HB Clinical Council Meeting

Date: **Wednesday, 10 April 2019**

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)
Jules Arthur (Co-Chair)
Chris McKenna
Dr Mark Peterson
David Warrington
Dr Robin Whyman
Lee-Ora Lusis
Dr Daniel Bernal
Dr Andy Phillips
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.	Board Report - March (Clinical and Consumer Councils' Combined) (for information only)	
6.	Workplan	
7.	Clinical Council Annual Plan – Progress Review	
	Section 2 – Reporting Committees to Council	
8.	Clinical Advisory & Governance Group – Verbal Update	3.15
9.	Council Committees Reports	3.20
	Section 3 – Discussion	
10.	Investments Update (Outcomes of Budget Prioritisation) – Andy Phillips	3.40
11.	Clinical Council Membership and Representation – Co-Chairs / Company Secretary	4.00
12.	Clinical Governance Structure - Co-Chairs / Company Secretary	4.30
	Section 4 – For Information (no presenters)	
13.	Matariki HB Regional Development Strategy and Social Inclusion Strategy (update)	-
14.	Violence Intervention Programme Report (update)	-
15.	**Section 5 – Recommendation to Exclude the Public**	

Public Excluded

Item	Section 6 – Routine	Time (pm)
16.	Minutes of Previous Meeting (Public Excluded)	5.00
17.	Matters Arising – Review Actions (Public Excluded)	
18.	Joint Clinical and Consumer Councils' Workshop Notes (for information only)	-
19.	Topics of Interest – Member Issues / Updates	

NEXT MEETING:

Wednesday, 8 May 2019
Te Waiora Meeting Room (Boardroom), HBDHB Corporate Office
Cnr Omahu Road & McLeod Street, Hastings

Interests Register
Feb-19

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
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	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
	General Practice New Zealand	Executive Member			
	General Practice Leaders Forum	Member			
Dr John Gommans	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
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 (Service Director - Mental Health & Addictions)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National GM of Mental Health & Addictions	Member		No	Low
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.
Debs Higgins (Senior Nurse)	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	Health HB	Employee	Role: Clinical Performance Support Lead	Yes	Low
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 (Chief Medical Officer - Hospital)	Dental Council of New Zealand	Appointed Member	Oral health professions regulator	No	

3/04/2019

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**
	Royal Australasian College of Dental Surgeons	Fellow	Continuing Professional Development	No	
	NZ Institute of Directors	Member	Professional Network	No	
	NZ Dental Association	Hon Life Member	Professional Network	No	
	Australian NZ Society of Paediatric Dentistry	Member	Professional Network	No	
	Association of Salaried Medical Specialists	Member	Trade union	Yes	Potential pecuniary interest
	NZ Society of Hospital and Community Dentistry	Member	Professional Network	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 MAGDALINOS ROOM, HAVELOCK NORTH FUNCTION CENTRE, TE MATA ROAD, HAVELOCK NORTH ON WEDNESDAY, 13 MARCH 2019, 1.00 PM

PUBLIC

Present: Dr John Gommans (Chair)
Jules Arthur (Co-Chair)
Dr Peter Culham
Debs Higgins
Dr Daniel Bernal
Dr Russell Wills
David Warrington
Dr Nicholas Jones
Dr Andy Phillips
Dr Robin Whyman
Anne McLeod
Lee-Ora Lusis
Dr David Rodgers
Chris McKenna (from 1.20 pm)

In Attendance: Kate Coley, Executive Director – People & Quality (ED P&Q)
Tracy Fricker, Council Administrator and EA to ED P&Q

Apologies: Dr Mark Peterson

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr John Gommans (Chair) welcomed everyone to the meeting. Apologies were noted as above.

2. INTEREST REGISTER

No conflicts of interests were noted for today's agenda items.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 13 February 2019, were confirmed as a correct record of the meeting.

Moved and carried.

The Clinical Council February report to the Board was provided in the meeting papers for information.

The Chair advised that the Board were interested in Council's discussion around the siloed approach to screening for various harms (condition-centred rather than person-centred), and how Council might progress resolving this. Screening needs to be easy for staff and patients, ideally having all the social harm screening questions/tools together on one form. It also needs to be available across sector and electronically. Suggestion made that this is a piece of work that the Strategy Working Group could look at. A 'starter for 10' paper was suggested as a

means of initiating this - to define the problem, what we would like to achieve and how we can go about it.

Action: ***Small working group to prepare a draft paper to bring back to Council. (Nick Jones, Russell Wills, Andy Phillips and Debs Higgins).***

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 Investments Update (Outcomes of Budget Prioritisation)
Update has been moved to the April meeting.

Item #2 New Clinical Governance Structure / Terms of Reference
Still awaiting the updated CAG TOR and confirmation of the PHO Representative.

TOR for all Advisory Groups are to be provided to Council for approval. A reminder to Co-Chars to be sent.

Item #3 ***Information Services Governance Group (ISGG)***
It was noted that this group is still to meet. Chair will discuss with Chris Ash and this item is to remain on matters arising until actioned.

Item #4 Interest Register
Updates noted at previous meeting actioned. *Item can now be closed.*

Item #5 Workplan and Annual Plan
Progress report template developed. Item #6 on today's agenda.

5. WORKPLAN

The workplan was provided for information. No issues discussed.

6. CLINICAL COUNCIL ANNUAL PLAN – PROGRESS REVIEW

The objectives from the 2018/19 Clinical Council Annual Plan have been placed in a template. Information will be added to the progress column and this progress report will remain as a regular item on the agenda.

SECTION 2: REPORTING COMMITTEES TO COUNCIL

7. CLINICAL ADVISORY & GOVERNANCE GROUP (CAG) – VERBAL UPDATE

Chris McKenna provided a brief update on matters discussed at the last CAG meeting including: Doing things differently - models of care; Healthcare Home; Manage My Health implemented in District Nursing. The CAG representative on Clinical Council is still to be resolved.

8. COUNCIL COMMITTEES REPORTS

- ***Professional Standards Committee*** – meeting due to be held yesterday but deferred due to transition period, with change of CMDO and EA support.

- ***Clinical Effectiveness & Audit Committee*** – meeting held last Wednesday. Key issues discussed included quality of data; low governance over issues in some areas; implementation and follow up of HDC recommendations; TOR and scope/role of committee

and the Sterile Services incident relating to CIMS/emergency management for Laboratories. A written report will be completed for Council.

- ***Consumer Experience Committee -*** have reviewed letter templates for complaint responses and drafted the policy for "Making Health Easy to Understand"; Customer/patient charter making more consumer friendly; inpatient feedback survey forms being reviewed and looking to have a more local survey to reflect the Hawke's Bay community.

SECTION 3: RECOMMENDATION TO EXCLUDE

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

10. Minutes of Previous Meetings (public excluded)
10.1 Clinical Council February Board Report
11. Matters Arising – Review Actions
12. Serious Adverse Event report 6 month update
12.1 Topics of Interest – Member Issues/Updates

The meeting closed at 1.30 pm.

Confirmed: _____
Chair

Date: _____

4

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)*** • Draft document – starter for 10 to discussed / co-design workshop	A Phillips	Apr	On Agenda item #10
2	12/09/18	***New Clinical Governance Structure / Terms of References*** • CAG TOR to be provided • Committee Co-Chairs to review/approve TOR for respective Advisory Groups • Reminder to be sent to Committee Co-Chairs	C McKenna Committee Co-Chairs Admin	Mar TBC Apr	Awaiting approval Ongoing Actioned
3	05/12/18	***Information Services Governance Group*** • Contact to be made with Chris Ash re: TOR, Membership, process for getting items on the agenda	J Gommans	Ongoing	
4	13/02/19	***Workplan*** • Relook at format of Council Workplan ***Annual Plan*** • Members to advise Co-Chairs which of the six annual plan objectives then have an interest in	Co-Chairs/ Company Secretary All members		
5	13/03/19	***Screening for Harms*** Small working group to prepare starter for 10 paper for discussion	Nick Jones, Russell Wills, Andy Phillips and Debs Higgins		

5

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council & Health Consumer Council** 25
	For the attention of: **HBDHB Board**
Document Owner:	Dr John Gommans (Co-Chair) Jules Arthur (Co-Chair) Rachel Ritchie (Chair)
Month:	March 2019
Consideration:	For Information

PERSON & WHANAU CENTRED CARE

Person & Whanau Centred Care is working 'w**ith'** people & whanau, rather than just doing **'to'** or **'for'** them.

RECOMMENDATIONS

That the HBDHB Board:

- **Notes** the contents of this report
- **Notes** HBDHB commitments to Person and Whanau Centred Care (PWCC) in the Clinical Services Plan (CSP) and initial drafts of the Strategic Plan
- **Advocates** for national changes and considers local changes to current funding models and other disincentives to providing PWCC in primary and community care
- **Ensures** PWCC becomes the norm; to do that, **requests** management to present a paper to the June 2019 Board meeting that:
  - **Enables** the identification and freeing up of appropriate resources to prioritise the development of PWCC across the HB health sector
  - **Prioritises** the provision of specific education and training to the HB health workforce on implementing PWCC
  - **Facilitates** raising the levels of PWCC awareness within HB communities and empowering consumers to partner in their own care and contribute to service developments

HB Clinical Council & Health Consumer Council held a combined three hour workshop on Wednesday 13 March 2019. The theme and objectives for the workshop were:

Primary & Community Healthcare

Implementing Person & Whanau Centred Care (PWCC) in line with Clinical Services Plan and People Plan

> *"Person and Whanau Centred care is working '**with'** people and whanau, rather than just doing **'to'** or **'for'** them'*

Objectives

- Discuss what is transferrable from the NUKA System of Care into HB primary and community care.
- Develop a vision/picture of what PWCC will look and feel like in HB primary and community healthcare in 5 to 10 years time.
- Agree what we need to do to get there.

Background reading sent out to participants included:

- Clinical Services Plan – Overview and key extracts
- Clinical and Consumer Council Joint Meeting Minutes 13 June 2018 – PWCC discussion extract
- Progress/Action Plan on PWCC from previous discussions
- Article on South Central Foundation (NUKA) approach to General Practice
- EMT Paper on 'Nuka System of Care – What is Transferrable to HB Health System'
- People Plan – Extracts Relating to PWCC and Values Based Culture/ Behaviours

WORKSHOP OUTCOMES

A detailed write up of all the ideas and discussion points captured at the workshop has been completed. Overall, these were very consistent with previous general discussion around 'Person and Whanau Centred Care' (PWCC), with an additional level of detail drawing on learnings from Nuka and current PHO discussions around Health Care Home (HCH).

A very high level summary of the points noted includes:

Vision - What should PWCC look/feel like in 10-15 years in primary and community care

- Everyone has ability to enrol with a healthcare provider of their choice
- No hierarchy - within teams/empowered
- Communication / consumers involved in decision making / not necessarily face to face e.g. telephone, email, virtual assessments
- Consumers are empowered to participate/partner at all levels
- Continuity of care
- Building relationships / responsive / personal / flexible / removing the time barrier of 15 minute appointments
- One stop shop
- Workforce working to their full potential, happy, healthy and wanting to be at work / skilled
- One system / lead carer / wrap around / triage - seeing right clinician at the right time
- Value time – clinicians and consumers
- Enhanced IT – access
- Health coaching/primary mental health advisors embedded

How Do We Get There? What do we need to do / stop doing?

- Importance of communication and continuing to use technology, enabling use, virtual consultations
- Resourcing professional development
- Eligibility for services, doing advance care planning which will take care of some eligibility and in turn may save money
- Getting the consumer voice in decisions going forward, in plain English, more sustainable multidisciplinary care etc
- Whanau wellness approach across sectors / social agencies; getting people to do the right thing e.g. health; education
- 'Close' the hospital and have services in the community
- Reduce outpatient appointments by 50%
- Community commissioning and ownership - different needs and models for the community – staged approach
- Stop using funding models as a barrier and think about what the model of care should be
- Primary care/secondary care one stop shop. Build a super clinic - concept central part to wraparound services for the community
- Make choices easier to change
- Create time and headspace of clinical leaders to work with consumers and look at the drivers for acute demand and different ways of working
- Time is need to stop and plan to look at change
- Investing in HCH, primary care
- Invest in clinical staff to enable keeping up on demand and changing to a new system
- Expectations in the community if I am sick, I am seen or if I need an operation it will be done
- Embed consumer engagement
- Every discussion comes back to funding and structures ? is it a wider conversation that needs to go to the MoH – consumers are frustrated at the lack of progress. Need to understand the process to be able to change the process

How do we know we've got there?

- Measures and goals to be SMART, in real time e.g. using Marama; identify by ethnicity, disability; self-identification care rather than coded
- Joy in healthcare; the community is thriving, equity is BAU, consumer input is BAU
- No more workshops / joint meetings on this topic
- Milestones vs done; journey vs destination
- Consumers understand the model and process
- Consumers perspective – right care, place, time and clinician
- Same day appointments of any length of time
- Healthy workplaces
- Healthcare is accessed in an equitable way
- Consumers have a greater sense of ownership of their own health
- Where there is consumer input / co-design there is ability and will to make the change
- You said / we did

All these outcomes will be fed into the strategic plan implementation phase when it commences in the new financial year.

BIGGER PICTURE

Although the workshop could be deemed a success as it achieved it's objectives, a number of issues came up during discussions which have caused us as Chairs, to look at the bigger picture and in turn, raise these with the CEO and Board. In doing this we also believe it is important to recap on the context and background to the whole issue of PWCC, with a particular focus on PWCC in primary and community care..

PWCC DIRECTION

The concept of PWCC has now been under discussion for several years, and has recently been incorporated into a number of commitments within the Clinical Services Plan, eg:

- *'Person and whanau centred care will become 'the way we do things around here'.*
- *'People and whanau will be equal partners in the planning and codesign of services'.*
- *'Person and whanau centred care is a core principle of commissioning'*
- *'We will support people to make good choices by making health easy to understand and navigate'*
- *'Consumers and whanau have choice to meet their needs and wants, with services easily accessed when they want them'*
- *'As well as ensuring our workforce is culturally competent, we need two key things to be happening: better design of all services and resourcing that is geared towards meeting the needs of underserved, plus targeted services that are wrapped around whanau with complex needs, supporting them to achieve their goals and aspirations and independently manage their own health and wellbeing'*

The CSP also includes a 'picture' of what a person and whanau centred system looks like in the future. This 'picture' is attached.

HCH is noted in the CSP as a model that has many of the features we want in primary care services. One of the six core attributes of HCH is:

> *Person & whānau centred: supports people to manage and organise their own care based on their preferences, and ensures that consumers, whānau, and caregivers are fully included in the development of their care plans and ultimately the design of primary care services.*

CSP references to Nuka include:

> *We have learnt a lot from the Nuka System of Care at the Southcentral Foundation in Alaska. We will take the lessons from Nuka but create a local system that is co-designed by our own communities and whānau, and is completely in tune with our Hawke's Bay culture. The Nuka System of Care incorporates key elements of the Health Care Home model, with multi-disciplinary teams providing integrated health and care services in primary health centres and the community, co-ordinating with a range of other services. This is combined with a broader approach to improving family and community wellbeing that extends well beyond the co-ordination of care services—for example, through initiatives like Nuka's Family Wellness Warriors programme, which aims to tackle family harm, abuse and neglect across the population through education, training and community engagement. Traditional healing is offered alongside other services, and all services build on indigenous culture (The King's Fund, n.d.).*

One of the key themes contained within the CSP is 'Evolving Primary Health Care'. Much of the discussion within this theme relates to PWCC:

'Evolving primary health care

A fundamentally different primary health care system is the lynchpin of this CSP. There are large expectations for a primary care response to burgeoning health need, and the model of general practice will continue to evolve to respond to this demand. There is a groundswell of readiness for a new approach and we already have examples of practices doing things differently. Some are implementing telephone triage to better manage appointments, holding daily team 'huddles', and there is good uptake in places of the patient portal. Strong relationships between primary care and the DHB need to be developed and nurtured to amplify the scale of this change.

Our health system needs to work with communities and people who need services to improve access, remove barriers and deliver proactive care and preventative strategies. This is particularly important for under-served populations with long term physical and mental health conditions, with an expectation of an integrated service. We know that cost can be a barrier to accessing primary care; some people delay or do not seek care when they need it, or access hospital services instead. As we expand and evolve primary care, embedding a wider range of services and specialism within it, we will develop equitable funding models that ensure costs are not shifted to consumers. Primary health centres will operate within community networks that are planned and developed as part of place-based planning.

Primary care teams will be expanded with new roles and capabilities

Traditional primary care is based on a medical model, focused on the role of general practitioner and practice nurse. This workforce is ageing, under significant workload pressure, and is unable to address all the health and related social needs of consumers. In future, the primary care team will be expanded with new roles including (for example): specialist long term conditions therapists or nurses, midwives, district nurses, care navigators or key workers, health promoters, social workers, behavioural practitioners, dietitians, mental health workers, clinical pharmacy facilitators as well as community pharmacists, therapists and home support carers. For example, community pharmacist skills will be harnessed to provide public health interventions and triage services and we will work to increase the number of non-medical prescribers. Behavioural practitioners will work with other team members such as dietitians and pharmacists. The full range of practitioners will not necessarily be employed by practices but will be a core part of a multi-disciplinary team around them, enabled by shared IT and providing holistic and culturally appropriate stepped care. Changes will be required to business models and/or funding models to ensure new and team-based workforce models can be developed.

PROGRESS

All the above sets out a very clear direction of what we need to do, and how, to embed PWCC in primary and community care, all of which is fully supported by both Councils. It does not however answer the questions of who will 'do' all this and when. A number of frustrations and concerns were raised during the workshop that relate to these two questions:

- *Create time and headspace of clinical leaders to work with consumers and look at the drivers for acute demand and different ways of working*
- *Time is need to stop and plan to look at change*
- *Every discussion comes back to funding and structures ? is it a wider conversation that needs to go to the MoH – consumers are frustrated at the lack of progress. Need to understand the process to be able to change the process*
- *Invest in clinical staff to enable keeping up on demand and changing to a new system*
- *Consumer view that we have been talking about this for long enough – it is time we saw some real change*

Within this context, Councils have acknowledged positive progress and planned organisational level processes such as:

- 'Person and Whanau Centred Care' is one of the six Core Goals currently incorporated into the developing Strategic Plan
- The development of an Implementation Plan for the Strategic Plan will formally commence in the new financial year
- Further work on transferring Nuka concepts into the HB health system is ongoing
- Implementation aspects of the People Plan will include socialisation and raising awareness of PWCC
- A number of 'operational issues' such as making health easy to understand, consumer feedback, and consumer engagement are being progressed

The general feeling from the workshop however, was that this is not sufficient 'if we really want to make a difference' for the benefit of all stakeholders. The belief was that HBDHB needs a greater level of commitment and needs to do more to advance PWCC across the sector. This needs to be done with consumers and communities working in partnership with clinicians, managers and providers.

RECOMMENDATIONS

Taking all this into account, we recommend that the HBDHB Board requests steps to be taken to:

- Continue to advocate for national changes and consider local changes to current funding models and other disincentives to providing PWCC
- Free up appropriate resources to prioritise the development of PWCC across the HB health sector
- Provide specific education and training to the HB health workforce on implementing PWCC
- Raise the levels of PWCC awareness within HB communities and empower consumers to partner in their own care and contribute to service developments

Problem with the current state	What a person and whānau centred system looks like in future
Services are not accessible or appropriate to the needs and wants of all groups.	Services are designed with communities, whānau and consumers to reflect their needs and wants, and are delivered as close to home as possible. Nobody misses out on the care they deserve because of affordability, transport, or other social issues.
A shortage of safe, warm and dry homes means children experience an unnecessary burden of childhood illness.	Issues of housing supply and affordability are addressed so that all children, including those in rental and social housing grown up in a safe, warm and dry home.
Lack of clear communication tailored to people and their whānau.	Health workers are friendly and welcoming and take time to develop relationships with people. Communication is clear and health information is easy for all people to understand.
Cultural competency is variable across services and workforce.	People and whānau have their cultural needs met no matter which health service they engage with.
Care is organised around the service rather than the people it serves and it tends to be focussed on a single issue and not holistic.	People have a broad range of services in the community, designed with them, to help them achieve their objectives and keep them well. Longer consultations are available when necessary and specialist services support primary care to manage people closer to home.
Care is not coordinated well, with too many referrals, delays, and discontinuity. There are multiple points where people can be lost in the system.	Everyone has a care plan that is developed with them and based in primary care. The consumer and whānau, and all health workers involved in their care can view and update the plan. Referrals are minimised by having a wider range of services available in primary care. Navigators support people and whānau with complex needs through the system.
Physical spaces are not well designed, lack privacy and can be inappropriate for children, older people, and whānau.	Assessments and interventions are delivered in appropriate spaces, both in primary care and the hospital. Health facilities are whānau friendly—consumers have whānau and support people on site, with specific areas for group conversations and meetings.
Workforce and services are stretched too thinly across both primary and secondary care. Hospital and theatres are full.	The hospital has a narrower scope in the future. People and whānau are empowered to self-care at home and can access services virtually when appropriate. Primary care consultations are targeted to those who need them most, and services are delivered by a range of different professionals working to the top of scope. Proactive care reduces the occurrence of acute events.
Discharge from hospital is not well planned and some people have poor experiences.	If people are admitted to hospital, their transfer back home is well supported and planned from day one, and involves the consumer, their whānau or support people, and other professionals involved in their care. People are able to return home as soon as they are medically fit, with appropriate care and support in place at home.
Expenditure is focussed at the hospital end of care.	The system is designed to deliver care when and where it will make best use of health system resources, meeting people's needs at the earliest and lowest cost opportunity and reducing the onset of complex health need.
Lack of IT development hinders service productivity.	Consumers, whānau and health professionals have access to modern IT infrastructure (hardware and applications) that supports self-care, access to services, and appropriate sharing of information. Tele-health supports equal access to specialist services for people living in remote or rural locations.

6

GOVERNANCE WORKPLAN PAPERS

Updated: 2 April 2019

CLINICAL & CONSUMER MEETING 10/11 APRIL 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				10-Apr-19			
IS updates/presentations 30 mins - Bi-monthly (Feb-Apr-Jun-Aug-Oct-Dec)		Anne Speden				10-Apr-19		24-Apr-19	
Matariki HB Regional Development Strategy and Social Inclusion Strategy update - 6 monthly (Sep-Mar)	E	Bernard TePaa	Shari Tidswell	5-Mar-19	13-Mar-19	10-Apr-19	11-Apr-19		27-Mar-19
Violence Intervention Programme Report (Committees reviewed in July - EMT Nov - April-19)	E	Colin Hutchison	Russell / Cheryl Newman	26-Mar-19	10-Apr-19	10-Apr-19	11-Apr-19		24-Apr-19

CLINICAL & CONSUMER MEETING 8/9 MAY 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting - update		Chris McKenna				8-May-19			
Collaborative Pathways - update (Nov & May) 6 mthly Clinical Council	E	Mark Peterson	Penny Rongotoa	21-May-19		8-May-19			
Early Supportive Discharge Service (EMT & CC only)		Colin Hutchison	Allison Stevenson	2-Apr-19		8-May-19			
Te Ara Whakawaiora - Access Rates 0-4 (local indicators) CHILD HEALTH		Chris Ash	Mark P/ Jil Garrett / Patrick	30-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19
After Hours Urgent Care Service Update 6mthly (Sep-Mar-Sep)	E	Wayne Woolrich		30-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19

CLINICAL & CONSUMER MEETING 12 /13 June 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Annual Plan 2019/20 SPEs to Board by end of June (include committees?)		Chris Ash	Robyn Richardson	4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Clinical Advisory & Governance Group Meeting - update		Chris McKenna				12-Jun-19			
IS updates/presentations 30 mins - Bi-monthly (Feb-Apr-Jun-Aug-Oct-Dec)		Anne Speden				12-Jun-19		26-Jun-19	
People Plan Progress Update Report - 6 monthly (Dec-Jan)		Kate Coley		4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19

CLINICAL & CONSUMER MEETING 10/ 11 July 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Clinical Advisory & Governance Group Meeting - update		Chris McKenna				10-Jul-19			

7

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2018/19

ACTION/PROGRESS REPORT

OBJECTIVE	PROGRESS TO
1. Provide a proactive and prioritised clinical perspective on issues and strategies to be addressed in the new 5 Year Strategic Plan for the HB health sector by 30 June 2019	
2. Co-design with Consumer Council and initiate the implementation of a detailed plan for the implementation of PWCC in HB by 30 June 2019	
3. Ensure the Clinical Governance Structure is fully implemented and integrated, with appropriate reporting, management and administration processes in place, by 30 June 2019	
4. Ensure the development and implemention of a sector wide process for monitoring, managing and reporting clinical risk, by 30 June 2019	
5. Facilitate the development of a HB Clinical Workforce Plan to support the new 5 Year Strategic Plan, by 30 June 19	
6. Promote and support the development and delivery of education and training of all clinicians on the Quadruple Aim and PWCC, and what these mean for clinicians, by 30 June 2019	

8

CLINICAL ADVISORY & GOVERNANCE GROUP UPDATE

Verbal

9

CLINICAL COMMITTEE REPORTS

10

INVESTMENTS UPDATE
(OUTCOMES OF BUDGET PRIORITISATION)

Verbal

11

CLINICAL COUNCIL MEMBERSHIP AND REPRESENTATION

Verbal

OURHEALTH
HAWKE'S BAY
Whakawateatia

CLINICAL GOVERNANCE STRUCTURE

12

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Matariki HB Regional Economic Development and Social Inclusion Strategy** 29
	For the attention of: **HBDHB Board**
Document Owner	Bernard Te Paa, Executive Director Equity and Health Improvement
Document Author(s)	Shari Tidswell, Intersector Development Manager
Reviewed by	Executive Management Team
Month/Year	March 2019
Purpose	This report provides and update on progress for the Matariki Strategies and the HBDHB's contribution to these.
Previous Consideration Discussions	This is reported six monthly.
Summary	The emphasis has shifted for the Matariki forum with partner agencies working on and sharing proposals for the Provincial Growth Fund (PGF). The Executive Leadership and Governance Groups are discussing alignment and their role in the PGF process. Business Hawke's Bay continues to work on establishing the supporting structure for the forum, with all staff support in place. HBDHB continues to support current projects and there has been particular success for the Rangatahi Ma Kia Eke project.
Contribution to Goals and Strategic Implications	Improving Health and Equity. Contributing to an intersectoral approach
Impact on Reducing Inequities/Disparities	Matariki as a cross-sector initiative focusses on the impacts of economic development in reducing equity amongst our communities.
Consumer Engagement	Completed in the development of both Strategies and the ongoing development of projects.
Other Consultation /Involvement	Not applicable for this report.
Financial/Budget Impact	Not applicable for this report.
Timing Issues	Not applicable
Announcements/ Communications	Link to the Matariki website on the Hawke's Bay DHB website

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report.
2. **Endorse** the key recommendations.

13

HAWKE'S BAY
District Health Board
Whakawāteatia

Board Six Month Update
Matariki – Regional Economic Development and Social Inclusion Strategies.

Author(s):	Shari Tidswell, Intersector Development Manager
Designations:	As above
Date:	**March, 2019**

OVERVIEW

Matariki includes two regional strategies designed to achieve regional development via economic development and social inclusion. Through the delivery of projects, these complementary strategies will support the regional, economic vision:

> *"Every household and every whānau has activity engaged in, contributing to and benefiting from a thriving Hawke's Bay economy."*

And social inclusion vision:

> *"Hawke's Bay is a vibrant, cohesive, diverse and safe community, where every child is given the best start in life and everyone has the opportunities that result in equity of outcomes."*

Underpinning this is the understanding that regional economic growth and supporting equitable opportunities for individuals, whānau and community go hand in hand.

An intersectoral approach is being used to deliver actions to support the strategies, including; community, Iwi, hapū, business and Government partners. The leadership structure reflects this approach with a two tiered leadership structure – Governance and Executive Leadership Groups, with membership including Iwi and Hapū governance and executive representatives.

Governance Group membership includes; five council (Mayors and Chair), five Māori leadership representatives and five business leaders providing leadership and overall direction for Matariki.

The Executive Leadership Group consists of senior officials and managers from all stakeholder groups including Government agencies. This group provides operational direction, project support and monitors progress on the strategy's actions. Administrative support is provided via Business Hawke's Bay.

HBDHB is the lead and/or contributing agency for the following actions:

Regional Economic Development

- Contributor - Project 1,000 (placing 1,000 youth into work)
- Contributor - coordinating infrastructure

Social Inclusion

- Lead agency – Social Responsible Employers
- Co-lead agency – Housing
- Contributor – Whānau centric places connected to the community
- Contribute – Develop a new sustainable operating system

PROGRESS ON ACTIONS LED OR CONTRIBUTED TO BY HBDHB

The Regional Growth Fund is stepping up with scheduling of Ministerial announcements in 'surge regions' including Hawke's Bay. Matariki partners have been working on proposals including a joint proposal from the local territorial authorities. The Executive Leadership Group is providing a process for reviewing funding applications – this will require proposals to demonstrate how they contribute to Matariki actions. The process for reviewing youth employment programmes has received positive feedback from central government.

The HBDHB continues to provide 'in kind' support for the Social Inclusion Working Group and via this support, has completed:

- Updates to the Executive Leadership Group
- Integrated the actions table from both strategies
- Updating of the Matariki website to reflect the aligned strategies https://www.hbreds.nz/
- Presented the Clinical Services Plan to the Governance and Executive Leadership Groups

The HBDHB is contributing to actions as noted below:

Theme	Action	Update
Social Inclusion		
Growing social responsible employers and enterprise	Support the employment of people with challenges that may impact on their capacity to obtain and retain employment.	• HBDHB and MSD lead this action • Rangatahi Ma Kia Eke project has placed 25 youth and has secured another year of funding • Evaluation is underway • HBDHB has completed a Disability Plan which will reduce barriers for people with disabilities
Whānau, households and communities driving social inclusion	Develop a new sustainable operating system to deliver social support services.	• HBDHB and Oranga Tamariki lead this action • Clinical Services Plan – co-design process is an example of moving to a sustainable operating system for health • HBDHB are members of the Wairoa Community Partnership Group, this is supporting an integrated/community-based response for funding services in Wairoa
	Review Housing Coalition's Terms of Reference	• HBDHB and TToH lead this action • Completed
	Undertake an analysis of social housing	• HBDHB and TToH lead this action • This is now part of a Government activity - HBDHB will contribute
	Develop a plan to address issues affecting housing supply and consider innovative approaches	• HBDHB and TToH lead this action • Currently working with Government policy and housing programme

Theme	Action	Update
Regional Economic Development		
Improve pathways to and through employment	Project 1,000	• HBDHB are key partners • Supporting the delivery of Rangatahi Ma Kia Eke with partner agencies; TPK, MSD, EIT, HDC, and OT • Establishing a support pathway for youth "failing drug test" • Working with TToH and Work and Income to provide referrals and support
	Ensure all major infrastructure development projects are optimising local employment	• HBDHB are key partners • Employment in building projects – working with Contracts Team and Facilities to support this process
	Increase the number of youth with driver licences	• Completed a map of driver licensing and provides support to develop the project plan

COMMENTS

Progress has been gradual due to the focus on the Provincial Growth Fund and the time required for Business Hawke's Bay to establish the supporting structure. The Governance and Executive Leadership Groups are operational and meeting regularly.

The Minister's expectations include intersectoral work. Matariki provides a framework for intersectoral work. Work on the Annual Plan for 2019/2020 includes links to Matariki actions and projects, which will support the Social Inclusion Strategy to be delivered and continues to deliver projects in the Regional Economic Development Strategy.

Through our membership on Matariki, we continue to grow our cross-sector opportunities and relationships.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
HBDHB continues to contribute to Governance and ELG	• Attend monthly meetings and contribute to actions	Kevin Snee Kevin Atkinson	Ongoing
Continue to support actions areas with 'in kind' support	• Support the ready for work actions. • Contribute to the work delivering whānau centric approaches • Complete the Housing Actions	Shari Tidswell	1 July 2019

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report.
2. **Endorse** the key recommendations.

HAWKE'S BAY District Health Board Whakawāteatia	**Haumaru Whanau/Violence intervention programme update** For the attention of: **Executive Management Team**
Document Owner	**Cheryl Newman, Haumaru Whanau Team Leader**
Document Author(s)	**Cheryl Newman, Haumaru Whanau Team Leader**
Reviewed by	Russell Wills
Month/Year	March 2019
Purpose	Monitoring
Previous Consideration Discussions	No
Summary	Key Issues/Actions There is ongoing review of the Violence Intervention Programme. Four key work streams have been identified as being of particular importance to building a broader and more comprehensive family harm programme for HBDHB. The details of these work streams is contained in the paper below.
Contribution to Goals and Strategic Implications	What are the implications and contributions of this issue on any major goal or strategy eg: Improving quality, safety and experience of care Improving Health and Equity for all populations Improving Value from public health system resources
Impact on Reducing Inequities/Disparities	What impact will this have on reducing inequities and has a HEAT Tool been applied? If yes, what are the implications / outcomes? A key work stream is ensuring that we understand the needs of Maori and Pacific groups in our community. Their feedback and engagement will form the foundations of our strategy and training models so a great deal of investment is being made in this work stream.
Consumer Engagement	What level of consumer engagement has been undertaken? Please see comments in paper below for details.
Other Consultation /Involvement	Who else was consulted / involved? How was consultation undertaken and input incorporated? N/A
Financial/Budget Impact	Nil

Timing Issues	N/A
Announcements/ Communications	Does any outcome need to be announced or communicated? If yes, please provide details: N/A

RECOMMENDATION:

It is recommended that the HBDHB Board, HB Clinical Council, HB Health Consumer Council, Māori Relationship Board and/or Pasifika Health Leadership Group:

1. **Note progress as outlined below and seek a further update in six months.**

HAWKE'S BAY District Health Board Whakawāteatia

Haumaru Whanau/Violence intervention programme update to EMT

Author:	**Cheryl Newman**
Designation:	**Haumaru Whanau Team Leader**
Date:	**20 March 2019**

FAMILY HARM REVIEW - Focus areas:

- ***Equitable services – responding to Maori and Pacific families.***

14

There is progress in developing a better understanding of community needs from health services where there are family harm concerns. This is a crucial foundation to the development of a strategy so is the greater part of our work. We are waiting for the final proposal from Hohou Rongo who we have approached to work with their established community groups to gather this impartial feedback, predominantly from the Maori community.

Talalelei Taufale is supporting us to develop a framework to gather feedback from our Pacific community groups.
A number of consumer council members are also been consulted and we expect that this piece of work will continue through 2019.
These actions are also included in the family violence and sexual violence focus area for the annual plan 2019-20.

- ***Wellbeing model***

We continue to support the view that a possible mechanism for improving responses to family harm and child protection concerns is to develop a wellbeing model for screening and brief intervention. Considering the wide range of harms impacting our community, challenges with resourcing sufficient services for each of the individual harms, numerous overlapping governance structures in place, we believe a broader 'Are you ok?' approach for families will better meet their needs, and that of the different services responding to these harms.

We are currently exploring the possibility of funding a position from our budget in 2019/20 to pilot a 'wellbeing warrior' role in the areas of highest need, possibly emergency department. We know that consistent face to face contact with staff is improving practice and therefore responses to patients. Alcohol Harm reduction have already been involved in discussions about the scope of the position and are supportive of trialling this. The joining of the suicide harm prevention programme with Haumaru Whanau adds further opportunities for growth of the wellbeing model.
In addition, we continue to invest in our programme champions and advocate with their management to ensure they attend training and development opportunities we have planned over the year. The champions offer us an opportunity to further trial a wellbeing warrior approach if we are successful in protecting their work time to undertake this role in their specific service area.

- ***Inter-sectorial family harm responses***

Oranga Whanau Government agencies group are continuing with their focused work on redesigning the community wide response to family harm, and ensuring Government agencies are prepared to address systems issues that impact on delivery of services. We continue to support this work and have added actions to the family violence and sexual violence focus area for the annual plan 2019-20. We are particularly seeking support to resource Oranga Whanau's coordination and membership growth, and more crucially ensure there is an equity focus to the actions. Our investment in the Oranga Whanau work is also informing possible future Governance structures. Upcoming events include a wānanga to increase community awareness of Oranga Whanau and create an opportunity for feedback on our purpose and framework, and also the establishment of regular briefings to make the groups work transparent to a wider audience.
We are in the very early stages of mapping possible joint training opportunities across our community, who may be involved and what level of resourcing this would require. We already have a number of organisations eager to pilot training for their employees, and some previously delivered joint training to further develop. This is likely to be followed up further towards the end of 2019 once we have a clear pathway established for DHB employees.

- ***Training structure***

There is a draft structure for training delivery that we are in the process of consulting with the VIP national training manager on. We will also be discussing this with the VIP improvement group at the next meeting to ensure it is viable for CNMs to support staff to participate in. MoH are still supportive of us exploring a training model that is compatible with our DHB but are clear on a deadline for disruption to the delivery of the contract being June 2019.

We continue to offer service specific training on request and there has been some positive feedback on this approach. It does mean that we will cover lower numbers of staff, but smaller group training means content is specific to their skill level and working environment.
We are still to establish how a family harm training programme could be supported and enhanced alongside the DHB's other training packages, especially in light of us pursing a wellbeing approach when screening for harms.

- ***Challenges***

Operational support is compromised whilst we focus on these areas of work; it is therefore not surprising that we are still seeing incidents of patient harm occurring due to insufficient application of the policy and procedures. We are following these up as and where we can with the expectation that Team Leaders/CNMs/ACNMs etc address any identified practice issues.
There has been no change in screening and disclosure rates. This includes in E.D where we have invested additional face to face support over the last 5 months. Via the VIP improvement group we have offered support with auditing to support more accurate data collection but this has not been taken up as yet.
We have not been able to recruit to the 6 month backfill position to date and this is impacting on the progress of the review. We are currently trying to identify funding that will allow us to re-advertise this position.
We have not yet established a steering group to support the development of a family harm strategy due to limited interest. The impact of this is that those services who are struggling the most with responses to vulnerable families are no further forward in improving practice.

We anticipate that further discussion and clear expectations in planning (Annual Plans, Clinical Services Plans etc) at a senior leadership level will assist in clarifying for operational leaders their obligations to support a review of responses.

- ***Next steps:***

Finalise the proposal for the relocation of Haumaru Whanau from Communities, Women and Children directorate.

Explore restructure of Haumaru Whanau to allow for development of the wellbeing model.

RECOMMENDATION:

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

1. **Note** update as provided
2. **Approve** further update to EMT in six months' time.

ATTACHMENTS:

Hawke's Bay District Health Board Violence Intervention Programme Evaluation: 2017-2018

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

VIP
violence intervention programme

Hawkes Bay District Health Board
Violence Intervention Programme Evaluation: 2017-2018

Attention: Dr Kevin Snee, Chief Executive
Claire Caddie, Director of Women, Children and Youth Services

Family Violence Intervention Coordinators (FVIC):
Yvette MacDonald
Cheryl Newman

Date: 13/12/ 2018

Introduction

The Ministry of Health's Violence Intervention Programme (VIP) seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This report reviews VIP evaluation documents submitted to the AUT evaluation team by Hawkes Bay staff in September 2018.

The evaluation period was 1st July 2017 – 30st June 2018. This report addresses the following evaluation activities:

1. Delphi audit of programme infrastructure (inputs) assessed against criteria for an ideal programme
2. VIP Snapshot clinical audits (outputs) to measure programme delivery in the Ministry of Health designated six services
3. Model for Improvement Plan-Do-Study-Act (PDSA) cycles to foster system learning and quality improvement

Evaluation tools and national evaluation reports are available at www.aut.ac.nz/vipevaluation.

1. Delphi audit of programme infrastructure

In 2018 a new Delphi audit tool (Table 1 in the Appendix) was implemented, replacing the previous tools for child abuse and neglect (CAN) and intimate partner violence (IPV). This was to reduce reporting burden, eliminate the ceiling effect and introduce new elements of infrastructure identified as important to programme sustainability. A new Ministry of Health target score will be established for 2019 based on the 2018 Delphi data. DHB Delphi range and medians will be available in the 2018 national report released early 2019, however DHB scores will not be identified in this inaugural year.

- Hawkes Bay DHB scored 43 (possible range 0-100). This is compared to a median of 72 based on the 95% of DHBs who have submitted data to date.
- The domain scores for Hawkes Bay were varied. Resource funding for the VIP was the strongest domain score whereas practice service delivery criteria were not met at all. A number of domains require focus particularly cultural responsiveness for Māori, collaboration with outside agencies and visible and accountable DHB leadership for the VIP.

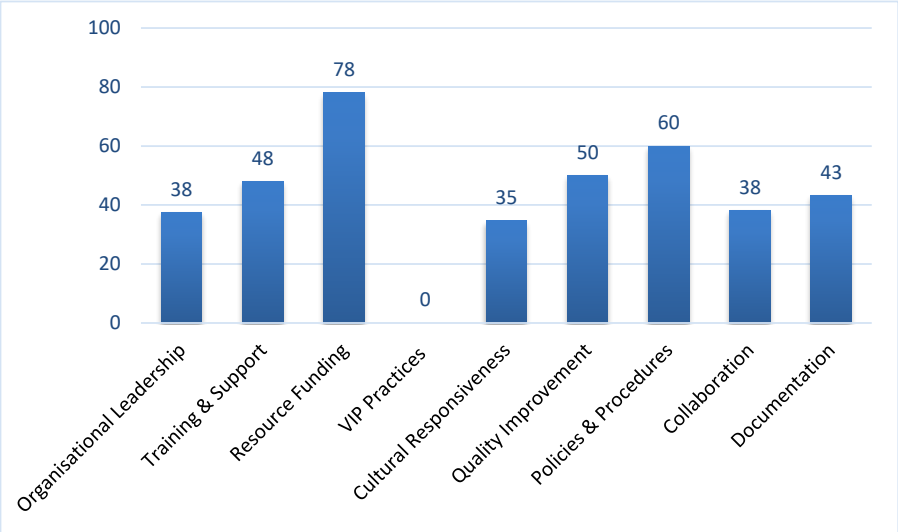


Figure 1. *Hawkes Bay DHB Delphi Domain Scores 2018*

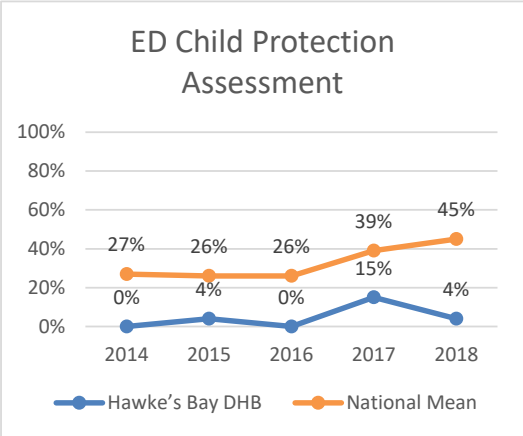
2. Clinical Snapshot Results

Child Protection Assessment and Concerns

The national 2016 Guideline[1] supports the use of a child protection checklist to increase the quality of child protection assessment and documentation for **all** children under 2 years of age presenting to emergency departments. Random samples of 25 charts during the April to June quarter in 2018 indicates that children under two years of age presenting to Hawkes Bay Emergency Department are not routinely assessed for child protection concerns. Although there was a notable increase from 0 in 2016 to 15% in 2017, this has fallen to 4% in 2018, well below the current Ministry of Health target of ≥ 80%.

[1] Fanslow, J., & Kelly, P. (2016). *Family violence assessment and intervention guideline: Child abuse and intimate partner violence* (2nd ed.). Wellington: Ministry of Health.

VIP expects the rate of child protection concern identification to be ≥ 5%. Within the random audit samples (2014-2018), the indicative rate of child protection concerns for children under the age of two presenting to the Hawkes Bay DHB was zero. This has consistently fallen below the national mean (see Table 2 in the Appendix) and the result is clearly attributable to the lack of routine assessment occurring in the DHB.



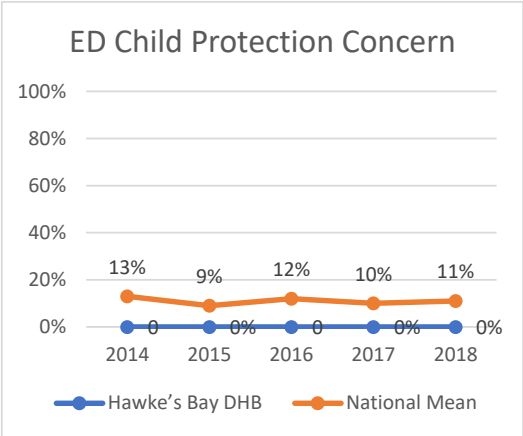


Figure 2. *Hawkes Bay Emergency Department Child Protection Assessment & Concern Rates for Children under Two Years (April-June 2014-2018)* Figure notes: Based on a random sample of 25 charts for each audit period. Includes children under two years of age presenting to the ED for any reason.

IPV Routine Enquiry and Disclosure

Successive services have been added to Snapshot IPV clinical audits beginning in 2014. Snapshot data from Hawkes Bay DHB is available for all six Ministry of Health designated services. Hawkes Bay DHB IPV routine enquiry and disclosure rates based on clinical audits of random samples of 25 charts per service, during the April to June quarter 2014 to 2018, are shown below.

The VIP aims for reliable IPV routine enquiry, indicated by screening rates ≥ 80%. Results suggest that there is inconsistent service delivery of VIP at the Hawkes Bay DHB with routine enquiry below target in all services, although Postnatal Maternity (76%) and Sexual Health (77%) are only slightly below. Rates in all services have remained relatively steady over the past two years. With the exception of Postnatal Maternity, the routine enquiry rates are below the national mean for the designated service (see Table 3 in the Appendix).

Research indicates that the quality of IPV screening influences women's decision whether or not to disclose IPV to a health worker.[2] The VIP expects IPV disclosure rates among women seeking health care to be at least as high as the population prevalence of 5%, given the negative impact of IPV on health and associated increase in health visits. Child Health Inpatient, Emergency Department, Alcohol and Drug, and Community Mental Health had disclosure rates above 5% of those screened (13%, 25%, 44% and 9% respectively). With the exception of Community Mental Health these disclosure rates exceeded the national mean. The high rate of disclosure in the Emergency Department despite lower rates of routine enquiry suggests assessment may be occurring selectively based on staff concerns of IPV.

[2] See Spangaro J, Koziol-McLain J, Zwi A, Rutherford A, Frail MA, Ruane J. Deciding to tell: Qualitative configurational analysis of decisions to disclose experience of intimate partner violence in antenatal care. *Soc Sci Med.* 2016;154:45-53; and Feder G, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. Arch Intern Med. 2006;166(1):22-37.

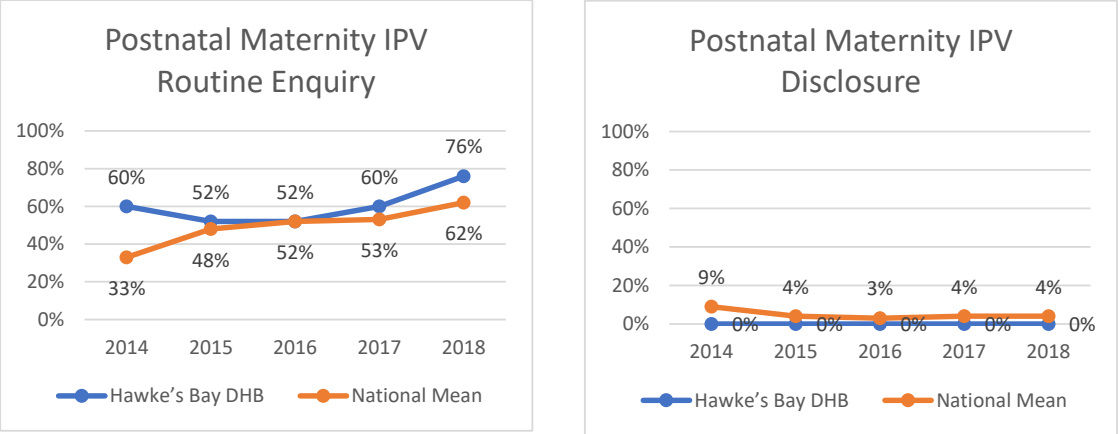


Figure 3. *Hawkes Bay Postnatal Maternity IPV Routine Enquiry & Disclosure rates 2014-2018*

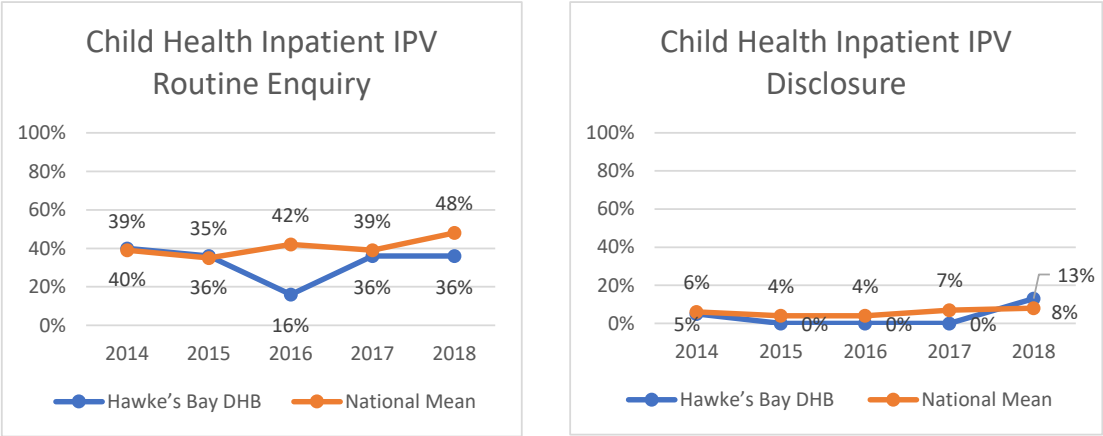


Figure 4. *Hawkes Bay Child Health Inpatient IPV Routine Enquiry & Disclosure rates 2014-2018*

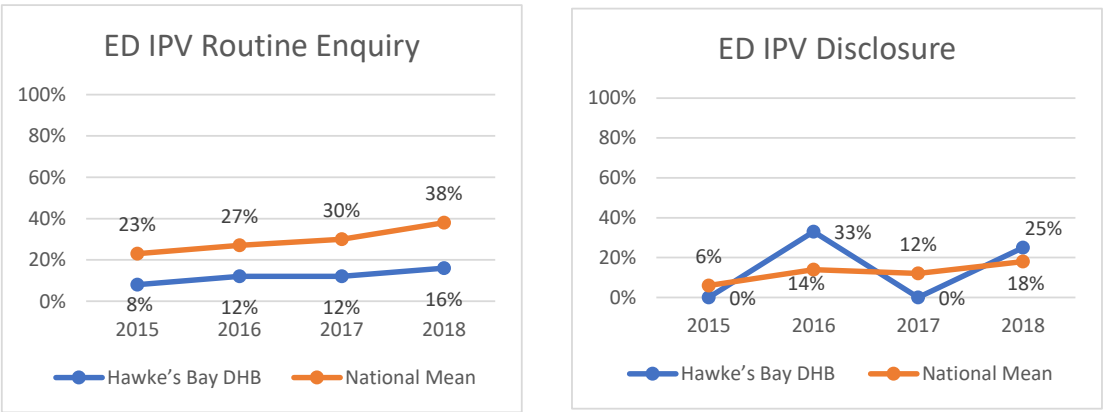
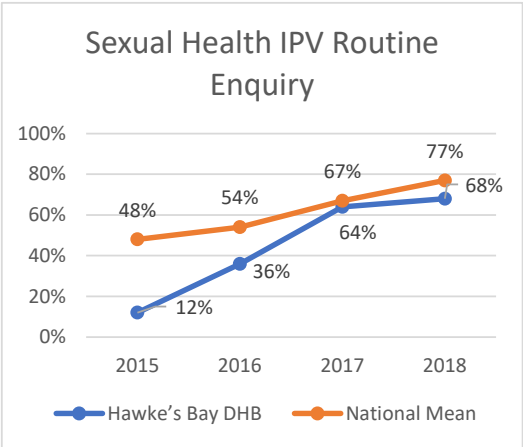


Figure 5. *Hawkes Bay Emergency Department IPV Routine Enquiry & Disclosure rates 2015-2018*



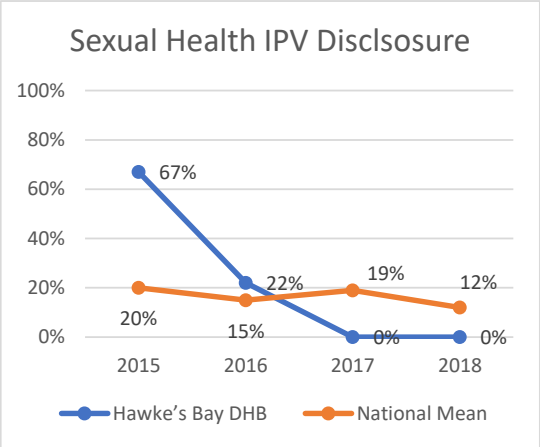
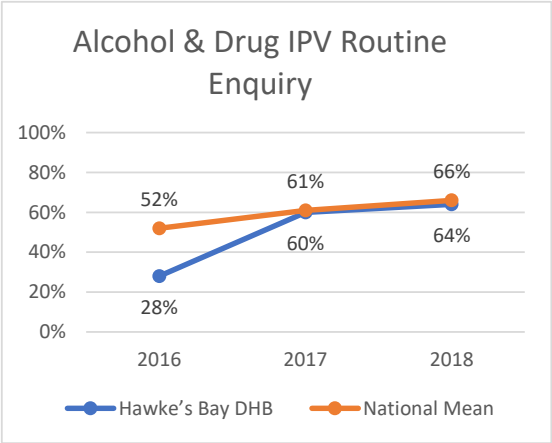


Figure 6. *Hawkes Bay Sexual Health IPV Routine Enquiry & Disclosure rates 2015-2018*



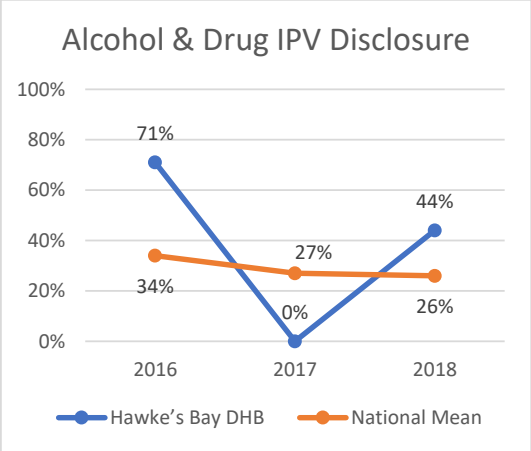
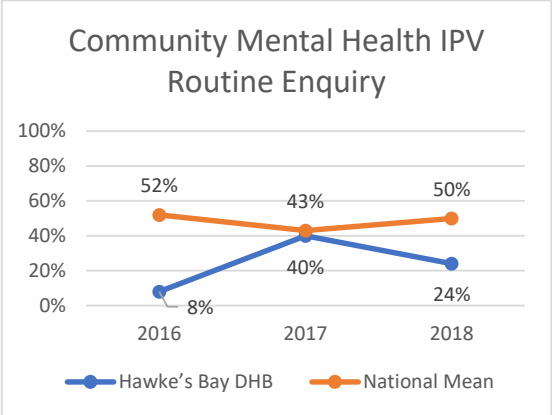


Figure 7. *Hawkes Bay DHB Alcohol & Drug Services IPV Routine Enquiry & Disclosure rates 2016-2018*



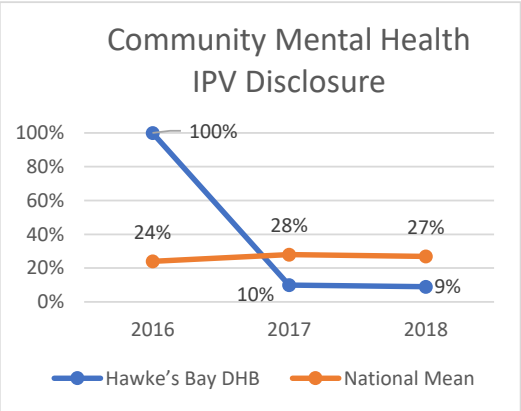


Figure 8. *Hawkes Bay Community Mental Health IPV Routine Enquiry & Disclosure rates 2016-2018*

3. Model for Improvement

Two PDSA plans were submitted in October 2018. The first aims to improve safety planning following an IPV disclosure by upskilling the social work team through an assessment of current knowledge and skills, observations and audit, followed by training in CAN and IPV safety planning and intervention practices. The second aims to ensure transfer of skills from core VIP training to practice through on-the-job follow up. These are good and clear efforts to enhance VIP practice which were not provided to us last year. If these are the first cycle and initiatives, we recommend that the DHB quality improvement and safety resource provide support to the VIP team in implementing the Model for Improvement (and PDSA cycles). PDSA resources on HIIRC may also be useful.

Summary

The Violence Intervention Programme team is to be recognised for the steady rates of IPV routine enquiry in most designated services and disclosure rates that indicate some of the women experiencing IPV are identified. The revised Delphi has highlighted a number of areas where the VIP requires support including organisational leadership, resourcing, collaboration with external agencies and a focus on cultural responsiveness for Māori. Quality improvement initiatives in these areas will help the VIP meet the guideline for effective practice. Organisational governance and leadership have an important role in communicating the Ministry's expectation of consistent quality family violence assessment and intervention across the DHB.

Please do not hesitate to contact us if you have any questions or comments.

Respectfully submitted,

Moira Howson
VIP Evaluation Project Lead
moira.howson@aut.ac.nz

Jane Koziol-McLain, PhD, RN
VIP Evaluation Principal Investigator
jane.koziol-mclain@aut.ac.nz

cc: Helen Fraser (Portfolio Manager, Ministry of Health), Miranda Ritchie (National VIP Manager for DHBs, Health Networks Limited), Kara-Dee Morden (VIP National Trainer, SHINE), Helen Garrick (VIP Education & Training Manager, SHINE)

Appendix

Table 1: *2018 Delphi domain definitions*

Domain	*Definition*	*Weight*	*# items*
Organisational leadership	Ownership, leadership and support evidenced through participation, communication and connection	14	9
Training and support	Staff receive the appropriate training, reinforcement and support to effectively implement VIP	11.8	8
Resource funding	VIP funding is fully allocated, supporting continuous and sustained coordinator/s with dedicated cultural resource	11.5	3
VIP practices	Intervention services including routine enquiry, health and risk assessment, safety planning, referrals and support, follow the Ministry of Health Family Violence Assessment and Intervention Guideline (FVAIG) procedures and are implemented at all levels of the DHB	11	8
Cultural Responsiveness	The programme includes education, support and services informed by people's diverse needs: Māori, multicultural, disabled and gender identity when living with family violence	10.9	7
Quality improvement	Strategic and continuous monitoring to ensure effective programme delivery	10.8	10
Policies and procedures	Policies and procedures exist, are reviewed, aligned to guidelines and legislation and are culturally responsive	10.6	5
Collaboration	Internal and external collaboration throughout programme and practice	10.5	5
Documentation	Easily accessible standardised documentation tools, aligned with FVAIG, are used	8.8	3
Total		**100**	**58**

Table 2. *Child protection assessment for children under two years of age presenting to the Hawkes Bay emergency department for any reason* (April – June, 2014-2018).*

		2014	*2015*	*2016*	*2017*	***2018***
Child Protection Assessment	*Hawke's Bay DHB*	0%	4%	0%	15%	4%
	National Mean	27%	26%	26%	39%	45%
	National Range	0%-61%	0-76%	0-96%	4-88%	0-100%
Child Protection Concern	*Hawke's Bay DHB*	0%	0%	0%	0%	0%
	National Mean	13%	9%	12%	10%	11%
	National Range	0-100%	0-75%	0-100%	0-50%	0-40%
Specialist Consultation	*Hawke's Bay DHB*	0%	0%	0%	0%	0%
	National Mean	89%	100%	93%	100%	92%

*Based on a random sample of 25 charts for each audit period

Table 3. *Intimate partner violence (IPV) routine enquiry, disclosure and referral of women presenting to Hawkes Bay DHB Ministry of Health VIP designated services (April - June, 2014-2018)*

Service		***2014***	***2015***	***2016***	***2017***	***2018***
Postnatal Maternity						
IPV Assessment	*Hawke's Bay DHB*	60%	52%	52%	60%	76%
	National Mean	33%	48%	52%	53%	62%
	National Range	0-72%	0 – 100%	16-96%	24-96%	16-96%
IPV Disclosure	*Hawke's Bay DHB*	0%	0%	0%	0%	0%
	National Mean	9%	4%	3%	4%	4%
	National Range	0-32%	0-33%	0-17%	0-21%	0-17%
IPV Referral	*Hawke's Bay DHB*	0%	0%	0%	0%	0%
	National Mean	67%	100%	83%	60%	86%
Child Health Inpatient						
IPV Assessment	*Hawke's Bay DHB*	*40%*	*36%*	*16%*	*36%*	36%
	National Mean	*39%*	*35%*	*42%*	*39%*	48%
	National Range	*0 -100%*	*12-92%*	*12-96%*	*0-80%*	12-84%
IPV Disclosure	*Hawke's Bay DHB*	5%	0%	0%	0%	13%
	National Mean	6%	4%	4%	7%	8%
	National Range	0 - 100%	0-33%	0-33%	0-63%	0-33%
IPV Referral	*Hawke's Bay DHB*	0%	0	0	0	100%
	National Mean	70%	100%	75%	69%	80%
Adult Emergency Department						
IPV Assessment	*Hawke's Bay DHB*	N/A	8%	12%	12%	16%
	National Mean		23%	27%	30%	30%
	National Range		0 – 68%	0-64%	4-64%	4-80%
IPV Disclosure	*Hawke's Bay DHB*		0%	33%	0%	25%
	National Mean		6%	14%	12%	18%
	National Range		0-100%	0-33%	0-100%	0-100%
IPV Referral	*Hawke's Bay DHB*		0%	100%	0%	100%
	National Mean		75%	94%	78%	70%

14

Service		2014	2015	2016	2017	2018
Sexual Health						
IPV Assessment	Hawke's Bay DHB	N/A	12%	36%	64%	68%
	National Mean		48%	54%	67%	77%
	National Range		0 – 88%	8-96%	43-94%	40-92%
IPV Disclosure	Hawke's Bay DHB		67%	22%	0%	0%
	National Mean		20%	15%	19%	12%
	National Range		0 – 100%	4-33%	0-44%	0-33%
IPV Referral	Hawke's Bay DHB		50%	100%	0%	0%
	National Mean		83%	69%	55%	69%
Alcohol & Drug						
IPV Assessment	Hawke's Bay DHB	N/A	N/A	28%	60%	64%
	National Mean			52%	61%	66%
	National Range			0-100%	0-100%	0-92%
IPV Disclosure	Hawke's Bay DHB			71%	0%	44%
	National Mean			34%	27%	26%
	National Range			0-48%	0-46%	0-44%
IPV Referral	Hawke's Bay DHB			40%	0%	57%
	National Mean			59%	88%	83%
Community Mental Health						
IPV Assessment	Hawke's Bay DHB	**N/A**	N/A	8%	40%	24%
	National Mean			52%	43%	50%
	National Range			0-84%	0-82%	0-90%
IPV Disclosure	Hawke's Bay DHB			100%	10%	9%
	National Mean			24%	28%	27%
	National Range			0-100%	0-50%	0-100%
IPV Referral	Hawke's Bay DHB			0%	100%	100%
	National Mean			64%	87%	76%

*Based on a random sample of 25 charts for each audit period.

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:

16. Minutes of Previous Meeting (Public Excluded)

17. Matters Arising – Review of Actions (Public Excluded)

18. Joint Clinical and Consumer Councils' Workshop Notes

19. Topics of Interest / Member Issues

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).