# Hawke's Bay Clinical Council Meeting

**Date:** **Wednesday, 12 April 2017**

**Meeting:** **3.00 pm to 5.30 pm**

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

**Council Members:**

Chris McKenna
Dr Mark Peterson
Dr John Gommans
David Warrington
Billy Allan
Dr Andy Phillips
Dr Robin Whyman
Lee-Ora Lusis
Jules Arthur
Dr Kiri Bird
Dr Tae Richardson
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod

**Apology:** Dr Mark Peterson

**In Attendance:**
Kate Coley, Executive Director - People & Quality
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator and EA to Executive Director - People & Quality
Graeme Norton, Chair HB Health Consumer Council
Kerri Nuku, Māori Relationship Board Representative

**PUBLIC MEETING**

| Item | Section 1 – Routine | Time (pm) |
|---|---|---|
| 1. | Apologies / Welcome | 3.00 |
| 2. | Interests Register | |
| 3. | Minutes of Previous Meeting | |
| 4. | Matters Arising – Review Actions | |
| 5. | Clinical Council Workplan | |
| | **Section 2 – Presentation / Discussion** | |
| 6. | Briefing on Wairoa GP Services Presentation – Sharon Mason & TePare Meihana | 3.10 |
| 7. | Establishing Health & Social Care Localities in HB – Tracee TeHuia & Jill Garrett | 3.30 |
| | **Section 3 – Monitoring** | |
| 8. | Te Ara Whakawaiora / Cardiology (national indicator) – Dr John Gommans | 3.40 |
| 9. | Rheumatic Fever Target 2016-17 – Nicky Skerman | 3.55 |
| | **Section 4 – Reporting Committees** | |
| 10. | HB Nursing Midwifery Leadership Council Update and Dashboard – C McKenna | 4.00 |
| 11. | Collaborative Pathways (4 monthly) – Leigh White | 4.05 |
| 12. | HB Radiology Services Committee | 4.10 |
| 13. | HB Laboratory Services Committee – Dr Kiri Bird | 4.15 |
| 14. | Clinical Advisory and Governance Committee (Feb Report) – Dr Tae Richardson | 4.20 |
| | **Section 5 – Quality and Governance** | |
| 15. | Implementation of the HB Clinical Governance Committee Structure - John Gommans, Chris McKenna, Andy Phillips and Russell Wills | 4.25 |
| 16. | Consumer Experience Feedback Results Q2 Presentation – Kate Coley | 4.35 |
| 17. | **Section 6 – Recommendation to Exclude the Public** | |

**PUBLIC EXCLUDED**

| Item | Section 7 – Routine | |
|---|---|---|
| 18. | Minutes of Previous Meeting | 4.45 |
| 19. | Matters Arising - Review Actions | |
| | **Section 8 – For Information / Discussion** | |
| 20. | Havelock North Gastroenteritis Outbreak August 2016 – Kate Coley | 4.50 |
| | **Section 9 – General** | |
| 21. | Topics of Interest – Member Issues / Updates | 5.10 |

**NEXT MEETING - Wednesday, 10 May 2017**

## Interests Register

**13 March 2017**

## Hawke's Bay Clinical Council

| **Name**<br>**Clinical Council Member** | **Interest**<br>**eg Organisation / Close Family Member** | Nature of Interest<br>**eg Role / Relationship** | Core Business<br>**Key Activity of Interest** | **Conflict of Interest**<br>**Yes / No** | **If Yes, Nature of Conflict:**<br>**- Real, potential, perceived**<br>**- Pecuniary / Personal**<br>**- 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 - now 20% owned by Southern Cross Primary Care (a subsidiary | Yes | Low |
| | Royal New Zealand College of General Practitioners | Board member | GP training and standards | Yes | Low |
| | City Medical Napier | Shareholder | Accident and Medical Clinic | Yes | Contract with HBDHB |
| | Daughter employed by HBDHB from November 2015 | Post Graduate Year One | Will not participate in discussions regarding Post Graduates in Community Care | Yes | Low |
| | 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 | 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 |
| | 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) | Immediate Past President and a current Director of IMSANZ | The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand | Yes | Low |
| | Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC) | Member and Chair elect of NZ Committee | RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ | Yes | Low |
| William Allan (Chief Pharmacist) | Pharmaceutical Society of New Zealand | Executive member | Pharmacy advocacy, professional standards and training | Yes | Low |
| | Pharmaceutical Management Agency (PHARMAC) | Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee) | Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML) | Yes | Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget |
| | Executive User Group for eMedicines programme (ITHB/HQSC) | Member (Central Region's representative) | Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines | Yes | Low |
| | Pharmacy Steering Group (MoH) | Member | Provide advice to the Ministry on the utilisation of pharmacists within the health workforce | Yes | Low |
| Jules Arthur (Midwifery Director) | National Midwifery Leaders group | Member | Forum for national midwifery and maternity issues | No | |
| | Central Region Midwifery Leaders report to TAS | Member | Regional approach to services | No | |
| | National Maternal Wellbeing and Child Protection group | Co Chair | To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner. | No | |
| | 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 | |
| Dr Kiri Bird (General Practitioner) | Te Timatanga Ararau Trust (Iron Maori) | Partner (Lee Grace) is a Trustee | Health and Wellbeing | Yes | Low - Contract with HBDHB |
| | Gascoigne Medical Raureka | General Practitioner | General Practice | Yes | Low |
| | Royal NZ College of General Practitioners | Member | Health and Wellbeing | No | |
| | Royal NZ College of General Practitioners | Lead Medical Educator in HB | Health and Wellbeing | No | |
| | Te Ora Board (Maori Doctors) | Deputy Chair | Health and Wellbeing | No | |
| | Te Akoranga a Maui (Maori chapter for RNZCGP) | Member | Health and Wellbeing | 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 Quality Advisory Committee) | Loco Ltd | Shareholding Director | Private business | No | |
| | Dr Bryn Jones employee of MoH | Husband | Role with Ministry of Health as Chief Advisor in Sector Capability and | Yes | Low |

| **Name**<br>**Clinical Council Member** | **Interest**<br>**eg Organisation / Close Family Member** | Nature of Interest<br>**eg Role / Relationship** | Core Business<br>**Key Activity of Interest** | **Conflict of Interest**<br>**Yes / No** | **If Yes, Nature of Conflict:**<br>**- Real, potential, perceived**<br>**- Pecuniary / Personal**<br>**- Describe relationship of Interest to** |
|---|---|---|---|---|---|
| | Clinical Quality Advisory Committee (CQAC) for Health HB | Member | Report on CQAC meetings to Council | No | |
| | HQSC / Ministry of Health's Patient Experience Survey Governance Group | Member as GP representative | | No | |
| | Life Education Trust Hawke's Bay | Trustee | | No | |
| | Dr Bryn Jones employee of MoH | Husband | Deputy Chief Strategy & Policy Officer (Acting) | No | |
| | Pacific Chapter of Royal NZ College of GPs | Secretary | | No | |
| Andrew Phillips (Director Allied Health HBDHB) | Nil | Not Applicable | Not Applicable | No | Nil |
| Dr David Rodgers (GP) | Tamatea Medical Centre | General Practitioner | Private business | Yes | Low. Provides services in primary care |
| | Tamatea Medical Centre | Wife Beth McElrea, also a GP (we job share) | Private business | Yes | Low. Provides services in primary care |
| | City Medical | Director and Shareholder | Medical Centre | Yes | Low. Provides services in primary care |
| | NZ Police | Medical Officer for Hawke's Bay | Provider of services for the NZ Police | No | |
| | Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board | Collaborative Clinical Pathways development | Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus). | No | |
| | Advanced Care Planning | Steering Group member | Health and Wellbeing | No | |
| | Urgent Care Alliance | Group member | Health and Wellbeing | Yes | Low. Ensure position declared when discussing issues around the development of urgent care services. |
| | National Advisory Committee of the RNZCGPs | Member | Health and Wellbeing | No | |
| | Health Hawke's Bay (PHO) | Medical Advisor - Sector Development | Health and Wellbeing | Yes | Low. Ensure position declared when discussing issues in this area relating to the PHO. |
| Debs Higgins (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 |
| | HBDHB employee Mary Wills | Spouse | Employee | 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 | |

**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, 8 MARCH 2017 AT 3.00 PM**

**PUBLIC**

**Present:**
Chris McKenna (Chair)
Dr Mark Peterson (Co-Chair)
Dr Kiri Bird
Dr John Gommans
Dr Russell Wills
Dr Robin Whyman
Dr David Rodgers
Dr Tae Richardson
Andy Phillips (from 3.25 pm)
Debs Higgins
William Allan
David Warrington
Lee-Ora Lusis

**In Attendance**:
Ken Foote, Company Secretary
Kate Coley, Executive Director – People & Quality (EDP&Q)
Dr Kevin Snee, Chief Executive Officer
Graeme Norton, Chair HB Health Consumer Council
Tracy Fricker, Clinical Council Administrator and EA to EDP&Q

**Apologies:** Dr John Gommans and Anne McLeod

## SECTION 1: ROUTINE

### 1. WELCOME AND APOLOGIES

Chris McKenna (Chair) welcomed everyone to the meeting. Lee-Ora Lusis is now a confirmed as a member of the Clinical Council following approval from the Boards.

Apologies were noted as above.

### 2. INTERESTS REGISTER

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

Dr David Rodgers advised a change to his interests. Lee-Ora Lusis has provided her interests which are to be included in the interests register.

***Action: Interest register to be updated for David Rodgers and Lee-Ora Lusis.***

### 3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 8 February 2017, were confirmed as a correct record of the meeting.

Moved and carried.

## 4. MATTERS ARISING, ACTIONS AND PROGRESS

**Item 1:** **Clinical Council Annual Work Plan 2016/17**
On today's agenda item #6.

**Item 2:** ***Clinical Governance and Committee Structures***
On today's agenda item #8.

**Item 3:** ***Palliative Care and Advanced Care Workshop***
On today's agenda item #7.

**Item 4:** **Interest Register**
Changes received and updated on register. *Item can now be closed.*

**Item 5:** **13-17 Year Old Primary Care Zero Rated Subsidy Framework**
Dr Russell Wills advised that he spoke with Associate Professor Simon Denny at the Centre for Youth Health who has provided him with information/evaluation tools, which he has forwarded to Jill Garrett and Patrick Le Geyt. *Item can now be closed.*

## 5. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers.

Ken Foote, Company Secretary reminded members to advise Brenda Crene, Board Administrator whether they will be attending the Health Sector Leadership Forum on 15 March.

## 6. REVIEW PROGRESS ON ANNUAL PLAN 2016/17 OBJECTIVES

The Chair advised that a small working group had met and developed the objectives. These were presented several months ago and it was agreed that we would discuss the 2016/17 objectives at this meeting to ensure they are right. The Chair advised at a recent meeting with the Board Chair and CEO, feedback received was that they are happy with the work of the Clinical Council, content at meetings and reports received. What the Clinical Council currently does meets governance needs.

The Chair posed the question do we have the objectives right for us, are we maximising clinical input on decision papers?

Following discussion, key points noted:

- Reword bullet point "support a review of the primary health care model of care" – remove the word "review" e.g. support/consider options for changes to the primary health model of care
- Need to be deliberate on what we focus on and that it is consistent with the overall strategy
- Need visibility on work occurring at the PHO
- Discussion on membership of Clinical Council, suggestion to add a community pharmacist. Clinical Council can make recommendations to the Chief Executive Officer on changes to the terms of reference. Need to think about the value of having a community pharmacist will add, which the Chief Pharmacist does not already provide, is it going to be an addition or in lieu of, there are already 16 members, how big do you want to grow, and what other groups are not currently represented around the table
- Would like to see a total workforce plan, as a governance group how can we maintain an oversight of this?
- Need more of a focus on abolishing health inequities and how we work in partnership with the Maori Relationship Board (MRB). Noting that a member of MRB is invited to Clinical Council meetings, discussion confirmed that MRB does have a direct advisory to the Board.

***Action:*** ***Request an update from primary care on where they are with the development of the model of care.***

## SECTION 2: FOR DISCUSSION AND INFORMATION

### 7. HB PALLIATIVE CARE STRATEGY

The Chair welcomed Mary Wills, Strategic Services Manager to the meeting and took the opportunity to thank her for everything she has brought to the Clinical Council since its inception in 2010, Mary is leaving the DHB to work for Presbyterian Support Services.

Mary Wills advised that since the last time the strategy was presented to Clinical Council a number of workshops with primary care and meetings with key stakeholders and consumers in Takapau and Central Hawke's Bay have occurred. There is also a meeting to be held in Wairoa by the end of March. Following feedback received so far, changes to the document include:

- Changing the name to emphasise early intervention and 'living well"
- A clearer focus on equity
- Describing the role of primary care and the relationship with specialist services
- The implementation plan will use the feedback from consumers and rural areas to inform the detailed work plan

Stakeholders have advised they would like timelines for implementation and more detail on how actions will be implemented and funded. This will be determined by the national palliative care strategy, the healthy ageing strategy and budget announcements in May.

Discussion held around the outcomes measures, these will measure the success of the strategy. Mary Wills advised that nationally there is not an outcomes framework for palliative care. This will need further discussion outside of this meeting.

The Clinical Council noted the amendments to the plan following the workshops and stakeholder meetings and **approved** the plan.

***Action:*** ***Further discussion to be had around outcome measures.***

### 8. CLINICAL COMMITTTEES REVIEW

Kate Coley, Executive Director – People and Quality advised that we want to progress this review as it is a key piece of work from a clinical governance perspective to support the Clinical Council. Today we need to look at the draft Terms of References (TOR) and Chairs for the Committees. There is still a piece of work on implementation of the clinical committee structure, communication, reporting templates, information flow up and down and administration support for the clinical committees and advisory groups. The intent is to have the clinical committees and advisory groups up and running by the end of May.

**Feedback on draft TOR (appendix 2):**

- Good to have directorates involved
- Midwifery is missing from some groups
- Need to be mindful of membership size
- Midwifery Director suggested the Midwifery Governance Group sit under the Patient Safety & Risk Management Committee – this will be reviewed
- The Chief Pharmacist suggested the Pharmacy & Therapeutics Committee (PTC) would sit better under the Patient Safety & Risk Management Committee, as the PTC remit includes medication events – this will be reviewed

- Having a Co-chair for staff growth / development opportunity for clinical leaders, young talent coming through, particularly after review in 12/12 months' time
- Functions are narrow at the moment, each group will need to shape their TOR
- To determine a mechanism to incorporate consumer members in the top five clinical committees.

**Feedback on Proposed Chairs:**

Discussion held on the proposed Chairs, with the following changes identified as well as proposing inclusion of a Deputy Chair for each committee:

| Clinical Committee | Proposed Chair | Proposed Deputy |
|---|---|---|
| Professional Standards and Performance Committee | John Gommans | Mark Peterson |
| Clinical Effectiveness & Audit Committee | Andrew Phillips | Tae Richardson |
| Patient Safety & Risk Management | Russell Wills | Chris McKenna |
| Patient Experience | Kate Coley | ? Consumer Rep |
| Information Management | David Rodgers | David Warrington |

The Clinical Council **endorsed** the proposed terms of references for the five Clinical Committees and the proposed Chairs / Deputy Chairs with the above feedback. The key responsibilities of members for the clinical committees and advisory groups and the next steps were **noted**.

## 9. TRAVEL PLAN UPDATE

The Chair welcomed Andrea Beattie (Property & Service Contracts Manager) to the meeting to provide an update on the GoWell Travel Plan.

***Key points:***

- Parking – remarking of car parks complete, installation of pay and display machines, signage, additional car pool parks and parking maps developed
- Parking back-end processes – policy developed, communications roll out to staff and community, face to face meetings with services and community groups, processing large volumes of applications for permits and exemptions and guaranteed ride home scheme established
- HBDHB Car Park Officer appointed and will start on 13 March
- Launch day 1 March – 40 spaces available at 10 am; 30 at 12.30 pm and 30 at 3 pm. On 6 March, 70 spaces were available at 10 am. Noticeable number of staff parking on streets around hospital
- Good feedback received from consumers on site and via social media on ability to find a car park
- Cycling – new secure lock up in place early March, shower facilities identified for active commuters
- Bus – extension of patient bus travel from 1 January has seen an increase in use
- Park and ride – investigations underway around a potential park and ride concept

The Clinical Council and CEO congratulated Andrea on the superb work undertaken on this project and also acknowledged Sharon Mason, Chief Operating Officer for overseeing it. The Clinical Council endorses and supports this initiative to free up car parks for our patients and their families.

### 10. DRAFT ANNUAL PLAN 2017/18

The Chair welcomed Tracee Te Huia (General Manager, Maori Health) and Carina Burgess (Head of Planning) to the meeting.

Tracee Te Huia advised that the report is clear that they would like the Clinical Council to note the contents of the draft annual plan, timeline and process and to provide feedback on the document.

***Feedback:***

- Good document, easy to follow
- Page 68 typo under expected benefits column – first sentence word "reduced" should be "improved health outcomes…"
- Discussion on KPIs for vulnerable children, family violence screening and staff training
- Would like to see aggregation of some the KPIs, looking at outcomes
- Page 5 – interpretation of 3. should read "…pregnant women and those with children up to 2 years of age"

Further feedback can be sent to Carina Burgess. A final draft of the Annual Plan will come back to Clinical Council at the end of May.

## SECTION 3: MONITORING

### 11. TE ARA WHAKAWAIORA / BREASTFEEDING (LOCAL INDICATOR)

The report was taken as read with no discussion.

## SECTION 4: REPORTING COMMITTEES

### 12. MATERNITY CLINICAL GOVERNANCE GROUP UPDATE

Jules Arthur provided a brief update on the report. The report is a small portion on what is reported to the Ministry and has been the same for quite some time. She would welcome feedback on what would be meaningful for the Clinical Council, is there anything different you would like included in this report.

Two successes to note:

- The official opening of the Waioha, which has now been open for 7 months. Consumer feedback has been positive
- The Napier Maternity Resource Centre has now been open for 3 years and there has been a marked difference of women engaging with the service early, 85% of women are approaching the centre in their first trimester of pregnancy. A hub has been created and it is also used as an assessment area for midwives.

***Action:*** ***Feedback on report content to be sent to Jules Arthur.***

### 13. FALLS MINIMISATION COMMITTEE UPDATE

The report was taken as read with no discussion.

### 14. CLINICAL ADVISORY & GOVERNANCE COMMITTEE

The report was not available for the meeting. Tae Richardson will ensure report is sent through for the next meeting papers.

**15. RECOMMENDATION TO EXCLUDE THE PUBLIC**

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

16. Minutes of Previous Meeting (Public Excluded)
17. Matters Arising – Review of Actions (Public Excluded) - Nil
17. Maintaining the Radiology Service to Primary & Secondary Care (draft)
18. High Level Budget Review Presentation
19. Support for Pacing Service
20. Member Topics of Interest

The meeting closed at 4.55 pm

Confirmed: _____
Chair

Date: _____

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

| Action No | Date issue raised | Action to be Taken | By Whom | By When | Status |
|---|---|---|---|---|---|
| 1 | 08/03/17 | ***Interest Register***<br>Note change for David Rodgers and new interests to be added for Lee-Ora Lusis. | Admin | Mar | Actioned. |
| 2 | 08/03/17 | ***Clinical Council Annual Plan 2016/17 Objectives***<br>Request an update from primary care on development of the model of care. | Co-Chairs | Mar | |
| 3 | 08/03/17 | ***HB Palliative Care Strategy***<br>Further discussion required re: outcome measures. | ? | ? | |
| 4 | 08/03/17 | ***Maternity Clinical Governance Group Update***<br>Provide feedback (if any) on report content to Jules Arthur. | All | Apr | |

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OURHEALTH HAWKE'S BAY Whakawateatia

## HB CLINICAL COUNCIL WORKPLAN 2016-2017

| Meeting Dates | Papers and Topics | Lead(s) |
|---|---|---|
| **10 May 17** | 3pm start, reverted to an ordinary meeting in the Boardroom | |
| | Laboratory Testing Guidelines | Andy Phillips |
| | ICU Learnings Report – Action Plan update (qtly) | Kate Coley |
| | Health Literacy Update | Kate Coley |
| | Values and Culture Business Case | Kate Coley |
| | People Strategy (2016-2021) | Kate Coley |
| | Legislative Compliance | Kate Coley |
| | Best Start Healthy Eating Plan *yearly review" for information | Tracee TeHuia / Shari |
| | Clinical Services Plan Presentation | Tracee/Tim/Carina/Sapare |
| | Final Draft Annual Plan 2017 | Carina Burgess |
| | ***Monitoring*** | |
| | HB Clinical Research Committee Update (6 monthly) | John Gommans |
| | Infection Control Committee (6 monthly) | Chris McKenna |
| | Clinical Advisory & Governance Committee | Tae Richardson |
| **14 Jun 17** | Youth Health Strategy Update for information | Nicky Skerman |
| | Consumer Experience Results (March, **June**, Sept, Dec) | Kate Coley |
| | Quality Accounts (draft) | Kate Coley |
| | Renal Services Review | Sharon Mason |
| | Social Inclusion | Tracee TeHuia |
| | ***Monitoring*** | |
| | Te Ara Whakawaiora / Oral Health (national indicator) | Robin Whyman |
| | Clinical Advisory & Governance Committee | Tae Richardson |
| **12 July 17** | Quality Accounts (draft) | Kate Coley |
| | Laboratory Service Committee | Kiri BIrd |
| | Radiology Services Committee | Mark Peterson |
| | Clinical Advisory & Governance Committee | Tae Richardson |
| **9 Aug 17** | **Annual Meeting 1.00pm start including lunch at 12.30pm Venue : TBA** | |
| | ICU Learnings Report – Action Plan update (qtly) | Kate Coley |
| | People Strategy Final | Kate Coley |
| | Quality Annual Plan review 16/17 | Kate Coley |
| | Collaborative Clinical Pathways | Mark / Leigh White |
| | Clinical Advisory & Governance Committee | Tae Richardson |
| **6 Sept 17** | **HB Health Sector Leadership Forum – venue East Pier, Napier** | |

| Meeting Dates | Papers and Topics | Lead(s) |
|---|---|---|
| **13 Sep 17** | Orthopaedic Review – phase 3 draft | Andy Phillips |
| | Quality Accounts Final | Kate Coley |
| | Quality Annual Plan 2017/18 year | Kate Coley |
| | Consumer Experience Results (March, **June**, Sept, Dec) | Kate Coley |
| | Havelock North Gastroenteritis 6 monthly review against plan | Kate Coley |
| | Serious Adverse Events draft (p/excl) | Kate Coley |
| | ***Monitoring*** | |
| | Te Ara Whakawaiora / Healthy Weight Strategy TBC | Patrick LeGeyt / Shari |
| | Falls minimisation Committee | Chris McKenna |
| | Maternity Clinical Governance Group | Chris McKenna |
| | Clinical Advisory & Governance Committee | Tae Richardson |
| **11 Oct 17** | People Strategy Quarterly report | Kate Coley |
| | Health and Social Care Localities | Tracee TeHuia |
| | ***Monitoring*** | |
| | Laboratory Service Committee | Kiri Bird |
| | Radiology Services Committee | Mark Peterson |
| | HB Nursing Midwifery Leadership Council Update & Dashboard 6mthly | Chris McKenna |
| | Clinical Advisory & Governance Committee | Tae Richardson |
| **8 Nov 17** | Travel Plan Update (May – Aug) | Andrea Beattie |
| | Tobacco Annual Update against plan | Tracee TeHuia |
| | ICU Learnings Report – Action Plan update (qtly) | Kate Coley |
| | ***Monitoring*** | |
| | HB Clinical Research Committee Update | John Gommans |
| | Te Ara Whakawaiora / Smoking TBC | Patrick LeGeyt / Penny |
| | Clinical Advisory & Governance Committee | Tae Richardson |
| **6 Dec 17** | Consumer Experience Results Qtly (Dec – Mar 18) | Kate Coley |
| | Clinical Pathways Committee | Mark Peterson / Leigh |
| | ***Monitoring*** | |
| | Clinical Advisory & Governance Committee | Tae Richardson |

OURHEALTH
HAWKE'S BAY
Whakawateatia

# BRIEFING ON WAIROA GP SERVICES

| | |
|---|---|
| OURHEALTH HAWKE'S BAY Whakawateatia | **Update on Establishing Health and Social Care Localities in Hawke's Bay** |
| | For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council** |
| Document Owner: | Tracee Te Huia ( Executive Director of Strategy and Health Improvement) |
| Document Author: | Jill Garrett (Primary Care Strategic Services Manager) |
| Reviewed by: | Paul Malan (Acting General Strategic Services Manager); Te Pare Meihana (Change Leader Wairoa Locality) and Executive Management Team |
| Month: | April 2017 |
| Consideration: | For Information |

**RECOMMENDATION**

**That the Māori Relationship Board, Clinical and Consumer Councils:**

1. Note the contents of this report.

## PROGRESS TO DATE ON LOCALITY DEVELOPMENT

Work is underway to establish Health and Social Care Localities in Central Hawke's Bay and Wairoa. The work in both localities is progressing well, and each are well placed to embed the initiatives that are currently underway and those being scoped. The Change Leadership roles are proving effective in growing the locality stakeholder membership, trust in the processes that are being followed and building effective relationships across the sector providers, both in health and the wider social sector.

Each locality has worked within a co-design, consumer driven approach. Projects have begun that address priority areas identified within health needs assessment, equity reporting and consumer consultation findings.

The range of initiatives are diverse within each of the localities. Where appropriate, direct links are made to contributing to existing DHB initiatives that are focused on rationalising the use of resources.

The benefits of attending the NUKA training in November last year is evident in the momentum that is growing within each of the localities. The confidence in where the process can lead and the autonomy of design is intrinsic to the NUKA model.

### Strategic Leadership Established

In both Wairoa and Central Hawke's Bay, a DHB-sponsored Change Leader role has been established and they have the confidence of their multiple and diverse stakeholder groups.

The Change Leaders have worked within existing networks to establish and or strengthen provider networks, which have included both the health sector and wider social and local government agencies.

Confidence in their abilities in relationship management, project management and as change agents who can effectively manage the challenges that the locality work presents, is evident in the progress to date that has been made in each locality.

**Activities and Progress in each Locality:**

**CENTRAL HAWKE'S BAY (CHB)**

The Strategic Plan developed by the CHB Health Liaison Group (HLG) has provided a good foundation for prioritising ideas that present to the group on health reform for the area. The four areas aligns current work to the following mission statements of the locality:

- Reducing barriers to access
- Establishing and maintaining effective communication lines
- Facilitating a dynamic workforce
- Strengthening trust between providers

Locality strength continues to grow through the trust that is building amongst the local providers and HLG members. The HLG are working under a collective impact model (see Appendix 1 for an overview). Assessment against the model illustrates strength in Governance and Infrastructure. More work needs to be done in Community Involvement and Evaluation and Improvement before they can be confident in moving towards phase 2 – impact and action.

The HLG are working towards developing principles, similar to those of NUKA that reinforce the branding logo of "Living Well in CHB". The focus will be building an expectation of what wellness looks like at home, in the workplace, in the community and recovering and managing your own health in times of acute illness

**CHB initiatives currently underway are:**

- Contributions to 'Saving 4000 bed days'**:** the Change Leader is brokering the process by which transitioning of care to CHB is activated based on agreed levels of acuity. The model is proactive rather than only activated when Hastings Hospital is in crisis. Evidence is being gathered to monitor bed utilisation rates as well as looking ahead to readmission rates. The thinking behind this is patients managed closer to home will have:
    - increased confidence in self-management;
    - fewer acute episodes; and
    - lower readmission rates.

- CHB Workforce Wellness Package. This involves working with Silver Fern Farms, Workforce NZ, The DHB Health Promotion team and Central Health to design and implement a wellness package of care that would reinforce "Living Well in Central Hawke's Bay" brand. It would be informed by successful work place models currently in operation in other large employers in the wider Hawke's Bay district.

- Communication and signage using the DHB "Choose Well" branding. Currently the Change Leader is working through issues specific to the locality. Adequate signage has been a request of the community for some time in relation to access to urgent care and after hours care.

- Broadening the membership of the Health Liaison Group. Membership now includes representation from the GPs of Tukituki Medical. Pharmacy have also signaled interest in being part of the group. Current membership includes: Local Government – Deputy Mayor, Consumer Council, MRB, Māori Health Provider, CHB Health Centre Operations Manager, Mayoral leadership forum, Aged Residential Care, CHB Māori Iwi representative, Nursing leadership, PHO and DHB.

**CHB initiatives currently being scoped;**

- A whānau wellness model, focusing on 10 whānau to demonstrate how to improve health collaboration and connected care across providers (moving towards a whānau ora approach

and the eventual utilisation/support of shared care record)

- Using ideas from the NUKA model to improve consumer voice in the design and evaluation of current service provision, "Consumer Circles" are being set up to provide context on current issues brought to the attention of the HLG. The first was palliative care. The second will be access to primary care.



**WAIROA**

The Locality Leadership team is formed and has a wide membership representative of the community approach to this development. The structure of the locality framework includes information and design teams' in the following;

- Consumer/whanau – are involved as partners in co-design processes using a NUKA system approach. Wairoa stakeholders who attended the NUKA training agreed to the benefits adopting this system of change to support the development of the locality as the way forward to improving health and social outcomes for the community.
- Clinical Governance – responsible for developing and monitoring implementation of clinical pathways of care
- Whānau Oranga – responsible for establishing an integrated model for addressing social issues within whānau using the Tairawhiti children's team Director as an advisor to the process.
- Pakeke – responsible for ensuring any design processes include marae, hapū and iwi, provide tikanga oversight to the developments.
- Rangatahi – responsible for concept testing any design changes from a rangatahi perspective. Feed in to the developments and oversee decision making processes to ensure the rangatahi voice has been heard.
- Integration staffing forums – will be provided with regular communications and ability to support work streams and provide feedback to any developments as they are occurring.

**Wairoa activities currently underway are:**

- An initial co-design workshop to understand the collective journey towards improving community and whānau outcomes in Wairoa has been held. Outcomes of the day included a vision statement and set of values and a draft set of community outcomes linked to the health and social care aspects for the Wairoa community. Next steps to be confirmed.
- A proposal to create a single general practice is currently being considered by the DHB and if this is approved will provide a new beginning for primary care in Wairoa. A single practice provides a platform to address many of the challenges smaller practices currently face and the Model of Care will be further explored as a priority project of the locality work streams.
- The Change Leader is currently working with Kahungunu Executive on three main areas – integration opportunities internally and across its three business units, implementation of a single point of entry for Whānau Ora, organisational culture development and contracts and reporting review.
- Wairoa continues to build on local integration and collaborative activities as well as progress more strategic developments under the Health and Social Care framework.

The locality has progressed the following:

- The co-location of services on the Health Centre site. Including Māori healing services and other natural therapies.
- A close working relationship between the three general practices and the two year general practice alliance contract with Health Hawkes Bay.
- The inter-sectoral E Tu Wairoa Family Violence Network.
- Establishing professional roles that work across primary care and interface with secondary care

e.g. Rural Nurse Specialist, Clinical Pharmacy Facilitator and Social Worker

- Planning to align district nursing with primary care
- Integrated diabetes management between primary and community services
- Integrated Clinical Governance committee.

**Wairoa initiatives currently being scoped:**

- Links have been made with the asset mapping process undertaken by Victoria University for Ngati Pahauwera
- Review of the Health Needs Assessment Report and aligning its recommendations with the strategic plan of the locality
- A briefing paper and business model to be prepared for EMT/Board re scoping of the single general practice model that has been reworked.
- Relationships forged with Social Investment Initiatives - Tairawhiti Children's Team and MSD Leadership

## EMERGING CHALLENGES

The work in both of the localities is progressing well, and each are well placed to embed the initiatives that are currently underway and those being scoped. Some emerging challenges include:

- Creating natural synergies between district wide and local strategies without compromising the principles and objectives of both. i.e formal mechanisms that link REDS[1] and SIS[2] with the Change Leaders in each locality.
- The role of the Change Leaders in intrinsically linking and influencing strategic plans and models at a district level without compromising individual strategies being developed at a local level.
- CHB have chosen Collective Impact (see Appendix 1) as its change methodology, however Wairoa will have different priorities. No one methodology should be used to drive the strategy of each locality. The selection and inclusion of what fits each will be key in maintaining local ownership of the process whilst achieving district wide outcomes.
- Building the confidence in the process requires dedicated resource. This is currently being identified as projects are developed. Formalising the process of resource allocation will be required in the future through new investment.
- "Back bone functions" (planning, contracting, analysis, reporting, etc.) are needed to support the work as it develops. Establishment of these functions will assist in avoiding duplication of resources, however a degree of autonomy is needed to create local ownership of outcomes.
- The quality assurance and research and development functions that will need to be in place to ensure best practice must be supported throughout the locality development and sustained over time.

[1] Regional Economic Development Strategy

[2] Social Inclusion Strategy

**STRATEGIC DEVELOPMENT OF HAWKES BAY LOCALITIES:**

In looking beyond CHB and Wairoa, three key questions have emerged that will require significant discussion and resolution before the wider strategy is developed and implemented further. These questions are:

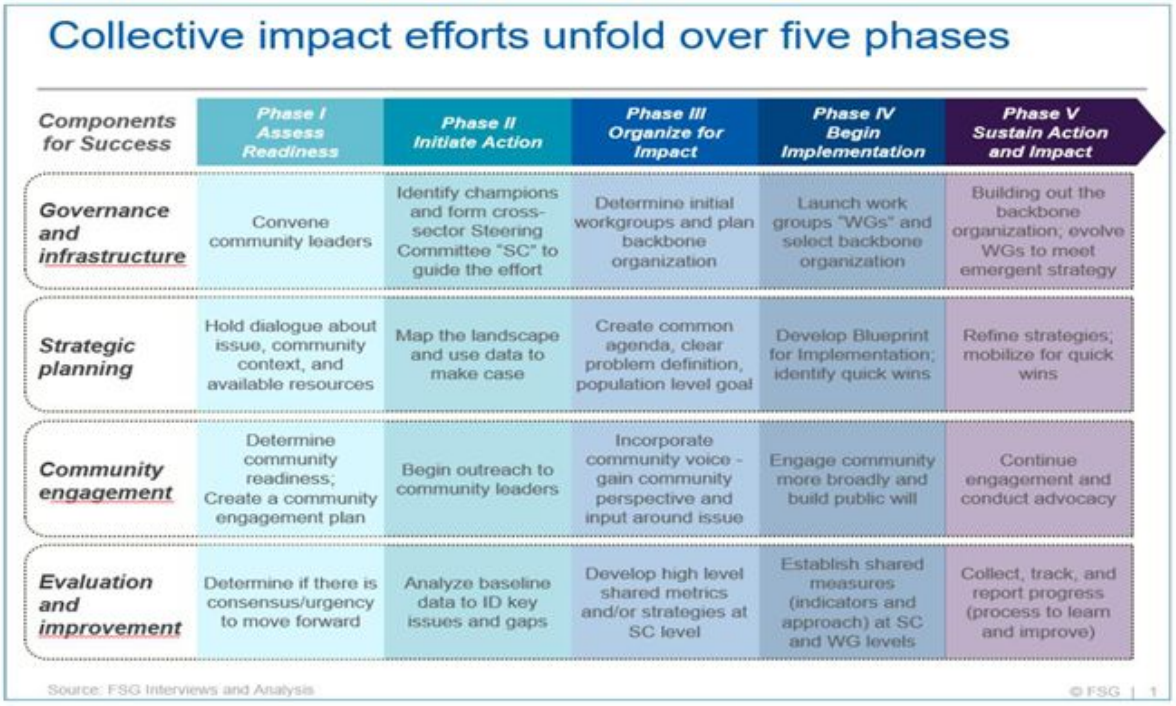
- Is health best placed to act as the lead agency in the development of health and social care localities?
- What are the mechanisms that will ensure the success of the locality work both district wide and locally?
- What form will research and development take and how will it be supported?

Answers to these questions will only be obtained through working with our community partners and other agencies in a collaborative way, and by identifying and implementing resources and processes that will enable the desired outcomes to be achieved. Answering them will also require a style of leadership that encourages bold thinking, tough conversations and experimentation. Evaluation and quality assurance will need to reflect this by looking for the planned and unplanned outcomes of the locality work. A balance therefore will need to be reached in identifying outcomes (success indicators) that both reassure and challenge the work that is being done in this space.

**APPENDIX 1: THE COLLECTIVE IMPACT MODEL**

The roles and responsibilities that fall out of a collective impact model – to support the work on the ground are outlined in diagram 1.0 below.

Diagram 1.0 – The Four Tiers of Collective Impact




At varying stages throughout both the locality development and the development of individual projects within each locality differing levels of input from a variety of roles will be required.

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|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Te Ara Whakawaiora: Report from the Target Champion for Cardiovascular Disease** |
| | For the attention of: **Maori Relationship Board, HB Clinical Council and HB Health Consumer Council** |
| Document Owner: | John Gommans, Chief Medical Officer |
| Document Author(s): | Paula Jones (Service Director) and Gay Brown (CNM Cardiology Services) |
| Reviewed by: | Health Service Leadership Team & Executive Management Team |
| Month: | April, 2017 |
| Consideration: | For Information |

**RECOMMENDATION**

**That MRB, Clinical and Consumer Councils:**

Note the contents of this report.

## OVERVIEW

This report is from Dr John Gommans CMDO-Hospital and champion for the acute 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.<br>• Total number (%) with complete data on ACS forms | 70% of high risk<br><br>>95% of ACS patients | John Gommans | April 2016 |

There continues to be positive result with the HBDHB and all DHBs within the central region meeting these target indicators.

## WHY IS THIS INDICATOR IMPORTANT?

Acute coronary syndromes are an important cause of mortality and morbidity in patients admitted to hospital, which can be modified by appropriate and prompt intervention including urgent angiography (within 3 days) for those identified as at high risk.

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 system for data collection. HBDHB commenced using the ANZACS-QI system in September 2013. The DHBs actively monitor these two indicators of concern.

## REGISTRY DATA COLLECTION INDICATOR

**Regional Data** – up to Quarter 2, 2016/17

% of all patients presenting with ACS who undergo coronary angiography and have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

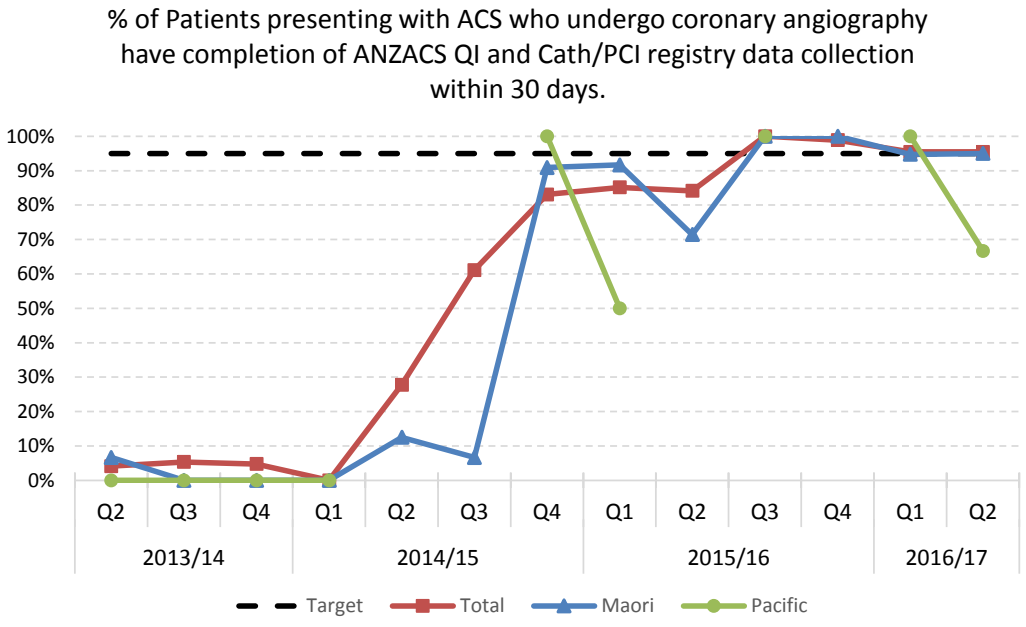
Registry Completion Quarterly Report - Jan 2017

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 | |
| 2015/2016 Q1 (Jun 2015 - Aug 2015) | 68/68 (100.0%) | 74/74 (100.0%) | 47/47 (100.0%) | 66/68 (97.1%) | 64/66 (97.0%) | 16/16 (100.0%) | 21/21 (100.0%) | 708/727 (97.4%) | 407/414 (98.3%) | 356/360 (98.9%) | 497/542 (91.7%) | 1968/2043 (96.3%) |
| 2015/2016 Q2 (Sep 2015 - Nov 2015) | 82/83 (98.8%) | 83/83 (100.0%) | 52/52 (100.0%) | 52/53 (98.1%) | 59/69 (85.5%) | 16/16 (100.0%) | 24/24 (100.0%) | 691/712 (97.1%) | 394/399 (98.7%) | 368/380 (96.8%) | 533/543 (98.2%) | 1986/2034 (97.6%) |
| 2015/2016 Q3 (Dec 2015 - Feb 2016) | 75/75 (100.0%) | 82/82 (100.0%) | 43/43 (100.0%) | 81/81 (100.0%) | 66/66 (100.0%) | 15/15 (100.0%) | 33/33 (100.0%) | 735/751 (97.9%) | 427/436 (97.9%) | 395/395 (100.0%) | 495/500 (99.0%) | 2052/2082 (98.6%) |
| 2015/2016 Q4 (Mar 2016 - May 2016) | 104/105 (99.0%) | 88/89 (98.9%) | 40/40 (100.0%) | 61/61 (100.0%) | 44/44 (100.0%) | 23/23 (100.0%) | 22/22 (100.0%) | 703/732 (96.0%) | 434/442 (98.2%) | 382/384 (99.5%) | 518/531 (97.6%) | 2037/2089 (97.5%) |
| 2016/2017 Q1 (Jun 2016 - Aug 2016) | 82/82 (100.0%) | 84/88 (95.5%) | 52/53 (98.1%) | 70/72 (97.2%) | 60/65 (92.3%) | 15/15 (100.0%) | 32/33 (97.0%) | 749/776 (96.5%) | 475/492 (96.5%) | 395/408 (96.8%) | 471/483 (97.5%) | 2090/2159 (96.8%) |
| 2016/2017 Q2 (Sep 2016 - Nov 2016) | 102/103 (99.0%) | 84/88 (95.5%) | 46/46 (100.0%) | 78/78 (100.0%) | 43/55 (78.2%) | 22/22 (100.0%) | 30/31 (96.8%) | 603/719 (83.9%) | 413/538 (76.8%) | 405/423 (95.7%) | 513/562 (91.3%) | 1934/2242 (86.3%) |

Quarter containing the date of admission signifying the start of each episode of care; Number (%) with both complete Cath Lab and ACS forms (Target is >95%); Denominator: Cath Lab patients with "STEMI<12h" or "other suspected/confirmed ACS" who have coronary angiogram.

**Hawke's Bay Data** – by ethnicity, up to Quarter 2, 2016/17




**Hawke's Bay Data** – by ethnicity, for Quarter 3 (Dec 2016 - Feb 2017)

% of all patients presenting with ACS who undergo coronary angiography and have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

| | Maori | Pacific | Indian | Asian | Eur/Oth |
|---|---|---|---|---|---|
| Hawke's Bay | 12/12 (100.0%) | 2/2 (100.0%) | 0/0 (100.0%) | 0/0 (100.0%) | 60/60 (100.0%) |

**Summary**

There has been significant improvement since interventions to address this target were first put in place in 2015. Satisfactory performance against the indicator has been sustained for the last year with Hawke's Bay meeting the >95% target for Maori and the total population for five consecuitive quarters.

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## ACCESS TO ANGIOGRAMS INDICATOR

**Regional Data** – up to Quarter 2, 2016/17

% of all patients with high risk ACS Who Receive an Angiogram within 3 days of Admission (data upto Quarter 2 20016/17).

Quarterly ANZACS-QI KPI Detailed Report

ANZACS-QI

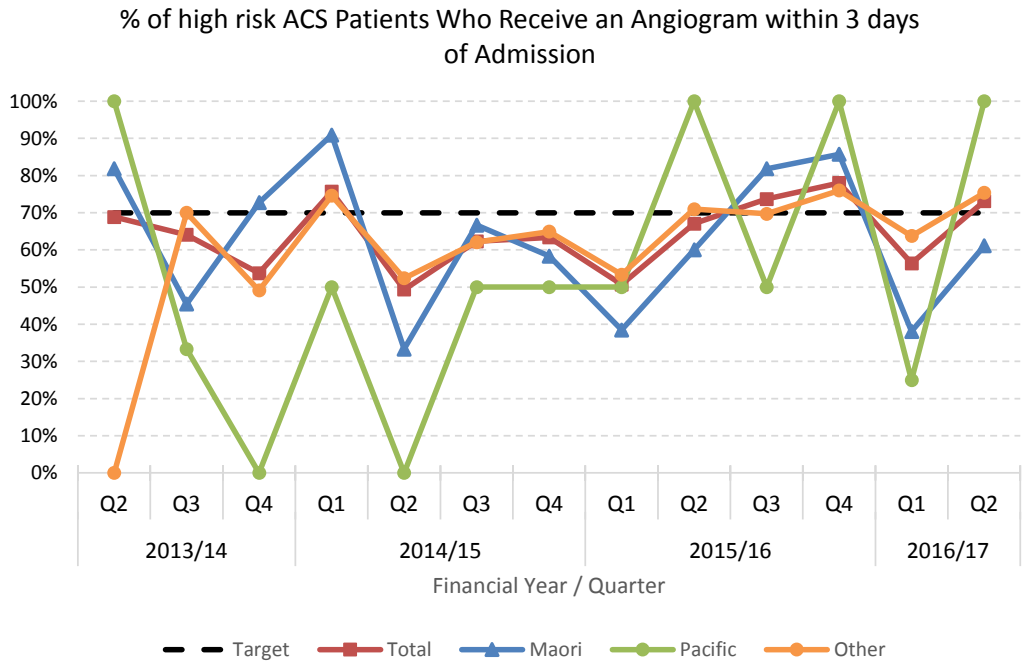
Door to Cath < 3-Days Quarterly KPI Report by DHB - Jan 2017

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 | |
| 2015/2016 Q1 (Jul 2015 - Sep 2015) | 65/73 (89.0%) | 38/76 (50.0%) | 41/51 (80.4%) | 52/69 (75.4%) | 59/67 (88.1%) | 11/19 (57.9%) | 13/21 (61.9%) | 557/707 (78.8%) | 272/408 (66.7%) | 279/376 (74.2%) | 472/557 (84.7%) | 1580/2048 (77.1%) |
| 2015/2016 Q2 (Oct 2015 - Dec 2015) | 76/83 (91.6%) | 57/85 (67.1%) | 32/50 (64.0%) | 46/58 (79.3%) | 62/68 (91.2%) | 11/13 (84.6%) | 14/27 (51.9%) | 628/767 (81.9%) | 284/435 (65.3%) | 298/384 (77.6%) | 440/513 (85.8%) | 1650/2099 (78.6%) |
| 2015/2016 Q3 (Jan 2016 - Mar 2016) | 78/86 (90.7%) | 56/79 (70.9%) | 41/43 (95.3%) | 58/78 (74.4%) | 54/58 (93.1%) | 18/21 (85.7%) | 23/32 (71.9%) | 577/727 (79.4%) | 324/457 (70.9%) | 328/397 (82.6%) | 451/530 (85.1%) | 1680/2111 (79.6%) |
| 2015/2016 Q4 (Apr 2016 - Jun 2016) | 88/98 (89.8%) | 71/91 (78.0%) | 38/46 (82.6%) | 49/59 (83.1%) | 42/43 (97.7%) | 16/21 (76.2%) | 22/30 (73.3%) | 560/725 (77.2%) | 321/435 (73.8%) | 326/388 (84.0%) | 417/504 (82.7%) | 1624/2052 (79.1%) |
| 2016/2017 Q1 (Jul 2016 - Sep 2016) | 82/87 (94.3%) | 53/94 (56.4%) | 33/46 (71.7%) | 56/78 (71.8%) | 72/73 (98.6%) | 13/17 (76.5%) | 16/28 (57.1%) | 601/800 (75.1%) | 385/497 (77.5%) | 325/423 (76.8%) | 456/526 (86.7%) | 1767/2246 (78.7%) |
| 2016/2017 Q2 (Oct 2016 - Dec 2016) | 94/105 (89.5%) | 68/93 (73.1%) | 34/39 (87.2%) | 59/80 (73.8%) | 56/58 (96.6%) | 18/23 (78.3%) | 15/25 (60.0%) | 551/701 (78.6%) | 402/536 (75.0%) | 344/423 (81.3%) | 432/497 (86.9%) | 1729/2157 (80.2%) |

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 Data** – by ethnicity, up to Quarter 2, 2016/17



**Hawke's Bay Data** – by ethnicity, for Quarter 3 (Dec 2016 - Feb 2017)

% of patients with high risk ACS who receive an angiogram within 3 days of admission

| Total | Maori | Pacific | Indian | Asian | Eur/Oth |
|---|---|---|---|---|---|
| 68/93<br>(73%) | 11/18<br>(61.1%) | 2/2<br>(100%) | 1/1<br>(100.0%) | 0/0<br>(0.0%) | 54/72<br>(75%) |

**Summary**

While Hawke's Bay met the overall >70% target for the total population in the second and third quarters of 2016-2017, consistently maintaining compliance and across all ethnic groups is challenging as many of these interventions (about two thirds) are delivered by specialist services based at Wellington Hospital with associated delays for patients admitted to Hawke's Bay Hospital regarding transport and access to regional beds.

For Maori, in the 2016-2017 year, progress is being made with improvement from 40% in Quarter 1 to 61% in Quarter 3, which is still below the 70% target. Due to small numbers there is also wide variation in the results of the non-European ethnicity groups. For Maori in quarter 3, just two cases would have resulted in a >10% improvement in result and achievement of the target.

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

Regarding the Registry Data Collection Indicator; Hawke's Bay has continued its satisfactory performance against this indicator for the last year, consistently meeting the >95% target for both Maori and the total population. The actions that were instituted two years ago will continue and ensure that we sustain this.

Regarding the Access to Angiograms Indicator; Hawke's Bay has struggled to consistently meet this target for both Maori and the total population. Many of these interventions (about two thirds) are delivered by specialist services based at Wellington Hospital with associated delays regarding transport and access to regional beds for Hawke's Bay patients.

Strategies already in place to improve local compliance include an additional local angiography list (now three times per week) and improved communication between CCDHB and HBDHB to support timely transfers of patients. In addition locum Cardiologists have been and will continue to be employed to complete additional angiography sessions.

In 2016 the Regional Cardiology Network membership was revised to include representation from Central Region DHB Service Managers to aid regional planning focus on improving compliance and reinforce the importance of Wellington supporting access from the provincial centres.

For the longer term solution, the Regional Cardiology Network has recommended to the regional CEOs that consideration be given to the implementation of an Interventional Angiography Service on site in Hawke's Bay within 3-4 years. Local provision of this service would remove the current delays awaiting transport to or beds in Wellington.

## RECOMMENDATIONS FROM TARGET CHAMPION

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

| Key Recommendations | Description | Responsible | Timeframe |
|---|---|---|---|
| Access to specialist tertiary service angiography services will be actively monitored. | Delays with transport and/or access to Cardiology Services in Wellington will be actively monitored and escalated to senior management if/when impacting on patient care. | Gay Brown<br>CNS Cardiology | Ongoing |
| A strategic assessment of options for provision of interventional cardiology services to people of Hawke's Bay be done. | That HBDHB undertakes a strategic assessment of options for provision of interventional cardiology services to the people of Hawke's Bay, including the possibility of implementing an on site service at Hawke's Bay Hospital within 3-4 years in line with the regional cardiac network's recommendation and the DHBs Clinical Services Plan to be developed in the coming year. | EMT | 2019 |

## CONCLUSION

There has been a positive and sustained result for the data collection indicator. Challenges remain in meeting the access to angiograms indicator that require ongoing local and regional actions in the short term pending a definitive long-term solution including possible local provision of this service within 3-4 years.

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|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Rheumatic Fever Target 2016-17** |
| | For the attention of:<br>**HB Clinical Council** |
| Document Owner: | Tim Evans, Executive Director Corporate Services |
| Document Author(s): | Nicky Skerman, Population Health Strategist WC&Y, and<br>Dr Rachel Eyre, Medical Officer of Health |
| Reviewed by: | Executive Management Team |
| Month: | March 2017 |
| Consideration: | For Information |



**RECOMMENDATION**

**That HB Clinical Council**

Note the contents of this report.

## OVERVIEW

This paper is to inform Clinical Council that:

1. The HBDHB will not meet the Rheumatic Fever Target for 2016/17
2. The Ministry of Health Rheumatic Fever Programme funding will change from 30 June 2017
3. The Primary Care Say Ahh Throat Swabbing Programme will discontinue in December 2017

### 1. Rheumatic Fever Target 2016-17

The Ministry of Health has informed us that for the 2016 calendar year Hawke's Bay shows four hospitalisations (a rate of 2.5 per 100,000) for first episode Rheumatic Fever. This is an increase of two cases from the 2015 year. However this is an indication of our target achievement only. The actual Ministry of Health / Better Public Service target applies to the financial year and we have two hospitalisations (although in actual four cases have been notified) for the period July to December 2016. This indicates that HBDHB is currently meeting but unlikely to meet the target rate of 1.4 per 100,000 population (2 cases) by the end of June 2017. However, with the wide confidence interval on the target (1-5 cases) we are still likely to meet 'partial achievement' status.

Notably, only one out of five of our most recent cases presented with a sore throat, so were not seen as part of the existing Rheumatic Fever prevention services that focus on throat swabbing. Two cases presented with chorea and two cases presented with sore joints. The Ministry of Health messages "*sore throat get it checked"* are Hawke's Bays Rheumatic Fever Programme's key messages, alongside the healthy homes messages and support programmes.

### *2. Ministry of Health Rheumatic Fever Programme Funding Change from 30 June 2017*

The Ministry has indicated that their funding for Rheumatic Fever will reduce from 30 June 2017. For HBDHB as one of the high incidence DHBs, the Ministry will continue funding of $153,364 for a period of five years from 1 July 2017. In addition, HBDHB has committed approximately

$305,000 per year of its own funds towards Rheumatic Fever prevention. The combined total investment in Rheumatic Fever from July 2017 will therefore be $458,364.
This funding investment has been informed by two evaluations and endorsed by the Rheumatic Fever Governance Group.

We continue to apply and invest in what we know works as a result of evaluations, e.g. both the School Based Throat Swabbing Programme and the Healthy Housing Rheumatic Fever Programme. These programmes will not be failsafe as poverty and the wider determinants of health are challenging conditions to turn around.

***Programmes that will continue to be funded from 1 July 2017***

- Continuation of the Say Ahh Throat Swabbing Programme in Flaxmere with a small increase revenue to cover increased costs. This was last evaluated in 2015 when the programme was considered to be highly effective in preventing new cases of Rheumatic Fever in the target population. This programme will be subject to an evaluation and review in 2018/19.

- The Child Healthy Housing Rheumatic Fever Programme will continue with the addition of a new four year Ministry of Health funded extended housing programme that targets pregnant woman and children 0-5 until 2020. This programme will also be evaluated in 2018/19 by HBDHB alongside a proposed MOH evaluation.

- Awareness raising efforts will need to be sustained post-2017. It is expected that much of this activity will become business as usual.

***3. Primary Care Say Ahh Programme discontinued***

The Primary Care Say Ahh Throat Swabbing Programme will be discontinued when the volumes are met. This is expected to be in December 2017.

This pilot programme was set up in 2015 within general practice with a goal to raising Rheumatic Fever awareness and practice change around throat swabbing. This programme was evaluated in 2016. The practice of throat swabbing and awareness around Rheumatic Fever prevention is expected to continue as business as usual. The PHO will receive some one-off funding in 2017/18 to support this change.

## BACKGROUND

In 2010 HBDHB began a concerted effort to reduce the incidence of Rheumatic Fever in Hawke's Bay with its investment in "Say Ahh", a school-based throat swabbing programme based in Flaxmere. This programme addressed the primordial factors associated with Group A Streptococcal (GAS) transmission. Say Ahh is now in its sixth year and there has been a significant reduction in the incidence of Rheumatic Fever in Hawke's Bay over that period.

In 2015, two new programmes were initiated as part of HBDHB's overall approach to Rheumatic Fever prevention. The "Primary Care Says Ahh", a throat swabbing and treatment programme aimed at high risk children and youth within the primary care setting, and the "Child Healthy Housing" programme, a social work-led intervention aimed at reducing Rheumatic Fever by addressing over-crowding and improving housing suitability/conditions.

In the 2013 Rheumatic Fever Prevention Plan, HBDHB committed to the goal of a two-thirds reduction in acute Rheumatic Fever initial hospitalisations by 2017, to 1.4 initial hospitalisations per 100,000. Last year Hawke's Bay met (and exceeded) our 2015/16 target of 2.0 per 100,000 with the rate of 1.9 per 100,000.

In 2012, the Government announced that Rheumatic Fever prevention would become a priority area as part of the whole-of-government 'Better Public Services' targets, resulting in the development of HBDHB's Rheumatic Fever Prevention Plan (20 October 2013 – 30 June 2017).

At the end of June 2017, the dedicated Ministry-led programme will end and current levels of Government funding for Rheumatic Fever will cease.

Funding will be available for five years to 2021/22 to "high incidence" DHBs (including Hawke's Bay) with a review in 2018/19 to assess whether funding will continue post 2021/22.

## MOST SUCCESSFUL ACTIVITIES



- In 2015 an evaluation of the Say Ahh school based programme was deemed to be "highly effective" in preventing new cases of Rheumatic Fever in the target population
- A defining feature of Say Ahh is the commitment to quality which underpins the programme (focus on training, systems around treatment and compliance, nurses working under standing orders, overall tight operational management, etc)
- Another key feature is that from the very beginning of Say Ahh, the identification and treatment aspects of the programme were linked with primordial prevention strategies, through the automatic referral of children with positive GAS results to the healthy homes programme (social work led)
- Building relationships and gaining support from other sectors has also been a key strength of Hawke's Bay's Rheumatic Fever prevention work, such as; working with WINZ to ensure families are receiving their correct proper entitlements, working with schools to disseminate key messages and working with Housing New Zealand to improve conditions in HNZC houses.

## CURRENT PICTURE

A key focus of 2016/17 has been the development of a strategic, coordinated approach to raising awareness and communications across the whole region with the development of a strategic plan and implementation plan for awareness raising of Rheumatic Fever prevention 2016-18.

- Governance arrangements were set up in 2016. This is provided by the Healthy Homes Governance Group with a wider intersectoral membership from December 2016. The Say Ahh Steering Group has provided an operational level of coordination, planning, information sharing and monitoring of clinical quality and its ongoing role will be reviewed.

- We have formally evaluated the complete sore throat management service to prioritise Hawke's Bays Rheumatic Fever services prior to the Ministry-led Rheumatic Fever Prevention Programme ending 30 June 2017.

Components of this review include:

- Hawkes Bay Healthy Housing Programme : Evaluation report December 2016: Dr Julia Scott Public Health Registrar HBDHB
- Hawkes Bay Sore Throat Management Services Evaluation : Rapid response clinics and youth pilot December 2016: Dr Janine Stevens Public Health Physician (external)

The Say Ahh programme has included a healthy homes/social work model from the very commencement of the programme. Since October 2016, the Ministry has expanded the Healthy Home initiative for a further four years. There has been an extended scope of the existing Rheumatic Fever Prevention Programme and Healthy Home Initiative to include a focus that is broader than the original objective of preventing Rheumatic Fever. The focus of the new contract is on warm, dry, healthy housing for 0-5 year olds.

## RHEUMATIC FEVER CASES 2016/17

The table below provides a summary of our most recent cases.

| Cases since 1 July 2016 to 16 Feb 2017 | Sore throat 4 weeks prior to presentation | 'Say Ahh' Throat swabbing school | Residence | Other comments |
|---|---|---|---|---|
| Case 1 | No | Yes | Flaxmere | |
| Case 2 | No | No, | Taradale | |
| Case 3 | No | No | Flaxmere | Young adult (23) |
| Case 4 | No | Yes | Flaxmere | |
| Case 5 | Yes | No | Havelock North | Young adult (18) |

In summary, none of the above cases represent 'programme failure' per se. Expert opinion has been sought about the increased visibility of these more challenging cases. It is anticipated that as we are able to prevent the more typical cases we will be left with the more complex cases to prevent. This could also represent increased health practitioner awareness about Rheumatic Fever in general, leading to the diagnosis of cases that in the past might have been missed.

### CONCLUSION

Hawke's Bay is seeing an increase in Rheumatic Fever cases compared to last year. However, at this low number with a wide confidence interval we will still likely reach "partial achievement" for the Ministry of Health and Better Public Health Service Target.

This trend of seeing cases with increased complexity and more young adults is one that is being investigated nationally to determine whether this represents a genuine national trend or not, as overall Rheumatic Fever rates decline. This trend should not be considered a "programme failure" per se but probably means that we have done well to target school aged children with the focus on sore throats matter. More nuanced approaches may be needed to address the more complex cases, for example, through improved primary care awareness of other at-risk age groups and presenting symptoms.

In the meantime we will continue to focus and invest in what we know works in Hawke's Bay. This includes; continuation of the targeted school based 'Say Ahh' sore throat swabbing, raising community awareness and significant investment in the child health housing initiative.

| | |
|---|---|
| OURHEALTH HAWKE'S BAY Whakawateatia | **Hawke's Bay Nursing & Midwifery Leadership Council Update** |
| | For the attention of: **Hawke's Bay Clinical Council** |
| Document Owner: | David Warrington, Chair HBNMLC |
| Reviewed by: | Chris McKenna, Chief Nursing Officer |
| Month: | April 2017 |
| Consideration: | For Information |



**RECOMMENDATION**

**That Clinical Council:**

Note the contents of this report.

## MEMBERSHIP

A number of HBNMLC members are well over their 2 year tenure. A full audit of members and tenure will be undertaken over the next few months and new members appointed accordingly. This review will also take in account the Nurse Director Roles for Maori and Primary.

## HB NURSING AND MIDWIFERY DASHBOARD

The Dashboard continues to be a work in progress as it is further developed and refined. The dashboard reflects the Guiding Principles from our Nursing and Midwifery Strategic Plan 2014-2019 and is progressing well with the results for Quarter 2 below (as of March 2017.) Each indicator has just been assigned to a HBNMLC member who are required to champion the indicator and speak to progress at each HBNMLC meeting. **Refer Appendix 1**
Quarter 3 results will be available mid-late April.

## NZNO FIFTH BIENNIAL EMPLOYMENT SURVEY RESULTS

The HBNMLC consider the survey findings an accurate reflection of the current nursing workforce. Support the six key themes:

- Workforce Morale from continued restructuring and change
- Workload and increasing patient acuity
- Better CCDM Visibility
- Access to flexible working options
- Great support of workplace injuries and illness
- Comparative pay and pay progression

The HBNMLC are reviewing these themes and undertaking what actions could be focused on and improve these areas.

**MECA NEGOTIATIONS**

With the current MECA due to end on 31 July 2017 the HBNMLC will provide feedback to NZNO with regards to the negotiations going forward. Specific feedback is likely to be around a MECA that engages the Senior Nurse Workforce.

**INMD 2017**

This year, celebrations will be more of a team/unit/service focus. This decision was made based on the combined feedback received from various nursing & midwifery groups. The evening function / awards will continue to be celebrated as a bi-annual event. Discussed possible barriers and will be revising the nomination process and form prior to the next event in 2018. The HBNMLC will continue to profile the dashboard and our high performing nurses & midwives each year.

# Nursing and Midwifery Dashboard

Quarter 2 2016-17

Updated 22nd March 2017

HAWKE'S BAY District Health Board Whakawāteatia

**Business Performance and Intelligence**

Click on Actual to date result to view more information

| Indicator | | | Prior Period Result | Period target | Actual to date | Trend and Result to target | Time Period Current Data | Owner of Indicator |
|---|---|---|---|---|---|---|---|---|
| Investing in Staff & Changing Culture (Smart System) | Increase Professional Development and Recognition Programme (PDRP) Participation | Hospital | 418 | - | 410 | ▼ | as at Feb 17 | Sally/Kay |
| | | Primary, Aged Care, NGO | 63 | - | 63 | — | as at Feb 17 | Michele/Kay |
| | Increase Midwives on Quality Leadership programme (QLP) Participation | Permanent Midwife Engagement | | - | 75% | — | as at Nov 15 | Jules |
| | | Competent | 23 | - | 23 | — | as at Dec 16 | |
| | | Proficient | 13 | - | 11 | ▼ | as at Dec 16 | |
| | | Leadership | 22 | - | 23 | ▲ | as at Dec 16 | |
| | Reduce average age of rural nursing workforce | HBDHB | | ≤ 45 | 47 | — | as at Dec 15 | Sonya |
| | | CHB | | ≤ 45 | 52 | ▼ | as at Dec 15 | |
| | | Wairoa | | ≤ 46 | 53 | ▼ | as at Dec 15 | |
| | Increase graduate nurses and midwife numbers | | 10.1% | - | 10.7% | ▲ | as at Aug 16 | Sally/Jules/Maree |
| | Number of graduate midwives | | 3 | 2 per year | 2 | — | as at Aug 16 | |
| | Nurse Entry to Practice (NEtP) Programme | Commenced | 19 | - | 14 | ▼ | as at intake Sep 16 | TBA/Sally/Maree |
| | | Finished | 23 | - | 24 | ▼ | as at intake Sep 16 | |
| | | Retained | 17 | - | 14 | ▼ | as at intake Sep 16 | |
| | New Graduate Mental Health (NESP) | DHB | 5 | - | 5 | ▲ | as at Dec 16 | Peta |
| | | DHB Retained | 2 | - | 0 | — | as at Dec 16 | |
| | | NGO | 1 | - | 1 | — | as at Dec 16 | |
| | | NGO Retained | 1 | - | 0 | — | as at Dec 16 | |
| | HCA Career force Level 3 Training | Enrolled | 33 | - | 38 | ▲ | as at Dec 16 | Sally |
| | | Withdrew | 3 | - | 4 | ▼ | as at Dec 16 | |
| | | Completed | 19 | - | 27 | ▲ | as at Dec 16 | |
| | Mandatory Training Completed | 3 Months | | ≥ 20% | 0.0% | — | as at Feb 17 | Jill |
| | Postgraduate qualifications (via the HWNZ PG nursing funding stream) | | 48 | - | 49 | ▲ | Calendar Year 2016 | Sally |
| Person and Whānau Centred (People Powered Health) | Improve patient experience by supporting reflective practice, peer reviews and learnings from patient stories | Communication | 8.7 | ≥ 8.5 | 8.4 | ▼ | Q1 2016-17 | Chris/Michele |
| | | Partnership | 9 | ≥ 8.5 | 8.4 | ▼ | Q1 2016-17 | |
| | | Coordination | 8.8 | ≥ 8.5 | 8.4 | ▼ | Q1 2016-17 | |
| | | Physical and emotional needs | 9 | ≥ 8.5 | 8.7 | ▲ | Q1 2016-17 | |
| | Maternity Consumer Survey (5 best possible service) | Antenatal Outpatient Service | 4.06 | - | 4.33 | ▲ | Q4: Sep - Nov 16 | Jules/Riz/Sonya |
| | | Antenatal Inpatient Service | 4.09 | - | 4.75 | ▲ | Q4: Sep - Nov 16 | |
| | | Labour & Delivery Service | 4.35 | - | 4.43 | ▲ | Q4: Sep - Nov 16 | |
| | | Postnatal Service | 4.02 | - | 4.21 | ▲ | Q4: Sep - Nov 16 | |
| | Effective contribution to targets | ED 6 Hour Rule | 92.4% | ≥ 95% | 94.7% | ▲ | Q2 2016-17 | David and Chris |
| | | Falls - Risk Assessment Took Place | 95.2% | ≥ 90% | 100.0% | ▲ | Q1 2016-17 | |
| | | Falls - Individualised Care Plan | 90.2% | ≥ 98% | 99.3% | ▲ | Q1 2016-17 | |
| | | Immunisation Coverage at 8 months of age | 95.6% | ≥ 95% | 95.3% | ▼ | 3 months to Dec 16 | |
| | | Hand Hygiene | 86.0% | ≥ 70% | 90.0% | ▲ | Q1: Jan to Mar 16 | |
| | Sick leave | Nursing & Midwifery | 3.0% | - | 3.3% | ▲ | Year end Mar 16 | Kerri |
| | Staff Turnover | Nursing & Midwifery | 9.2% | - | 9.5% | ▲ | Year end Sep 16 | Kerri |
| Financial Flows and Models (Value and High Performance) | Number of Nurses per 100,000 population | Enrolled Nurses | | 61 | 61 | — | as at Feb 16 | Sally |
| | | Nurse Practitioners | | 3 | 6 | ▲ | as at Feb 16 | |
| | | Registered Nurses | | 1,087 | 1,061 | ▼ | as at Feb 16 | |
| | Number of LMC's | | | - | 49 | — | as at May 16 | Jules |
| | Credentialing (Number of nurses credentialed in all 6 nursing skills) | | | - | 22 | — | as at Dec 16 | Sally |
| | Skill mix (RN on DHB/NZNO MECA) | Step 1 | 4.2% | - | 4.3% | ▼ | as at Feb 17 | David |
| | | Step 2 | 6.1% | - | 7.0% | ▲ | as at Feb 17 | |
| | | Step 3 | 4.3% | - | 4.5% | ▲ | as at Feb 17 | |
| | | Step 4 | 4.3% | - | 4.3% | ▼ | as at Feb 17 | |
| | | Step 5 | 81.0% | - | 80.0% | ▼ | as at Feb 17 | |
| Whole of Public Service Delivery (One Team) | Demonstrate activities which improve equity and reduce disparities | DNA | 7.5% | ≤ 7.5% | 6.7% | ▼ | Q2 2016-17 | |
| | | LMC Registration by 12 weeks | 63.7% | ≥ 80.0% | 65.7% | ▲ | Q1 2016-17 | Michele |
| | | Brief advice and Support - Primary | 81.3% | ≥ 90.0% | 80.9% | ▼ | Q1 2016-17 | Michele |
| | | Brief advice and Support - Secondary | 99.1% | ≥ 95.0% | 99.0% | ▼ | Q2 2016-17 | Chris |
| | Recruit and retain Maori and Pacific nurses and midwives to meet population needs | | 11.3% | ≥ 13.8% | 11.5% | ▲ | as at Feb 17 | Aria/Liz |
| | Attendance to Engaging Effectively with Maori training | HBDHB | 78.80% | 100% | 80.7% | ▲ | Q2 2016-17 | Jill/Liz |
| | | Nursing Staff | 82.90% | 100% | 85.4% | ▲ | Q2 2016-17 | |

Legend

- Current period exceed, meets or is within 0.5% of target or previous result
- Current period is below target or previous result by 0.5% to 5%
- Current period is below target or previous result by more than 5%
- Indicator does not have a target

— No change in trend direction

▼ Trend down in the last 3 reporting periods

▲ Trend up in the last 3 reporting periods

| | |
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| HAWKE'S BAY District Health Board Whakawāteatia | collaborative clinical pathways<br>**Collaborative Pathways (CP)** |
| | For the attention of:<br>**HB Clinical Council, HB Health Consumer Council** |
| Document Owner: | Mark Peterson, Chief Medical Officer Primary Care |
| Document Author: | Leigh White, Portfolio Manager Strategic Services |
| Reviewed by: | Jill Garrett (Primary Care, Strategic Service Manager); Paul Malan (Acting Head of Strategic Services Manager) and the Executive Management Team |
| Month: | April 2017 |
| Consideration: | For information |

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**RECOMMENDATION**

**That HB Clinical Council and HB Health Consumer Council**

Note the contents of this report

## EXECUTIVE SUMMARY

The purpose of this overview is to highlight the gains that have been made to date in the work programme of Clinical Pathways (CPs) and to clearly delineate between the three key components of ongoing work:

1. The socialisation and uptake of clinical guidelines.
2. The range of pathways developed and under development
3. The current risks and challenges

The primary purpose of CPs is to provide specific guidance on the sequencing of care steps and the timeline of interventions that will lead to enhanced outcomes. In addition, pathways highlight the collaboration of service provision needed for the person's management. The CPs provide prompts in regard to social care and support, an equity lens to ensure culture and ethnicity are considered and provide a pivotal link in the continuity of care that crosses primary-secondary care boundaries. Collaborative pathways are a critical component to integration, however we are still striving to get the right technical platform to support the programme.

## 1. The socialisation and uptake of clinical pathways.

Currently there are 901 active users of CPs in the Hawkes Bay District. To become an active user; access has been provided, logins verified against use and education and training has been provided. Active users include medical, nursing, pharmacists and allied health staff *(refer to table 1)*. Already we have seen 85 new users enrolled since September 2016.

| Users | Numbers |
|---|---|
| Nurse or Midwife | 369 |
| Student Medical | 1 |
| Personal Social Services | 2 |
| Senior Doctors | 43 |
| Unknown | 108 |
| Administrative Services | 11 |
| General Practitioner | 217 |
| Professional Manager | 37 |
| Emergency Services | 2 |
| Junior Doctors | 5 |
| Pharmacist | 64 |
| Allied health Professionals | 21 |
| Support Services | 16 |

Table 1: Split of active users

The CP Programme has been "on watch" since July 2016. Constant requests for new pathway development have had to be managed carefully so as to promote the current use and efficacy of pathways already in place and prioritise development of future pathways to best reflect the priority areas of the DHB.

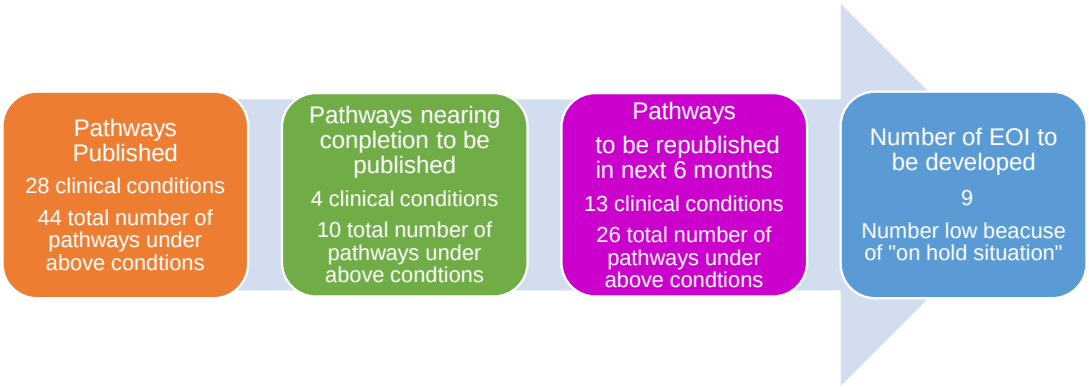


Diagram 1: Pathway development to date and ongoing

The development of CPs is demonstrating their role as an enabler of change in clinical practice and in the integration of care. An example of this has been demonstrated in the integrated primary and secondary care team approach to rectify a short fall in the capacity of radiology to meet current demand. Both sectors have worked towards developing a Musculoskeletal Corticosteroid Pathway that will ensure appropriate referral from primary care to secondary care for triage. This pathway has just been published and we would hope to see a decrease of referrals for this procedure within 6 months.

Our data now depicts use in primary and secondary care. Diagram 2 below shows user activity in the past 90 days. A process was established by the CP Team to give a single login each to AAU and ED and Diagram 2 confirms that CPs are now being accessed in those areas. Single department logins will continue to be implemented in other wards of the hospital. It was also noted in the data that the top 5 pathways accessed in secondary care are: Cellulitis, Asthma (Adult), Asthma (children), Atrial Fibrillation and Heart failure.

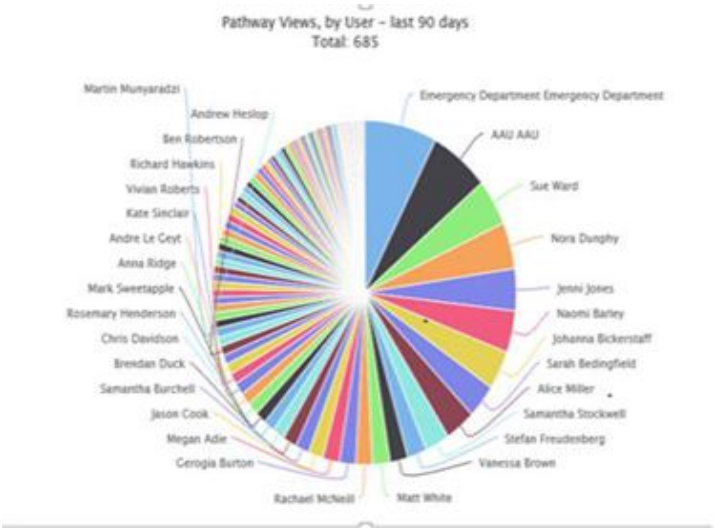


Diagram 2: Pathways views by Users in last 90 days

## 2. The range of pathways developed and under development

New Pathway development aligns to the strategic priorities of the MoH and key focus areas of the DHB.

| Target | Explanation/Example |
|---|---|
| ED 6 hour target | Cellulitis Pathways for Secondary Care has been implemented into ED/MEC February 2017. Feedback to date, has been positive. |
| Elective Services | Review of the Hip/Knee Pathway using the proof of concept being developed by NeXXT[1] will be priority and this work will commence April 11 2017. |
| FCT | Lung, Colorectal have been developed and published; Breast nearing completion for publication; Gynaecology in developmental stages and early discussion in the development of Prostate. |

To date, there is limited international and national research that examines CPs impact on quality of care and health savings ($) but a good example of a CP that demonstrates a difference is as below.

[1] The CP team is undertaking a "proof of concept" with NexXt, commencing April 11 ending 31 October 2017. The cost of the contract is 35K

*In the development of pathways there is always consideration of benefits. For example, the Cellulitis Pathway Adult (published November 2016) recommends oral boosted therapy to be used in practice rather than intravenous antibiotics twice a day. This does not only support best and standardised practice but demonstrates healthcare cost saving and savings for the person who may not need antibiotics and does not need to visit the GP twice a day.*

## 3. The current risks and challenges

**Licence agreements**: The current licensing agreements are due for review and possible renewal.

**Map of Medicine (UK) Contractual agreement:** 30 June 2017

**MoU agreement with Midcentral:** 31 July 2017

As agreed by EMT (10th January 2017) we have contracted with NeXXt, for a proof of concept commencing 11 April 2017. The contract is to develop a dynamic system to use the MoM pathways for adult cellulitis and osteoarthritis of hip and knee to make them much more useable, especially for General Practice. The ideal result will be to both inform any referral process and to create electronic referrals and claiming if appropriate within the pathway and then write back to the patient record in the practice PMS.

Two practices, Taradale Medical Centre and Tamatea Medical Centre, have agreed to be pilot sites to work with Nexxt in the initial development.

The proof of concept will help to inform the decision to renew the MoM licence agreement or to explore other IT support.

**Central Region approach (MidCentral and Whanganui):**

The working relationship with MidCentral is posing some challenges. The HBDHB CP team have the following concerns and are taking appropriate steps to address

- lack of clinical input into central region pathway development
- persistent editorial publishing errors due to inexperienced editors
- turn-over of staff

**Regional Work**

We are experiencing that regional work is often guided by what the larger DHBs require as opposed to what we believe we are offering locally. This has been demonstrated through development of the Hepatitis C pathway. In HB, we have a small high risk population group (approx. 143 people) that has been cared for by secondary care. Primary and secondary clinicians have agreed that our current pathway should continue. Currently, our pathway promotes good relationships between primary and secondary over the managing of this disease and it meets local need, equity, and demographics. However, this does not align to the pathway established regionally that includes use of a regional service provider. As this is a new contract, we would prefer to delay any change to our pathway until the new service is well enough established for us to make an informed decision.

**CONCLUSION**

It must be reiterated that nationally there seems to be a wide variation in the patterns of development, testing, and revision among pathway developers and we in HB are not unique in constantly questioning this programme.

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|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Radiology Services Report** |
| | For the attention of:<br>**HB Clinical Council** |
| Document Owner: | Dr Mark Peterson, CMO Primary Care |
| Month: | April 2017 |
| Consideration: | For Information |



**RECOMMENDATION**

**That HB Clinical Council:**

Note the contents of this report.

The RSC met on 21 March 2017. This was the first meeting for the year and the December meeting had been cancelled as a quorum could not be achieved with the proposed dates.

Somewhat out of the usual order of things the business case for Maintaining the Radiology Service for Primary and Secondary Care was received. This report came to Clinical Council in February and was supported at that time. In the ideal world this would have been reviewed by the RSC prior to it coming to Clinical Council but the timeframes and relative urgency of the case in response to the peer review of the Radiology Service meant this was not possible. The RSC did not suggest any changes.

Implementation of the National Criteria for Access to Community Radiology was discussed. This had been planned to be presented at a Primary Care CME session in April but with the resignation of the HOD radiology this will need to be postponed. Given that these criteria have been endorsed by Clinical Council the radiology department have been encouraged to communicate with the referrer directly if requests are made outside of the guidelines.

There have been issues with appointment times for x-rays, particularly at Napier Health Centre where there is a sole charge radiographer. General Practices have been encouraged to ensure that patients do ring for appointments. This will be taken up at a Practice Managers meeting.

Waiting times for scan were updated. For MRI the wait has reduced from 16 weeks to 8-10 weeks, US from 32 weeks to 10 weeks. The wait for US guided steroid injections is still approximately 12 months but in the next few weeks about half of the referrals will be referred back to GPs suggesting a landmark guided injection be performed. An initial letter has been sent already to GPs but the return of referrals has been delayed until the US guided steroid injection clinical pathway has been published which should be very soon.

There was further discussion about the ability of providers to share images (and reports). This has been discussed before but there was a Sentinel Event last year that was in part related to the inability of providers and clinicians to access all of the US images of a patients pregnancy. There does seem a willingness of all providers to have all images shared but there are still technical issues that need to be overcome and the cost of data storage is also a concern. The new CIO will need to be made aware of the problem.

The committee noted that this would be the last meeting for Dr Andrew West the Acting HOD as he will be returning to the UK in May.

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Laboratory Services Report** |
| | For the attention of:<br>**HB Clinical Council** |
| Document Owner: | Dr Mark Peterson, CMO Primary Care |
| Document Author: | Dr Kiri Bird, Chair Laboratory Services Committee |
| Month: | April 2017 |
| Consideration: | For Information |



**RECOMMENDATION**

**That HB Clinical Council:**

Note the contents of this report.

**New Membership**

The Laboratory Committee welcomed new members to the committee including Shelli Turner (HBDHB Laboratory Manager), Ross Boswell (HBDHB Laboratory Clinical Director), Kay Crozier (Midwife representative) and Sara Selman (Pharmacist, Health HB).

**Laboratory Testing Guidelines**

Background:

*In April 2016, HB Clinical Council were informed of the following:*

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

The laboratory is currently reviewing the Laboratory Testing Guidelines and will present the final draft document to the Clinical Council.

**Urine Pregnancy Tests**

In December 2016, Medsafe reported that investigations have cleared EasyChek pregnancy test kits and no further actions were being undertaken. An evaluation of EasyChek, Innovocan and a third kit were being carried out by the New Zealand Point-of-care Testing Advisory Group, including Hawke's Bay. The Laboratory Committee are awaiting the results of this evaluation before making any final decisions.

**Laboratory Results on Discharge Summary**

It was brought to the attention of the laboratory committee that there appears to be a cutting and pasting of laboratory results from ECA into discharge notes. This practice carries a risk as results may not yet be authorised at that particular time or may be later amended due to sample validity issues, examination issues or being a wrong blood in tube issue.

Laboratory Committee is reviewing this practice and liaising with Information Services team for possible solutions.

**Mark as Read Policy Review**
'The Clinical Management of Test Results Including Electronic Marked as Read Policy – CPG033' needs to be reviewed.

Several issues have been raised with the current process including:

- Clinicians receiving results in ECA for patients that are no longer under their care.
- Outpatient encounters are not closed off so there are a large number of open referrals.
- Some areas (within HBDHB and PHOs) are unable to manage/view electronic reports hence paper reports are being sent by the laboratory. The number of paper reports generated has an impact on laboratory resources. The use of paper reports also carries a risk as no audit trail is available to ensure reports have reached the requestor and if results are amended or later deleted due to quality issues then this may result in the paper report being outdated.

It was noted that the current system needs to improve for all users. The above issues to be investigated with Information Services team. The policy is to be reviewed by the Laboratory Committee.

# Clinical Council Report

Clinical Advisory and Governance Committee

| **Date:** | 14 February 2017 | **Time:** | 5.30pm |
|---|---|---|---|
| **Item** | **Summary** | | |
| **1. Planning** | | | |
| 1.1 HHB Annual Plan Reporting Q4 (Apr-Jun)<br>1.2 IPIF – Q4 report (April-June) | Information paper provided on Q4 activity along with summary of programme tracking across the 2015/6 year.<br>Information paper provided with Q3 IPIF target achievements (Q4 unavailable at time report was written) and update on non-target activity e.g. Foundation Standards. | | |
| **2. Matters Arising & Decision Papers** | | | |
| 2.1 Clinical Event Management<br><br><br><br><br><br>2.2 Brief Update | Appendix D – Suggested clinical incidents to be reported to PHO and considerations for implementation.<br>The appendix has now been updatd to reflect a clear process for sharing event information based on the SAC rating system. Examples of incident have also been provided. This process will be reflected in the algorithms prior to sharing with General Practice and consideration given to how this will be reflected in the HSQC national register.<br>Committee ENDORSED document which is summary of activity since last meeting on specific clinical activities of the DHB and PHO (see below) | | |
| **AREAS OF INTEREST** | | | |
| **3. Looking Ahead for CAG** | Brief discussion on membership and how this needs to look moving forward | | |
| **7. INFORMATION PAPERS** | | | |
| 7.1 Contract Reporting<br>7.1.1 B4SC<br>7.1.2 Mental Health<br>7.1.3 More Heart and Diabetes Checks | Copies of contract reporting submitted to DHB provided as information paper and acknowledged by Committee. | | |
| 5.2 Transform and Sustain | Summary provided on the refresh and where to from here. Key points noted<br>➢ Some lines in the Workstream diagram do not seem to be a PHO alignment. *Response from Kate is that this is on her radar*<br>➢ With such a large number of projects, what are the priorities, what is the expectation that primary care participates? *Response from Tracee: this level of detail sits within the scoping up of the project. The priorities sit with the eleven intentions of Transform and sustain*<br>➢ When and how is this being launched? *Response from Tracee: It will be launched in April and all groups that have been spoken to will get an invitation.* | | |
| 5.3 Acute Kidney Injury Project Update | Sick day guidance – following feedback from the clinician survey a patient sick day guidance sheet has been developed in consultation with Maori Health and clinicians. The CAG committee provided feedback on this document. This will be used during Phase Three. | | |
| 5.4 Medicine Related Falls Risk Assessment Tool (MrFRAT) | The Medicine Related Falls Risk Assessment Tool (MrFRAT) developed by clinical pharmacists Brendan Duck and Peter McIntosh, has been socialised throughout Hawke's Bay Age Related Residential Care (ARRC) Facilities during 2015 and 2016, supported by an ARRC Registered Nurse (RN) guide and Prescriber guide written by Health Hawke's Bay Clinical Advisory Pharmacist, Di Vicary. This screening tool is completed by the ARRC RN during care plan development as well as being reviewed following a fall. Clinician awareness of medicines contributing to falls is increased following a MrFRAT screen and enables strategies to be considered, including reviewing medicines proactively, to minimise the risk. An unexpected positive consequences has been the raised knowledge around a national standard for falls | | |

| | |
|---|---|
| | measurement and increased falls monitoring. The MrFRAT tool has recently been placed onto InterRAI, this will enable the NASC team use as well as by ARRC RNs. MrFRAT has been shared with NHS Scotland via Dr Anne Hendry and an American nursing student who approached Health Hawke's Bay for permission to use it in her postgraduate research. This project is now completed. |
| 5.6 System Level Measures | Draft progress report and verbal update provided. Outlied the key measures and the contributory measures with an overview of the financial allocation attached to each. |
| 5.7 Patient Experience Survey (PES) | Verbal update give outlining progress to date. Initial workshop well attended which highlight a number of concerns within the sector. 6 practces coming on board before July 1st with remainder coming on in a phased approach. |

**Health Hawke's Bay – Te Oranga Hawke's Bay**
**Clinical and Quality Advisory Committee**
**HHB Brief Updates**

| | **Content/Comments** | **Management Lead** |
|---|---|---|
| **Quality** | | |
| System Level Measures | Refer to SLM Progress Report | Victoria Speers |
| Enrolment | High Needs Enrolment Programme<br>Quarter 1 – 81 new enrolments, 60 GP Consults/46 Nurse Consults<br>Quarter 2 – 54 New Enrolments, 43 GP Consults/23 Nurse Consults | |
| Cornerstone | 17/20 Practices accredited<br>2/20 Practices have scheduled accreditation dates for March 2017<br>1/20 Practice aiming for May 2017 | |
| Foundation Standards | 3/8 practices accredited - Met.<br>4/8 practices in progress – On Track<br>1/8 practice not started – HHB have offered to fund an independent resources to support practice to achieve Foundation Standards by 1 July 2017. | |
| Health Hawke's Bay IT Leadership Group | The Health Hawke's Bay IT Leadership Group met for the final time in 2016. Some clear outcomes were gained from the group as to appropriate work streams:<br>• Complete work on a draft data governance framework.<br>• Complete an analysis of providers for a Primary Care shared IT support.<br>• Support from the group for exploring reporting and claiming systems to enhance delivery of programmes and data extraction. | Michele McCarthy |
| Data Governance | A draft data governance paper and options for a framework is nearly finished for presentation to PHOLT. | |
| National Enrolment Service (NES) | Health Hawke's Bay currently has 69 % of their practices on NES. By the end of the February 97% of practices are projected to be on board. This also gives on boarded practices the ability to perform the Primary Care Patient Experience Survey. | |
| Patient Experience Survey (PES) | Health Quality and Safety Commission have completed a roadshow in Hawke's Bay to promote the PES. This session was well attended by General Practice, Primary Care, Health Hawke's Bay and HBDHB.<br>5 General Practices have volunteered to undertake the PES before 1 July, which will give Health Hawke's Bay a clear chance to evaluate its delivery. The remainde3r of practices will come on-board following July 1 2017. | |
| **Clinical Programmes and Team updates** | | |
| Mental Health | Continuing stakeholder engagement, with a meeting to be held on 16 February 2017 to finalise the future model of care. | Trish Freer |
| Palliative Care | Paper accepted by the Board in December 2016. We are in discussions with the DHB regarding submitting as a business case for future sustainable funding. | |
| B4SC | HHB have met all quarterly targets from October to December 2016.<br>As at the end of December The Raising Healthy Kids target was at 52%, expected to rise over the next few months to meet the 95% target by December 2017. | |

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| | Four in-service dates have been set for this year – topics to be advised. | |
| Diabetes | Working collaboratively with the DHB trialling the new service matrix assessment with Greendale Medical Centre under the Long Term Conditions Strategy. | |
| Long Term Conditions | Nine Long Term Condition (Stanford model) courses were held from October to December 2016. Three of these courses were specifically Diabetes courses run through Hastings Health Centre and Te Mata Peak Practice. A Diabetes seminar was held afterward where all participants were invited to attend. The seminar had a Diabetes nurse, dietician and podiatrist as speakers. The other six courses were held in high needs communities, marae, churches and Māori Health providers. Two of these courses were delivered to the Tuvaluan Pacific Island community in their own language by Tuvaluan trained facilitators.<br>• Total number registered 106<br>• Total number who completed the course 74<br>• Māori who completed the course 14<br>• Pacific Island who completed the course25 | |
| Whānau Wellness | Access to the programme ceased for cohort 1 on the 21st December 2016 post attendance at the final education quarterly sessions.<br>***Recruitment of 2017 cohort:***<br>▪ Health Hawke's Bay encouraged and supported general practices to identify and recruit potential families for the programme<br>▪ Some practices chose not to participate in the programme<br>▪ At least 1 whānau member attended a Welcome Session to successfully gain access to the programme<br>***2017 Cohort Demographic data***<br>▪ 802 individuals have signed up to participate in the programme from 1 January – 31 December 2017, of this:<br>- 62% are Māori<br>- 30% are Pacific<br>- 8% are of other ethnicities living in NZ Deprivation 9-10 (Quintile 5)<br>- 68% of the new cohort are over the age of 13yrs of age<br>▪ 59% of the cohort are residents of Hastings, of this 36% live in Flaxmere<br>▪ 28% live in Napier<br>▪ 8% live in Wairoa s<br>▪ 3% live in Havelock North<br>▪ 2% live in rural Hastings i.e. Waimarama and Central Hawke's Bay<br>These families have access to the programme from 1 January – 31 December 2017 | Lillian Ward |
| Health Literacy | ***HL online training modules:***<br>• Thirty-six people have enrolled in the course from 10 organisations.<br>• Twenty-five individuals have completed the training and achieved a pass grade. The remaining 11 individuals are at varying stages of completion. | |

| | | |
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| | • Local organisations represented are Tamatea Medical, HHB, HBDHB, The Doctors Hastings, and Enliven<br>Organisations from outside HB are Whaiorangi Trust a Tauranga-based Māori Health and Social Services Provider, Hutt Valley DHB, Nelson Bays PHO, Auckland DHB and Nelson-Marlborough DHB.<br><br>***HL Strategic Campaign:***<br>Project manager recruited. Initial engagement and project scoping has commenced alongside leaders from three communities – Whakatu, Anderson Park and Maraenui – with each community taking a unique and innovative approach to building health literacy locally.<br><br>An independent Kaupapa Māori action researcher and topic experts have been engaged in initial discussions around involvement in the projects. Roles will be solidified and service agreements placed next reporting period. | |
| Social Workers in VLCA practices | *Health Hawke's Bay funds a total of 5.5 fulltime equivalent positions within general practices* as follows:<br>- Hastings Health Centre x 1 FTE (Non VLCA provider)<br>- The Doctors Napier x 1 FTE – Recruiting to this position during Q3 (Non VLCA provider)<br>- Totara Health x 1 FTE (VLCA provider)<br>- The Doctors Hastings (non VLCA provider) & Gascoigne Medical (VLCA Provider) x 0.5<br>- Hauora Heretaunga x 0.5 FTE (VLCA provider)<br>- Tamatea Medical, Carlyle Medical x 0.5 FTE (Non VLCA providers)<br>- Maraenui Medical Centre x 0.5 FTE (VLCA provider)<br>- Wairoa Alliance x 0.5 FTE (3 x VLCA practices)<br>- Social Work Mentor/Support x 0.5 FTE (Social work mentoring/support across all providers)<br><br>***Narrative:*** *As the recruitment and orientation processes within general practices have been staggered over the past reporting period Health Hawke's Bay confirms that SW resource target population is those High Need Populations who are participants in the following HHB funded SIA programme:*<br>- *Whānau Wellness Resource Programme*<br>- *Multidisciplinary Services/Nurse Clinics*<br>- *Primary Care/Emergency Department Cooperative*<br><br>*Note; 1 x VLCA provider opted not to utilise Social Work support services for their HN population* | |
| Workforce Development | • Analyse and feedback on GP and Practice Nurse surveys<br>• Develop practice administration survey<br>• Develop strategic workforce plan | Bobbie Cameron |
| **Steering Group or Expert Advisory Group Feedback** | | |
| B4 School Check | CAG meeting held 2 December 2016 at 8am | Trish Freer |
| Palliative Care | Steering group is due to meet on 20 February 2017. | Trish Freer |
| Whānau Wellness | | Lillian Ward |
| **Health Hawke's Bay Staff Directory** | | |
| For further information on any of the above information please contact the indicated management lead or author: | | |

| | | |
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| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Implementation of the Hawke's Bay Clinical Governance Committee Structure** |
| | For the attention of: **HB Clinical Council** |
| Document Owner:<br>Document Author(s): | Chris McKenna, Andy Philips, John Gommans, Mark Peterson, Russell Wills<br>Kate Coley |
| Reviewed by: | Chris McKenna, Ken Foote, Andy Phillips, John Gommans, Mark Peterson and Russell Wills |
| Month: | April, 2017 |
| Consideration: | For Discussion and endorsement |

15

**RECOMMENDATION**

**That the HB Clinical Council:**

- **Endorse** the proposed Advisory Group Structure.(Appendix 1)
- **Endorse** the proposed Chairs (where identified)
- **Note** Clinical Council Chairs will identify appropriate clinical leads for Advisory Groups without an identified Chair
- **Note** the next steps

## Purpose

The purpose of this paper is to outline the next steps for the full implementation of the clinical governance structure including confirmation of the Advisory Group structure reporting through to the Clinical Council Committees.

***Clinical Governance***

Clinical Governance is defined as:

"*the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks and fostering an environment of excellence in care for consumers, patients, community*"

An effective system of clinical governance at all levels of the health system is essential to ensure continuous improvement in the safety and quality of care, Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to promote a culture of reporting and support improvement.

The HBDHB has established the Clinical Council as 'the principal clinical governance, leadership and advisory group for the Hawkes Bay health system. The Clinical Committees and Advisory Groups described in this paper form the structural components of this clinical governance system.

## The HB Health System Clinical Governance Structure

At its March 2017 meeting, Clinical Council endorsed the new clinical governance structure for the Hawkes Bay health system, identified the Clinical Committees, and agreed their Terms of reference, their chairs and deputy chairs. The five clinical committees will meet quarterly and receive a report from each of the Advisory Groups. On a planned basis or as significant issues arise each committee will provide the Clinical Council with a written report summarising issues, activities, lessons learned and improvements identified and implemented by these groups. The purpose of these reports is to ensure that the Clinical Council can provide assurance that all patient safety and clinical quality matters are being managed appropriately and that there is a focus on learning and continuous improvement.

The five clinical committees:

- ***Professional Standards and Performance Committee*** – to provide assurance that all essential requirements relating to credentialing, professional standards, clinical training and research are actively promoted and maintained
    - Proposed Chair/Deputy Chair: - Chief Medical & Dental Officer (CM&DO)/ Nurse Director (Medical) (Acting)

- ***Clinical Effectiveness & Audit Committee*** – to provide assurance that quality clinical practice is delivered by all publicly funded health service, diagnostic, pharmaceutical and therapeutic providers.
    - Proposed Chair/Deputy Chair – Chief Allied Health Professions Officer (CAHPO) /GP Representative

- ***Patient Safety & Risk Management*** – to provide assurance that all matters relating to patient safety and clinical risk are effectively monitored and managed
    - Proposed Chair/Deputy Chair --- Medical Director, QIPS/Chief Nursing & Midwifery Officer (CN&MO)

- ***Patient Experience –*** to jointly develop and recommend strategies, systems, policies, processes and actions that will contribute to the continuous improvement of patient's experience within the HB health system
    - Proposed Chair/Deputy Chair ---- TBC/Consumer Representative

- ***Information Management*** – to provide advice and clinical advocacy for the provision of appropriate ICT systems, processes and data, to aid effective clinical decision making and the provision of quality care.
    - Proposed Chair/Deputy Chair – GP Representative/Nurse Director (Medical) (Acting)

## Advisory Groups

As agreed at the March 2017 meeting the proposed Chairs and Deputy Chairs have reviewed and confirmed the advisory group structure. The following outlines the perspectives of those chairs and a full structure chart can be found in Appendix 1.

The below table outlines the proposed advisory groups and the proposed Chairs as advised by the committee chairs:

| | **Advisory Group** | **Proposed Chair** |
|---|---|---|
| Professional Standards & Performance Committee | Allied Health Professions Forum | CAHPO |
| | Credentialing: SMO, Nursing, Allied Health | Clinical Director<br>CN&MO<br>CAHPO |
| | Nursing & Midwifery Council | CN&MO |
| | Pre-vocational/RMO Advisory Group | Director, Medical Training |
| | Research | CM&DO |

| | **Advisory Group** | **Proposed Chair** |
|---|---|---|
| | | |
| Patient Safety & Risk Management Committee | Clinical Risk & Events | CM&DO |
| | Falls Harm Minimisation Committee | Nurse Director (Surgical) |
| | Family Violence | Family Violence Intervention Programme Coordinator |
| | Morbidity & Mortality | Medical Director, QIPS |
| | Patient at Risk | HoD, ICU |
| | Restraint Committee | Nurse Director (Older persons, Mental Health) |
| | Maternity Governance Group | Midwifery Director |
| | | |
| Clinical Effectiveness & Audit Committee | System Integration | *TBC (EDSHI)* |
| | Equity | *TBC (EDSHI)* |
| | Laboratory | GP - Kiri Bird |
| | Radiology | Chief Medical Officer, Primary Care (CMO) |
| | Pharmacy & Therapeutics | Chief Pharmacist |
| | Infection Prevention & Control | Infectious Diseases Consultant Physician |
| | Trauma Committee | Consultant Surgeon |
| | Clinical Audit | *TBC* |
| | Clinical Pathways | CMO |
| | | |
| Information Management Committee | Policy | Patient Safety & Clinical Compliance Manager |
| | Privacy | TBD/ Chief Information Officer |
| | Records Management | Education & Development Manager |
| | Forms & Templates | Education & Development Manager |
| | | |
| Patient Experience Committee | N/A | TBD & Consumer Representative |

**Terms of Reference Development**

As with Clinical Council and the Clinical Committees, these Advisory Groups are governance groups that provide advice and recommendations in regards to matters relating to 'quality of care, continuously improving, minimizing risks and fostering an environment of excellence in care for consumers, patients, community'. Each group will perform their tasks within the functions set out in their respective Terms of reference. Whilst there is a shared responsibility and accountability with managers, clinicians and staff' to achieve this, it is intended that the responsibilities of the groups are for good governance, not operational nor line management. The TOR will reflect these principles.

It is proposed that the TOR "Purpose" section would have three parts:

- *Reporting*: To provide assurance to the (insert name of Clinical Committee to which the Advisory Group reports here) in regard to….
- *Communication*: To communicate to the rest of the organisation significant risks discovered and recommended actions, any relevant learnings identified by the Advisory Group, via the Clinical Committee

- *Compliance*: To ensure compliance with statutory requirements e.g., Health and Disability Commissioner's Code of Health and Disability Consumers' Rights, Coroner's Act, Ministry of Health requirements and organisation policies.

The TOR template will be adjusted to reflect these recommendations.

The level of authority of each group will be included in the TOR. As all committees and advisory groups report to Clinical Council, any authority delegated to them is derived from the level of authority held by Council. This currently includes:

- The authority to make decisions and/or provide advice and recommendations to ….
- To make decisions and issue directives on quality clinical practice and patient safety issues that:
  - Relate directly to the functions and aims of Council as set out in the ToR; and
  - Relate directly to the provision of, or access to, HBDHB publicly funded health services; and
  - Are clinically and financially sustainable; and
  - Are affordable within HBDHB's current budgets.

Within the Advisory Group there should be a varied representation from across the sector, operational managers and multi-disciplinary clinical representatives.

It is the responsibility of the Chairs of the Clinical Committees to meet with the chairs of the Advisory Groups and ensure that the TOR are refreshed, the representation on the group is determined and the frequency of meetings and administration support is in place. This work will be completed before the end of June 2017. All TOR for Advisory Groups will be presented to the Clinical Committee for consideration of endorsement. The Clinical Committees will have responsibility to ensure that the Advisory Group TOR are confirmed and representatives identified and provide a report to Clinical Council at the July 2017 meeting.

**Quality Dashboard**

To support the linkage between this clinical governance structure and the operational management a quality dashboard will be developed for consideration by Clinical Council. The intent of this dashboard is to identify a number of core indicators and targets that align to the advisory group and clinical committee's structure which will provide assurance to Clinical Council that the sector is delivering high quality and safe patient care. For example Hospital Standardised Mortality rate, Number of falls that harm patients etc.

These indicators will be developed through a bottom up approach and strong clinical engagement to ensure that there is both responsibility and accountability for those agreed measures.

There is limited capacity to analyse and interpret data so it is important that we choose indicators for the dashboard wisely. It is suggested that Clinical Committees choose no more than five (5) indicators or targets. In determining the measures it is recommended that the following principles be considered:

The indicators should each have a clear description and rationale, including:

- Indicator or a target – targets are preferred as they are more likely to drive change
- Why it is important – indicators and targets should assess things that matter e.g. prevalent (e.g. family violence) or serious (e.g. SMR)
- What it means (if higher, is this really worse? e.g. more complaints could mean worse care or more accessible complaints system or litigious society)
- Is it a measure of inputs, outputs, process, impacts or outcome? In general, outcome measures preferred because they tend to drive system change.
- Can it be gamed e.g. ED waiting times in the UK

- Is it a measure of whole of system, hospital only, primary care only, ARC, and which matters the most? e.g. ED waiting times are a measure of a whole hospital's ability to process patients efficiently
- How does it link to organizational objectives – you should only measure what you are likely to act upon
- Routinely collected data, rather than requiring new collection
- Valid and reliable
- Disaggregated by ethnicity – equity matters.

**Challenges**

During the establishment of the advisory groups there will be a number of implementation challenges summarised below:

- Improvement should happen – The purpose of Advisory Groups and Clinical Committees is to ensure that lessons are learnt and shared, and that improvement occurs. Systems to ensure these happen will need to be established, e.g. a mechanism to share lessons learnt, recommendations and warnings or change policy, and a mechanism to decide which issues need to be elevated to a formal improvement programme.
- Administration/coordination –adequate secretarial resource will be required to support the effective management and administration of each group and committee, and thegovernance structure as a whole. This will require establishment of a new post responsible for ensuring TOR are maintained, new appointments put in place, reports are prepared, submitted and distributed, coordination of the structure, liaison with Advisory Group and Clinical Committee chairs etc. Funding for this post has not currently been agreed
- Payment structure and necessary budget will need to be effectively managed for non DHB employees
- TOR need to be standardised with some guiding principles and standard operating procedures
- Need to establish an accountability framework in regards to the formal and informal relationships between chairs
- Training & Development requirements for each of the groups

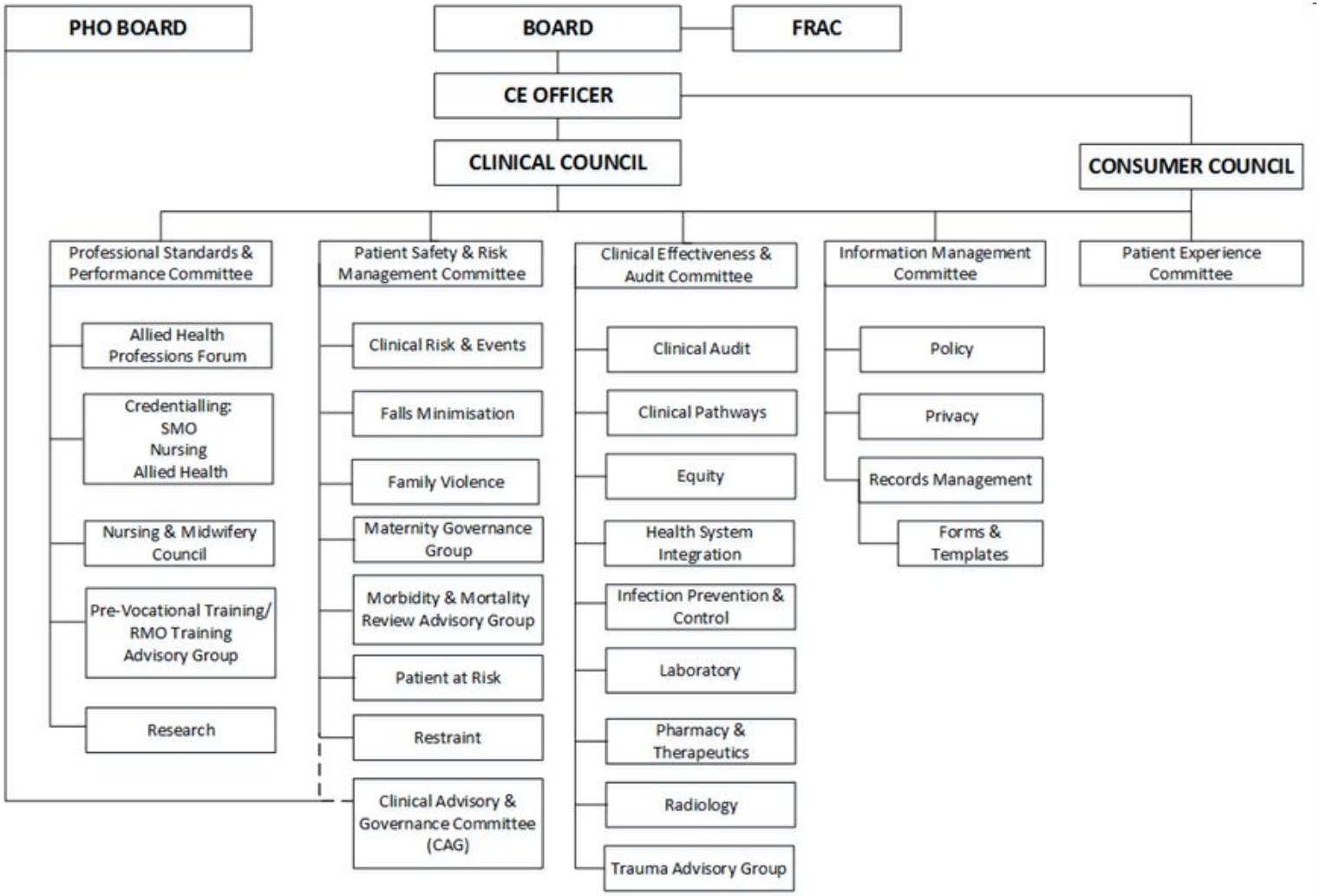


## Next Steps

A high level plan for next steps is presented below.

| Activity | Responsibility | Timeframe |
|---|---|---|
| Resolve current implementation issues and considerations and work with Clinical Council chairs and Chairs of Clinical Committees | EDPQ, Company Secretary | March - June |
| All Committee and Advisory Groups established, Terms of Reference in place, meeting schedule and reporting timeframes established. | Chairs, | End June |
| Development of Dashboard | Chairs, Clinical Committees & Advisory Groups | July |
| Report provided to Clinical Council | Chairs (Clinical Committees) | July |

**APPENDIX 1 – CLINICAL GOVERNANCE COMMITTEE STRUCTURE**



| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Consumer Experience Feedback Quarterly Report** |
| | For the attention of: **HB Clinical Council and HB Health Consumer Council** |
| Document Owner/Author: | Jeanette Rendle, Consumer Engagement Manager |
| Reviewed by: | Kate Coley, Executive Director People & Quality |
| Month: | April 2017 |
| Consideration: | For Information |

**RECOMMENDATION**

**That HB Clinical Council and HB Health Consumer Council:**

Note the contents of the presentation.



**OVERVIEW**

The National Adult inpatient experience quarterly report was shared last month. Comment was received requesting that this information be presented alongside other patient experience measures including the Real Time Survey in Mental Health Services, the Waioha Survey in the Primary Birthing Centre and all feedback received direct to the DHB through the consumer engagement team.

As requested, the information was updated and presented to the Board on 29 March and will be presented to Clinical Council on 12 April and Consumer Council on 13 April.

The presentation includes feedback mechanisms, respondent and demographic details, themes, trends and next steps.

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:

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

**19. Matters Arising – Review of Actions (Public Excluded)**

**20. Havelock North Gastroenteritis Outbreak August 2016**

**21. Member 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).