HB Clinical Council Meeting

Date: **Wednesday, 10 October 2018**

Meeting: **3.00 pm to 5:30 pm**

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

Council Members:

Dr John Gommans (Co-Chair)
Dr Andy Phillips (Co-Chair)
Chris McKenna
Dr Mark Peterson
David Warrington
Dr Robin Whyman
Lee-Ora Lusis
Dr Daniel Bernal
Jules Arthur
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Peter Culham
Dr Nicholas Jones

Apology:

In Attendance:

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

Public

Item	Section 1 – Routine	Time (pm)
1.	Welcome and receive apologies	3:00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Workplan	

	Section 2 – Presentation	
6.	Quality Dashboard presentation – Kate Coley & Russell Wills	3:10
	Section 3 – For Discussion	
7.	Conception to Five Years including the first 1000 days – Jules Arthur & Russell Wills	3:20
	Section 4 – Reporting Committees to Council	
8.	Clinical Advisory & Governance Group Update – Chris McKenna	3:45
9.	Professional Standards & Performance Committee – John Gommans & David Warrington	3:50
	Section 5 – For Information Only	
10.	Havelock North Gastroenteritis Outbreak (final) – Kate Coley	3:55
11.	Clinical Portal Project Update – no presenter	-
12.	Te Ara Whakawaiora - Cardiovascular (National Indicator) – no presenter	-
13.	**Section 6 – Recommendation to Exclude the Public**	

Public Excluded

Item	**Section 7 – Routine**	
14.	Minutes of Previous Meetings	
15.	Matters Arising – Review Actions - nil	
	Section 8 – Discussion	
16.	Cardiology Review and plan of action – Colin Hutchison & Paula Jones 16.1 Action Plan 16.2 Project Mandate	4:00
17.	Annual General Meeting – John Gommans & Andy Phillips 17.1 Minutes of AGM 17.2 AGM Actions & Council Workplan - Committee ToRs for Approval 17.3 Process for appointment of Chair(s) 17.4 Clinical Council Chair/Co-Chair Role Description	4:20
18.	Topics of Interest – Member Issues / Updates	5:20

Next Meeting:

Wednesday, 14 November 2018 at 3.00 pm, Boardroom, HBDHB Corporate Office

Combined meeting with Consumer Council on 6 December (TBC)

Interests Register
Sep-18

Hawke's Bay Clinical Council

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice	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
	Family member employed by HBDHB since November 2015	Daughter, RMO	Will note interest if discussions occur around RMOs.	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that agrees the contract.	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Primary Health Alliance	Executive Member	Primary Care advocacy organisation	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	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)	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)	Chair of NZ AMDC	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMDC representing those based in NZ	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
David Warrington (Nurse Director - Older Persons)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Advisory & Governance Committee)	Loco Ltd	Shareholding Director	Private business	No	
	Clinical Advisory & Governance Committee (CAG) for Health HB (Tenure ends 27/06/18)	Member	Report on CAG meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Ministry of Health - First Specialist Assessment Oversight Group	Member		No	
	Locum General Practitioner			No	
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
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
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	National Advisory Committee of the RNZCGPs	Member and CP Teacher	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.

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Debs Higgins (Senior Nurse)	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Clinical Director Oral Health)	NZ Institute of Directors	Member	Continuing professional development for company directors	No	
	Australian - NZ Society of Paediatric Dentists	Member	Continuing professional development for dentists providing care to children and advocacy for child oral health.	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Director	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health			
	Kidney Health Australia - Caring for Australasians with Renal Impairment	Member		No	Guidelines group - involved with the group "Management of chronic kidney disease among Aboriginal, Torres Strait Islander Peoples and Maori".
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
Dr Peter Culham (GP)	Havelock North Properties Limited	Shareholder	Medical Centre owner	Yes	Low, pecuniary, hold leases with healthcare providers
	Te Mata Peak Practice	GP and Director	General Practice	Yes	Low, pecuniary, provides primary care services
	C&G Healthcare	Director	Private business	No	No further exposure beyond mentioned above
	Royal NZ College of General Practitioners	Fellow		No	
Daniel Bernal	New Zealand Hospital Pharmacists Association	Member	Discussion	No	
	Pharmaceutical Society of New Zealand	Member	Access their resources, record my CPD on their website.	No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 12 SEPTEMBER 2018 1.00 PM

PUBLIC

Present:	Dr John Gommans (Chair) Dr Andy Phillips (Co-Chair) Dr Robin Whyman Dr Nicholas Jones Dr David Rodgers Dr Peter Culham Debs Higgins Jules Arthur Dr Daniel Bernal Chris McKenna Dr Russell Wills Lee-Ora Lusis Anne McLeod
In Attendance:	Kate Coley, Executive Director – People & Quality (ED P&Q) Tracy Fricker, Council Administrator and EA to ED P&Q Rachel Ritchie, Consumer Council Chair (from 1.45 pm)
Apologies:	Dr Mark Peterson and David Warrington

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr John Gommans (Chair) welcomed everyone to the meeting. Congratulations were extended to Dan Bernal on his official appointment as Chief Pharmacist and permanent membership of Clinical Council.

Apologies were noted as above.

2. INTEREST REGISTER

No conflicts of interests were noted for agenda items.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 8 August 2018, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 Investments Update (Outcomes of Budget Prioritisation)
A paper and presentation to be provided by Andy Phillips at the October meeting.

Item #2 Interest Register

Interests for Dr David Rodgers amended. *Item can be closed.*

Item #3 Workplan

Item for discussion today under item #23 of the Annual General Meeting. *Item can be closed.*

Item #4 Violence Intervention Programme

The VIP pathway is being updated and will be provided when completed. It was noted that primary care have pathways for individual clinicians to follow and would be happy to share.

Action: Debs Higgins to make contact with Cheryl Newman.

Clinical Leaders yet to meet to discuss how to influence clinicians to screen for VIP.

Action: John Gommans to raise at the Heads of Department Meeting, Chris McKenna to raise at the Nurse Directors Meeting and Anne McLeod to raise at the Allied Health Professionals Advisory Group.

Item #5 Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs

Time to be allocated for further discussion at the November meeting.

Action: All members to send key issues to Jill Garrett.

SECTION 2: FOR DISCUSSION

5. AFTER HOURS URGENT CARE UPDATE

The report provided a high level six-month review of the Urgent Care After Hours Service. It noted that a comprehensive 12-month review will be completed where recommendations will be made to improve how care is provided in the community.

General discussion took place including: growth of triage 3 and 4 in ED from some practices; proximity to ED being a factor in attendances; change in cost to consumers; access to care overnight; co-payment arrangements and next day GP appointments being available; GPs believing ED provides GP-level care and need to direct people back to their GP; having triage overnight in City Medical and an overnight emergency service in Hastings; identifying a clear set of KPIs and being clear on what we want to achieve; investment to make the changes required and the St Johns Service being underutilised.

The Chair congratulated David Rodgers and summarised that the urgent care plan was put together quickly under challenging circumstances. While there are different agendas behind this, the purpose was to get people currently using urgent care re-connected with their primary care provider and improve access to their GP. ED provides a free service for the poor population of Hastings who live close by which is a non-competitive model for primary care. Options include re-prioritising the current urgent care money, looking at next day appointments and whether CHB can join the model. There are options which can be explored to better enhance the service for doctors, nurses and the community. There is a need for joined up access points for care.

The Clinical Council **noted** the report.

Health Awards (unscheduled late item for discussion)

The Chair welcomed Anna Kirk, Communication Manager to the meeting to discuss the shortlisting process for the Hawke's Bay Health Awards. Following feedback received last year,

the categories have been amended to prioritise living the values and resolving health inequities. Entries close this Friday and will be sent out for shortlisting next week. There has been media around the Health Awards and alcohol. Alcohol will not be provided with the ticket but will be available for purchase only.

General discussion took place regarding the judging process, assisting people from across the health sector to put in entries, cost of tickets and whether the Clinical Council should even be involved in the shortlisting process. It was suggested that the Consumer Council be involved as they see things from the point of the consumer who our services are aimed at.

Clinical Council members allocated for the categories as below (volunteers at meeting plus allocations by chairs):

- ***Commitment to quality improvement and patient safety*** – Russell Wills, Chris McKenna, Dan Bernal, Andy Phillips
- ***Excellence in evidenced-based research delivering innovative solutions*** – Debs Higgins, Chris McKenna, Nick Jones, Dan Bernal
- ***Excellence in service improvement*** – Russell Wills, Jules Arthur, Mark Peterson, David Warrington
- ***Excellence in clinical care*** – Peter Culham, Anne McLeod, Lee-ora Lusis, Chris McKenna
- ***Commitment to reducing inequities*** – Nick Jones, Anne McLeod, Lee-ora Lusis, Andy Phillips
- ***Commitment to working together to improve community health and wellbeing*** – Peter Culham, Debs Higgins, Robin Whyman, Jules Arthur

The shortlisting needs to be completed and returned by Thursday, 11 October.

Action: Shortlisting process to be reviewed to include or use Consumer Council and the Maori Relationship Board instead of Clinical Council next year. (Anna Kirk)

6. MATARIKI REGIONAL DEVELOPMENT STRATEGY AND SOCIAL INCLUSION (6-MONTH UPDATE)

The paper was provided for information only.

Query raised why this paper was even on the agenda for a clinical governance committee. The Co-Chair advised that the Board values clinical council opinion on papers coming to it with the expectation that any major issues would be flagged to them. The Co-Chairs and Company Secretary review all papers against a set of criteria before agreeing to their presence on the agenda. EMT is currently reviewing these criteria and Council's agenda needs to reflect our primary role and purpose.

SECTION 3: COMMITTEE REPORTS

7. CLINICAL ADVISORY & GOVERNANCE GROUP (CAG)

The minutes from the last CAG meeting were provided in the meeting papers for information. Chris Mckenna advised that the vacant CAG representative on Clinical Council is to be discussed at the next CAG meeting on 18 September.

8. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

9. Topics of interest - Member Issues / Updates
10. Minutes of Previous Meetings (public excluded)
11. Matters Arising – Review Actions
12. Mid-point HealthCert Surveillance Audit – corrective actions

The meeting closed at 2.00 pm.

Confirmed: _____
Chair

Date: _____

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/04/18	***Investments Update (Outcomes of Budget Prioritisation)*** • Paper and presentation to be provided	A Phillips	Oct	Moved to November
2	08/08/18	***Violence Intervention Programme*** • Pathway details to be provided to guide clinicians. • Contact to be made with C Newman re: Primary Care Pathway • Clinical Leaders (CMDO, CNMO, CAHPO and CMO (Primary) to discuss how to influence clinicians to screen for family violence: - HOD Meeting - Nurse Directors Meeting	C Newman D Higgins J Gommans C McKenna	TBC Sep/Oct Sep/Oct Sep/Oct	
3	08/08/18	***Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs*** • Key issues to be sent to Jill Garrett • Paper to be dicussed further at a future meeting (Quarterly update due in November)	All members All members	Sep Nov	
4	12/09/18	***Health Awards – Shortlighting*** • List of members to be allocated for each category and sent to Anna Kirk. • Anna Kirk to review process for next year to include Consumer Council / Maori Relationship Board.	Co-Chairs	ASAP	Actioned

Clinical Council Workplan as at 3 October 2018 (subject to change)	EMT Member	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Te Ara Whakawaiora - Cardiovascular (National Indicator)	John Gommans	10-Oct-18	11-Oct-18		31-Oct-18
Te Ara Whakawaiora - Improving Access Indicator	Colin Hutchison	10-Oct-18	11-Oct-18		31-Oct-18
Cardiology Review and plan of action (6 monthly update requested by EMT 6 March)	Colin Hutchison	10-Oct-18			31-Oct-18
Conception to Five Years, including first 1000 days (Clinical Action Dec 17)	Andy Phillips	10-Oct-18			
Quality Dashboard Presentation (Oct, jan for Feb19 mtg, Apr, July)	Kate Coley	10-Oct-18		31-Oct-18	
Havelock North Gastroenteritis Outbreak Final	Kate Coley	10-Oct-18		31-Oct-18	
National Mental Health Inquiry - detail is about to be released TBC	Colin Hutchison	10-Oct-18	11-Oct-18		31-Oct-18
Clinical Portal Project Update (EMT Clinical & FRAC) - 10 minutes	Anne Speden	10-Oct-18		31-Oct-18	
Clinical Advisory & Governance Group Report (July Aug Oct Nov Dec Feb Mar 19) WRITTEN	Chris McKenna	10-Oct-18			
Clinical Research Committee Update - issue annual report via email TBC	John Gommans	10-Oct-18			31-Oct-18
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18)	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Collaborative Pathways update (Nov - May) 6mthly Clinical Council only	Mark Peterson	14-Nov-18			
Clinical Portal Project Update (EMT Clinical & FRAC) - for information	Anne Speden	14-Nov-18		28-Nov-18	
Te Ara Whakawaiora REVIEW	Patrick LeGeyt	14-Nov-18	15-Nov-18		28-Nov-18
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	Chris Ash	14-Nov-18	15-Nov-18		28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-Nov) each year Board action Nov 17	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Alcohol Harm Reduction Strategy (6 monthly update) Nov-May-Nov-May	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov Dec Feb Mar 19) WRITTEN	Chris McKenna	14-Nov-18			
Clinical Services Plan in final form (Summary)	Ken Foote	14-Nov-18	15-Nov-18		28-Nov-18
Health Equity Report	Andy Phillips	14-Nov-18	15-Nov-18		28-Nov-18
National Bowel Screening Programme, Indicative Equity Outcomes in Māori and Pasifika	Chris Ash	14-Nov-18	15-Nov-18		28-Nov-18
Radiology Facility Development Business Case	Colin Hutchison	14-Nov-18			31-Oct-18
Prioritisation Process - Clinical Council Action 8 Aug 18	Andy Phillips / Chris Ash	14-Nov-18			
Violence Intervention Programme Presentation Committees reviewed in July - once progress made, come back	Colin Hutchison	14-Nov-18	15-Nov-18		28-Nov-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Andy Phillips	5-Dec-18	6-Dec-18		19-Dec-18
Te Ara Whakawaiora - Improving First Specialist Appointment Access (previously did not attend)	Colin Hutchison	5-Dec-18	6-Dec-18		19-Dec-18
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov Dec Feb Mar 19) VERBAL	Chris McKenna	5-Dec-18			
Maternal Wellbeing Programme Update (Board update action 25/7)	Patrick LeGeyt	5-Dec-18	6-Dec-18		19-Dec-18
Mobility action plan implementation - progress update on the phases	Andy Phillips	5-Dec-18	6-Dec-18		19-Dec-18
People Plan (6 monthly - Dec, Jun)	Kate Coley	5-Dec-18	6-Dec-18		19-Dec-18
Quality Dashboard Quarterly Report (July, Oct, jan for Feb19 mtg, Apr, July)	Kate Coley	13-Feb-19		27-Feb-19	
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	Chris Ash	13-Feb-19	14-Feb-19		27-Feb-19
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov Dec Feb Mar 19) WRITTEN OR VERBAL TBC	Chris McKenna	13-Feb-19			
IS updates/presentations 30 mins - Bi-monthly Feb Apr Jun Aug Oct Dec	Anne Speden	13-Feb-19		27-Feb-19	
Ngatahi Vulnerable Children's Workforce Development - annual progress Feb 19	Colin Hutchison	13-Feb-19	14-Feb-19		27-Feb-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-Mar	Andy Phillips	13-Mar-19	14-Mar-19		27-Mar-19
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Chris McKenna	13-Mar-19	14-Mar-19		27-Mar-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	13-Mar-19	13-Mar-19		27-Mar-19
Clinical Advisory & Governance Group Report (July Aug Sept Oct Nov Dec Feb Mar 19) WRITTEN OR VERBAL TBC	Chris McKenna	13-Mar-19			
Quality Dashboard Quarterly Report (July, Oct, jan for Feb19 mtg, Apr, July)	Kate Coley	10-Apr-19		24-Apr-19	
IS updates/presentations 30 mins - Bi-monthly Feb Apr Jun Aug Oct Dec	Anne Speden	10-Apr-19		24-Apr-19	
Collaborative Pathways update (Nov - May) 6mthly	Penny Rongotoa				
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	Mark P/ Jil Garrett / Patrick	9-May-19		29-May-19	
Alcohol Harm Reduction Strategy (6 monthly update) Nov-May-Nov-May	Rachel Eyre	9-May-19		29-May-19	

QUALITY DASHBOARD

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Conception to five years – including the first 1,000 days. How do we give Hawke's Bay kids the best start?**
	For the attention of: **HB Clinical Council**
Document Owner	Andy Phillips, Executive Director, Health Improvement and Equity
Document Author(s)	Shari Tidswell, Intersector Development Manager
Reviewed by	Jules Arthur, Russell Wills, Patrick Le Geyt Executive Management Team
Month/Year	October 2018
Purpose	For discussion to identify future action
Previous Consideration Discussions	This report was requested following discussions at Clinical Council
Summary	Clinical Council asked that a report be produced to start discussion on giving Hawke's Bay tamariki the best start in life. There is significant research showing the impact the first 1,000 day has (positive and negative) on our lives - development, epigenetics, future health/wellbeing and social outcomes. This is a "critical stage" for influencing the future of each tamariki. So there is merit in initiating a discussion on what the Hawke's Bay health system can do in partnership with intersectoral organisations to enhance outcomes for tamariki and reduce inequity for Māori and Pasifika communities. This is a discussion paper that provides a high level summary of evidence and opportunities for the HBDHB to enhance existing activity and find new approaches.
Contribution to Goals and Strategic Implications	Supports – equity strategies for early engagement with a LMC, tobacco and healthy weight; national health targets for tobacco, healthy weight, ASH 0-4, breastfeeding and child health. Aligned with – Clinical Services Plan - coordination and greater investment in prevention.

Impact on Reducing Inequities/Disparities	HEAT has identified inequity for Māori and Pasifika pregnant women and tamariki, especially those living in underserved communities – with these pregnant women experiencing higher rates of pre-term birth, smoke exposed pregnancies and emergency interventions and tamariki experiencing high rates of; ASH conditions, cold damp homes, obesity, benefit dependency and exposure to tobacco (as noted in the HBDHB Equity Report, Te Ara Whakawaiora reports and Children's Commissioner reports). Social status is identified in research as affecting the first 1,000 days – less social status the greater the negative impact. Poverty is a strong influencer. The inequitable distribution of these means that many Māori and Pasifika whānau in Hawke's experience inequity in development for tamariki in the first 1,000 days. This has been identified as a key priority for the Clinical Services Plan. The outcome of inequity in early years are life-long impacts on health and wellbeing including; higher risk of long-term conditions (heart disease, diabetes etc).
Consumer Engagement	The communities we serve were consulted in the development of the HBDHB equity strategies, the research informing this paper and more recently, consultation for Social Inclusion. Whānau clearly identified a need to be involved in plans, development of programmes and having services that are responsive to them. They also want coordinated service – "people need to talk to each other".
Other Consultation /Involvement	This item was requested by Clinical Council members and consultation has taken place with key HBDHB staff. This paper has been designed to start this discussion, by providing a summary of information and recommendations on future steps
Financial/Budget Impact	NA
Timing Issues	NA
Announcements/ Communications	NA

RECOMMENDATION:

It is recommended that HB Clinical Council:

- **Discuss** the contents of this report

HAWKE'S BAY District Health Board Whakawāteatia

Conception to five years – including the first 1,000 days How do we give Hawke's Bay tamariki the best start?

Authors:	**Shari Tidswell**
Designation:	**Intersector Development Manager**
Date:	**October 2018**

OVERVIEW

Plunket New Zealand has led the discussion around "First 1,000 days of a child's life" in New Zealand. Initial research published in a series of Lancet journal articles in 2008 looked at the impact of nutrition on a child's development, the first thousand days (from conception to around a child's third birthday). Then a UNICEF report identified this period as a "unique opportunity when the foundations of optimum health, growth and neurodevelopment across the lifespan is established"[1]. While this report focused on developing countries, the associated risks - infectious disease, environmental hazards, violence and poor nutrition, adversely affect all tamariki and poverty is a key linking factor in both developing and developed countries. The Manaakitia A Tātou Tamariki (Children's Commissioner) Report "1,000 Days to get it Right for Every Child"[2] notes - tamariki are most vulnerable to long-term consequences of deprivation in the first 1,000 days. Centre for Community Child Health (Victoria Australia) "the First Thousand Days: an evidence paper"[3] looks at biological processes including adaptivity, epigenetics, synaptic pruning and the telomere effect, along with social climate and ecological influences, concluding that: "Promoting 'optimal conditions' in early life is the best hope we have of hardwiring 'healthy' psychological, structural, immune, metabolic and behavioural response patterns in order to prevent many avoidable diseases."

There is evidence to include tamariki up to five years, including early childhood education engagement demonstrated as a key resiliency factor for tamariki in longitudinal studies in New Zealand and internationally. Behaviour change in nutrition and physical activity shows long-term benefits up until the age of 10 years, but most significantly up to five years. Preparing tamariki for school also supports greater gains throughout the education system and into employment. Also there is opportunity to implement remedial steps to address exposure to harmful factors i.e. stress, poor diet and trauma, as early as possible benefits tamariki. Finally, research by the Centre for Disease Control and Kaiser Institute[4] on adverse childhood experience shows that these experiences have long-term impacts on health and wellbeing and are best prevented early in life.

Supporting whānau from pre-conception to five years will provide an effective return for the whānau, the health sector and community as a whole. Targeting whānau experiencing the greatest inequity is effective. The OECD recommends investing early in tamariki's lives, concentrating on the most "vulnerable", designing interventions that are effective across the lifespan and working on a range of wellbeing indicators. To ensure effective outcomes, providers/funders must monitor progress, innovate to improve impact, evaluate to identify what is working and reallocate investment to programmes that work.

[1] https://www.unicef-irc.org/article/958/
[2] http://www.hauora.co.nz/assets/files/Children/1000-days-to-get-it-right-for-every-child.pdf
[3] http://apo.org.au/system/files/108431/apo-nid108431-436656.pdf
[4] https://www.cdc.gov/violenceprevention/acestudy/index.html

Kōmihana ā Whānau (Families Commission) identify the determinants of health as being the areas to work on i.e. housing, family violence, income and education. The "Victorian Report" (Australia) supports education and empowerment, and re-engineering environments (making life more physically active, increasing access to healthy food, improving safety and connecting communities). Investment in services is deemed less valuable than investing in improving the conditions people live in. Tom Moore (Murdoch Children's Research Institute) suggested a first 1,000 days in all policy approach – as a way of managing the system level intervention needed.

An OECD report from 2009 provides a framework for making a difference to the lives of tamariki:

- Invest early in children's lives
- Concentrate on improving the lot of vulnerable children
- Design interventions for children that reinforce positive development across their life cycle and across a range of wellbeing outcomes
- Regularly collect high-quality information on children's wellbeing that is nationally and internationally comparable; and
- Continuously experiment with policies and programmes for children, rigorously evaluating them to see whether they enhance child wellbeing, and reallocating money from programmes that don't work to those that do

What are the barriers to a best start?
When reviewing impact on tamariki's development, health and wellbeing, the following areas have the most significant detrimental impact on child development (WHO):

- Infectious diseases
- Environmental hazards
- Family harm
- Poor nutrition
- Unstable whānau environment

Influencing all of these are poverty and other determinants of health. Hawke's Bay has lower than national average wages, higher numbers of households receiving a means-tested benefits (2,335 whānau with a five year old and under receive financial assistance from Work and Income). Also a significant housing shortage in (376 whānau on the Social Housing Register in September 2017). Meaning, proportionally more tamariki experience poverty in Hawke's Bay than nationally.

Other significant issues for Māori tamariki include the impact of colonisation resulting in inter-generational trauma and the kaupapa Pakeha design of many services that introduce systematic barriers for Māori and Pasifika whānau.

Infectious diseases
Hawke's Bay has rates of; rheumatic fever, sexually transmitted diseases and norovirus, which are higher than the national average. Ambulatory Sensitive Hospitalisations for under-fives is an indicator for preventable disease and is also over the national average. Māori and Pasifika families have the highest rates.

Environmental hazards
The most dangerous environmental hazard for tamariki in Hawke's Bay is smoking. Pregnant Māori wāhine have the high smoking rates (42%), this impacts the development of their tamariki and their health. Cold/damp homes are hazardous – from 1 June to 30 September 2017, the Child Health Team assessed and implemented plans for 625 homes with 246 requiring insulation (HBDHB data). Injuries and deaths from household hazards are high in Hawke's Bay. The impact of parent health even prior to conception impacts on a child's development. Specifically the harmful effects of alcohol and other drugs use (i.e. foetal alcohol syndrome disorder).

Other environmental hazards such as whānau violence, high crime in their neighbourhood, unsafe conditions in their environment, are stressors. Parental stress impacts tamariki wellbeing with the highest impact in the first thousand days. Feeling unsafe is a stressor for both tamariki and parents.

Family Harm

Family harm has the most insidious impact on tamariki and across generations. Hawke's Bay Police attended 2,804 whānau harm incidents over 12 months where tamariki five and under were present. Of these, 259 tamariki experienced five or more incidents in a year and 28 experienced more than 10 (2017 Police internal data). Family violence is under-reported so this will be an under-representation of tamariki effected. High deprivation communities have the highest numbers of incidents. Tamariki under-five are presently at 41% of all family harm incidents.

Adverse Childhood Experiences (ACEs [5] are common and they have long-term, damaging consequences. ACEs are dose responsive, with each experience contributing to increased chronic disease, risk behaviours, lost life potential and risk of early death. These experiences occur within the whānau environment. The ACE study[6] revealed that one does not just "get over" or "grow out of" negative childhood experiences, they are best prevented.

Poor nutrition

Twenty-five percent of pregnant women were obese with 66 (2015/16 data) diagnosed with gestational diabetes. An overweight mother is a risk factor for childhood obesity. Breastfeeding is optimal nutrition for a tamariki in the first 6 months. Hawke's Bay rates are lower than the national average – at hospital discharge the rate is 85% and reduces as tamariki get older, at six weeks 54% for non-Māori, 36% for Māori. Breastfeeding provides resilience against obesity later in life, supports brain development and provides protection again disease, so is effective in supporting a best start for tamariki.

Data provided from the Before School Checks shows 13% of tamariki are above the 98th percentile (obese). Rates for those from high deprivation communities, Māori and Pasifika are higher. Hawke's Bay is lower than the national average for all ethnicities for caries free at five years. These both indicate poor diet.

Unstable whānau environment

Sole parent benefit rates provides an indicator for whānau breakdown; with one parent no longer in the whānau home – 1,379 whānau with an under-five receive this benefit (December 2017 HB Work and Income data). Transience also contributes to instability - the growth of whānau in temporary accommodation contributes to transience - there were 376 whānau on priority housing lists (September 2017 MSD data). Other indicators are; parents incarcerated, protection orders in place and child referred to CYF (unable to secure data).

Underpinning all of the above areas are poverty and inequity. The burden of detrimental impacts is unevenly spread with tamariki living in poverty more likely to experience; disease and hospitalisation, have smoking parents, live in cold damp homes, be obese and have inadequate/insecure accommodation. These tamariki are more likely to identify as Māori and Pasifika indicating inequity for these ethnic groups.

All of these factors influence each other, and are directly influenced by; income (negatively by poverty), the social climate (which has created complex issues and inequity) and ACEs.

[5] ACES are identified as growing up (prior to age 18) in a household with:

- Abuse – emotional, physical and sexual
- Household challenges – mother treated violently, substance abuse, mental illness, separation and incarcerated household member
- Neglect – emotional and physical

[6] Understanding of Adverse Childhood experiences (ACEs) is based on a study completed by the Centre for Disease Control and Kaiser
https://www.cdc.gov/violenceprevention/acestudy/about_ace.html

EFFECTIVE RESPONSES

Targeted programmes

Evidence shows that targeted programmes are effective when they are designed with and for the whānau receiving them. Targeted programmes also have the benefit of improving equity when targeted at whānau experiencing inequity. In contrast, universal programmes can increase inequity, with wealthier whānau engaging earlier and being more able to mobilise opportunities. The DHB has targeted programmes – the throat swabbing programme has reduced the rheumatic fever rates for tamariki, and the immunisation outreach programmes have managed to achieve equitable immunisation and reduce preventable childhood disease. There are also; oral health, skins, Child Healthy Homes and hand washing education programmes.

Māori and Pasifika whānau in Hawke's Bay experience the highest level of inequity and are over-represented in underserved communities. The importance of engagement in Maori culture is critical as this influences the behaviour of whānau and their understanding of child development. Programmes/services co-designed with these whānau are an opportunity to utilise the unique cultural qualities that can support child development.

Coordinated delivery

Building on existing points of engagement is cost-effective and provides a holistic approach for whānau. "One stop shop" or "no wrong door" approaches, allow whānau to build a relationship with a person/provider, who can respond to their needs.

Utilising services such as maternity services, LMCs, Well Child providers, Whānau Ora providers, early childhood education and primary care, can provide opportunities to link whānau with support, information and additional services. There needs to be effective communication between providers based on a shared whānau plan and these professionals need training to adapt their practise and support whānau education. Including understanding epigenetics, ACEs and being responsive to Māori and Pasifika cultures.

Innovation

Innovative programmes are evidence based and use continuous quality improvement to ensure they are achieving the outcomes they seek and measure impact. There is opportunity for co-design with Māori and Pasifika. Also whānau led programmes from design to delivering, creating responses that are whānau centric.

Working intersectorally to re-engineering environments whānau live in and influence the determinants of health including employment, education, housing and community safety. This would mean working with communities and key stakeholders including; Councils, Ministry of Social Development, Police, Housing NZ and others. These interventions can impact on inequity, determinants of health and poverty positively.

Undertake a systems level approach like first thousand days in all policy or a lifespan approach – "cradle to cradle" or life cycle approach. Will support the opportunities to combine outcomes and impact multiple influences on wellbeing i.e. Safe Sleep programme linked to tikanga via weaving, supported healthy environments and individual health.

Positive Childhood Experiences

Preventing ACEs and increasing the positive experiences for tamariki is effective in increasing tamariki health and wellbeing. Creating a positive whānau and community environment builds resilience. The following resiliency factors, support whānau to provide Positive Childhood Experiences:

- Strong connection with whānau and culture
- Strong connection with positive peers
- Strong connection with non-parental adult
- Opportunities to develop self-esteem
- Feeling like a valued member of the community

Identifying our role in prevention is important, this includes family violence screening programmes, and providing effective addiction and mental health services. The Centre for Disease Control identifies these and home visits during pregnancy and for whānau with newborns, parenting training, social support for parents, teen parenting programmes, high quality early childhood education and a living wage. The DHB also needs to work with our intersector partners to prevent and effectively respond to ACEs and increase Positive Childhood Experience.

CONCLUSION

There are strong international and local insights to encourage HBDHB to focus investment and services delivered to pregnant women and children in the first 1,000 days. Neuroscience, research into nutrition and child development support early intervention. There is also evidence to continue that support up until tamariki attend school, allowing engagement of early childhood education, prevention and early intervention including ACEs, PCEs.

Addressing poverty and deprivation are critical factors to effectively support tamariki and their whānau to have the best start in life. The Manaakitia A Tātou Tamariki report[7] clearly identifies the impact of poverty on tamariki. Deprivation (and poverty) is strongly linked to social isolation, childhood infectious diseases, hazardous environments, whānau harm, poor nutrition and unstable whānau environments. Research into Adverse Childhood Events identifies many of these as adverse and demonstrates the long-term health and wellbeing implications[8].

To give children the best start, initiatives need to be whānau-centric, work from pre-conception to five years, have a wellbeing approach, be culturally responsive and address the barriers via targeted approaches that are coordinated and innovative.

RECOMMENDATIONS

To deliver effectively and support whānau to provide tamariki with the best start HBDHB could:

1) Have a coordinated approach from conception to 5 years to support a whānau wellbeing and take advantage of early development of potential and intervention.
2) Work with whānau to deliver whānau centric services with a wellbeing focus. Including the potential for a 'one whānau plan.
3) Work intersectorally to prevent Adverse Childhood Experiences and Promoting Positive Childhood Experiences, address determinants of health and support community wellbeing. Potentially leveraging of Matariki and other cross-sector initiatives.
4) Working with communities to understand their strengths and support needs and then targeting resources to increase equity and delivering culturally responsive services.
5) Provide resources for innovative programmes that are co-designed with whānau and are evaluated. If delivering equitable outcomes and making health improvements continue to resource.

Establish measurement tools which provide an overview for tamariki wellbeing from conception to 5 years. Building on the current work developing directorate dashboards.

ATTACHMENT

Ready for School Map

[7] http://www.occ.org.nz/assets/Uploads/EAG/Final-report/Final-report-Solutions-to-child-poverty-evidence-for-action.pdf

[8] Kaiser Permantente and the US Centre for Disease Control, ACES Study, 1997

INTEGRATED SERVICES 'READY FOR SCHOOL'

Whānau voice
→ service design
→ their plan

Pre-conception
→ Healthy wāhine
→ Healthy choices
→ Healthy relationships

Wellbeing approach
→ whānau ora
→ thriving
→ whānau centric

Addressing ACEs
→ prevention
→ early intervention
→ responding to high doses – screening/follow-up

Consistent Messages

WHAT ?

'MAP FOR CHILDREN 0-4 YEARS IN HAWKES' BAY'
From a range of requests to:
→ Develop an approach for first 1000 days
→ Integrate services + planning for 0-4yr olds
→ Respond to high smoking rates in hapū wāhine
→ Increase healthy weight children

HOW ? Strategy document

WHO ? Census data, Maternity Services Report, Board Reporting, Education Counts, MSD Data & Policy

WHERE ? From service mapping Web search

Evidence plus research plus innovation

UNIVERSAL SERVICES

Health clinical	Maternity	Well Child	Education	For
Free GP visit lactation support	Confirmed Pregnancy to 6weeks post-birth		Antenatal education	Hapū wāhine
Newborn screening GP Imms Free visits	First 6 weeks	Milestone checks		Newborn/baby
Oral health check GP Imms (15mths)		Injury prevention Milestone checks		Toddler
GP free visits		B4SchoolCheck	20hrs free ECE	Child

BEST PRACTICE

WHAT CAN BE INFLUENCED?	WHAT WORKS?
Health Behaviours • Smokefree • Alcohol free pregnancy • Breastfeeding 6 months • Healthy weight pregnancy and @ 4years	• Changing values and incentives • Knowledge/consistent message • ? • Knowledge, Healthy First Food, healthy weight plan, portions
ACES • Violence free • Abuse free • Stable whānau } reducing stress in children	• Secure attachment • Whanau support • Stopping violence • Strong protective factor • Engaging in quality ECE (20hrs)
Engaging with Services • LMC early (before 3 months) • Enrolled with a GP	• Knowledge • Responsive/integrated service
Environment • Warm dry homes • Safe communities • Employment • Smokefree • Water only • Safe homes	• Housing warrant of fitness legislation • Connections –knowing your neighbour • Socially responsible employment • Legislation and signage • Supported in setting (education, sports, home) • Installed safety resource checks (smoke alarms, door latches, plug protects, bath mats)

Police reports from family harm incidents involving children under 5yrs over 1 year (2016/17)	2804

Beneficiary Rates (Youngest child under 5yrs) 2017 data	Wairoa	Napier	Hastings	CHB
Māori	182	437	666	69
Pasifika	0	35	104	2
European	8	321	266	47

Mental Health Hospitalisation of parents with children under 5yrs	No data available
Incarceration Rates Parents of children under 5yrs	No data recorded

Hapū wāhine

Ethnicity (2016 data)		Dep Index 10		Healthy weight		Smokefree		
Maori	43%	Maori	67%	Maori	23%	Maori	51%	64% normal birth (spontaneous vaginal) 57% engaged with an LMC @ 3months
European	42%	European	11%	European	56%	European	84.5%	
Pasifika	6%	Pasifika	64%	Pasifika	18%	Pasifika	79.7%	

Pepe

2016 (births)	Breast-fed (6 weeks)		Locality		SUDI (per 1000)	
	Maori	66%	Hastings	51.3%	Maori	1.34
	Other	72%	Napier	35.5%	Other	0.81
			CHB	6.9%		
			Wairoa	5.1%		

Toddler

Oral Health Check @ 2yrs enrolment		Immunisation rates @ 8mths		Hospitalisation ASH		
Māori	74%	Māori	94%	Māori	79.5%	Healthy home assessment
Other	100%	Other	95.6%	Other	66.9%	

Tamariki

Participating in ECE (Jan 2017)		Oral Health Caries Free @ 4 years (2016)		B4SchoolCheck (Nov 2016-Oct 2017)		Hospitalisation ASH (2016)		Healthy Weight (98th percentile) 2017	
Māori	96.2%	Māori	44%	Māori (909)	100%	Māori	79.5%	Māori	10.5%
European	98.2%	European	74%	European (142)	100%	Other	66.9%	European	29.8%
Pasifika	95.4%							Pasifika	5.2%

TARGETED SERVICES

Specialist care	LMC & GP referrals
Outreach	Immunisation those not engaging Oral health DNAs
Cessation	Smoking hapu wahine, incentive programme Smoking whanau
Safe sleep	High risk (smoking, bed sharing) watia kura programme and high deprivation
Healthy weight	Hapu wahine with GDM Maternal GRx Children in 98th percentile High dep engaged with Wellchild/Plunket
Healthy home	High dep and/or child with health issues Warm dry homes programme
Injury prevention	High dep household engaged with Wellchild/Plunket
Income support	Unemployed – no supporting partner, DPB, supplements, benefits

October 30 2018, Agenda Item 1.4

Minutes

Clinical Advisory and Governance Committee

Date	18 September 2018	**Start Time:**	5.30pm
Venue	Tukituki Meeting Room, 2nd Floor, GJ Gardner Building		
Present	Chris McKenna (Chair), Dr Mark Peterson, Dr Kevin Choy, Dr Rachel Monk, Dr Raewyn Paku, Anne McLeod, Maurice King		
In Attendance	CEO, Wayne Woolrich, Group Manager Corporate Services, Carina Burgess and Heather Johnson (minutes)		

The Chair welcomed Dr Raewyn Paku, Dr Rachel Monk, Dr Kevin Choy (Professional Advisors) and Anne McLeod (Allied Health) to their inaugural meeting. A mihi provided the group with personal insight and an understanding of what each person brings to the table. The Chair acknowledged that it was an exciting time for primary care and that she was very pleased to have new voices around the table.

Item	Minute
1. Administration	**1.1 Apologies** KJ Patel (HHB Medical Advisor who will bring an operational focus) and Julia Ebbett **1.2 Interest Register** The Interest Register was circulated for updates. **1.3 Conflicts with today's Agenda** No conflicts. **1.4 Draft Minutes - 24 July 2018** The Minutes as circulated were accepted as a true and accurate record. **1.5 Action Items** The Action Register was worked through with several items still work in progress. **1.6 Committee Work plan** Refer Item 3.4 **1.7 Items approved since last meeting** No items approved since the last meeting.
2. Items for Approval	**2.1 No items for approval.**

3. Items for Discussion	**3.1 Acute Kidney Injury Research** Di Vicary (DHB) provided the committee with background and an update on progress of the Acute Kidney Injury Research that has been undertaken and the proposed roll out process. The Sick Day guidance is a self-management tool not an assessment tool. The committee agreed that communication was key to obtaining engagement from the consumer, General Practice and Pharmacy and approved rolling out the Sick Day guidance sheet. **3.2 Strategic Priorities** The CEO, Wayne Woolrich outlined the strategic focus for the PHO over the next three years and more specifically the PHO's plan to : • Establish foundations and commit to equity in health outcomes • Commit to working better as a health system • Play a lead role in the evolution of general practice across the network • Redesign our services The PHO is committed to leading change and to support General Practice to look at new ways of servicing the changing needs of the population. It was agreed that the proposed change pathway of Health Care Homes could present challenges in implementation with the committee looking forward to being involved in the business case to support this model. **3.3 Scheduling and timing of meetings 2019** CEO, Wayne Woolrich outlined the rationale for reducing the number of governance meetings to six per year and advised the meeting that the PHO proposed to use the CAG forum to deliver high quality content and as an opportunity for free flowing discussion around key pieces of work as opposed to operational matters. Committee agreed to six CAG meetings per annum to be held on a Thursday from 5.30pm to 7.30pm. **3.4 Work plan items 2018/19** The meeting discussed the proposed work plan items for 2018/19 and acknowledged that to date CAG have been involved in discussions around key pieces of work and programmes after the event. It was agreed that CAG needs to be afforded the opportunity to have input earlier in the development of programmes. **3.5 Clinical Services Plan** The CEO provided the committee with some background to the release of the Clinical Services Plan (CSP) with the video outlining the broad overview of the direction of travel. It was agreed that communication is the key to socialising this plan and obtaining a wide range of feedback within the timeframe of six weeks. The PHO to look into the possibility of sending the CSP video to general practice to have running on the screen in their waiting rooms. **3.6 Flexible Funding evaluation approach** Group Manager Corporate Services, Carina Burgess presented the Flexible Funding approach that outlined the objectives and approach to this important piece of work. The committee were assured that the evaluation is still in the draft design phase. A panel (to determine the successful provider to undertake the evaluation) will be convened and will include a mix of

	consumers to ensure that there is broad input. Based on the MoH directive that consumers need to get the right care at the right time it is imperative that this evaluation is conducted openly and transparently with clear positive outcomes.		
4. Other items for Information	**4.1 After Hours Urgent Care – 6 month review** Taken as read. **4.2 Health Hawke's Bay Annual Pan** Taken as read.		
5. Any other business	The Chair broadly discussed the opportunity for another CAG member to be appointed to Clinical Council. The Chair advised that she will be on leave for the next meeting and asked the Deputy Dr Mark Peterson to Chair the meeting.		
Meeting closed:	7.36pm	**Next meeting:**	30 October 2018

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HAWKE'S BAY District Health Board Whakawāteatia	**Professional Standards and Performance Committee Update**
	For the attention of: **HB Clinical Council**
Document Owner(s)	John Gommans, Chief Medical and Dental Officer David Warrington, Nurse Director Medical Directorate
Document Author	John Gommans, Chief Medical and Dental Officer
Reviewed by	N/A
Month/Year	October, 2018
Purpose	For Information
Previous Consideration Discussions	N/A
Summary	Key Issues/Actions
Contribution to Goals and Strategic Implications	To provide assurance to the Hawkes Bay Clinical Council that all essential requirements relating to credentialing, accreditation, professional standards, clinical training and research are actively promoted and maintained.
Impact on Reducing Inequities/Disparities	Terms of Reference include quadruple aim re pursuit of improved health and equity for all populations
Consumer Engagement	Awaiting appointment of a Consumer Council Member for this Committee
Other Consultation /Involvement	Chairs of Advisory Groups reporting to this Committee
Financial/Budget Impact	N/A
Timing Issues	N/A
Announcements/ Communications	N/A

RECOMMENDATION:

It is recommended that the HB Clinical Council:

1. **Note** the contents of this report
2. **Provide feedback** on any issues/points of interest raised

Professional Standards & Performance Committee Report to Clinical Council

Author:	**John Gommans**
Designation:	**Chief Medical and Dental Officer**
Date:	**2 October 2018**

OVERVIEW

This is the first report of the Professional Standards and Performance Committee (PS&PC) that contributes to Council's new Clinical Governances Committee Structure.

It purpose is to provide assurance to the Hawkes Bay Clinical Council that all essential requirements relating to credentialing, accreditation, professional standards, clinical training and research are actively promoted and maintained.

The PS&PC governs the following Advisory Groups (AG) and meets with their chairs quarterly.

- Allied Health Professions AG
- Hawke's Bay Clinical Research AG
- Medical Credentialing AG
- Nursing and Allied Health Credentialing AG
- Nursing and Midwifery Leadership AG
- Resident Medical Officers (RMO) Training AG

Other members of PS&PC include the CMO Primary Care, CMDO-Hospital, CNMO, CAHPO, Executive Director People & Quality and Senior Advisor Cultural Competency – or their delegates.

A Consumer Council representative has yet to be advised.

ESTABLISHMENT OF NEW STRUCTURE

This PS&PC have met quarterly since the new governance structure was first agreed (Four times: Nov 2017, Feb, May and Aug 2018). The initial meetings focused on purpose and functions of both the PS&PC and the Advisory Groups, finalising membership, aligning and updating terms of reference (ongoing), meeting structure and consistency around how each Advisory Group would report through to this Committee.

ADVISORY GROUP REPORTING

Whilst a relatively new process, the agreed reporting method pending definitive advice from Clinical Council, for these Advisory Groups through to the PS&PC was to supply their minutes for review supplemented by a verbal update highlighting any key accomplishments, concerns or issues for wider discussion and if required further escalation. Although informal and evolving, this process is currently working well.

The Committee acknowledges the importance of receiving feedback from Clinical Council on how to enhance the process and any issues raised.

CONCERN OR POINTS OF INTEREST

The Committee has chosen to only report to Council items of concern or significant points of interest that it believes Clinical Council should be aware of.

Chair roles
It was noted that there is potential for conflict of interest with Chair roles given that in some circumstances the same individual chairs both an Advisory Group and Committee, and in one instance also Clinical Council i.e. chairing at 2-3 levels. It was advised that this should be avoided wherever possible (or as a minimum co-chairs utilised) to ensure a degree of independence.

Credentialing of clinicians and departments
The Committee reviewed the arrangements for credentialing within Provider/Health Services. It was noted that credentialing of departments was done as part of medical credentialing i.e. the credentialing of doctors. Given the multi-disciplinary nature of departments it was considered inappropriate to exclude other clinical groups from the process. Further the current process involved a 'disconnect' between medical (clinical) credentialing and operational management of departments/services making it difficult to resolve any issues identified. Therefore, it was agreed that department credentialing would no longer be a responsibility solely of the Medical Credentialing AG.

There was discussion regarding combing credentialing of all clinicians under one AG. However, doctors require regular (annual/biannual) credentialing of their routine scopes of practice as well as any additional/new procedures to satisfy Ministry and Medical Council requirements whereas Nursing and Allied Health credentialing is only required for exceptional scopes of practice outside routine work of their professional groups. Therefore, it was decided to continue with the two separate Clinician Credentialing AG.

The Medical Credentialing AG; this now focuses on reviewing and ratifying credentials and scope of practice of new SMO appointments and the regular reassessments of current SMOs including feedback of any issues and themes via a formal letter to the Head of Department, Clinical Director and Service Director. This change has worked well over the last year with much of the work achieved by email with a very engaged AG membership. Mark Peterson has joined this AG to assist with credentialing of GPs working in the Wairoa ED and Inpatient Unit, using the Rural Hospital Medicine body's recommended scope of practice document and process.

The Nursing & Allied Health Credentialing AG; this focuses on the needs of these two professional groups to credential advanced scopes of practice. Of concern, this group has struggled to meet over the last 18 months even by email. This is believed to be a risk to staff potentially practising outside their agreed scope and to services wanting to introduce change but is not thought to represent a risk to patients at this stage. The Chair supported by the Nursing & Allied Health Directors has reviewed and updated the membership of this AG with a meeting planned for 5 October.

Departmental Credentialing; the process for Department Credentialing has not been resolved. Discussion with the National CMO Group indicates that currently this is not done well across any DHBs, and none have a good policy or procedure. An external review team is likely to be the most appropriate approach noting that a number of departments get regular accreditation by colleges and other training bodies, and we don't want to duplicate work that is already being done.

SUMMARY
The Credentialing AGs have seen significant scrutiny and change; outstanding issues include departmental credentialing and reinstating the Nursing and Allied Health Credentialing AG. No significant concerns are noted in the other advisory groups reporting to this Committee. However, a common theme across all Advisory Groups is the busyness of people and the reduced ability to engage in governance activities.

RECOMMENDATION:

It is recommended that the Board, Clinical Council and/or other:

1. **Note** the contents of this report.
2. **Provide** feedback on the issues/points of interest raised.

HAWKE'S BAY District Health Board Whakawāteatia	**Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations**
	For the attention of: **HB Clinical Council, Finance Risk and Audit Committee**
Document Owner and Author	Kate Coley, Executive Director of People and Quality
Reviewed by	Executive Management Team
Month/Year	October, 2018
Purpose	For Information
Previous Consideration Discussions	Third update
Summary	This is the third update for Board in relation to the endorsed recommendations in relation to the Havelock North Gastroenteritis Outbreak review report from March 2017. Nearly all of the recommendations have been completed or have amalgamated with other pieces of work so have been closed. All these items are in red. It should be noted that a number of these will require national guidelines and/or changes to policy which the DHB has only the ability to influence. The recommendation table in **Appendix 1** has been updated.

RECOMMENDATION:

It is recommended that HB Clinical Council, Finance Risk and Audit Committee and Board :

1. **Note** the contents of this report and agree that updates will be provided as and when new information is provided from a national perspective.

Havelock North Gastroenteritis Outbreak – Progress Report on Review Recommendations

Author:	**Kate Coley**
Designation:	**Executive Director of People & Quality**
Date:	**October 2018**

PURPOSE

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

EXECUTIVE SUMMARY

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

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

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

In summary, these recommendations and strategies for improvement included:

1. Incorporating relevant learnings from this outbreak into the emergency response and emergency management communications strategy

2. Reviewing and implementing an agreed set of principles and capabilities for managing outbreak information

3. Strengthening public health outbreak management system

4. Developing and implementing guidelines for the management of large scale (outbreak) microbiological testing

5. Strengthening collaboration and integration of Primary Care, Community and Hospital Health Services

6. Strengthening outbreak management through shared learnings, at both local and national levels.

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

ATTACHMENT

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

RECOMMENDATION:

That the HB Clinical Council, Finance Risk and Audit Committee and Board

1. **Note** the contents of this report.

Appendix 1 - Action Plan Progress Report

Recommendation	Activity	Priority	Responsibility	Progress Update March '18	Expected completion Date
a) Enhancing outbreak management and emergency response system	**a) Identify triggers for Incident Management Team initial meeting.**	Low	ED of PS		**Completed**
	b) Review Situation Unit processes to allow effective use of team members.			**Workshop held and process redesigned**	**Completed**
	c) Look at a plan for resilience of the organisation and its staff.			**Work is underway with the ministry. Once a national guideline is developed then we will develop a plan aligned to those guidelines. Emergency response Coordinator will action this item however this work is not likely to be completed due to the national guideline development until end of 2019.**	**Closed**
	d) Briefings and planning meetings need to be conducted separately, briefing for all staff involved (look at possibility of streaming briefings), planning for Incident Management Team on duty – process to include format and who included.				**Completed**
	e) Process manual for EOC needs to be reviewed.				**Completed**
	f) The Incident Management Team roster needs to be prominent in the EOC.				**Completed**
	g) Individuals in the Incident Management Team need some cross training to allow flexibility in placement in roles.		EDSHI/DPH		**Completed**
	h) New – Population Health Service Outbreak Management Policy review			**Review underway and will be completed by year end.**	**To be completed by year end**

b) Strengthening Collaboration and Integration of Primary Care, Community and Hospital Health Services	**a) Develop a district-wide infection prevention and control outbreak management guideline** **b) Early meeting of all community responders to agree action.** **c) The trigger for the activation of the Emergency Services Coordinating Committee needs to be examined.** **d) Provision of situation reports and advisories to primary care in future events to become part of standard practice.** **e) Telephone calls to key agencies to alert the need to read emails would assist in information dissemination.** **f) Investigation into health access to Population warning announcements may be useful.** **g) Process for the management and support of other agencies needs to be prepared.** **h) Coordination of effort needs to be addressed.** **i) A plan for PHO response and collaboration with the wider DHB needs to be prepared.** **j) Need to define roles and expectations for community staff working within primary care.** **k) Options for changing the model of care in general practice need to be investigated.** **l) Investigate a DHB or PHO member onsite for aged residential care.** **m) Residential care database of all residents and those in independent living required.** **n) Identify mechanism to integrate primary care and community healthcare providers into HBDHB outbreak management system to enable:** **i. Timely notification of alerts (e.g. after-hours contact lists)** **ii. Integration of providers into the incident management processes when required** iii. **Sharing of outbreak status reports and communications.**	Low	ED of PS & GM HHB	**Underway – Infection control & Population Health to review** **Discussions held, to be incorporated into plan** **Underway – discussions ongoing** **To be incorporated into the CSP overarching programme** **PHO placed within CIMS structure. Changes made to alerting procedure and communication plan**	**To be completed by year end** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **To be completed by year end** **Completed** **Completed** **Completed**

c) Strengthening outbreak management through shared learnings	**a) Development of an interagency collaborative framework and ethos in the management of large scale disease outbreaks including:** **i. development of an agreed set of principles, activities and capabilities for managing large scale outbreaks** **ii. creating a tool for coordinating and linking key stakeholders (e.g. industries, government agencies and relevant non-government organisations)** **b) Rules of engagement regarding information gathering for the MoH would avoid duplication of effort.** **c) A process for the implementation of a MoH national expert group could provide this advice early in an event.** d) **Population and dissemination of lessons learnt to assist DHB's and territorial local authorities with outbreak planning responses to major events.**	Low	ED of PS	**A regional surge capacity agreement in place for resource sharing among public health services. The role out of a national Emergency Management Information System (EMIS) as a shared information platform remains limited. Civil Defence and the Ministry of Health continue to maintain separate systems and support resources are limited.** **Public Health capacity within the Ministry of Health has been increased with the appointment of a new Director of Public Health and two deputies.** ***Passed to ministry for action.*** ***Passed to ministry for action.*** ***Passed to ministry for action***.	**Further EMIS development on hold pending a more comprehensive information system review recently announced by the Ministry for Civil Defence and Emergency Management. Timeframe not yet specified.** **Close** **Completed** **Closed** **Closed** **Closed**
d) Strengthening HBDHB's Outbreak Management System	**a) Review mechanisms to better integrate and coordinate population health teams into the organisation-wide incident management processes.**	Moderate	ED of PS & Dir Pop Health	**Number of workshops with structure refined and team identified. Exercised during paratyphoid outbreak**	**Completed**

	b) Review outbreak management processes including: **i. Formally integrate ESR roles into the surveillance outbreak management process** **ii. Risk identification and mitigation strategies** **iii. Identify resources required for the consistent inputting of data during an outbreak event (e.g. Health EMIS)** **iv. Develop guidelines for workforce resource planning and defining criteria for accessing external staff resources** **v. Develop an outbreak timeline framework for implementation throughout the duration of an event** **vi. Develop a process to triage calls and manage inquiries** **vii. Identifying processes to understanding community resilience during an outbreak (e.g. household surveys).**			**The need for an information system to manage clinical cases and their contacts has been identified as a high priority. Functional requirements have been developed by the Canterbury public health service and shared with HB. The potential for a national solution to be developed is under consideration of the national Population Health Clinical Network.** **More work is required to strengthen epidemiological surveillance capability within the DHB planning and intelligence function. Outbreak and event forecasting methods yet to be embedded within the intelligence function. Health EMIS is not currently being further developed by the Ministry of Health.**	**Requires national activity to be implemented.** **Close**
	c) Moving the Population Health Service into the DHB EOC environment early needs a process.			**c. See 4a above re discussion on interoperability between DHB emergency response and Population Health.**	**Completed**
	d) A model tying together the methods of surveillance required in an outbreak event would allow better management of surveillance. This would include the process for surveys, ESR provision of data locally and nationally and management of the data collected.			**d) There has been progress on the lab testing component of outbreak surveillance. However there is currently no national project to address national epidemiological surveillance requirements. The issue has been referred to the**	**Closed**

	e) Investigate a process for surveillance in schools and workplaces in order to allow early identification of increased absenteeism. f) Undertake workforce planning with the CNIDWAU to determine future resource requirements for Drinking Water Assessors. g) Identify training requirements and implement the training programme (e.g. Health EMIS, document management).			Ministry of Health and the NZ Microbiological Society We are awaiting the government response to the inquiry recommendation on this this point. An HRC funded study on novel methods of surveillance that is part of the Havelock North Drinking Water Research programme led by HBDHB will provide evidence	ESR study on school based surveillance to report by February 2019 Ministry response expected later in 2019 Close Completed Completed
d) Outbreak Communication Strategy	a) The DHBs communication strategy is reviewed and outbreak processes are defined to: i. Facilitate an advanced (early and proactive) communication plan that includes: ▪ identification of all agencies that need to be informed ▪ define process for health services to identify key stakeholders and inform communications team ▪ risk assessment and decision making for communication and managing external influencing factors (e.g. local elections) ▪ identify one-voice fronting all communications (management/clinical) ▪ prepare strategic communications (e.g. video-clips)	Mod	ED of CS	All activities incorporated	Completed

	ii. Promote an early announcement of outbreak communication for all stakeholders (staff and the Population) that includes: ▪ consistent messaging ▪ announcement of planned information updates iii. Enable mass communication to staff and the Population that includes: ▪ the use of technologies (e.g. text messaging) ▪ maintaining current contact directories for key staff and external stakeholders iv. The communications team need to increase capacity during events in order to manage the workload particularly with the media v. Contact database data to be updated. Contact with community pharmacy needs to be by fax initially				
e) Information and Document Management Systems	a) A review of the EOC process for filing emergency response and recovery documents is undertaken. b) Review of cascade of information process required. c) Process for preparation of advisories and fact sheets to be investigated. d) Need a process for consistent data collection – what data, from where, how collected, presentation and surveillance process. Forecasting of data requirements would allow consistency of data presentation. e) The presentation of data needs to be agreed early. f) The DHB establishes a standardised naming convention system for all emergency management events. g) An organisation information management policy is developed and implemented in accordance with the	High	ED of P&Q	Part of planning and intelligence work, workshop planned. To be included in planning and intelligence work. Agreed and established Policy in draft. Wider context around overall Records Management across the DHB.	Completed Completed Completed Completed Completed Completed Close – part of wider project – currently

	New Zealand Archives Standard and Population Records Act 2005.			Records Management Project TOR being developed. Company secretary leading piece of work	being developed and considered
f) Guidelines for the Management of Large Scale (Outbreak) Microbiological Testing	**a) Development of national laboratory service guidelines for implementation at local level.**	High	ED of S & HI	**Clinical Microbiologist Dr Rosemary Ikram is progressing this through the NZ microbiological network.**	**Escalation of issue to national level complete. Timeframe for completion of national guidelines is unknown.** **Close**
g) Additional actions arising out of the Government Inquiry State One Findings	**a. DWAs to require water suppliers to demonstrate collaboration with HBRC so as to ensure they have a better understanding of catchment risks. DWAs also to require more holistic investigations into *e.coli* transgressions.** **b. HBDHB to address critical DWA shortage** **c. Implement escalation and enforcement policy** **d. Manage transgressions within a drinking water reticulation as potentially due to source water contamination even if source water samples are clear** **e. Work with the Ministry of Education to establish a real time school absenteeism reporting system**	High	ED of S & HI	**Now embedded into practice** **Resolved** **Local policy now in place – may be subject to further input from Ministry of Health** **Ongoing.** **The Director of Public Health Dr Caroline McElnay advised the Havelock North inquiry that the Ministry of Health is awaiting the results of a feasibility study on this before making any decisions. Study results due early 2019. National system potentially due later in 2019 but may take longer.**	**Complete** **Complete** **Close** **Close**

	f. Establish better information exchange processes between drinking water and communicable disease teams. **g. Develop a sustainable governance framework for the Drinking Water Joint Working Group (JWG)** h. **Work with the JWG to identify potential untreated self-supplied dwellings and other buildings at risk from source water contamination. Provide advice or other risk mitigation measures to those supply owners**. **i. Ensure HBDHB has intelligence capacity to provide epidemiological forecasts.**			**Water transgressions are a fixed agenda item at fortnightly Communicable Disease meetings.** **Drinking Water Joint Committee established and fully operational. Secretarial support from HBRC** **JWG allocated responsibility for the resolving self-supply issues**. **Work at a National level needs to be undertaken. Once completed further conversations and development of capacity within the Business Intelligence team will need to be completed.**	**Completed** **Completed** **Ongoing** **ESR study expected to be complete by June 2019** **Close**

HAWKE'S BAY District Health Board

Clinical Portal Implementation (CP) – EMT/FRAC Project Progress Report

Project Name	Clinical Portal & Radiology (RHIP)	Date	18 / 09 / 2018
		Prepared by	Lyle Chetty
Project Manager	Lyle Chetty		

Description: The Clinical Portal (CP) project is moving clinical information from a customised Patient Administration system (ECA). ECA will remain for patient administration while clinical information will migrate to Orion Health's Clinical Portal as part of a regionally hosted solution, in-line with a region wide agreement.

HBDHB Clinical Portal Implementation Project

OVERALL PROJECT STATUS & TREND – to date ending 29/08/2018

Status	Trend	Rationale
G	▶	**Status = Green** • Patient Demographics and Alerts data now live, testing completed and business sign-off to be confirmed before comms roll-out. **Trend = Amber** • After extensive analysis, data migration speed will be limited by platform constraints; CP team working with clinical SMEs to safely reduce volume of data to be migrated (i.e. 10 years' history, no deceased patients are options) to decrease time to migrate;

Planning & Activities – to date ending 13/09/2018

Progress To Date

- Data migration activities for Patient Demographics complete;
- Activities commenced for data preparation to migrate Encounters data;
- Workshop with Orion Health produced short-list of value-add work items, based on national DHB experience and Service Design workshop with senior clinical staff;
- CP project team collaborating with clinicians to deliver value-add outcomes in parallel with data migration; short-list of work items targeted for delivery Q4 2018.

Upcoming Activities

- Regional optimisation and clinical focus:
  - Platform Architecture Review – Modern & Resilient 'Fit for Future'
  - Strategic Partner Frameworks i.e. Orion – 'Mutually Agreed Outcomes'
  - Service Delivery Review – 'Optimise Support Including Service Level Agreements'
  - Capital Spend Optimisation – Measurable Business Outcomes
  - Service Design – Clinical Workflow, then Technology
- Project delivery team to deliver up to four new value-add functions to clinicians in Q4 2018;
- Encounters data migration to commence mid-late September.

Budget

- Capital & operational expenditure for 2018/19 within budget

Progressive Rollout Out Dates
• April – Hawke's Bay clinicians can view Regional data – complete • From end August - Hawke's Bay can view Regional and HBDHB Demographic data migration (was July but nurses strike delayed these activities) - complete • Through to December 2018 – Progressive rollout to be planned in consultation with stakeholders – rollout options being developed (for example, migration up to 10 years' initially to give clinicians value sooner)

Issues	Mitigating actions underway
• Complexity of data preparation has added more effort to data migration activities • Analysis of ECA data has identified a number of data inconsistencies • Patient Safety is a high risk area	• Working with SMEs to deliver value-added 'stream' of work in parallel with data migration to provide more functionality to users in shorter time-frame • Issues scoped & actions underway to remediate ECA source data to required quality, but adds significant effort/time • Engaged with People & Quality and Patient Safety teams to assess ECA-to-CP changes & build mitigations

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

12

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

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

OVERVIEW

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

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

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

WHY IS THIS INDICATOR IMPORTANT?

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

RECOMMENDATION:

That EMT, the MRB, Clinical and Consumer Councils:

Note the contents of this report

FIGURE 1

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

Central Region DHB

Registry Completion Quarterly Report - Jul 2018

Central Region DHBs

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

Hawke's Bay DHB

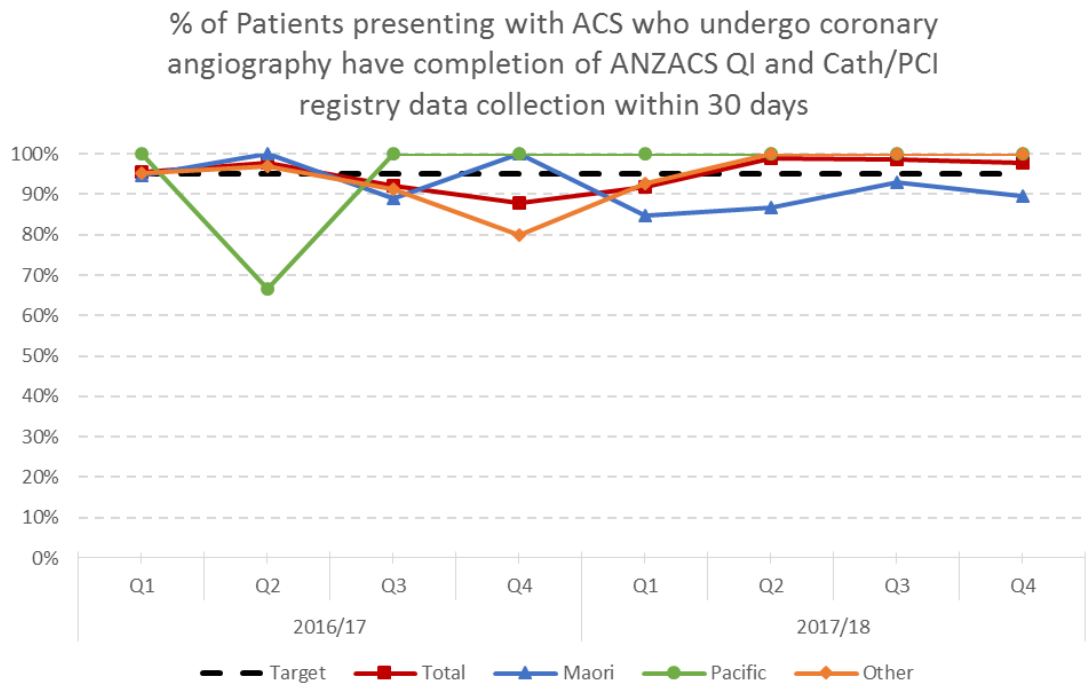

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FIGURE 1 - CONTINUED

Hawke's Bay DHB

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

FIGURE 1 COMMENT

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

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

FIGURE 2

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

Central Region DHB

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

Central Region DHBs

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

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

Hawke's Bay DHB

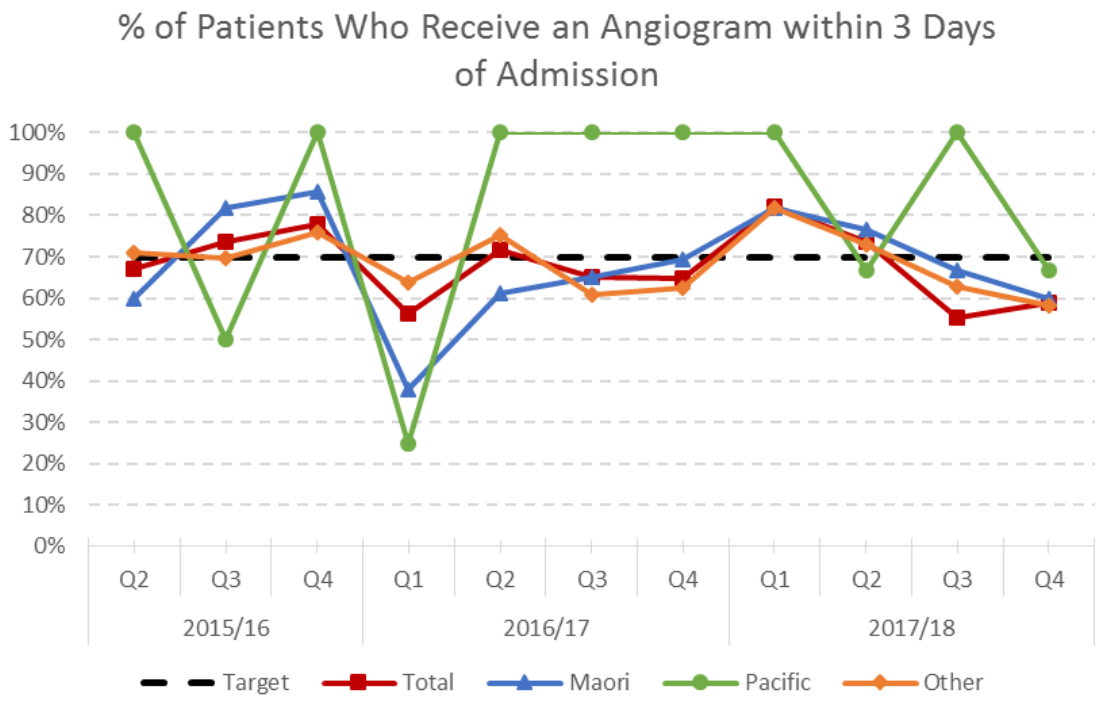

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FIGURE 2 - CONTINUED

Hawke's Bay DHB

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

FIGURE 2 comment

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

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

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

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

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

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

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

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

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

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

Strategies continue to ensure sustained compliance for these indicators:

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

RECOMMENDATIONS FROM TARGET CHAMPION

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

CONCLUSION

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

OURHEALTH
HAWKE'S BAY
Whakawateatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

14. Minutes of Previous Meeting (Public Excluded)

15. Matters Arising – Review of Actions

16. Cardiology Review and plan of action

17. Annual General Meeting

- **17.1 Minutes of AGM**
- **17.2 AGM Actions and Council Workplan**
- **17.3 Process for appointment of Chair(s)**
- **17.4 Clinical Council Chair/Co-Chair Role Description**

18. Topics of Interest – Member Issues / Updates

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).