
Gynaecology	0	0.0%	1	3.8%
Medical	24	52.2%	9	34.6%
Mental Health Service	0	0.0%	1	3.8%
NO DATA	3	6.5%	4	15.4%
Orthopaedics	3	6.5%	3	11.5%
Paediatric	0	0.0%	1	3.8%
Surgical	13	28.3%	6	23.1%
Urology	3	6.5%	1	3.8%
Total	46	100.0%	26	100.0%

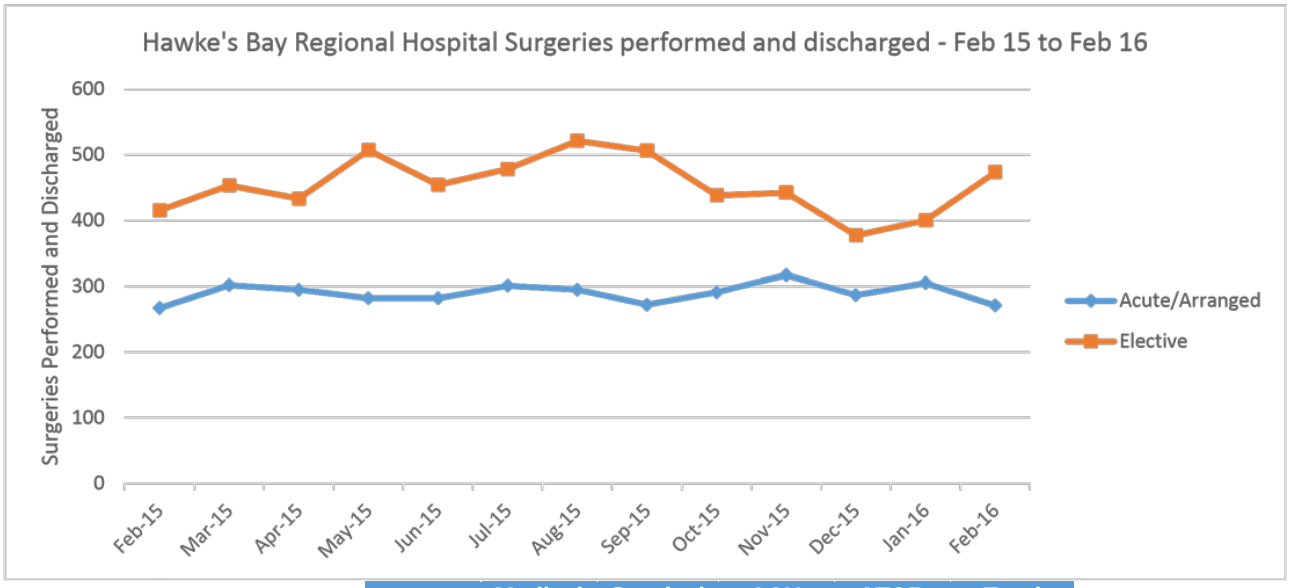
	HB Hospital - Excluding Theatre, Discharge lounge and peri-op	HB Hospital - Med, Surg and Rehab (Includes Extra beds opened)	CHB	Wairoa - Excluding Maternity
Feb-15	86.3%	90.7%	86.9%	50.9%
Feb-16	83.8%	85.3%	64.9%	34.2%
Variance	-2.4%	-5.4%	-22.0%	-16.6%

Comment:

Average occupancy for February 16 was lower compared to previous year for overall Hastings Regional hospital. Within the Medical, Surgical and AT&R specialty groups, occupancy has decreased to 85.3% in February 16 from 90.7% for February 15

Below are the beds closed for February 15 and 16. Please note that 2016 has one extra day due to being a leap year.

Surgeries Performed and Discharged



	Medical	Surgical	AAU	AT&R	Total Beds Closed
Feb-15	30	1	0	0	31
Feb-16	42	22	40	25	129

Note: Due to flex beds not entered into Capacity Planner for Medical and Surgical this could overstate the occupancy rate.

	Acute/Arranged	Elective
Feb-15	267	415
Feb-16	271	473
Variance	4	58

Comment:

Surgeries performed and discharged have increased for Acute/Arranged surgeries of 4 events and increased for elective surgeries by 58 events for February 16 compared to February 15. Overall there is an increase of 62 surgeries performed in February 16 compared to February 15.

Criteria:

All surgeries performed on site at Hawke's Bay Regional Hospital with a theatre event
Excludes IDF

HAWKE'S BAY District Health Board Whakawāteatia	**Transform & Sustain Refresh (draft)**
	For the attention of: **Clinical Council, Consumer Council and Maori Relationship Board (MRB)**
Document Owner:	Tim Evans
Reviewed by:	Executive Management Team
Month:	April, 2016
Consideration:	For Information and decision.

14

RECOMMENDATION

That Clinical, Consumer Council and MRB:

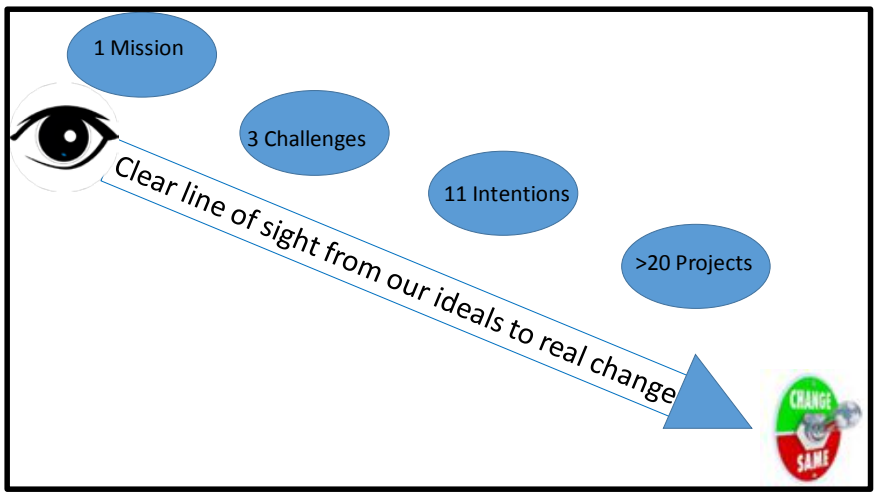
- Note the reasoning and process thus far in refreshing the implementation programme underpinning the Strategy
- Agree the proposed approach and timetable for widening the discussion and project design.

OVERVIEW

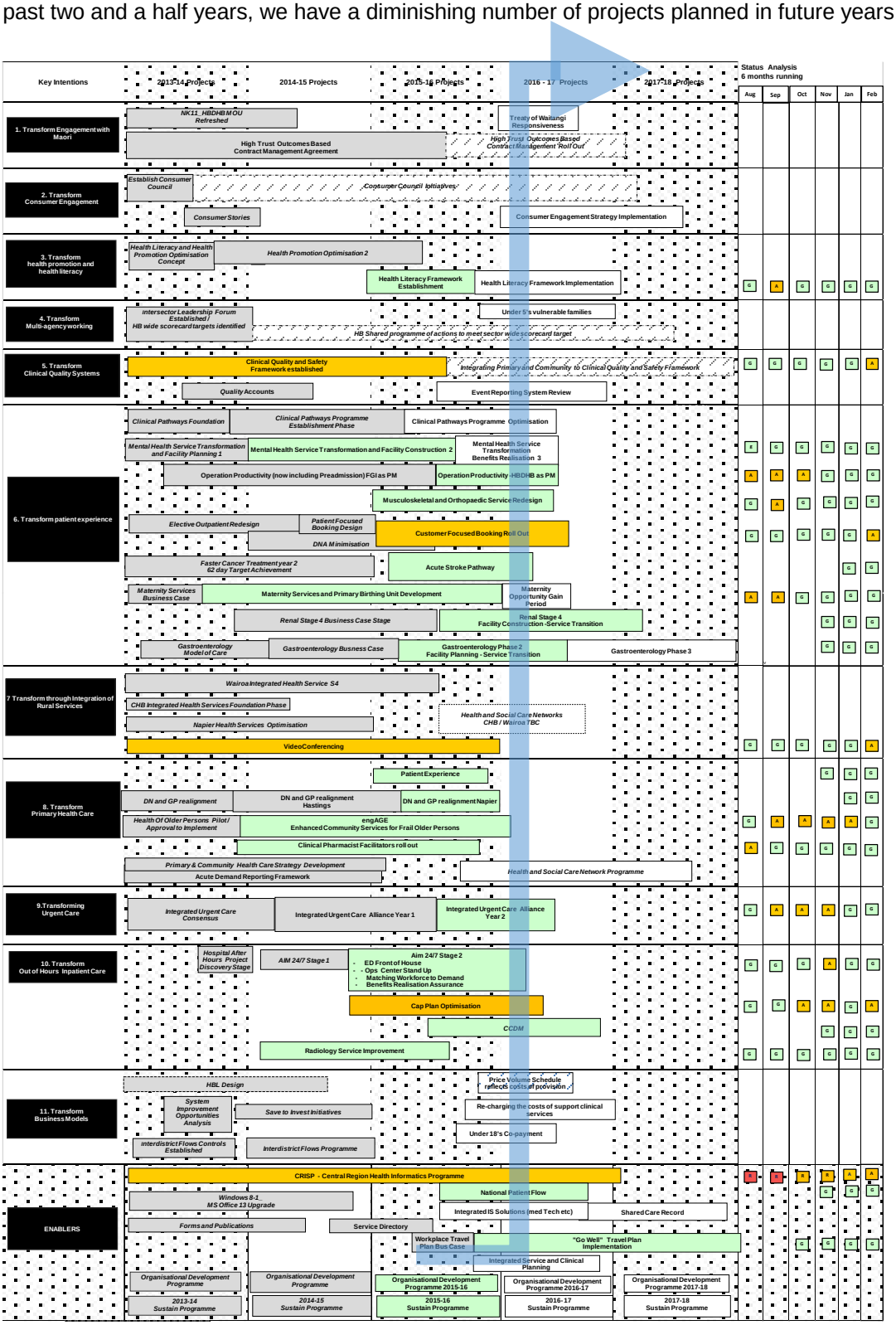
The Transform & Sustain Strategy, a 5 year strategy published in December 2013, is now half way through its planning horizon. The Strategy is not therefore due for replacement, but the underpinning programme projects which achieve the intentions of the Strategy are due a refresh. This paper updates the District Health Board on out how that refresh has begun, and seeks agreement to the proposed milestoned timetable to complete.

BACKGROUND

The Transform and Sustain Strategy was designed to ensure that we moved from a clear statement our strategic mission in a clear and direct line to projects which make real change happen:



In developing the Strategy we agreed that it would be “emergent”. That is to say that the high level Mission and Challenges would not change, (at least in our 5 year timescale), but the translation into action through intentions and projects would need to be adaptive. While there has been a healthy programme of live projects with over 20 live in the programme at any given time over the past two and a half years, we have a diminishing number of projects planned in future years:



The aim of the refresh is therefore to:

- check if we have been achieving the outcomes set out in Transform & Sustain;
- to generate new Projects and (if necessary) Intentions to progress those outcomes;
- to engage stakeholders in the refresh and new project specification

PROCESS TO DATE

The Project management Office made a list of all of the 24 "outcome" descriptions given in the Transform & Sustain document. Executive Management Team scored these for achievement to date separately and individually.

In a Team day on 15 November 2015 the aggregated and individual scores were played back in to an EMT. These were discussed and moderated to get an EMT consensus idea of where we were not yet achieving desired outcomes.

In the afternoon of that team day the Health Services Leadership made their assessment in syndicate groups of the 8 areas of best progress and 8 areas of least progress. This was then played back and compared against the EMT aggregate scoring. The degree of match remarkable. There was then some generation of ideas to progress in the areas that we need to improve.

The agreed areas for further work were distilled from the November workshop and presented to EMT on 1 March. EMT amended these further to arrive at 6 agreed areas for future focus:

⇒ Person and Whanau Centred Care (people as equal partners in their healthcare)

⇒ Health and Social Care Networks (creating strong primary and community care clusters)

⇒ Whole of Public Sector delivery (delivering effectively with public sector partners)

⇒ Information System connectivity (and improved outpatient process)

⇒ Financial Flows and models (incentivising and funding the right behaviours)

⇒ Investing in Staff and changing culture (equipping our staff for a changing world)

The need to address health inequity was a repeated theme to be woven into all of these focus areas. The team day then concentrated on identifying what work streams and projects we have in progress, or about to begin to deliver benefit in these focus areas.

The Executive Team members finally generated proposed new projects and work streams to deliver outcomes in the 6 focus areas.

It was generally agreed that each of the focus areas and consequent work would fit comfortably into our current framework of 11 intentions.

FUTURE DEVELOPMENT

The work thus far has been generated by the DHB and Health Services executive leadership. That does involve a lot of clinical input, managerial expertise, health sector, and some cultural perspective, but lacks consumer, wider sector, and broader cultural input. These areas of focus need to be discussed with and endorsed and/or amended by wider stakeholder groups.

We also need to brain storm our whole community of interest to generate ideas, work streams and projects to progress in the future focus areas (if indeed they are endorsed or more if added).

Finally we need to find ways to engage widely in co-designing the precise nature of our future crop of projects so they deliver the right change effectively and efficiently.

A draft timetable follows:

Key Steps	**Proposed Timeframes**
1. Pre-discussion re how we optimally use the Leadership Meeting scheduled for the 17th May 2016. • Graeme Norton; Chris McKenna; Kevin Atkinson; Mark Peterson; Ken Foote	March / April
2. Run sessions to discuss "have we got it right / what have we missed", information sharing etc.	
• Finance	April and early May
• Quality and Safety	
• IS and Business Intelligence	
• Human Resources	
• Strategic Services and Planning	
• HS Leadership and Service Directorships	
• T&S Union Engagement Forum	
• Clinical Council and Primary Care (possibly CAG)	
3. Run various workshops to ask "What would we be doing (how would we be working) with your people if we are doing it right? (Vulnerable Families; Co-Design and Engagement etc.)	
• Consumer Council	Early to mid-May April to mid-May 17 May 2016
• MRB	
• Leadership Forum	
4. Final Presentation Process	
• EMT	31 May
• Clinical Council	8 June
• Consumer Council	9 June
• DHB Board (FRAC)/ PHO Board	29 June/tba
5. Business As Usual protocol for project co-design documented and agreed	30 June

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. Matters Arising – Review of Actions
- Public Excluded

19. Learnings from ICU Review 2013

20. 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).

GLOSSARY OF COMMONLY USED ACRONYMS

A&D	Alcohol and Drug
AAU	Acute Assessment Unit
AIM	Acute Inpatient Management
ACC	Accident Compensation Corporation
ACP	Advanced Care Planning
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ACP	Advanced Care Planning
AP	Annual Plan
ASH	Ambulatory Sensitive Hospitalisation
AT & R	Assessment, Treatment & Rehabilitation
B4SC	Before School Check
BSI	Blood Stream Infection
CBF	Capitation Based Funding
CCDHB	Capital & Coast District Health Board
CCN	Clinical Charge Nurse
CCP	Contribution to cost pressure
CCU	Coronary Care Unit
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHB	Central Hawke's Bay
CHS	Community Health Services
CMA	Chief Medical Advisor
CME / CNE	Continuing Medical / Nursing Education
CMO	Chief Medical Officer
CMS	Contract Management System
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CPHAC	Community & Public Health Advisory Committee
CPI	Consumer Price Index
CPO	Co-ordinated Primary Options
CQAC	Clinical and Quality Audit Committee (PHO)
CRISP	Central Region Information System Plan
CSSD	Central Sterile Supply Department
CTA	Clinical Training Agency
CWDs	Case Weighted Discharges
CVD	Cardiovascular Disease
DHB	District Health Board
DHBSS	District Health Boards Shared Services
DNA	Did Not Attend
DRG	Diagnostic Related Group
DSAC	Disability Support Advisory Committee
DSS	Disability Support Services
DSU	Day Surgery Unit
ED	Emergency Department
ECA	Electronic Clinical Application

ECG	Electrocardiograph
EDS	Electronic Discharge Summary
EMT	Executive Management Team
EoIs	Expressions of Interest
ER	Employment Relations
ESU	Enrolled Service User
ESPIs	Elective Service Patient Flow Indicator
FACEM	Fellow of Australasian College of Emergency Medicine
FAR	Finance, Audit and Risk Committee (PHO)
FRAC	Finance, Risk and Audit Committee (HBDHB)
FMIS	Financial Management Information System
FSA	First Specialist Assessment
FTE	Full Time Equivalent
GIS	Geographical Information System
GL	General Ledger
GM	General Manager
GMS	General Medicine Subsidy
GP	General Practitioner
GP	General Practice Leadership Forum (PHO)
GPSI	General Practitioners with Special Interests
GPSS	General Practice Support Services
HAC	Hospital Advisory Committee
H&DC	Health and Disability Commissioner
HBDHB	Hawke's Bay District Health Board
HBL	Health Benefits Limited
HHB	Health Hawke's Bay
HQSC	Health Quality & Safety Commission
HOPSI	Health Older Persons Service Improvement
HP	Health Promotion
HR	Human Resources
HS	Health Services
HWNZ	Health Workforce New Zealand
IANZ	International Accreditation New Zealand
ICS	Integrated Care Services
IDFs	Inter District Flows
IR	Industrial Relations
IS	Information Systems
IT	Information Technology
IUC	Integrated Urgent Care
K10	Kessler 10 questionnaire (MHI assessment tool)
KHW	Kahungunu Hikoi Whenua
KPI	Key Performance Indicator
LMC	Lead Maternity Carer
LTC	Long Term Conditions
MDO	Maori Development Organisation
MECA	Multi Employment Collective Agreement
MHI	Mental Health Initiative (PHO)
MHS	Maori Health Service
MOPS	Maintenance of Professional Standards
MOH	Ministry of Health
MOSS	Medical Officer Special Scale
MOU	Memorandum of Understanding

MRI	Magnetic Resonance Imaging
MRB	Māori Relationship Board
MSD	Ministry of Social Development
NASC	Needs Assessment Service Coordination
NCSP	National Cervical Screening Programme
NGO	Non Government Organisation
NHB	National Health Board
NHC	Napier Health Centre
NHI	National Health Index
NKII	Ngati Kahungunu Iwi Inc
NMDS	National Minimum Dataset
NRT	Nicotine Replacement Therapy
NZHIS	NZ Health Information Services
NZNO	NZ Nurses Organisation
NZPHD	NZ Public Health and Disability Act 2000
OPF	Operational Policy Framework
OPTIONS	Options Hawke's Bay
ORBS	Operating Results By Service
ORL	Otorhinolaryngology (Ear, Nose and Throat)
OSH	Occupational Safety and Health
PAS	Performance Appraisal System
PBFF	Population Based Funding Formula
PCI	Palliative Care Initiative (PCI)
PDR	Performance Development Review
PHLG	Pacific Health Leadership Group
PHO	Primary Health Organisation
PIB	Proposal for Inclusion in Budget
P&P	Planning and Performance
PMS	Patient Management System
POAC	Primary Options to Acute Care
POC	Package of Care
PPC	Priority Population Committee (PHO)
PPP	PHO Performance Programme
PSA	Public Service Association
PSAAP	PHO Service Agreement Amendment Protocol Group
QHNZ	Quality Health NZ
QRT	Quality Review Team
Q&R	Quality and Risk
RFP	Request for Proposal
RIS/PACS	Radiology Information System Picture Archiving and Communication System
RMO	Resident Medical Officer
RSP	Regional Service Plan
RTS	Regional Tertiary Services
SCBU	Special Care Baby Unit
SLAT	Service Level Alliance Team
SFIP	Service and Financial Improvement Programme
SIA	Services to Improve Access
SMO	Senior Medical Officer
SNA	Special Needs Assessment
SSP	Statement of Service Performance
SOI	Statement of Intent

SUR	Service Utilisation Report
TAS	Technical Advisory Service
TOR	Terms of Reference
UCA	Urgent Care Alliance
WBS	Work Breakdown Structure
YTD	Year to Date