Hawke's Bay Clinical Council Meeting

Date: **Wednesday, 14 September 2016**

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
Dr Caroline McElnay
Robyn O'Dwyer
Jules Arthur
Dr Kiri Bird
Dr Tae Richardson
Dr David Rodgers
Dr Russell Wills
Debs Higgins
Anne McLeod

Apologies: Drs Robin Whyman; David Rodgers, Caroline McElnay and Andy Phillips

In Attendance:

Ken Foote, Company Secretary
Kaye Lafferty, Patient Safety & Clinical Compliance Manager (on behalf of Kate Coley, Director – QIPS)
Tracy Fricker, Council Administrator and EA to Director QIPS
Graeme Norton, Chair HB Health Consumer Council

PUBLIC MEETING

Item	Section 1 – Routine	Time (pm)
1.	Apologies / Welcome	**3.00**
2.	Interests Register	
3.	Minutes of Previous Meeting Minutes of Annual General Meeting	
4.	Matters Arising – Review Actions	
5.	Clinical Council Workplan	

	Section 2 – For Decision	
6.	Complementary Therapies Policy Report - Complementary Therapies Policy (final draft)	**3.10**
7.	Quality Accounts 2016 Report – Jeanette Rendle (Consumer Engagement Manager) - Quality Accounts 2016 (final draft) - Communication Plan	**3.15**
	Section 3 – For Discussion	
8.	Presentation: Manage My Health Provider Portal – Gina McEwan (IS Manager)	**3.25**
9.	Designated Prescriber – Registered Nurses – Sally Houliston (Nurse Consultant) - Medicines Regulations 2016 - Registered Nurses Prescribing – Fact Sheet	**3.40**
10.	Health & Social Care Networks Update – Belinda Sleight (Project Manager)	**3.55**
	Section 4 – Reporting Committees / Monitoring	
11.	Falls Minimisation Committee Update – Chris McKenna	**4.10**
12.	Maternity Clinical Governance Dashboard – Chris McKenna - Hawke's Bay Maternity Services Annual Report (under separate cover)	**4.05**
13.	Urgent Care Project Update – Graeme Norton (UCA Chair)	**4.15**
14.	Clinical Advisory & Governance (CAG) Committee – Dr Tae Richardson	**4.20**
15.	Laboratory Services Committee Report for information – Dr Kiri Bird	**-**
	Section 5 – For Information only (no presenter)	
16.	Te Ara Whakawaioria / Healthy Weight Strategy	**-**
	Section 6 – General	
17.	Gastro Outbreak Havelock North (Update and Presentation) – Ken Foote - Internal Review Framework	**4.30**
18.	**Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	**Section 7 – Routine**	
19.	Minutes of Previous Meeting	**4.50**
20.	Matters Arising - Review Actions	
	Section 8 – Presentation / Discussion	
21.	Health Awards – Anna Kirk	**4.55**
22.	Serious Adverse Events – Kaye Lafferty (Patient Safety & Clinical Compliance Manager)	**5.10**
23.	Letter received from CAG on Governance Matters	**5.20**
24.	Member Topics of Interest	

NEXT MEETING AGM, Wednesday 12 October 2016, commencing at 3.00 pm in the HBDHB Boardroom

Interests Register

Sep-16

Hawke's Bay Clinical Council

Name Clinical Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	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	Taradale Medical Centre	Shareholder and Director	General Practice - now 20% owned by Southern Cross Primary Care (a subsidiary of	Yes	Low
	Royal New Zealand College of General Practitioners	Board member	GP training and standards	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	Daughter employed by HBDHB from November 2015	Post Graduate Year One	Will not participate in discussions regarding Post Graduates in Community Care	Yes	Low
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that agrees the contract.	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr John Gommans (Chief Medical Officer - Hospital)	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Immediate Past President and a current Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
	Royal Australasian College of Physicians (RACP), Adult Medicine Division Committee (AMDC)	Member and Chair elect of NZ Committee	RACP represents Physicians in all Adult Medicine specialties across Australasia; the NZ AMD representing those based in NZ	Yes	Low
Dr Caroline McElnay (Director Population Health & Health Equity Champion)	NZ College of Public Health Medicine	President until October 2017	NZCPHM represents the interests of Public Health Medicine specialsits in NZ, provides training of registrars, ongoing accrediation of specialists and advocacy on public health matters.	*No*	
	RNZ Plunket Society	National Board member	Provision of heath and social services to children under 5 years, advocacy for children	*No*	

8/09/2016

Name **Clinical Council Member**	**Interest** **eg Organisation / Close Family Member**	**Nature of Interest** **eg Role / Relationship**	**Core Business** **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
William Allan (Chief Pharmacist)	Pharmaceutical Society of New Zealand	Executive member	Pharmacy advocacy, professional standards and training	Yes	Low
	Pharmaceutical Management Agency (PHARMAC)	Member, Tender Medical Subcommittee of PTAC (Pharmacology & Therapeutics Advisory Committee)	Provide advice to PHARMAC on the clinical suitability of tenders for subsidised medicines for inclusion in the Pharmaceutical Schedule and Hospital Medicines List (HML)	Yes	Low. Influences the cost of subsidised medicines to the DHB's combined pharmaceutical budget
	Executive User Group for eMedicines programme (ITHB/HQSC)	Member (Central Region's representative)	Provide leadership and guidance to the HITB and HQSC on the eMedicines (Hospital) programme (electronic prescribing & administration; eMedicines Reconciliation)	Yes	Low
	Pharmacy Steering Group (MoH)	Member	Provide advice to the Ministry on the utilisation of pharmacists within the health workforce	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders group	Member	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	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	
Robyn O'Dwyer (Nurse Practioner Whanau Ora)	Wairoa Health Care Center	Nurse Practitioner	General Practice	No	
	The College of Primary Care Nurses	Member	National submissions/member of nursing leadership	No	

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	The College of Maori Nurses	Member		No	
	New Zealand Scientific Society of Diabetes	Member		No	
David Warrington (Nurse Director - Older Persons)	Havelock North Chiropractic	Wife is Practitioner and Co-owner	Chriopractic care and treatment, primary and preventative	Yes	Low
	Pilates Works	Wife is CE and Co-owner	Rehabilitation, Primary and preventative.	Yes	Low
	National Directors of Mental Health Nursing	Member		No	Low
Dr Tae Richardson (GP and Chair of Clinical Quality 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 Implementation	Yes	Low
	Clinical Quality Advisory Committee (CQAC) for Health HB	Member	Report on CQAC meetings to Council	No	
	HQSC / Ministry of Health's Patient Experience Survey Governance Group	Member as GP representative		No	
	Life Education Trust Hawke's Bay	Trustee		No	
	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
	Directions Youth Health	Wife Beth involved	Assisting youth in HB	No	
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	NZ Police	Medical Officer for Hawke's Bay	Provider of services for the NZ Police	No	
	Health Hawke's Bay (PHO) initially - from 1 July 2015 under HB District Health Board	Collaborative Clinical Pathways development	Was the Champion for the initial work, however on 1 July this moved under the HBDHB umbrella (with a community focus).	No	
	Advanced Care Planning	Steering Group member	Health and Wellbeing	No	
	Urgent Care Alliance	Group member	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues around the development of urgent care services.

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	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)	The Hastings Heatlh Centre	Practice Nurse Family Violence Intervention Coordinator	Delivery of primary health care - General Practice and training of Clinicians in family violence intervention.	No	
	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	LIVE (Local Initiative for Violence Elimination)	Member of management Committee	Network of agencies that provide family violence intervention services.	No	
	Eastern Institute of Technology (EIT)	Lecturer - Nursing	Education.	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					

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE "THE LIBRARY", MISSION ESTATE, CHURCH ROAD, NAPIER ON WEDNESDAY, 10 AUGUST 2016 AT 1.00 PM

PUBLIC

Present:
Dr Mark Peterson (Co-Chair)
Chris McKenna (Co-Chair)
Dr Tae Richardson
Dr David Rodgers
Dr Robin Whyman
Dr Kiri Bird
Debs Higgins
William Allan
David Warrington
Jules Arthur
Anne McLeod
Dr Andy Phillips (2.10 pm)
Dr Malcolm Arnold (3.10 pm)

In Attendance:
Dr Kevin Snee, Chief Executive Officer, Hawke's Bay District Health Board (2.10 pm)
Ken Foote, Company Secretary
Dr Nick Jones, Public Health Specialist *(on behalf of Dr Caroline McElnay)*
Barbara Ryan, Quality Improvement & Innovation Team Leader *(on behalf of Kate Coley, Director Quality Improvement & Patient Safety)*
Graeme Norton, Chair HB Health Consumer Council (2.25 pm)
Kerri Nuku, Māori Relationship Board Member
Dr Russell Wills (Medical Director QIPS)
Tracy Fricker, Council Administrator and EA to DQIPS

Apologies:
Dr John Gommans and Dr Caroline McElnay

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr Mark Peterson (Chair) welcomed everyone to the meeting. Apologies were noted as above. Andy Phillips, Malcolm Arnold and Graeme Norton advised they would be late to the meeting.

The Chair also welcomed Dr Russell Wills (Medical Director QIPS) to the meeting as an invited guest. He will replace Dr Malcolm Arnold as a member on the Clinical Council who is standing down.

2. INTERESTS REGISTER

No conflicts of interests for agenda items.

One new interest received from Debs Higgins post last meeting. This has been added to the register.

David Warrington advised that he has changes to the interest register which he will email to be updated.

Action: Changes to interest register to be actioned when received.

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the meeting held on 13 July 2016, were confirmed as a correct record of the meeting with the following minor changes:

- Page 4 first bullet point under questions/feedback should be "…it is a clinical governance group"
- Page 5 – Renal Stage 4 under questions/feedback last bullet point regarding Ballantyne House name "yes" to be replaced with "unknown".

Moved and carried.

4. MATTERS ARISING, ACTIONS AND PROGRESS

Item 1: **Clinical Council Member Portfolios**
To be discussed as part of the Annual General Meeting item #32.

Item 2: **Alternative Health Provider - Complementary Therapies Policy**
Final draft of policy on agenda for today's meeting item #13.

Item 3: **Health Equity Update**
Copy of presentation sent out with meeting minutes in July. *Item can be closed*.

Item 4: **Meeting Attendance (Quorum for September Meeting)**
Noted. *Item can be closed.*

5. CLINICAL COUNCIL WORK PLAN

The work plan was included in the meeting papers for information.

SECTION 2: PRESENTATION / UPDATES / DISCUSSION

6. OPERATION PRODUCTIVITY PRESENTATION

The Chair welcomed Rika Hentschel (Service Director – Surgical) to the meeting. Also in attendance were Anna Harland (Theatre Manager) and Ben Duffus (Improvement Advisor).

The presentation focused on the background of the project, what the driving forces were behind the initiative, the critical success factors and the next steps.

Key points:

- March 2014 – Elective Productivity Project commenced with key focus on achieving elective surgery targets, looking at barriers and opportunities for improvement
- September 2014 - Theatre Productivity Project (using consultant group FGI) commenced to further implement changes within Theatre environment that would support Electives Productivity
- March 2015 - project re-branded as "Operation Productivity" – started new workstreams and finished outstanding ones and looked at how to integrate the project into "business as usual"
- All the workstreams helped us to reach our elective target
- Staff engagement was paramount to the project's success. Each programme of work has been driven by staff
- Within current resource 431 additional sessions were undertaken between September 2014 and July 2016 (equivalent to 1,724 hours of operating time)

- We are now using 80-87% of theatre capacity
- Establishment of a Theatre Management Committee, robust discussions regarding problems held and agreements made to change
- Shift in culture, gained momentum and staff got on board
- Perseverance with complex projects:
  - pre-admission project – started in 2010, hard to get engagement, no agreement on a system or process. Operation Productivity supported and there is now a clear process for pre-admissions in place for all but two specialties
  - call bell system – automated system now set up in the department to improve flow and reduce telephone calls
- Two evening workshops held to focus on how we can meet the MoH target, having already made steps to maximise internal capacity. These workshops were well attended by clinicians and management and came up with four initiatives:
  1. Extended sessions
  2. Weekend elective lists
  3. Sunday Orthopaedic trauma lists
  4. Outsourcing elective plan

The next step is to close as a project and become business as usual. In future the brand will change to "Operation Production Planning". Goals:

- Short term – continuous improvement on operations
- Medium term – four initiatives from workshops
- Long term – future planning, anticipating demand, clarify about in-house capability

Questions / Feedback:

- What is the impact on RMO workloads for PGY1 & 2 and how is it factored into planning? A business case will include wraparound costs for all staff. Increase of House Officer support for the weekend workload has been approved to help with the weekend discharges.

- How are the medium term initiatives going? Will capacity be increased in-house? The weekend trauma sessions can be started quickly, it is a concept that is used at other DHBs. Extended sessions, need to work through some of the nursing contracts to be able to extend them. The extra weekend elective sessions – we have already been doing some ad-hoc Saturday sessions, not just to meet the elective target but to also meet the fast cancer treatment. A more formal process needs to be set up and resourced properly to ensure the rest of the hospital can cope if we add additional sessions, including Laboratory and Radiology.

- Has any analysis been done on the trauma we are seeing and how we can get rid of some of that trauma? Our trauma rates are consistent with a gradual increase and are no different to other DHBs our size. There is an Injury Prevention Interagency meeting that Population Health participate in and they advocated for the reduction of speeds in the roads around Hastings. There was partial success with that. If we are looking at weekend trauma servicing, one of the most sensible things to do is how can we reduce trauma in the first place.

- In terms of the weekend elective lists are we looking at doing minor procedures so it puts less pressure on the rest of the hospital? Yes, currently under discussion what would make up weekend lists e.g. doing day cases and procedures that require less resourcing.

- A problem that arises is small departments who have limited staffing doing weekend work. This needs to be discussed properly as part of the bigger picture. Turning it into a programme of work will be the next challenge. The progress so far is good to see.

The Clinical Council is supportive of the work being undertaken.

7. COLLABORATIVE CLINICAL PATHWAYS BUSINESS CASE

The Chair welcomed Leigh White (Portfolio Manager – Long Term Conditions) and Mary Wills (Head of Strategic Services) to the meeting.

The Chair advised that the report included in the papers was developed over the last few months as a proposal. After a conversation at a recent GP Conference, the Chair now suggested that we need to look at the clinical pathways we already have before developing more. Clinical Council needs to feedback on the direction we are going given that funding was approved under the prioritisation programme. How can we best use that funding?

Leigh White advised she was employed in September last year to look at Clinical Pathways there was a focus on developing a number of pathways so we could get buy-in if we had more pathways available. One of the difficulties has been the interface with the IT solutions, in particular MedTech and Map of Medicine (MoM). We do now have a single sign-on which means GPs can access directly through MedTech which has been well received in general practice. The next step is to do a stock take of what we are currently doing and look at what we have got and implementation. Leigh has contacted other areas which use the MoM and they are all struggling with the implementation phase and IT interfaces. MoM is an enabler but is only one function to a whole system approach. There are great opportunities for the MOM and integration with eReferrals. eReferrals are working well in general practice but they go into the secondary service and stop at the door. We need to look at the practice in both primary and secondary. Leigh will be contacting Canterbury DHB regarding their use of the tool. Auckland are using a tool called "pathway navigator".

At the moment the clinical pathways are not consumer orientated, we have a node in there that respects Maori, Pacific and ethnicity. We will encourage GPs to use this when they start to use the MoM. We can now access back end monitoring, once all GPs are socialised to use, we can then see who is accessing the maps. To move forward we need to look at the implementation and we need strong clinical leadership in general practice and secondary services.

Mary Wills advised that the focus needs to shift to using and promoting the pathways. How do we do this?

Questions / Feedback:

- Agree we need clinical leadership. Need to target the A&E Centres with the new urgent care contract. If we can increase the uptake of clinical pathways it may help achieve the goal of decreasing ED admissions after hours.

- There has been some frustration with the one system login and have not had much input from the PHO with reminders to use the up and coming pathways that are being formulated. More engagement with GPs is needed. If we don't readily know about the information we can't use it. GPs don't always access the GP portal.

- EMT are supportive of the work being done with clinical pathways. This work needs to be supported with a change in our business processes to make it work as an organisation. We need to look at implementation issues from a business as well clinical perspective. Have we got the flows into the system right so that it doesn't get frustrating for all involved, and does the pathway reflect the reality on the ground not what we would like to see happen.

- We have to align with GPs and do it completely.

- Is there a systematic rollout to GPs? Since the single sign-on all practice managers have been emailed and Leigh has started to visit practices to spend some time going through the MoM process. There are other advantages with the MoM, professional development, ability to write your own notes etc.

- There are enormous costs with this programme. The idea of stardardised disease based care has been around forever and is a very small part of what we are trying to create which is a same system approach, doing things in new innovative ways that improve health outcomes that haven't been done before. Our principle behind things is that we are wanting to change things not create pathways for what we already have. We need to show what we have here can function in the way we want it to and demonstrate this. If not, we need to look at other ways of doing things.

- They have to be primary and secondary. There has to be a push back by secondary with a culture change. It is clear in the maps criteria what secondary services expect and if it is not in there it should be pushed back to the GP, but ensuring there is no risk to the patient. If you follow the map and have done the referral you need to make sure that the referral is accepted, it is a two way street.

- We won't get a whole of system change if we don't get push back. Primary care have to be able to say this doesn't work and it is not in the best interests of the patient, what we are doing in secondary care is not working and we will need to create a new pathway.

- How far way are we from current tool linking with eReferral? We are getting through MedTech and are learning about eReferral, there is a gap because no one owns that programme. Information Services support it, but there is no one monitoring or implementing the changes. At the moment we are trying to align some of the eReferral information to the MoM. Changes made to eReferral templates incur a cost.

- Well done for the work done so far. It appears that there are a number of projects within the project. eReferrals, a piece of work needs to be done around that which is an IT issue. There is work around feedback and generating the data to drive performance. There is also marketing to GPs and how the secondary care system responds to receipt of those referrals.

- What would really good marketing to GPs of this look like? Not sure if it has been adequately launched in primary care, there have been bits and pieces but not fully launched, nothing about the capacity and benefits to the clinician and patient. Need to get the right information out at the right time to the right people e.g. through a CME session in the Education Centre. Once we know the capabilities and what we want to achieve with the pathways and secondary services on board, having some of the secondary specialists who have been involved in pathways explaining how it benefits their service so there is buy-in both ways, will have more uptake from primary. Success would be seeing your patient and being able to explain to them where they are going and who they will be seeing so that you can chart the whole way through from primary to secondary. It is about the whole system approach.

- What makes change is when you can see the benefits for your patients.

- Not having to do the same thing twice. What we would like is that as you are going through the pathway you are also able to create a referral letter if that is required and make laboratory and radiology requests if they are required as well. That will make GPs use them, it makes their job easier.

- Would like to see that these pathways improve health outcomes and evidence that locally they are doing things that patient's value. At the moment the focus is about how will this make our job easier, with no focus on what is important to patients. Health outcome improvements and something that patient's value would help marketing and get buy-in.

8. TRAVEL PLAN UPDATE

The Chair welcomed Andrea Beattie (Property & Service Contracts Manager) to the meeting. Andrea provided an update on the activity undertaken in the last quarter.

Key points:

- The steering group has been reconvened and working groups have been established involving bi-partite union delegates, Maori Health Service, Population Health, Consumer Council members, Regional Council and the Hastings District Council.

- Review of parking layout changes has occurred and looking at implementing some priority parks specifically for patients and other user groups, making sure there are sufficient mobility parks, road marking and signage. With revamping the current layout we can get an extra 25 parks.

- New bus services staring next month – an express service from Napier to Hastings to cater for 7 am shift and also the 8 am shift and at the end of the day to take people back. Also the Flaxmere to hospital run has been realigned as well as for Havelock North.

- In discussion about extending the free patient travel service to Flaxmere. Currently only Napier to Hastings and back. Assisting the Regional Council where we can in promoting better use of those services.

- The express bus coming from Napier with have a concession rate of $3.65 instead of $4.30, in future we may be able to do better than that.

- Management technology to manage car parking on site, project manager to manage that and have that up and running for February next year. Started work on monitoring measurement and will use the HEAT tool and other factors like DNA rates and complaints.

- Drafted policies and procedures for management.

- Visited Canterbury DHB, they have a travel plan which is in the early stages as well to see what worked for them, what didn't work etc. We got some ideas on how they manage their parking and got copies of their management forms.

- GoWell out in the community - meeting with the Disability Reference Group next week about the changes we are proposing on site, presentation to Transform and Sustain and the end of the month, invited to do joint presentation with the Regional Council to the Regional Transport Committee and we have representation on the Active Transport Group. Will also be doing a presentation to Health Hawke's Bay.

Questions/Feedback

- This is a fantastic opportunity for co-benefits in health sustainability, climate change issues and opportunities for health benefits from this type of initiative. We need to get on board and demonstrate that we can change staff transport to work. What is our target/goal percentage wise? 10% initially.

- How many additional parks on site? There will be 25 new parks across the site. There is a lot of mixed use at the moment first in, first served. We want to road mark and sign them for purpose rather than mixed use. Approximately 100 of the main car park will be specifically for outpatient clinics with the remainder for visitors/patient use.

- Will there be monitoring of car parks? We are hoping to use Security or to have an enforcement type position that will look after all the parking. We can do some of that through existing security systems and cameras.

- A lengthy discussion took place at the Maori Relationship Board (MRB) regarding the benefits. It is how the message is promoted and that it should be one of many initiatives.

- The travel plan has been linked with the Healthy Workforce work.
- To what level can the dedicated patient car parks be enforced? What action can the organisation take against people who are not following the rules? We obtained a legal opinion, we can fine people like councils do. Moving to towing or clamping is aggressive and would be a last resort.
- We need to think about why we need people to park for, and how can that change.

9. DRAFT QUALITY ACCOUNTS

The Chair welcomed Jeanette Rendle (Consumer Engagement Manager) to the meeting.

The Quality Accounts will go to the Boards for endorsement in October. This is an opportunity for you to provide your feedback and depending on the level of feedback provided it will be fed into these accounts or next year's accounts. The template is set for this year but we could change it next year.

It is a document for our community. At the Maori Relationship Board this morning there was discussion around some of the language used in the document. Once it is written we need to share it with our community, feedback around that would be valuable. The analysts are still working on getting the correct data, this is still being finalised. Is there anything you think is missing?

Feedback:

- It is taking what we had last year and improving it further, looks great and has good information and is easily readable for consumers.
- Great job in pulling together the document, good to see the information that is in it.
- Page 9 – the blurb next to the 23% could be read as 15 smokers. The date needs to be on the one line or changed "2014 to 2015".
- Page 9 – Hapū Mama needs macrons above the "a" i.e. Hapū Māmā.
- Page 12 under urgent care, make it clear that the urgent care alliance is working on these things.
- The visual and general format is great, need to relook at the reading age, too many words. Cut the words back and increasing the font size would make a big difference to the way it would resinate with the public. Simplify it a bit.
- The Quality Accounts have evolved every year. In putting this together we are often criticised of working in silos and this is another example of that, we have all the information set out along the lines of services. A thought for next year would be that if we look at our 5 year strategy Transform and Sustain and use those headings and ask what is the whole sector doing to achieve those goals.
- Focus on quality and the delivery of our plan. There is a disconnect and does not appear to focus on quality we do a lot of quality reporting already like readmission rates, surgical site infections, the measures we report to the Health Quality & Safety Commission (HQSC). Some of those indicators are included. The focus of the Quality Accounts is to show quality overall rather than on niche indicators.
- There is a strong criteria we have to meet from the HQSC and we take into consideration the feedback they have given us on the year prior, we have to meet those parameters as well.

- It is about reporting those things clearly and in a readable way. The working party have identified that already.

- We have mentioned "manage my health" are we confident that we are not raising expectations? That information was provided to us by primary care. The intention is that everyone will have access to it in the future.

- The challenge for this document in the future will be we can articulate what we define as quality, but as a public document my thoughts about quality might be quite different.

Any further feedback on the Quality Accounts can be emailed in the next two weeks to jeanette.rendle@hbdhb.govt.nz.

10. PRIMARY CARE SMOKE FREE

The Chair advised that a lot of work has been done to improve the number of our patients who are recorded as being smokers and giving them Smokefree advice. The PHO was behind earlier in the year with the target of 90%, they worked hard but came up short with 83.1%.

Dr David Rodgers advised that the next quarter should look much better with the ability to record smoking intervention advice given off-site e.g. at Directions etc.

Not all DHBs were using the same data sources. Some were using text messages and recording them as a contact, we weren't. We started late to meet the target of 30 June. There were some practices who contacted all their patients who didn't have changed contact information and they still came up short of the 90% target.

This target is with us for another 12 months. The target will then be changed to Infants in Smokefree Homes at 6 weeks. This target should be a lot easier to capture the information. The difficulty with the current target is that you may not see your patient within the 12 month timeframe.

11. GOVERNING FOR QUALITY

Ken Foote (Company Secretary) advised that this is Kate Coley's (Director QIPS) paper in response to the Health Quality Safety Commission's publication "Governing for Quality". It looks at the overall quality and safety systems operating within the DHB. The Board has ultimate responsible for this and have delegated it to the Clinical Council who primarily provide clinical advice. It is a matter of providing an assessment to them as to where we are regarding quality and safety systems across the board as a DHB.

A number of actions have been identified arising from a self-assessment and they have been incorporated into the QIPS Annual Plan. It has been noted that while a self-assessment is a good thing to do, for a greater level of assurance for the Board the recommendation is that a peer review is undertaken. We have been in contact with the HQSC to identify who might be suitable to undertake this. This requires endorsement from the Clinical Council as principle advisors to the Board.

Comments / Feedback

- An executive member should be at all Clinical Council Meetings, either the CEO, COO or PHO CEO.

- Looking at the committee structure document in the papers 26 committees, there are at least 12 groups which are missing. There is a piece of work to do on the structure of those clinical governance committees and reporting up.

- All is not as good as it could be and there are a range of actions in the paper on how we can raise quality and safety assurance. It is a matter of reading that action plan with this and acknowledge that we need to improve in some areas.

- The seven areas of action are framed well with the appropriate governance framework. What we have to do is turn the work programme into the framework, where does it all fit. Supportive, just need to look at how we structure things.

- Five years down the track were are still maturing as a clinical governance committee. We are just now getting to the point where we are saying we are the people who should be doing the clinical governance. We just need confidence that all the committees are doing their jobs.

- It is also important to acknowledge that we are also doing a lot of work around risk management. Things that concern us about quality start out as risks. Once we get on top of that, it is how we report them up to the appropriate governance areas.

- If there are any clinical risk areas identified in the DHB, it is having the confidence to bring them to the table here. Issues need to be elevated and we are a key group they should come to.

- Induction process for members is important. We need to ensure that anyone in a clinical governance role is clear on their responsibilities and they have the skills to bring to the task.

The Clinical Council endorsed the actions identified in the paper, which will be incorporated into the overarching Quality Annual Plan.

12. ICU LEARNINGS UPDATE

Chris McKenna (Co-Chair) advised that there is an ongoing action plan in place as a result of the review and is confident that this is in hand.

13. COMPLEMENTARY THERAPIES POLICY

Dr Andy Phillips advised that this is the second time the policy has been to Clinical Council, the last time being the March meeting. Changes were made following feedback at that meeting. The intent of the policy was to set up some principles, not that complementary therapy was valid or not. If complementary therapists are going to work on DHB sites or premises associated with the DHB that there should be some governance around that. There is already a policy for complementary and alternative medicines so that is not included in this policy. The policy includes as many complementary therapies as possible and as discussed last time, some of the detail has been removed.

Questions / Feedback:

- What input have we had from complementary therapists? Would be interested in their thoughts about the register.

- Agree to the policy in principle. Need to be respectful of qualifications e.g. LMCs have access agreements and have to provide their APC and indemnity insurance and function under the midwives code of conduct.

- How do you deal with the unregulated health worker? One of the complications of this is that they are not necessarily professionals who are part of a regulated system. They might have a practicing certificate, membership to a body etc. Deliberately tried not to go through every profession and set out strictly what the requirements would be, that would be too prescriptive.

- The analogy between LMCs and complementary therapists is a nice one, this is nothing special, it is what we ask of everybody providing a service.

- Are we regulating people that are coming in to do this as a profession to get paid or regulating people that are coming onto DHB premises for a patient because they can? There is a difference between those two things. The use of complementary therapies is usually patient driven.

- In the principles it talks about people having the necessary skills and knowledge to provide treatment and that their area of practice is recognised by a sector regulator or professional association. The trick is getting good governance that meets our need without putting up barriers.

- Remember the intent of the policy was to prevent charlatanism on DHB property, we have a professional obligation to ensure that doesn't happen. Nothing in the document seems onerous. We want to encourage these linkages to occur, the document has been improved from last time.

- The document has been improved, but anxious about this document saying things like "Reiki can boost your energy", don't want people saying that HBDHB said that Reiki works for this or that. Need to look at how this section is worded.

- There are therapies that are part of everyday practice our psychologists use mindfulness, nurses use massage which is common practice.

- The definition of this policy is to manage unregulated complementary therapies. This is included in the purpose.

- Are we clear that the DHB is not going to be paying for these therapies? This is patient driven, people for it themselves if they chose to use complementary therapy. The DHB is not going to spend money on this, but we need to ensure that if these therapies are used on our premises that they are properly managed.

- We also need to be mindful of those complementary therapists who are funded by ACC and the PHO.

- Number 8 under principles is it practitioner records or DHB records – assuming it is practitioner records? Yes. Also suggest that the whole section on Treatment Guidelines could be removed. This is a principles policy and does not need that level of detail.

Andy Phillips summarised that he has tried to limit the scope of the policy to complementary therapists, nothing to do with medication as that information is in another policy, he has not addressed the monetary issue as that is also covered by another policy. He needs to include some more therapy professions e.g. chiropractic, osteopathy and any others you can think of. Agrees about the point of the wording of the complementary therapies of pages 3 and 4, it infers that they are successfully done, he will re-word that.

The final version of the policy will come back to the September meeting for endorsement. Any further feedback can be sent to andy.phillips@hbdhb.govt.nz.

SECTION 3: MONITORING / FOR INFORMATION

14. TE ARA WHAKAWAIORA / CULTURALLY COMPETENT WORKFORCE

Report tabled for information. No issues discussed.

15. TE ARA WHAKAWAIORA / MENTAL HEALTH

Report tabled for information. No issues discussed.

16. ANNUAL MĀORI PLAN Q4 (APR-JUN 2016) NON-FINANCIAL EXCEPTIONS

Report and dashboard tabled for information. No issues discussed.

17. CERTIFICATION – FINDINGS AND NEXT STEPS

Report tabled for information. No issues discussed.

18. RECOMMENDATION TO EXCLUDE THE PUBLIC

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

19. Minutes of Previous Meeting (Public Excluded)
20. Matters Arising – Review of Actions (Public Excluded)
21. Community Based Pharmacy Services in HB – Strategic Direction 2016-2020
22. Improving the Quality of Unscheduled Care & Acute Patient Flow
23. Radiology update
24. Laboratory update

Moved and Carried.

Meeting closed at: 3.25 pm

Confirmed: _____
Chair

Date: _____

MINUTES OF THE HAWKE'S BAY CLINICAL COUNCIL ANNUAL GENERAL MEETING HELD IN THE "THE LIBRARY", MISSION ESTATE, CHURCH ROAD, NAPIER ON WEDNESDAY, 10 AUGUST 2016 AT 3.25 PM

PUBLIC

Present:
Dr Mark Peterson (Co-Chair)
Chris McKenna (Co-Chair)
Dr Tae Richardson
Dr David Rodgers
Dr Robin Whyman
Dr Malcolm Arnold
Dr Andy Phillips
Dr Kiri Bird
Debs Higgins
William Allan
David Warrington
Jules Arthur
Anne McLeod

In Attendance:
Dr Kevin Snee, Chief Executive Officer, Hawke's Bay District Health Board
Ken Foote, Company Secretary
Dr Nick Jones, Public Health Specialist *(on behalf of Dr Caroline McElnay)*
Barbara Ryan, Quality Improvement & Innovation Team Leader *(on behalf of Kate Coley, Director Quality Improvement & Patient Safety)*
Tracy Fricker, Council Administrator and EA to DQIPS
Graeme Norton, Chair HB Health Consumer Council
Kerri Nuku, Māori Relationship Board Member
Dr Russell Wills, Medical Director QIPS

Apologies:
Dr John Gommans and Dr Caroline McElnay

SECTION 7: ANNUAL MEETING

25. WELCOME AND OPENING

Dr Mark Peterson (the Chair) welcomed everyone to the Annual General Meeting.

26. APOLOGIES

Apologies were noted as above.

27. MINUTES OF PREVIOUS ANNUAL MEETING

The minutes from the previous Annual General Meeting held on 12 August 2015 were confirmed as a correct record of the meeting.

Moved and carried.

28. MATTERS ARISING FROM ANNUAL GENERAL MEETING

The matters arising from the Annual General Meeting in 2015 were noted as actioned.

29. ELECTION OF CHAIR / CO-CHAIRS

The Chair advised that he and Chris McKenna were happy to stand as Co-Chairs for the next 12 months.

Ken Foote (Company Secretary) called for nominations of the positions of Chair and Co-Chair.

David Rodgers nominated Mark Peterson and Chris McKenna. This was seconded by Debs Higgins.

The Company Secretary confirmed that with no further nominations Dr Mark Peterson and Chris McKenna were duly elected as Co-Chairs.

30. REVIEW OF LAST 12 MONTHS (2015-16) YEAR IN SUMMARY

Information included in the meeting papers. No discussion held.

SECTION 8: WORKSHOP

31. REVIEW HB CLINICAL COUNCIL TERMS OF REFERENCE

The updated Terms of Reference are included in the meeting papers for information. The Terms of Reference were reviewed last year.

32. QIPS ANNUAL PLAN

The QIPS Annual Plan was included in the meeting papers. No discussion regarding this document. Please provide feedback on the draft plan to kate.coley@hbdhb.govt.nz.

33. CLINICAL GOVERNANCE COMMITTEE STRUCTURE

See Appendix 1 for notes from the discussion held regarding Clinical Committees.

34. REVIEW OF COUNCIL'S ANNUAL WORK PLAN 2015-16 (PAST YEAR) AND DEVELOPMENT OF ANNUAL WORK PLAN 2016/17

See Appendix 1 for notes from the discussion held regarding the priority areas/actions for focus in 2017.

Before closing the meeting the Chair acknowledged Dr Malcolm Arnold's contribution to the Clinical Council during his tenure.

The meeting closed at 5.10 pm

Confirmed: _____
Chair

Date: _____

Appendix 1

CLINICAL COUNCIL ANNUAL MEETING HELD 10 AUGUST 2016

WORKSHOP NOTES

STRUCTURE

Ken Foote facilitated the Workshop which commenced at 4.40 pm, requiring some prioritisation for the use of the 20-30 minutes available.

Ken outlined a general structure which would require some review of the issues/objectives set for 2015/16 (to help identify what needed to be carried forward), and then looking ahead to the priority challenges for 2016/17.

Specifically the components of this process include:

- Review/confirm existing TOR for Council
  - Discuss/confirm existing scope, structure and processes
- Review/confirm existing Functions, Roles and Strategies set out in the Annual Plan 2015/16
- Review achievements of 2015/16 Annual Plan objectives – agree on issues to be carried forward.
- Review notes from last year's Annual Meeting Workshop to agree/confirm achievement / non achievement of issues, strategies, actions, trends identified, and what needs to be waived and/or carried forward
- Review the "QIPS 2016/17 Annual Plan" to identify specific areas of focus for Clinical Council.
- Review/approve the "Governing for Quality Plan" as a reminder of Council's role to provide clinical improvement and patient safety advice and assurance to the HBDHB and HHB Boards, to help them meet their respective due diligence governance responsibilities in this area.
- To discuss agree how Clinical Council and individual members would be integrated/included within the proposed new clinical governance committee / advisory group structures.
- To open up the meeting for members to raise issues or suggest ideas where Council could proactively add value to the Hawke's Bay Health system, and our consumers?

CLINICAL COMMITTEES

Given the limited time available, it was agreed to focus initially on the proposed new committee structure.

It was suggested that each member should have a role on at least one Advisory Group and (where appropriate) one of the Committees.

General discussion on the proposed structure resulted in agreement to make the following changes:

- Correct the name of CAG, to "Clinical Advisory & Governance Committee"
- Move "Maternity Governance Group' to sit under "Clinical Effectiveness and Audit".
- Rename "Research Education & Training" to Professional Development & Research" or other such title to reflect the Advisory Groups sitting under it.
- Add "Education & Development Group" to sit under "Professional Development & Research" (once new name confirmed).

- Acknowledge two components of Records Management with 'Clinical Records' reporting to Director of Quality Improvement & Patient Safety.

Initial expressions of interest for membership of Advisory Groups were:

- **Professional Development & Research**
  - Research — John Gommans
  - Credentialing
    - SMO — Robin Whyman
    - Nursing — Chris McKenna
    - Allied Health — Andy Phillips
  - Nursing & Midwifery Council — David Warrington
  - Allied Health Forum — Anne McLeod, Andy Phillips, Billy Allan
  - Pre Vocational Training / RMOs — Russell Wills
  - Education & Professional Development — Anne McLeod

- **Clinical Effectiveness : Audit**
  - Clinical Audit — ?
  - Clinical Pathways — Mark Peterson, Andy Phillips, David Rogers
  - Laboratory — Kiri Bird
  - Radiology — Mark Peterson
  - Pharmacy & Therapeutics — Billy Allan
  - Maternity Governance Group — Jules Arthur

- **Patient Safety & Risk Management**
  - Infection Control — Chris McKenna
  - Falls — Chris McKenna, Andy Phillips, Robyn O'Dwyer
  - Clinical Events — John Gommans, Andy Phillips, Robyn O'Dwyer
  - Restraint — ?
  - Clinical Risk — ?
  - Patient at Risk — ?
  - Family Violence — Russell Wills, Jules Arthur, Debs Higgins, Andy Phillips

- **Patient Experience**
  - Complaints / Compliments etc — Russell Wills

- **Information Management**
  - Data Quality & Integrity — Caroline McElnay, David Rogers

With the limited time remaining, members were asked to suggest other priority areas/actions for focus in 2017 – these included:

- **Meeting Agendas**
  - Need to be more manageable
  - Focus on those papers/presentations with significant clinical issues – be more selective
  - Accept more papers as "information only" requiring no presentation or general discussion, but providing for members to raise concerns at the meeting and/or provide feedback direct to the document owner/author.
- **Advisory & Assurance Function**
  - Review "risk management" processes and reporting to ensure Clinical Council has full visibility of all significant clinical quality and patient safety issues, so that they can assure themselves that appropriate mitigation actions/plans are being implemented and therefore provide the Boards of HBDHB and HHB with appropriate and relevant "early warnings". Advice and/or assurance on such matters.
- **Engagement with Consumer Council**
  - Agreed that more needs to be done on the "partnership" envisaged
- **Workforce Development**
  - Still a high priority to prepare the workforce for "new" environment and culture
- **Health Literacy**
  - Would like to see real progress
- **Prioritisation Process**
  - Keen to see enhancements come out of the current review
- **Proactive / Innovative**
  - Agreed that members need to be more proactive and innovative in bringing issues to Council, rather than just 'reacting' to papers presented to it.

NEXT STEPS

General agreement that the Co-Chairs, Kate Coley and Ken Foote would work together to update/prepare a draft Annual Plan for 2016/17 for discussion with Council in September 2016, based on comments above.

Further discussions will be required as memberships and TORs are developed for the new committee structure.

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	10/2/16	***Clinical Council Member Portfolios within the 2015/16 Council's Annual Plan review*** To be finalised		Sep	On agenda
2	9/3/16	***Alternative Health Provider*** (**Complementary Therapies Policy)** Revised and final provided for approval	A Phillips	Sep	On agenda

5

OURHEALTH HAWKE'S BAY Whakawateatia

HB CLINICAL COUNCIL WORKPLAN 2016-2017

Meetings 2016	Papers and Topics	Lead(s)
12 Oct	Orthopaedic Review – closure phase 1 Draft – Reducing Alcohol-Related Harm Draft – New Patient Safety and Experience Dashboard 2016/17 Clinical Council Workplan Update - Renal – Stage 4 13-17 Year Old Primary Care Zero Fees Subsidy ***Monitoring*** HB Nursing Midwifery Leadership Council Update Final – HB Integrated Palliative Care Urgent Care PROPOSAL update Radiology Services Committee Infection Prevention Control Committee Qtly	Andy Phillips Caroline McElnay Kate Coley Kate and Ken Sharon Mason Tim Evans / P LeGeyte Chris McKenna Mary Wills Liz Stockley Mark Peterson Chris McKenna
9 Nov	ICU Learings Action Plan update Qtly Draft - Developing a Person Whanau Centred Culture Draft - Event / Complaint / Hazard / Risk Management System Endocsopy / Gastro Project Build Update Travel Plan – verbal Allied Health Professions Forum Tobacco – Annual Update against the Plan (for noting) ** Final – Reducing Alcohol-Related Harm ***Monitoring*** Te Ara Whakawaiora / Smoking (national indicator) ** HB Clinical Research Committee Update Urgent Care Update Laboratory Services Committee Update CAG report update Annual Maori Plan Q1	Kate Coley Kate Coley Kate Coley Sharon Mason Sharon Mason Andy Phillips Caroline McElnay Caroline McElnay Caroline McElnay John Gommans TBC Kiri Bird Tae Richardson Tracee TeHuia
24 Nov	**HB Health Awards presentation evening**	**Venue to be confirmed**

Meetings 2016	Papers and Topics	Lead(s)
7 Dec	Discussion - HB Workforce Plan	GM HR
	Final - Renal Stage 4	Sharon Mason
	Draft - Orthopaedic Review – Phase 2	Andy Phillips
	Quality Imprmovement Programme	Kate Coley
	Monitoring	
	Health and Social Care Networks Update	Belinda Sleight
	Urgent Care Update	TBC
	Clinical Pathways Committee	Leigh White
	CAG Report	Tae Richardson

HAWKE'S BAY District Health Board Whakawāteatia	**Complementary Therapies Policy**
	For the attention of: **HB Clinical Council**
Document Owner:	Andy Phillips, Chief Allied Health Professions Officer
Reviewed by:	Clinical and Consumer Council (Aug Meeting) and Executive Management Team
Month:	September, 2016
Consideration:	For Approval

RECOMMENDATION

That HB Clinical Council:

1. Approve the attached policy on complementary therapies

SITUATION

Concern was raised by Clinical Council that it might appear to consumers that complementary therapy practitioners who are not DHB staff but are operating on or adjacent to DHB owned premises.

BACKGROUND

In developing a policy covering complementary therapies it was necessary to strike a balance between supporting consumers' choice of using such services whilst establishing good governance where Hawkes Bay DHB has a responsibility to consumers.

ASSESSMENT

Hawkes Bay DHB recognises that there is increasing interest in the practice of complementary therapies in health care. The purpose of this policy is not to limit either practice or consumer choice, but to ensure professional standards and high quality service.

This policy promotes good practice when a consumer decides to contract with a non-DHB employee for complementary therapy services.

The DHB is not yet persuaded that the evidence base of these therapies is sufficiently strong to support the use of public funding to support these therapies.

Note:
Consumer Council felt they had reviewed this fully at their August Meeting.
The Māori Relationship Board will review this in October with Andy presenting.

HAWKE'S BAY DISTRICT HEALTH BOARD	**Manual:**	Clinical Policy Guidelines
	Doc No:	XXX
Complementary Therapies Policy	**Date Issued:**	September 2016
	Date Reviewed:	
	Approved:	Clinical Council
	Signature:	Andy Phillips, CAHPO
	Page:	1 of 9

PURPOSE

- To ensure that complementary therapies are practiced safely on DHB premises
- To ensure that patients and Whanau access complementary therapies in an informed and appropriate way.
- To provide a robust framework to support practitioners to provide complementary therapies safely and appropriately.

PRINCIPLES

1. The policy applies to all complementary therapists practicing on Hawkes Bay DHB premises and to all patients receiving complementary therapies within Hawkes Bay DHB premises.
2. All complementary therapists are bound by the Health and Disability Act and Code (2014).
3. The therapist must have written evidence of a qualification in their area of practice recognised by the sector regulator - or the relevant professional association
4. The Manager /deputy of the Hawkes Bay DHB premises will be responsible for ensuring therapists are current members of their relevant professional body and have up to date personal liability insurance.
5. Hawkes Bay DHB will maintain a register of Complementary Therapy practitioners who meet the agreed criteria to practice on Hawkes Bay DHB premises.
6. All therapists must have the necessary knowledge or skills to treat individuals.
7. Individual therapists are responsible for - ensuring confidentiality of client information; maintaining adequate up to date indemnity insurance; ensuring a current knowledge base of treatments and their own area of therapy.
8. Documentation of consent **must** be recorded by the practitioners in the client's records and stored by practitioners in accordance with Information Governance requirements.
9. Written information on the complementary therapies must be provided to clients to help inform their decision.
10. Consumers have the right to access any complementary therapists they wish.
11. It is expected that Complementary Therapy Practitioners and DHB staff offering conventional treatment will collaborate effectively in the treatment and care of consumers
12. Hawkes Bay DHB does not accept any liability for any patient harm occurring to consumers accessing complementary therapies that are not provided by a Hawkes Bay DHB employee.

INTRODUCTION

Hawkes Bay District Health Board (HBDHB) recognises that there is increasing interest in the practice of complementary therapies in health care. The purpose of these guidelines and protocols for specific therapies is not to limit either practice or patient choice, but to ensure professional standards and high quality service.

These guidelines offer areas of good practice when a consumer decides to contract with a non-DHB employee for complementary therapy services.

In developing these guidelines the DHB is not making any claims on the validity or evidence base of these procedures. It is the responsibility of each individual practitioner to ensure they discuss fully with the service user the evidence base of the proposed treatment and any potential risks.

The DHB is not yet persuaded that the evidence base of these therapies is sufficiently strong to support the use of public funding to support these therapies.

In accordance with the above guidelines the complementary therapy:

- Must work alongside existing medical treatment without compromising existing care.
- Must be based on current evidence and best practice.
- Must be based on consultation, planning, education and demonstrable competence.
- Must comply with local policies.

The main purpose in the use of these therapies is to help:

- Promote relaxation.
- Reduce anxiety.
- Ease symptoms such as pain, nausea, poor sleep patterns.
- Help the patient find coping mechanisms and strategies.

SCOPE

This policy covers the following complementary therapies:

- Aromatherapy
- Reflexology
- Indian head massage
- Reiki
- Yoga
- Hypnotherapy
- Osteopathy
- Chiropractic treatment

6.1

DEFINITIONS

Complementary and Alternative Medicines (CAM)

CAM is an 'umbrella' term used to describe a range of health systems, modalities and practices that may have little in common other than that they are practised alongside or as an alternative to mainstream medicine. There may however be similarities in philosophy and approach – for example, the need to take a holistic approach to health care, including the interactions between physical, spiritual, social and psychological aspects.

CAMs are considered to be any non-medically prescribed substances that a person uses with the belief that they will improve health or well-being. The term includes but is not limited to:

- Herbal medicines; herbalism
- Nutritional therapy (vitamins and minerals)
- Health food supplements (e.g. royal jelly)
- Colloids / cell salts
- Chinese medicine
- Rongoa Māori

The use of Complementary and Alternative Medicines is out of scope of this policy and is covered by a separate HBDHB policy - HBDHB/IVTG/144.

Complementary Therapies

Complementary therapies are used alongside orthodox treatments with the aim of providing psychological and emotional support through the relief of symptoms'

The following therapies may be practiced:

Aromatherapy – is the use of pure essential oils generally applied in the form of massage, but can also be used in special aromatherapy diffusers. Their main use in this situation is to calm and relax the individual. Blends, usually of three different oils are chosen in conjunction with the client, which take account of their preferences and medical history.

Reflexology- Reflexology is based on the principle that certain points on the feet and hands, called reflex points, correspond to various parts of the body and that by applying pressure to these points in a systematic way, a practitioner can help to release tensions and encourage the body's natural healing processes.

Indian Head Massage - has been practiced for over a thousand years, easing tension and promoting a sense of relaxation and well-being. Other parts of the body may respond to this relaxed state. A head massage takes 30-40 minutes and covers the upper back, shoulders, neck, face, scalp, arms and hands.

Reiki - Reiki (pronounced ray-key) was developed in Japan in the early 1900's. Reiki can produce a feeling of deep relaxation, a boost in energy levels and a reduction in tension and anxiety. During a treatment a reiki practitioner lays their hands on a recipient in a series of positions over head, torso and legs.

There are different levels of reiki practitioners; level one is for people who have learnt reiki to treat themselves, or use informally with friends; level two is practitioner level, to give reiki treatments to patients; level 3 is reiki master or teacher. Practitioners should have attained level 2 as the minimum to practice in accordance with this policy.

Yoga – Is an ancient tradition of mental and physical exercises, which started in India over 5,000 years ago and is now widely practiced in NZ. There are many different styles of yoga. It includes physical exercises, breathing techniques and relaxation.

Hypnotherapy - Hypnosis describes an interaction between a therapist and client. The therapist attempts to influence perceptions, feelings, thinking and behaviour by asking the client to concentrate on ideas and images that may evoke the intended effect. Hypnotherapy can help reduce stress and anxiety, improve quality of sleep and help prepare for investigations and treatments.

Osteopathy - is a health care system of diagnosis and treatment that emphasises the relationship between structure and function in the body, and the ways it can be affected through manipulative therapy and other treatment modalities

Chiropractic Treatment – is concerned with the diagnosis and treatment of mechanical disorders of the musculoskeletal system, especially the spine, under the belief that such a disorder affects general health via the nervous system. The main chiropractic treatment technique involves manual therapy, especially manipulation of the spine, other joints, and soft tissues, but may also include exercises and health and lifestyle counseling.

ROLES AND RESPONSIBILITIES

Hawkes Bay DHB Management Responsibilities

The DHB recognises that local management has a responsibility to implement and monitor/audit the use of the Complementary Therapies protocols within their area of management. These responsibilities include:

- Where appropriate, negotiating and agreeing with local therapists the place of a complementary therapy as outlined in the protocols to support normal clinical activities, and ensuring where appropriate this is reflected in a written care plan.
- Final agreement prior to therapies being commenced on DHB premises. The management team will be responsible for the monitoring of any therapies practised.
- Ensuring that details held on the DHB register are up-to-date and correct. They will also maintain a list of practising complementary therapists.
- Auditing complementary therapy practitioners compliance with this policy

Complementary Therapy Practitioners Responsibilities

Assessment

- The patient or carer will be assessed by individual therapists at the first visit to ensure the referral is appropriate and any preferred choice of therapy is suitable
- Specific therapies may have contraindications relevant to them
- Any concerns about contraindications including those arising from conventional treatment must be discussed with a Hawkes Bay DHB health professional closely involved in the patients care

Safe Practice

- The practitioner should provide written evidence of a qualification in their area of practice recognised by the sector regulator - or the relevant professional association

6.1

- Therapists will be required to practice using guidelines based on the current evidence of best practice. Any concerns that arise during treatment should be referred to the appropriate Hawkes Bay DHB health professional.
- All therapists will be required to have indemnity insurance and be a member of an appropriate professional body.
- Any complementary therapist using products and oils on patients must ensure that they have the up to date information as to whether the patients' condition would be harmed or worsened as a result of their use. (For example this could be in the form of contra indicators to patients and their disease. There are many information sources available to obtain this advice.)

Consent

- Complementary therapy practitioners must obtain appropriate consent.
- Consent for the therapy must be obtained before the complementary therapy practitioner carries out the complementary therapy.
- Documentation of consent must be recorded in the client's records and stored safely by the practitioner in accordance with Information Governance requirements.
- Written information on the complementary therapies must be provided to clients to help inform their decision.

Written Information

Written information must be provided including the following;

- A description of the therapy and what that entails for the patient.
- A statement to the effect that the therapy is not an alternative to conventional therapies.
- A statement explaining that all therapists have completed relevant qualifications appropriate to their practice.

Record keeping

Therapists will keep all records of treatments/interventions provided and these will be kept by the practitioner in secured storage according to information governance requirements. As part of the records information on age, sex, ethnicity and address of patient will be documented.

Training Requirements

All professionals who wish to practice complementary therapies must hold a qqualification in their area of practice recognised by the sector regulator - or the relevant professional association.

They must also:

- Be able to show how they keep themselves updated.
- Be able to demonstrate they have personal liability insurance that would cover them for practice within the DHB Premises.
- Understand and acknowledge the boundaries they have with accountability for their own practice.
- Adhere to these guidelines.

REFERENCES

NICE Supportive and Palliative Care Improving Outcomes Guidance (2004).

RELATED DOCUMENTS

Complementary and Alternative Medicines - HBDHB policy - HBDHB/IVTG/144

KEYWORDS

Complementary Therapies, Aromatherapy, Reflexology, Indian head massage, Reiki, Yoga, Hypnotherapy, Osteopathy, Chiropractic treatment

For further information please contact the Chief Allied Health Professions Officer, HBDHB

Appendix 1

6.1

Hawke's Bay District Health Board
Register of Complementary Therapists offering therapy and consulting with patients on HBDHB premises

Name	Qualifications	Therapies Offered	Professional Body	Indemnity Insurance	Review Meeting

Appendix 2

Complementary Therapist Agreement to Comply with the Policy

I have received, read and understood the policy and will adhere to it.

Complementary Therapist: …… Dated: ……

Centre Manager: …… Dated: ……

Appendix 3

6.1

CONSENT FORM FOR COMPLEMENTARY THERAPY

Patient Name: ……...

Date of Birth: ……

Leaflet/Literature Provided to the Patient: YES ☐ NO ☐

I sign to confirm that:

1. I have received the information provided by the therapist YES ☐ NO ☐
2. I have understood this information YES ☐ NO ☐
3. I consent to the therapy YES ☐ NO ☐
4. I have an existing medical problem and my GP consents to the therapy YES ☐ NO ☐ N/A ☐

1. Signed: ……... Date: ……
   (Patient)

   Signed: ……. Date: ……
   (Complementary Therapist)

   Therapy Offered: ……..

2. Signed: ……... Date: ……
   (Patient)

   Signed: ……. Date: ……
   (Complementary Therapist)

   Therapy Offered: ……..

3. Signed: ……... Date: ……
   (Patient)

   Signed: ……. Date: ……
   (Complementary Therapist)

   Therapy Offered: ……..

4. Signed: ……... Date: ……
   (Patient)

   Signed: ……. Date: ……
   (Complementary Therapist)

   Therapy Offered: ……..

HAWKE'S BAY District Health Board Whakawāteatia	**Quality Accounts 2016**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Consumer Council**
Document Owner: Document Author(s):	Jeanette Rendle, Consumer Engagement Manager Quality Accounts Working Group and Service Directorates
Reviewed by:	Executive Management Team
Month:	September 2016
Consideration:	For final review and endorsement

RECOMMENDATION

That the Māori Relationship Board, Clinical and Consumer Council

1. Provide final feedback and endorsement of the Quality Accounts prior to sign off by the Board at their 28 September meeting
2. Provide feedback and endorsement of the communications plan

INTRODUCTION / PURPOSE

The publication of the annual Quality Accounts was initiated in 2013, following the Health Quality & Safety Commissions (HQSC) guidance publication in July 2012 and the MOH's request that Quality Accounts should be produced annually detailing our performance against both national and local quality and safety indicators. The Quality Accounts are predominantly aimed at our community and therefore the aim is to keep them as short as possible, be visual, easy to read and understand; using photo's, images, stories, quotes, and examples to enhance the results and achievements. The guiding principles are accountability and transparency, meaningful and relevant whole of system outcomes and continuous quality improvement.

A working group was established of representatives from Consumer and Clinical Councils, Māori Health Service and Clinical teams across the sector to write a document publishing positive stories and the impacts on health outcomes of our community.

The first draft has been reviewed by HB Clinical Council, HB Health Consumer Council, Māori Relationship Board, Executive Management Team and Clinical Advisory and Governance Committee Meeting. First round feedback has been incorporated with some remaining data and information to be collated and adjustments to images and layout made.

This is a further opportunity for final review, to see changes based on previous feedback and provide endorsement before going to HBDHB and HHB Boards.

A communications plan has been developed to support the promotion of the Quality Accounts including posters, website presence, social media and print advertising. The posters will be developed to highlight specific quality improvement initiatives and direct consumers to the publication in both hard copy and website formats.

SUMMARY

The most updated draft publication is attached along with the communications plan for final review and endorsement.

KA ARONUI KI TE KOUNGA

FOCUSED ON QUALITY

OUR QUALITY PICTURE 2016

OURHEALTH
HAWKE'S BAY
Whakawāteatia

I MŌHIO RĀNEI KOE, IA RĀ ...
DID YOU KNOW THAT EVERY DAY...

6 babies will be born

10 fragile babies will be cared for in the special care baby unit

An orderly can walk on average 15km

16 people will get their free annual diabetes check

22 women will have a mammogram and a further 28 a cervical smear test

35 operations will be completed in theatre

3 children will receive one of their vaccinations

85 people will be admitted to Hawke's Bay Fallen Soldiers' Memorial Hospital

200 visits/appointments will be made to support people with mental health issues

209 visits will be made by District Nurses and Home Service Nurses

245 children on average will be seen for their free dental health check

260 people will receive meals on wheels

1,334 people will see their local family doctor

4,400 prescriptions will be written

5,680 laboratory tests will be completed

5,915 items of laundry will be delivered to the hospital

Icons made by Freepik from www.flaticon.com

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Te hauora o te Matau-ā-Māui: Healthy Hawke's Bay

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RĀRANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT
Showing ***respect*** for each other, our staff, patients and consumers. This means I actively seek to understand what matters to you.

RĀRANGA TE TIRA PARTNERSHIP
Working together in ***partnership*** across the community. This means I will work with you and your whānau on what matters to you.

ĀKINA IMPROVEMENT
Continuous ***improvement*** in everything we do. This means that I actively seek to improve my service.

TAUWHIRO CARE
Delivering high quality ***care*** to patients and consumers. This means I show empathy and treat you with care, compassion and dignity.

All quotes are provided by our consumers


2

NAU MAI KI TĀ TĀTOU WHAKAAHUA KOUNGA
WELCOME TO OUR QUALITY PICTURE

We are pleased to share with you our fourth Hawke's Bay Health sector's quality accounts demonstrating our commitment to high quality health care, living our values and sharing with you our successes and future plans. As you will see, we have come a long way and our teams have worked hard to achieve some excellent results in meeting the Ministry's health targets and the Health Quality and Safety Commission's Quality Safety Markers; however, there is still more to do.

Every day people access the health and disability services across our sector and, for some, the experience, the care, and support they receive exceeds their expectations; however in some instances we fall short. As a sector, we believe our consumers should be at the centre of health care and treat them as if they were part of our own family/whānau, so as a sector our commitment is to continually improve the safety and quality of care for all.

In these quality accounts we have focused on some of the improvements currently underway across Hawke's Bay which, we believe, will better meet the needs of our community and give us the opportunity to deliver the best care possible. At the same time we need to continue to manage the risks of providing health care and reduce incidents of unintentional harm that can occur while receiving care. These accounts show how we are meeting these challenges – showing our successes and where we need to improve and focus in the future. We welcome any feedback, as well as any suggestions for future topics.

What quality means to us?

Ākina, one of our sector values means *that we continuously look for ways in which we can make improvements and learn when things don't go as well as we planned.* Achieving high quality care across the sector means the care is the right care, in the right place, at the right time, every time. We want to help develop our staff to become far more person and whānau centred, really understanding our consumers' goals and needs, working in partnership to improve the health of our communities.

KEVIN ATKINSON

CHAIR
Hawke's Bay District Health Board

BAYDEN BARBER

CHAIR
Health Hawke's Bay - Te oranga Hawke's Bay

CHRIS McKENNA

CO-CHAIR
Hawke's Bay Clinical Council

MARK PETERSON

CO-CHAIR
Hawke's Bay Clinical Council

GRAEME NORTON

CHAIR
Hawke's Bay Health Consumer Council

TŌ MĀTOU POARI HAUMANU, KIRITAKI HOKI
OUR CLINICAL COUNCIL AND CONSUMER COUNCIL

Combined leadership through the Clinical and Consumer Councils in Hawke's Bay

Establishing the Hawke's Bay Clinical Council (2010) and Hawke's Bay Health Consumer Council (2013) has helped us make change across our health sector – hearing the voice of both our clinicians and consumers.

The Clinical Council is made up of a number of health professionals from across our sector, including hospital specialists, family doctors, nurses and allied health (social workers, pharmacists) to provide leadership and oversight around safety and clinical improvements.

The Hawke's Bay Health Consumer Council provides a strong voice for the community and consumers on health service planning and delivery. The Council is tasked with enhancing the consumer experience, making sure our services meet our communities' needs.

A strong sense of teamwork and working together has been established between the councils which means that all service improvements and changes must be reviewed and recommended by both councils before they are discussed and approved by the Hawke's Bay DHB Board. The key to success to date has been the commitment at board and senior executive levels to support both these councils so that both clinical and consumer voices are able to grow.

As a further advance on working together, the Clinical and Consumer councils held combined monthly meetings in the past year. They worked on deepening their shared understanding of person and whānau centered care and how to advance this way of working across the health sector.

Each of the councils' annual plans has a section they share. Consumers are increasingly routinely invited to "co-design" services with clinicians, managers and other stakeholders. Trusting relationships are being built as a result, and we are getting better at it.

2015 was the year of the consumer with the Partnership Advisory Group for mental health being the supreme award winner at the Hawke's Bay Health Awards in November. Graeme Norton, Chair of Consumer Council also won the leadership award in 2015.

(translation)

WORKING IN PARTNERSHIP FOR QUALITY

Introduction. Profile MRB, EMT, QIPS

Maori Relationship Board

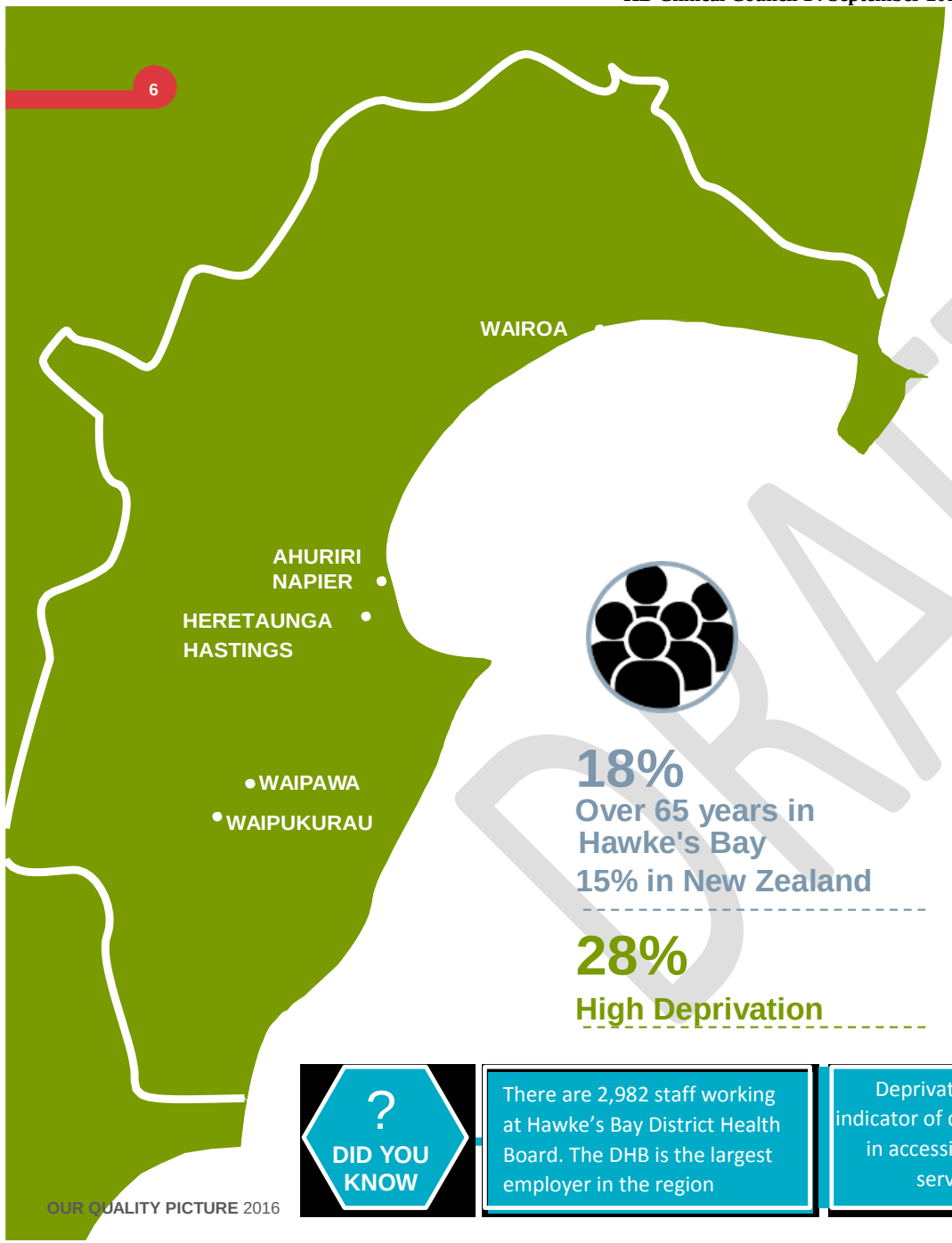
The Māori Relationship Board (MRB) exists to maximise the relationship between the Hawke's Bay District Health Board (HBDHB) and our local iwi - Ngāti Kahungunu Iwi Incorporated. MRB represent and provide a strong voice for the Māori population within the Kahungunu rohe (territory). MRB are aspirational and quality improvement focussed when it comes to identifying and removing health inequities (see page 7) and improving services and outcomes for Māori. MRB members include representatives from Ngāti Kahungunu, HBDHB Board, the Hawke's Bay Community and Ahuriri District Health who provide advice and recommendations that ensure services, policies, strategies and plans are responsive to the needs of Māori in our community.

Executive Management Team

Being written

Quality Improvement and Patient Safety Service

Being written



KO WAI MĀTOU?
WHO ARE WE?

160,650
Hawke's Bay population 2015/16

25.6%
Māori in Hawke's Bay

3.7%
Pacific people in Hawke's Bay

18%
Over 65 years in Hawke's Bay
15% in New Zealand

28%
High Deprivation

13.5%
Youth in Hawke's Bay (15 – 24 years of age)

4.1%
Asian people in Hawke's Bay

87%
Urban (city) residents versus 13% Rural

? DID YOU KNOW

There are 2,982 staff working at Hawke's Bay District Health Board. The DHB is the largest employer in the region

Deprivation is an indicator of disadvantage in accessing health services

The median household income in Wairoa is $42,400 per annum. This is $21,400 less than the NZ median

The gap in life expectancy for Maori and non Maori is 8.2 years for males and 7.7 for females.

TE WHAKATIKA I TE HAUORA TAURITE KORE
TACKLING HEALTH INEQUITY

Many things in life are unequal but some things shouldn't be. Health inequities are inequalities in health that are avoidable or preventable. Hawke's Bay is a great place to live, but not everyone currently has the same opportunity to be healthy. Some parts of our community have better health than others and we need to make sure everyone enjoys the same level of health and wellbeing.

A recent update of the 2014 Health Equity Report shows that Hawke's Bay is improving in some areas.

Good progress is being made to achieve equity in the following areas:

- ✓ **Difference between Māori and non- Māori avoidable deaths almost gone.** If current trends continue there will be no difference between Māori and non- Māori avoidable death rates by 2017, largely due to disease prevention, effective treatment and/or medical care.
- ✓ **Reduction in hospital admissions for 0-4 year olds** that could have been avoided by prevention programmes and better access to treatment in primary care.
- ✓ **Reduction in teenage pregnancy** largely due to improved access to primary care contraceptive and sexual health services.

Life expectancy (how long we live) is improving but there is still significant inequity. It will take at least 50 years for Māori to have the same life expectancy as non-Māori in Hawke's Bay if current trends continue.

In the coming year, focus will be given to the areas where health equity is unchanged or worsening:

- × **Acute respiratory.** Child admissions are increasing and are associated with poor housing conditions.
- × **High smoking rates for Māori women.** Forty-three percent of Maori women giving birth in the past year were smokers. At the current slow rate of decrease it will take another fifteen years before rates are the same as non-Māori.
- × **Obesity in four year olds** has increased since 2009 with significant variation across communities. Nearly 12% of children living in places like Camberley and Tamatea are obese compared to less than 1% of four year olds in Havelock North Central or Poraiti.
- × **Oral health for five year olds.** There has been no improvement in oral health for five year olds. Māori and Pasifika children and children living in less affluent communities have significantly more dental decay.


8

TE ĀWHINA TANGATA KI TE AUKATI MOMI PAIPA
HELPING PEOPLE TO STOP SMOKING

23% of all women who had a baby at the Hawke's Bay DHB facility during 2014 and 2015 were current smokers.

Hapū māmā who are māori are five times more likely to be smokers. Encouraging hapū māmā to stop smoking during pregnancy may also help them kick the habit for good and so provide better health benefits for māmā and reduce contact to second-hand smoke by pēpe (baby).

The Increasing Smokefree Pregnancy programme is a collaboration between Kahungunu Choices Health Services, Hawke's Bay DHB Maternity Services and the Smokefree Team to provide support, education and incentives to hapū māmā wanting to stop smoking. Incentives include free nappies at one, four, eight and twelve weeks if they remained smokefree. Those whānau members who smoke and are living with the hapū māmā can also receive incentives at one, four, eight and twelve weeks if they remain smokefree.

RANGATAHI MAKE BETTER CHOICES

Smoking rates among Year 10 students are lower now than 15 years ago but one in four young māori girls of this age remain regular smokers. Over 60% of māori girls 14 – 15 years have used a tobacco product at some stage. Social supply and retail purchase are the main sources of cigarettes and tobacco for young people.

The "Breaking Cycles Challenge" engaged with Alternative Education providers in Hawkes Bay to provide education to youth aged 15-19 years old to lead healthy, active and smoke free lifestyles. The challenge was run over eight weeks with education, health, social, challenges and cessation components all factored in to the programme. The focus was smokefree and youth health, where engagement with providers once a week provided expert cessation advice and support to youth wanting help to stop smoking. In collaboration with Directions Youth Health Centre the aim was to support rangatahi (teenagers) to make better decisions for their health and wellbeing and create healthy lifestyles.

TE WHAKARANEA I NGĀ TAMARIKI TAUMAHA TIKA
INCREASING THE NUMBER OF HEALTHY WEIGHT CHILDREN

The best start for healthy weight children is keeping healthy during pregnancy, breastfeeding and healthy eating for our young children. The evidence suggests that this gives each child a good start in life and can protect against obesity throughout adulthood.

The Maternal Nutrition Programme delivers "Healthy First Foods" with Well Child Providers and gives information and practical skills to families/whānau on feeding children from six months of age.

Children under five who develop healthy eating behaviours are likely to maintain these over their lifetime. This is supported by the entire family/ whānau role modelling healthy eating and activity.

The Pre School Active Families Programme, developed and funded by the DHB, is delivered by Sport Hawke's Bay. They work with 45 families annually, providing support in the home and engaging family/whānau in community programmes.

Reducing the amount of sugar children consume not only supports healthy weight, it also improves oral health, concentration and overall wellbeing. "Water Only Schools" are being supported with resources, policy development and activities.

Kura Tuatahi – ki te whakangao i ngā rangatira mo apopo: Investing in tomorrow

Central Health were once again the winners of the Commitment to Reducing Inequalities Award at the Hawke's Bay Health Awards in 2015. For the third year running their winning entry has a long term goal of seeing a new generation of Māori who are strong, healthy and leading the way for their families/ whānau.

The biggest impact can be made when issues are addressed in children/ tamariki rather than waiting for them to become adults with poor health habits. The Kura Tuatahi – Investing in Tomorrow project aimed to improve nutrition, establish a habit of physical activity, prevent smoking uptake and provide access to nurse-led clinics to deliver early health care, and health promotion.

The project started out focusing on schools with the highest proportion of Māori and was later expanded to include the five kohanga in Central Hawke's Bay.

Innovations included 10 week touch rugby module for all schools to complete, Kia Tunua – healthy cooking on a budget for children/ tamariki and their families/ whānau, Supermarket Tour Toolkit, Healthy Lunches Toolkit, on-site nurse led clinics, social media resource (Facebook), using advertising budget to become lead sponsor for Iron Māori Tamariki in Hawke's Bay

There were many success stories including The Terrace School in Waipukurau (70% Maori) which was awarded the NZ Heart Foundation's Healthy Heart Start Award (Healthy Heart Tick) for their healthy lunches programme. This is an astonishing achievement for a school which, until last year, only offered choices such as pies, sausages, and chips

TE TIAKI KŌHUKIHUKI
URGENT CARE

Emergency Department presentations continue to increase and many of those who do come have coughs, colds or other minor medical conditions that would have been better treated by a nurse, family doctor or an accident and medical centre.

Last year we told you that the Urgent Care Alliance (a group of over 50 health professionals, managers and consumers across our region) was working to challenge and change the way health services are delivered, and to break down barriers like getting an appointment at short notice.

We highlighted several options the Urgent Care Alliance were looking at to improve some of the issues, and these have been further developed by the Alliance in the last twelve months.

- Improved access to emergency dental treatment - As of 1 October 2016 there will be provision for 720 very low cost appointments available for anyone in Hawke's Bay who needs emergency dental treatment. Consumers can be referred by their own family doctor, by the hospital or simply walk in to Te Taiwhenua o Heretaunga during opening hours for treatment.

- Communicating better with our community and helping consumers with more information so they can make better choices about where to go for treatment - This led to the implementation of the "choose well" campaign. The launch of a new health sector wide website (www.ourhealthhb.nz) supports our community with information, advice and alternatives. You may also have noticed "choose well" billboards and banners.

- Transport assistance is currently being reviewed and we expect a number of recommendations to be made in the next year to support this.

- Provision of urgent care services continues to be a priority. We are continuing to look at ways to improve access to health professionals both during and outside of normal working hours.

"I love building relationships with whānau, listening to their stories and knowing I have made a difference"

TE WHAKAHEKE I TE HUNGA KORE TAE MAI
REDUCING OUR DID NOT ATTEND RATES

An interpretation of the term rawakore is to be "without resources". Knowledge, transport, health literacy are examples of resources required to gain access to health services. At the DHB, we strive for equity and equal access to healthcare; however, we know there are many among us without these resources to help them on their journey.

To assist our community, the Māori Health Unit employs Kaitakawaenga to ensure that everyone is aware of their appointments, can get to their appointments, and can truly have equal access to healthcare.

Two of our Kaitakawaenga are Wirihana Raihania-White and Speedy White. Their work involves ringing people when they have appointments, visiting them in person, bringing them to appointments when needed, establishing relationships with whānau and listening to their stories. As they will tell you, "without the relationship, nothing else is possible."

Wirihana and Speedy take pride in their work every day, although they will say, "this is just what we do" to make a difference to people on their healthcare journey.

Customer focused bookings

The Customer Focused Booking project was initiated in September 2015. The goal of the project is to co-design a customer focused booking system that will result in improved attendance at appointments, full clinic utility, reduced waiting times and improved levels of customer satisfaction.

The project team have made good progress with placing the customer at the heart of the booking process this year and this focus will continue into 2016/17. Some of our progress is as follows:

Consumer information – we call this "demographics". The information we hold on file is not always up to date and this affects consumers being advised of an appointment. We have completed a review of our demographics form and how we collect this information, and we're getting ready to implement changes.

Online booking system – We completed a thorough review of technology solutions to support consumers being able to book and reschedule their own clinic appointments. We have chosen software we feel is the best for our systems, and we'll be rolling out a pilot within the next few months.

Text-to-remind tool – We have worked together with consumers to find out how we best use our text reminder system to meet consumer needs (see page 14). A set of recommendations are now being implemented to make this service more effective and more valuable to our consumers.

Clinic scheduling – Work to date to support our clinics running efficiently has included a review of clinic capacity and how clinics are scheduled. We continue to look at how our outpatient clinics run and changes we can make to make them even better.

Did not attend rates – There is still inequality for Maori when it comes to not being able to attend appointments. The project group will continue to monitor the data and identify issues to support system changes to promote equity and access to healthcare.

"Mum has dementia, and it is a challenge for her to manage her own appointments. Could you please send the reminder to me as her caregiver as well?

HE WHEAKO KIRITAKI CONSUMER EXPERIENCE

Measuring what matters most to our consumers and how you experience our services is essential in improving the way we do things.

National Inpatient Experience Survey

Feedback about the care provided in our Hospital is a good indicator of how well services are working for patients and family/whānau. As with other District Health Boards, we send a survey every three months to a selection of adults who spent at least one night in our hospital, inviting them to participate in the survey.

330 people responded to our surveys over the last 12 months (July 2015 to June 2016) and scored us positively across the following four domains: communication, coordination, needs and partnership (see page 15).

In addition to the scores, our reporting captures lots of comments and feedback that we share with our services. This feedback has highlighted those areas we can improve (pain management, privacy and discharge planning).

Real time surveys

If you have visited Nga Rau Rakau, Napier & Hastings Community Mental Health, Te Harakeke Child and Family Service (CAFS), and the Home Based Treatment Team recently you may have noticed iPads placed in reception areas and staff encouraging users of the service and their family/whānau to take up to three minutes of their time to "tell us what you think" in an online survey. This feedback is anonymous and captures your thoughts. We are encouraging consumers to complete the survey after each appointment or interaction as we know experiences can be different each time.

178 surveys were completed between March and July 2016 with the average rating 4.01 out of 5. We received the highest rating to the question "I would recommend this service to friends and family if they needed similar care or treatment".

Workshops

In July 2016 consumers from Wairoa to Waipukurau attended a workshop reviewing the "text to remind" tool - the method used to remind outpatients of their scheduled appointments. This workshop was useful in finding out how we can best use the tool to meet consumer needs, improve the consumer experience and increase attendance of appointments. The ultimate aims are to ensure equitable health services for all and best use of our resources.

"Whenever I was talking with staff they showed great empathy, displayed a calming sense of humour (yet) … they were professional and competent".

Results from the 2015/16 National Patient Experience Survey

Our scores have improved on last year across all four areas and in some cases are higher than the New Zealand average.

86% Felt we communicated well, and we listened to your questions

(3% increase on last year)

87% Felt you were involved in any decisions about your care and treatment

(2% increase on last year)

88% Felt you received good care and support and we treated you with dignity and respect

(3% increase on last year)

85% Felt you were given consistent information from the teams that were treating you

(2% increase on last year)

We still have room for improvement. The survey did identify areas of concern, such as discharge planning, which we will focus on improving in the coming year.

"I wasn't given info on medications prior to discharge. I felt confused about when to take them when I got home".

Image of consumer engaging with health professional

HAUORA TAUPORI
POPULATION HEALTH

We work with people and communities to prevent disease, have a safe environment and support people to be healthy and well. Population health covers areas such as reducing harm from alcohol, drugs, tobacco and hazardous substances, water safety and sanitation, promoting physical activity and healthy eating, healthy housing, sexual health, preventing disease through on-time immunisation, managing notified communicable diseases, and cancer screening.

KEY RESULTS

- Eight drinking water suppliers signed up to the Drinking Water Assistance Programme and 96 suppliers were assisted with developing water safety plans and risk management plans
- 228 homes were insulated through DHB healthy housing programmes in the last three years
- Plans developed to increase the activity and wellness of infants and children – Hawke's Bay Healthy Weight Strategy and Best Start: Healthy Eating and Activity

OUR FOCUS 2016/2017

- Support workplaces to have healthy workplace policies
- Support schools to have policies on drinks with no sugar
- Develop a position statement on alcohol harms and outline actions to address them
- Improve the information on pamphlets given to the public on communicable disease
- Continue to address housing issues and poor insulation

Did you know?

568 communicable disease cases notified

619 liquor licence applications received

186 tobacco retailers had compliance/ education visits

123 women supported to breast & cervical screening services

TE TIAKI HAUORA MATUA PRIMARY HEALTH CARE

Primary health care is the first place you go to for health services; often this is your general practice or health centre. The doctors, nurses and pharmacists working in our community provide a range of health services aimed to keep you well, from health promotion and screening to diagnosis and treatment of medical conditions.

KEY RESULTS

- More people have been supported to stay at home to look after their respiratory condition (breathing). This is because general practice and hospital services have worked together to support people earlier with better understanding, tools and access.
- 2,197 four year old children have received health checks before they start school. We have exceeded the target of 90% set by the Ministry of Health.
- 344 whānau (1440 individuals) were enrolled in our first Whānau Wellness Resource Programme which is a 12 month step-up programme including support to access general practice, medicines, tests and education.
- Whāriki/Stanford, a self-management programme has supported the development of Māori community champions and 81% of whānau using the programme have completed it (see page 21)

OUR FOCUS 2016/2017

- A review of systems that support patient safety continues within general practice
- Identify how primary and secondary care will work together to support better patient outcomes (system-level measures)
- Patient experience survey for primary care being developed by the Health Quality and Safety Commission is set to come to Hawke's Bay
- Improving Health Literacy - a new online training programme has been developed to support the people who work in general practice to understand more about the people that come to see them, their understanding of the health system and their health needs.

Did you know?

67 Cardiovascular Disease risk assessments were completed daily in general practice

(these forecast your risk of a Heart Attack or Stroke within the next 5 years)

710,857 (2% increase on last year) nurse and doctor consultations in general practice

17 daily diabetic annual reviews were held in general practice

"Manage my Health allows me to access my general practice 24/7. I can use my tablet any time to book appointments or request repeat prescriptions, which is essential when my asthma medications run out. I can read the doctors notes from my consultation and email her if I need clarification. And there is no more waiting for ages for the receptionist to answer the phone".

Respiratory Programme

Managing your breathing issue is now easier because we have joined together general practice and hospital services to provide better service for patients with respiratory issues and concerns. This is called the Respiratory Programme. The solution has been to increase access to your doctor or nurse, for early diagnosis and to provide education enabling self-management and improved quality of life. Nurses have received education sessions to increase their skills for providing extended services for patients with respiratory conditions.

- More people (300% increase) are now using the Pulmonary Rehabilitation service.
- More people (225% increase) have been provided a spirometry (lung function) test at their health centre.
- The number of days people have not needed to be in hospital because of their breathing problems has been reduced by 740 days compared to last year.
- More people saw their doctor for breathing issues and were treated by their doctor reducing the need to see a specialist at the hospital; this reduced referrals from 658 in 2012 to 28 referrals in 2015.

"I feel I know better how to take care of the little lung capacity I have left… the programme has given me another ten years of productivity".

Supporting you to keep well

Consumer Portal

Did you know that you can access your own medical records and make your own appointments? Ask your practice about Manage My Health or Health 365. Currently ten practices in Hawke's Bay have access to this technology, and by the end of the year most general practices will have access to this technology.

Improving self-management of health issues in our community

Self-management has become a popular term for changing how people manage their own health. This is especially true for those with long term conditions, such as heart disease and diabetes. Health Hawke's Bay has developed a team of Master Trainers and Stanford / Whāriki Facilitators to provide group education sessions to people in their communities which aim to improve people's skills and confidence in managing their own health problems.

Support includes helping people understand their condition, developing the skills to empower good decision making, establishing goal setting and problem solving approaches. The programme supports patients being leaders in their own health and well-being, in close partnership with their medical practitioner. The Whāriki Stanford programme has been in place now for 12 months. During that time, 435 people have participated with 81% completion rate for Maori using the programme.

We have a targeted focus to support individuals and whānau to navigate the complex range of health services rolling out this coming year

Whāriki translates to "the woven mat". It is considered a special skill to be able to weave, taking time and concentration to complete. It allows contemplation and, once complete, is a great achievement.

TE TĀRŪRŪ ME TE MAHI WHAKAORA

ACUTE AND MEDICAL

We are responsible for providing safe and effective care across a number of services including:
Emergency Department, Intensive Care Unit, Radiology, Renal Services, Cancer Services, General Medicine, Cardiology, Respiratory and Palliative Care.

KEY RESULTS

- Continuing to reduce average length of stay for medical patients
- Refurbishment of the Emergency Department (ED) front of house
- Dedicated team adding additional support to Patients at risk of deterioration within the hospital 24/7
- Medical Day Unit now well established and providing 6 beds for those admitted to the hospital for minor investigations and procedures

OUR FOCUS 2016/2017

- Continue to focus on flow of acute patients through the hospital
- In preparation for the National Bowel screening programme and to meet current needs in our community, plans are underway to commence building a standalone gastroenterology and endoscopy suite in early 2017
- With the appointment of a Clinical Nurse Specialist, Trauma and national data collection, we will review and optimise our trauma (serious injury) care
- Continue to focus on the right numbers of staff with the right skills at the right place at the right time.

? DID YOU KNOW

We provide a **24 hour** acute service 7 days per week

45,269 People presented to the emergency department

We have **97** acute adult medical beds

13,342 people with injuries presented to ED. 2,190 were admitted, 79 with severe trauma

The most common cause of severe trauma is motor vehicle accidents

24/7 Stroke thrombolysis

In June 2016, the stroke team began providing 24/7 stroke thrombolysis (a treatment to dissolve the dangerous clots in blood vessels, improve blood flow and prevent damage to tissues and organs) to clinically eligible patients presenting to the Emergency Department with acute stroke.

Our Hawke's Bay stroke team are working closely with our Wellington counterparts, and video conferencing is being used to provide stroke expertise for patients presenting outside of working hours. This technology allows us to be in a position to offer therapy aimed at improving outcomes for clinically eligible stroke patients whenever they need it.

Emergency Department (ED) front of house

Last year we had lots of feedback from the community about how we could improve the ED waiting room. The front of house redesign project is finished, and the improvements are sure to help both staff and patients.

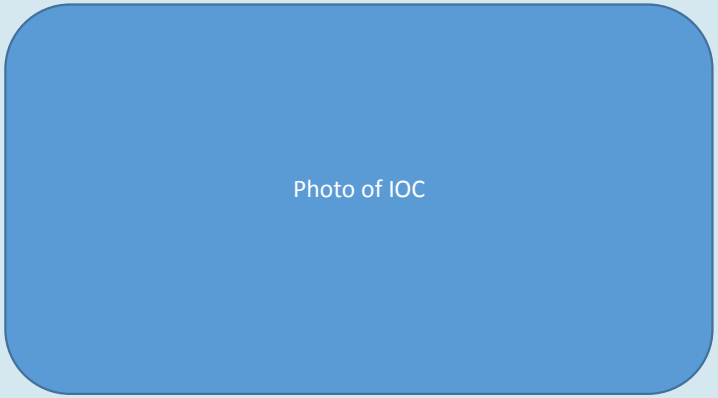
A new wall and electric doors now define ED as its own space, rather than a general thoroughfare into the hospital. This provides a clear process from the front door for patients/visitors and family/whānau. Increased clinical space (a new triage booth and five assessment/intervention bays) will optimise patient privacy, and commencement of interventions therefore supporting patient flow. The clear view that staff now have of patients in the waiting room will also support staff and patient safety.

Integrated Operations Centre (IOC)

The Integrated Operations Centre was opened in March 2016. The main purpose of the IOC is to provide a central hub where the hospital activity is visible and patient flow across the hospital is coordinated. The IOC has become an integral part of the daily management of acute patient flow, which assists us to:

- Provide visibility of real time hospital wide activity
- Predict demand and, therefore, better manage capacity
- Alert us to areas at risk
- Manage patient flow from ED to discharge
- Support us to provide best use of our staff capacity to meet the demand

A key part of the IOC room is the three large screens, which gives us visibility of real time activity and prediction data. These screens show us at a glance what is happening and where any trouble spots are; we can then better support staff to provide high quality care and manage demand through the hospital.



"The Doctor chatted to me the day after surgery so I wasn't still foggy... and took time to answer all my questions. The Anaesthetist was calming and talked through his role and made me feel calm. The nurse kept me updated with the discharge process"

TE POKA TINANA SURGICAL

We are responsible for providing surgical procedures for our consumers, whether they be elective (planned) or acute (not planned or accident) in our seven theatres, carrying out day case surgeries and caring for consumers after they have undergone surgery.

KEY RESULTS

- We exceeded the national elective health target and completed 7,469 surgeries. This was 360 more surgeries than planned.
- Of these we completed 401 hip/knee joint replacements. This was 97 more than last year
- We've prioritised cancer treatment surgery, and conducted xxx of breast cancer operations.
- Stat about average length of stay after hip/knee op – improvement on last year?
- Appointment of a Vascular Surgeon meaning consumers don't need to be sent out of the region for vascular surgery

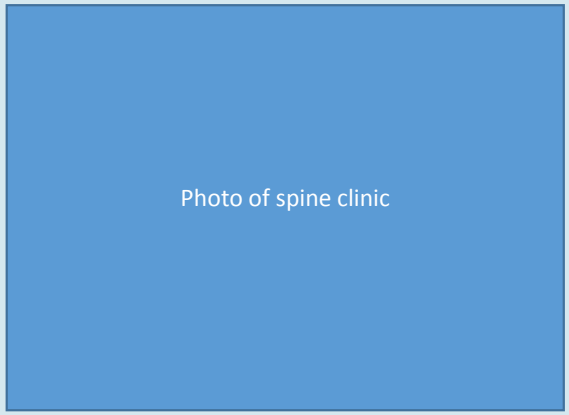
OUR FOCUS 2016/2017

- Continue to improve the numbers of our community receiving surgery
- Updating our theatre facilities to meet the needs of the Hawke's Bay community
- Working with the Ministry of Health to gain funding to support musculoskeletal services focusing on reducing health inequities
- National Patient flow?
- Reduce the wait time for acute surgery by increasing our theatre opening times across the week.

? DID YOU KNOW

- **198** people are seen in the fracture clinic (Villa 1) weekly
- We do around **35** surgeries each day in our 7 Theatres and endoscopy suite
- **1,2670** patients are admitted to our 3 surgical wards yearly
- Around **95** people are seen daily at surgical outpatient clinics
- **819** gynaecology operations completed this year (62 more than last year)

"The day before the procedure I had to come in for the pre-op meeting… I had to see 4 different people who all asked the same questions"



Spine Clinic

Not all people experiencing back pain require surgery. We now have advanced practitioner physiotherapists running a spine clinic providing assessment, diagnosis and physiotherapy treatment. This commenced in Hastings in February 2016 and in Napier in August 2016. These clinics were introduced to provide quicker service to our patients, and release orthopaedics surgeons to focus on surgery.

The clinics have been successful to date with 90% of patients being referred to the spine clinic not needing orthopaedic surgeon follow up.

Improving pre-surgery visits

In February 2016 we commenced the re-design of our pre-admissions process. These are the visits you have with us prior to your surgery to ensure you are safe and ready for surgery.

Our previous system of two different processes and multiple visits was creating confusion and frustration for staff and consumers. Consumers were experiencing significant delays and feeling like they were "double handled" with the same or similar information requested and recorded by different staff members.

We want a consumer centric, safe, efficient, consistent and streamlined process. Ultimately we will have you visit us prior to your surgery only if required, and then only once. In many cases you will only need to be seen by a specialist trained pre-admissions registered nurse. At times, the nurses are able to complete a telephone assessment so that you don't need to come in for a pre-admissions appointment.

So far we have concentrated on improving pre-surgery visits for our healthiest (low risk) patients and have commenced nurse led clinics for orthopaedic, gynaecology, ophthalmology and ear, nose and throat (ENT) specialties. Our next focus will be general surgery and neurology.

"The Spine clinic has provided me with a service that has been focused on rehabilitation catered to my specific needs. Before I began attending the clinic, I had been struggling with menial chores and pain management for around 5 months with no improvement. The clinic has helped me get back into everyday life with a degree of normality by achieving specific milestones. Being able to put my socks on in the morning is just one of those milestones achieved since attending the spine clinic."

HE WĀHINE, HE TAMARIKI, HE TAIOHI HOKI
WOMEN, CHILDREN AND YOUTH

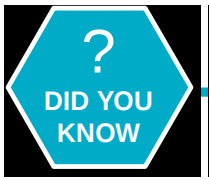
Women, Children and Youth services provide services from early pregnancy through to family/whānau with children under the age of 15 in Napier, Hastings, Central Hawke's Bay and Wairoa. We support women, children and family/whānau through all aspects of their children's health journey from birth to teenagers providing acute and long term conditions assessment and care inclusive of audiology, and ongoing child development services. There is a particular focus on our most disadvantaged with a strong partnership with our violence intervention programmes.

Teenagers living with diabetes

Last year we noticed that many of our teenagers were having a tough time following their diabetic plan. It was hard for them to follow medical treatment which ultimately impacted on their diabetes and led to many coming in to ICU and children's ward with serious health issues related to their diabetes. We submitted a bid, which was approved, for funding to employ a children's outpatient social worker who could work closely with these rangatahi. The results so far have been really positive. Relationships have been built, education and understanding has improved. Important appointments are being attended more consistently now, and engagement with the diabetes team has lifted. Since January 2016 we have engaged with eight high risk teenagers and their family/whānau, the majority of whom are now participating in their diabetic plan and are starting to be more positive about their future with diabetes.

- $2.8m"Waioha" primary birthing centre completed
- Established Maternity Consumer Forums led by consumer members
- Funding to support implementation of the Fetal Alcohol Spectrum Disorder (FASD) programme secured
- Audiology (hearing clinic) waitlist reduced from 2 years to 8 weeks
- Maternity Wellbeing Child Protection coordinator appointed

- Improving consumer engagement to help design and monitor services
- Review of patient management and access to non-acute (non-urgent) services
- Engaging with our youth to look at ways to improve their health
- Improving Family Violence Intervention screening rates (see page 25)
- Increasing the number of births without intervention
- Continuing to improve the coordination of care for women and children with complex needs
- Continuing to collaborate with children and youth agencies and providers



Family Violence, Child Abuse & Neglect, Elder Abuse & Neglect Training was delivered to 298 staff in 2015

Around 14% of babies born in Hawke's Bay require admission to the Special Care Baby Unit (SCBU)

On average we have 16 children daily in our Paediatric - Children's Ward

We gave out 626 Pepi-Pods this year

Child Development Service managed 1,500 new referrals this year

"We were cared for with respect and we went home happy with our new little bundle of joy….thank you"

Family Violence Routine Screening

Family violence is a serious issue in Hawke's Bay. The New Zealand Police attend a family violence callout every six minutes, and on average across the country there are ten family violence incidents per 10,000 people. In Hawke's Bay we have 52 incidents per 10,000 people. That is over five times the national average!

Violence and abuse in families has damaging physical and mental health effects. The impact of witnessing violence can be devastating for children. Hawke's Bay children are exposed to more violence than any others in the country. We know that being a victim of abuse or witnessing abuse is linked to poor health outcomes such as obesity, diabetes, heart disease and depression.

Health care providers across the health sector come into contact with the majority of the population regularly and are therefore in an ideal position to assist people experiencing violence and abuse.

An example of this would be the Visiting Neurodevelopmental Therapists working in the Child Development team. They are well placed to incorporate routine family violence screening questions into their everyday practice. They find that women are appreciative of being asked, and it often enhances their relationship. Recently, during a consultation for a minor developmental need with her child, one mum disclosed extensive family violence in response to the routine questioning and is now working with agencies to support her and her children to move away from that situation. This will have a positive impact.

"Mum has a plan in place, has talked to family and friends and is considering moving out…"

Hawke's Bay Maternity

Hawke's Bay Maternity services work across the sector providing midwifery/maternity care. There are 36 lead maternity carer (LMC) midwives offering care to 2000 women in our region every year. The DHB midwifery and medical staff support and provide care in partnership with woman, family/whānau, LMC midwives and general practice.

Our particular focus over the last year has been building our new $2.8 million primary birthing centre – Waioha - in Hastings and ensuring our culture supports the best place of birth for women/wāhine to achieve the healthiest, safest outcome for themselves and their newborn baby/pēpi.

We continue to focus on involving and engaging with our consumers and encourage those who use our services to have their say. We ask women to complete the Maternity consumer survey monkey "Have Your Say" to capture real time feedback and our maternity community facebook page continues to grow with over 1000 followers. This feedback in all its forms helps us to shape and change how we deliver services to better meet the needs of our community.

Our Napier Maternity resource centre has grown in strength with over 280 women dropping in for pregnancy testing and early booking with a midwife.

"The feedback and uptake from our staff has been nothing but positive and likely to continue to grow so we are very happy how the process is going thus far. Through this relationship we can provide our patients with a level of support and follow up care that is unprecedented both in Hawkes Bay and provincial New Zealand. "- St John's Ambulance Service Acting Territory Manager.

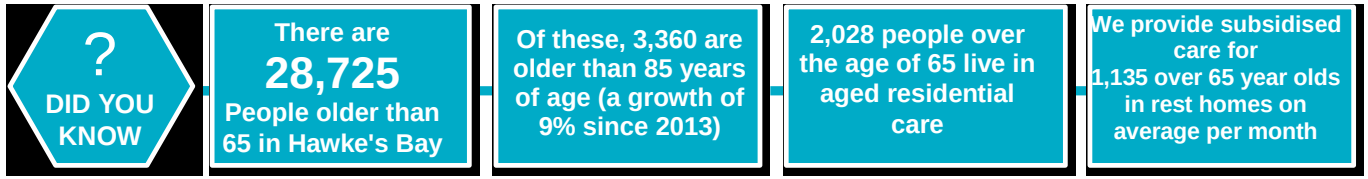
TE ORANGA PĀKEKE
OLDER PERSONS HEALTH

We are responsible for providing a range of services to older people in Hawke's Bay. In the last year the engAGE service has been developed to better support frail older people who live at home to remain independent. This service has three main parts:

- engAGE team meetings are held at general practices across Hawkes Bay. These meetings allow health professionals from across the hospital and community to work more closely together and learn from each other. Team members visit older people at home and work with them to make a plan to achieve their well-being goals.
- engAGE ORBIT team works at the Emergency Department to support older people to return to their home rather than having to stay in hospital. This team is now working longer days, 7 days a week. ORBIT also take referrals from St John's Ambulance and see people in their homes to complete assessments, provide equipment and co-ordinate services for older people who need a rapid response (after a fall for instance).
- engAGE Intermediate Care Beds are beds at residential care facilities in the community where older people can stay for a short period. This service can be used by people who are unwell and cannot manage at home but do not need to be in hospital OR by people who have been in hospital and are well again but not independent enough to go home. The engAGE team works with these people to develop a plan together to get them home and back to independence.

- Since November, over 400 people have received input from the engAGE Community Multi-disciplinary team.
- Since November, ORBIT's move to longer hours 7 days a week has enabled them to see over 800 extra consumers.
- Since June, ORBIT have received 27 referrals from St John's paramedics. These 27 people have either been seen at home or given advice over the phone.
- Since March, 55 people have spent over 800 bed days in Intermediate Care Beds. Approximately two thirds of these people have returned to their own home.

- engAGE service to be developed in Wairoa and Central Hawke's Bay
- engAGE ORBIT team working with Accident and Medical facilities
- Evaluating the impact of the new engAGE service



"Being at home is just huge to Mum, as it is to us"

engAGE Age Well

Jessie is an 84 year old woman who lives at home alone with a supportive family.

She had three admissions to hospital in the space of a month with recurrent diarrhoea which is hard to get rid of and difficult to treat. During each hospital admission it would resolve with antibiotics but would recur when Jessie returned home.

Jessie was losing weight, becoming weak and losing confidence to be able to manage at home. Her family were extremely worried and suggested that she should move into a rest home.

Jessie was referred to engAGE for help with discharge planning and follow-up. She spent 3 weeks in an Intermediate Care Bed (ICB) located in the community with regular input from Physiotherapy and monitoring of her weight and food intake. A family meeting took place before discharge.

Jessie went home with support from engAGE and a plan in place for re-admission to an Intermediate Care Bed if she required it. Jessie has remained well and at home with no further hospital admissions.

"I'd much rather be here and have this situation in place thanks to Dr Lucy"- Jessie.

"The change in her from her last hospital release is just incredible. At home she's just Mum"- Jessie's daughter.

TE ORANGA HINENGARO MENTAL HEALTH

We are responsible for delivering mental health services to people with moderate to severe mental health illness. We have community teams situated in Wairoa, Napier, Hastings and Waipukurau and a residential addiction service in Napier.

MENTAL HEALTH SERVICES
He Wāhanga Ōranga Hinengaro

KEY RESULTS

- Completion of a $22 million new building - Ngā Rau Rākau Mental Health Inpatient Unit
- Length of inpatient stay has decreased since the opening of the new inpatient unit resulting in more effective care for patients
- Ongoing implementation of a new model of care for the way services are delivered. We have established home based treatment, community resilience programmes and intensive day programmes which have decreased inpatient hospitalisations.
- Wait time for first appointment at Te Harekeke /Child and Family Service has reduced. In December 2015, 59% of people were seen within 3 weeks. In July 100% of people were seen within 3 weeks of referral

OUR FOCUS 2016/2017

- Continuing to develop and implement new services to support our consumers
- Strengthening the Community Mental Health Teams to manage and reduce the number of consumers needing acute treatment
- Recruit further staff to support our Mental Health Crisis Teams
- Continue to reduce the time children and their families wait for their first appointment with Te Harakeke/Child and Family Service

? DID YOU KNOW

X appointments with Child, Adolescent and Family Service (CAFS) per day

We have an inter-professional crisis team who are available all day, every day

We provide Maternal Mental Health specialist services for pregnant women who experience moderate to severe mental health issues

15 beds in Springhill Treatment Centre

""Big thumbs up to the newly formed Home Based Support team. I was able to experience their professional, caring and empathetic support … when my daughter had a blip in her mental health. The support received… was exceptional (with three visits) over the weekend and each visit left (her) feeling more empowered and confident… 10/10 to the DHB for this service".

Opening of Nga Rau Rakau

On February 23, 2016, we celebrated the milestone achievement of officially opening the new mental health inpatient unit, Ngā Rau Rākau. Minister of Health, Jonathan Coleman, and Partnership Advisory Group Chair, Deborah Grace, officiated with cutting the ribbon.

The name of the new unit, Ngā Rau Rākau, means a collection of trees. By standing together, as part of the forest, Ngā Rau Rākau, the trees are protected, they are sheltered, they grow healthier, they grow stronger, they are supported and safe. And that's what developing our mental health services has been all about - growing the service, listening and transforming mental health services for Hawke's Bay people.

Home Based Treatment intervention prevents admission

Waekura Home Based Treatment prevents inpatient admissions and makes a positive difference in the life of consumers and their family/whānau.

A powerful case study: A young adult presented to the Emergency Department. The impression gained from the notes was that the consumer was recommended to be admitted to the inpatient unit.

The mental health assessment indicated moderate risk and the Home Based Team (HBT) thought this was a situation that could be managed effectively in the home setting.

The consumer was not keen on being admitted to the inpatient unit but needed support to cope with the impact of an upcoming significant event. Staff used multiple strengths-based, evidence-based counselling approaches which gave the family and consumer confidence to deal with the situation.

The consumer engaged well with HBT, stayed at home, was monitored at a relative's house, was visited daily by whānau, and received regular HBT clinician interventions.

The consumer also re-engaged with friends, built confidence, became much more resilient, and developed more positive thinking.

TE TUAWHENUA, Ā-WAHA, TE HAPORI HOKI
RURAL, ORAL AND COMMUNITY

The Rural, Oral and Community Directorate (ROC) has services located in Wairoa, Central Hawke's Bay, Napier and Hastings. Most of our services support people staying well in their community with a focus on integration and collaboration of services with primary care, Māori providers and other providers. ROC services provide a diverse range of care including: community nursing, pulmonary long term management, continence services, ostomy. Napier Health, outpatients, public health nursing, integrated sexual health services, Health Care Centre – Wairoa (HCC) – a general practice, Central Hawke's Bay Health Centre, diabetes service, endocrinology, hospital dental and community dental service (school dental service).

KEY RESULTS

- Community Nurses working alongside general practices in both Napier and Hastings.
- Increase in pulmonary long term conditions group sessions for patients with breathing issues. 10 groups increased to 22 and are more accessible in the community. For the first time, the programme was implemented in Wairoa.
- Networking with health providers in the community is progressing in Central Hawke's Bay and Wairoa

OUR FOCUS 2016/2017

- Implementing the District Nurses more closely with General Practice into Wairoa and Central Hawke's Bay.
- Involving other health providers in improving access for Māori children and whānau to dental care.
- More healthy warm homes
- Reducing hospital admissions for children.

? DID YOU KNOW

7,763 patients enrolled in a general practice in Wairoa

From January (when the programme began) to June 1,163 people attended pulmonary long term management sessions

28,024 children enrolled with community dental

2,950 Clinic appointments were held in Napier Health

Development of the Pulmonary Long Term Management Service

During 2014/2105 the Pulmonary Rehabilitation Service experienced a large increase in referrals to attend the Pulmonary Rehabilitation courses which at the time were offered four times a year in Napier, Hastings and twice yearly in Central Hawke's Bay. The increase in referrals was due to improved access to spirometer (lung function) services in the primary care setting.

The Pulmonary Rehabilitation Specialty Clinical Nurse identified the service could not accommodate this level of referrals and a business case was developed to alter the service model and allow for increased service provision throughout Hawke's Bay.

This resulted in the development of the Pulmonary Long Term Management Service and implementation of a new model which commenced in January 2016. This has doubled the availability of Pulmonary Rehabilitation courses in the community, and allowed the service to be offered in Wairoa as well as Central Hawke's Bay.

The programme outcomes for this patient group have demonstrated reduced presentations to the emergency department, reduced hospitalisations, improved quality of life and fitness. Patients and families have an increased understanding of their condition and improved confidence with self-management.

E Tu Wairoa – Violence Free Whānau

In 2015 Wairoa leaders decided to establish an intersectoral network with the purpose of creating a tikanga based approach to eliminating violence in our homes and community.

The network is chaired by the Wairoa Health Centre manager and to date have launched the E Tu Whānau charter with a commitment from many community members and leaders including Wairoa Mayor, Craig Little.

A programme of action has been developed and recruitment of a network coordinator is underway. The network has also secured funding to develop and deliver tikanga based programmes to address family violence.

This is an exciting collaboration of providers and community members who believe in a common goal and have worked across structures and barriers to establish a family violence intervention model that is locally grown and delivered.

NGĀ WHĀINGA HAUORA Ā-MOTU
NATIONAL HEALTH TARGETS

Our results

✓ **105%**

7,469 surgeries were delivered. That is 360 more than the plan

✗ **63% of people**

referred with a high suspicion of cancer received their first treatment within 62 days

✓ **95% of eight-month olds had their immunisations on time.**

✓ **88% of the eligible population had their Cardiovascular Disease risk assessed in the last five years.**

✗ **93% of people spent less than six hours in the Emergency Department.**

✓ **99% of hospitalised smokers were offered advice to quit.**

✗ **81% of those consumers who are smokers and have a family doctor were offered advice to quit.**

NGĀ WHĀINGA HAUORA Ā-MOTU – HE TIROHANGA
NATIONAL HEALTH TARGETS - AT A GLANCE

HEALTH TARGET	TARGET	OUR RESULT	TREND (since last year)	COMMENT
Shorter stays in Emergency Department	95%	Not Achieved	↓	TBC
Improved access to elective surgery	100%	Exceeded (105%)	↑	This year we have continued to focus on 'Operation Productivity' and increasing Hip and Knee surgeries (pg22) to increase the number of people receiving surgery.
Faster Cancer Treatment	85%	Not achieved (63%)	N/A	The Faster Cancer Treatment team are working with improved processes to identify patients on the cancer pathway and we expect to see improvement in the coming year.
Increased Immunisation	95%	Achieved	-	Hawkes' Bay DHB remains one of the top performers in this Health Target. All immunization service providers are working well together.
Better help for smokers to quit (Hospitals)	95%	Exceeded	-	Hawke's Bay DHB has achieved this target for the last three years.
Better help for smokers to quit (Primary Care)	90%	Not achieved (81%)	↓	General Practice continues to have a strong focus on helping smokers to quit including "Stoptober" campaign in October, practice resources and recruitment of a community smokefree community systems coordinator
More heart and diabetes checks	90%	Not achieved (88%)	↓	We have maintained our performance in this area and continue to focus on priority groups who are most at risk of heart disease and diabetes.

KEY:

↑ Improved our performance against the health target.

↓ Our performance against the health target has declined

– Our performance against the health target has stayed the same.

Photo courtesy of HB Today

HE AITUĀ TAUMAHA
SERIOUS ADVERSE EVENTS

In hospital

A serious adverse event is an event which has led to significant additional treatment, is life-threatening or has led to an unexpected death or major loss of function.

These events are uncommon; however with 38,715 hospital admissions in 2015/2016, we continue to focus on improving the quality and safety of the care that we provide to all our consumers so that we can prevent these events in the future.

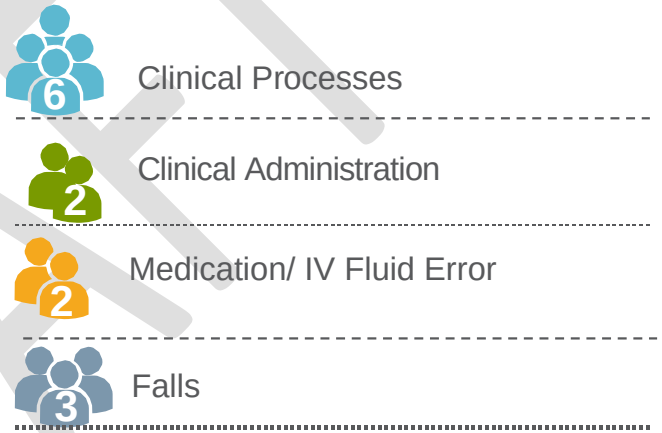
In 2015/2016 Hawke's Bay DHB had 13 serious adverse events which is an increase by two from last year.

When a serious adverse event occurs, we review our processes to try to determine the major cause, or causes that led to the event. When these causes are known, interventions are recommended to try to prevent the recurrence of the same or similar adverse event in the future. The aim is to enhance patient safety by learning from adverse events when they occur.

Did you know?

- Incidents indicate where we need improvement
- The more we report the better we will get through learning and improving
- We reported 4,168 incidents last year
- 13 of these were classified as serious adverse events
- Serious Adverse Event reviews focus on what happened? Why did it happen? What can be done to prevent it happening again?

Serious events 2015/2016



Our focus 2016-2017

- Distribute key patient safety learnings across the sector
- Develop an education programme to train reviewers of serious adverse events
- Work with PHO, GPs and aged care facilities to establish a reporting and learning programme/culture
- Upgrade our electronic risk management system

The Health Quality and Safety Commission releases an annual report titled 'Making our health and disability services safer', which is due to be released later this year. In this report we will provide more detail surrounding these events.

NGĀ MEA MATUA O TE HAUMARU TŪRORO Ā-MOTU
NATIONAL PATIENT SAFETY PRIORITIES

In hospital

The Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's health care through the national patient safety campaign 'Open for Better Care'. All of New Zealand's District Health Boards need to report on how well they are doing against key targets. These targets are about making sure consumers are not harmed from a fall when in our care, that we reduce the number of infections and that we make sure that when consumers have surgery that they receive the necessary medicines, and that we work as part of a team.

This is how we are doing (results for Jan-Apr 2016 unless otherwise specified):

Falls prevention 1: older consumers assessed for risk. Target 90%

Falls prevention 2: percentage of older patients assessed as at risk of falling who receive an individualized care plan addressing these risks. Target 90%

Hand hygiene: percentage of health professionals who clean their hands before and after having contact with a patient. Target 70%

Surgical site infection targets (Oct-Dec 2015):

Antibiotic administered in the hour before surgery. Target 100% (Achieved 100% in the three quarters prior)

Right antibiotic in the right dose.

Target 95%

Appropriate skin antisepsis in surgery.

Target 100%

Preventing harm from medicines in hospital

In the hospital we commonly use a group of pain killer medicines called 'opioids' (e.g. 'morphine', 'oxycodone', 'codeine'). Unfortunately these medicines can cause serious side effects like constipation. Constipation is when you haven't had a bowel motion ('poo') for three days or more. It can be painful and delay your recovery.

We introduced three things to reduce the number of patients having constipation while on opioids:

1) A patient leaflet and poster to help patients and staff describe bowel motions using the 'Bristol Stool Chart'.
2) A stamp for the patient's health record, to improve how we record each patient's bowel activity - giving us a clearer view of which patients are constipated or at risk of becoming so.
3) A 'laxative ladder' to describe the best laxatives to prevent and treat constipation.

Preventing harm from surgery in hospital

The 'Safe Surgery Program' aims to improve quality and safety of health care services provided to patients having surgery through the use of a 'surgical safety checklist'. The checklist is used to ensure patients receive the right surgery with the right preparation.

This year, a 'paperless' checklist (a poster with prompts) was introduced in our operating theatres. Theatre staff (nurses, doctors and anaesthetists) from Hawke's Bay and Royston Hospitals worked together to ensure they use the checklist in the same way. This enables staff to speak up and ask questions without fear.

Preventing harm from falls in hospital and the community

Last year we planned to take a 'wrap-around' approach to preventing falls and we've made some good progress on this since then. Representatives from HBDHB, Health Hawke's Bay (PHO), Sport Hawke's Bay, St John's Ambulance, ACC, and local Aged Care Facilities meet regularly to actively coordinate falls prevention activities across the region.

During the national 'April Falls' campaign (run in April), the group chose to highlight the falls risk associated with poor vision with 'eyes on falls', offering free eye checks.

An 8-week program called 'Upright and Active' (funded by Age Concern) introduces Tai Chi to improve flexibility and strength. Green Prescription offers individual support programmes and Kori Tinana Mo Nga Kaumatua Taster programmes is offered to kaumatua, based in marae.

We've looked into why people fall in hospital and have found poor lighting at the bedside to be a key factor. We now have an upgrade of the over-bed lighting included in the facilities' maintenance plan.

Preventing Harm from Infection

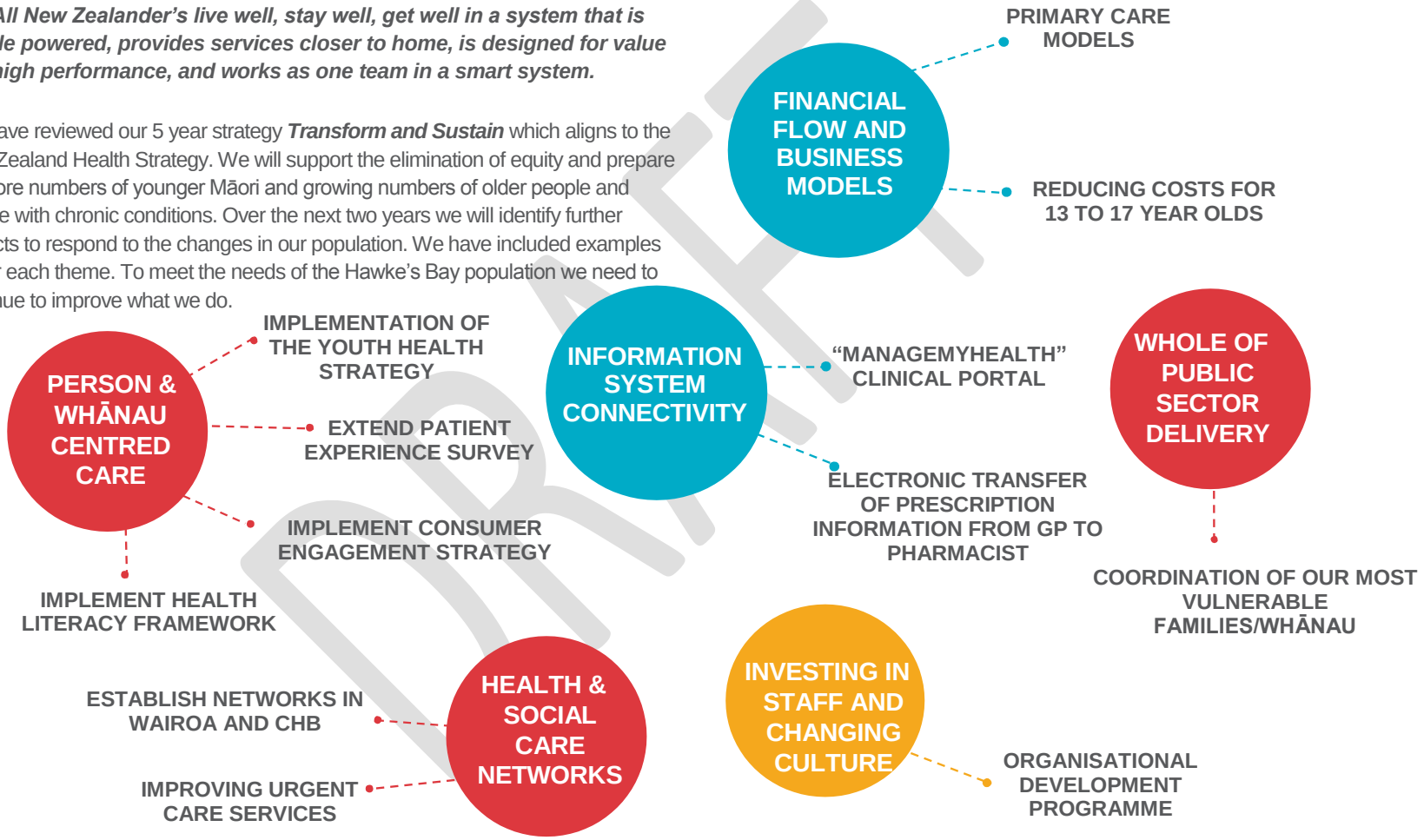
Hand hygiene is recognised as the single most effective way to prevent the spread of infection. As at June 2016 Hawkes Bay District Health Board has achieved 87.5% in the national hand hygiene programme and continues to rank amongst the top performers in NZ.

This year our focus will be the promotion of appropriate usage of antibiotics. We see this as an important patient safety issue to prevent the overuse of antibiotic and the development of multi resistant organisms. Our aim is to improve patient outcomes.

TŌ TĀTOU ARONGA MŌ ĀPŌPŌ
OUR FUTURE FOCUS

With the refresh of the New Zealand Health Strategy, we will be working to ensure that: ***All New Zealander's live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.***

We have reviewed our 5 year strategy ***Transform and Sustain*** which aligns to the New Zealand Health Strategy. We will support the elimination of equity and prepare for more numbers of younger Māori and growing numbers of older people and people with chronic conditions. Over the next two years we will identify further projects to respond to the changes in our population. We have included examples under each theme. To meet the needs of the Hawke's Bay population we need to continue to improve what we do.



OUR QUALITY PICTURE 2016

KO Ā KOUTOU WHAKAHOKINGA KŌRERO
YOUR FEEDBACK

Consumer feedback

We welcome and appreciate receiving feedback. To improve our services we need to hear your story. Whether compliments, comments, questions or suggestions, complaints or a mixture, your feedback is valuable. It helps us see where we are performing well and where we could improve.

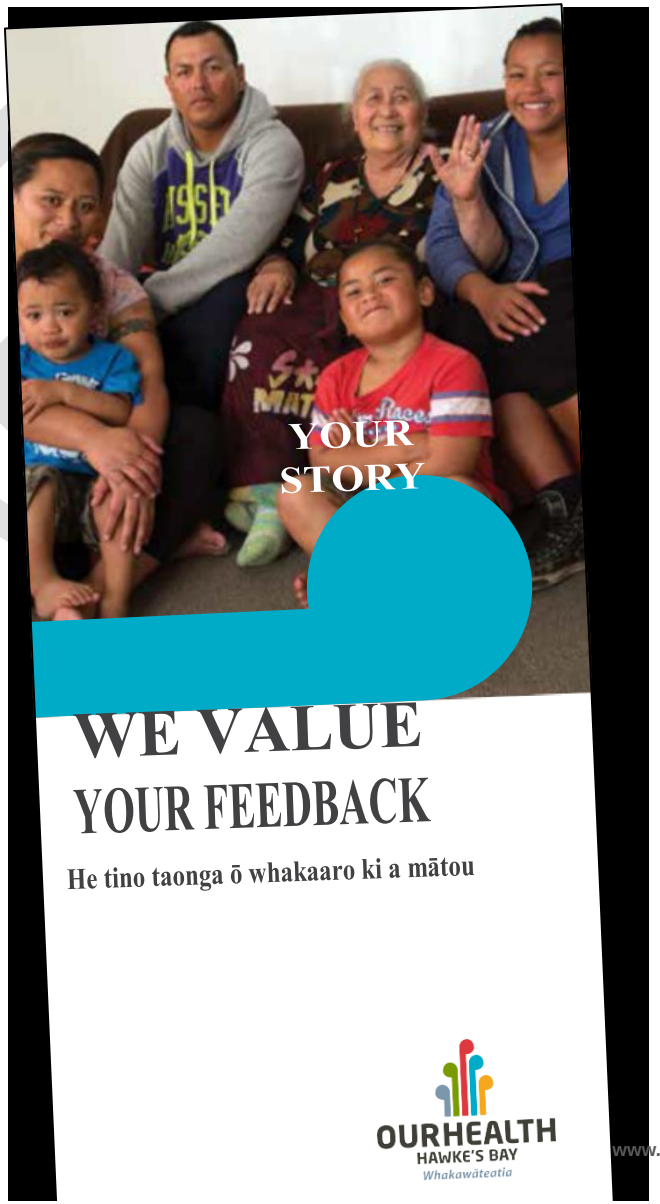
You can give feedback in a number of ways:

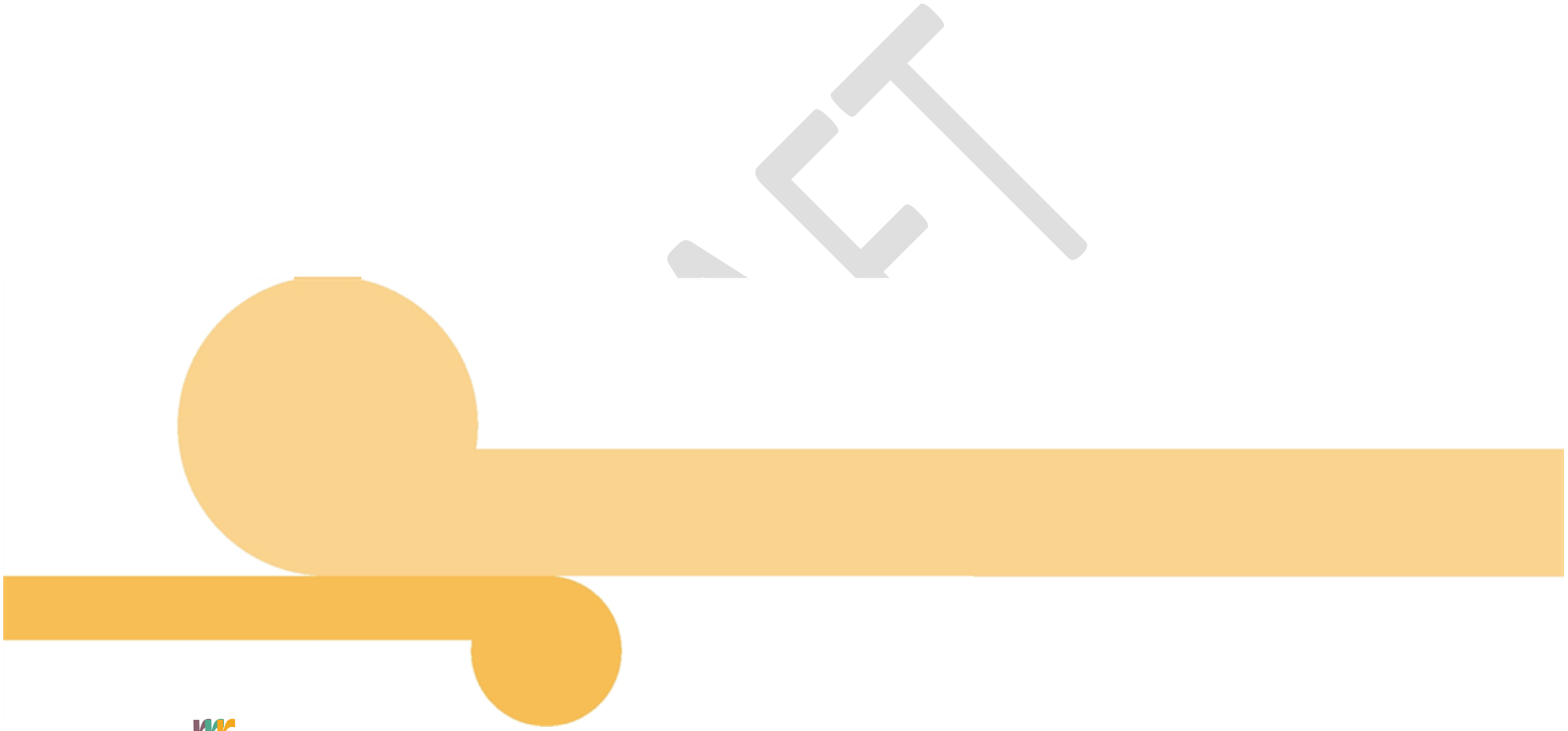
- email us: feedback@hbdhb.govt.nz
- complete an online feedback form: www.ourhealthhb.nz
- phone us: 0800 000 443
- complete a freepost feedback form which may be given to you when you visit, or which can be found in many areas across the DHB's sites.

You may receive a phone call or receive a request to complete a survey based on your experience. It is your choice to take part or not.

Then what happens?

Your feedback will be passed to the manager of the area you are providing feedback on. We will acknowledge your feedback, and if your feedback is a complaint an investigation will take place. We will let you know what we have found out and this may include what we have done to make things better, or what we are planning on doing to ensure things improve.





OUR HEALTH
HAWKE'S BAY

Communications Plan for release of Quality Accounts 2016

What	By Whom	When
Quality Account Final ready for endorsement	Jeanette to develop in conjunction with working group, DHB services and PHO. Consultation via EMT, MRB, Consumer and Clinical Councils	16 September 2016
Posters to support Quality Accounts ready for final endorsement (developed to highlight specific quality improvement initiatives and to direct consumers to publication -web/hard copy)	Pauline to develop with guidance from Working Group and consultation feedback	16 September 2016
Final signoff of Quality Accounts and Posters	HBDHB Board HHB Board	28 September 2016 13 October 2016
Printing quote for how many copies of posters and Booklets to be decided	Jeanette to advise how many copies to be printed plus cost centre and purchase order on receipt of quote from printer	ASAP
PDFs off to printer following sign off	Pauline/Anna	14 October 2016
Printed copies distribution list	Jeanette to provide distribution list to include libraries, council General Practice, HBDHB, PHO facilities	To be completed on time of printed copies to be received
At the same time of distribution of printed copies carousel to go up on Our Health Website	Pauline to complete carousel visual	Visual to be completed by 20 October 2016 To be published on ourhealth website
Press release	Anna to develop PR use spokesperson from Consumer Council on release, What it means and why people should be interested.	To be released in early November to coincide with posters and booklets being distributed
In Focus	Anna	November 2016
Facebook /Staff notices	Anna	November 2016
Newspaper advertisement Napier and Hastings Mail	Anna/Pauline to develop advertisement Kate to cover purchase order and cost centre	November 2016

MANAGE MY HEALTH PROVIDER PORTAL

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Designated Prescriber – Registered Nurses**
	For the attention of: **HB Clinical Council**
Document Owner: Document Author(s):	Chris McKenna, Chief Nursing Officer Sally Houliston, Nurse Consultant Workforce Development
Reviewed by:	Health Services Leadership Team and Executive Management Team
Month:	September 2016
Consideration:	For Information and support

9

RECOMMENDATION

That HB Clinical Council:

Note the contents of this report and positioning of the nursing workforce to support and enable the implementation of nurse prescribing.

OVERVIEW

The Medicines (Designated Prescriber-Registered Nurses) Regulation 2016 means that registered nurses, authorised by Nursing Council of New Zealand (referred to as 'the Council'), will be able to prescribe for patients with a range of conditions such as minor infections, respiratory disease or cardiovascular health concerns, in outpatient or nurse led clinics. This is important because in New Zealand, as elsewhere in the developed world, there is growing demand for care for those living with these chronic conditions. The case for the expansion of registered nurse prescribing, beyond diabetes care, is compelling. It enables nurses to make a bigger contribution to health care in New Zealand and should lead to the achievement of more equitable results for groups with poorer health outcomes, particularly Māori and Pacific people and those with disabilities, as well as those in remote and rural areas. The development of this new framework has been five years in the making. Nursing Council consulted extensively with numerous stakeholders and proceeded cautiously to develop a model that has widespread support.

BACKGROUND

The first prescribing nurse practitioner (NP) was authorised in 2001 and the first registered nurses (RNs) to prescribe followed a decade later in 2011 with the demonstration trial of prescribing diabetes nurse specialists (of which HBDHB participated in this trial). That same year, then Health Minister Tony Ryall, invited Council to apply to widen prescribing rights to other suitably qualified RNs. Following a consultation process, Council submitted its application for RN prescribing rights at the end of 2014. In June this year, the Medicines (Designated Prescriber-Registered Nurses) Regulations 2016 received the Governor General's Seal. This means that the Regulations are now law and will be in force from 20 September 2016 (refer attachment 1).

Registered nurse prescribing in primary health and specialty teams is designed to improve patient access to health care and medicines and to meet the demand of growing numbers of New Zealanders with chronic health conditions such as hypertension, asthma and diabetes. Registered

nurse prescribing covers diabetes and related conditions, hypertension, respiratory diseases including asthma and COPD, anxiety, depression, heart failure, gout, palliative care, contraception, common skin conditions and infections.

Registered nurses working in collaborative teams in a range of settings - including general practice, specialist outpatient clinics, family planning, sexual health, public health, district and home care, and in rural and remote areas - are already regularly involved in medicines management and education of patients. The new regulation will enable nurses to take accountability for prescribing decisions based on their assessments rather than working under standing orders or asking a doctor to sign a prescription. It will also improve patient access to health care and the medicines they need, make care more convenient for patients and free up doctors' time. The nurse will prescribe a small number of medicines from the approved list of medicines relevant to their area of practice and competence.

This development for prescribing for registered nurses builds on registered nurse prescribing in diabetes health. The diabetes initiative has seen approximately 55 nurses nationally achieve prescribing rights in an area of high and increasing patient need. Registered nurses prescribing in diabetes health work in teams with doctors, nurses and dieticians to manage and monitor patients. Prescribing authority adds to their skills and their contribution to patient care. It has been evaluated as being beneficial and safe and supported by the multidisciplinary team. Benefits to employers were identified as increased productivity of clinical staff, cost savings, improved service delivery, improved access to services including saving patients time and money[1].

Difference between Registered Nurse Prescribing and Nurse Practitioner

A clear difference between a registered nurse with prescribing authority and a nurse practitioner exists.[2]

	Registered nurse prescribing in primary health and specialty teams	**Nurse practitioner**
Prescribing authority	Designated prescriber: able to prescribe specified prescription medicines.	Authorised prescriber: able to prescribe any prescription medicine.
Scope of practice	Must work in a collaborative team with an authorised prescriber available for consultation. Able to diagnose and treat common conditions (e.g. asthma, diabetes, hypertension) within a collaborative interdisciplinary team.	Able to independently assess, diagnose and treat a range of acute and/or chronic conditions for a population group in an area of practice. May work autonomously or within a healthcare organisation. Consults with health professional colleagues when relevant.
Additional qualification	Postgraduate diploma in registered nurse prescribing for	Clinical master's degree in nursing

[1] Registered nurse prescribing in diabetes health secondary care evaluation and case studies, found in Budge, C. and Snell, H. (2013). Registered Nurse Prescribing in Diabetes: 2012 Managed National Roll Out Project Report. New Zealand. Prepared for Health Workforce New Zealand by the New Zealand Society for the Study of Diabetes. Available at: http://www.nzssd.org.nz/healthprofs/13%2010%20Registered%20Nurse%20Prescribing%20in%20Diabetes%20Care%20final%20report.pdf

[2] Nursing Council of New Zealand (2016). Preparing to prescribe in primary health and specialty teams: Guidance for registered nurses and employers. Available at: http://www.nursingcouncil.org.nz/News/Registered-nurse-prescribing-in-primary-health-and-specialty-teams-to-be-introduced-in-September-2016

	long-term and common conditions	

Another recent change is the Medicines (Standing Order) Amendment Regulations 2016, extends the definition of who are permitted to issue standing orders to include optometrists and nurse practitioners. This means nurse practitioners can issue standing orders and must comply with the regulatory requirements for monitoring and audit of the standing orders they issue (Medicines Standing Order Regulation 2002 and Standing Orders Guidelines, Ministry of Health. Nurse practitioners having the ability to issue standing orders will improve access to medicines and effective treatment and allows nurse practitioners to work to the full extent of their scope.

Educational and Clinical Requirements for Registered Nurse Prescribing

Three years clinical experience as well as a postgraduate diploma for registered nurses prescribing in long term and common conditions are the entry requirements for nurses wanting to become authorised to prescribe. The clinical practice must be in the area where the nurse intends to prescribe.

The postgraduate diploma covers:

1. Pathophysiology;
2. Pharmacology;
3. Assessment and diagnostic reasoning in relation to the clinical management of, and prescribing for, patients with long term and common conditions in New Zealand;
4. A prescribing practicum to develop diagnostic skills, patient consultation and assessment skills, clinical decision making and monitoring skills - a minimum of 150 hours under the supervision and mentorship of a prescribing mentor.
    a. Prescribing Mentor - is a senior medical practitioner or nurse practitioner who has agreed to support and assess the nurse
    b. Assessment will be against the Competencies for nurse prescribers
    c. Before enrolling in the practicum, the registered nurse needs to be working for an employer that supports nurse prescribing and where they have a collaborative working relationship with a multidisciplinary team as well as the support of a prescribing mentor
    d. The nurse and their mentor will be supported by the postgraduate diploma academic teaching staff during the prescribing practicum.

Locally, the School of Nursing at Eastern Institute of Technology have developed a nurse prescribing practicum to meet RN prescribing requirements (refer attachment 2). Nursing Council accreditation visit for this paper is scheduled for 2nd & 3rd November 2016, and subject to approval, EIT will offer the prescribing paper in semester 1 2017.

Making Prescribing Work

Support for nurse prescribing is essential to make it work. Nurses will need to work in a position that actively supports their prescribing and where the authorised prescriber mentors (senior medical practitioners or nurse practitioners) are available for consultation and advice about prescribing decisions, if the patient's presenting health concerns are more complex than the nurse can safely manage independently.

Prescribing nurses should also have sufficient time and resources allocated to allow effective assessment, diagnosis and consultation with patients to ensure safe and appropriate prescribing decisions.

Any prescribing framework needs to be linked to clinical governance structures, such as within the DHB or PHO, and committees that overs quality and risk and medicines review e.g. Pharmacy and Therapeutics Committee.

IMPLEMENTATION WITHIN HB HEALTH SECTOR

There is opportunity for nurses to contribute even further to the health needs of the population, especially in communities with high health needs and other inequalities, with nurse prescribing as another enabler. This might be in areas such as:

- Rheumatic fever, throat infections, strep throat
- Skin infections
- Teenage pregnancy
- Wound care.

An enabling framework for supporting a nurse to move into nurse prescribing is necessary. This needs to include the following steps:

1. Potential population identified where nurse prescribing can be implemented
2. Primary Care or Speciality Team agree and can provide mentor support (SMO / GP / NP)
3. Chief Nursing Officer (or delegate) support given prior to commencing prescribing practicum (to ensure all relevant supports in place)
4. Notification and linkage into governance i.e. Pharmacy & Therapeutics Committee or PHO Clinical Advisory Group (CAG)

NEXT STEPS

Continuing to build capability and capacity of the nursing workforce is required to support nurses to move through into prescribing endorsement (in addition to the enabling framework described). This capability is already occurring through the Health Workforce New Zealand (HWNZ) postgraduate nursing funding contract. The Chief Nursing Officer and senior nursing leadership teams have been supporting the nursing workforce with the academic requirements in preparation for nurse prescribing. It is known, through the HBDHB HWNZ postgraduate data that there is a cohort of nurses who currently work in primary health and specialty teams within the HB health sector who have the relevant academic preparation and would be ready to commence a prescribing practicum, if there was appropriate prescribing and organisational support to do so. There is another small cohort of nurses who have already achieved the equivalent academic requirements, and would be able to be assessed against competencies for nurse prescribers.

With continuation of the HWNZ PG nursing contract, the capability and capacity of the workforce will continue to be developed, utilising prioritisation criteria to support in particular, nurses working in clinical areas with teams, where nurse prescribing can make a difference to population health. This will be done in conjunction with relevant nurse leaders, clinical teams and other professional teams, with the Chief Nursing Officer giving final approval before the nurse enters into the prescribing practicum.

ATTACHMENTS

- Medicines (Designated Prescriber-Registered Nurses) Regulations 2016
- RN Prescribing Fact Sheet

2016/140

Medicines (Designated Prescriber—Registered Nurses) Regulations 2016

Jerry Mateparae, Governor-General

Order in Council

At Wellington this 20th day of June 2016

Present:
His Excellency the Governor-General in Council

These regulations are made under sections 105 and 105B of the Medicines Act 1981—

(a) on the advice and with the consent of the Executive Council; and

(b) on the advice of the Minister of Health given in accordance with section 105(1) of that Act.

Contents

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4	Interpretation	2
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8	Assessment of competence to be completed	3
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10	Prohibition against prescribing specified prescription medicines	4
11	Revocation	4

Regulations

1 Title

These regulations are the Medicines (Designated Prescriber—Registered Nurses) Regulations 2016.

2 Commencement

These regulations come into force on 20 September 2016.

3 Purpose

The purpose of these regulations is—

(a) to authorise registered nurses who meet specified requirements for qualifications, training, and competence to be designated prescribers for the purpose of prescribing specified prescription medicines; and

(b) to provide for the qualifications, training, and competence requirements; and

(c) to prohibit registered nurses from prescribing specified prescription medicines if they fail to comply with the requirements; and

(d) to make non-compliance with the requirements an offence.

4 Interpretation

In these regulations, unless the context otherwise requires,—

Act means the Medicines Act 1981

registered nurse means a health practitioner who—

(a) is, or is deemed to be, registered with the Nursing Council of New Zealand continued by section 114(1)(a) of the Health Practitioners Competence Assurance Act 2003 as a practitioner of the profession of nursing and whose scope of practice permits the performance of registered nurse functions; and

(b) holds a current practising certificate

specified prescription medicine means a prescription medicine that—

(a) is specified for prescription by registered nurses by notice in the *Gazette* under section 105(5A) of the Act; or

(b) belongs to a class or description of prescription medicines that are specified for prescription by registered nurses by notice in the *Gazette* under section 105(5A) of the Act.

5 Authority to prescribe specified prescription medicine

A registered nurse may prescribe a specified prescription medicine if he or she complies with the requirements of regulations 6, 7, and 8.

6 Requirements for commencing to prescribe for first time

Before prescribing a specified prescription medicine for the first time, a registered nurse must—

(a) obtain the qualifications required for registered nurses, or a class of registered nurses, specified by the Nursing Council by notice in the *Gazette* for the purposes of these regulations; and

(b) undertake and successfully complete the training for registered nurses, or a class of registered nurses, specified by the Nursing Council by notice in the *Gazette* for the purposes of these regulations; and

(c) demonstrate to the satisfaction of the Nursing Council that he or she is sufficiently knowledgeable to safely prescribe specified prescription medicines; and

(d) be authorised by the Nursing Council to prescribe specified prescription medicines.

7 Other training to be undertaken

Before prescribing a specified prescription medicine, a registered nurse must—

(a) undertake and successfully complete any training for registered nurses, or a class of registered nurses, specified by the Nursing Council by notice in the *Gazette* for the purposes of these regulations; and

(b) do so within the periods, or at the times, specified for the purpose in the notice, if the training is of an ongoing nature.

8 Assessment of competence to be completed

Before prescribing a specified prescription medicine, a registered nurse must—

(a) successfully complete any assessment of his or her competence to prescribe specified prescription medicines that is specified by the Nursing Council by notice in the *Gazette* for the purposes of these regulations; and

(b) do so within the periods, or at the times, specified for the purpose in the notice, if the assessment is to be completed at regular intervals.

9 *Gazette* notices

(1) For the purposes of these regulations, a notice in the *Gazette*—

(a) comes into force on the day after the date of its publication or on a later date specified for the purpose in the notice; and

(b) may provide that it expires, if not revoked earlier, at the end of a specified day.

(2) Within 5 working days after the date of publication of a notice in the *Gazette* for the purposes of these regulations, and while the notice remains in force, the

Nursing Council must ensure that an up-to-date version of the notice is available—

(a) on the Internet; and

(b) at the office of the Nursing Council during business hours, so that members of the public may—

(i) inspect the notice free of charge; and

(ii) obtain a copy of the notice for a reasonable fee.

10 Prohibition against prescribing specified prescription medicines

(1) A registered nurse must not prescribe a specified prescription medicine unless he or she complies with the requirements of regulations 6, 7, and 8.

(2) A registered nurse commits an offence if he or she breaches subclause (1) and is liable on conviction to a fine not exceeding $500.

11 Revocation

The Medicines (Designated Prescriber—Registered Nurses Practising in Diabetes Health) Regulations 2011 (SR 2011/54) are revoked on the close of 30 November 2016.

Michael Webster,
Clerk of the Executive Council.

Explanatory note

This note is not part of the regulations, but is intended to indicate their general effect.

These regulations come into force on 20 September 2016. They permit certain registered nurses to prescribe prescription medicines that are specified for prescription by registered nurses by notice in the *Gazette* under section 105(5A) of the Medicines Act 1981. To be permitted to do so, registered nurses must meet the requirements of the regulations relating to qualifications, training, and competence.

The Nursing Council may specify details of the qualifications, training, and competence requirements by notice in the *Gazette*.

A registered nurse who does not meet those requirements must not prescribe the specified prescription medicines. A registered nurse who does so commits an offence and is liable on conviction to a fine not exceeding $500.

These regulations supersede the Medicines (Designated Prescriber—Registered Nurses Practising in Diabetes Health) Regulations 2011 (the **2011 Regulations**). However, as a transitional measure, the 2011 Regulations are not revoked until the close of 30 November 2016.

Issued under the authority of the Legislation Act 2012.
Date of notification in *Gazette*: 23 June 2016.
These regulations are administered by the Ministry of Health.

Wellington, New Zealand:
Published under the authority of the New Zealand Government—2016

Postgraduate Diploma (RN Prescribing)
Fact Sheet and Education Pathway

In accordance with Nursing Council of New Zealand

The Eastern Institute of Technology (EIT) is pleased to advise that our Nursing Council of New Zealand (NCNZ) accreditation for the RN prescribing postgraduate diploma will be undertaken in November this year. We are hopeful of a successful outcome for this accreditation process, based upon which, we anticipate offering the PG Diploma for RN Prescribing from Semester 1 2017.

Here is some information on RN Prescribing, based on the information we have received from NCNZ, following which we have provided our anticipated pathway to completion of the programme at EIT.

For any queries on the programme, please contact:

Ass Prof Clare Harvey (Postgraduate Programmes Co-ordinator) – Email charvey@eit.ac.nz ; Tel 06 9748000 ext.5714

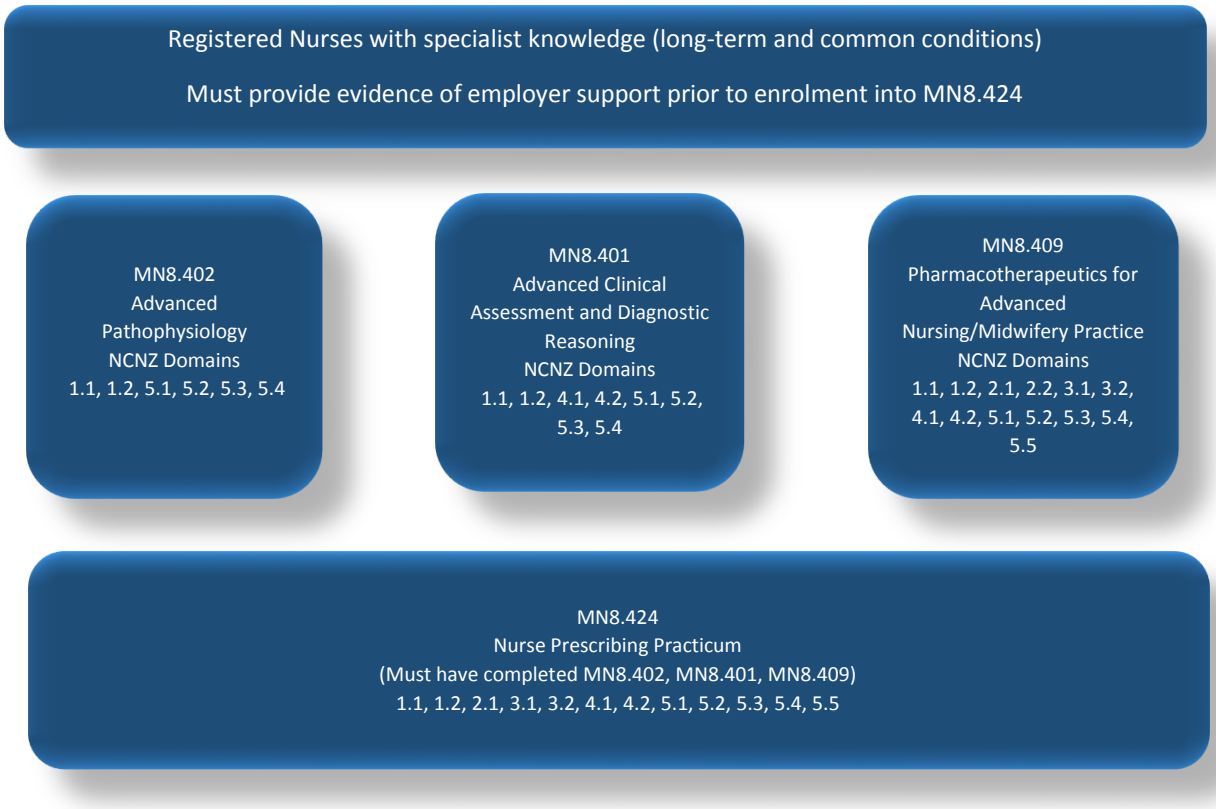
Ms Jennifer Roberts (Head of School) – Email jroberts@eit.ac.nz ; Tel 06 9748000 ext. 5480

Frequently Asked Questions

Questions	Answers
What is nurse prescribing?	Nurse prescribing is a prescribed postgraduate qualification for registered nurses (RN), registered with the Nursing Council of New Zealand (NCNZ). RNs who are awarded a postgraduate diploma in registered nurse prescribing will enable them to prescribe within primary health and specialty teams. Provision for this qualification falls under Section 12 of the Health Practitioners Competence Assurance (HPCA) Act 2003.
What competency standards are required?	The NCNZ states that, "*nurses working under the registered scope of practice, will be qualified as a nurse prescriber, working within the competencies and criteria developed specifically for the additional qualification*". The competencies can be found at: http://www.nursingcouncil.org.nz/News/Application-for-prescribing-rights-for-registered-nurses
What are the pre-requisites for nurse prescribing?	Requirements for nurse prescribing can be found at: http://www.nursingcouncil.org.nz/News/Application-for-prescribing-rights-for-registered-nurses • A minimum of three years' experience in the area of prescribing practice. • Employer support to undertake the programme • Completion of a postgraduate diploma in registered nurse prescribing for long term and common conditions. • Completed a prescribing practicum of 150 hours with a designated authorised prescriber (medical or nurse practitioner) as part of the postgraduate diploma. • A limited list of medications from which the nurse can prescribe within their competence and area of practice.

Questions	Answers
	• A condition included in their scope of practice to complete a further 12 months of supervised prescribing practice when they are authorised by the NCNZ to prescribe. • Ongoing competence requirements for prescribing. *(List adapted from NCNZ website)*
What subjects are included the postgraduate diploma?	The NCNZ have directed the content of the postgraduate diploma. The programme requires students to study: • Advanced pathophysiology; • Advanced clinical assessment; • Advanced pharmacology; • Complete a minimum of 150 hours in a prescribing practicum *(under the supervision of an authorised prescriber i.e. medical or nurse practitioner).*
What employment opportunities are there?	The NCNZ requires that a RN wanting to enrol in a prescribing qualification **must have an agreement by an employer to undertake the study, and have an identified position as an RN prescriber in long terms conditions and common conditions.** This agreement includes the identification of an authorised prescriber mentor within the area that the RN is intending to prescribe.
Is there a panel interview with NCNZ?	No, however, the NCNZ requires notification from the tertiary education institution that all requirements have been met. RNs must provide a portfolio of evidence to the NCNZ on application for recognition of the award.
If the practicum requirements for the NP pathway has been completed, can RN Prescribing (without registration as a NP) be undertaken?	Yes, if a RN has completed the practicum requirements for registration as a NP, but has decided to change pathways to prescribing practice, recognition of prior learning can be considered, based on the requirement that the RN has been in the area of practice where prescribing will be undertaken, for a minimum of three years.
Will diabetes prescribers be able to awarded RN prescribing rights?	The NCNZ will manage this process directly and will contact all diabetes prescribers. Awards will be made on an individual basis.

Education Pathway for RN Prescribing at EIT



Learning Plan for completion of the PG Diploma (RN Prescribing)

Part Time Study

Year	Semester 1	Semester 2
1	MN8.402 Advanced Pathophysiology	MN8.401 Advanced Clinical Assessment and Diagnostic
2	MN8.409 Pharmacotherapeutics for Advanced Nursing/Midwifery Practice	MN8.424 Nurse Prescribing Practicum

Full Time Study

Year	Semester 1	Semester 2
1	MN8.402 Advanced Pathophysiology MN8.401 Advanced Clinical Assessment and Diagnostic	MN8.409 Pharmacotherapeutics for Advanced Nursing/Midwifery Practice
2	MN8.424 Nurse Prescribing Practicum	

HAWKE'S BAY District Health Board Whakawāteatia	**Health and Social Care Networks**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owners:	Liz Stockley, GM Primary Care; Tracee Te Huia, GM Māori Health
Document Author(s):	Belinda Sleight, Project Manager Strategic Services
Reviewed by:	Executive Management Team
Month:	September 2016
Consideration:	For Information

RECOMMENDATION

Māori Relationship Board, Clinical and Consumer Councils

1. Note the contents of this report.

OVERVIEW

The Health and Social Care Networks Programme began in April, and is required to report progress to EMT and the Committees on a quarterly basis. This report provides an update on activity during June-August. Work to develop the foundations of the Networks has now established the purpose, design principles and geographic boundaries for Networks; additional parameters and guidelines for Network development are now being drafted. The first two Networks will be established in Wairoa and Central Hawke's Bay. Change Leadership in each of these localities is now building relationships within each community and developing a work programme for change.

OVERARCHING PROGRAMME

Our approach to clustering services as Networks is gaining momentum, with the purpose, design principles and geographic boundaries of Networks gaining approval from EMT and the Committees in July. Using these design principles to guide us, we are now developing foundational parameters that describe appropriate collaborative behaviours, organisation and leadership structures, accountability and trajectories for greater autonomy over time. This work is benefitting from the input of the Network Programme Action Group, whose members are experienced in designing and delivering health services in community settings. Additionally, we are also learning from the experience of Counties Manukau, Auckland and Waitemata DHBs, all of which are at various stages of developing and rolling out locality-based service planning and delivery. A meeting in July with staff from these organisations has established the intention to work more closely together and to identify other sources of learnings, so that we can optimise progress along our similar journeys.

The programme is gaining a new Sponsor in Tracee Te Huia, GM of Māori Health, as current Sponsor Liz Stockley resigned her position at Health Hawke's Bay in June. This change has been an opportunity to clarify aspects of the programme itself, and to also consider how best to communicate the expected outcomes and benefits to the many stakeholders. A Programme Brief has been drafted with assistance from Liz and Kate Rawstron (new PMO Manager) and a Communications Plan is currently being developed within input from the Action Group and DHB Communications staff. Once the key programme-level messages have been agreed, we will begin rolling out communications to stakeholders, particularly Health Services staff and general practice.

A major feature of the Networks Programme is dependence on other initiatives outside of its scope. The key dependencies are projects already underway or in planning, namely the shared patient record, and model of care in general practice. Aligning intent and dove-tailing timeframes between these dependencies and the Network establishment activities in Wairoa and Central Hawke's Bay is essential, as the dependencies enable central design principles of Networks, being joined-up (multi-disciplinary) team work, earlier and proactive interventions, and empowerment of patients/consumers as leaders in their own care.

The next steps are to finalise Network parameters so that our approach to Networks is clearly articulated, and begin socialising the Network concept with stakeholders. In particular, we need to solidify the relationship and joint working with the Ministry of Social Development (MSD) at the organisational-level, so that this supports the on-the-ground activity that is happening in both Wairoa and Central Hawke's Bay. In these localities, local MSD representatives have been involved in community meetings and subsequent discussions regarding Network establishment, and there are a number of MSD-funded organisations/services that are active in the relationship building and discovery work currently being conducted in their communities. It would be valuable, however, to gain the support of MSD at the regional level, to enhance and the local bonds, and to demonstrate true partnership through things like jointly-developed performance measures and funding pools, for example.

WAIROA NETWORK

Te Pare Meihana, Manager of the Wairoa Integrated Family Health Centre, has been seconded to lead Network establishment; this role is also supported by Māori Health with the aim of the Change Leader working with Kahungunu Executive to prepare them for future developments that the Network model will bring. Appointment of Te Pare's backfill, a two year fixed term position, is imminent.

There has been an agreement in principle by the Wairoa provider leadership and key community leaders that the local decision making process for the Network will be two tiered.

1. A Network Leadership Team (NLT) will include provider leaders and representation from the connected communities of interest e.g. Rangatahi, Pakeke, Iwi, Clinical Governance, E Tu Wairoa. This group will work closely with the Change Leader, feeding into the work plan and supporting the processes that will be required to re-shape services, models and funding.
2. A Community Governance Committee will be established through an Expression of Interest (EOI) process. This group will have final sign-off before business cases are forwarded through to the DHB/MSD. This group will be tasked with the responsibility to review documents and proposals to ensure that what is being proposed by the NLT meets the needs and aspirations of the community as have been identified in the outcomes framework and locality planning documents.

When the workstreams are completed, the proposals will be presented to the Community Governance Committee for final approval before the business cases are released to the DHB/MSD for consideration and final approvals.

The Wairoa General Practice Alliance is progressing well, with an agreed 16/17 contract in place. The Alliance has begun initial planning to establish a single practice for Wairoa. It is proposed that this business case will come through the Network leadership structure (as described above) for consideration and sign-off.

The Wairoa Health Needs Assessment report is due for release 31 August 2016, with a community hui planned to present the report and the Network framework.

The next steps for the Wairoa Network include establishing the shared vision and outcomes framework, and developing the Network programme plan and identified workstream priorities including general practice integration, vulnerable whānau model, youth health model, model of care, Whānau Ora framework, management and governance options, contracting and funding models, acute services integration, community services integration, aged care.

CENTRAL HAWKE'S BAY NETWORK

The change process is being led by Jill Garrett, Strategic Services Manager for Primary Care, who is experienced in change management within community development health settings. A project structure has been put in place, including a milestone map and associated deliverables.

The Change Leader's major focus in Central Hawke's Bay has been to develop relationships between providers, consumers, the DHB, and PHO, with good progress being made. This is the foundation upon which a Network for Central Hawke's Bay will be built.

Out of extensive community consultation, both current and historical, a Health Liaison Group has been formed. This group is chaired by Ian Sharp, ex pharmacist of Waipukurau and current deputy mayor, and has representation covering Iwi, Council (local and regional), nursing, aged care, Mayoral Health Task Force, consumers, and Māori health provider Central Health.

A key focus is on building the relationship with the Waipukurau-based Tuki Tuki Medical general practice, and gaining their involvement in the Network. Under the current Rural SLAT - Alliance Agreement (PHO-DHB- General Practice) work is nearing completion on the finalisation of an Alliance strategic and annual plan. Included in the plan is the intent to work proactively with the Network development to strengthen partnerships with health providers within CHB, work towards the development of new models of care including strengthening clinical leadership within the nursing workforce, and integrating services with outlying rural communities Takapau and Porongahau.

Underpinning the success of the Network relies heavily on the development of a high trust model of engagement. To progress this, we are providing training in collaborative impact, so that the team is well prepared to hear (and act upon) the messages from the South Central Foundation's NUKA model, when this group visit Hawke's Bay in November.

HAWKE'S BAY District Health Board Whakawāteatia	**Falls Minimisation Committee Update**
	For the attention of: **HB Clinical Council**
Document Owner:	Chris McKenna, Chief Nursing Officer
Reviewed by:	N/A
Month:	September 2016
Consideration:	For Information

RECOMMENDATION

That HB Clinical Council:

Note the contents of this report.

"APRIL FALLS" Campaign

The campaign entitled "Eye on Falls" was rolled out in April with posters/banners/resources visiable, internal review of the Quality Team was completed with positive results. Focus was on community collaboration and working with community groups by using electronic platforms.

HBDHB

The HBDHB are looking as several initiatives to manage and reduce falls, these include:

- Installing new lighting in B2 corridors, to reduce shadows.
- Facilities are looking at extending the non-slip shower vinyl so it extends out into the room, not sure if this would extend the area of issues or move the problem.
- Decision matrix for the use of bedrails guideline is being piloted.

Discussion was also held around DHB Trauma Stats that were presented by Susan Hawken CNS Trauma. Key points noted.

- This data is collected for the MOH.
- There is strict criteria to be classified as "major trauma"
- In major trauma – the second largest cause is falls with a lot of elderly people who have fallen not included in these stats as they do not meet the criteria
- Surprised by the number of severe trauma from falls.
- Discussed factors relating to the age range of minor trauma admissions.
- 45% of minor trauma for the month of July 2016 is due to falls

QUARTERLY REPORT FOR FALLS 65+

Report relates to patients over 65 years of age presenting to ED with fall as main condition.
Current report shows :

- Increase over the last 2x quarters of 2015/16 in Residential & Other category.
- Males have shown double the increase compared to females
- Falls in home category has reduced.

Findings will be dicussed with CNSs Gerontology to find out what might be occurring in aged residential setting to show this rise in last 6 months.

SPORT HAWKE'S BAY

Due to a lack of available funding, Sport HB are not able to fund programmes and aren't doing too much in this space currently. Concerns falls will take a slight back seat to pressure from new initiatives.

ACC

ACC have released $30.5 million to co-fund across the country for 3 years. It was made clear that it will not be a fee for service approach.

Recent follow up meeting held between DHB, potential community providers of activation programmes and ACC. ACC presented its requirements of providers of services for lower to moderate risk people.

- Providers of community based activities will need to become accredited providers and will need to meet 9 key issues covering education component, balance and strength component, assessment and outcome measurement.
- ACC wants to work with them through one lead provider. The lead provider will have a co-ordination role. Paul is pulling together a meeting of interested providers.

High to moderate risk people will be DHB's responsibility. Clarification on patient management will come about through pathway design. Discussion to occur on relative roles of Gerontologist, Engage, Community Occupational Therapy and Community Physiotherapy.

ST JOHN

Membership has been extended to include Melanie Bolton, Healthcare Coordinator from St John.
St John are referring approximately 5-6 patients per week directly to Orbit Group around falls for various reasons with great outcomes.

HAWKE'S BAY District Health Board Whakawāteatia	**Maternity Clinical Governance Group January to June 2016** For the attention of: **HB Clinical Council**
Document Owner: Document Author	Chris McKenna, Chief Nursing Officer Jules Arthur, Midwifery Director
Reviewed by:	Chris McKenna
Month:	September 2016
Consideration:	For Information

12

RECOMMENDATION

That HB Clinical Council

Note the contents of this report.

OVERVIEW

The Maternity Quality and Safety Programme (MQSP) Implemented as part of the Maternity Quality Initiative, involves ongoing, systematic review by local multidisciplinary teams working together to identify potential improvements to maternity services and the ongoing work to implement those improvements. This programme is driven by HBDHB midwifery and medical leaders working collaboratively, with consumers, and practitioners across our health services continuum.

The initial objectives of the Maternity Quality and Safety Programme of appointing a programme co-ordinator, establishing consumer representation and to implementing a multidisciplinary governance group to have the overview of the quality of the Maternity Services and identify areas for improvement have all been achieved.

The Ministry of Health have recently re-evaluated their high level priorities moving the focus for our MQSP to:

- Strengthening Maternity Services to ensure equity of access to a sustainable model of community based continuity of care, to strengthen multidisciplinary collaboration for good outcomes and to promote and protect normal birth.
- Better support for women and families that need it most, including better specialist support for women and families with additional needs and better health literacy and engagement of vulnerable population groups.
- Embedding maternity quality and safety to meet the National Maternity Standards commitments and to ensure continued growth of local quality and safety activity.
- Improving integration of maternity and child health services to reduce access barriers and promote seamless care for women and their families during pregnancy and beyond.

These four new priorities build on the goals set out in original Maternity Action Plan and align with our ongoing objectives to maintain the three New Zealand Standards of Maternity Care:

- Maternity Services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.

- Maternity Services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage.
- All women have access to a nationally consistent, comprehensive range of Maternity Services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women.

The Maternity Quality Safety Programme is presently mid-way through executing the two year plan of the current "Establishing Contract".

The two year plan presents three 'Key Actions Projects' to address these four new priorities.

1. Increasing normal birth and decreasing intervention
2. Increasing Early Engagement with a Lead Maternity Carer in the first trimester of pregnancy
3. Developing a Maternity Consumers Members Network and increasing consumer engagement across the service

Each of these projects are discussed in more depth within the remainder of this report.

Additionally, the Maternity Quality and Safety Programme monitor and respond to the National Maternity Clinical Indicators internal and external reporting. The New Zealand Maternity Clinical Indicators were established from a collaboration between the Ministry of Health and maternity stakeholders representing consumer, midwifery, obstetric, general practice, paediatric and anaesthetic perspectives. There are currently 21 maternity clinical indicators with the latest six being introduced in September 2015. Evaluators of our indicators need to remain mindful of the population we serve being one with significantly high health inequalities. Compared to other areas of New Zealand, Hawke's Bay is a region with significant health inequalities. This is contributed to by our 25% Māori population (10% higher than average), 35% of our population residing in the most deprived areas of the region, 30% of our young Māori not in education, training or employment, one in three of our adult population determined as obese, one in five are not smoke free, and one in every four Hawke's Bay adults are classed as a hazardous drinker. These, along with numerous other factors, present significant health inequalities that lead to poor access of primary care and high rates of complex pregnancies for Hawke's Bay.

The reported clinical indicator trends benchmarked against the national average, enable us to adjust current clinical management and address areas where quality and patient care can be improved. The table demonstrating how Hawke's Bay benchmarks against the national average as well as our intenal data trends for 1st January to 30th June 2016 can be found on page 8 of this report.

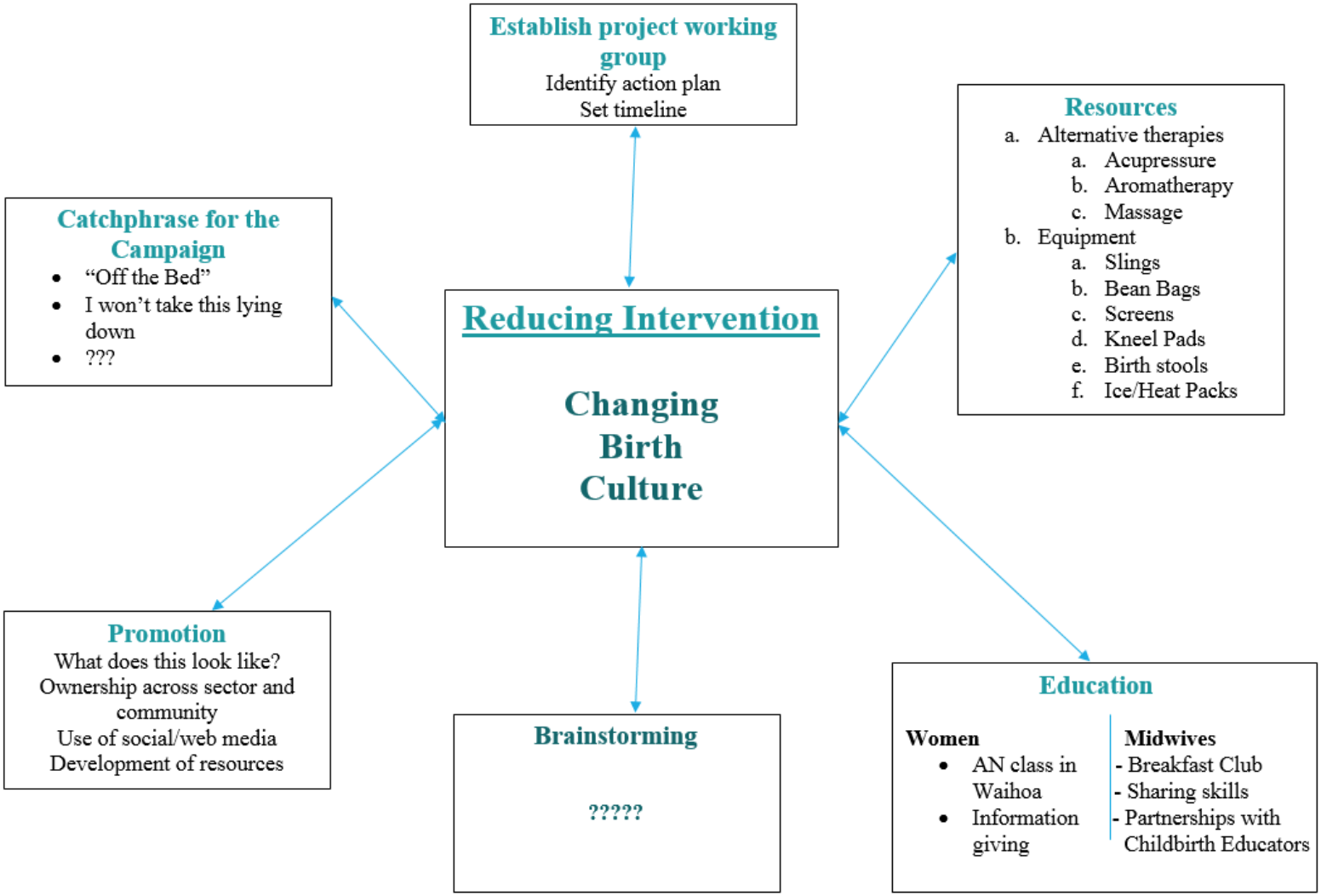
Key Actions Projects
Increasing normal birth and decreasing intervention - **Establishment of the primary birthing centre Waioha to increase positive outcomes**

- Waioha Build project completed by the end of quarter four, with the facility itself being opened on 4th July 2016 with highly successful staff and public open days inclusive of a Waioha specific information leaflet.
- Preparation around facilitating normal birth is ongoing with the key focus being to change the birth culture. Communication and education within the maternity services are at the forefront with a breakfast club being initiated to support midwifery led evidence based discussions and professional support to make change.
- Functionality and operations were worked through prior to opening and teething problems are now being ironed out.
- An 'Options for place of birth' consumer information leaflet is being worked through.
- Low risk women are birthing in the centre, with care being provided in a midwifery-led primary birth environment, thus reducing births in our secondary care birthing suite creating a decrease in the likelihood of intervention during labour.
- Developing campaign to support ongoing birth culture change to support normal birth.

Early figures for the primary birthing centre are very encouraging with a birth rate percentage of 33.2% of the total births for the month of July as demonstrated in the table below.

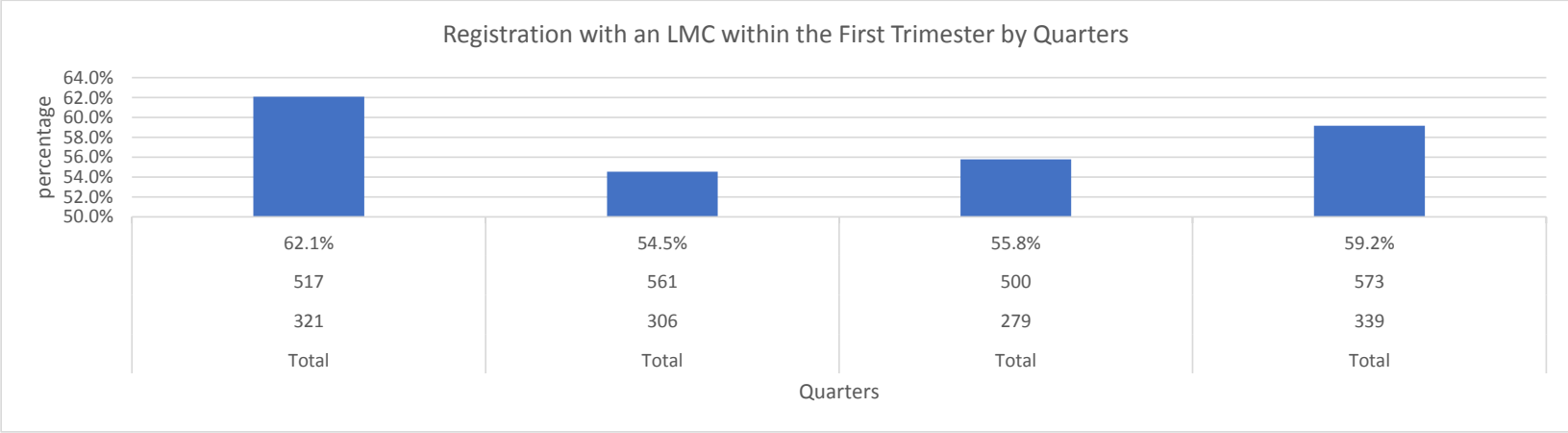
Waioha July 2016		
Births	Total number of births across the service this month	175
	Number of women birthing in Waioha this month	58
	Number of Primiparous women birthing in Waioha this month	13 (22.4%)
	Percentage of total births this month occurring in Waioha	33.2%
Transfers	Total number of women transferring from Waioha (AN, PN, Neonatal)	24
	Transfer in labour rate of all women who commenced labour in Waioha	21%
	Overall transfer rate of labouring women from Waioha to secondary services from ALL women who birthed this month	9.2 %
Utilisation	Total number of women accessing Waioha (assessments/births/transfers)	83
	Number of water births in Waioha	17
	Number of individual LMC's accessing Waioha for assessment or labour/birth	27

Changing Birth Culture – Campaign for Normal Birth Mindmap

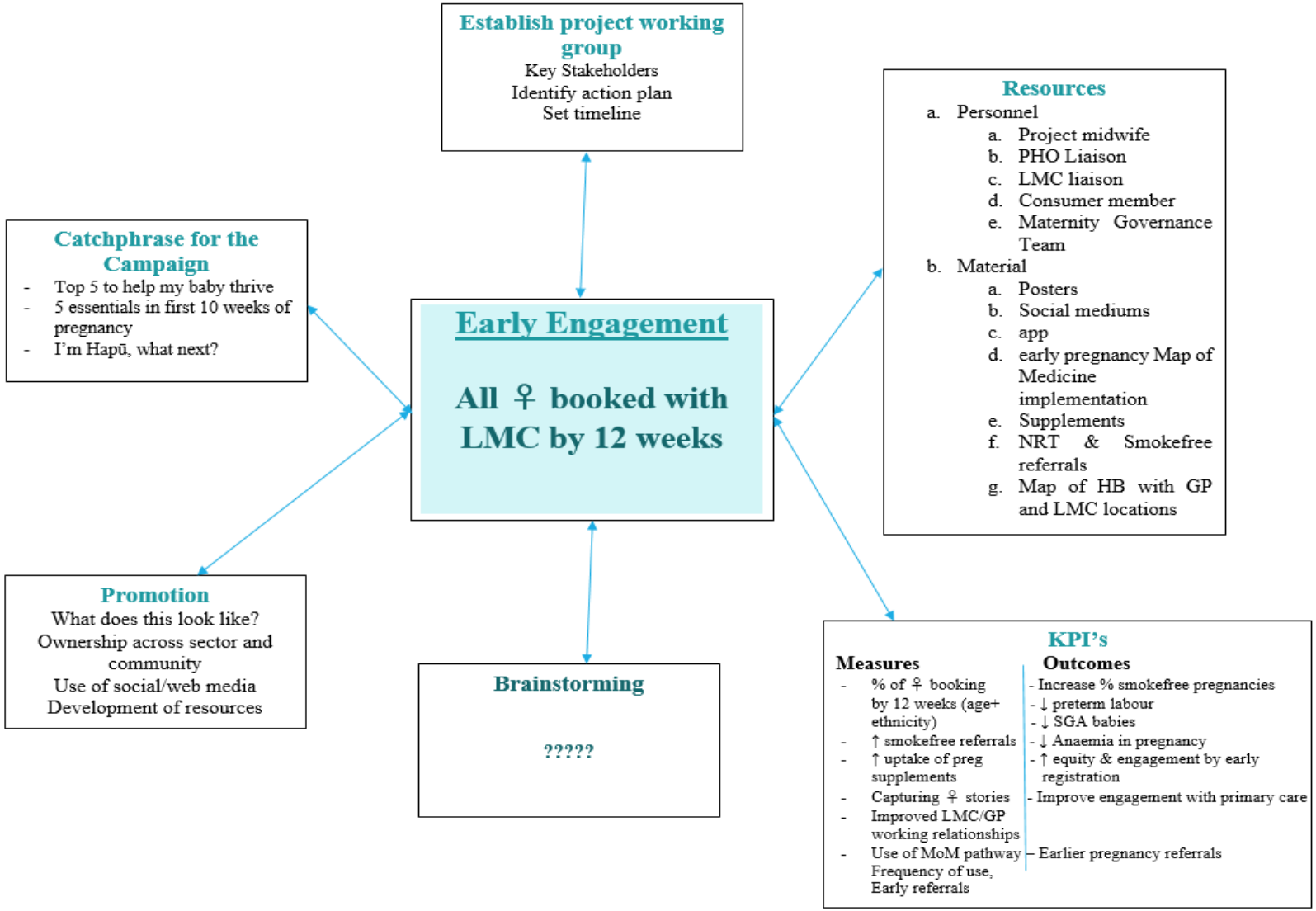


Increasing Early Engagement with a Lead Maternity Carer in the first trimester of pregnancy - **Increase the overall percentage of women in Hawke's Bay who register with a Lead Maternity Carer before 12 weeks of pregnancy to 80% (national target).**

- Work has commenced on furthering the evaluation of the proof of concept pilot and auctioning the recommendations Presentations of the evaluation and answers to key questions are happening in the PHO landscape and key links established to work with primary care to ensure shared key principles, shared understanding and a successful implementation that is sustainable.
- The 5 in 10 (First five thing to do in the first ten weeks of pregnancy) promotional material is currently being designed and a project work stream group is being identified and brought together of key stakeholders.
- Increasing numbers of women accessing Napier Maternity Resource Centre for on the spot LMC registration, occurring via community wide word of mouth and social media advertising. The service has also improved awareness of its existence and functionality amongst primary care providers
- Ongoing promotion of the importance of registration with an LMC via social media and traditional communication methods including promotion of the Find Your Midwife website
- Ongoing work continues to ensure that data sourced from LMCs in relation to date and gestation they engage with the pregnant woman, is accurate. The implementation of the 'booking form triage system' where incomplete or incorrect bookings are returned for completion is also ensuring our registration data is accurate.
- Improvement and development of the HBDHB consumer website to increase usage of this information platform has also occurred over the last two quarters. Maternity pages are now present with increased information regarding pregnancy available and direct links to the FYM website



Early Engagement Mindmap Workstream



Developing a Maternity Consumers Members Network and increasing consumer engagement across the service

- The two maternity consumer representatives have become established and valuable members of the maternity team over the last six months, members of the maternity clinical governance group, involvement in our key quality initiatives identified in 2 year MOH action plan and have been networking with numerous community based connections being made and relationship with hard to reach groups being established. Organisations such as Heretaunga Women's Centre, Te Taiwhenua O Heretaunga, Plunket, the Teen parents unit at both Colenso and Flaxmere, several GP practices, Family Start, the NZ Police Force, Napier Family Centre, several early childhood centres, the Bumps Birth and Babies Expo have all been reached by the representatives who were well received
- The consumers are considered an integral part of operational and strategic direction with involvement in discussion and planning for maternity services
- The consumers hosted their first Consumer Forum with DHB maternity staff at Napier Plunket Hub, where around 20 mums with babies attended and plenty of feedback was received. There have also been guest speakers at at least three coffee groups during the last six months. Key issues identified over recent months are concerns around recognition and support regarding tongue tie, overstretched staff, prolonged waiting times for neonatal discharges and conflicting advice regarding breastfeeding. Resolution towards all of these isses are a workin progress.
- Consumer input has been provided on numerous consumer information literature documents over the first half of the year, in particular the primary birthing centre and the caesarean section wound infection project.
- The consumer members have additionally managed to undertake numerous planned and spontaneous face to face meetings with women and their whānau, promote utilisation of the online consumer survey and obtain over ten written consumer journeys to publish in the annual clinical report
- The consumer members have been widely published across the hospital campus, throughout the community on social media and in the local media. This has raised significant awareness to the support available to women and their whānau and how their voices can be heard. The consumer representatives are currently working on sharing the stories and concerns they have obtained from our community at the upcoming maternity annual clinical report presentation day.
- Development of a Waioha specific online consumer survey has commenced.

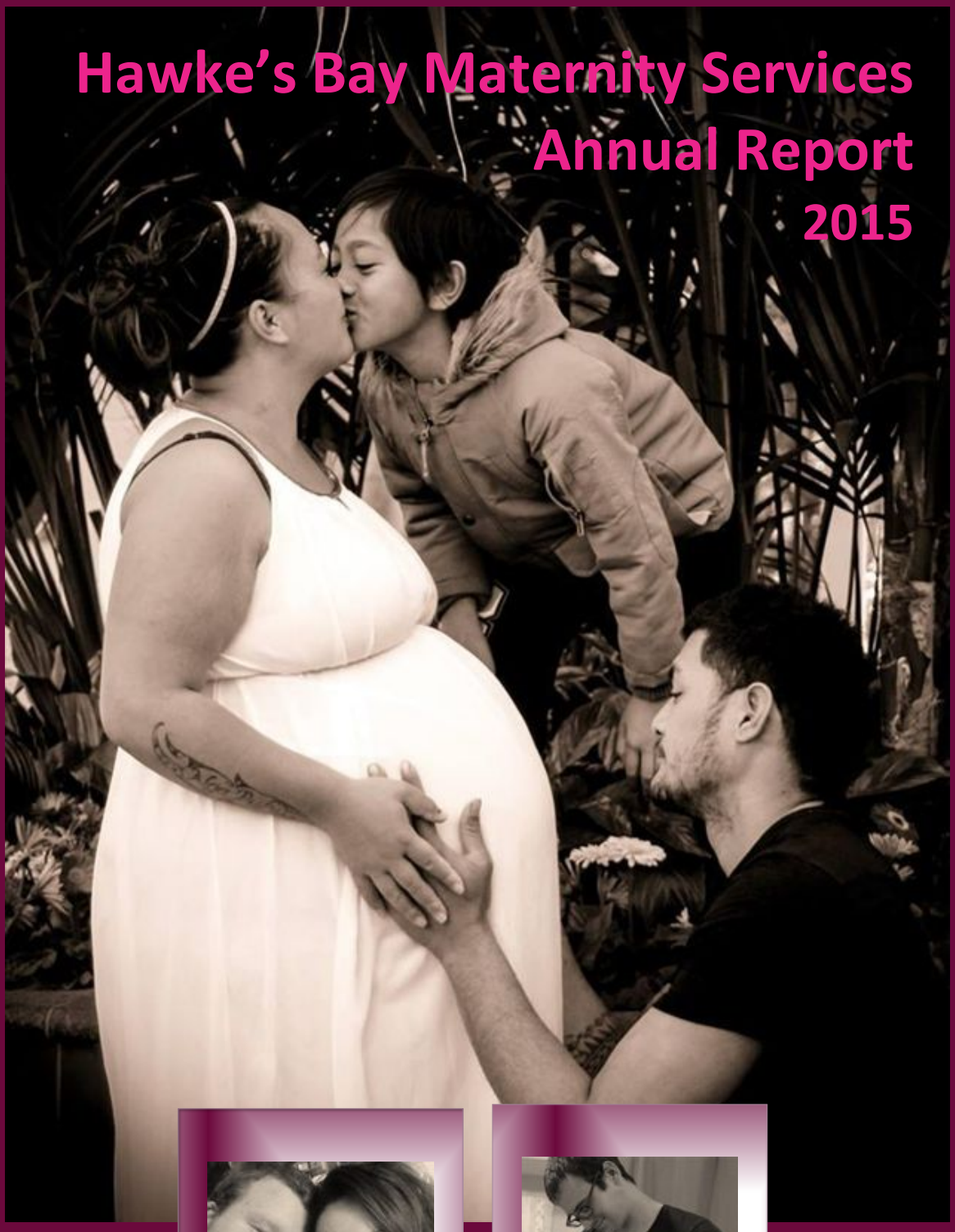
Clinical Indicator Internal Data Overview - based on most current internal reporting

Indicator	KEY: U Unfavourable; S Static; F Favourable	MOH National average 2014	2015 Internal Data	2016 internal Data Jan - June	Trend Direction against the 2014 National Average	Current Performance against the 2014 National Average
1: Registration with a Lead Maternity Carer in the first trimester of pregnancy- All Women MOH target		67.7%	58.0%	55%	↓	U
2: Spontaneous vaginal birth among standard primiparae		68.9%	60.2%	64%	↓	U
3: Instrumental vaginal birth among standard primiparae		15.2%	19.3%	18.3%	↑	U
4: Caesarean section among standard primiparae		15.6%	20.2%	17.6%	↑	U
5: Induction of labour among standard primiparae		5.6%	8.6%	9.1%	↑	U
6: Intact lower genital tract among standard primiparae giving birth vaginally		27.7%	44.2%	41%	↑	F
7: Episiotomy and no third- or fourth-degree tear among standard primiparae giving birth vaginally		22.7%	15.9%	9.68%	↓	F
8: Third- or fourth-degree tear and no episiotomy among standard primiparae giving birth vaginally		4.5%	6.1%	7%	↑	U
9: Episiotomy and third- or fourth-degree tear among standard primiparae giving birth vaginally		1.5%	2.9%	2.8%	↑	U
10: General anaesthetic for all women giving birth by Caesarean Section		8.4%	11.5%	12.7%	↑	U
11: Blood transfusion for all women giving birth by Caesarean Section		3.2%	3.8%	3.7%	↑	S
12: Blood transfusion during birth admission for vaginal birth for all women		2.1%	2.4%	1.7%	↓	F
13: Diagnosis of eclampsia during birth admission for all women		n/a	0%	0%	=	F
14. Peripartum hysterectomy		n/a	0.05%	0.03%	↓	F
15. Mechanical ventilation during pregnancy or postnatal period		n/a	0%	0.0%	=	F
16: Maternal tobacco use during postnatal period for all women: Status at Discharge		12.8%	21.6%	22.3%	↑	U
17. Women giving birth with a BMI over 35 at registration		8.8%	3.42%	2.4%	↓	F
18: Preterm births, 32 to 36 weeks gestation, for all women		7.4%	8.9%	8.5%	↑	U
19. Small babies at term (37–42 weeks gestation)		3.0%	Data warehouse unable to retrieve this new data at time of report			Na
20. Small babies at term born at 40–42 weeks gestation		39.4%	Data warehouse unable to retrieve this new data at time of report			Na
21. Babies born at 37+ week's gestation requiring respiratory support		2.0%	1.8%	2.3%	=	F

Please note that the trend direction is the comparison of our 2016 internal data with the latest MOH 2014 national average data from all maternity facilities

12.1

Hawke's Bay Maternity Services Annual Report 2015



HAWKE'S BAY
District Health Board
Whakawāteatia

Hawke's Bay Maternity

Please find the "HB Maternity Services Annual Report" on the website:

http://www.hawkesbay.health.nz/about-us/hawkes-bay-clinical-council/

URGENT CARE PROJECT UPDATE

13

Verbal

HEALTH HAWKE'S BAY

Clinical Council Report

Clinical Advisory and Governance Committee

Date: 26 July 2016	Time: 5.30pm
Item	**Summary**
4.1 Quality Plan	The Health Hawke's Bay draft Quality Plan outlines the quality improvement activities planned for 2016/7 year. The activities are grouped according to the three pillars of the Health Hawke's Bay Quality Improvement and Safety Structure: Best Value, Individual and whanau focus, and equity. The CAG committee members present endorsed the draft quality plan along with the recommendation to update the Health Hawke's Bay Quality Improvement and Safety Structure to reflect the New Zealand Health and Disability sector quality dimensions.
5.1 Under 18s Proposal	Patrick Le Geyt provided a verbal update on the Under 18s proposal.
5.2 Last Days of Life	The CAG committee members present endorsed the Last Days of Life documentation and proposed implementation path.
5.3 Brief Update	The CAG committee members present endorsed the Brief Update (below) for sharing with general practice and Clinical Council.
6. Equity and Health Outcomes of Māori A. Health Literacy B. He Taura Tieke C. Whānau Wellness D. Stanford Programme	The committee had an hour to share ideas and thoughts on the listed programmes and how the CAG Committee and the Priority Population Advisory Committee support these programmes from a clinical governance and equity perspective respectively. Discussion was also had around the clinical governance function of the CAG committee, the elements of clinical governance, and how the next twelve month workplan and agenda structure will support the CAG Committee to ensure they receive the necessary information, at the appropriate time, in order for them to advise the Board. It was noted that there is an important role for this Committee to support the Board on new pieces of work and initiatives (national and local) from a clinical governance perspective.
5.4 Workforce Development	The CAG committee members present endorsed the proposed questions that will form the General Practitioner and Nurse workforce survey, with suggestions for minor changes and additions.
INFORMATION PAPERS	
7. Contract Reporting 7.1 B4SC 7.2 PIPI	A copy of the reports submitted to the DHB / MOH for the listed contracts was provided to the CAG Committee for information. These were taken as read.
General Business	Verbal
Renewal of Tenure – Smith, Riley	Ms Smith and Ms Riley tenure has been renewed for six months to allow the new CAG Committee Chair to be appointed and time for the Committee advisory structure to be reviewed.

July 2106, Agenda Item 5.3

Health Hawke's Bay – Te Oranga Hawke's Bay
Clinical Advisory and Governance Committee
Health Hawke's Bay Brief Updates
For Information

	Content/Comments	Management Lead
Transformation		
Clinical Pathways	**Please see attached** CCP Update June 2016.docx Update June 2016.docx Single Sign In.doc	**Leigh White**
engAGE	**Please see attached** CAG Brief Engage update July 2016.pd	**Paul Malan/ Sarah Shanahan**
Clinical Pharmacist Facilitators in General Practice	**Hawke's Bay's Clinical Pharmacist Facilitation Team** Project Update to HHB Clinical Advisory and Governance committee / General Practice – 26th July 2016 After a proof of concept, evaluation and business case for a Clinical Pharmacist Facilitation team working in general practices the HBDHB Board approved (April 2014) the establishment of the service with 8 FTE facilitators. **Phase 1** of the Clinical Pharmacist Facilitators programme rollout has concluded with the appointment of a new Team Leader and two new part-time Clinical Pharmacist Facilitators. **Completed** **Phase 2**. Four additional Clinical Pharmacist Facilitators commenced Monday 14th December 2015. This brings the Team complement up to 7 FTE. Table 1 summarises the full team and the practices which the Clinical Pharmacist Facilitators are initially associated with (with nominal number of hours per week allocated). **Completed** **Phase 3** has commenced - the recruitment of the last FTE Clinical Pharmacist Facilitator. The appointment of this position will be targeted for Wairoa. Recruitment for this position has been more difficult than anticipated. After a third round of advertising we are undertaking interviews in late July / early August. Chief Pharmacist	Billy Allan Chief Pharmacist
Highlights		
Whānau Wellness Resource Programme	PHOLT and PPC endorsed recruitment for the next cohort of 200 whānau onto the WWRP. Targeted recruitment will occur via general practice for the following defined population, Māori, Pacific and Other ethnicities living in Quintile 5 and Māori and Pacific living in Quintile 4 with a Community Services Card. HHB hopes to go live with the new cohort from 1 September 2016 – 31 August 2017.	Lillian Ward

OURHEALTH HAWKE'S BAY	**Collaborative Clinical Pathway**
	For the attention of: **Health Hawke's Bay Clinical Advisory and Governance Committee**
Document Owner:	Leigh White, Portfolio Manager, Strategic Services
Month:	June 2016
Consideration:	For update

RECOMMENDATION

That HHB Clinical Advisory and Governance Committee

Read the papers (attached) as an update and refer any questions to Leigh White.

Hawke's Bay Collaborative Clinical Pathways Update 2016

OURHEALTH

Published Pathways (update June 2016)

- Atril Fibrillation
- Assessment of Acute Chest Pain
- Asthma in Adults (Acute/Chronic)
- Asthma in Children (Wheeze in Preschool, Acute (1-15 yrs.), Chronic 5-15 yrs.)
- COPD (Suspected, Stable, Management of Acute)
- Dementia (Assessment ,Uncomplicated)
- Diabetes – (Type 1,2, Foot Ulcer)
- DVT (Lower Limb)
- Gout
- Heart Failure (Suspected, Manamgent in Primary Care)
- Lung Cancer (Suspected)

Under Development (Nearing Publication next 2-3 months)

- Community Acquired Pneumonia (Now - July 2016)
- PVD (Multi feedback closed 8 July)
- Abnormal Thyroid
- Urinary Incontinence
- Cellulitis
- Last Days of Life

Early development (Aim for Publication 3-6 months)

- Diabetes – Older Person
- Dental-Toothache
- Eczema in Children
- Dehydration

Faster Cancer Treatments **

- Colerectal (Suspected, Iron Deficiency Anaemia, Altered bowel Habits, Rectal Bleeding & Surveillance)
- Breast (Commencing development)
- Hep C (awaiting regional input)

On the List – coming up/?

- Mobility Action Pathway/Falls/Obesity
- Fraility/Self-Management

Published Pathways

- Obstructive Sleep Disorder (Suspected)
- Osteoporosis
- Lung cancer (Suspected)
- Melanoma (Suspected)
- Osteroarthritic Hip
- Osteroartic Knee
- Osteoporosis and Fracture Prevention
- Rhinosinusitis
- Services for Older people
- Skin Lesions
- Smoking Cessation ABCD
- Stroke and Transient Ischaemic Attack (Primary Care)
- Vertigo Assessment and Management

Great News

We now have single sign on for general practice – Yes taken some time – but now working (*Refer to attach, but we will also be visiting you to meet and further educate*).

Always good to hear from GPs with what pathways we should be doing and also come and help develop. Contact Leigh White: mapofmedicine@hawkesbaydhb.govt.nz

With the application of single sign on we will now be able to monitor who accesses the Maps and work out our top 5 access

Why do?

- Reduce variation
- Reduce inappropriate referrals
- Redirect referrals to better value services
- Reduce unplanned admissions
- Promote integrated care
- Right care rime time right place
- Better informed people

Forgotten your password if need to register Simply email: mapofmedicine@hbdhb.govt.nz

Item 5.3 C Update June 2016_14BB6582.docx

Date: 07th July 2016

ATTENTION: **All Clinical Staff**

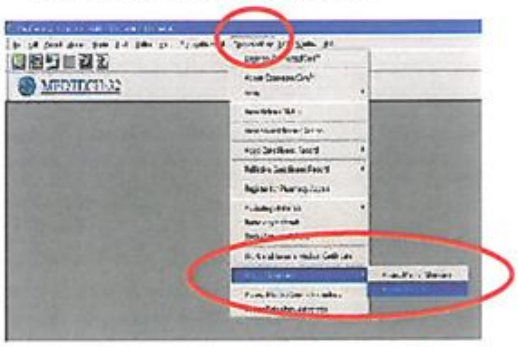
TOPIC: **Accessing Map of Medicine via ConnectedCare tab within Medtech – single sign-on to MoM**

ACTION: **Note**

As of Monday 04th July clinicians who use Internet Explorer 11 who previously experienced issues accessing Map of Medicine (MoM) via the ConnectedCare tab within Medtech should now be able to successfully load and use MoM from within Medtech following the release of fixes developed by MoM (otherwise known as single sign-on).

Please see below for instructions on how to access MoM via the ConnectedCare tab:

1. Go to the ConnectedCare tab within Medtech:
2. Select 'Map of Medicine'
3. Select 'Access Map of Medicine'

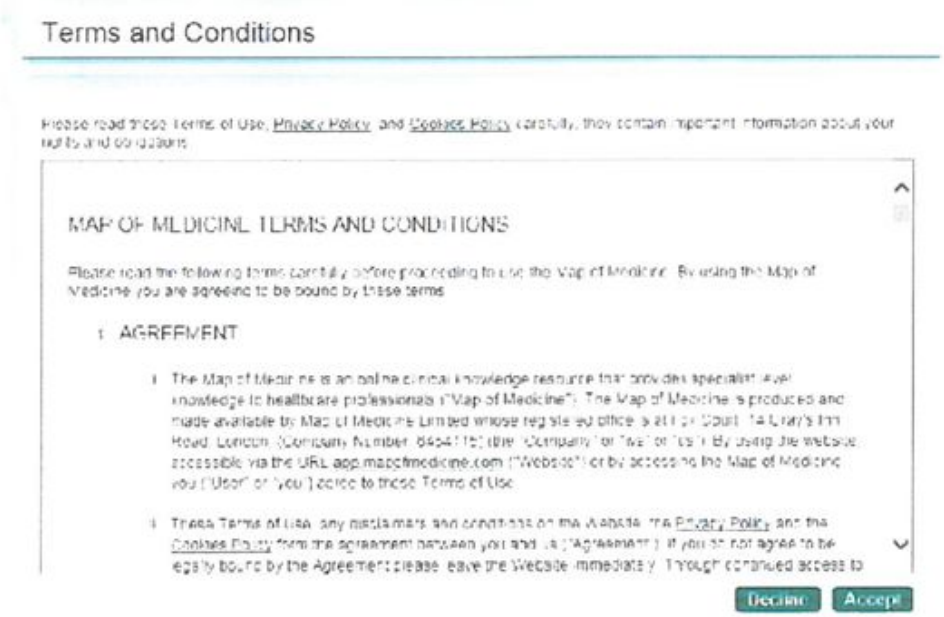


4. Type in your username and password (if you are unsure/forgotten these details or you have not registered to use MoM please email alaina.glue@wrpho.org.nz)

5. Click 'Remember Me'

If you have forgotten your username and/or password, or you are presented with the below error message when accessing MoM via ConnectedCare tab please contact clinicalpathways@midcentraldhb.govt.nz.

For those clinicians that work in multiple general practice sites you should be able to access MoM via the ConnectedCare tab with the same username and password by selecting 'Already have an account'. When you change from one site to the next you will be presented with the following screen – you will need to accept each time.



If you have any queries or experience any issues please do not hesitate to contact the Collaborative Clinical Pathway Team by emailing clinicalpathways@midcentraldhb.govt.nz.

Kind regards,

Alaina Glue
Project Director - Collaborative Clinical Pathways
Central PHO
Ph: 06 353 1725

engAGE Brief Update for Health Hawke's Bay CAG Committee July 2016.

Community MDTs:
Feedback from practices and from Dr Mark Peterson via the City Medical GPs meeting is that there is dissatisfaction amongst some practices regarding the Letter of Agreement that has been offererd to practices to acknowledge their collaboration with engAGE, DN/GP alignment and Clinical Pharmacist Facilitators. The dissatisfaction relates to the wording of the contract (excessive clauses) and the amount of money offered. Work is on-going between senior leaders in the DHB and Primary Care to resolve this issue.
Recruitment of Allied Health staff for the engAGE team is now complete and weekly MDT meetings continue.

ORBIT Team:
On 7th June the engAGE ORBIT team started taking referrals directly from St John's Ambulance under the St John's ORBIT Frailty Pathway. This pathway allows paramedics to refer to a rapid response Allied Health team who can perform home visits to frail older people to assess and provide equipment, arrange supports, liaise with family and arrange appropriate follow-up. In some cases this has negated the need for older people to be transported to ED. In others, it has allowed earlier intervention for older people who St John's staff identify as needing Allied Health in-put and co-ordination of services. There have been 15 referrals in the first 5 weeks of this pathway. This is currently in trial with weekly feedback to St John's staff on the appropriateness and outcomes of referrals and it is anticipated that this pathway will continue as business as usual following the trial period.
There have been no further referrals from City Medical.

engAGE in ARRC (intermediate and short stay beds):
Utilisation of this service remains high. In the 20 weeks since roll out at the end of February, 79 patients have been referred for this service. 47 patients have had Intermediate stays with MDT in-put and 32 patients have had Short stays following direct GP referral. There have been 740 bed days used (with 7 patients still in facilities at the time of writing). On average two thirds of patients are being discharged to their own homes with one thrird being admitted to permanent residential care following joint planning with patient, family, GP and MDT. Clinical and administrative processes continue to be refined.

LABORATORY SERVICES COMMITTEE REPORT

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HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora- Healthy Weight Strategy**
	For the attention of: **Māori Relationship Board, Clinical and Consumer Council**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Shari Tidswell, Team Leader/Population Health Advisor
Reviewed by:	Executive Management Team
Month:	September 2016
Consideration:	For Information

RECOMMENDATION

Māori Relationship Board, Clinical and Consumer Council

Note the contents of this report.

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OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from Annual Māori Plan (AMP) quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board. The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of that TAW programme is to provide the Board with a report each month from one of the champions. This report is from Director Population Health, Champion for the Healthy Weight Indicator.

UPCOMING REPORTS

The following are the indicators of concern, allocated EMT champion and reporting month for each.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Obesity *National Indicator*	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	≥95%	Caroline McElnay	Shari Tidswell	**SEPT 2016**

MĀORI HEALTH PLAN INDICATOR:

At the end of 2015 the Board endorsed the Hawke's Bay Healthy Weight Strategy and requested a plan to outline activity to support childhood healthy weight. The resulting Best Start: Healthy Eating and Activity Plan was endorsed in May 2016. This Plan reflected the evidence that demonstrated early intervention has the greatest lifetime impact.

WHY IS THIS INDICATOR IMPORTANT?

This indicator focuses on increasing the proportion of 4 year olds who have a healthy weight (not overweight, obese or underweight). This is a new area of focus for the Board. We are not yet seeing improvements with 9.3% of Māori 4 year olds in the obese weight category (and increasing over the past three years) compared with 3% of "other" 4 year olds. Evidence shows that these children will be more likely to have a healthy weight in later life due to the combination of physiological and behavioural changes which are laid down in early life.

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

Achieving the new health target: "By December 2017, 95 per cent of obese children identified in the Before School Check (B4SC) programme will be referred to a health professional for clinical assessment". We continue to focus on achieving an increase in healthy weight and evidence based referrals. We will achieve this by providing whānau with two referrals; (1) a health professional and (2) a community based programme which supports lifestyle changes.

We need to engage better with women, parents, whānau and communities by sharing information about the importance of nutrition in the early years and also by asking how best to support healthy nutrition. This support is not just from health service providers or about health information but from across the whole community in order to support access to healthier food choices for our tamariki.

Breastfeeding is strongly protective in maintaining healthy weight, yet we see very little improvement in our breastfeeding rates with significant variations in breastfeeding rates by ethnicity. We need to understand better why to support women to breastfeed and increasing breastfeeding rates.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR?

Process and training has been completed to support children identified at B4 School Checks with a BMI over 18.3, are offered support including nurse education, referral to Active Families and general practitioner assessment. This referral process and wider support for childhood healthy weight are covered in the DHB Plan.

The Best Start: Healthy Eating and Activity Plan has been approved and endorsed by HBDHB Board and Committees. The Plan has key objectives:

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

The Plan was developed using the evidence base and community input – both sources support early intervention by focusing on childhood healthy weight beginning with healthy weight during pregnancy. This Plan has been shared with other DHBs and the sector in Hawke's Bay.

Currently delivered activities include:

- Gestational diabetes screening and support

- Maternal GRx programme
- Breastfeeding support/resources via Kahungunu Executive and Te Taiwhenua o Heretaunga
- Promoting World Breastfeeding Week- Facebook brelfies, breastfeeding friendly cafes were the focus
- Active Families under 5
- Healthy First Foods 0-2 year, deliver via Plunket and Well Child/Tamariki Ora provider
- Launching Healthy Foods 2-5 years with B4 School Check Nurses
- HBDHB Healthy Eating Policy adopted including educative traffic light model, supporting breastfeeding for staff/visitors/patients
- School and environment survey for HB conducted with Informus

Funding is now secured to support the school based programme.
See table below for detail on progress toward planned outcomes.

CONCLUSION

It is critical to invest in the prevention and management to increase healthy weights over a long-term in order to reap the benefits of healthy weight young children - including cementing the behavioural and environmental changes that can support ongoing healthy weights.

Report for Te Ara Whakawaiora- Health Weight Strategy

At the end of 2015 the Board endorsed the Hawke's Bay Healthy Weight Strategy and request a plan to outline activity to support childhood health weight. The resulting Best Start: healthy eating and activity plan was endorsed May 2016. This plan reflected the evidence which show early intervention has the greatest lifetime impact – with activity focusing on

Indicator	Date	Recommendation(s) to Board	Champion Progress Update
Obesity Strategy 1) Obesity Strategy completed 2) Health Promotion Plan **Champion:** Caroline McElnay, Director Population Health **Document Writer:** Shari Tidswell, Team Leader/Population Health Advisor	August 2016	This indicator focuses on increasing the proportion of 4 year olds who have a healthy weight (not overweight, obese or underweight). This is a new area of focus for the Board and we are not yet seeing improvements with 9.3% of Maori 4 year olds in the obese weight category (and increasing over the past 3 years) compared with 3% of "other" 4 year olds. Evidence shows that these children will be more likely to have a healthy weight in later life due to the combination of physiological and behavioural changes which are laid down in early life. Achieving the new health target: "By December 2017, 95 per cent of obese children identified in the Before School Check (B4SC) programme will be referred to a health professional for clinical assessment". We continue to focus on achieving an increase in healthy weight and evidence based referrals. We will achieve this by providing whanau with two referrals 1) a health professional and 2) a community based programme which support lifestyle changes. We need to engage better with women, parents, whanau and communities, by sharing information about the importance of nutrition in the early years and also by asking how best to support healthy nutrition. This support is not just from health service providers or about health information but from across the whole community in order to support access to healthier food choices for our Tamariki. Breastfeeding is strongly protective in maintaining healthy weight, yet we see very little improvement in our breastfeeding rates with significant variations in breastfeeding rates by	The Best Start: Healthy Eating and Activity plan has been approved and endorsed all the Board and DHB councils. The plan has key objectives: • Increasing healthy eating environments, by increasing healthy eating choices and physical activity opportunities. • Developing and delivering prevention programmes which include food literacy, maternal nutrition, implementing policy and physical activity. • Interventions which support children to have healthy weight. • Providing leadership in Hawke's Bay for health eating. The plan was developed using the evidence base and community input – both supporting early intervention by focusing on childhood healthy weight beginning with healthy weight during pregnancy. This Plan has been shared with other DHB's and the sector in HB. Currently delivered activities include: • Gestational diabetes screening and support, all women identified are screened and supported • Maternal GRx programme 160 referral (July 2015 – June 2016) 50% Maori and Pasifika • Breastfeeding support/resources via KE and TToH • Promoting World Breastfeeding Week- Facebook brelfies, breastfeeding friendly cafes were the focus. 174 women accessing supporting via Kahungunu Executive and Te Taiwhenua O Heretaunga (Last financial year)

		ethnicity. We need to understand better why to support women to breastfeed and increasing breastfeeding rates. **CONCLUSION** It is critical to invest in the prevention and management to increase healthy weights over a long term in order to reap the benefits of healthy weight young children - including cementing the behavioural and environmental changes that can support ongoing healthy weights.	• Active Families under 5 – 57 whanau engaged 67% Maori. 72% are more active and 63% note improved healthy food choices. • Healthy First Foods 0-2 year, deliver via Plunket and Well Child Tamariki Ora provider. 100 families engaged 69% Maori. Launching Healthy Foods 2-5 years with B4 School Check Nurses • HBDHB Healthy Eating Policy adopted including educative traffic light model, supporting breastfeeding for staff/visitors/patients • School and environment survey for HB conducted with Informus • Funding secured to support the school based programme. • Promoting "Water Only School" message and supporting 6 schools to extend their water only policy.

HAWKE'S BAY District Health Board Whakawāteatia	**Internal Review – Gastro Outbreak Havelock North**
	For the attention of: **Māori Relationship Board, HB Clinical Council and HB Health Consumer Council**
Document Owner: Document Authors:	Kate Coley Director of Quality Improvement & Patient Safety Kate Coley and Ken Foote
Reviewed by:	Ken Foote, HBDHB Board
Month:	September, 2016
Consideration:	For Information and feedback

RECOMMENDATION

That the Maori Relationship Board, Clinical and Consumer Councils:

1. Note the intent to undertake a full review of HBDHB's reponse to the recent gastro outbreak in Havelock North.
2. Note the Review Co-ordinator position overview.
3. Note the Review Framework.

PURPOSE

The purpose of this paper is to provide EMT & Board with the opportunity to provide input on the draft framework for an internal review of the Gastro Outbreak in Havelock North.

EXECUTIVE SUMMARY

In light of the proposed independent inquiry by the government, and in line with our normal procedures, following the implementation of a CIMS structure, HBDHB will undertake a full review of our reponse to the recent gastro outbreak in Havelock North.

The review will be run by a designated review co-ordinator (overview of position attached), supported during the period with other individuals, to gather all information and analyse this to inform the drafting of a report.

Also attached is an overview of the intended review framework.

HAVELOCK NORTH GASTRO INCIDENT

HBDHB Review Coordinator

PURPOSE

Co-ordinate and support the process of debriefing and reviewing health sector responsibilities and involvement in the Havelock North Gastro Incident, and prepare a comprehensive HBDHB Report.

TASKS

- Develop a plan for debriefing and reviewing health sector involvement in response, communications and recovery
- Oversee internal review of HBDHB practices and procedures in relation to drinking water, including:
    - Standard monitoring and management issues
    - Mechanisms for identification of a potential 'outbreak' or other significant public health issue
    - Contingency plans for responding to such an 'outbreak'/issue
    - Previous intelligence and actions relating to Brookvale Road bore contamination
- Delegate tasks as appropriate, including facilitation of stakeholder surveys and debriefs
- Coordinate and consolidate all relevant data, documentation, debriefs and reviews
- Draft a comprehensive report
- Finalise report after peer review
- Coordinate HBDHB organisational input into Government Inquiry
- Follow up on 'lessons learned' to ensure all recommendations are implemented

DELEGATION

- Delegated authority from HBDHB CEO to:
    - Require performance of tasks set out in the Review Plans
    - Direct priority of action (after consultation where appropriate).
- No specific financial delegations but may request allocation of resources to achieve review tasks
- Liaise with Ministry of Health and HDC as appropriate.

ACCOUNTABILITY

- Accountable to HBDHB CEO

GASTRO OUTBREAK REVIEW FRAMEWORK

PURPOSE	METHODOLOGY / APPROACH	KEY STAKEHOLDERS	OTHER AREAS TO CONSIDER	REPORT OUTLINE	REVIEW PROCESS	TIMEFRAME
• Review of how HBDHB responded to the gastro outbreak in Havelock North • Ensure that HBDHB met all of its legislative requirements & obligations • Review of HBDHB practices and procedures in relation to drinking water • Identification of: - Positives - Issues - Areas of concern • Any learnings • Recommendations for the future • Follow up on implementation of agreed actions	• Staff Survey • Interviews / Debriefing with key stakeholders • Review of all documentation gathered during the period • Review of EOC processes • Review of current policy / procedures / guidelines in the event of a public health outbreak • Review of all policies, guidelines, protocols in relation to water monitoring	Debriefs: • EOC Team Members • EMT • Directorate Leadership Teams • Staff Groups: - Public Health - ED/AAU - District Nursing - Infection Control - Communications • Ministry of Health • Age Residential Care facility managers (Havelock North) • PHO / GPs • Community Pharmacists • Hastings District Council • Consumer / Community – through linkages of Consumer Council	• Government inquiry - Linkage and liaison • Legislative requirements /Inquiries Act requirements • CIMS / EOC Structure and Functioning	• Executive summary • Background • Analysis/data/business intelligence reports • Timeline of issues and activities • Findings: - Key Themes - Positives - Negatives - Impact on business as usual - Learnings • Recommendations • Next steps / implementation • Monitoring and progress reports • Preparation for Government inquiry - Risks for DHB • Summary of Appendices on response and water monitoring practices	• Framework approved (EMT, Board) • Communication to all staff with regards to the internal review • Engage support • Gathering of information / data • Analysis / theming • Verbal Update - Board • Drafting paper • Review by: - EMT - Clinical Council - Consumer Council • Review by legal • Finalise Report • Endorse by Board • Circulation of report • Monitor implementation of agreed actions	• 30 & 31 August • 1 September • W/C 5 September • 12 – 26 September • 26 – 30 September • 28 September • 26 – 7 October • 11 October • 12 October • 13 October • 10 – 14 October • 17 – 21 October • 26 October • Post Board meeting • Agreed timeline

17.1

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:

19. Minutes of Previous Meeting (Public Excluded)

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

21. Health Awards

22. Serious Adverse Events Draft

23. Member Topics of Interest

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).